Introduction

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
I.1	5/1/24	850	I.1	The purpose of Summer EBT.
I.2	5/1/24	850	I.2	Added Summer EBT to Emergency and Special Assistance Programs list.
I.3				

I.1 IMM OVERVIEW

The primary purpose of the Income Maintenance Manual (IMM) is to document and communicate the West Virginia Department of Human Services (DOHS) policies and procedures related to determining initial and ongoing eligibility for the DOHS's Income Maintenance and Emergency and Special Assistance programs. The IMM is used by DOHS staff and the public.

DOHS makes every attempt to ensure that the information contained in the IMM is accurate as of the date of issuance. Compliance with all applicable West Virginia state laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations, is required. Specifically, readers must consider the content in this manual, along with applicable federal and state laws and regulations, when determining actions or interpreting guidelines.

Disclaimer regarding gender-specific terms: Throughout the IMM, whenever a gender-specific term is used, it should be understood as referring to both genders, unless explicitly stated. This is done solely for the purpose of making the text easier to read, and no offense or sexism is intended.

The programs covered by the IMM, in alphabetical order, are:

- **AIDS Drug Assistance Program (ADAP)**, a state-administered program that provides Food and Drug Administration (FDA)-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare.
- **Low Income Energy Assistance Program (LIEAP)**, which partially offsets heating costs for eligible low-income individuals responsible for a home heating cost.
- **Medicaid,** which provides comprehensive health insurance for eligible low-income adults and children and the aged, blind or disabled. Medicaid also provides assistance with paying for Medicare cost-sharing for certain low-income individuals through the Medicare Buy-in Program. The Medicaid Work Incentive (M-WIN) program is a full coverage Medicaid group that assists individuals with disabilities in becoming independent of public assistance by enabling them to enter the workforce without losing essential medical care.
- **Non-Emergency Medical Transportation (NEMT),** a program which reimburses Medicaid and Children with Special Health Care Needs (CSHCN) clients for the cost of transportation and other expenses associated with receiving medical services.
- **School Clothing Allowance (SCA)**, two programs, WV WORKS School Clothing Allowance and West Virginia School Clothing Allowance, to assist eligible families with the purchase of clothes for school.

- **Special Pharmacy**, which provides state-funded assistance to qualifying individuals to pay for anti-rejection drugs needed after transplants, and certain anti-psychotic drugs.
- **Supplemental Nutrition Assistance Program** (**SNAP)**, formerly known as Food Stamps, which provides a monthly financial supplement to qualifying low income families to purchase nutritious food.
- **SNAP Employment and Training (SNAP E&T)**, which provides SNAP clients with opportunities to gain skills, training, or experience to improve their employment prospects and reduce their reliance on SNAP benefits.
- **West Virginia Children's Health Insurance Program (WVCHIP)**, providing comprehensive health insurance to certain children whose income is too high to be eligible for Medicaid.
- **WV WORKS**, West Virginia's implementation of Temporary Assistance for Needy Families (TANF), provides monthly cash assistance along with a variety of employment and education related services to low income families with dependent children with the goals of assisting economically dependent and at-risk families to become self-supporting, enhancing the well-being of children, and assisting families near the poverty level to remain self-sufficient.

Policies related to Emergency and Special Assistance Programs are also included in the IMM.

- **Emergency Assistance**, which is used to help qualifying individuals and families address a financial crisis when they are without available resources.
- **Indigent Burial**, which provides assistance with a decent burial for qualifying low-income individuals who die and have no resources to pay for the interment costs at the time of death.
- **Special Reduced Residential Service Rate (20% Utility Program),** which enables certain SNAP, Supplemental Security Income (SSI) and WV WORKS clients to receive a 20% discount from their natural gas, electric and water companies during the winter months.
- **Summer EBT (SEBT)** provides summer feeding assistance to income eligible children whose school participates in the National School Lunch Program (NSLP) and receives free or reduced priced meals, or receives another qualifying benefit administered by the Department.
- **Tele-Assistance and Lifeline**, which provide reduced rate telephone service to qualified low-income individuals.
- **Refugee Assistance**, which provides cash and medical assistance to eligible refugees, regardless of nationality.

I.2 IMM STRUCTURE

IMM Chapters 1 through 15 cover common processes used by Medicaid, Supplemental Nutrition Assistance Program (SNAP), and WV WORKS, and may apply to other programs. These chapters first present policies and procedures common across multiple programs, with exceptions noted, and then describe program specific requirements starting with SNAP, followed by WV WORKS, then Medicaid coverage groups.

IMM Chapters 16 through 28 are program-specific. If a program name appears in a chapter title, then that chapter applies only to that program. For example, “Chapter 16, Specific SNAP Program Requirements,” contains information pertinent only to SNAP.

Following this Introduction are three reference sections:

- The List of Acronyms defines common acronyms used throughout the IMM and identifies the chapters in which they appear.
- The List of Forms identifies all of the state forms referenced in the IMM, by form number and common name.

  The Glossary defines common terms used throughout the IMM and identifies the chapters in which they appear. Terms used in only one chapter are defined in that chapter.

The table below summarizes the purpose and content of each chapter.

#	Name	Brief Description
1	Application/Redetermination Process	Explains the common program application and redetermination policies and procedures as well as those specific to SNAP, WV WORKS, Medicaid coverage groups, and other DOHS healthcare assistance programs.
2	Common Eligibility Requirements	Describes eligibility requirements common to SNAP, WV WORKS, Medicaid, WVCHIP, Special Pharmacy, and ADAP.
3	Eligibility Determination Groups	Contains the policy for SNAP, WV WORKS, and all Medicaid coverage groups used to determine: • The Assistance Group (AG) - Who receives the benefit; • The Income Group (IG) - Whose income and assets are counted; and • The Needs Group (NG) - Whose needs are considered
4	Income	Contains the policies for determining income eligibility for SNAP, WV WORKS, most Medicaid coverage groups, and other DOHS

#	Name	Brief Description
		healthcare assistance programs. Instructions for defining income and determining when it is counted are also included.
5	Assets	Contains the policies for determining asset eligibility for SNAP, WV WORKS, and most Medicaid coverage groups. Instructions for defining assets, determining when they are counted, and determining their value are also included.
6	Data Exchanges	Describes the electronic data sources used to verify information reported by the client, when they can be used, and for which programs.
7	Verification	Explains the general verification process and requirements for SNAP, WV WORKS, most Medicaid coverage groups, and WVCHIP.
8	Resource Development (WV WORKS and Medicaid only)	Describes the requirements and processes to assist clients in developing alternate or additional sources of income to reduce or eliminate the need for WV WORKS and Medicaid.
9	Client Notification	Defines notification requirements for SNAP, WV WORKS and most Medicaid coverage groups, and explains the specific notices used by each program for common notification actions.
10	The Case Maintenance Process	Describes all activities that are required between assistance group (AG) approval and the first redetermination, and between subsequent redeterminations, to ensure only eligible clients receive benefits and the benefit amounts are correct.
11	Benefit Repayment	Provides detailed instructions for taking corrective action when it is discovered that excess benefits have been issued.
12	Benefit Replacement	Contains policies and procedures related to replacement of benefits, electronic benefit transfer (EBT) cards, and personal identification numbers (PIN).
13	Determining Disability, Incapacity and Blindness	Explains how disability is established for programs which require that a medically determined physical and/or mental impairment exist for the client and/or family to receive benefits.
14	Work Requirements (SNAP and WV WORKS only)	Details work requirements for SNAP and WV WORKS. There are no work requirements for Medicaid.
15	Noncitizens, Refugees and Citizenship	Describes the documentation requirements for identifying the noncitizen’s immigration status.
16	Specific SNAP Program Requirements	Sets forth specific policies and procedures which apply only to SNAP, including special living situations and emergency SNAP assistance for disaster victims.

#	Name	Brief Description
17	SNAP Employment & Training (SNAP E&T)	Describes SNAP E&T activities, as well as application, eligibility, and case management processes.
18	WV WORKS Activities/ Requirements	Describes the work requirements of WV WORKS and the services available to assist participants in meeting these requirements and maintaining independence from cash assistance.
19	School Clothing Allowance	Sets forth specific eligibility and case maintenance policies and procedures which apply to the WV WORKS School Clothing Allowance (SCA) program and the West Virginia School Clothing Allowance (WVSCA) program.
20	Emergency and Special Assistance Programs	Contains the application, eligibility, and case maintenance requirements and processes for the following programs: Emergency Assistance, Indigent Burial, Special Reduced Residential Service Rate (20% Utility Discount Program), Summer EBT, Tel-Assistance, and Lifeline.
21	Low Income Energy Assistance Program (LIEAP)	Describes the benefits, as well as the outreach, application, eligibility, and case maintenance requirements and processes.
22	West Virginia Children's Health Insurance Program (WVCHIP)	Presents information about the application, eligibility and case maintenance process for this health insurance program for children birth to age 19.
23	Specific Medicaid Requirements	Provides an overview of the Medicaid program and specific requirements that must be met and procedures to follow.
24	Medicaid Long Term Care	Describes the policies and procedures for long term care nursing facility coverage, waiver services, and Children with Disabilities Community Service Program (CDCSP).
25	Medicare Buy-In Procedure	Describes the buy-in process whereby DOHS pays the Medicare Part A and/or Part B premium for certain Medicaid clients who are also eligible for Medicare.
26	Medicaid Work Incentive (M-WIN)	Outlines the specific guidelines for determining eligibility and conducting case management for this Medicaid coverage group.
27	Non-Emergency Medical Transportation (NEMT)	Describes the eligibility requirements for NEMT.
28	Special Pharmacy	Describes the eligibility and case maintenance process to the Special Pharmacy Program, which help pay for certain necessary drugs for individuals not eligible for Medicaid.

I.3 IMM CHANGE PROCESS

DOHS updates the IMM on a regular basis in order to remain consistent with changing state and federal policies and regulations.

Changes are documented and communicated in two ways:

1. By DW-17 number, also known as the “change number.” The DW-17 summarizes all of the IMM changes made at a single point in time, by chapter. The DW-17s can be found and searched on the DOHS website at: http://www.DoHS.wv.gov/bcf/Services/familyassistance/Pages/IMMSearch.aspx.

2. Within each chapter, the “Change Log” following the Table of Contents, documents the date a section was changed, the associated DW-17 number, and highlights the specific changes made.

Chapter 1

Application/Redetermination Process

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
1.1				
1.2	6/1/19	772	1.2.3.A	Outlining worker responsibilities for certain felonies
	4/1/20	784	1.2.2.A 1.2.6, B & C 1.2.9 1.2.11 1.2.12.B.3 1.2.12.E	Changed inROADS to WV Path
	5/1/20	785	1.2.1.E.1	Defining major life activities in reference to ADA
	4/1/21	803	1.2.1.D	Changed phone number for DFA.
	5/1/21	804	1.2.6.C	Removed word citizenship.
	7/1/21	806	1.2.1.E.3 1.2.1.E.4	Detailed Worker Responsibilities Changed (OMRS) to (RRIS)
	9/1/21	808	1.2.3.A	Removed language regarding reactivation
	5/1/22	821	1.2.10.A	Clarification on when to accept late verification
	6/1/22	822	1.2.3.A&E 1.2.5 1.2.12.D	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	10/1/22	828	1.2.1.E	Update complaint procedure & Nondiscrimination
	4/1/23	835	1.2.11	Added new policy - when Medicaid or WVCHIP coverage is closed for failure to submit a redetermination form, the 90-day reconsideration period applies to all Medicaid and WVCHIP coverage groups.
	7/1/23	838	1.2.1.E	Corrected FNS web address

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	12/1/23	844	1.2.3.A	Clarified USDA FNS intent that screening and referral process for SNAP E&T is a function and responsibility of eligibility.
	3/1/24	848	1.2.3.F 1.2.3.F.2	Updated worker's responsibility Removed worker must use his best judgment and added the client should self-identify to their race-ethnicity per FNS Final Rule Revision of Civil Rights Data Collection Methods
	5/1/24	850	1.2	Added the Summer EBT Program
	9/1/24	854	1.2.6.B 1.2.6.C	Added WV WORKS to list of online applications for WV PATH. Removed reference to SNAP and SCA from Community Partners section.
	2/1/25	860	1.2.3.A	Removed and combined two worker requirements; added a bullet to clarify what it is to screen an adult SNAP applicant/client for work requirements.
	3/1/25	861	1.2.3.A	Added back the requirement to provide the oral explanation of SNAP work requirements.
	4/1/25	862	1.2.3.A	Making a correction to the manual to include WVCHIP's obligation to provide each applicant with a copy of Notice of Privacy Practices (NOPP) and notify the client of the eligibility decision within the appropriate time frame.
	6/1/25	864	1.2.2.D	Removed sentence requiring Medicaid clients to apply for alternate means of support. Added requirement for Medicaid applicants and clients who qualify for Medicare buy-in program to enroll in Medicare Parts A and B as a condition of eligibility.
1.3	4/1/20	784	1.3.1.B & 2 1.3.4.A.2 1.3.5	Changed inROADS to WV Path
	7/1/21	806	1.3.1.A.3	Clarified that both parents must sign
	5/1/23	837	1.3.4.B	Clarifies the DFA-MA-1 can be used to apply for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI-1).
	9/1/24	854	1.3.1.B.1	Add WV WORKS to list of applications to be applied for through WV PATH.
1.4	5/1/19	771	1.4.17.C.2	Revised language for drug felons

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	5/1/19	771	1.4.17.C.5	Revised language for drug felons
	6/1/19	772	1.4.17.C.2	Lottery and gaming winnings
	12/1/19	779	1.4.2	Clarifying what constitutes as a completed SNAP application
	4/1/20	784	1.4.1	Changed inROADS to WV Path
			1.4.3	
			1.4.4, A&B	
			1.4.9	
			1.4.13	
			1.4.18.A&D	
			1.4.19.C	
	10/1/10	794	1.4.17.C	Replaced ineligible and alien
	6/1/21	805	1.4.1.E	Removed language about ABAWD
	6/1/21	805	1.4.17.C.1	Replaced voucher with benefit
	9/1/21	808	1.4.7	Removed language regarding reactivation
			1.4.19.C.1	Updated definitions for Admin. Terminal
	1/1/22	814	1.4.1.D	
	2/1/22	816	1.4.1.D	Updated definition of PRC-2 form
	7/1/22	824	1.4.18.A	When CSLE/CSLR is mailed
			1.4.18.E.2	Clarify CSLE/CSLR
	1/1/23	830	1.4.2	Wording updated for clarification.
	9/1/23	840	1.4	Added new purpose for SNAP
			1.4.1.F	Face-to-Face language waiver removed
	2/1/25	860	1.4.4	Clarify when a second signature/CAF is required at application.
			1.4.7	Updated and clarified worker screening for SNAP work requirements.
	7/1/25	866	1.4.1.D	Explains each element of the PRC-2 and what constitutes a completed PRC-2.
	1/1/26	872	1.4.1.D	Change 12 months to 6 months.
			1.4.14	Change 12 months to 6 months.
			1.4.14.A.1	Updated details in the on month and two-month certification sections. Change 12 months to 6 months.
			1.4.14.A.2	PRC-2 process is now specific to the 24-month certification population only (AD).
			1.4.14.B.1	Change 12 months to 6 months.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			1.4.14.B.2	Change 12 months to 6 months.
			1.4.20	Establishes the prohibition on using SNAP benefits to purchase soda in West Virginia beginning January 1, 2026.
			1.4.20.A	Defines the soda restriction, specifying it applies to all soda products (regular, diet, zero-calorie)
			1.4.20.B	Clarifies that only Soda is restricted; milk, juices and water remain eligible for purchase with SNAP benefits.
			1.11.5.B	Indicated that for SNAP it is 6 month and TANF it is 12-month certifications.
1.5	10/23/17	746	1.5.7D	Policy was added to include drug use requirements as part of the initial interview for applicants of WV WORKS.
			1.5.9	The drug use questionnaire must be completed within 10 working days of the initial contact when a client expresses an interest in applying for WV WORKS.
			1.5.11	Added policy regarding the requirements of a payee for the WV WORKS benefit for not cooperating with drug testing.
	4/1/18	755	1.5.7.A.2	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/18	756	1.5.18	Clarified positive drug test must not be offered DCA
	5/1/19	771	1.5.18	Moved language from 18.19.3.G
	6/1/19	772	1.5.8	Application processing due to non-receipt of compliance
	6/1/19	772	1.5.9	Removed duplicate sentence
	9/1/19	776	1.5.19	Clarified WV WORKS orientation may be completed individually or in a group.
	3/1/20	782	1.5.7.E & 1.5.8.18	Changed language to transitional benefit
	4/1/20	784	1.5.17.B.2 & 1.5.18	Changed inROADS to WV Path
	7/1/20	788	1.5.18.A	Clarified DCA eligibility after a sanction period.
	7/1/21	806	1.5.22.B	Mentioned use of ADARA-1 to capture ADA accommodations within WV WORKS
	9/1/21	808	1.5.7.G.2 1.5.17.B.1	Removed language regarding expunged accounts Updated definitions for Admin Terminal & expunged
	3/1/22	818	1.5.7 & 17	Expungement changed to 365 days

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	6/1/22	822	1.5.7.A.3 1.5.18 1.5.19.C 1.5.22.F 1.5.7.G	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	7/1/22	824	1.5.17.B.1 1.5.16	Clarify WV WORKS expungement. Clarify WV WORKS expungement.
	7/1/23	838	1.5.20 1.5.21 1.5.22.A 1.5.22.E 1.5.23.B	References to the WV WORKS Coaching Conversation Guide (DFA-WVW-CCG-1) were removed. Removed statement that the PRC is the same for all participants. Updated to include the Initial SSP with the PRC. References to the WV WORKS Coaching Conversation Guide (DFA-WVW-CCG-1) were removed. Removed references to The Referral Form for Accommodations for the Disabled, DFA-ADA-1, and Follow-Up to DFA-ADA-1, DFA-ADA-1a.
	5/1/24	850	1.5.7.D 1.5.17.B.1 1.5.18.A	Clarified that only work-eligible individuals must complete the drug questionnaire. Add expungement information for Summer EBT. The applicant will be required to attend Orientation, sign the DFA-WVW-4 and the List of Local Services.
	9/1/24	854	1.5.1 1.5.2 1.5.3 1.5.9 1.5.16	Add online application as a method of applying for WV WORKS. Add an application is complete when the client submits an online application. The rights and responsibilities are included with the online application, the DFA-RR-1 is not required. If the online application Is not complete or additional relevant information is discovered during the face-to-face interview, a new DFA-2 and DFA-RR-1 will be required. Add the date of application is the date the application is submitted online. And a referral to see section 1.2 for the online process. Add online application to agency time limits. A new DFA-2 or online review is required for redetermination. Individuals submitting electronic reviews must electronically sign.
	1/1/25	859	1.5.17	Add minimum benefit issuance is $35 and maximum benefit issuance is $811.
	3/1/25	861	1.5.9	Online applications must be issued an appointment notice to complete the above requirements when the

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				applicant is unable to be reached by phone to schedule the face-to-face interview.
	6/1/25	864	1.5.18	Wording removed regarding relocation payments, did not apply to this chapter.
	2/1/26	873	1.5.16	The eligibility system schedules a redetermination due to receipt of another benefit, such as SNAP benefits, under the same case number.
1.6	4/1/18	755	1.6.11.B	Reflect the December 2017 change in the way Medical ID cards are issued.
	6/1/18	760	1.6.11.A.1	Updated to include the steps required when the Marketplace determines potential eligibility for a MAGI coverage group
	6/1/18	760	1.6.11.B.1	Updated language to change HBPE to PE. Also changed the word hospital to Qualified Provider when the text refers to a facility making a presumptive eligibility decision.
	4/1/20	784	1.6.1 1.6.4 1.6.5 1.6.11.B	Changed inROADS to WV Path
	7/1/20	790	1.6.5	Added policy regarding designation of authorized reps
	1/1/23	830	1.6.11.B	Remove West Virginia from WV Foster Care.
1.7	4/1/18	755	1.7.3 1.7.8.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.7.7.B	Changed inROADS to WV Path
	5/1/22	821	1.7.4	Changed from 13 calendar days to 13 business days
	5/1/25	863	1.7.7.A	Removed language referencing compatibility provisions
1.8	4/1/18	755	1.8.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	5/1/19	771	1.8.6.A	Added timeframes that had been removed
	4/1/20	784	1.8.6.A	Changed inROADS to WV Path
	1/1/23	830	1.8.7.C	The provider was changed from Molina Medicaid Solutions to Gainwell Technologies.
	12/1/24	858	1.8.1	Updated language for who can be included on a Medicaid Application.
	5/1/25	863	1.8.6.A	Removed language referencing compatibility provisions
1.9	4/1/18	755	1.9.6.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/22	819	1.9.5	Change to postpartum period
	4/1/22	819	1.9.6.B	819
1.10	4/1/18	755	1.10.6.A	Reflect the December 2017 change in the way Medical

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				ID cards are issued.
	4/1/20	784	1.10.5	Changed inROADS to WV Path
1.11	4/1/18	755	1.11.2, 1.11.6.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.11.5.B	Changed inROADS to WV Path
	5/1/25	863	1.11.5.A	Removed language referencing compatibility provisions
1.12	4/1/18	755	1.12.1.C.1	Reflect the December 2017 change in the way Medical ID cards are issued.
1.13	4/1/18	755	1.13.3.A	Reflect the December 2017 change in the way Medical ID cards are issued.
1.14	4/1/18	755	1.14.7, 1.14.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	7/1/24	853	1.14.1	Corrected spelling error for the word process.
	10/1/24	857	1.14.1	Added new policy that SSI Medicaid recipients entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B are deemed eligible for QMB coverage.
			1.14.5	Added the term SSI to indicate the policy is for the beginning date of eligibility for SSI coverage only. Added the policy for when deemed QMB coverage begins.
			1.14.7	Added language referring to 10.14.1 for closures of SSI Medicaid cases.
	5/1/25	865	1.14.1	Added note referencing policy regarding SSI and Medicare eligible individuals.
			1.14.6	Added reference to policy regarding the loss of SSI eligibility for Deemed QMB eligible individuals.
1.15	4/1/18	755	1.15.3, 1.15.3.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.15.2	Changed inROADS to WV Path
1.16	4/1/18	755	1.16.4, 1.16.11.A, 1.16.11.B	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.16	Changed inROADS to WV Path
	5/1/23	837	1.16.1	Updated to clarify all the applications that can be used to apply for Medicare Premium Assistance Programs per section 1.3
	6/1/24	851	1.16.10.C	Added language regarding the automatic renewal

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	4/1/25	862	1.16.10.C	process for Non-MAGI Medicaid SSI-Related/Non-Cash Assistance. Removed language referencing reasonable compatibility provisions.
	5/1/25	865	1.16.1 1.16.10	Added policy that there is no application process for SSI and Medicare eligible individuals. Added policy that SSI and Medicare eligible individuals have no redetermination schedule.
	6/1/25	864	1.16.9.C, 1.16.10.B, 1.16.10.C 1.16.10.D.1 1.06.10.D.2 1.16.11.B.1	Removed policy regarding backdating of QI-1 into the previous year. Updated section title to include QI-1. Removed section regarding period of eligibility for QI-1 beginning annually in January. Added QI-1 to the policy regarding refunds of Medicare premiums from SSA when coverage is backdated.
1.17	4/1/18	755	1.17.3, 1.17.7	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.17.1	Changed inROADS to WV Path
1.18	4/1/18	755	1.18.9.A.1, 1.18.10.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.18.1	Changed inROADS to WV Path
1.19	4/1/18	755	1.19.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.19.1	Changed inROADS to WV Path
	11/1/23	842	1.19.6	Extend redetermination from six to twelve
	6/1/24	851	1.19.6	Added language regarding the automatic renewal for Non-MAGI Medicaid SSI-Related/Non-Cash Assistance.
	4/1/25	862	1.19.6	Removed language referencing reasonable compatibility provisions.
1.20	4/1/18	755	1.20.7.A.1, 1.20.7.B	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.20.1	Changed inROADS to WV Path
1.21	4/1/18	755	1.21.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.21.6.B	Changed inROADS to WV Path

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	1/1/23 4/1/25	830 862	1.21 1.21.6.A	Remove West Virginia from WV Foster Care. Removed language referencing reasonable compatibility provisions.
1.22	10/1/20	794	1.22	Replaced word illegal
1.23	4/1/18 4/1/20 6/1/24 7/1/24	755 784 851 852	1.23.10 1.23 1.23 1.23 1.23.4 1.23.5 1.23.6 1.23.7 1.23.10	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path Clarified the application process for the ADAP program that if a client is determined ineligible for all full-coverage Medicaid groups, the ADAP application is completed. Changed who makes the ADAP eligibility decision from Bureau for Medical Services (BMS) with AIDS Drug Assistance Program (ADAP). Changed to correct form to be signed to ADAP application. Updated ADAP's contact information. Updated to ADAP from BMS. Updated to ADAP from BMS. Updated to ADAP from BMS.
1.24	4/1/18 8/1/23	755 839	1.24.1 1.24.1 1.24.2	Reflect the December 2017 change in the way Medical ID cards are issued. Update BCC application process and clarify WVBCCSP relationship with BCC. Update redetermine process as well.
App A	4/1/20 10/1/20 6/1/21 11/1/24	784 794 805 856		Changed inROADS to WV Path Replaced Illegal Replaced voucher with benefit Corrected for Children Under Age 19 and Pregnant Women Group to have 13 business days instead of 13 calendar days to complete applications.
App B	6/1/22	822		Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
App C				
App D	4/1/18 3/1/20 6/1/22	755 782 822		Reflect the December 2017 change in the way Medical ID cards are issued. Changed language to transitional benefit Corrected Day Care to Child Care and removed GED & Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
App E	4/1/20 10/1/22	784 828		Changed inROADS to WV Path Corrected WVSOS email address

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
App F				
App G				

1.1 INTRODUCTION

This chapter describes the application and redetermination processes for the Supplemental Nutrition Assistance Program (SNAP)—formerly known as the Food Stamp Program, WV WORKS and Medicaid coverage groups, except those related to long term care. (See Chapter 24). Also included is specific information about each program.

Common requirements not specific to any program or coverage group are included together. The common section is followed by a section describing all of the Department of Human Services' (DOHS) application forms. The remaining sections cover policies and procedures specific to each program or Medicaid coverage group.

1.2 COMMON INFORMATION

This section contains general information about the application process and information common to the Supplemental Nutrition Assistance Program (SNAP), WV WORKS and most Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) coverage groups.

1.2.1 APPLICANT'S AND POTENTIAL APPLICANT'S RIGHTS

1.2.1.A Right to Apply

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.

NOTE: The applicant may designate a representative to act on their behalf, known as an "Authorized Representative." Each program has specific requirements related to the Authorized Representative.

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

Certain programs, such as Children with Disabilities Community Service Program (CDCSP), Intellectual and Developmental Disabilities (I/DD) Waiver, Aged and Disabled Waiver (ADW) and Traumatic Brain Injury (TBI) Waiver, require a medical and/or other determination by a community agency or government division other than the DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, such programs is pending, he must not be refused the right to apply, but must be evaluated for any or all Department programs.

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 Community Services Manager (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 at the scheduled time, he

must be seen on that day and not be required to return again to complete the application process.

SNAP ONLY: SNAP applicants must be given a scheduled interview if 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.

1.2.1.B Right to General Information

The Worker must provide the requested information to all those who have applied for benefits, or who inquire about the requirements for receiving benefits. This information 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 appropriate Policy Unit.
- Applicants, potential applicants, or their authorized representative must not be referred to the Policy Unit for a direct response.
- The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation.

1.2.1.C Right to Consideration for All Programs

It is the Worker's responsibility to explain and make available all of the Department of Human Services' (DOHS) programs for which the applicant could qualify. The Worker must evaluate potential eligibility for all programs based on the available information, unless the applicant specifically states he is not interested in being considered for a specific program.

When an applicant has been evaluated and eligibility is confirmed, a client notice is issued from the eligibility system 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.

1.2.1.D 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 contact with the DOHS in conjunction with benefits. If the contact is made via any method other than a face-to-face, the application and declination form must be mailed to the client.

West Virginia election laws require that DOHS offices provide voter registration services in conjunction with the following benefits:

- WV WORKS
- SNAP
- Low-Income Energy Assistance Program (LIEAP)
- Medicaid

NOTE: When an individual who applied for Medicaid through the Federally Facilitated Marketplace (FFM) expresses to the DOHS an interest in voter registration, the Worker must provide a voter registration application. The Worker must also send 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 E, F, and G for Worker, County, and State Coordinator responsibilities related to assistance with voter registration.

The BFA State Coordinator may be contacted at 304-352-4431.

1.2.1.E Right to Fair and Equitable Treatment of Applicants and Clients

West Virginia has established procedures for ensuring fair and equitable treatment of applicants and recipients of public assistance (clients). The DOHS prohibits discrimination against its applicants and clients on the basis 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 DOHS. (Not all prohibited bases will apply to all programs and/or employment activities.)

Applicable state and federal laws include the following:

- 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
- United States Department of Agriculture (USDA) Departmental regulation 4330-2
- USDA Regulation, 7CFR Part 16

1.2.1.E.1 Individuals with Disabilities

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;
- Has a record of such an impairment; or
- Is being regarded as having such an impairment.

NOTE: Major life activities are defined in this manual's glossary.

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

1. 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.

2. 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.

1.2.1.E.2 Individuals with Limited English Proficiency (LEP)

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.

1.2.1.E.3 Worker Responsibilities

The Worker has the following responsibilities to ensure fair and equitable treatment of applicants and clients:

- 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 , or an individual informs the agency, 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 Some examples of reasonable modifications or accommodations can be found below in 1.2.1.E.4.

  - A reasonable accommodation can be requested for physical, mental or LEP (limited English proficiency) issues that would present a barrier to accessing programs and services. The worker must use the DFA-ADARA-1 (Family Assistance Reasonable Accommodations Report Form) to capture any information about the barrier and the disposition of the reasonable accommodation request. A copy of the DFA-ADARA-1 should be placed into the case record and a copy made available to the BFA ADA Coordinator. A copy of the DFA-ADARA-1 must also be made available to the client upon request.

  - The worker must honor the right of the client to fair hearings regarding reasonable accommodations and is responsible for sending this information to the Office of Inspector General, Board of Review.

- If an individual requires an interpreter, the Worker must contact local resources to locate one.

- Enter an indicator in the case record to alert that an accommodation may be needed and also to track cases for Federal reporting requirements.

1.2.1.E.4 Methods and Examples of Accommodations

At this time, West Virginia offers the following methods of accommodations to all applicants and clients:

➢ *Sign Language Interpretation*

The Worker must:

- Attempt to locate free certified sign language interpreters in the community in advance.
- Contact the Commission for the Deaf and Hard of Hearing in advance to locate names and numbers of local interpreters (if any).
- Contact the current contract holder for language translation and interpreter services.

➢ *Visual Impairment Services*

Provide general public information in a method accommodating the individual's visual impairment.

Public entities such as the DOHS 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.

➢ *Foreign Language Interpreter Services*

If an individual requires an interpreter, the Worker must contact local resources to locate one. If a local community resource cannot be located, the Supervisor of the Worker must contact the DFA Policy Unit for assistance. Following is information about some resources:

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

- Community Resources: Examples of community resources include, but are not limited to the Board of Education, local colleges, and the Division of Rehabilitation Services (DRS).
- Participants in the Refugee Assistance Program: Interpreter services are available for individuals who are participating in the Refugee Assistance Program (See Section 15.8). A request for services can be made by contacting the following agency:

  Refugee Resettlement and Immigration Services
  827 Fairmont Road, Suite 203
  Morgantown, West Virginia 26501
  (304) 343-1036

> **Accommodations for an Individual with Disabilities Example 1:** 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.
>
> **Accommodations for an Individual with Disabilities Example 2:** A client is physically unable to come to the local office for appointments made to keep his benefits. A reasonable accommodation is for the Worker to arrange to do a phone interview and/or a home visit, if necessary.
>
> **Accommodations for an Individual with Disabilities Example 3:** 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 workstation to conduct the interview.

1.2.1.E.5 Complaint Procedures – Client Responsibilities

Any person who believes that he or she has been the subject of discrimination on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisals and where applicable, marital status, familial or parental status, or retaliation for prior civil rights activity, 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 individual or his authorized representative can file 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:

West Virginia Department of Human Services
Office of Human Resource Management
EEO/Civil Rights Officer
One Davis Square, Suite 400
Charleston, West Virginia 25301

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

Centralized Case Management Operations
U.S. Department of Health & Human Services
Room 509F HHH Bldg
200 Independence Avenue, SW
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; and,
- The signature of the person or representative making the complaint.

➢ *SNAP Only*

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 (USDA)
Office of the Assistant Secretary for Civil Rights
1400 Independence Ave., SW
Washington, D.C. 20250-9410
(866) 632-9992

The individual may also file a Civil Rights program complaint of discrimination with USDA by completing the USDA Program Discrimination Complaint Form AD-3027, found online, 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
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
Fax: (202) 690-7442
Email: 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 (below is the link for a listing of hotline numbers by State): https://www.fns.usda.gov/contact-us.

1.2.1.E.6 Complaint Procedures – DOHS Responsibilities

Each complaint received must be investigated and corrective action taken, if appropriate. The investigations and corrective actions are handled in conjunction with DOHS's Equal Employment Opportunity (EEO) Officer.

Each DOHS office must post the American with Disabilities Act (ADA)/Section 504 Notice in a prominent area to provide information regarding rights under the ADA and Section 504.

➢ *SNAP Only*

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:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a complainant should complete a Form AD 3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1). Mail: Food and Nutrition Services, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or
(833) 620-1071; or
2) Fax: (833) 256-1665 or (202) 690-7442; or
3) Email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

1.2.2 OVERVIEW OF THE ELIGIBILITY DETERMINATION PROCESS

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

1.2.2.A 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, through the FFM, through People's Access to Help (WV PATH), in person, or it may be received by DOHS through the SSA's data exchange.

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

1.2.2.B Redetermination Process

Periodic reviews of total eligibility for recipients are mandated by federal law. These are redeterminations and take place at specific intervals, depending on the program or Medicaid coverage group. Failure by the client to complete a redetermination will result in termination of benefits. If the client completes the redetermination process by the specified program deadline(s) and remains eligible, benefits must be uninterrupted and received at approximately the same time.

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

1.2.2.C 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).

The case maintenance process may involve a review or activities that update the Department's information about the client's circumstances between the application and first redetermination and between redeterminations. Changes in eligibility or the benefit amount may occur. If so, eligibility 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.

1.2.2.D Resource Development

SNAP clients 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.

WV WORKS clients are responsible for taking necessary steps to apply for alternate available resources. This resource development is part of the Personal Responsibility Contract (PRC). See Section 8.2 for details and exceptions.

Medicaid applicants and clients who qualify for Medicare Buy-In must enroll in Medicare Parts A and B as a condition of eligibility; See Section 8.2.2 for details and exemptions. All other

Medicaid clients 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 Medicaid eligibility.

1.2.3 WORKER RESPONSIBILITIES

1.2.3.A General

The Worker has the following general responsibilities in the application process. Program-specific responsibilities are found in the program sections of this chapter. The Worker must:

- Accept an application from any person or his representative who wishes to apply.
- Determine if the applicant requires special assistance.
- Ensure the client is given the opportunity to apply for all of the Department's programs on the date that he expresses an interest.
- 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.

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

- Prior to eligibility 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 eligibility 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, or by telephone.
    - The Worker must determine if there is an existing EBT account. He must also inform the client of the availability of any balance remaining in the account.
- Obtain all pertinent, necessary information through verification, when appropriate.

- During the SNAP interview, explain to the client they are required to self-attest whether they or any other member of their household have been convicted of certain crimes as an adult and if they are complying with the terms of their conviction. See 3.2.1.B.3. The worker should emphasize this attestation is legally binding. If the applicant's attestation is questionable, the Agency must verify each element of the questionable attestation.
- Assist the client in obtaining information required to establish his eligibility.
    - Determine whether or not the client is able to cooperate.
    - If he is able, but has not complied, instruct the client 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.
- Maintain the confidentiality of all information received from or about the client.
- Per client request, make his case information available, including all electronic submissions and paper documentation, during normal business hours. See DOHS Common Chapters Section 230 for additional information.
- Ensure that copies of all pertinent information are placed in the client's case record or given to appropriate staff to file.
- Ensure that proper case recordings are made to document the Worker's actions and the reason for such actions.
- Ensure that information about available community resources addressing sexual harassment and domestic violence, sexual assault, and stalking 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. See Section 1.2.12.D, Special Situations for additional information about handling domestic violence situations.

- Inform the client that he is authorized to receive information and referral services about Temporary Assistance to Needy Families (TANF; i.e. WV WORKS) and other programs offered by the DOHS.
- Provide a voter registration application and declination form at any point a client engages in contact with the Department in conjunction with benefits. If the contact is made via any method other than a face-to-face, the application and declination form must be mailed to the client. See Section 1.2.1.D to assure compliance with this procedure.
- Prior to imposing any penalties or assigning any countable months for an ABAWD, screen all adult SNAP recipients at application and redetermination for:
    - All exemptions from the ABAWD time limit; and
    - Whether the individual should be referred to participation in SNAP E&T.

  The worker must provide an oral explanation of all SNAP work requirements to the client; this includes explaining ABAWD and Work Registration requirements and how to meet each work requirement. Any adult member of the SNAP AG can attest to ABAWD exemption information for another adult AG member.
- **MEDICAID/WVCHIP ONLY**: Provide each applicant with a copy of the Department's Notice of Privacy Practices (NOPP). This includes clients who are completing a redetermination. 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 DOHS HIPAA Privacy Officer. When an in-office intake interview is not 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/WVCHIP application and redetermination.
- Notify the client of the eligibility decision as soon as possible, but at least within the processing time frames for each program or Medicaid/WVCHIP coverage group.

NOTE: When an application has been made for WV WORKS and/or Medicaid/WVCHIP 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. See Section 1.2.9.

1.2.3.B 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 a home visit due to illness or inability to travel, when he has no person to act on his behalf.

NOTE: For SNAP, 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. The client may refuse entry to the Department's representative.

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

1.2.3.C Collateral Contacts

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/client of a department program.

1.2.3.C.1 SNAP Only Exception

DOHS 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 the official department letterhead of the issuing law enforcement agency and verifies the following:

- 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, 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 DOHS Common Chapters Sections 200 – 250.

1.2.3.D Coding Cases as Confidential

When the Worker is aware that an applicant is an employee of the Department, a relative of a Department employee, or otherwise clearly may have an interest in limiting access to his case information, he must notify his Supervisor. The Supervisor codes the case as confidential for the client's protection.

1.2.3.E Cases Involving Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking

When the client discloses a sexual harassment and domestic violence, sexual assault, and stalking 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 case must be coded in the eligibility system with the sexual harassment and domestic violence, sexual assault, and stalking indicator to alert all who access the case about the client's situation.
- Copies of any information that involve a sexual harassment and domestic violence, sexual assault, and stalking situation must never be placed in the case record to ensure the safety of the client and to ensure that the alleged abuser does not gain access to information that may compromise the safety of the client.
- If it is necessary to make contacts with a sexual harassment and domestic violence, sexual assault, and stalking agency or the Division of Children and Adult Services, or 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 that is secured and available only to Supervisors. Information maintained in a separate file regarding sexual harassment and domestic violence, sexual assault, and stalking may be presented as evidence at a Fair Hearing, as long as the client agrees to use of the information for such purpose.

- Information about a sexual harassment and domestic violence, sexual assault, and stalking situation or the whereabouts of an individual or family who has left a sexual harassment and domestic violence, sexual assault, and stalking situation for a safer residence must never be recorded in the case record, in order to ensure the safety of the individual or family.

1.2.3.F Determining Race and Ethnicity for Federal Reporting

It is the Worker's responsibility to ask the client during the interview process their race and ethnicity and correctly enter the information in the eligibility system.

1.2.3.F.1 Race

When a client identifies himself as being of a single race or a combination of races, the appropriate race is entered in the eligibility system. 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

1.2.3.F.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

For Medicaid or WVCHIP, if Hispanic or Latino:

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

> **Race and Ethnicity Example 1:** The client identifies his race as Black, with some Hispanic ancestry. His ethnicity is entered as “Hispanic or Latino.”
>
> **Race and Ethnicity Example 2:** The client identifies his race as White, with no Hispanic background. His ethnicity is entered as “None of the above.”

In all cases, the client should self-identify to their race and/or ethnicity. The worker should only choose no response if the client refuses to self-identify.

1.2.4 CLIENT RESPONSIBILITY

The client's responsibility is to provide complete and accurate information about his circumstances so that the Worker is able to make a correct determination about his eligibility.

1.2.5 INTAKE INTERVIEW

The policies in this section apply to interviews that are required, as well as interviews requested by the client.

WV WORKS, Emergency Low Income Heating Assistance Program (LIEAP), and Emergency Assistance require a face-to-face interview. An interview is required for SNAP but may be completed by phone or face-to-face. Medicaid does not require an interview.

The interview may be completed by the client or authorized representative visiting the office, or by the Worker 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 that is specific to a particular program.

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 household misses a scheduled interview appointment, it is the household's responsibility for rescheduling. To the extent practicable, the State agency must accommodate the applicant.

SNAP-ONLY EXCEPTION: 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.

Regardless of the program or Medicaid 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.
- Informing him that 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.
- 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 the benefits are 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 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 that address sexual harassment and domestic violence, sexual assault, and stalking issues is made available to all persons who could benefit from it. All clients who request assistance in dealing with sexual harassment and domestic violence, sexual assault, and stalking should be referred 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.

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.

1.2.6 APPLICATION SUBMISSION

The Department must accept applications submitted by mail, fax, in-person, telephone, or electronically through WV PATH, the Federally Facilitated Marketplace (FFM), or the Social Security Administration (SSA).

The Worker must accept an application from any person or his authorized representative who wishes to apply.

1.2.6.A Paper Applications

The Department responds to requests for applications to be mailed to potential applicants and accepts applications submitted by mail. 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 program or Medicaid coverage group 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.

1.2.6.A.1 Applications Requested by Telephone

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

- If the applicant wishes, a Worker will complete the application for him in a face-to-face interview, either in the office or in his home.
- 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 depending on the program, a face-to-face or telephone interview, if required.
- If the applicant wishes, he may complete the WV PATH application process, if applicable.

1.2.6.A.2 Applications Submitted by Mail

When the application form is returned containing at least the applicant's name, address, and signature, an application is considered complete and requires action from the Worker to Approve, Deny, or Withdraw.

The date of application is the date the completed application form is received by the county office.

Complete applications forms must be date-stamped when received.

The application is logged and assigned to a Worker for processing and completion.

1.2.6.B WV PATH – People's Access to Help

The client may submit applications online using WV PATH for some programs including, but not limited to, SNAP, WV WORKS, certain Medicaid coverage groups, and WVCHIP.

Individuals submitting applications using WV PATH must electronically sign the application.

When the application is submitted by WV PATH, the date of application is the date the application is submitted.

1.2.6.C Community Partners

Some WV PATH 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 that include, but are not limited to, Medicaid, WVCHIP, and LIEAP. An example of a Community Partner is the Primary Care Association.

Community Partners who enter into an agreement with DOHS are permitted to verify the identity 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.

1.2.6.D Federally Facilitated Marketplace

Individuals may apply online at the Federally Facilitated Marketplace (FFM, the Marketplace) for insurance affordability programs and MAGI Medicaid coverage groups, including Parents/Caretaker Relatives, Adult, Pregnant Women, Children Under Age 19, and WVCHIP.

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 WVCHIP and forward the data file to the eligibility system. The eligibility system will determine the specific Medicaid or WVCHIP 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 (ACA) in West Virginia 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.

1.2.7 CLIENT NOTIFICATION

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. Under some circumstances, the eligibility system automatically generates notification to the client.

NOTE: There is specific, court-ordered client notification policy that must be followed. There are also specific forms that must be used and detailed procedures to follow. See Chapter 9.

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.

When an applicant may be eligible for a program or Medicaid coverage group for which he did not request, a notification is issued from the eligibility system to inform the applicant that he must contact his local office for information or to apply.

1.2.8 COMPLETION OF THE APPLICATION PROCESS

The application process is completed when the following have occurred:

1. The Worker has:
   - Approved the application when all eligibility requirements are met; or
   - Denied the application when at least one eligibility requirement is not met, or the client has failed to establish eligibility.
2. The client is notified of the action taken.

The client receives his initial benefit, if eligible.

1.2.9 ADDITION OF A BENEFIT TO AN ACTIVE CASE

When a member of the SNAP AG applies for WV WORKS or Medicaid, a new application form is not required when all of the following conditions are met:

- The latest application or redetermination for the existing program or Medicaid coverage group was completed using a DFA-2 or WV PATH application.
- Sufficient information about eligibility requirements for the new program or Medicaid coverage group is on the latest DFA-2 or WV PATH application.
- Verification required for the new program or Medicaid coverage group is contained in or recorded in the eligibility system or the case record.
- The DFA-2 or WV PATH application contains the signatures required for the new program or Medicaid coverage group.
- If required, program sections on the DFA-RR-1 were previously completed.

NOTE: A recording in the eligibility system case record must justify the lack of a DFA-2 or WV PATH application.

1.2.10 REAPPLICATIONS

1.2.10.A SNAP

When an application has been made and requested information is not received, according to the

time limits established in Section 1.4, the client must not be made to complete a new application if the information is returned within 60 days of the original application date. However, if the application was denied due to income or any other circumstances other than requested verification, the applicant must reapply.

1.2.10.B WV WORKS and Medicaid

If an applicant AG fails to provide the verifications requested on the DFA-6 or verification checklist within the specified time limit and the application is denied, the AG must be given an opportunity to have its eligibility established for up to 60 days from the date of application without completion of a new form.

If the client brings in the verifications before the 60-day period has expired, the Worker determines the AG's eligibility based on the original application, noting in Case Comments any changes which have occurred since the form was completed. If the application is approved, WV WORKS benefits are not retroactive to the date of application because the approval delay was the fault of the client. Benefits are issued from the date the client provides the verification. The Worker provides benefits using information reported during the original application and any other pertinent information provided prior to approval when the following conditions are met:

- The reapplication occurs no later than the end of the second month following the month of the most recent AG closure;
- The AG was closed for reasons other than failure to complete a redetermination, and a redetermination was not due the effective month of closure;
- The AG, Needs Group, Income Group composition, income, and other eligibility factors have not changed significantly;
- The category of relatedness has not changed (not applicable for WV WORKS);
- The information provided by the client is not questionable; and,
- The latest application form contains the appropriate signatures.

MEDICAID-ONLY NOTE: AFDC-Related and SSI-Related Medicaid AGs that do not have a spenddown, but are closed due to a change in the AG's circumstances that results in a spenddown, are not required to reapply or complete a new application for the new period of consideration (POC) that follows AG closure. See Section 10.17.

MEDICAID-ONLY NOTE: When the latest application form is a DFA-SLA-1 or a DFA-QSQ- 1, the AG may only be reopened for a Medicaid coverage group for which such forms are appropriate.

1.2.11 REDETERMINATIONS

Each program and Medicaid coverage group has its own policies related to redetermination. Please see the program-specific sections for details.

NOTE: At redetermination for one program or Medicaid coverage group, the client may want to apply for an additional benefit. If so, the same DFA-2 or WV PATH *application is used as an application for the new benefit and a redetermination for the active AG, regardless of the program or Medicaid coverage group.*

Medicaid and WVCHIP NOTE: If coverage is closed for failure to submit a redetermination form, or necessary information, but the client responds and provides the information within 90 days of the effective date of closure, the Worker must determine eligibility in a timely manner without requiring a new application. Eligibility may be back dated up to three months, provided all eligibility requirements were met.

1.2.11.A Redeterminations Submitted by Mail

Clients of some Medicaid coverage groups, WVCHIP, and other programs receive an instruction letter and redetermination form that 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 DOHS office or the Customer Service Reporting Center as directed by the letter. The client may always request a face-to-face interview.

1.2.11.B Redeterminations Submitted by WV PATH

Clients of some Medicaid coverage groups, WVCHIP, 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 using WV PATH. The client receives certain information in the letter that must be entered online to use the WV PATH redetermination process.

No signature page is required, and the redetermination is considered electronically signed when the client 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.

The Worker processes redeterminations submitted by WV PATH using the eligibility system.

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

1.2.12 SPECIAL SITUATIONS

1.2.12.A 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 that 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.

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 Worker must obtain the following information by telephone from the other state.

- Date on which the client last received or will receive his last benefits;
- Effective date of the termination of benefits;
- The individuals included in the benefit;
- Whether or not any of the client's last benefits were returned to the agency; and,
- Whether or not the client owes a repayment to any program.

The American Public Human Services Association (APHSA) Directory contains current telephone numbers for other states. This information may also be found on state websites on the internet.

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

1.2.12.A.1 SNAP Cases Containing ABAWDs

The Worker must contact the other state to determine and record how many months of his three-month limit without meeting the work requirement he has used since the start of the 36-month period in West Virginia.

1.2.12.A.2 WV WORKS

The Worker must determine how many months the client received TANF payments in the other state.

States had until July 1997 to convert from AFDC/U to a TANF-funded program. Therefore, for benefits received prior to July 1997, 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.

1.2.12.A.3 Medicaid

When an individual receiving Medicaid from another state moves to West Virginia and applies for Medicaid, the Worker must determine when payments by the previous state of residence stopped. See Chapter 24 for Long Term Care cases. Medicaid coverage in West Virginia will begin the month the client establishes residence in West Virginia.

1.2.12.B Application Made or Received in the Incorrect County

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

1.2.12.B.1 Applications Made by Mail or in-Person

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 application 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.
- Inform the client of additional requirements he may have to complete in the correct county.
- 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.

1.2.12.B.2 Applications Requested by Telephone

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

1.2.12.B.3 Applications Submitted by WV PATH

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

1.2.12.C Communication with the 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. The SSA uses different eligibility criteria than DOHS. The Worker may issue a verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

1.2.12.D Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking

Information about community resources that address the issue of sexual harassment and domestic violence, sexual assault, and stalking 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. When possible, this must be accomplished during the office interview. In order to ensure the safety of the individual to whom information about sexual harassment and domestic violence, sexual assault, and stalking is given, it is suggested that the sexual harassment and domestic violence, sexual assault, and stalking information be part of a packet that contains a variety of information.

If, during the interview, the Worker observes language or other behavior that is threatening and discussion of such matters could pose a possible threat to the client, the Worker must avoid direct discussion with the client. In those instances, a referral to the local domestic violence program, other available community resources, 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 sexual harassment and domestic violence, sexual assault, and stalking services is available at all times.

Programs and Medicaid coverage groups have different allowances for verifications when the applicant attests to being a victim of sexual harassment and domestic violence, sexual assault, and stalking. See Chapter 7.

1.2.12.E Applications Submitted from the WV 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 who have been admitted as inpatients in medical institutions 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 the Medicaid Management Information System (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

client is not coded as incarcerated, so the living arrangement code in the case can be updated.

- If the individual is not a current Medicaid client, BMS will notify DOC or RJA to assist the individual with submitting an application via WV PATH.
    - The WV PATH applications will be forwarded to the 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.

1.3 APPLICATION FORMS

The forms described in this section are used to make an application for programs and Medicaid coverage groups included in the Income Maintenance Manual (IMM) such as the Supplemental Nutrition Assistance Program (SNAP), WV WORKS, Low-Income Energy Assistance Program (LIEAP), School Clothing Allowance (SCA), and health coverage programs that include Medicaid, the West Virginia Children's Health Insurance Program (WVCHIP), and qualified health plans.

The application:

- Is used for gathering client information which is used to determine eligibility and the need for other services offered by the Department of Human Services (DOHS).
- Is a fact sheet containing relevant information about the assistance group (AG) and other members of the household who are not included in the AG?
- Serves as a legal document and may be used in any court case.

Program-specific instructions for application completion or usage are described in the application procedures under each program and coverage group section and summarized in Appendix A.

1.3.1 COMMON APPLICATION FORMS

The applications listed below can be used to apply for one or more programs including SNAP, WV WORKS, Medicaid, and WVCHIP.

1.3.1.A Application for Benefits DFA-2

The DFA-2 is also known as the "CAF" or Common Application Form.

1.3.1.A.1 Purpose

The DFA-2 can be used to apply for most Division of Family Assistance (DFA) programs including SNAP, WV WORKS, and Medicaid as well as WVCHIP.

Because the DFA-2 can be used for multiple programs, denial of an application for one program may lead to approval for another.

The DFA-2 which contains, at a minimum the applicant's name, address, and signature is used to protect the date of application for SNAP, Medicaid, and Emergency Assistance (EA).

1.3.1.A.2 Submission Format

The DFA-2 may be:

- Completed by the Worker in the eligibility system; or,
- Completed on paper, known as the DFA-2 shelf document, when circumstances do not permit completion of the application process in the eligibility system.

1.3.1.A.3 Related Forms

➢ *Rights and Responsibilities DFA-RR-1*

The DFA-RR-1 is required each time a DFA-2 or DFA-5 is completed. The client must read, or have read to him, all the statements preceding his signature before signing the form. He must also indicate his understanding of, or agreement with, each statement by checking the appropriate block beside the statement.

The Worker must provide any explanation and information the client needs to understand the statements. After completing all applicable sections, the client signs the form. For WV WORKS, when both parents are in the home, both must sign. Failure to sign the form results in ineligibility.

When a client checks "no" to an item, it does not result in immediate ineligibility. The client has to actually fail to comply with the requirement in order to result in ineligibility.

> **Rights and Responsibilities Example:** The client applying for SNAP benefits checks "no" to the statement concerning the requirement to cooperate with Quality Control (QC). The AG is eligible, and benefits are approved. QC selects the case for review in the second month. The client refuses to cooperate and, only then, is notice of closure sent.

➢ *Document for Protection of Application Date DFA-5*

When the applicant has completed the application, and there is a technical failure that prevents printing the DFA-2, Form DFA-5 must be signed by the applicant, attached, and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when a DFA-5 has been signed.

➢ *Request for Information and/or Verification Checklist DFA-6*

When the Worker does not have sufficient information to make a decision, it is necessary to complete form DFA-6 or verification checklist to inform the applicant of the additional information needed. All requests for verification must be made using the DFA-6 form and/or verification checklist.

The Worker must clearly state on the form what items must be returned by the applicant, as well as the date by which the information must be returned.

The applicant's failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the application will be considered failure to provide verification and will result in a denial of the application.

➢ *Release of Confidential Information Statement DFA-CI-1*

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

1.3.1.B WV PATH Application

WV PATH is the online system that allows clients to be evaluated for or apply for certain benefits.

1.3.1.B.1 Purpose

This application can be used for:

- SNAP
- Medicaid
- WVCHIP

- WV WORKS
- Health care coverage through the Federally Facilitated Marketplace (FFM)
- Medicare Premium Assistance (MPA)
- Regular LIEAP and
- School Clothing Allowance (SCA)

The rights and responsibilities are included with the WV PATH application; the DFA-RR-1 is not required.

1.3.1.B.2 Submission Format

The WV PATH application is submitted by the applicant through the Department's public-facing web portal.

1.3.2 SNAP ONLY APPLICATION FORM DFA-SNAP-1

The DFA-SNAP-1 Application for SNAP is used for SNAP-only applications. No DFA-RR-1 is required.

NOTE: Printing a DFA-2 after the interview is not required if a signed DFA-SNAP-1 is received.

1.3.3 WV WORKS ONLY DFA-RFA-1

The DFA-RFA-1 Request for Assistance may be used to protect the date of application for WV WORKS. The form is considered complete when it contains, at a minimum, the applicant's name, address, and signature.

The DFA-RFA-1 should be used when the client is in the local office and time does not permit conducting an interview on the date the client wishes to apply for benefits. If the applicant does not follow through with the application requirements for WV WORKS, the correct action is denial of those benefits in the eligibility system.

When an application is requested by mail, the DFA-2 or other appropriate program application must be sent. The DFA-RFA-1 must not be mailed to the client.

1.3.4 MEDICAID APPLICATION FORMS

1.3.4.A Single Streamlined Application (SLA), DFA-SLA-1, DFA-SLA-2

1.3.4.A.1 Purpose

The SLA, also known as the Application for Health Coverage and Help Paying Cost, allows individuals to apply with the Department for all health coverage programs including WVCHIP.

The DFA-SLA-1 and DFA-SLA-2 (short form) are the shelf document (paper) versions of the single-streamlined application used to apply for health coverage only. These applications collect information needed to determine eligibility for health care coverage groups on the basis of Modified Adjusted Gross Income (MAGI).

- The DFA-SLA-1 is used for a family, or when there is more than one individual in the household.
- The DFA-SLA-2 is used by a single individual.

The SLA is available at community and business sites throughout the State. The form is given to anyone who requests it, regardless of the county in which he resides, if different from the county of the special outreach site.

The SLA must be available for distribution in all county DOHS offices and provided to anyone who makes the request.

When the client requests the SLA mailed to him, this must occur the same day as his request.

When received, the client has the option of completing the SLA the day he receives the form and leaving it at the DOHS office for processing, taking it with him for completion and returning it to the local office at a later date, or returning with the form for completion in the office.

NOTE: Regardless of the option chosen, at no point is the applicant required to register with the receptionist or meet with a Worker in order to receive a SLA or have it processed.

1.3.4.A.2 Submission Format

The SLA can be submitted by mail, phone, electronically through the Federally Facilitated Marketplace (FFM) or WV PATH, or in person for all health coverage and insurance affordability programs.

1.3.4.A.3 Related Forms

- ***Supplement to Application for Health Coverage DFA-SLA-S1***

The DFA-SLA-S1 is the supplement used in addition to the DFA-SLA-1 or DFA- SLA-2 to collect additional information required to determine eligibility for Medicaid coverage groups on a basis other than MAGI.

The DFA-SLA-S1 is a supplement only and is not used as an application.

1.3.4.B Medical Assistance Application DFA-MA-1

The DFA-MA-1 is a shelf document that can only be used to apply for the following Long Term Care (LTC) Medicaid categories: Nursing Facilities Services, Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities, Aged and Disabled Waiver (ADW), Intellectual Disabilities and Developmental Disabilities (IDD) Waiver, Traumatic Brain Injury (TBI) Waiver, and Children with Disabilities Community Service Program (CDCSP). The DFA-MA-1 can also be used to apply for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Medicare Individuals (QI-1).

The DFA-RR-1 is not required.

The DFA-MA-1 must only be used for applicants that are not eligible for Medicaid coverage using the Modified Adjusted Gross Income (MAGI) methodology, otherwise the DFA-SLA-1 and DFA-SLA-S1 or DFA-2 must be used as the Medicaid application.

1.3.4.C QMB/SLIMB/QI-1 Application DFA-QSQ-1

The DFA-QSQ-1 is used for QMB, SLIMB, and QI-1 applications only.

No DFA-RR-1 is required.

When Low Income Subsidy (LIS) files are received from the Social Security Administration (SSA), applicants who are not current Medicare Premium Assistance (MPA) clients are issued a DFA-QSQ-1 through the eligibility system.

1.3.5 OTHER PROGRAMS

The table below lists the application forms used for other DOHS assistance programs.

Program	Application Form – Common		Application Form – Program-Specific
AIDS Drug Assistance Program (ADAP)	DFA-2 or DFA-SLA-1 with DFA-SLA-S1 to determine Medicaid eligibility.	AND	ADAP Application
Breast and Cervical Cancer (BCC) Program	WV PATH	OR	BCC Application DFA-BCC-1
Children with Special Health Care Needs (CSHCN)	Not applicable.	-	CSHCN Program Application CSHCN-1
Emergency Assistance	DFA-2	OR	Emergency Assistance Application DFA-EA-1
Indigent Burial Program	Not applicable.	-	Application for Indigent Burial Program DFA-BU-1 Affidavit of Responsible Relative DFA-BU-2
Low Income Energy Assistance Program (LIEAP)	DFA-2 and DFA-LIEAP-1b Supplemental LIEAP Form WV PATH and DFA-LIEAP-1b	OR	LIEAP Application DFA-LIEAP-1 Supplemental LIEAP Form DFA-LIEAP-1b
LIEAP Emergency Repair and Replacement	Not applicable.	-	Application for Emergency Repair and Replacement DFA-LIEAP-ERR-1

Program	Application Form – Common		Application Form – Program-Specific
Refugee Assistance Program	DFA-2. Follow application procedures for each program and see Chapter 15 for special instructions related to refugees.	-	Not applicable.
Special Pharmacy	Not applicable.	-	Special Pharmacy Application DFA-SP-1
West Virginia School Clothing Allowance (WV SCA)	DFA-2 WV PATH	OR	SCA Application DFA-WVSC-1

1.4 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

This section describes the process for determining initial and ongoing eligibility for the Supplemental Nutrition Assistance Program (SNAP). The purpose of SNAP is to provide an effective method of assuring that the food needs of low-income assistance groups (AG) are met. This is accomplished through the issuance of SNAP benefits to AGs who meet the eligibility criteria established by the Food and Nutrition Services (FNS) of the U.S. Department of Agriculture (USDA). Benefits are issued to the AG's electronic benefits transfer (EBT) account.

Another purpose of SNAP is to assist low-income adults in obtaining employment and increasing their earnings. Such employment and earnings, along with program benefits, will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households.

These SNAP benefits may be used in grocery stores or other establishments that are authorized by USDA to accept SNAP benefits. The AG may purchase any food or food products for human consumption. SNAP may also be used to purchase Meals on Wheels meals, seeds, and plants for food production in home gardens. In addition, homeless AGs may purchase meals from a public or private non-profit establishment approved to feed homeless persons. Alcoholic beverages, tobacco, and non-edible items, such as cleaning supplies and paper products, are specifically excluded.

1.4.1 APPLICATION PROCESS

Applications may be submitted using the DFA-2, DFA-SNAP-1, or WV PATH. See Section 1.2 for the WV PATH process. When an AG completes an application, the worker must offer to provide a copy of the completed application. If the AG specifically requests the copy of the application be in an electronic format, the worker must provide a copy in an electronic format.

Usually an application form is required to reapply for SNAP benefits. However, there are times when an AG may reapply without completing a new form.

When the client requests benefits following the denial of an application or redetermination beyond the time limits specified in Section 1.4.9 below, a new application form and interview is required.

When benefits are closed due to a change in circumstance, other than a missed redetermination, and the client requests his benefit be reopened within the certification period, no new application form is required when the client has not missed an issuance month. When no issuance month has been missed, the AG remains in the original certification period.

If the AG has missed an issuance month and is not eligible for reinstatement of benefits, a new application form and interview is required. If the application is approved, the AG will be assigned a new certification period.

> **Application Example 1:** An application is made on June 10, and a DFA-6 is issued with a due date of June 20. The client does not provide the requested verification and the application is denied. On July 20, the client provides the information and the Worker is able to determine eligibility for the AG. Benefits are approved as of July 20, and no new application form is required.
>
> **Application Example 2:** Same example as above, except the requested verification is not returned until August 20. The benefit may not be approved until the client completes a new application and interview.

1.4.1.A Failure to Provide Requested Verifications

If an applicant AG fails to provide the verifications requested on the DFA-6 or verification checklist within the specified time limit and the application is denied, the AG must be given an opportunity to have its eligibility established for up to 60 days from the date of application without completion of a new form.

If the client brings in the verifications before the 60-day period has expired, the Worker determines the AG's eligibility based on the original application, noting in Case Comments any changes which have occurred since the form was completed. If the application is approved, SNAP benefits are not retroactive to the date of application because the approval delay was the fault of the client. Benefits are issued from the date the client provides the verification. The Worker provides benefits using information reported during the original application and any other pertinent information provided prior to approval.

> **Application Example 3:** Mr. Balsam applied for SNAP benefits on November 1. A DFA-6 was issued requesting verification of income by November 30. Mr. Balsam did not provide the verification by this date and his application was denied. Mr. Balsam brought in the requested information on December 5. No new application form is required because he provided verification within 60 days of the date of application. However, if Mr. Balsam is eligible, SNAP benefits are issued from December 5.

Different procedures apply when the case is closed because of failure to provide needed verification at the time of redetermination. When the client provides the verification within 30 days of the end of the certification period, it is still considered a redetermination and a new

application is not required. See Section 1.4.18, Application and Redetermination Variations, for instructions on proration due to delayed processing.

> **Application Example 4:** Ms. Sunflower reports the start of a new job on July 1. A DFA-6 is issued to her with a due date of July 10. Ms. Sunflower does not provide the requested information by that date and the benefit is closed effective July 31. On July 30, she provides the requested information and benefits are reopened effective August 1. No new application form or interview is required. The AG remains in the original certification period.
>
> **Application Example 5:** Same example as above, except that the information is not returned until August 5. Benefits may not be approved until Ms. Sunflower completes a new application and interview. The AG will be assigned a new certification period if the application is approved.

1.4.1.B Categorically Eligible AGs

Categorically Eligible AGs, as defined in Section 1.4.17.C, do not require a new form when all of the following conditions are met:

- There is a WV WORKS application pending; and
- SNAP benefits were denied; and
- Subsequent to the denial, they are determined eligible to receive WV WORKS; and
- The AG is otherwise Categorically Eligible.

The Worker provides benefits using the original application and any other pertinent information provided subsequent to that application. Benefits are paid from the date for which WV WORKS eligibility is established or the date of the original SNAP application, whichever is later. Changes must be recorded in case comments.

NOTE: If an active WV WORKS case, also certified for SNAP benefits, is closed and there is enough information to continue the SNAP certification, benefits are continued with no interruption. A new application must not be required. See Chapter 10.

1.4.1.C SNAP Work Requirement Penalty Expires

When an individual's SNAP work requirement penalty expires, or he becomes exempt, he is added to the AG, if otherwise eligible, without having to complete an application, unless he is the sole AG member.

1.4.1.D Interim Contact Report (PRC-2)

An interim contact form is a SNAP form due at the midpoint of the SNAP certification period. The purpose of the PRC-2 is for the SNAP AG to have an avenue to report changes that have occurred since the last SNAP application or redetermination. A PRC-2 is not a full redetermination.

PRC-2 Elements
The SNAP AG must report the following changes on the PRC-2:

- A change in the total earned and unearned income of more than $125 from the amount last used to determine the eligibility of SNAP.
- Changes in the source of income, including starting or stopping a job, or changing jobs if the job change includes a change in income of more than $125 from the amount last used to determine eligibility for SNAP.
- Changes in household composition of an AG member, such as the addition or loss of an AG member.
- When an Able-Bodied Adult Without Dependent's work hours are less than 80 hours per month.
    - Reminder: The worker cannot screen the AG while processing the PRC-2.
- Changes in residency (where the household physically lives) and/or new shelter expense amount.
- Changes in the amount of child support an AG member is legally obligated to pay. Only the actual amount paid is taken into consideration when providing a deduction.
- When the AG receives lottery or gambling winnings equal to or greater than $4,500.

Note: The PRC-2 also contains a section for ADA reasonable accommodations. ADA is not an element of SNAP eligibility, but the eligibility worker is required to follow up if information is provided on the PRC-2.

Complete PRC-2
PRC-2's are complete when:

- The AG reports "I have read this form, and I made no changes" or "I have read this form, and I have reported changes" on the PRC-2; and
- If "I reported changes," at least one change is reported on the form; and
- If a change to income was reported on the form, proof of income is required; and
- All pages of the PRC-2 are received; and
- The form is signed with an acceptable signature.

***NOTE**: The PRC-2 Is considered complete if new information is received through verified upon receipt Data Exchange(s). This information is not required to be reported on the PRC-2, because the information is readily available to DOHS. Examples include but are not limited to: UCI, Child Support.*

Proration in the 13th month:

- If the AG reports changes that are needed to determine eligibility and verification is requested on the DFA-6, prorate the benefit from the date the information is returned to the agency. If verification is returned after the last day of the 13th month, SNAP remains closed, and the AG must reapply

- If the AG reports only expense changes, the benefit will not be prorated. A full month's benefit will be received for the 13th month. The date of the benefit is the date the PRC-2 was initially received by the agency, which will be in the 12th month. When verification of the expense is received prior to confirmation in the eligibility system, the deduction will be allowed. If the expense is NOT verified, the PRC-2 is processed without the deduction. If verification of an expense is received after confirmation in the eligibility system, the verified expense is considered a reported change. Increases/decreases to SNAP based on a reported change are effective the month following the change report.

1.4.1.E Able-Bodied Adult without Dependents (ABAWD) Exemption

A new application is not required for an ineligible ABAWD unless he is the sole AG member when the following occur:

- The ABAWD becomes exempt;
- The State of West Virginia begins a new 36-month tracking period.

1.4.1.F Late Redetermination Submission

When a SNAP AG is closed for failure to return a completed redetermination form, a new application is not required when the completed redetermination form is returned by the last day of the month following the end of the certification period. All SNAP redeterminations require an interview. See Section 1.4.18, Application/Redetermination Variations.

1.4.1.F Reinstating from the Date the Household Provides the Information

A SNAP AG can be reinstated from the date the household provides the information and/or necessary verification without a new application when they meet the following conditions:

- The SNAP benefits must be in closed status,
- The SNAP AG has at least one full month remaining in the certification period after the last month benefits are received,
- The SNAP AG must report and verify a change in circumstances during the 30 days following the last month benefits are received, and
- The SNAP AG must be eligible for SNAP benefits during the reinstatement month and the remaining months of the certification period.

1.4.2 COMPLETE APPLICATION

An application form is considered complete when all relevant sections of the application form to a SNAP application are completed and the application form is signed by a responsible member of the AG or an authorized representative.

The client is not required to provide a complete application form to begin the application process so long as the incomplete application form contains, at a minimum, the client's name, address, and signature. An incomplete application containing, at a minimum, the client's name, address, and signature protects the date of application through the application process and must be acted upon.

Whether the application received is complete or is an allowable incomplete application, an interview must be scheduled. See Section 1.4.4, Interview Required, below.

If, at any time during the application process, the client refuses to sign an application form that contains at a minimum, the client's name, address, then it is a withdrawal and appropriate eligibility system action and client notification must be completed. The recording in case comments must specify that the client did not want to sign the application and the reason for the decision.

NOTE: The Worker should always encourage the client to sign the application to avoid a misunderstanding that he was denied the right to apply.

When the applicant chooses to leave or end the interview before it is complete and does not indicate to the Worker that he wants to withdraw his application, it is considered a withdrawal and appropriate action is taken.

1.4.3 DATE OF APPLICATION

The date of application is the date the applicant submits a DFA-2 or DFA-SNAP- 1 in person, by fax, other electronic transmission, or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or fax, it is considered an original application and the date of application is the date that the form with the name, address, and signature is received in the local office.

All SNAP applicants must be screened for Expedited Service on the day the application is made, whether the client is applying for SNAP benefits only or SNAP benefits in combination with any other program.

When the application is submitted by WV PATH, the date of application is the date it is submitted.

NOTE: When the applicant has completed an in-office interview and there is a technical failure that prevents printing the DFA-2, Form DFA-5 must be signed by the applicant. The DFA-5 is used only in conjunction with an application completed in the eligibility system when the DFA-2 (aka "CAF") cannot be printed for signature. Completion of the form, with no corresponding application in the eligibility system, does not protect the date of application.

Form DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when a DFA-5 has been signed. However, completion of a DFA-5 alone, without a corresponding application in the eligibility system, does not protect the date of application.

When a new DFA-2 or DFA-SNAP-1 is not required, the date of application depends on the situation. See Section 1.4.1, Application Process, above.

1.4.4 INTERVIEW REQUIRED

An interview is required when an application form is required. See Section 1.4.1, Application Process, above for situations when an application form is not required. See Section 1.4.5, Who Must Be Interviewed, below about authorized representatives.

All individuals who apply for SNAP benefits using any method, are interviewed by phone unless the individual chooses to be interviewed face-to-face.

The worker must explain the interview options that are available.

When only the name, address and signature are provided a second signature via the CAF must be provided by the SNAP AG prior to benefit issuance. The agency must provide the AG ten days to submit the second signature before the application can be denied.

If the client provided enough information to determine eligibility, but the Worker discovers discrepancies or additional information from the interview, the customer must provide another signature attesting the information provided during the phone interview is accurate.

Note: If an application is received providing income, household composition, and utility amounts but the worker discovers there is a rent obligation, it is not necessary to require a second signature.

When a SNAP application is submitted using WV PATH, the Worker must schedule an interview with the client after the application is received.

1.4.4.A Procedures for Missed Scheduled Interviews

When an application is received in person, by mail, or by WV PATH, and the client subsequently misses a scheduled interview, the following procedures apply.

- Notice must be sent to the client informing him that he missed the scheduled interview and that it is his responsibility to reschedule. The notice is system-generated once the Worker updates the client's status to "no show." This notice must be sent to the client within a reasonable amount of time to ensure that the interview and/or application can be completed within the 30-day application processing period.
- If the client contacts the office within 30 days from the application date, the Worker reschedules the interview and issues a notice to confirm the rescheduled appointment. If eligibility is established in the 30-day application processing period, benefits are prorated from the date of application. The application is denied on the 30th day after the application date, if the interview cannot be rescheduled within the 30-day application processing period.
- If the client misses both interviews or fails to keep or postpones the second interview at his request until after the 30th day following the date of application, the delay is the fault of the client. No benefits are issued until he completes an interview and supplies information to establish eligibility. The beginning date of eligibility is the date the information is supplied. Provisions in Section 1.4 for the beginning date of eligibility apply when the client completes all application requirements, including the interview, within 60 days of the date of application.
- Deny the application on the 30th day after the date of application when the client misses the scheduled interview and does not contact the office to reschedule it.

> **Missed Interview Example:** An application is received by mail on October 1 and an interview is scheduled for October 10. The client fails to complete the interview and the notice of missed interview was issued. The client does not contact the Worker to reschedule the interview by October 30 and the Worker denies the application on October 31.

1.4.4.B Face-to-Face Interview Waiver Application Process

A scheduled interview notice is not required when an interview is conducted the same day the application is received. A scheduled interview notice is required when an interview is not conducted on the date the application is received. This is applicable, regardless of the method in which the application is received.

The interview must take place the same day the application is received via WV PATH or a scheduled interview notice is required. When the application is submitted through WV PATH after business hours, the filing date is considered the same day.

1.4.5 WHO MUST BE INTERVIEWED

1.4.5.A AG Member

Any adult member of the AG may be interviewed and sign the DFA-2, DFA-SNAP-1, or WV PATH application. If there is no member of the AG age 18 or over, any member may apply.

The applicant may bring any person he chooses to the interview. This person may participate in the interview only to the extent the applicant wishes. The AG must be informed that it is responsible for repayment of any over issuance caused by erroneous information provided by this person.

1.4.5.B Authorized Representative

An adult non-AG member may participate in the interview as an authorized representative (AR) of the AG, either with or without an AG member. This individual must be authorized and designated in writing by an adult member of the AG or by any AG member if there is no member

at least age 18. The authorized representative must have sufficient knowledge of the AG's circumstances to provide the necessary information. The authorized representative may act on the AG's behalf in making an application, completing a redetermination or reporting information during the certification period. See Section 10.4 for reported changes.

Different individuals may be selected for each activity which may involve an authorized representative, i.e., one AR may participate in an interview and a different AR may report a change. Unless it is otherwise documented from the AG, the authorized representative who completes the application is assumed to be authorized to report changes as well.

NOTE: An authorized EBT cardholder is considered to be authorized to report changes as well, but must not be considered authorized to complete an application or redetermination, unless specified by the AG.

A recording must be made in case comments regarding the authorized representatives' status.

The AG must be informed that it is responsible for repayment of any over issuance caused by erroneous information provided by the authorized representative.

➢ *Restrictions of Authorized Representatives*

The Regional Director (RD) or Community Services Manager (CSM) may disqualify an authorized representative or authorized cardholder for up to one year, provided there is evidence that the individual has committed any one of the following offenses:

- Misrepresenting an AG's circumstances; or
- Knowingly providing false information about the AG; or
- Using SNAP benefits improperly; or
- Using WV WORKS benefits improperly.

The Worker must send written notification to the affected AG and the authorized representative or authorized cardholder 30 days prior to the date of the disqualification. The letter must include: the fact that disqualification of the individual is proposed, the reason for the action, the AG's right to a Fair Hearing, the telephone number of the office and the name of the person to contact for additional information.

This disqualification provision does not apply to drug and alcoholic treatment centers and Group Living Facilities (GLFs) which act as authorized representatives, information providers or authorized cardholders for their residents.

The following restrictions apply for SNAP Authorized Representatives:

- Homeless meal providers may not act as authorized representatives for homeless SNAP clients.
- Individual disqualified for an Intentional Program violation cannot act as an authorized representative during the disqualification period unless it has been determined no one else can serve as an authorized representative.
- Retailers accepting SNAP cannot act as authorized representatives.
- DOHS employees or contractors involved in certification or issuance processes may not act as authorized representatives without written approval from the Community Services Manager (CSM) or Regional Director (RD) and there is no one else can serve as an authorized representative.

1.4.6 WHO MUST SIGN

More than one signature is never required for a SNAP application.

If an applicant for, or recipient of WV WORKS is applying for SNAP benefits, the SNAP benefits cannot be denied solely because of the absence of the two signatures that may be required for WV WORKS. The rules governing who must sign are the same as below.

Only an AG member or authorized representative may sign the application.

1.4.6.A Acceptable Signatures for SNAP

- Handwritten signatures
  - If an individual is unable to write his or her own name, but the agency has verified the individual's identity, the individual may sign with an "X." An agency representative must witness and attest to this type of signature. This method of signature should be used to accommodate individuals who request to sign in this manner. The case record must indicate why an "X" was used for signature.
- Electronic signatures
  - An approved electronic signature is one where the individual must accept terms and conditions to proceed with signing. Electronic signatures on PATH meet this definition.
    - **NOTE**: This does not include typing one's own name onto an application or redetermination form.
- Unwritten signatures

- The agency will only accept unwritten signatures as a means to comply with civil rights laws. This method of signature is a last resort and the DFA Policy Unit must be consulted prior to accepting an unwritten signature. The case record must be documented with why this signature method was utilized. In this circumstance, the agency is not required to also obtain a written signature.

> **Example:** An unwritten signature may be necessary if an applicant has two broken hands and is able to comply with other aspects of the application and interview process.

1.4.7 CONTENT OF THE INTERVIEW

The identity of the applicant AG member and/or authorized representative must be verified and documented in the case record prior to benefit approval.

In addition to the responsibilities in Section 1.2, the Worker has the following additional responsibilities during the intake interview specific to SNAP:

- Screen for expedited service.
- Explain all aspects of SNAP including application processing time limits, expedited service, basis of initial and ongoing issuance, combined issuance, method of issuance, date benefits should be received, how to use SNAP benefits and the EBT card.

NOTE: The Worker must determine if there is an existing EBT account. He must also inform the client of the availability of any balance remaining in the account.

- For homeless AGs with shelter costs, explain the option of using the Homeless Shelter Standard Deduction versus actual shelter and SNAP Standard Utility Allowance (SUA) costs.
- Explain that the receipt of SNAP has no effect on time limits for WV WORKS, and SNAP benefits may continue even when WV WORKS stops.
- Explain certification periods and specific reporting requirements.
- Explain the Department of Human Services' (DOHS) employment and training programs and the requirements for keeping job/training appointments, accepting employment or training, registering for SNAP Employment and Training (SNAP E&T) and the consequences for failing to comply with the requirements.
- Screen all adult SNAP recipients for SNAP general work and ABAWD exemptions; screen all adult SNAP recipients to determine if the work requirement is being met.

- Explain the authorization to receive information and referral services about Temporary Assistance for Needy Families (TANF) and other programs offered by the West Virginia DOHS.
- Explain the following about Electronic Benefits Transfer (EBT):
    - SNAP benefits will be deposited into an EBT account and accessed with an EBT card
    - When the card will be received and how to create a personal identification number (PIN).
    - The card must be activated prior to use.
    - When the benefits will be available in the account
    - The importance of choosing an authorized cardholder who can also access the EBT account

> *NOTE: For EBT, the AG may have an authorized cardholder to spend benefits from the AG's EBT account. There is not a separate case or EBT account, but the authorized cardholder has a separate EBT card with his own Personal Identification Number (PIN) and uses the card to spend benefits from the AG's EBT account in the same manner as the AG's payee. The authorized cardholder, authorized representative and the information provider may be the same or different individuals, at the discretion of the AG's payee.*

    - Services which are available by calling the EBT Helpline and using either the Interactive Voice Response Unit (IVRU) or speaking with a Customer Service Representative (CSR). These services include, but are not limited to, activation of a new card, deactivating a lost/stolen/damaged EBT card, obtaining a new or different PIN, cancellation of an authorized cardholder or checking an account balance.

The client must be told during the intake interview that his Combined Issuance must last until his next issuance is available and the date his next issuance will be available. He must also be told that no additional SNAP benefits are available should he use them all prior to receipt of the next issuance.

1.4.8 DUE DATE OF ADDITIONAL INFORMATION

Additional information requested from the applicant is due 10 calendar days from the date of the DFA-6 or verification checklist.

1.4.9 AGENCY TIME LIMITS

It is a requirement that the DFA-6 or verification checklist be given to applicants no later than 10 days after the date of application, if one is required.

The Worker must take eligibility determination action on all applications.

If eligible, the client's first SNAP benefits must be available for use within 30 days of the date of application, unless Expedited Service applies. See Section 1.4.16, Expedited Processing.

> **Agency Time Limits Example 1:** Mr. Marigold submits a SNAP application by mail on April 8. The Worker completes a phone interview with him on April 12 and issues a verification checklist for Mr. Marigold to return verification of income by April 22. He fails to return the information by April 22, so the Worker must deny the application on or after April 23, but no later than May 8, which is the 31st day from the date of application.
>
> **Agency Time Limits Example 2:** Mrs. Violet submits a SNAP application using WV PATH on May 1. The Worker completes a phone interview with her on May 6 and no further verification is needed. Even though the Worker has until May 31 for Mrs. Violet to receive her first SNAP benefits, the application should be processed on May 6 or as close to this date as possible.

Following are the time limits for denying an application.

Denial Reason	Time Limit
Application and Interview completed, found ineligible	No later than the 31st day from the date of application
Client has not responded to DFA-6	Wait until after the 10th day, but no later than the 31st day
Client missed scheduled interview	Wait until the 31st day

1.4.10 AGENCY DELAYS

If, because of an agency error, an application has not been acted on within the required time limit, corrective action must be taken immediately.

If the agency failed to request the necessary verification, the Worker must immediately send a DFA-6 or verification checklist to the applicant and note that the application is pending. When the information is received, benefits are retroactive to the date of application.

If the agency failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the agency acted in a timely manner. See Section 9.2 for notification requirements.

> **Agency Delay Example:** Application was made November 2. The pending information was received November 17, but the Worker overlooked the application until December 17. It was processed on December 17 when the Worker discovered the error. The client was found eligible. The client is issued benefits retroactive to November 2.

1.4.11 REPAYMENT

When there is an outstanding claim, the eligibility system automatically initiates repayment upon approval. See Chapter 11.

1.4.12 PENALTIES

The Worker must determine if any member(s) of the applicant AG has been disqualified and the length of the disqualification period.

1.4.12.A Work Requirement Penalty

Individuals who have not complied with a SNAP work requirement may be ineligible for a specified time. The Worker must determine if any AG member is still subject to a penalty. See Chapter 14.

1.4.12.B Disqualifications

Individuals who have committed an Intentional Program Violation (IPV) are ineligible for a specified time, determined by the number of previous IPV disqualifications. See Chapter 3.

1.4.13 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the date of application when all eligibility criteria are met within 30 days of the date of application or the date that a signed signature page from WV PATH is received. Benefits for the initial month are prorated from the date of application, over the number of days remaining in the month. Initial month means the first month following any period of time in which the AG was not participating.

NOTE: A sole AG who is an ABAWD that loses eligibility for failure to meet ABAWD requirements must reapply. If the client is not eligible on the date of application, the application must be denied. If the client is eligible, the benefits are prorated from the date of application.

If the AG fails to provide the information requested on a DFA-6, verification checklist or an electronic signature within the 30-day processing time limit but provides it within 60 days of the original application date, the date of eligibility is the date the information was provided. See Section 1.4.3. This only applies at application.

EXCEPTION: For migrant and seasonal farm workers, the initial month is the first month following any break in certification of more than one month.

If an AG applies in West Virginia but received SNAP benefits for the same month in another state, the beginning date of eligibility is the first day of the month following the last month of receipt from the other state.

1.4.14 CERTIFICATION PERIOD

The beginning date of eligibility starts the AG's Certification Period.

The client's certification period must be the longest possible period but must not exceed 24 months for AGs in which all adult members are elderly or disabled with no earned income or only excluded earned income. All other AGs are certified for 6 months except for applications that qualify for expedited services and verifications have been postponed.

1.4.14.A Establishing the Certification Period

1.4.14.A.1 Certification Periods

Upon determination of eligibility, an AG is assigned one of four certification periods as follows.

- ***One Month***

Expedited Service cases which apply prior to the 16th of the month and do not provide the necessary verifications prior to approval. If verifications are provided within the time limit given, the certification period is extended an additional 5 or 23 months based on the AG's reporting requirements.

- ***Two Months***

AGs eligible for Expedited Service who apply on or after the 16th of the month and have verification postponed. See Section 1.4.19.A.3, Combined Issuance. If verifications are provided within the time limit given, the certification period is extended an additional 4 or 22 months, based on the AG's composition and income.

- ***6 Months***

All AGs except those described below for 24 months.

- ***24 Months***

All AGs in which there is no earned income or only excluded earned income and all adult AG members are:

- At least age 60; and/or
- Disabled.

NOTE: These AGs may include individuals under age 18 as long as all adults are disabled and/or elderly.

1.4.14.A.2 Interim Contact Report

For households certified for 24 months, an interim contact report (PRC-2) must also be made at the 12-month point of the certification period. However, no interview is required for this report. The Interim Contact Report is automatically mailed to the AG by the eligibility system. The client must complete the Interim Contact Report and return it to the local office or complete the interim contact report on the PATH public portal.

1.4.14.B Adjusting the Certification Period

1.4.14.B.1 Extending a Certification Period

Once a 6-month certification period is established, the worker may extend it to a total of 24 months only when all adult AG members are elderly or disabled and the AG has no earnings or only excluded earnings. No certification period may exceed a total of 24 months.

1.4.14.B.2 Shortening a Certification Period

Once a 24-month certification period is established, the Worker must shorten it in the following situations and advance notice must be given.

- The AG has an onset of non-excluded earned income;
- The AG is joined by an individual with non-excluded earned income;
- The AG is joined by an adult who is not elderly or disabled.

When the AG no longer qualifies for a 24-month certification period, the Worker must complete a redetermination when the advance notice period ends and assign a new certification period based on the AG's current circumstances.

AGs certified for 6 months may not have their certification period shortened for any reason except ineligibility.

EXCEPTION: When an adult who is not elderly or disabled joins the AG and the AG is approved for WV WORKS, the Worker must give advance notice that the SNAP certification period was shortened. No additional SNAP redetermination is required at this time. The WV WORKS application serves as the SNAP redetermination in this instance only.

➢ *Shortening a Certification Period Examples*

Example 1: An AG is composed of two elderly individuals who have only unearned income. The 24-month certification period is January 2026 through December 2026. On June 2, 2026, the AG adds their 25-year-old son, who is not disabled. The Worker notifies the AG that the certification period is being shortened, and they must report for a redetermination in July 2016. When the redetermination is completed, a new 6-month certification period is assigned based upon the AG's new circumstances.

Example 2: An elderly couple with only unearned income is certified for 24 months beginning January 2026. On May 20, 2026, their 30-year-old daughter and her 10-year-old child move into the home. The daughter applies for WV WORKS for her and her child and is approved for benefits beginning in June 2026. The Worker sends advance notice to the household that their certification is being shortened and they must complete a redetermination. When the redetermination is completed and changes are made for the current circumstances, the certification is reset to 6 months.

Example 3: An elderly couple with only unearned income is certified for 24 months beginning January 2016. On May 24, 2016, their 12-year-old granddaughter moves in with them. They apply for WV WORKS and are approved for benefits beginning May 2016. The SNAP certification period is not shorted because the new AG member is not an adult. The WV WORKS application does not serve as the SNAP redetermination.

Example 4: A one-person AG with no income is certified for 6 months, as the AG member has a pending Retirement, Survivors, and Disability Insurance (RSDI) disability claim. In the second month of the certification period, the RSDI is awarded and it is determined the AG is still eligible for SNAP. The certification period is extended 22 months to equal a total of 24 months, now that all adult AG members are disabled without earnings.

Example 5: An AG composed of two elderly adults with earnings and one child is certified for 6 months. In the second month, the AG reports the loss of earned income. Because all of the adult AG members are elderly without earned income, the certification period must be extended to 24 months. The extended certification period starts the month the change is effective.

Example 6: An AG with only excluded earnings is composed of two children and two disabled adults and is certified for 24 months. In the 19th month, the AG reports the onset of non-excluded earnings. The Worker must send the advance notice informing the household that a recertification interview is required. Upon completion of the interview and changes made for the current circumstances, their certification period is reset at 6 months.

1.4.15 REDETERMINATION

Redetermination procedures follow the same procedures as an application. An interview is required unless it is completed by the Social Security Administration (SSA). When found eligible, the client's new certification period is established based on the current household circumstances.

1.4.16 EXPEDITED PROCESSING

Expedited Service is the term used for special procedures in processing applications meeting specific requirements.

It is possible for a client to qualify for Expedited Service at any time during the application process.

1.4.16.A Eligibility Requirements

The following groups of cases are eligible for Expedited Service if otherwise eligible. They are:

- Those whose monthly gross income is less than $150 and whose liquid assets do not exceed $100.

- Migrant and seasonal farm worker AGs which have been determined Destitute, as defined in Chapter 4, and whose liquid assets do not exceed $100.
- Eligible AGs whose combined monthly gross countable income and liquid assets are less than the AG's monthly paid and unpaid shelter and the appropriate utility standard, if eligible. The AG's income and liquid assets must be less than the AG's monthly paid and unpaid shelter costs and the SUA amount for which the AG is eligible.

There is no limit to the number of times an AG may be certified under expedited procedures, as long as, prior to each expedited certification:

- The AG either completes the verification requirements that were postponed at the last expedited certification; or
- Was certified under normal processing standards since the last expedited certification.

NOTE: Liquid assets must be evaluated when determining eligibility for Expedited Services even though the assets may not be counted toward the SNAP asset limit or are not required to be verified.

Expedited Service Example 1: Mr. Aster was due for redetermination in April. He kept his scheduled appointment and continues to be eligible. He is not eligible for Expedited Service because his normal issuance cycle continues.

Expedited Service Example 2: Mr. Begonia applies for SNAP benefits on May 1 and is found eligible for Expedited Service. He is certified for one month only and verification is postponed. He reapplies on May 12 for June. He provides all verification that was postponed from the previous expedited certification. Mr. Begonia has $0 income and is eligible beginning in June. He qualifies for Expedited Service because he provided the postponed verification from the previous expedited certification.

1.4.16.B Screening for Expedited Service

Every applicant must be screened, and a decision made on the date of application for eligibility for Expedited Service whether or not the applicant requests this service.

If, for any reason, an AG is not identified on the date of application as being eligible for Expedited Service, or is not eligible at that time, and the Worker subsequently discovers that the AG is entitled, the Worker provides Expedited Service as if entitlement had been established on

the date of application. However, the time limits are calculated from the date the Worker discovers the entitlement, not from the date of application.

AGs requesting, but not entitled to Expedited Service, have their applications processed according to normal standards. See Section 9.2 for notification requirements.

The DFA-2, DFA-SNAP-1 or the case record must show that the application was screened for Expedited Service and the justification for the Worker's decision at application. Any changes in the original decision documented in the case record.

1.4.16.C Variations in Application Processing Procedures

AGs which qualify for Expedited Service are entitled to receive faster service. To ensure faster service, some exceptions to standard procedures apply.

1.4.16.C.1 Verification/Work Requirements

Only verification of identity is required prior to approval for Expedited Service.

Verification of standard eligibility requirements is temporarily postponed, unless verification can occur within the Expedited Service time frame.

Eligibility requirements must be met prior to approval, even though routine verification is temporarily postponed for Expedited Service.

This does not mean that eligibility requirements are waived prior to approval, only that the routine verification of them is postponed. This also applies to the verification of and the application for a Social Security Number (SSN). All reasonable efforts must be made to meet all routine verification requirements prior to approval. See Chapter 7.

Postponed verification must be received prior to the second issuance.

If the applicant is able to verify identity, before, or at the same time, the additional information for which the case was pending is received, procedures for Expedited Service apply. The client also qualifies for Expedited Service if the verification of identity is received at the same time the pending information is received. In addition, if the pending information is received, but not acted on, and then the verification of identity is received, Expedited Service procedures are appropriate. This must be explained to the client.

Prior to approval, the non-exempt individual(s) who completes the application process is subject to the work requirements that apply at application. The Worker must also attempt to have all other non- exempt individuals in the AG comply with the work requirements prior to approval. When this is not possible within the Expedited Service time frame, all other non-exempt individuals must comply with the work requirements by the second issuance.

EXCEPTION: Combined issuance procedures require compliance prior to the third issuance.

1.4.16.C.2 Time Limits

Federal regulations require that SNAP benefits must be available for use by an eligible Expedited Service AG no later than the close of business on the seventh calendar day following the date of application.

To ensure this happens, consideration must be given to the following factors:

- SNAP benefits are available in the client's EBT account the day after approval in the eligibility system.
- If the AG does not already have an EBT card and/or PIN, the EBT card is mailed the day after entry of information in the eligibility system.
- The client must have benefits available for use no later than seven calendar days after the date of application, including weekends and holidays.
- If Expedited Service eligibility is overlooked on the date of application or the client subsequently becomes eligible for Expedited Service, action must be taken on the same date the Worker discovers the client is eligible.
- The intention of the Expedited Service policy is to provide assistance quickly. When an uncontrollable situation forces a delay, the application must be processed as soon as possible. A recording in the eligibility system must substantiate the reason any expedited service approval was not confirmed timely.

1.4.17 SPECIAL CONSIDERATIONS

Special considerations are outlined below.

1.4.17.A Joint Supplemental Security Income (SSI) and SNAP Application/Redetermination Process

Social Security Administration (SSA) offices accept SNAP applications for pure SSI AGs and forward them to the local office for eligibility determination.

The work requirements in Section 14.2 are waived for individuals who complete the joint SSI/SNAP application process until eligibility for SSI is determined.

The date of application is the date the SSA/DHS-1 was signed at the SSA office.

NOTE: When a resident of an institution applies for SSI and SNAP benefits jointly prior to leaving the institution, the application date is the date the individual leaves the institution.

A pure SSI AG is one in which all members of the AG are either recipients of, or applicants for, SSI on the date application is made.

1.4.17.A.1 The SSA Responsibilities

- Inform each client in a pure SSI AG that he may apply for SNAP benefits at the SSA or the local DOHS office, and that service may be faster if they choose to apply at the DOHS office. If the client prefers to apply at the DOHS office, the SSA provides him with the address and telephone number of the appropriate office.
- Assist the client in completing form SSA/DHS-1.
- Inform the client to contact the local office about the status of his application.
- If the AG qualifies for Expedited Service, inform the applicant that the AG may receive these benefits faster if he applies at, or delivers the application to, the local office.
- Forward the SSA/DHS-1 to the local office within one working day, following procedures worked out between the CSM and the SSA contact person. See Section 1.2.12.C.
- Complete an SSA/DHS-1 for a redetermination when the client requests this service. SSA may initiate this action. Since SSA accepts the client's statement that his case is due for redetermination, the local office may receive, SSA/DHS-1 for persons who are not actually due for redetermination.

- The local office completes the redetermination when the SSA/DHS-1 is received, whether it is due or not.
- A redetermination is indicated by “Recertification” written in red at the top of the SSA/DHS-1.
- All procedures and time limits which apply to applications accepted by the SSA, apply to redeterminations accepted by the SSA.

1.4.17.A.2 Worker Responsibilities

- Screen and, if eligible, process the application for Expedited Service.

  NOTE: The date of application for the Expedited Service time limits is the date the application is received in the local office.

- Screen the SSA/DHS-1 to determine if further information is necessary.

  If the form is incomplete, any needed information must be supplied by the client. The form is not returned to the SSA, and, under no circumstances, is the client required to visit the local office for completion of the form. The client can be requested to visit the office, but the application cannot be denied solely because he does not. Needed information may be obtained by telephone, mail, or home visit.

  If verification not provided by the SSA is needed, the Worker must notify the client of the required information within three working days of the date the application is received from the SSA.
- Process according to normal procedures if the AG does not qualify for Expedited Service.
- Process any SSA/DHS-1 forms completed as redeterminations the same way applications are handled.

1.4.17.A.3 Quality Control (QC) Errors

If an error is a result of information supplied by the SSA, it is not included in the county's error rate. However, if the SSA supplied the correct information and the Worker failed to take the appropriate action, the county is charged with the QC error.

1.4.17.B Mail-In SNAP Applications

If the client calls to request an application be mailed to him, the Worker must screen the client for Expedited Service over the telephone and advise him of his potential eligibility.

If the client is eligible for Expedited Service, the Worker may complete the interview over the telephone and mail the completed application to the client for signature. The days the application is in the mail to and from the household and the days the application is in the household's possession pending their signature will not be included in the Expedited Service period. Case comments will need to be made stating the day the application is mailed and the date it is received in the office with a signature.

If the client is eligible for Expedited Service and cannot complete a telephone interview or is not eligible for Expedited Service, the Worker will mail the application. The Worker schedules an interview no later than five working days after the DFA-2 or DFA-SNAP-1 is received. The interview may be scheduled by telephone or by letter.

If the applicant keeps the appointment for the interview, procedures for the intake interview and application processing apply. See Section 1.4.4.A, Procedures for Missed Scheduled Interviews.

1.4.17.C Categorical Eligibility

Categorical Eligibility may be determined at any time as long as the eligibility requirements are met.

1.4.17.C.1 Who Is Eligible?

➢ ***AGs Authorized to Receive a TANF-Funded Benefit***

When an AG has at least one member who is authorized to receive benefits from TANF-funded programs or is authorized to receive information and referral services about TANF and other department programs, the AG is categorically eligible.

Authorized to receive means the AG is coded in the eligibility system as active for a benefit whether they are receiving it or not. Those authorized to receive include individuals who have

been determined eligible for benefits and notified of the determination, even if benefits have not been received or accessed or the benefits have been suspended, recouped or not paid because they are less than a minimum amount or they have not yet received the information or referral.

TANF-funded Programs: The following are TANF-funded programs:

- WV WORKS: Any month for which the AG is authorized to receive benefits.
- Employment Assistance Program (EAP): Any month for which the AG is authorized to receive benefits.
- Diversionary Cash Assistance (DCA): three months beginning with the month of approval.
- Support Service Payments: As long as actively enrolled in Work Programs (WP)
- School Clothing Allowance (SCA) and West Virginia School Clothing Allowance (WVSCA): Until the benefit expiration date

Authorized for Information and Referral Services

AGs with income at or below 200% are authorized to receive information and referral services. The DFA-SNAP- I&R-1 is mailed to the AG by the eligibility system to inform the client of potential programs or services available to him. The DFA-SNAP-I&R is paid for by TANF/MOE funds.

➢ *AGs Containing Only Individuals Authorized to Receive SSI*

When the AG contains only individuals approved for SSI, the AG is categorically eligible. This also includes the following:

- Persons determined eligible for SSI even though benefits have not been paid yet.
- Persons determined eligible, but who receive zero benefits, such as:
    - SSI recipients whose benefits are withheld for repayment.
    - Persons whose SSI payments are suspended.

1.4.17.C.2 Who Is Not Categorically Eligible?

An AG cannot be categorically eligible in the following situations:

- A person who is normally required to be a member of the AG is disqualified due to an IPV.

- The AG refuses to cooperate in providing information necessary to make an eligibility determination.
- The AG is ineligible due to the striker provisions.
- An AG who is the recipient of a substantial lottery or single gaming win that is greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled member.
- An AG who contains an individual(s) who have been convicted of certain felony offenses as an adult and is not complying with the terms of their sentence.
- A person who is normally required to be a member of the AG is disqualified due to being convicted of a specific felony offense. The felony must meet two criteria:

  The felony must involve an element of the possession, use, or distribution of a controlled substance as defined by Section 802 (6) of the Controlled Substance Act; and

  The offense of conviction has at least one of the following elements:

  - Misuse of SNAP benefits
  - Loss of Life
  - Causing of physical injury
- The AG does not meet any of the requirements in Categorical Eligibility, Who is Eligible section above.

NOTE: Persons who are normally required to be included in the AG are individuals who purchase and prepare with a member of the AG or are require under Section 3.2.1.A to be included in the AG.

- The presence of any of the following people does not prevent the remaining AG members from being categorically eligible.
  - Non-qualified non-citizen
  - Ineligible student
  - Any individual disqualified due to enumeration
  - A person institutionalized in a non-exempt facility

1.4.17.C.3 Presumed Eligibility Requirements

Once it is determined that an AG qualifies for Categorical Eligibility, the following eligibility requirements are presumed to be met.

- Asset limit: The transfer of assets policy is applied as appropriate. See Chapter 5.
- Gross income limit, when applicable
- Net income limit
- Sponsored non-citizen information
- Residency
- SSN information: Only if the AG member is receiving a benefit which requires the SSN to be verified.

If any of the presumed information is questionable, it is verified. All other eligibility requirements of the SNAP Program are applicable to categorically eligible AGs.

NOTE: While categorically eligible AGs are presumed to meet both income limits, those with more than two members are not automatically eligible for SNAP. The monthly net income of an AG must be eligible for an issuance based on IMM 4.4.3.C. Categorically eligible AGs containing one or two individuals automatically receive the minimum benefit, unless it is a prorated benefit.

1.4.17.C.4 Special Processing Requirements

The following special processing requirements apply.

➢ *TANF Benefit Applicants*

To determine if an AG is categorically eligible due to its status as a recipient of TANF-funded benefits, the Worker may temporarily postpone, within the 30-day processing limit, the SNAP eligibility determination if the AG is not eligible for Expedited Service and appears categorically eligible.

The Worker must not deny an AG that could be categorically eligible until the 30th day to determine if the AG is eligible to receive a TANF-funded benefit.

This applies to AGs that:

- Have an application for TANF-funded benefits pending; and
- Are denied SNAP benefits; and
- Are later determined eligible for TANF-funded benefits; and
- Are otherwise categorically eligible.

The Worker must provide benefits using the original application and any information supplied later. Benefits are issued from the date for which TANF-funded benefit eligibility is established or the date of the original SNAP application, whichever is later. The client cannot be required to complete a new DFA-2, DFA-SNAP-1 or another interview. The Worker may contact the client to update the DFA-2 or DFA- SNAP-1 information by mail or by telephone.

➢ *SSI Applicants*

Persons who apply for SSI and SNAP benefits at the same time have SNAP eligibility determined as any other AG until Categorical Eligibility is met.

SSI applicants who are denied SNAP benefits must be informed in the denial notice of the possibility of potential Categorical Eligibility should they become SSI recipients.

1.4.17.C.5 Categorical Eligibility Examples

Categorical Eligibility Example 1: A WV WORKS case was closed five months ago but is still enrolled in Work Programs (WP) as the AG is still eligible for support service payments. The AG last received a payment four months ago but is still categorically eligible.

Categorical Eligibility Example 2: A person applies for SNAP benefits and is authorized to receive information and referral services about TANF-funded programs. The DFA-SNAP I&R-1 is mailed out the day of approval and the client receives it five days later. The client is categorically eligible from the day of application even though the DFA-SNAP I&R-1 is received five days later.

Categorical Eligibility Example 3: A family of five with a total gross income of 185% FPL applies for SNAP benefits. The household income exceeds the gross income limit for SNAP; however, the family is eligible to receive information and referral services because their income is below 200% FPL, which means the AG is presumed to have met the gross income limit (as well as the other

requirements listed in 1.4.17.C.3). The family's net income must then be calculated to determine if they are eligible for an issuance.

Categorical Eligibility Example 4: Four individuals who purchase and prepare together apply for SNAP. One of the individuals is ineligible due to an IPV disqualification. The AG cannot be categorically eligible, so must meet all SNAP requirements to be eligible, including being within the gross income, net income and asset limits.

Categorical Eligibility Example 5: A mother, father and three children apply for SNAP benefits. The father is an non-qualified non-citizen. If the SNAP AG's total gross income (including the amount deemed by the ineligible father) is equal to or less than 200% FPL, the AG can be determined categorically eligible.

Categorical Eligibility Example 6: An individual who purchases and prepares with other members of a SNAP AG is an ineligible student who has a felony conviction for drug possession, which had an element of misuse of SNAP benefits, or loss of life or the causing of bodily injury. The individual's status as a student has no effect on categorical eligibility. However, the felony offense for possession of a controlled substance with any of the three elements listed in Section 1.4.17.C.2 prevents the AG from being categorically eligible.

1.4.18 APPLICATION/REDETERMINATION VARIATIONS

Redetermination procedures are the same as application procedures except in the following situations.

1.4.18.A Redetermination Forms

The following methods can be used for redetermination:

- System generated redetermination forms (CSLE or CSLR)
- WV PATH
- DFA-2 and DFA-RR-1
- DFA-SNAP-1

The eligibility system automatically mails the CSLE/CSLR in the month prior to the last month of certification. The form must be completed and returned prior to the scheduled interview date

specified on the CSLE/CSLR. The form is considered complete when signed and dated by the client or his authorized representative or completed and submitted by WV PATH.

1.4.18.B Redetermination Cycle

When a case is redetermined and found eligible, a new certification period is established. See Section 1.4.14, Certification Period.

1.4.18.C Redetermination Interview

An interview is required regardless of the method by which the redetermination is completed. A phone interview is conducted unless one or more of the following criteria is met:

- The client or his authorized representative requests a face-to-face interview. The Worker must schedule the appointment; or
- The Department determines that a phone interview is not appropriate due to questionable circumstances. The criteria stated in Section 7.2 for questionable circumstances for verifications, also apply to and serve as guidance for scheduling face-to-face interviews due to questionable circumstances. Supervisory approval and case documentation is required when scheduling a face-to-face interview due to questionable circumstances.

1.4.18.D Scheduling Interviews

When the client submits a redetermination, either in person, by mail, fax or WV PATH, but fails to complete a scheduled interview for redetermination, he is notified of the missed interview and that it is his responsibility to reschedule the interview. In addition, he receives notice of AG closure if the redetermination is not completed.

When the client does not submit a redetermination form, he is only notified of AG closure.

> **Scheduling an Interview Example 1:** A SNAP redetermination is scheduled for September 1. The client calls the office and requests a redetermination form be mailed to him and that an interview be scheduled to accommodate his work hours. The interview is scheduled for September 10 and the client returns the redetermination form by mail on September 7. The client misses the scheduled

> interview on September 10. Because he filed a redetermination by mail, but missed a scheduled interview, the Worker sends a notice to inform the client he is responsible for scheduling another interview. At adverse notice deadline, if the client has not completed the interview, a closure notice is sent.
>
> **Scheduling an Interview Example 2:** Same situation as above, but the client does not file a redetermination or appear for an interview. No notice is required for a missed interview because a redetermination was not submitted, but a closure notice is sent.

All SNAP AGs must receive a notice of expiration of the certification period. For cases certified for more than one month, the notice must be received in the month prior to the last month of certification.

The local office has the following options in scheduling redetermination interviews:

- Schedule an interview by sending an appointment letter to each AG to be redetermined.

  The appointment may be scheduled anytime during the last month of certification. However, if the client's appointment is scheduled after the 15th, he may request and must be granted an appointment for the 15th or earlier. The client must be given 15 days from the date of the appointment letter before any penalties are applied for failure to keep the appointment.

- Redeterminations for pure SSI AGs may be initiated by SSA staff and completed by the Worker. The AG is notified of this service by form ES-RT-3. See Special Considerations below.

1.4.18.D.1 Aligning SNAP, TANF and MAGI Medicaid/CHIP Review Dates

The following information will be needed for MAGI Medicaid and WVCHIP only during the SNAP Redetermination interview. The household’s tax filing status will need to be updated. Verification procedures found in Section 7.2 must be followed to approve or deny MAGI Medicaid and WVCHIP. MAGI Medicaid and WVCHIP must also have their period of eligibility renewed to align with TANF redeterminations.

- If the CSLE/CSLR is not completed and returned by the end of the certification period, benefits are stopped. Notice of closure is required, but advance notice is not required.

- If the CSLE is returned in the month after the end of the certification period, no DFA-2 or DFA-SNAP-1 is required for reapplication. The CSLE/CSLR is used as the application form and benefits are prorated from the date the application is received in that month.
- If the CSLE/CSLR is used as an application form, an interview is required.

NOTE: Failure of client to provide information related to Medicaid or WVCHIP only will have no effect on SNAP benefits.

When an AG submits a completed CSLE/CSLR or WV PATH redetermination prior to the scheduled interview date, the Worker must contact the AG at the scheduled time to conduct the telephone interview. The Worker must make a reasonable attempt to contact the AG to conduct the telephone interview. If an AG does not answer the Worker's call, the Worker must document in case comments the reasonable attempt(s) made prior to a determination that the appointment was missed. The AG is notified of the missed interview and it is the AG's responsibility to reschedule. The notice of missed interview is included in the notice of closure and/or denial.

When an AG submits a completed CSLE/CSLR or WV PATH redetermination after the originally scheduled interview date, the Worker must schedule another interview appointment. The interview appointment must be scheduled using current system procedures allowing time to provide notice to the client and to conduct the interview.

1.4.18.E Completion

A SNAP redetermination is a reapplication for benefits. Under no circumstances are benefits continued past the month of redetermination, unless a redetermination is completed, and the client is found eligible.

If the recipient is no longer eligible, the SNAP AG is closed.

1.4.18.E.1 Benefit Issuance at Redetermination

➢ *Uninterrupted Benefits at Redetermination*

Clients who submit their redetermination form in a timely manner, complete the interview and provide requested verification within the agency time limits, must receive uninterrupted benefits or have lost benefits restored if the Agency's delay causes benefits to be interrupted. The client

does not lose the right to uninterrupted benefits if the time limits established for verification extends into the new certification period.

Clients who fail to submit their redetermination form timely, fail to complete an interview or fail to submit missing verification by the established deadline lose the right to uninterrupted benefits.

Uninterrupted benefits are benefits received within 30 days of the last issuance. For longer certifications, uninterrupted benefits are benefits received at the usual time in the issuance cycle.

EXCEPTION: AGs which have met all redetermination requirements are entitled to uninterrupted benefits. When this cannot be done due to the time frame for submitting missing verification, the Worker must take action to reinstate benefits so that the client receives benefits within five working days after supplying the missing verification, if eligible. Some failures to provide verification may only result in loss of a deduction, not ineligibility.

➢ *Benefits Not Prorated*

In the following redetermination situations, benefits are not prorated, and the certification period begins the month following the end of the previous certification period.

- The verification is due within the last month of the certification period and is returned by the last day of the certification period; or
- The verification is due after the last day of the certification period and is returned by the date the Worker specifies. A reapplication is not required.
- The redetermination is not submitted until the month following the end of the certification period due to an Agency error.

➢ *Benefits Prorated*

In the following redetermination situations, benefits are prorated, and the certification period begins the month following the end of the previous certification period and a reapplication is not required.

- The verification is due within the last month of the certification period and is not returned until the following month. Benefits are prorated from the date the verification is returned.
- The verification is due after the last day of the certification period and is returned after the due date, but by the end of the month it was due. Benefits are prorated from the date the verification is returned.

1.4.18.E.2 When a New Application Is Required

In the following redetermination situations, a new application is required. Benefits for the first month of certification and the beginning of the certification period are determined as they are for any other applicant.

- The verification is due within the last month of the certification period and is not returned by the end of the certification period or during the following month; or
- The verification is due after the last day of the certification period and is not returned by the last day of the month it was due, i.e., the month following the end of the certification period.
- The AG does not submit a redetermination before the end of the certification period.

  If the CSLE/CSLR is not completed and returned by the end of the certification period, benefits are stopped. Notice of closure is required, but advance notice is not required. If the CSLE/CSLR is returned in the month after the end of the certification period, no DFA-2 or DFA-SNAP-1 is required for reapplication. The CSLE/CSLR is used as the application form and benefits are prorated from the date the application is received in that month. You must screen for expedited service for any household that applies after the end of the certification period and, if determined eligible for expedited service, the household must have an opportunity to participate within 7 days from the date the CSLE/CSLR was filed.

  Redetermination Example 1: A SNAP AG is redetermined on July 3 and submits required verification by July 20. The new certification period begins August 1. Benefits are not prorated.

  Redetermination Example 2: Same situation as above, but the verification is not provided until August 4. No reapplication is required, and August is the first month of the new certification period. Benefits are prorated from August 4.

  Redetermination Example 3: A SNAP AG is redetermined on July 29 and the verification is due by August 8. The verification is received in the local office on August 4. The first month of the new certification period is August. Benefits are not prorated.

  Redetermination Example 4: Same situation as above, but the verification is returned on August 20. The first month of the new certification period is August. Benefits are prorated from August 20.

  Redetermination Example 5: Same situation, but the verification is not returned until September 3. The AG must apply with a new application because the

verification was not returned within the month following the last month of the certification period.

1.4.18.F Overdue Redetermination

SNAP AGs which are due for redetermination and for whom a redetermination has not been completed are automatically closed by the eligibility system on the adverse action deadline of the month when a redetermination is due. A redetermination is not considered completed until SNAP benefits have been confirmed as approved or denied within the eligibility system.

1.4.19 THE BENEFIT

USDA is responsible for authorizing business establishments to accept SNAP benefits. SNAP benefits may be used to purchase food for home preparation and/or seeds and plants which produce food for home consumption. SNAP benefits cannot be used to buy soda (see section 1.4.20) or hot foods that are ready to eat or foods that may be eaten in the store.

SNAP benefits are deposited into an Electronic Benefit Transfer (EBT) account and accessed by using an EBT card. This is the SNAP identification card for the AG.

1.4.19.A Initial Benefits

Initial benefits are usually received or are available within three days of entry in the eligibility system.

1.4.19.A.1 Amount

A determination of the initial SNAP benefit month must be made to determine if initial benefits must be prorated. Any month determined to be an initial month must have benefits prorated. The amount of the initial allotment is prorated over the remainder of the month from the date of application. The full month's countable income is used to determine the full month's allotment. The amount of the initial benefit due the recipient is based on the number of days left in the

approval month from the date of application as compared to the full month's benefit. Use Chapter 4, Appendix D.

1.4.19.A.2 Method of Issuance

Upon approval, the eligibility system issues a prorated amount for the current month and the next month’s benefit is issued based on the schedule in Ongoing Benefits below.

See Section 1.4.15, Expediting Processing, for combined issuance when Expedited Service applies.

1.4.19.A.3 Combined Issuance

When a SNAP applicant meets all the following criteria, his first prorated benefit and first full benefit must be issued at the same time.

- The client applies for an initial month's benefits. Initial month is defined as the first month for which the AG is certified for SNAP benefits following any period of time during which the AG was not certified.
- Application is made on or after the 16th of the month.
- The client is eligible for the initial month and the next subsequent month.
- The client is eligible for Expedited Service.

To reduce the time period between the receipt of the Combined Issuance and the third month's issuance, the approval must be confirmed by the first working day of the third month if the client continues to be eligible.

The policy regarding Combined Issuance applies when the applicant is also a WV WORKS applicant. The procedures used to accomplish the Combined Issuance must not delay the processing of WV WORKS AGs.

The eligibility system notifies each client who receives a Combined Issuance.

1.4.19.B Ongoing Benefits

1.4.19.B.1 Amount

Once eligibility is established, the AG is eligible to receive the full monthly allotment of the SNAP benefits for the certification period.

NOTE: When it is determined that a full month's benefit is $0, the application is denied or the AG is closed. This applies whether or not the AG is categorically eligible.

1.4.19.B.2 Method of Issuance

SNAP benefits are available in the EBT account on a staggered schedule the first nine calendar days of the month, based upon the payee's last name.

First Letter of Last Name	Calendar Day of Month
B, X, Y, Z	1
C, F	2
H, N, V	3
I, M, O, U	4
Q, S	5
A, W	6
J, K, P	7
D, E, R	8
G, L, T	9

1.4.19.C Electronic Benefits Transfer

SNAP benefits are deposited into an EBT account and accessed by using the EBT card and a Personal Identification Number (PIN), similar to a personal debit or ATM card.

The possession of two or more EBT cards that do not identify the individual may be subject to criminal charges.

The following outlines definitions and procedures which are specific to EBT. Additional information about how EBT affects other policy and procedures is found in specific Manual sections which apply.

1.4.19.C.1 EBT Definitions and Terminology

The following is a list of commonly used terms or acronyms associated with EBT.

ADMINISTRATIVE TERMINAL

EBT vendor system used to inquire into EBT account information.

AUTHORIZED CARDHOLDER

An individual, who, in addition to the payee, may be issued an EBT card and access to the EBT account.

CUSTOMER SERVICE REPRESENTATIVE (CSR)

The CSR for the EBT vendor who is reached through the IVRU toll-free number also referred to as the EBT Helpline. This person has the ability to replace or deactivate lost, stolen or damaged cards and to file a claim on behalf of a client regarding transactions.

DEMOGRAPHIC INFORMATION

Identifying information about the AG's primary person which is sent to the EBT vendor in order to set up an EBT account and mail the EBT card. This includes the name, SSN and date of birth of the AG's primary person and the payee's address.

ELECTRONIC BENEFITS TRANSFER (EBT)

EBT or the use of a card to access WV WORKS, CSI and DCA cash benefits, and SNAP benefits.

EBT HELPLINE

The toll-free number through which the client may access the Interactive Voice Response Unit (IVRU) or CSR.

EXPUNGMENT

274 days from the date of issuance and immediately when it has been determined all members of the Assistance Group are deceased and independent verification of the death(s) have been obtained by the worker.

INTERACTIVE VOICE RESPONSE UNIT (IVRU)

The IVRU is also referred to as EBT Helpline. The EBT vendor operates the IVRU seven days a week, 24 hours a day. Functions of the IVRU include, but are not limited to, account balance inquiries, card activation and PIN changes.

MOUNTAIN STATE CARD

The West Virginia EBT card.

PAYEE

The term payee identifies the person to whom benefits are issued.

For EBT purposes, certain information about the eligibility system primary person is sent automatically to the EBT vendor in what is called a demographic record. This information is used to set up the EBT account, mail the EBT card and to identify the payee and authorized cardholders for security card replacement procedures. The card is sent to the primary person. A primary person who is not a payee can be issued an EBT card as an authorized cardholder, if so designated by the payee.

PERSONAL IDENTIFICATION NUMBER (PIN)

This number must be used to access EBT benefits with the EBT card. This is not the eligibility system PIN number.

POINT OF SALE (POS) EQUIPMENT

This is used to spend SNAP benefits at a store. Account balance inquiries may be made using a store's POS machine located at the Service Desk. Account balances also appear on all receipts printed by a POS machine.

PROTECTIVE PAYEE

A protective payee is a person, or an organization appointed to receive the benefits for anyone who cannot manage or direct the management of his or her own basic needs.

STATUS THE EBT CARD

Deactivate the card so that it cannot be used. This occurs when a replacement card is requested, a payee is changed, or an authorized cardholder is removed or changed.

1.4.19.C.2 EBT Card Issuance

➢ *Initial Card Issuance*

The EBT card is issued when the first benefit to be issued into an EBT account is approved. It is mailed the day after the approval in the eligibility system. When the card is received the cardholder must call the EBT Helpline to create a PIN and activate the card.

All cards are mailed to the payee following the address hierarchy in the eligibility system, which includes the card(s) for any additional authorized cardholder(s). It is the responsibility of the payee to distribute the cards to any other cardholder(s).

➢ *Legal Guardian or Protective Payee*

When the Worker indicates in the eligibility system that the AG has a legal guardian or protective payee, all cards are mailed to the address of that individual. Current policy contains no reference to a specified legal guardian as a payee. Any other representative or protective payee is indicated in eligibility system as a protective payee.

➢ *Authorized Cardholder*

The AG may designate an additional individual(s) as an authorized cardholder for EBT. The authorized cardholder has his own card and PIN and accesses the EBT account for the specified benefit(s) without restriction. For this reason, the choice of an authorized cardholder and its importance must be stressed with the applicant or recipient. The authorized cardholder is designated, changed, or removed in the eligibility system.

When the individual designated as primary person for the AG has a legal guardian or protective payee coded in the eligibility system, the card for the AG is mailed to that person. In this situation, if the primary person or other individual

NOTE: Only one authorized cardholder may be selected for SNAP benefits. If the AG receives both SNAP benefits and cash assistance, they may select one authorized cardholder for each benefit. The maximum number of cards issued for any case is three.

must have a card, the information must be entered in the eligibility system as an authorized cardholder. All cards are mailed to the address of the legal guardian or protective payee.

In order to terminate an authorized cardholder's access to benefits, the payee must call the EBT IVRU to deactivate the card and contact the DOHS Customer Service or local office to remove or change the cardholder. The DOHS Customer Service Center and local office staff cannot deactivate a card.

➢ *Cardholder Security*

The demographic information sent to the EBT vendor for the primary person in the AG is the SSN, date of birth and address to which the card is sent. No demographic information is sent for any authorized cardholder. The authorized cardholder must know the date of birth of the AG's primary person and the address to which the card(s) is mailed. If the SSN is requested for a PIN change, the AG's primary person provides his own SSN and the authorized cardholder or representative/protective payee must provide zeros.

➢ *Frequent Card Replacement*

After a client requests a replacement EBT card four or more times in a rolling 12-month time period, an education letter is issued. This letter contains the penalties for trafficking, opportunities for additional education of card handling procedures, and informs the client that future replacements may be blocked until contact is made with the Department.

Investigations and Fraud Management (IFM) will determine if the client meets the criteria for investigation and will notify the Worker for additional action needed on the case.

1.4.20 SNAP HEALTHY CHOICES DEMONSTRATION WAIVER

1.4.20.A USDA FNS Waiver

Effective January 1, 2026, SNAP benefits may not be used to purchase soda products in West Virginia. This includes all soda, whether regular, diet, or zero-calorie. The restriction applies statewide to all SNAP households, and remains in effect through December 31, 2027, unless extended by federal approval.

1.4.20.B Allowable Beverages

The restriction applies only to soda products. Milk and milk products, fruit and vegetable juices, water, and water products remain eligible for purchase with SNAP benefits.

NOTE: Clients who use benefits in other states are subject to the purchasing rules of the state where the transaction occurs.

1.5 WV WORKS

NOTE: When WV WORKS applicants are also Supplemental Nutrition Assistance Program (SNAP) and/or Medicaid applicants, requirements in Section 1.2 and Section 1.4 also apply to the SNAP portion of the case and the requirements in Sections 1.2 and 1.6 - 1.22 apply to the Medicaid portion.

1.5.1 APPLICATION FORMS

This section describes the process for determining initial and ongoing eligibility for the WV WORKS Program. A DFA-2 or online application is used.

NOTE: When an application has been made for WV WORKS and/or Medicaid and the application is denied or withdrawn and approved for Diversionary Cash Assistance (DCA), the assistance group (AG) or non-recipient Work-Eligible Individual must not be required to make an additional application for SNAP. SNAP eligibility must be determined based on the information provided for the other programs.

1.5.2 COMPLETE APPLICATION

The application is complete when the client signs a DFA-2 or DFA-5 which contains, at a minimum, his name and address or he submits an online application. The rights and responsibilities are included with the online application; the DFA-RR-1 is not required.

If the client chooses not to sign the DFA-2, the application is considered incomplete, and the Worker must take appropriate eligibility system action to deny the application, complete client notification, and

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

record in case comments that the client did not want to sign the application and the reason for his decision. The Worker must encourage the client to sign the application so there is no misunderstanding that he was denied the right to apply. If the online application is not complete, or additional relevant information is discovered during the face-to-face interview, a new DFA-2 and DFA-RR-1 will be required.

1.5.2.A Caretaker Relative Option

When a parent(s) is included with his own child(ren) in the AG, the DFA-WVW-10 must not be signed. The form is used only when a caretaker relative receives cash assistance only for children to whom he is not a parent.

For cases in which the caretaker relative is not a natural or adoptive parent, form DFA-WVW-10 must be explained. The form must be signed and completed prior to approval, but not necessarily during the intake interview. Refusal, or other failure, of the caretaker relative to sign the form results in denial of eligibility for the caretaker relative for at least 12 months. Eligibility continues to be denied beyond 12 months, for as long as the caretaker fails to choose. The original form must be filed in the case record and the client must be given a copy. See Section 3.4 for details about the limited choice for the caretaker.

1.5.3 DATE OF APPLICATION

The date of application is the date that the DFA-2, which contains, at a minimum, the applicant's name and address, is signed or the application is submitted online. See section 1.2 for the online process. Benefits are prorated from the date of application when all other eligibility requirements are met.

If a household which became ineligible due to a lump sum payment requests recomputation, the date of application is the date of the request.

Because approval depends upon making the application, attending orientation, and completing a Personal Responsibility Contract (PRC) / Self-Sufficiency Plan (SSP) as well as providing verifications, all of which may not be available to the client on the date of application, form DFA-RFA-1 is available to protect the date of application for proration purposes. There must be a full application made subsequent to each DFA-RFA-1. If the applicant fails to follow through with the application, the Worker must deny the DFA- RFA-1 in the eligibility system.

The DFA-RFA-1 may only be used when a DFA-2 is not completed at the time the client expresses an intent to apply for WV WORKS.

1.5.4 INTERVIEW REQUIRED

A face-to-face interview is required.

If a home visit is scheduled for the intake interview, eligibility is not affected 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 Missed Home Visit 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.

1.5.5 WHO MUST BE INTERVIEWED?

1.5.5.A Parent(s)

Information in this item applies only to the intake interview. While it is possible to have only one parent participate in the intake interview, it will usually be necessary for both parents to be interviewed about the PRC/SSP and other WV WORKS requirements.

If the child is living with both parents or a parent and a stepparent, both must be interviewed unless:

- One parent or stepparent is hospitalized; or
- One parent or stepparent is employed, and his working hours preclude participation in the interview during the agency's normal working hours.

1.5.5.B Specified Relative

The specified relative with whom the child lives must participate in the intake interview. See Chapter 3 for definition of specified relative.

When the specified relative with whom the child lives has a legal committee, the committee must be interviewed.

If the child is living with only one specified relative and he is unable to participate in the interview, a representative may participate in the intake interview. A written statement, signed by the specified relative, who gives the representative authority to apply on his behalf, is required. However, the specified relative who chooses to be included in the AG must be interviewed about the PRC/SSP and other WV WORKS requirements.

1.5.6 WHO MUST SIGN?

The individual(s) who is interviewed must sign the DFA-2. If the child(ren) lives with both parents or a parent and a stepparent, both must sign, even if separate interviews are conducted.

1.5.7 CONTENT OF THE INTERVIEW

In addition to the requirements outlined in Section 1.2, the following specific requirements apply.

1.5.7.A Local Services

1.5.7.A.1 Bureau for Child Support Enforcement (BCSE)

Explain redirection requirements, good cause, penalties for failure to cooperate without good cause, possible referral to BCSE for signature of paternity acknowledgment, and obtain the signature on the DFA-AP-1 or the DFA-AP-1A of the relative with whom the child lives.

1.5.7.A.2 Medicaid

Explain that Medicaid eligibility is a separate determination and how and when the Medical ID card is issued, if appropriate.

1.5.7.A.3 Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking

Explain that information is available throughout the office and from the Worker regarding sexual harassment and domestic violence, sexual assault, and stalking and that this subject is discussed with all clients. No individual is specifically targeted to receive the information. Disclosure of sexual harassment and domestic violence, sexual assault, and stalking may have an effect on any SSP work requirements or time limits the client is expected to meet while a WV WORKS recipient. If sexual harassment and domestic violence, sexual assault, and stalking is disclosed, the Worker must make a referral to the appropriate community resource or domestic violence program to develop a plan to assist the client in meeting any WV WORKS requirements. See Sections 14.7 for good cause for not complying with the WV WORKS work requirements and Section 18.2 and Section 18.5 for WV WORKS time limits.

1.5.7.A.4 Earned Income Tax Credit (EITC)

Briefly explain that this is a tax credit for people who work or have worked and had earned income under a specified amount. Pamphlets should be in the local offices to explain the EITC in more detail.

1.5.7.B Work Requirements

Explain that participation in a work activity is an eligibility requirement.

- Explain the purpose of WV WORKS; DCA payments, if appropriate; Transitional Medicaid (TM), childcare assistance and job placement.
- Non-recipient Work-Eligible Individuals – Explain that non-recipient Work-Eligible Individuals living in the household with an eligible child must complete the PRC, SSP, orientation, and be enrolled in a work activity and meet all other program requirements or the AG is ineligible for WV WORKS.

1.5.7.C Outstanding Claims

Before the case is approved, the Worker must determine if there is a WV WORKS, Aid to Families with Dependent Children (AFDC), or AFDC-Related Medicaid claim outstanding against any member of the AG or the non-recipient Work-Eligible Individual. If so, the Worker must initiate appropriate repayment procedures prior to approval.

If the client has been making voluntary payments, he must be informed that repayment must be made, when possible, from his monthly benefit, i.e., recoupment.

1.5.7.D WV WORKS Eligibility

The worker must discuss the following:

- Explain beginning date of eligibility and the importance of establishing eligibility as soon as possible.
- PRC – Explanation and completion of the PRC is not required to be part of the intake interview, but it may be done at the same time. See Personal Responsibility Contract (PRC) below for details about the PRC requirements.
- SSP – List the goals of each participant and the tasks necessary to accomplish those goals. See Section 1.5.21, Self-Sufficiency Plan (SSP), for details about the SSP requirements.
- The Worker must explain that WV WORKS orientation is required if one has not been completed.
- The Worker must explain that work-eligible applicants must complete a mandatory drug screening questionnaire, penalties for failure to cooperate, penalty for providing false information and possible referral to Children & Adult Services. The Worker must explain referrals to a substance abuse treatment and counseling program and a job skills program may be made.
- When the applicant is a Caretaker Relative, the Worker must explain the option of being included or excluded from the AG and answer the client's questions about the consequences of each choice.

1.5.7.E WV WORKS TRANSITIONAL BENEFIT

Discuss the two types of transitional benefit options

- Option 1 – Up to a six-month period during which the former WV WORKS participant may be eligible for continued support payments and services; or
- Option 2 – The West Virginia Employment Assistance Program (EAP) which allows the employed former WV WORKS recipient to continue to receive the WV WORKS payment he received prior to becoming employed for up to a six-month period.

1.5.7.F Client Reporting Responsibilities

1.5.7.F.1 Lump Sum

If the client indicates he may be receiving a lump sum payment, explain the lump sum policy.

1.5.7.F.2 Pregnancy

Explain the need for the client to report immediately when anyone in the AG or a non-recipient Work-Eligible Individual becomes pregnant.

1.5.7.G Benefit Issuance Options

The Worker must explain that the client can choose between direct deposit and Electronic Benefits Transfer (EBT).

1.5.7.G.1 Direct Deposit

The Worker must:

- Provide an enrollment brochure.
- Explain the advantages of receiving WV WORKS, child support pass- through, and Child Support Incentive (CSI) benefits by direct deposit and that enrollment is optional. The client uses a bank of his choice and once the benefit is deposited, the client is responsible for all dealings with his bank and for all fees and penalties associated with

his own bank account. The WV WORKS benefit is deposited on the last State workday of the month prior to the month the benefit is due. The CSI benefit is available on approximately the 20th calendar day of the month.

- Explain how to enroll and dis-enroll in direct deposit.
- Explain that the effective date of the first direct deposit is dependent upon the date of submission of the direct deposit enrollment form and the accuracy of the information provided and is the responsibility of the Auditor's Office. It is generally the month following the month of enrollment.
- Explain that the client will receive the WV WORKS and CSI by EBT until direct deposit is effective. He may contact his bank or the Auditor's Office to determine when the benefit has been deposited. After the initial WV WORKS benefit, only the monthly WV WORKS and CSI benefits are direct deposited.
- Explain that once the client chooses direct deposit, this choice continues until the client cancels it with the Auditor's Office. This is true even if the case is closed and later reopened.
- Explain changes in bank account information must be reported to the State Auditor's Office after enrollment.
- Explain that when the benefit cannot be deposited into a bank account after enrollment, benefits will be deposited into an EBT account and the client must re-enroll in direct deposit. Until the client submits updated information to re-enroll, benefits will be deposited into an EBT account and accessed with an EBT card.

1.5.7.G.2 EBT

The Worker must explain:

- WV WORKS, DCA and CSI cash benefits will be deposited into an EBT account and accessed with an EBT card. If the WV WORKS and CSI benefits are direct deposited, the WV WORKS benefit and any WV WORKS and CSI supplemental benefits go in the EBT account.
- When the card will be received
- The cardholder must call the EBT hotline to create a PIN and activate their card prior to use.

- When the benefits will be available in the account.

NOTE: The Worker must determine if there is an existing EBT account He must also inform the client of the availability of any balance remaining in the account.

- The importance of choosing an authorized cardholder who can also access the EBT account.
- Services are available by calling the Interactive Voice Response Unit (IVRU) or by talking with a Customer Service Representative (CSR). These services include, but are not limited to, activation of a new card, replacing a lost/stolen/damaged EBT card, obtaining a new or different PIN, cancellation of an authorized cardholder and checking an account balance(s).

NOTE: For EBT, the AG may have an authorized cardholder to spend benefits from the AG's EBT account. There is not a separate case or EBT account, but the authorized cardholder has a separate EBT card with his own PIN and uses the card to spend benefits from the AG's EBT account in the same manner as the AG's payee. The authorized cardholder and the authorized representative may be the same or different individuals at the discretion of the AG.

- EBT WV WORKS or Temporary Assistance for Needy Families (TANF) funds must not be used or accessed in adult entertainment establishments, casinos, gaming establishments, or liquor stores. This provision applies only to establishments which primarily or exclusively sell these products and does not include grocery stores or other establishments which also offer gaming activities or sell these products in addition to other goods.
- Benefits deposited into the account must be used within 365 days of last use or they will be expunged.

1.5.8 DUE DATE OF ADDITIONAL INFORMATION

The client and the Worker agree on the date by which additional verification must be obtained.

The Worker must give the client at least 10 days for the information to be returned.

The Worker must approve, deny or withdraw the application within 30 days of the date of application.

EXCEPTION: Application processing shall not be delayed beyond required processing time limits when verification is required to prove an individual who was convicted of certain felonies is complying with the terms of their sentence. See 3.2.1.B.3. If this verification is not received timely, the worker should process the application without consideration of the individual's felony and compliance. This should be reevaluated at redetermination.

1.5.9 AGENCY TIME LIMITS

By the 10th working day following the date of the initial contact when a client expresses an interest in applying for WV WORKS, the Worker must have completed all of the following duties. The initial contact by the client may be in person or by telephone to start the 10-day period.

- Receipt of the DFA-2, online application, or DFA-RFA-1. This must be completed prior to orientation and prior to completion of the PRC; and
- The client's orientation, when it appears the AG will be eligible; and
- The initial SSP negotiation, when it appears the AG will be eligible; and
- The applicant must complete the Drug Use Questionnaire, DFA-WVW-DAST-1.

NOTE: Any individual who refuses a Drug Use Questionnaire or a drug test is ineligible for WV WORKS assistance. He becomes a non-recipient work-eligible individual and may still receive WV WORKS for the other members of the household who are otherwise eligible. During the period of ineligibility, he must choose a protective payee who has successfully completed the DFA-WVW-DAST-1 for the WV WORKS benefit for the other members of the WV WORKS AG. Any individual that has had their benefits suspended and has not designated a protective payee for the benefits must be referred to Children & Adult Services.

The Worker must complete an individual orientation session when the next scheduled group orientation session is after the tenth working day.

The Worker must approve, deny or withdraw the application within 30 days of the date of application. When the application must be denied because the client has not responded to a DFA-6 or verification checklist, the Worker must wait until after the tenth day but no later than the 31st day to deny the application. Online applications must be issued an appointment notice to complete the above requirements when the applicant is unable to be reached by phone to schedule the face-to-face interview. Failure to keep the face-to-face appointment to complete the above requirements must result in denial of the application.

EXCEPTION: When the delay is a result of factors outside the control of the Department of Human Services (DOHS) and the applicant, or when the client requests a delay, any of the above actions may be postponed. When action is postponed due to the client's request, his request must be recorded in case comments.

Time Limits Example 1: An applicant telephones the office on June 26, to find out how to apply for WV WORKS. At that time, an appointment is scheduled for him to meet with a Worker on July 5. The next group orientation after the application is completed is July 12, which is past the 10-day time limit. Therefore, the Worker must complete an individual orientation session for this applicant, preferably at the intake interview on July 5.

Time Limits Example 2: An applicant contacts the office by telephone on September 10, to find out how to apply for WV WORKS. At that time, an appointment is scheduled for him to meet with a Worker on September 13 and to attend group orientation on September 19. The applicant is caring for his mother until she can be placed in a nursing home. Placement is expected on September 25, so he requests that his appointments be rescheduled for later that same week. He is then scheduled to meet with the Worker on September 26 and to attend group orientation later that same day. Although the application process is completed outside the time limit, it is due to the client's request which is recorded in case comments.

1.5.10 AGENCY DELAYS

If an application has not been acted on within the required time limit due to agency error, corrective action must be taken immediately.

1.5.11 PAYEE

The payee is the individual in whose name the WV WORKS benefit is issued.

The parent/caretaker relative with whom the child is residing is the payee.

- When the child lives with two parents who are included in the benefit, the parents choose the payee.
- When a child lives with a parent and a non-recipient Work-Eligible Parent, the payee should be the recipient parent.
- When the child lives with a parent and a stepparent, the parent is the payee.
- When the child lives with one relative other than a parent, the specified relative is the payee.
- When a child lives with two specified relatives other than a parent, they must choose who will be the payee.
- When the parent is an unemancipated minor, the parent or other responsible adult with whom the minor parent lives, or who supervises the minor parent's living arrangement, is the payee.
- When a child lives with an adult who is ineligible due to non-cooperation with drug testing requirements, the payee is designated by the applicant.

For EBT purposes, certain information about the eligibility system primary person is automatically sent to the EBT vendor in what is called a demographic record. This information is used to set up the EBT account, mail the EBT card and to identify the payee and authorized cardholders for security purpose when a call is made to the IVRU. See Chapter 12 for card replacement procedures. The card is sent to the payee, regardless of whether or not he is the primary person. A primary person who is not a payee is issued an EBT card as an authorized cardholder.

1.5.12 REPAYMENT AND SANCTIONS

1.5.12.A Repayment

Before the case is approved, the Worker must determine if there is a WV WORKS, AFDC, or AFDC-Related Medicaid claim outstanding against any member of the AG or the non-recipient

Work-Eligible Individual. If so, the Worker must initiate appropriate repayment procedures prior to approval.

If the client has been making voluntary payments, he must be informed that repayment must be made, when possible, from his monthly benefit, i.e., recoupment.

1.5.12.B Sanctions

When the AG has been sanctioned for failure to cooperate with WV WORKS, the benefit is subsequently closed. If a reapplication is made, the AG remains closed until the sanction period ends.

1.5.13 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is retroactive to the date of application once the following requirements are met complete orientation, complete PRC, complete SSP, and receive necessary verifications including the results of a drug test if required.

There are other circumstances which also affect the beginning date of eligibility as follows:

- If, in the 30-day period prior to the date of application, a parent or caretaker relative included in the payment, or non-recipient Work-Eligible Individual:
    - voluntarily reduces their hours, without good cause; or
    - quits full-time or part-time employment or training for employment, without good cause; or
    - refuses full-time or part-time employment or training for employment, without good cause,

The AG is ineligible until 45 days after the employment or training is no longer available. Benefits may not be issued for any part of the 45-day period of ineligibility. See Chapter 14 for the determination of good cause.

NOTE: The 45-day period of ineligibility applies only to AG members and non-recipient Work-Eligible Individuals at application.

> **Eligibility Date Example 1:** A WV WORKS adult recipient marries an individual who quit a job in the 30-day period prior to the request to add him to the AG. There is no 45-day period of ineligibility in adding him and no sanction is applied because this did not occur at application.

Once an AG is a recipient of WV WORKS, the 45-day ineligibility period will not apply to any active WV WORKS case through the month of closure. Any of the three situations described above are sanctionable offenses in an active WV WORKS case.

When an AG meets all of the following criteria, it is considered a violation and they are not subject to the 45-day ineligibility period. Instead, the AG or non-recipient Work-Eligible Individual is reopened, and a sanction subsequently applied. See Chapter 14 for details about applying a sanction.

- The AG was closed due to earnings of a parent, a non-recipient Work- Eligible Individual, or a non-parent caretaker included in the payment and he later quits his job without good cause; and
- The quit occurs within the effective month of closure; and
- The parent, non-recipient Work-Eligible Individual or non-parent caretaker, reapplies for a monthly WV WORKS check during the effective month of closure.

Because the case is considered to be open until the last day of the effective month of closure, the violation is treated as non-compliance and a sanction is imposed. If another sanction(s) has been previously imposed, this sanction is imposed at the next highest level.

The AG is approved for the month following the effective month of closure and then is notified of the imposition of the sanction at the next level. As with any other WV WORKS case, the individual must be provided an opportunity to establish good cause and/or comply during the 13-day advance notice period prior to imposition of the sanction.

> **Eligibility Date Example 2:** A parent is placed in full-time employment on March 5. His anticipated earnings make him ineligible and the AG is closed on March 7, effective March. On March 22, the parent comes to the office to ask for WV WORKS benefits again and states that he quit his job on March 19. The Worker determines that he did not have good cause for quitting, but that he met all other eligibility requirements. His eligibility starts April 1 since he already received benefits for March. There is no sanction applied to the April benefits for this offense, but the Worker notifies him immediately about the imposition of a sanction beginning in May and schedules a good cause hearing.
>
> **Eligibility Date Example 3:** A parent is placed in full-time employment with a produce shipping company. Two months later, he is laid off. The 45-day waiting period does not apply.

Eligibility Date Example 4: A caretaker relative included in the payment is hired by a temporary agency. Three months later the temporary job ends. The 45- day waiting period does not apply.

Eligibility Date Example 5: A non-recipient Work-Eligible Individual has been working 25 hours per week at a fast-food restaurant. He quits and then applies for WV WORKS, it is established he did not have good cause. The 45-day waiting period applies.

- When an assistance group becomes ineligible due to failure of a parent or caretaker, without good cause, to meet the 24-month work requirement, the beginning date of eligibility cannot be any earlier than the first day on which he participates in an activity which meets the 24-month work requirement.

EXECEPTION: A parent with a newborn child has good cause while the child is less than 12 weeks of age for failure to meet the 24-month work requirement.

- If the non-parent caretaker is no longer in a 12-month period for which he chose to be included, eligibility for the otherwise eligible child(ren) may begin as soon as the 12-month period ends, so long as the caretaker chooses exclusion from the assistance group.

NOTE: When a non-parent caretaker's 12-month period for which he chose to be included ends, he may again receive WV WORKS for the otherwise eligible child(ren), even when not meeting the 24-month work requirement, as long as he chooses to be excluded from the AG.
If he reapplies during the 12-month period for which he chose inclusion, or after the 12-month period ends and he again chooses to be included, he must meet the 24-month work requirement to receive WV WORKS for the child(ren).

- If the AG or non-recipient Work-Eligible Individual is serving a WV WORKS sanction, the beginning date of eligibility is the day after the sanction period ends. See Section 14.8.1. He must re-apply to again receive WV WORKS benefits.

1.5.14 EXPEDITED PROCESSING

There are no requirements for expedited processing. Cases are approved in the order in which eligibility is established.

1.5.15 CLIENT NOTIFICATION

See Chapter 9.

1.5.16 REDETERMINATION SCHEDULE

Cases are normally redetermined annually. A new DFA-2 or online review is required for redetermination. The individual(s) who is interviewed must sign the DFA-2. If the child(ren) lives with both parents or a parent and a stepparent, both must sign. Individuals submitting electronic reviews must electronically sign.

The redetermination schedule is set automatically by the eligibility system, unless the Worker and Supervisor agree that a redetermination must be completed earlier. When a case is reopened without a DFA-2, the Worker must ensure that the client continues in the same redetermination cycle.

Cases may be redetermined more frequently at the discretion of the Worker and Supervisor when any of the following occur:

- There are persons in the AG or non-recipient Work-Eligible Individuals who frequently change jobs or work intermittently;
- The Division of Program and Quality Improvement (DPQI) has found a client error in the case;
- The composition of the household has frequently changed and is likely to continue to change;
- A substantial change is expected;
- The household reports expenses exceeding its income; or
- The eligibility system schedules a redetermination due to receipt of another benefit, such as SNAP benefits, under the same case number.

Note: When the WV WORKS redetermination is aligned with another benefit, a face-to-face interview is still required for the WV WORKS benefit.

1.5.17 THE BENEFIT

The following explains the WV WORKS benefit and how it is issued. The WV WORKS benefit is issued by EBT, unless the client chooses direct deposit. If the client chooses direct deposit, his monthly WV WORKS benefit is deposited into his own bank account. The direct deposit process is described in Direct Deposit below.

The minimum WV WORKS benefit issuance is $35. The maximum is $811.

1.5.17.A The WV WORKS Benefit

All benefits which are not issued by direct deposit are deposited into an EBT account. Any newly opened case has an EBT account set up and the WV WORKS, DCA and CSI payments are deposited into the EBT account. This applies to the initial benefit for those AGs who choose direct deposit also. Benefits are accessed with the EBT card. There is no warrant number for an EBT benefit.

The initial WV WORKS benefit amount may be different than the ongoing benefit amount.

The initial WV WORKS benefit is prorated from the date of application once all eligibility requirements are met, including signing the PRC and initial SSP, and participating in orientation.

The ongoing monthly benefit is a full monthly benefit and is not prorated.

1.5.17.A.1 Direct Deposit

The client may choose direct deposit, even though EBT is available. When he chooses direct deposit, the monthly WV WORKS and CSI benefits are deposited in the client's own checking or savings account. The account must be in the name of the payee for the WV WORKS benefit.

- ***Enrollment in Direct Deposit and Effective Date***

The client must complete an enrollment form, attach any other appropriate information requested on the form and mail it directly to the State Auditor's Office. If he returns the form to the local office, the Worker forwards the form to the Auditor's Office. Questions about the direct

deposit process or the individual's effective date, after submission of the enrollment form, must be directed to the Auditor's Office at the toll-free number, 1-800-500-4079 or at 304-558-2251.

Direct deposit is generally effective the month following the month in which the form is submitted, when all account information is valid. Until direct deposit is effective, the client receives an EBT deposit.

➢ *Receipt of the Direct Deposit Benefit*

The benefit is deposited into the account and available to the client on the last State workday of the month which is prior to the month for which the benefit is due. No check stub or deposit information is mailed to the client. Questions regarding deposit of the benefit must be directed to the individual's bank or the Auditor's Office.

Direct deposit of the WV WORKS benefit is indicated in the eligibility system with a warrant number which begins with a five.

When the WV WORKS benefit cannot be direct deposited for any reason, the WV WORKS benefit will then be available on the EBT card.

Any time that a direct deposit transaction cannot be completed, the client is removed from direct deposit and he must re-enroll to receive his benefit in this manner. Until such time as he re-enrolls, he will receive an EBT deposit.

NOTE: Only the monthly WV WORKS, Pass-through, and CSI benefits may be received by direct deposit.

➢ *Disenrollment from Direct Deposit*

The client must request removal from direct deposit by submitting a written request directly to the Auditor's Office at the address shown on the enrollment form or by calling the Auditor's Office. Identifying information may be requested.

1.5.17.B EBT

Benefits will be in an EBT account and accessed by using the EBT card and a Personal Identification Number (PIN), similar to a personal debit or an automated teller machine (ATM) card. The AG may still choose direct deposit for the monthly WV WORKS benefit. The following outlines procedures which are specific to EBT.

1.5.17.B.1 EBT Definitions and Terminology

The following is a list of commonly used terms or acronyms associated with EBT.

ADMINISTRATIVE TERMINAL

EBT vendor system used to inquire into EBT account information.

AUTHORIZED CARDHOLDER

An individual, who, in addition to the payee, may be issued an EBT card and access an EBT account.

AUTOMATED TELLER MACHINE (ATM)

May be used to access cash EBT benefits.

CUSTOMER SERVICE REPRESENTATIVE (CSR)

The CSR for the EBT vendor who is reached through the IVRU toll-free number also referred to as the EBT Helpline. This person has the ability to replace or deactivate lost, stolen or damaged cards and to file a claim on behalf of a client regarding transactions.

DEMOGRAPHIC INFORMATION

Identifying information about the AG's primary person which is sent to the EBT vendor in order to set up an EBT account and mail the EBT card. This includes the name, SSN and date of birth of the AG's primary person and the payee's address.

ELECTRONIC BENEFITS TRANSFER (EBT)

EBT or the use of a card to access WV WORKS, CSI and DCA cash benefits, and SNAP benefits.

EBT HELPLINE

The toll-free number through which the client may access the Interactive Voice Response Unit (IVRU) or CSR.

EXPUNGED ACCOUNT

When benefits are not used from the EBT account for 274 days from the day of issuance for SNAP, 365 days from the date of last use for WV WORKS, and 122 days from date of issuance for Summer EBT, those benefits are removed from the account and are not available to the AG. Other benefit months may remain on the account. Expungement of EBT benefits must occur immediately when it has been determined all members of the SNAP Assistance Group are deceased and independent verification of the death(s) have been obtained by the worker.

INTERACTIVE VOICE RESPONSE UNIT (IVRU)

The IVRU is also referred to as EBT Helpline. The EBT vendor operates the IVRU seven days a week, 24 hours a day. Functions of the IVRU include, but are not limited to, account balance inquiries, card activation and PIN changes.

MOUNTAIN STATE CARD

The West Virginia EBT card

PERSONAL IDENTIFICATION NUMBER (PIN)

This number must be used to access EBT benefits with the EBT card. This is not the eligibility system PIN number.

POINT OF SALE (POS) EQUIPMENT

This is used to spend cash or SNAP benefits at a store.

STATUS THE EBT CARD

Deactivate the card so that it cannot be used. This occurs when a replacement card is requested, a payee is changed, or an authorized cardholder is removed or changed.

1.5.17.B.2 EBT Card Issuance

➢ *Initial Card Issuance*

The EBT card is issued when the first benefit to be issued into an EBT account is approved. It is mailed the day after the approval in the eligibility system. Once the benefit account is set up and benefits are deposited into the EBT account, they are accessed with the EBT card. The client must call the EBT Helpline to create the PIN and activate the card prior to use.

All cards are mailed to the payee. See Effect on Card Distribution of Legal Guardian or Protective Payee below when the AG has a legal guardian or protective payee. This includes the card(s) for any additional authorized cardholder(s). It is the responsibility of the payee to distribute the cards to any other cardholder(s).

➢ *Effect on Card Distribution of Legal Guardian or Protective Payee*

When the AG has a legal guardian or protective payee, all cards are mailed to the address of that individual. Current policy contains no reference to a specified legal guardian as a payee.

Any other representative or protective payee is indicated in the eligibility system as a protective payee.

➢ *Authorized Cardholder*

The AG may designate an additional individual(s) as an authorized cardholder for EBT. The authorized cardholder has his own card and PIN and accesses the EBT account for the specified benefit(s) without restriction. For this reason, the choice of an authorized cardholder and its importance must be stressed with the applicant or recipient. The authorized cardholder is designated, changed or removed in the eligibility system.

WV WORKS AGs may select only one authorized cardholder for WV WORKS. If the AG receives both SNAP and cash assistance, they may select one authorized cardholder for each benefit.

The maximum number of cards issued for any case is three.

Once an authorized cardholder is chosen, the payee may stop the cardholder's access to the EBT account by calling the EBT IVRU. DOHS Customer Service Center and local office staff cannot deactivate a card. However, the DOHS Customer Service Center or local office Worker can change or remove a cardholder. If the client first calls the IVRU to stop access to the account, he must still contact the DOHS Customer Service Center or local office to remove or change the cardholder.

➢ *Cardholder Security*

The demographic information sent to the EBT vendor for the primary person in the household is the Social Security Number, Date of Birth and address to which the card is sent.

No demographic information is sent for any authorized cardholder. The authorized cardholder must know the date of birth of the primary person and the address to which the card(s) is mailed.

If the SSN is requested for a PIN change, the primary person provides his own and the authorized cardholder or representative/protective payee must provide zeros.

1.5.18 DIVERSIONARY CASH ASSISTANCE (DCA)

DCA is a payment method available only to WV WORKS applicants. This method allows a maximum lump sum benefit of an amount equal to the maximum WV WORKS benefit amount, based on family size, multiplied by three. The amount of the DCA payment is based on need and is not automatically issued at the maximum amount. The household becomes ineligible for WV WORKS for three months, regardless of the amount of payment issued.

DCA is available to an applicant at the Worker's discretion only. It is not a program for which the client applies and is found eligible or ineligible. The Worker and/or Supervisor must determine if a DCA payment is appropriate and offer it to an applicant. The applicant may choose to accept or decline without any effect on his eligibility for an ongoing WV WORKS benefit. Supervisory approval is required for all DCA payments. To be considered for DCA, an applicant must be WV WORKS eligible. If an applicant refuses to cooperate with drug testing as a result of a Drug Use Questionnaire, DFA-WVW-DAST-1 or has a positive drug test, he must not be offered a DCA.

DCA provides an opportunity to relieve a temporary financial need as an alternative to receipt of ongoing WV WORKS payments. When the Worker and the applicant are confident that a one-time payment will meet the temporary need, DCA is explored.

When a case is approved for DCA, the AG must not be required to file a new application for SNAP. SNAP eligibility must be determined based on the information provided on the WV WORKS application.

The DCA benefit is deposited into the EBT account.

DCA does not count toward the 60-month lifetime limit or the 24-month limit.

Transitional Medicaid is available only when all requirements in Section 23.10 are met. Transitional Medicaid eligibility is not based on receipt of DCA.

DCA payments are not subject to repayment unless fraud is established.

DCA is available only one time for an applicant family. Acceptance of the DCA payment in lieu of ongoing WV WORKS payments is an option for the client.

NOTE: If the household contains even one AG member or a non-recipient Work-Eligible Individual who was included in a household with received a DCA payment, another DCA payment cannot be made to that AG. The Worker must check issuance history to determine if a non-recipient Work-Eligible Individual was included in a household which received a DCA payment as these individuals are not tracked by the system.

1.5.18.A Determining If DCA Is Appropriate

The following guidelines are used to determine if DCA is appropriate.

- The AG must demonstrate a need which cannot be met with current or anticipated family resources.
- A member of the AG or a non-recipient Work-Eligible Individual in the household must be employed or have a verified promise of employment or other verified source of income within two months of application.
- The applicant must agree to accept DCA by signing the Diversionary Cash Assistance Agreement, DFA-WVW-3, which lists conditions and expectations.
- Child support received by the parent/caretaker or BCSE belongs to the family and is not used to reimburse the DOHS for the DCA.

NOTE: Child support pass-through is not counted as income in determining DCA.

- The household does not include any member who is serving a WV WORKS sanction. The entire AG remains ineligible until the sanction period ends. Once the sanction period ends, he may be again considered for DCA.

> **DCA Example:** A WV WORKS AG is closed due to imposition of the fourth sanction. During the time the AG is closed, the client finds part-time employment and is later offered a better-paying full-time job out of state. He reapplies at the end of his ineligibility period and asks to be considered for a DCA payment to accept the job out of state. The AG is approved for a DCA, if he is otherwise eligible for such payment.

- If an adult or child would be required to be included in a WV WORKS AG, he is required to be included in a DCA AG and cannot be excluded simply to qualify for DCA. This

applies even when no member of the applicant AG has previously received a DCA payment.

- The applicant must agree to have the WV WORKS application withdrawn.
- The applicant will be required to attend Orientation, sign the DFA-WVW-4 and the List of Local Services.

1.5.18.B Determining Financial Eligibility for the DCA

Financial eligibility for the DCA is determined by comparing the gross, non-excluded, countable income of the AG to 100% of the Standard of Need (SON), based on the number of people in the AG.

If the income is equal to or less than the appropriate SON, the Worker must determine the AG's countable income. See Section 4.5.

If the countable income is less than the maximum WV WORKS benefit amount for the AG size shown in Chapter 4, Appendix A, the AG is eligible for DCA.

1.5.18.C Determining the DCA Amount

The DCA amount is determined as follows.

- Determine the maximum WV WORKS amount that is payable to a family of the same size. This number does not include a non-recipient Work-Eligible Individual. No incentives or reductions are applied when determining the DCA amount.
- Multiply the amount by three. This result is the maximum DCA payment which may be issued.
- There are no circumstances under which the maximum DCA payment amount may be exceeded.

- Determine the amount needed to meet the temporary financial need. The amount may include expenses related to future employment needs and ongoing household expenses.

> *NOTE: Because payment is limited to one-time-only, the Worker must be certain to include all such needs in this determination. Supplemental payments may not be issued, even if the maximum amount was not used for the first DCA and even if the transaction can be made the same day.*

- Compare the amount of the temporary financial need to the maximum DCA amount.

  If the DCA is sufficient to meet the need, payment is issued for the amount of the temporary need.

  If the DCA is not sufficient to meet the need, the DCA may still be approved if the Worker and the client determine that other arrangements can be made to meet the remainder of the need. Support services must not be considered to be a resource that can be used to meet the additional need not covered by the DCA.

  When there is no other resource available to meet the need, DCA is not appropriate. The client is then considered for an ongoing WV WORKS benefit.

- The recipient AG members and the non-recipient Work-Eligible Individual that are included in any DCA payment are considered to receive the benefit of that payment for 3 months. These individuals cannot be included in any other DCA AG for any month for which they received the benefit in another DCA AG.

1.5.18.D Verification of Temporary Needs

When possible, the Worker must verify the need and the amount.

The DCA payment is not limited to only those needs which can be verified. In addition, the amount of the DCA is not limited to only verifiable costs. The Worker is expected to use prudent judgment in determining which needs can be verified.

> **Verifiable Costs Example:** An applicant has agreed to accept a DCA payment instead of an ongoing WV WORKS benefit. In order to accept an offer of employment, he must move his family to another state. The following needs are identified: car repairs, overnight lodging for the family for the trip, food for the family for the trip, rent in a new dwelling for a month, utility deposits and some

specialized tools for the new employment. The Worker verifies that the applicant has a car and has the client obtain an estimate of the repair costs.

He also verifies the cost of the specialized tools for the new employment based on the client's statement that they are necessary. The client does not want his future employer to know that he is receiving help from the DOHS to accept the job, so the Worker does not contact the employer to confirm the need for the tools. However, he does contact some local employers of the same type to ensure that such tools would be used. Note that, in this case, it is assumed that the client has written verification of his employment. Otherwise, contact with the future employer would be necessary to verify the employment.

The Worker and the client agree on the amount needed for the family for overnight lodging, rent, utility deposits and food. These items are not verifiable, since the client does not yet have a place to live in the new state and does not know where he will stay overnight on the drive. It is reasonable to assume that these costs will be incurred in moving to another state, and the amount is negotiated.

1.5.19 ORIENTATION

The purpose of Orientation to WV WORKS is to inform all applicants about WV WORKS, the general policies and requirements.

Orientation is part of the application process. It is an opportunity to make sure that each person understands the services available and the program requirements. It also gives the applicant an easy way to ask questions and receive answers. This will also begin the assessment process by allowing the Worker to determine the issues most important to the applicant.

Each adult and emancipated minor in the WV WORKS AG and non-recipient Work-Eligible Individual must receive orientation to the program. Orientation may be conducted in a group, or individually.

The important point of orientation is that information be presented uniformly using the standardized orientation materials and the applicant leaves with a good understanding of the Program, his general requirements and services available to him. Not only is it important that each applicant in a District or Region receive the same information, it is equally important that all applicants statewide receive the same information. For that reason, the three forms described below are used to accomplish uniformity. Their use is mandatory.

Attending a WV WORKS orientation and signing the DFA-WVW-4 are eligibility requirements, so eligibility may not be established until these are completed. However, when the AG reapplies for benefits within 3 months of the last day of the effective month of closure, the AG members or non-recipient Work-Eligible Individuals may not be required to complete another orientation session.

> **Orientation Not Required Example:** An AG is closed on April 10. The last day of the effective month of closure is April 30. If he reapplies on or before July 31, no new orientation is required.

1.5.19.A Orientation to WV WORKS (DFA-WVW-4)

This form contains a brief summary of some of the requirements unique to WV WORKS. The Worker must explain the information included on the form and add additional information in response to specific questions. Under no circumstances may delivery of the form to the client with no discussion of the information substitute for a full, uniform orientation to the program.

In addition to the information on the form, when an SSP has not already been completed and will not be completed during the orientation session, the Worker must provide the applicant with a blank copy of the SSP. This will allow time for the applicant to be prepared for the SSP interview.

1.5.19.B PRC

For detailed information about the PRC process, see Section 1.5.20.

1.5.19.C WV WORKS List of Local Services

The WV WORKS List of Local Services template is included in Appendix D of this chapter. This is a template to assist local offices in producing a list of local services which the client may need or be required to use. The final list may be prepared by each District office or be prepared regionally, depending upon the availability of the services. It is designed to be developed once and reproduced for use during orientation. Use of this list including the attachment is mandatory and must be updated as changes occur. Under no circumstances is staff to copy this template exactly as listed in Appendix D for use. With the exception of Attachment A, the WV WORKS List of Local Services must be designed to reflect the availability and list of services in a

particular District or surrounding area/region. It is recommended that the Worker include the most recent Community Resource Guide or Quick Guide with the WV WORKS List of Local Services.

The applicant is expected to initial each item after it is discussed with him, but his eligibility is not affected if he does not. Under no circumstances may delivery of the form to the client substitute for a discussion of all the items on the form.

In addition to the items listed on the WV WORKS List of Local Services, there must be a complete discussion of sexual harassment and domestic violence, sexual assault, and stalking issues which include the following:

- A discussion of the DOHS's efforts to protect the safety of clients in sexual harassment and domestic violence, sexual assault, and stalking situations by choosing the Family Violence Option included in welfare reform legislation;
- Explain literature is available in different locations throughout the office and from the Worker;
- The benefits of disclosure of sexual harassment and domestic violence, sexual assault, and stalking as it relates to work participation requirements and program time limits; and
- How to disclose, i.e., to the Worker, other individual, etc. It is important that the Worker inform the client that this information is given to everyone who applies and does not indicate the Worker has any knowledge or suspicion of sexual harassment and domestic violence, sexual assault, and stalking. This is especially important when two parents or two non-parent caretakers are being interviewed.

Information on Attachment A of the template regarding sexual harassment must be discussed by the Worker with the client.

1.5.20 BRIDGE TO STRONGER FAMILIES

The West Virginia Bridge Model uses the Bridge to Stronger Families, DFA-WVW-Bridge, for the participant to discuss the pillars of: family stability, well-being, job development and job readiness, employment, job retention and stronger families with his Case Manager. Each of these pillars has five levels the participant can self-identify as fitting into. In addition to introducing the overall WV Bridge Model to Case Management, each pillar should be discussed. Once the Case Manager has discussed each pillar, he may engage in follow up questions. When the participant has selected the statement which best describes his current situation, the Case Manager will discuss with him the area he would most like to change which would then become his goal.

It is recommended that the DFA-WVW-Bridge be updated during the 12/24/36/48-month evaluations and is required to be completed or updated during home visits.

The Self-Sufficiency Plan, DFA-SSP-1 is used to outline each participant's goal(s) identified by completing the DFA-WVW-Bridge. The WV WORKS Goal Action Plan, DFA-SSP-1a may be used in conjunction with the DFA-SSP-1 when the participant needs smaller steps.

1.5.21 PERSONAL RESPONSIBILITY CONTRACT (PRC)

The PRC, form DFA-PRC-1, is a contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Worker, as the representative of the DOHS.

Completion and signature of the PRC form is required prior to approving the WV WORKS AG. However, when the client reapplies for benefits within three months of the last day of the effective month of closure, no new PRC is required.

> **PRC Example:** An AG is closed on April 10. The last day of the effective month of closure is April 30. If he reapplies on or before July 31, no new PRC is required.

Failure, without good cause, to adhere to the responsibilities or any tasks listed on the PRC after signature, results in imposition of a sanction against the AG. See Section 14.8 for information about sanctions.

A separate PRC is completed and signed by each adult and emancipated minor in a WV WORKS AG, and any non-recipient Work-Eligible Individuals in the household. The participant's signature indicates that he understands and accepts the responsibility inherent in the program.

The Worker must sign the form as the DOHS's representative. The Worker's signature indicates that he has explained the participant's rights and responsibilities and the DOHS's responsibilities to the participant. It also indicates that the Worker has addressed all of the participant's questions and concerns before requesting him to sign it.

The PRC states the purpose of the WV WORKS Program and lists the participant's rights and responsibilities.

Some of the items listed on the PRC duplicate information on the DFA-2. However, the signature on the DFA-2 does not substitute for the signature on the PRC and vice versa.

1.5.22 SELF-SUFFICIENCY PLAN (SSP)

The Self-Sufficiency Plan (SSP), form DFA-SSP-1, is a negotiated contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Worker, as the representative of the DOHS. The SSP is specific to each participant. It lists the goals, as well as the tasks necessary to accomplish the goals, including specific appointments, assignments and activities for the adult/emancipated minor. In addition, the SSP identifies the circumstances which impede attainment of the established goals and specifies the services needed to overcome the impediments.

The services listed on the SSP may be Support Service Payments or any other type of service provided to the participant or to which he has been referred. When there are no support services available at the time to appropriately address the barrier, the Worker must note this on the form and periodically review the availability of needed services.

Guidance for the assessment process which is crucial to the completion of the SSP is found in Section 18.7.

A separate SSP is completed for each adult and emancipated minor in a WV WORKS AG, and any non-recipient Work-Eligible Individuals in the household.

Completion and signature of the SSP is required to be completed within 10 days of the initial contact when the client expresses an interest in applying for WV WORKS. The initial SSP may be completed on a paper form or in the eligibility system. When the initial SSP is completed on a paper form, the eligibility system must be updated as soon as possible. Whenever the participant reapplies for benefits, a new SSP is required. The participant and Worker must sign and date the initial SSP and each change or addition when they occur. The signatures indicate their agreement to the initial SSP and subsequent changes. The participant's signature indicates that he understands and accepts the responsibility inherent in the program.

The SSP is a working document and revisions are made when either the participant or the Worker believes it necessary. Frequent changes are expected as the participant progresses toward his goal.

There are four additional considerations for the Worker during the negotiation of the Self-Sufficiency Plan, as follows.

1.5.22.A Initial SSP

A full assessment of the family situation is required to complete a valid, long-term SSP. To prevent a delay in the receipt of benefits to the client, an initial SSP must be completed on the Personal Responsibility Contract (PRC) within 10 days of the initial contact when a client expresses an interest in applying for WV WORKS. It is understood that the initial SSP will not be as comprehensive as subsequent plans. It is recommended that the Case Manager include the date and time of the initial home visit along with any barrier removal activities on the initial SSP.

Prior to completion of the initial SSP, the Worker must explore the following with the participant, at a minimum:

- Does the participant state a disability of any kind? The Worker must code the case management system when the participant has a documented disability.
- Is transportation a problem?
- Is childcare a problem?
- Does the participant state family problems would interfere with an activity?

These factors, as well as any other information readily available, must be considered when negotiating the initial SSP.

1.5.22.B First Full SSP

After the assessment process described in Section 18.7 has been implemented, the Worker is required to complete a full SSP. The first full SSP must be completed and signed within 30 days of the date of application and must be based on information determined through the assessment process, including the information obtained from form DFA-WVW-3A.

1.5.22.C Subsequent Changes to the SSP

Changes may be made to the SSP when the participant and the Worker agree that changes are appropriate. These changes may be a result of identifying a new impediment to a goal, acceleration of the progress toward self-sufficiency, or on any other change in the client's circumstances. It may also be changed based on the addition of available services to the area or the loss of such services.

1.5.22.D WV WORKS Goal Action Plan DFA-SSP-1a

The WV WORKS Goal Action Plan, DFA-SSP-1a may be used in conjunction with the Self-Sufficiency Plan, DFA-SSP-1. It is not a replacement of the DFA-SSP-1 or a stand-alone form. When the participant requires smaller steps to meet his goal(s) or has multiple goals identified, this form is used.

Once each goal is reached or when the participant has changed his goal, a new DFA-SSP-1a is completed and the DFA-SSP-1 is updated if needed.

1.5.22.E WV WORKS Coaching Conversation Guide

The Self-Sufficiency Appraisal Addendum and Coaching Guide, DFA-WVW-CCG-2 is used to review and revise goals identified on the Bridge to Stronger Families, the WV WORKS Goal Action Plan, or the Self-Sufficiency Plan. The Case Manager discusses each goal, how his family impacts his ability to reach his goals, and how the Case Manager can assist the participant with reaching his goals. This form is used in subsequent meetings once the participant has begun working on achieving his identified goals

1.5.22.F Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking Considerations

During the completion of the SSP, the Worker must make every opportunity available for the individual to disclose sexual harassment and domestic violence, sexual assault, and stalking issues which may affect the participant's particular requirements as a WV WORKS recipient. It must be stressed with the participant that disclosure may be a benefit in the negotiation process.

If, based on observation of a couple during an interview, the Worker suspects sexual harassment and domestic violence, sexual assault, and stalking is a factor, he may attempt to set up a separate interview at a later date. However, any attempt to do so must be done in a manner which ensures the client's safety. Under no circumstances must the individual's safety be compromised or is the participant to be penalized for refusal to conduct a separate interview.

NOTE: When the participant's SSP involves requirements or exemptions due to sexual harassment and domestic violence, sexual assault, and stalking or plan monitoring with a domestic violence agency, the Worker must take special precautions when recording exemption information on the form or in the eligibility system. No copy of any such plan is filed in the record. The Worker may make phone contacts to monitor the plan and record only general information, i.e. the name of the individual to whom he spoke, but not the organization; a statement that the current plan is being followed satisfactorily, etc. When monitoring the plan, the Worker must not contact the abuser, his relatives or friends, nor leave any messages regarding sexual harassment and domestic violence, sexual assault, and stalking. The domestic violence indicator in the eligibility system serves as documentation of the reason for the requirements or exemption.

1.5.23 RIGHTS OF APPLICANTS AND PARTICIPANTS WITH DISABILITIES

1.5.23.A Introduction

The West Virginia Human Rights Act, West Virginia Code § 5-11-1, the Americans with Disabilities Act of 1990 (ADA) and the Rehabilitation Act of 1993 apply to all programs established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) which established the TANF program. WV WORKS was established as a TANF program, and as such, the laws established under the Acts referenced above apply to WV WORKS.

These Acts provide:

- That no qualified individual with a recognized ADA disability will, by reason of that disability, be excluded from participation in, be denied any of the benefits or be discriminated against by the agency administering the program
- Discrimination by any agency which receives Federal financial assistance to support their TANF program is prohibited

All TANF agencies are subject to review by the Office of Civil Rights and any complaints regarding discrimination are to be referred to and investigated by that office. See Section 1.2 for directions on filing a complaint and for the right to fair and equitable treatment of applicants and participants.

1.5.23.B Accommodations for the Disabled in WV WORKS

Under Section 504 of the Rehabilitation Act and the ADA, a disability is defined as an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. A disability substantially limits a person's life activities. The Worker has the responsibility to inform the Work-Eligible Individual that disclosure of any or all of these conditions is voluntary. The Worker must provide any appropriate referrals once the information is provided.

Disabled individuals may have a temporary barrier or exemption. Individuals with disabilities should not be automatically excluded because this practice denies those individuals access to the TANF programs and services. This results in the discriminatory exclusion of disabled individuals from participating in the program. Under the law, every effort must be made to modify practices and policy, when appropriate, so disabled individuals may receive modified training and accommodated job opportunities. This policy allows the disabled to participate in the program and benefit from the employment and training opportunities offered to all other participants.

Two concepts are central to making WV WORKS accessible to all applicants and participants:

- Individualized treatment – All individuals with disabilities must be treated on a case-by-case basis, in a way that is appropriate to accommodate their disabilities.
- Effective and meaningful opportunity – All disabled applicants and participants must be allowed to participate and given the opportunity to benefit from TANF programs in the same manner as all other participants and must be allowed to have meaningful access to the program.

Reasonable accommodations and services must be available to all disabled participants, so all services and programs are accessible to disabled individuals. These types of modifications are required at application and throughout all stages of the WV WORKS program and continue as necessary through employment or even during an extension of the 60-month limit of benefits. Any accommodation and/or modification must be documented in case comments.

Workers must make appropriate referrals to local service agencies that provide the services and assistance necessary to ensure the applicants' successful participation.

NOTE: WV WORKS participants who have a documented disability must be coded in the case management system in addition to other component codes even if a referral to a local service agency is declined by the participant. When this occurs, it must be documented in case comments that a referral was offered and refused.

The worker must use the DFA-ADARA-1 (Family Assistance Reasonable Accommodations Report Form) to capture any information about the barrier and the disposition of the reasonable accommodation request.

The worker must honor the right of the client to fair hearings regarding reasonable accommodations and is responsible for sending this information to the Office of Inspector General, Board of Review.

1.6 COMMON POLICIES IN THE MEDICAID APPLICATION PROCESS

The policies and procedures in this section apply to the application process for all Medicaid coverage groups, unless stated otherwise; some exceptions apply. Policies and procedures specific to each coverage group are described in Sections 1.7 – 1.24.

1.6.1 APPLICATION FORMS

Applicants for all Medicaid coverage groups can use the DFA-2, WV PATH, the single streamlined application (DFA-SLA-1 or DFA-SLA-2, with supplement if required) or the Federally Facilitated Marketplace (FFM, the Marketplace) to apply.

Coverage group-specific information, including the need for supplemental application forms, is provided below in the sections about each coverage group.

1.6.2 NO INTERVIEW REQUIRED

There is no interview required for any Medicaid coverage group. The Worker may contact an applicant for additional information if needed.

Although no interview is required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable.

1.6.3 DATE OF APPLICATION

Unless specified otherwise in the coverage group specific sections below, the date of application is the date the Department of Human Services (DOHS) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name and address and signature.

EXCEPTION: See Section 1.16 QMB/SLMB/QI-1 for when the application is received electronically LIS/MPA file.

NOTE: When a faxed copy or other electronic transmission of an application is received that contains a minimum of the applicant's name, address and signature, it is considered an original application and no additional signature is required.

1.6.4 DUE DATE OF ADDITIONAL INFORMATION

When the client visits the office and an interview is conducted, the Worker and client decide on a reasonable time for the client to return the information.

When the client mails the application or completes the application in WV PATH or the Marketplace, the Worker then uses the verification checklist or form DFA-6 to inform the client of additional information needed.

The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.

EXCEPTION: for SSI-Related Aged, Blind, or Disabled, additional information related to medical bills is due 30 days from the date of application.

1.6.5 COMPLETE APPLICATION

The application is complete when the applicant or his authorized representative submits the correct application which contains, at a minimum, his name, address and signature. When the applicant submits his application by WV PATH or the Marketplace, the application is considered complete when the application is signed electronically.

An application is considered incomplete when the client chooses not to sign the SLA, DFA-2, or DFA-5. When this occurs, it is a withdrawal, and appropriate eligibility system action and client notification must be completed. The recording in case comments must specify that the client did not want to sign the application and the reason for his decision. The client should always be encouraged to sign the application so there is no misunderstanding that he was denied the right to apply.

➢ *Authorized Representatives*

The applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature.

Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization to the DOHS.

The authorized representative is responsible to the same extent as the client being represented, including confidentially of any information regarding the client provided by the agency and agreeing to the terms of the Rights and Responsibilities.

Examples of documents the applicant may submit with the Medicaid application to verify he has designated an authorized representative include, but are not limited to:

- Single Streamlined Application (DFA-SLA-1, Appendix C)
- Application for Long Term Care Medicaid and Children with Disabilities Community Service Program (DFA-MA-1)
- Durable power of attorney (POA) and/or medical power of attorney documentation, unless limited in scope
- Court orders designating a guardian or conservator (signed by court)
- Healthcare surrogate documentation for an incapacitated applicant (signed by physician and surrogate)

1.6.6 AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received, and the client is determined eligible, medical coverage is retroactive to the date eligibility would have been established.

When the application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay and coverage must be backdated for any prior eligibility period. This may be more than three months if due to an agency error.

If the Department simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the Department acted in a timely manner.

The Medicaid client may be eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time and the delay is not due to factors beyond the control of the Department. See Chapter 10.

NOTE: For Medicaid AGs, when the last case action was a denial due solely to failure to meet spenddown within the application processing time limit, the period of consideration (POC) and/or period of eligibility (POE) is backdated, if appropriate, based on the date the client requests reconsideration of his application.

1.6.6.A Documenting Reason for Delay

To document the reason for any delay in processing a Medicaid application, the Worker must record in comments:

- All actions taken in processing the application; and,
- The results of required case reviews.

The instructions for these procedures are found below.

A rebuttable presumption that the application was not acted on within a reasonable period of time exists when conditions such as, but not limited to, are met:

- Proper documentation, as shown below, which establishes that delay is due exclusively to factors beyond the control of the Department, is not in the case record.
- Documentation for the required case review is not in the case record.

This presumption may be rebutted only by clear and convincing evidence that all necessary actions by the Department for processing the application were undertaken in a timely fashion. This presumption may not be rebutted solely by the testimony of a Worker who failed to meet the documentation requirements.

1.6.6.A.1 Instructions for Documentation for Pending Medicaid Applications

For all Medicaid applications, the documentation in the eligibility system must include, but is not limited to, the following:

- Date of application.
- Date the verification checklist or DFA-6 and 6A were mailed or given to the client.

- Date medical bills submitted by the client were received in the local office.
- Date medical expenses were added to the eligibility system.
- The result of each 30-day review found on comments (instructions in item 2 below).
- All actions related to the MRT process, when applicable, which include, but are not limited to:
    - Date initial medical reports are requested
    - Date of follow-up activity required to obtain initial reports
    - Date medical reports are received in the county office
    - Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
    - Date of follow-up activity required to obtain the additional medical information
    - Date additional medical reports are received in the county office
    - Date material is referred to MRT
    - Date the Worker is notified of the final MRT decision.

This information appears in the eligibility system.

1.6.6.A.2 Procedure for Review of Pending Applications

Applications that have not been entered in the eligibility system must be reviewed at least every 30 days.

The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. Comments must document the reason the application has not been acted on.

- If this reason is not beyond the control of the Department, the Worker must immediately take any actions are necessary to process the application.
- If the application has not been acted on within the required time limit due to missing information from the applicant, the Worker must send a DFA-20 or eligibility system notice NMRL to the applicant informing him of the information which has not been received by the Department. The DFA-20 or NMRL is sent to the applicant at the time of the expiration of the maximum allowable time for acting on the application.

1.6.7 EXPEDITED PROCESSING

There are no Medicaid requirements for expedited processing. Cases are approved in the order in which eligibility is established. For application processing time limits, see Section 1.6.6 Agency Delays and Agency Time Limits within each coverage group.

1.6.8 ELIGIBILITY SYSTEM ACTION

Regardless of the eligibility decision, all applications must be processed, and eligibility system action is required to complete the application process.

Each application requires eligibility system action to approve, deny or withdraw.

1.6.9 CLIENT NOTIFICATION

The client must be informed that he is eligible for Medicaid coverage and the date that his coverage begins.

Client notification is accomplished by the eligibility system, when the case is properly coded. The notification includes the beginning date of eligibility. See Chapter 9.

1.6.10 REPAYMENT AND PENALTIES

Repayment and Penalties do not apply to the Medicaid application process. Repayment from the client is only pursued if intentional misrepresentation is established; see Section 11.4.

See Section 2.4 for an explanation of requirements to cooperate with Quality Control (QC) if selected for a QC review.

1.6.11 SPECIAL SITUATIONS

1.6.11.A Coordination between DOHS and the Federally Facilitated Marketplace

The Affordable Care Act (ACA) established standards and guidelines for ensuring a coordinated and timely process for performing eligibility determinations, for facilitating enrollment into coverage and for transferring the applicant's information between the Department and the Federally Facilitated Marketplace (FFM or Marketplace).

The Department must enter into an agreement with the Marketplace which outlines the responsibilities of each agency to ensure prompt determination of eligibility and enrollment in the appropriate insurance affordability program based on the date the single-streamlined application (SLA) is submitted to either the Department or the Marketplace.

The Act also requires that no matter where the applicant submits the SLA, the Department or the Marketplace, they will receive an eligibility determination for any insurance affordability program and be able to enroll in the appropriate coverage, if eligible, without delay.

Regardless of where the applicant submits their SLA, eligibility can be determined for insurance affordability programs including MAGI coverage groups based on the information collected on the application without requiring additional action by the applicant.

NOTE: The SLA does not provide sufficient information for the Department to determine eligibility for non-MAGI coverage groups. If the client indicates potential eligibility for a non-MAGI coverage group, the Department must provide the client with the DFA-SLA-S1 to obtain the additional information needed to determine eligibility. See Section 23.8.2 for information regarding determining eligibility between MAGI and non-MAGI coverage groups.

1.6.11.A.1 Applications Taken by the Marketplace

West Virginia entered into an agreement with the FFM whereby the Department will accept as final the Medicaid and WVCHIP eligibility determinations made by the Marketplace based on MAGI.

The Marketplace determines eligibility for MAGI Medicaid groups and WVCHIP only, in real time without delay when possible. Non-financial and financial information about the applicant is matched with the Federal Data Hub (FDH).

When completing the eligibility determination for an applicant that submits an SLA to the Marketplace, the Marketplace must:

- Accept the SLA;
- Check for existing Medicaid or WVCHIP coverage;
- Verify citizenship/immigration status, residency, incarceration status, current monthly income and annual income;
- Apply the reasonable compatibility standard and reconcile any differences;
- Apply West Virginia's state eligibility rules;
- Complete the eligibility determination;
- Provide appropriate notices, fair hearing rights, and communications to the client;
- Transfer the eligible client's electronic account to the Department, without delay;
- Transfer applications to the Department for applicants requesting a full determination of Medicaid on a basis other than MAGI; and,
- Transfer to the Department for a full eligibility determination, without delay, the electronic account of a client that indicates on their application potential eligibility for a non-MAGI coverage group.

- If the individual is over income for MAGI Medicaid or WVCHIP, evaluate him for the insurance affordability programs, Advance Premium Tax Credits and Cost Sharing Reductions (APTC/CSR).

➢ *Marketplace Determines Eligibility for a MAGI Coverage Group*

When the Marketplace determines the applicant is eligible for a MAGI coverage group, the DOHS must:

- Accept electronic accounts transferred from the Marketplace for clients determined Medicaid or WVCHIP eligible based on MAGI.
- Promptly complete enrollment into the correct Medicaid or WVCHIP coverage group.
- Not request any additional information or verifications from the client.
- Provide additional notification of enrollment to the client, including benefits available.

➢ *Marketplace Determines Potential Eligibility for a MAGI Coverage Group*

When the Marketplace determines the applicant is potentially eligible for a MAGI coverage group, the DOHS must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a MAGI group
- Notify the Marketplace of receipt of the electronic account
- Not request additional information of verifications from the client already verified electronically
- Conduct any additional verifications that may be required
- Promptly determine eligibility without requiring another application; ensure timeliness standards in this chapter are met
- Notify the client and the Marketplace of the final eligibility determination

➢ *Marketplace Determines Potential Eligibility for a Non-MAGI Coverage Group*

When the Marketplace determines the client is potentially eligible for a non-MAGI coverage group, the Department must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a non-MAGI group, or when the client requests a full determination.
- Notify the Marketplace of receipt of the electronic account.
- Not request additional information or verifications from the client already verified electronically.
- Promptly determine eligibility without requiring another application; ensure timeliness standards in this chapter are met.
- Notify the Marketplace of the final eligibility determination.

1.6.11.A.2 Applications Taken by DOHS

The Worker determines eligibility for MAGI Medicaid and WVCHIP groups. Non-financial and financial information about the applicant is matched by the FDH in real time.

➢ *DOHS Determines Eligibility for a MAGI Coverage Group*

When the Department determines the client is eligible for Medicaid or WVCHIP based on MAGI, the Department must:

- Promptly enroll the applicant into the MAGI coverage group. The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group.

➢ *DOHS Determines Applicant Not Eligible for a MAGI Coverage Group*

When the Department determines the applicant is not eligible for Medicaid or WVCHIP based on MAGI, the Department must:

- Promptly determine potential eligibility for APTC/CSR and transfer the applicant's electronic account to the Marketplace; and
- Certify for the Marketplace the criteria applied in determining eligibility; and
- Provide the applicant with a combined eligibility notice, including notice of the Medicaid denial or closure, transfer of their electronic account to the Marketplace, and fair hearing rights.

The DOHS 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 WVCHIP due to income, and he attests to disability, he may be eligible for an SSI-Related, Medicaid Work Incentive Network (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.

When the Department determines the applicant is not eligible for Medicaid or WVCHIP based on MAGI, but are completing a determination for a non-MAGI coverage group, the Department must:

- Promptly determine potential eligibility for APTC/CSR and transfer the client's electronic account to the Marketplace.
- Provide notice to the Marketplace that the client is not Medicaid or WVCHIP eligible based on MAGI, but that a final determination based on non-MAGI is pending.
- Provide notice to the client in simple language that the Department determined them ineligible for Medicaid or WVCHIP based upon MAGI standards but are continuing to evaluate them for coverage for non-MAGI coverage groups.
- Provide coordinated content in the notice including that the client's account was transferred to the Marketplace for an evaluation for APTC/CSR, and that enrollment in APTC/CSR will not affect their potential Medicaid eligibility.
- Provide the client notice of the final non-MAGI Medicaid eligibility determination and fair hearing rights. If the client is determined eligible for a non-MAGI coverage group, the notice should inform the client that the Marketplace will be notified of the client's eligibility, and that Medicaid eligibility will result in closure of APTC/CSR.
- Notify the Marketplace of the final eligibility determination based on non-MAGI.

1.6.11.A.3 Coordination between DOHS and the Marketplace Involving Appeals

The Department must establish a secure electronic interface so that:

- The Marketplace can notify the Department when an applicant has requested a fair hearing; and
- The applicant's electronic account, including information provided as part of the appeal, can be transferred between the Department and the Marketplace.

When conducting a fair hearing, the Department should not request information or documentation from the applicant that is already included in their electronic account.

The Department must transmit to the Marketplace the hearing decision made by the Department.

1.6.11.B Presumptive Eligibility

Individuals receiving services through a Qualified Provider who are interested in applying for Medicaid may apply with the assistance of an Authorized Employee. Qualified Providers may elect to provide Presumptive Eligibility (PE) determinations to individuals who are without any other form of health coverage. Additional information about Qualified Providers can be found in Chapter 400 of the West Virginia Medicaid Provider Manual. Presumptive Eligibility (PE) is not permitted for any other program. It 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.

Coverage groups eligible for PE:

- Children under age 19
- Pregnant Women
- Parents/Caretaker Relatives
- Adult Group
- Former Foster Children
- Breast and Cervical Cancer (BCC) women receiving current treatment

Presumptive Eligibility is limited to once every twelve months, with the exception of pregnant women, who are eligible once per pregnancy.

➢ *Duties of the Authorized Employee*

The Authorized Employee, which could also include the DOHS hospital employee, makes a PE decision based on preliminary information provided by the individual seeking treatment, or his Authorized Representative (AR) (someone with the patient who would reasonably be expected to know about the individual seeking benefits, including attesting to the individual's U.S. citizenship or satisfactory immigration status). The Authorized Employee 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 WV PATH portal as Community Partners, the Authorized Employee sends the information electronically to the eligibility system and issues a Medical ID card with a PE Medicaid ID. The period of eligibility begins on the date of determination and ends on the last day of the next month, or when a full Medicaid application determination is made, whichever occurs earlier. The decision is not subject to fair hearing rights and advance notice is not required.

The Authorized Employee must assist the applicant or his AR in completing the single streamlined application (SLA) for Medicaid and forward the application to the Department.

If the applicant or his AR is unable or unwilling to complete the full Medicaid application at that time, the Authorized Employee will explain to the patient or AR the different options for completing the SLA. If the applicant indicates he would like to complete his application via telephone, the Authorized Employee must have him contact the call center at 1-877-716-1212. The Authorized Employee should explain that he must call this number because he will be required to give a recorded telephonic signature.

➢ *DOHS Worker Responsibilities*

Upon receipt of a completed PE application, which should include the PE Medicaid ID, the DOHS Worker begins processing the application. 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. Income is verified by the same method as any other application. Medicaid eligibility begins on the first day of the month of the PE determination. Retroactive backdating is allowed with the Medicaid application, if the client is eligible.

The DOHS Worker or the Qualified Provider 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 facility at which the DOHS Worker is placed will have agreed to accept responsibility for all decisions and outcomes of the DOHS Authorized Employee. The DOHS Worker that is at the facility will follow the same procedures for taking Presumptive Eligibility applications as any other PE worker.

1.6.11.C Changing Coverage Groups and Redetermination Period

When one coverage group is closed and another opened, the AG may be assigned a new certification period.

1.6.11.D Spenddown

Spenddown applies to SSI-related and AFDC–related coverage groups only.

Cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.6.11.E Death of the Only Individual Prior to Application or Approval

Death of an individual does not interfere with approval of a Medicaid application. If an application is made prior to an individual's death, the application is processed as usual and approved, if eligible. This item outlines the special procedures that the Worker must follow in the application process and at approval when the only member of a Medicaid AG dies prior to making an application.

1.6.11.E.1 Who Must Sign the Application?

If another individual makes the application on behalf of the deceased person, it is preferable that the person be a relative, but any other individual who is interested may make the application.

The Worker must obtain as much information as possible about the deceased person’s income and assets, but routine verification is not required.

1.6.11.E.2 MRT Referral

It is not necessary to refer the case to MRT when the deceased person’s disability resulted in his death. However, a MRT referral may be necessary to establish blindness or disability when there is a request for Medicaid coverage for a month(s) prior to the person's death and such blindness or disability was not the cause of death, or the Worker is unable to determine if the blindness or disability existed during the month(s).

All other policies and procedures related to disability coverage groups apply.

1.7 MAGI CHILDREN UNDER AGE 19

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The new Children Under Age 19 coverage group combines prior coverage for children under the AFDC group, Qualified Child and Poverty-Level Children coverage groups into one group. Eligibility is determined using MAGI methodologies.

1.7.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

The following can be included on the same application:

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.7.2 WHO MUST SIGN?

The following person(s) must sign the application, depending on the living situation of the child:

- One parent with whom the child lives; or
- The adult with whom the child lives; or
- The representative of an adoption agency that has legal custody of the child; or
- The child who does not live with a parent(s) or other adult.

1.7.3 CONTENT OF THE INTERVIEW

Although not required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable. In addition, the following must be discussed with the client:

- An explanation of the 12-month period of continuous Medicaid eligibility (CME). See Section 10.7.
- That any child under age 18 may be evaluated for SSI-Related Medicaid as a blind or disabled child
- That the client must report when any child becomes pregnant

1.7.4 AGENCY TIME LIMITS

Action must be taken to approve the application within 13 business days of the date a complete application is received in the county office. If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client at least 10 days to provide it, as required in Section 1.6.4 above.

Eligibility system action must be taken to deny or withdraw the application within 30 days of the date of application, if the application cannot be approved.

When an application is made at the same time for another Medicaid coverage group(s) for another family member(s), or for other Programs, the application must be approved within 13 business days, if eligible, even though the application process for other individuals or for other Programs may still be pending.

1.7.5 PAYEE

Depending on the child's living situation, the payee is a parent, other adult household member, or the child.

1.7.6 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

1.7.7 REDETERMINATION

1.7.7.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. If determined eligible after completing the redetermination process, the DOHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated auto-renewal verification checklist form provides the following information:

- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,

- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call is included if the individual has questions about submitting the pre-populated auto-renewal verification checklist online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to three months.

1.7.7.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DOHS must only request the information on the change reported.

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 12-month SNAP or TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid or WVCHIP AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month Medicaid certification period. The new Medicaid certification period is renewed from June 1, 2014, through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.7.8 THE BENEFIT

1.7.8.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.7.8.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.8 MAGI ADULT GROUP

The Affordable Care Act (ACA) established a categorically mandatory coverage group known as "the Adult Group." Eligibility for this group is determined using MAGI methodologies.

1.8.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Spouses
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.8.2 WHO MUST SIGN?

The application must be signed by an adult in the household or their authorized representative.

1.8.3 AGENCY TIME LIMITS

Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.

1.8.4 PAYEE

The payee is the primary person in the household.

1.8.5 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

1.8.6 REDETERMINATION

1.8.6.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated which matches current information with the hub.

If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the client agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the information must be submitted;
- Specific information necessary to complete the redetermination;
- The opportunity to report changes;
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up;
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed; and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call is included if the individual has questions about submitting the pre-populated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefits.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to 3 months.

1.8.6.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DOHS must only request the information on the change reported.

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 12-month SNAP or TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month Medicaid certification period. The new Medicaid certification period is from June 1, 2014, through May 31, 2015.

When the redetermination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.8.7 THE BENEFIT

1.8.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.8.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.8.7.C Medical Frailty

Clients in the Adult Group self-attested as medically frail are eligible for either of the following Benefit Packages:

- Traditional Medicaid Benefit Package
- Alternative Benefit Package

If an individual attests they are medically frail, such as having a physical, mental or emotional health condition or a chronic substance abuse, physical, behavior, intellectual or developmental condition in which assistance is needed, the client is placed in the Traditional Benefit Package. Should the client contact the Department and opt to enroll in the Alternative Benefit Package the

Worker will code as such in the eligibility system to ensure the correct alternative is provided to Gainwell Member Services.

1.9 MAGI PREGNANT WOMEN

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The Pregnant Women coverage group combines former Poverty-Level and Deemed Poverty-Level Pregnant Woman coverage groups.

1.9.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.9.2 AGENCY TIME LIMITS

Eligibility system action must be taken to approve the application within 13 business days of the date a completed application is received in the local office. If additional information or

verification is required after the complete application is received, the Worker must request it immediately to allow the client at least 10 days to provide it.

When a DFA-2 is used, the application for Medicaid coverage as a pregnant woman must be approved within 13 business days of the date a complete application is received, even though the application for another program may not require faster processing.

Eligibility system action must be taken to deny or withdraw the application within 30 days of the date of application if the application cannot be approved.

1.9.3 BEGINNING DATE OF ELIGIBILITY

1.9.3.A Application while Pregnant

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

1.9.3.B Application after Pregnancy Ends

When the client applies within three months of the termination of the pregnancy, eligibility may be backdated up to three months, prior to the month of application, in which she met all eligibility requirements.

1.9.4 REFERALS TO THE OFFICE OF MATERNAL CHILD AND FAMILY HEALTH (OMCFH)

When the pregnant woman's application is denied for any reason, or a WVCHIP or children's Medicaid application is denied when a child is pregnant, a referral is made to the OMCFH. A list of these denied applications is generated by the eligibility system and made available to the OMCFH. This permits OMCFH to evaluate the client for other available government-sponsored health care.

1.9.5 REDETERMINATION

A redetermination is completed the twelfth month of the postpartum period. Reviews are scheduled 12 months after the pregnancy end date, or, if information about the pregnancy is not updated, 12 months after the pregnancy due date.

In no instance is Medicaid coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is determined before the client is notified that her Medicaid eligibility will end. If eligible for other Medicaid, or WVCHIP, that coverage must not begin until expiration of the postpartum period.

If no redetermination is completed, Medicaid coverage is automatically closed after the adverse notice period.

Rolling Redeterminations do not apply to the Pregnant Women coverage group. When the pregnancy is due or reported ending, the client will be evaluated for MAGI Medicaid using the automatic procedures described above for the Adult Group.

1.9.6 THE BENEFIT

1.9.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.9.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

The eligible pregnant woman must be notified that she remains eligible for 12 months after the month in which her pregnancy ends.

NOTE: A Child Under Age 19 who becomes pregnant must receive Medicaid in the Pregnant Women coverage group.

The Pregnant Woman's eligibility ends on the last day of the 12 month postpartum period or on the last day of the effective month of closure.

1.10 CONTINUOUSLY ELIGIBLE NEWBORN (CEN) CHILDREN

1.10.1 APPLICATION FORM

No application is required for CEN children who are born to Medicaid eligible women. See Chapter 23. An application is required for children who are born to non-Medicaid Eligible women as described in Section 1.7.

1.10.2 AGENCY TIME LIMITS

The Worker must open CEN coverage within five workdays of the date the birth is reported.

1.10.3 PAYEE

Depending on the child's living situation, the payee is a parent, other adult household member, or the child.

1.10.4 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month the child was born.

1.10.5 REDETERMINATION

The redetermination for the CEN child is scheduled in the month before the month the child becomes one year old to ensure that the child is evaluated for all coverage groups.

The redetermination process is initiated by the eligibility system, which generates the redetermination form. The redetermination form may be submitted by mail or online by use of WV PATH.

The redetermination form provides the following information:

- A statement that the assistance group(s) (AG(s)) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the redetermination must be submitted;
- Any verification which must be submitted with the form;
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed;
- Instructions for submitting the redetermination online by using WV PATH; and,
- A phone number to call if the individual has questions about submitting the redetermination online.

The redetermination may be submitted online by use of WV PATH until the end of the month in which the redetermination is due. Redeterminations submitted online are considered electronically signed.

When the redetermination is completed and the individual(s) remains eligible under another coverage group, the new eligibility period must begin the month immediately following the month of the redetermination.

1.10.6 THE BENEFIT

1.10.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.10.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.11 MAGI PARENTS/CARETAKER RELATIVES

1.11.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of the applicant.

NOTE: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes – himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.

- Individuals who are under age 19 may be included on an application submitted by an adult application filer, even if the child and the application filer are not in a familial or tax relationship.

  Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.11.2 PAYEE

The payee is the individual in whose name the Medical ID card is written.

1.11.3 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. However, eligibility may be backdated up to three months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

When the client is eligible for backdated coverage, the system must be coded with the month, year on which the backdated period begins.

This date is always the first day of the month of backdated coverage.

1.11.4 CLIENT NOTIFICATION

The client must be informed that he is eligible for Medicaid coverage and the date that his coverage begins.

See Chapter 9.

1.11.5 REDETERMINATION

1.11.5.A Redetermination Schedule

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

Redeterminations occur annually. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,
- The date by which the information must be submitted,
- Specific information necessary to complete the redetermination,
- The opportunity to report changes,
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call if the individual has questions about submitting the pre-populated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be backdated up to three months.

1.11.5.B Rolling Redeterminations

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 6-month SNAP or a 12-month TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month

> Medicaid certification period. The new Medicaid certification period is from June 1, 2014, through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.11.6 THE BENEFIT

1.11.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.11.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.12 DEEMED PARENTS/CARETAKER RELATIVES

Eligibility is based on the income of the Parents/Caretaker Relatives coverage group. See Section 23.10.8 for the eligibility requirements that must be met. There are three groups in this section: Extended Medicaid, Children Covered as Recipients of Adoption Assistance, and Children Covered as Recipients of Foster Care Payments.

1.12.1 EXTENDED MEDICAID

1.12.1.A Application

There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to onset or increase of spousal support.

The client must be notified that his Medicaid continues and of the eligibility period. If the case is closed in error, the client cannot be required to reapply. The Worker must evaluate the client for all other coverage groups when Extended Medicaid ends.

1.12.1.B Redetermination

Extended Medicaid cases are not redetermined.

1.12.1.C The Benefit

1.12.1.C.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.12.1.C.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the four-month Extended Medicaid period.

At the end date of eligibility, all AG members must be evaluated for all other Medicaid coverage groups.

1.12.2 CHILDREN COVERED AS RECIPIENTS OF ADOPTION ASSISTANCE

The Office of Children and Adult Services is responsible for these cases.

1.12.3 CHILDREN COVERED AS RECIPIENTS OF FOSTER CARE PAYMENTS

The Office of Children and Adult Services is responsible for these cases.

1.13 TRANSITIONAL MEDICAID (TM)

Eligibility is based on the income of the Parents/Caretaker Relatives Medicaid Coverage Group. See Section 23.10.9 for the eligibility requirements that must be met. This coverage group is for AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to increase or onset of employment income.

1.13.1 APPLICATION PROCESS

There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to increase or onset of employment income.

1.13.2 REDETERMINATION

Although there is no formal redetermination process for TM cases, clients must comply with the requirements for Phase I recipients found in Chapter 23, to qualify for Phase II coverage.

1.13.3 THE BENEFIT

1.13.3.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.13.3.B Ending Date of Eligibility

Phase I coverage ends on the last day of the sixth month of the Phase I period, or on the last day of the effective month of closure, whichever occurs first.

Phase II coverage ends on the last day of the sixth month of the Phase II period, or on the last day of the effective month of closure, whichever occurs first.

1.14 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

1.14.1 APPLICATION PROCESS

There is no application form for SSI Medicaid. The Worker receives an eligibility system alert when data exchange information indicates that a person is approved for SSI. See Section 6.3.4.A.

When the Worker fails to open an SSI Medicaid case for an individual listed on the data exchange, and the person is a recipient of SSI and entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B, the Buy-In Unit requests that a case be opened. The Worker must open the SSI Medicaid AG at the request of the Buy-In Unit, unless he knows that the client is not living in the State.

Note: Refer to 1.16.1 regarding the application process for SSI and Medicare Eligible Individuals.

The Worker may use information found in SOLQ to open SSI Medicaid. See below to determine the beginning date of eligibility.

When the client has been approved for SSI and needs medical coverage, but has not appeared on the data exchange, the Worker may use a written or verbal referral from Social Security Administration (SSA), which contains the necessary information to approve the AG. When the client requests this method, his request must be honored. When an SSI recipient moves to West Virginia from another state, the Worker must verify SSI eligibility with SSA and must notify the former state of residence that a case is open in West Virginia. See Chapter 2.

Some states make a supplemental payment to SSI recipients. Receipt of the state supplement qualifies them for Medicaid in these states. However, such payments from other states do not qualify a client for SSI Medicaid in West Virginia. Therefore, receipt of SSI Medicaid in another state does not always automatically result in eligibility in West Virginia.

1.14.2 DATE OF APPLICATION

The date of application is the first day of the month which shows on data exchange as the Medicaid effective date, or the date given on the SSA referral or by the Bureau for Medical Services (BMS) Buy-In Unit.

1.14.3 AGENCY TIME LIMITS

The Worker must enter the State Data Exchange (SDX) information for approval within 45 days of the date on which the client first appears on data exchange, or the referral from SSA or the BMS Buy-In Unit is received.

1.14.4 PAYEE

The SSI recipient is the payee, unless the use of a substitute payee is justified.

1.14.5 BEGINNING DATE OF ELIGIBILITY

When the data exchange is used to approve the Medicaid AG, the beginning date of SSI Medicaid eligibility is established as follows:

- SSI Medicaid eligibility begins with the first month for which an SSI payment is made. This is either the month after the month of application for SSI or the month following the month in which SSI eligibility is established.

  The beginning date of eligibility is based on the age of the individual. The date is determined by the following:

  - Age 21 or over – The beginning date of eligibility is the Medicaid effective date on data exchange.
  - Under age 21 –The beginning date of eligibility is the month prior to the month of the Medicaid effective date on data exchange.
- If the individual has past medical bills, his eligibility begins up to three months prior to the month of the first SSI payment. Past medical bills are indicated on the SDX file and the Medicaid effective date on data exchange reflects this for backdated Medicaid coverage.

When documentation other than data exchange is used to approve the Medicaid AG, the beginning date of SSI Medicaid eligibility is established as follows:

- If the document used for verification gives the beginning date of SSI payment, but does not indicate if any back medical bills exist, the client must be questioned about any unpaid medical bills incurred during the 3 months prior to that date. If he has unpaid bills, coverage is backdated to the earliest of the 3 months in which the bills were incurred. If

he has no unpaid bills, the first day of the month the SSI payment began is his Medicaid eligibility date.

- If the document used for verification does not give the beginning payment date for SSI, the Medicaid eligibility date is no more than 3 months prior to the month in which his receipt of an SSI payment is verified. If he has unpaid bills, coverage is backdated to the earliest of the 3 months. If the client has unpaid medical bills incurred more than 3 months prior to the date of verification, the approval must be delayed until his name appears on data exchange.

1.14.6 REDETERMINATION

There is no redetermination of SSI Medicaid eligibility. The SSI Medicaid eligibility continues as long as the client is considered eligible according to SSA. The eligibility system will provide an alert when the client is no longer eligible.

Refer to 1.16.10 regarding the loss of SSI eligibility for Deemed Qualified Medicare Beneficiary eligible individuals.

1.14.7 THE BENEFIT

The Medical ID card for the SSI recipient will be included in the Medicaid approval notice.

1.14.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.14.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure. Refer to 10.14.1 for information on closure of SSI.

1.15 DEEMED SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

Deemed SSI Recipients includes the following:

- Disabled Adult Children (DAC)
- Blind, Disabled - Substantial Gainful Activity (SGA)
- Essential Spouses of SSI Recipients
- Pass-Through
- Pickle Amendment Coverage (PAC)
- Disabled Widows and Widowers
- Drug Addicts and Alcoholics

1.15.1 APPLICATION PROCESS

No application is required for Deemed SSI Recipients. When SSI benefits are terminated, eligibility as a Deemed SSI Recipient must be evaluated. SDX alerts indicate potential eligibility.

- SGAs, Essential Spouses and Pass-Throughs do not require a Worker determination.
- PAC AG cases require a financial determination by the Worker and a PAC evaluation is completed for any Medicaid applicant or client who may meet the eligibility requirements.

When the Worker determines that the client is a Deemed SSI Recipient, he must enter the appropriate code in the eligibility system.

1.15.2 REDETERMINATION

The only Deemed SSI coverage group which requires a redetermination is Pickle Amendment Coverage (PAC).

- The PAC redetermination is completed annually.
- The redetermination form is generated by the eligibility system and mailed to the recipient in the 11th month of eligibility and is due by the first day of the 12th month.
- The redetermination may also be completed using form DFA-PAC-4 or online by using WV PATH.

- Failure to complete and return the redetermination results in AG closure. The PAC AG may be reopened using the redetermination form when it is returned by the last day of the 13th month and the individual is otherwise eligible. After the end of the 13th month, a new application must be completed.

1.15.3 THE BENEFIT

The Medical ID card for the SSI recipient will be included in the Medicaid approval notice.

1.15.3.A Ongoing Benefits

Effective December 21, 2017, there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.15.3.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.16 QUALIFIED MEDICARE BENEFICIARIES (QMB), SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB), AND QUALIFIED INDIVIDUALS (QI-1)

QMB, SLIMB and QI-1 are Medicare Premium Assistance (MPA) programs.

1.16.1 APPLICATION FORMS

The DFA-QSQ-1 is the primary application to apply for QMB. SLIMB or QI-1. No DFA-R/R-1 is required when using this form.

Additional ways a client can apply for the Medicare Premium Assistance (MPA) programs, also see section 1.3:

- WV PATH is the client portal where a client can apply for all benefits. Depending on how the client applies on the site, WV PATH may not collect asset information. Worker may need to have the client complete the DFA-SLA-S1 to collect asset information.
- The DFA-2
- The SLA-1 with the SLA-S1
- The SLA-2 with the SLA-S1
- The DFA-MA-1 can be used to apply for MPA programs when the client is also applying for Long Term Care Medicaid.

When Low Income Subsidy (LIS) files are received from the Social Security Administration (SSA), applicants who are not current Medicaid Premium Assistance clients are issued a DFA-QSQ-1 through the eligibility system.

Note: Clients who are eligible for SSI, and entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B, are deemed eligible for Qualified Medicare Beneficiary (QMB) coverage without an application. This coverage is established from a monthly batch program, a data exchange, or from other sources. The SSI and Deemed QMB coverages will be received dually in the eligibility system.

1.16.1.A Applications Requested by Client

When the QMB, SLIMB or QI-1 client requests an application, the Worker must explain:

- The date of application for QMB, SLIMB or QI-1 coverage is the day the signed application form, which contains a name and address, is received in the DOHS office or submitted through WV PATH.
- The processing time frame is 30 days, beginning with the date of application.
- In addition to QMB, SLIMB, or QI-1, the client may qualify for other coverage groups, but additional information or contact may be required.

1.16.1.B Applications Initiated from the Social Security Administration's (SSA) Low Income Subsidy (LIS)/MPA Data Exchange

If the individual expresses an interest in MPA when he applies for (LIS) prescription drug assistance at the SSA, an application is mailed to him when the eligibility system receives the LIS/MPA data exchange containing his file.

LIS files are sent daily, Monday through Friday, with the exception of federal holidays, to the eligibility system through data exchange. The Worker receives an eligibility system alert when a client's file is received and can access the LIS application information on the data exchange screens.

When the eligibility system receives a LIS file, it determines if the applicant is an MPA client, a client of other DFA program benefits, or is unknown to the system, and responds accordingly.

- When the LIS/MPA applicant is a current MPA client, no action is taken by the eligibility system nor required by the Worker.
- When the LIS/MPA applicant is a client of other programs, or known to the eligibility system, the system issues a DFA-QSQ-1. No action is required by the Worker.
- When the LIS/MPA applicant is unknown to the eligibility system, the system issues a DFA-QSQ-1. No action is required by the Worker.

The eligibility system issues the DFA-QSQ-1 the next business day after it receives the LIS data from SSA. The DFA-QSQ-1 is issued to the address in the eligibility system 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, data exchange displays a discrepancy indicator.

NOTE: If the MPA applicant has had no case in the eligibility system in the last 30 days, the eligibility system 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: 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 an eligibility system verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

1.16.2 DATE OF APPLICATION

1.16.2.A Applications Requested by the Client

The date of application is the date the applicant submits a DFA-SLA with supplement, DFA-QSQ-1, or DFA-2 in person, by fax or other electronic transmission, WV PATH, the Marketplace, or by mail, which contains, at a minimum, his name and address and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address and signature is received in the local office.

1.16.2.B Applications Initiated from SSA's LIS/MPA Data Exchange

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

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.

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.

1.16.3 WHO MUST SIGN?

The applicant(s) for QMB, SLIMB or QI-1 or his authorized representative must sign the application.

1.16.4 CONTENT OF THE INTERVIEW

An interview is not routinely required, but when an interview is conducted, the interview requirements in Section 1.2 are applicable. The following must be discussed with the applicant(s) if an interview is conducted:

- The client may receive a refund of Medicare premiums from SSA after QMB, SLIMB, or QI-1 approval.
- Medicare Buy-In for QMB does not begin until the calendar month after approval of the application. The Department does not begin to pay his Medicare deductible, co-insurance and premiums until the following month.
- Medicare Buy-In for SLIMB and QI-1 may be backdated up to three months prior to the month of application, if eligibility is established.
- SLIMB and QI-1 recipients do not receive a Medical ID card.
- Individuals dually eligible for QMB and Medically Needy cases with a spenddown may receive more than one approval notice with their Medical ID card enclosed.
- QMB recipients are eligible for payment of co-insurance and deductibles for nursing facility costs without a contribution. See Chapter 24.

1.16.5 DUE DATE OF ADDITIONAL INFORMATION

When the client visits the office and an interview is conducted, the Worker and client decide on a reasonable time for the client to return the information.

When the client mails the application or completes the application in WV PATH or the Marketplace, the Worker then uses the verification checklist or form DFA-6 to inform the client of additional information needed. The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.

If the client does not return the DFA-QSQ-1 within 31 days from the date the eligibility system received the LIS file, the eligibility system sends a denial notice. No action is required by the Worker.

> **Additional Information Example 1:** Ms. Maple's LIS data file is received by the eligibility system on August 2, 2010. She has no history of benefits with the Department. The next business day, the eligibility system issues a DFA-QSQ-1. Ms. Maple does not return the form. The eligibility system automatically denies the application and notifies Ms. Maple.
>
> **Additional Information Example 1.2:** Same as above. Ms. Maple's DFA-QSQ-1 is received in the local office on August 16, 2010 and her application is approved for QMB.

1.16.6 AGENCY TIME LIMITS

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

For applications initiated from the LIS/MPA data exchange, action must be taken within 30 days of the date the file is received by the eligibility system.

When LIS files indicate an individual is not currently eligible for Medicare but will receive it in a future month beyond the allowable processing time for MPA applications, the Worker must deny the application. However, if this individual reapplies within three months of the date he began receiving Medicare and was previously denied MPA for the sole reason of being approved for, but not yet receiving Medicare, his reapplication must be considered as a request for backdated coverage. All other policy related to MPA and backdated coverage applies.

> **Time Limit Example 1.1:** Mr. Birch's LIS/MPA file is received April 3 and indicates he will not receive Medicare until August. In order to comply with MPA processing time limits, the Worker must deny the MPA. Mr. Birch reapplies for MPA at the local office in September. The Worker must consider this application as including a request for backdated benefits to the month he began receiving Medicare and approves SLIMB effective August.
>
> **Time Limit Example 1.2:** Same as above, except Mr. Birch reapplies for SLIMB in December. If he requests backdated MPA, his SLIMB application is treated like any other and can be approved effective September.

1.16.7 AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is eligible, medical coverage is retroactive to the date eligibility would have been established for QMB, SLIMB or QI-1.

When the QMB, SLIMB or QI-1 application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay. QMB, SLIMB and QI-1 cases must have the eligibility period backdated.

> **Agency Delay Example:** Ms. Willow applies for LIS at the SSA on October 26, 2016 and expresses an interest in MPA. This is her LIS/MPA application date. She returns her DFA-QSQ-1 with all verifications on October 29, 2010, but they are misplaced. The Worker takes corrective action in December 2016 and notes the LIS application date in October. Since the client was otherwise eligible in October, the Worker backdates the QMB with a beginning eligibility date of November 2016.

The QMB client is eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time. See Chapter 10.

1.16.8 PAYEE

The QMB, SLIMB or QI-1 recipient is the payee. When there are eligible spouses, the spouses choose the payee.

1.16.9 BEGINNING DATE OF ELIGIBILITY

1.16.9.A QMB

The beginning date of eligibility for QMB is the first day of the month following the month in which the application for QMB coverage is approved. Eligibility for QMB cannot be backdated unless there is a corrective action.

> **QMB Beginning Date of Eligibility Example:** Ms. Willow applies for LIS at the SSA on October 26, 2016 and expresses an interest in MPA. This is her LIS/MPA application date. She returns her DFA-QSQ-1 with all verifications on October 29, 2010, but they are misplaced. The Worker takes corrective action in December 2016 and notes the LIS application date in October. Since the client was otherwise eligible in October, the Worker backdates the QMB with a beginning eligibility date of November 2, 2016 and approves her for QMB effective December 2016. Even though Ms. Willow's LIS application date is in October, QMB is effective the month following the month in which the application is approved. QMB cannot be backdated to November 2010.

NOTE: When the individual falls within the QMB income range and qualifies for that coverage, he is not approved for SLIMB to obtain backdated premium payment.

1.16.9.B SLIMB

The beginning date of eligibility for SLMB is the first day of the month in which the application for SLIMB coverage is approved. Eligibility for SLIMB coverage may be backdated up to three months prior to the month of application, if all eligibility requirements were met.

> **SLIMB Beginning Date of Eligibility Example:** Mr. Cedar applies for LIS at the SSA on October 29, 2015 and expresses an interest in MPA. This is his LIS/MPA

application date. He visits his local office on November 1, 2015, completes a DFA-QSQ-1 and is approved for SLMB with backdated coverage to August 2015. The LIS/MPA data exchange is transmitted November 2, 2015. The Worker checks her data exchange alerts and finds Mr. Cedar's LIS application date is October 2015. She takes corrective action and backdates his beginning date of coverage to July 2015, if otherwise eligible.

1.16.9.C QI-1

The beginning date of eligibility for QI-1 is the first day of the month in which the application for QI-1 coverage is approved. Eligibility for QI-1 coverage may be backdated up to three months prior to the month of application, if all eligibility requirements were met.

QI-1 Beginning Date of Eligibility Example: Ms. Elm applies for LIS at the SSA on September 17, 2015 and expresses an interest in MPA. This is her LIS/MPA application date. She visits her local office on October 1, 2015, completes a DFA-QSQ-1, and is approved for SLIMB with backdated coverage to July 2015. The LIS/MPA data exchange is transmitted October 2, 2015. The Worker checks her data exchange alerts and finds Ms. Elm's LIS application date is September 2015. She takes corrective action and backdates his beginning date of coverage to June 2015, if otherwise eligible.

1.16.10 REDETERMINATION

1.16.10.A Redetermination Process

The redetermination may be submitted by mail or online by use of WV PATH.

The redetermination may also be completed using the DFA-QSQ-1 or DFA-2.

1.16.10.B Redetermination Schedule

QMB, SLIMB and QI-1 cases are redetermined annually, scheduled in the 12th month of eligibility.

Note: An individual deemed eligible for Qualified Medicare Beneficiary (QMB) due to receiving SSI will not have a redetermination cycle for the coverage. The QMB coverage is continued as long as the client is considered eligible for SSI according to SSA and entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B. The eligibility system will provide an alert when the client is no longer SSI eligible. The eligibility system will set a redetermination date for two months after SSI Medicaid closure and mail the redetermination form.

1.16.10.C Redetermination Date

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches the current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstances during the certification period.

When the redetermination process cannot be completed automatically, a pre-populated form and letter of explanation is generated by the eligibility system and sent to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure.

The letter of explanation provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the redetermination must be submitted;
- Any verification which must be submitted with the form;

- A statement that the AG(s) will be closed after advance notice, if the redetermination is not completed;
- Instructions for submitting the redetermination by online by using WV PATH; and,
- A phone number to call if the individual has questions about submitting the redetermination online.

The redetermination may be submitted online by use of WV PATH until the end of the month in which the redetermination is due.

1.16.10.D Completion of the Redetermination

1.16.10.D.1 QMB, SLIMB, and QI-1

When the redetermination is completed and the individual(s) remains eligible, the new period of eligibility (POE) begins the month immediately following the month the redetermination was due.

NOTE: When a QMB redetermination is completed in the 13th month, the new POE begins the first day of the month the redetermination was due.

1.16.11 THE BENEFIT

1.16.11.A QMB

Medicaid coverage is limited to payment of the Medicare, Parts A and B, premium and payment of all Medicare coinsurance deductibles, including those related to nursing facility services. This is accomplished by the BMS Buy-In Unit.

The Medical ID card will be issued each time there is an approval or renewal for any household member. The Medical ID card does not include any date parameters since eligibility may terminate.

1.16.11.B SLIMB and QI-1

SLIMB and QI-1 clients do not receive a Medical ID card.

Medicaid coverage is limited to payment of the Medicare, Part B, premium. This is accomplished by the BMS Buy-In Unit.

1.16.11.B.1 Retroactive Benefits

When coverage is backdated, the SLIMB or QI-1 client receives a refund of paid Medicare premiums from SSA, after buy-in is accomplished.

1.16.11.B.2 Ongoing Benefits

The Department pays the client's Medicare, Part B, premium only.

1.16.11.C Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

When QMB, SLIMB and QI-1 eligibility ends, it ends effective the month following the month in which ineligibility occurs, or whenever the advance notice period ends.

1.17 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

1.17.1 APPLICATION FORMS

The Single-Streamlined Application (DFA-SLA-1) and supplement (DFA-SLA-S1), DFA-2 or WV PATH is used.

1.17.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse or the authorized representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.17.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable. In addition, the following must be discussed if an interview is conducted:

- The QDWI recipient has only his Medicare, Part A, premium paid.
- The QDWI recipient receives no Medical ID card.

1.17.4 AGENCY TIME LIMITS

The Worker must send a copy of the DFA-2 or DFA-MA-1 to the Buy-In Unit at BMS within 30 days of the date of application, when the client is eligible for QDWI.

1.17.5 PAYEE

The QDWI client is the payee.

1.17.6 REDETERMINATION

The BMS Buy-In Unit notifies the county office when the QDWI case is due for redetermination.

The redetermination cycle is set by the eligibility system.

1.17.7 THE BENEFIT

Medicaid coverage is limited to payment of the Medicare Part A, premium. The Buy-In Unit at BMS is responsible for this process. No Medical ID card is sent to this coverage group.

Eligibility ends when the Buy-In Unit at BMS notifies SSA that buy-in has terminated.

1.18 SUPPLEMENTAL SECURITY INCOME (SSI)-RELATED MEDICAID (AGED, BLIND, DISABLED)

The definitions of disability for Medicaid purposes are the same as the definitions used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or Retirement, Survivors, and Disability Insurance (RSDI) based on disability, which are as follows.

AGED

Individuals age 65 and older.

BLINDNESS

To meet the definition of blindness, the individual must have:

- Central visual acuity that cannot be corrected to better than 20/200 in the better eye; or
- A limitation of the field of vision in the better eye so that the widest diameter of the visual field subtends an angle of 20 degrees or less.

DISABILITY, INDIVIDUALS AGE 18 OR OVER

An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment that has lasted, or is expected to last, for a continuous period of at least 12 months, or is expected to result in death.

DISABILITY, INDIVIDUALS UNDER AGE 18

The child who is under age 18 is considered to be disabled if he has a medically determinable physical or mental impairment (or combination of impairments), the impairment(s) results in marked and severe functional limitations, and the impairment(s) has lasted (or is expected to last) for at least one year or to result in death.

An individual under age 18 is not considered a child if he:

- Is legally married;
- Is divorced; or
- Is over age 16 and has been emancipated by a court of law.

1.18.1 DATE OF APPLICATION

The date of application is the date the Department of Human Services (DOHS) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name, address, and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.3 are met.

1.18.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse, or the authorized representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.18.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements in Section 1.2 are applicable. In addition, the following must be discussed with the applicant if an interview is conducted:

- That an aged individual may have his eligibility determined as a blind or disabled individual if he wishes.
- The spenddown processes.
- The specific months which will constitute the Period of Consideration (POC) based on the six-month POC that will most benefit the client. The beginning date of eligibility may be backdated up to three months prior to the month of application when all eligibility requirements are met, and the client has medical expenses for which he seeks payment.
- The MRT process, if applicable.
- That when a spouse apply, one spouse may be approved, when eligible, while the application for the other spouse remains pending.
- Relationship with QMB/SLIMB. See Section 1.16.

1.18.4 DUE DATE OF ADDITIONAL INFORMATION

Additional information related to medical bills is due 30 days from the date of application.

1.18.5 AGENCY TIME LIMITS

1.18.5.A Application Processing Limits

- SSI Age-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.
- SSI Blind-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.
- SSI Disability-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 90 days of the date of application.

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness or disability is established, the deprivation factor is changed.

Information related to medical bills in cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.18.5.B MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the time limits in the table below apply to the MRT process.

Required Action	Time Limit
Request medical records and reports	By the 7th day after application

Required Action	Time Limit
Follow-up request(s) for medical records or reports	By 30 days after initial request (and each 30 days thereafter)
Submission to the MRT	By the 7th day after medical records/reports received
Receipt of file and logged	By the 2nd day after receipt by the MRT
Initial review by the MRT staff	By the 7th day after receipt
Physician review (initial)	By the 14th day after receipt
Additional medical information requested (if required) by physician	By the 7th day after initial physician review
Physician's final review	By the 7th day after receipt of additional medical information
Final decision (completion of ES-RT-3 and/or DFA-RT-3M form[s])	By the 7th day after final physician's review
File returned to county office	By the 3rd day after final physician's review
Notice to the client	By the 7th day after receipt of final decision at county office

1.18.6 PAYEE

The client is the payee. Spouses may decide who the payee is.

1.18.7 BEGINNING DATE OF ELIGIBILITY

1.18.7.A Non-Spenddown

The beginning date of eligibility is the first day of the month of the period of consideration (POC).

1.18.7.B Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker in the eligibility system are not paid by Medicaid.

This date may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

1.18.8 REDETERMINATION

1.18.8.A Non-Spenddown

1.18.8.A.1 The Redetermination List

Non-Spenddown AGs are redetermined in the sixth month of the POC. The six-month period begins with the month of application. The date of the next redetermination is automatically coded in the eligibility system.

The eligibility system alerts the Worker when a redetermination is due and sends a redetermination form to the client.

1.18.8.A.2 Completion of Redetermination

When the redetermination is completed and the AG remains eligible, the new POC begins the month immediately following the month of the redetermination.

1.18.8.B Spenddown

Spenddown AGs are not redetermined and are closed at the end of the sixth month of the POC. The last month of the six-month POC is coded in the eligibility system.

The client must reapply for a new POC using one of the application methods described above.

Spenddown AGs are mailed a letter at adverse action notice deadline during the sixth month of the POC. This letter informs the client that his eligibility will end on the last day of the month and that he must reapply for Medicaid coverage.

1.18.9 THE BENEFIT

1.18.9.A.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.18.9.A.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.18.10 SPOUSES APPLY – ONE APPROVED, ONE PENDING

When an application for an SSI-Related coverage group is made for a couple and one spouse is eligible, but the application for the other remains pending because disability has not been established, the procedure is as follows:

- Approve the application for the eligible spouse. Deeming procedures in Chapter 4 apply.
- Send an approval notice to the eligible individual and include an explanation that eligibility for the spouse has not been established and the reason.

If the spouse is determined eligible at a later date, the procedures depend upon whether or not the previously ineligible spouse has income, whether or not such income was deemed to the client, and whether or not there is a spenddown.

1.18.10.A Income of Previously Ineligible Spouse Does Not Cause Spenddown

When the income of the previously ineligible spouse equals $0, or has been deemed to the client spouse, or does not cause the AG to have a spenddown, the following procedures apply.

- Take eligibility system action to add the spouse to the AG. The beginning period of consideration (POC) or period of eligibility (POE) for the spouse is the same as for the client;
- Send an approval notice to the recipient to inform him that eligibility for the spouse has been established and the date on which his medical coverage begins.
- If the individual is added after the deadline date in the sixth month of the POC, proper eligibility system procedures must be followed to insure issuance of a Medical ID card.

1.18.10.B Income of Previously Ineligible Spouse Causes Spenddown

When the previously ineligible spouse has income, but it was not deemed to the client spouse, and it causes the AG to have a spenddown, the following procedures apply.

If the eligible spouse did not previously have a spenddown, but the addition of the previously ineligible spouse and his income makes the AG subject to spenddown, the following actions are taken:

- The previously ineligible spouse is added to the AG; and
- The AG is closed after proper notice and is reopened with a new POC. The new POC must not cover any period of time in which the AG was in a POE; and
- The AG must be supplied with proper notice about the spenddown and the procedures which now apply.

If the eligible spouse had a spenddown which was met and is currently in an active AG, the following actions are taken:

- Add the previously ineligible spouse to the AG for the current POC. The AG is not closed prior to the end of the current POC due to increased countable income.
- When the AG reapplies for a new POC, all income is counted, and appropriate spenddown procedures apply.

If the spouse is determined ineligible, the Worker sends the recipient a denial notice.

The Worker must update the eligibility system and make a recording in case comments about the denial.

1.19 SSI-RELATED/NON-CASH ASSISTANCE

A coverage group for individuals who are eligible for but not receiving Supplemental Security Income (SSI) payments.

1.19.1 DATE OF APPLICATION

The date of application is the date the Department of Human Services (DOHS) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name and address and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.2.10 are met.

1.19.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse, or the representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.19.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements in Section 1.2 are applicable. In addition, the following must be discussed with the applicant if an interview is conducted.

- That an aged individual may have his eligibility determined as a blind or disabled individual if he wishes.
- The beginning date of eligibility may be backdated up to three months prior to the month of application when all eligibility requirements are met, and the client has medical expenses for which he seeks payment.
- The MRT process, if applicable.
- That when a couple applies, one spouse may be approved, when eligible, while the

application for the other spouse remains pending.

- Relationship with QMB/SLIMB. See Section 1.16.

1.19.4 AGENCY TIME LIMITS

1.19.4.A Agency Processing Limits

- SSI Age-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.
- SSI Blind-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.
- SSI Disability-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken with 90 days of the date of application.

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness or disability is established, the deprivation factor is changed.

1.19.4.B MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the time limits in the table below apply to the MRT process.

Required Action	Time Limit
Request medical records and reports	By the 7th day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request (and each 30 days thereafter)
Submission to the MRT	By the 7th day after medical records/reports received
Receipt of file and logged	By the 2nd day after receipt by the MRT

Required Action	Time Limit
Initial review by the MRT staff	By the 7th day after receipt
Physician review (initial)	By the 14th day after receipt
Additional medical information requested (if required) by physician	By the 7th day after initial physician review
Physician's final review	By the 7th day after receipt of additional medical information
Final decision (completion of ES-RT-3 and/or DFA-RT-3M form[s])	By the 7th day after final physician's review
File returned to county office	By the 3rd day after final physician's review
Notice to the client	By the 7th day after receipt of final decision at county office

1.19.5 PAYEE

The client is the payee. Couples may decide who the payee is.

1.19.6 REDETERMINATION

SSI-Related/Non-Cash Assistance Medicaid AGs are redetermined every twelve months in the last month of the current POC. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

When the redetermination process cannot be completed automatically, a pre-populated form is generated by the eligibility system and sent to the client.

1.19.7 THE BENEFIT

1.19.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month

1.19.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.20 AFDC-RELATED MEDICAID

Caretaker Relatives and pregnant women are eligible for Medicaid under this coverage group when certain conditions are met as described in Chapter 23. This coverage group is not subject to the spenddown provision. Medically Needy AGs are subject to the spenddown provision.

NOTE: Supplemental Security Income (SSI) recipients, whether they are adults or children, are not included in the AG, IG, or NG.

1.20.1 DATE OF APPLICATION

The date of application is the date the Department of Human Services (DOHS) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name and address and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.2.10 are met.

1.20.2 WHO MUST SIGN?

The specified relative with whom the child lives. If the child is living with both parents, both must sign unless:

- One parent is hospitalized; or
- One parent is incarcerated.

When the specified relative with whom the child lives has a legal committee, the committee must sign.

1.20.3 AGENCY TIME LIMITS

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Information related to medical bills in cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.20.4 PAYEE

The parent or other specified relative who is the caretaker relative is the payee. When both parents are in the home, either parent may be the payee.

1.20.5 BEGINNING DATE OF ELIGIBILITY

This date may be backdated up to 3 months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

1.20.5.A Non-Spenddown

The beginning date of eligibility is the first day of the month of the POC.

1.20.5.B Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker in the eligibility system, are not paid by Medicaid.

1.20.6 REDETERMINATION

1.20.6.A Non-Spenddown

Non-Spenddown AGs are redetermined every six months in the last month of the current POC. The eligibility system alerts the Worker when a redetermination is due and sends a letter to the client.

The Worker, after receipt of the alert, is responsible for scheduling the redetermination so that it is completed prior to or during the month in which it is due.

An appointment letter is generated by the eligibility system to notify the client of the redetermination and the date the interview is scheduled.

When the redetermination is completed and the AG remains eligible, the new POC must begin the month immediately following the month of the redetermination. The new beginning POC is automatically coded in the eligibility system.

1.20.6.B Spenddown

Spenddown AGs are not redetermined and are closed at the end of the sixth month of the POC. The client must reapply for a new POC.

Spenddown AGs may come into the office at any time to reapply for a new POC.

Spenddown AGs are mailed a computer-generated letter at the adverse action deadline of the 6th month of the POC. This letter informs the client that his eligibility will end on the last day of the month and that he must reapply for Medicaid coverage.

1.20.7 THE BENEFIT

1.20.7.A Non-Spenddown

1.20.7.A.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.20.7.A.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.20.7.B Spenddown

A Medical ID card is issued when the eligibility system entries bring the spenddown amount to $0. All eligible individuals who are included in the AG which meets spenddown appear on the Medical ID card.

1.20.7.B.1 Ending Date of Eligibility

The ending date of eligibility is the last day of the effective date of closure. The spenddown AG automatically closes at adverse action deadline of the 6th month of the POC, effective the last day of the POC.

- A member(s) of the Income Group experiences an increase in income;
- An individual(s) with income is added to the Income Group; or
- An individual(s) is removed from the Needs Group.

1.21 FORMER FOSTER CHILDREN

The Affordable Care Act (ACA) established a new categorically mandatory coverage group called the Former Foster Children group.

1.21.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.21.2 WHO MUST SIGN?

The application must be signed by an adult in the household or their authorized representative.

1.21.3 AGENCY TIME LMITS

Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.

1.21.4 PAYEE

The payee is the former foster child.

1.21.5 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. Eligibility may be backdated up to 3 months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

1.21.6 REDETERMINATION

1.21.6.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,
- The date by which the information must be submitted,
- Specific information necessary to complete the redetermination,
- The opportunity to report changes,
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated auto-renewal verification checklist form online by using WV PATH. A phone number to call if the individual has questions about submitting the pre-populated auto-renewal verification checklist online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to 3 months.

1.21.6.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DOHS must only request the information on the change reported. When the information is received, the client is evaluated for rolling redetermination. If the agency has enough information available to renew eligibility with respect to all the eligibility criteria, the agency must begin a new 12-month certification period.

> **Redetermination Example 1:** Rose is determined eligible from February 1, 2014 through January 31, 2015. On June 2, 2014, Rose calls and reports a change in income. The information is provided to the Department on June 6, 2014. The Worker evaluates and determines enough information is available to renew

eligibility. The benefit is given a new certification period effective July 1, 2014 through June 30, 2015.

Redetermination Example 2: A redetermination for SNAP benefits is completed on May 14, 2014. The certification period is April 1, 2014 through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to recertify. The WVCHIP certification period is renewed from June 1, 2014 through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.21.7 THE BENEFIT

1.21.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.21.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.22 NON-QUALIFIED NONCITIZENS

This coverage group provides emergency support to certain individuals with severe medical conditions.

1.22.1 WHO MUST SIGN?

The applicant or his authorized representative must sign the application.

1.22.2 PAYEE

The client who is the noncitizen or his authorized representative is the payee.

1.22.3 BEGINNING DATE OF ELIGIBILITY

Eligibility for emergency Medicaid coverage begins the date that the applicant's emergency medical situation starts.

1.22.4 REDETERMINATION

The case is opened when treatment for the medical emergency begins and closed at the end of the medical emergency.

When the client has an ongoing emergency, the Worker must check periodically to determine if the emergency has ended. If a Medical Review Team (MRT) decision was part of the client's eligibility determination, MRT redetermination requirements apply.

1.22.5 THE BENEFIT

1.22.5.A Ongoing Benefits

The client is issued a verification of medical coverage for the valid Period of Eligibility (POE).

1.22.5.B Ending Date of Eligibility

Eligibility for emergency Medicaid coverage ends on the date the medical emergency is resolved.

1.23 AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The AIDS Drug Assistance Program (ADAP), or also referred to as the AIDS Special Pharmacy Program or the ADAP West Virginia Special Pharmacy Program, is a Bureau of Public Health (BPH) program contracted with BMS to administer the medical services provided. The eligibility decision is made by the AIDS Drug Assistance Program (ADAP), rather than the Worker.

1.23.1 APPLICATION FORMS

- DFA-2, Single-Streamlined Application (SLA), or WV PATH – The DFA-2 is completed to determine Medicaid eligibility.
- ADAP Application – If determined ineligible for all full-coverage Medicaid groups except an SSI-Related Medicaid with an unmet spenddown, an ADAP application for West Virginia Special Pharmacy must be completed. This application is available on the Department of Human Services (DOHS) Intranet Forms page.

1.23.2 COMPLETE APPLICATION

The ADAP application is complete when page 1 is signed by the applicant and page 2, the Physician's Report, is signed by the physician.

NOTE: The resource development policies in Chapter 8 do not apply to ADAP. Potential eligibility for, or receipt of Medicare, Part D, does not affect the application or referral process for the ADAP eligibility determination.

1.23.3 DATE OF APPLICATION

The date of application is the date the Department of Human Services (DOHS) receives the application in person, by fax or other electronic transmission, through WV PATH or the Federally Facilitated Marketplace (FFM), or by mail, which contains, at a minimum, the applicant's name and address and signature.

When the client previously applied for Medicaid and is pending spenddown, the date the client inquiries about the AIDS Special Pharmacy program coverage is the date of application.

1.23.4 WHO MUST SIGN?

The client or his representative must sign the ADAP application.

1.23.5 AGENCY TIME LIMITS

From the date of application, defined above, the applicant must return the completed ADAP application to the Worker within 30 days of the Medicaid application.

Upon receipt, the Worker must forward the most recent DFA-2, SLA or ADAP applications to:

ATF
P.O. Box 6360
Wheeling, WV 26003
Phone: 304-232-6822

1.23.6 AGENCY DELAYS

When the DOHS fails to request necessary verification or information, the Worker must immediately send form DFA-6 or the eligibility system verification checklist to request it. The Worker must inform the client that the application is being held pending.

Applications for the ADAP are processed by ADAP. When a Worker determines he has not forwarded the eligibility information to ADAP, he must forward it immediately.

1.23.7 PAYEE

The ADAP individual is the payee for services. BMS handles payment for all services.

1.23.8 THE BEGINNING DATE OF ELIGIBILITY

ADAP determines the date eligibility begins.

1.23.9 REDETERMINATION

Redetermination does not apply to ADAP.

1.23.10 THE BENEFIT

No Medical ID card is issued.

If the client becomes eligible under any other Medicaid coverage group or meets his spenddown, the Worker must notify ADAP immediately and specify the beginning date of Medicaid eligibility.

Otherwise, ADAP determines when eligibility ends.

1.24 BREAST AND CERVICAL CANCER MEDICAID COVERAGE GROUP (BCC) APPLICATION PROCESS

1.24.1 APPLICATION PROCESS

To be eligible for Breast and Cervical Medicaid (BCC), the client must:

- Be enrolled in the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) through the office of Maternal, Child and Family Health (OMCFH) and the Center for Disease Control (CDC).
- Be diagnosed with breast or cervical cancer or certain pre-cancerous conditions and actively receiving cancer treatment.
- Be a woman under age 65 who is not receiving Medicare benefits.
- Be uninsured or under-insured or otherwise lacking creditable medical coverage.
    - IMM Chapter 22, Appendix A identifies the different types of insurance benefits that will affect BCC eligibility and the types of insurance that a client can have while still having BCC Medicaid.
- Not be eligible for a mandatory Medicaid coverage group.

The application process must be completed in the following order:

- Before a client can be approved for BCC Medicaid, they must be an active participant in the WVBCCSP. To enroll in WVBCCSP, the client must:
    - Contact a WVBCCSP Screening Provider who will determine eligibility for WVBCCSP, assist the client with the completion of the DFA-BCC-1, and provide a blank CDC Certificate of Diagnosis for the client's treating physician to fill out and sign.
    - The Screening Provider will fax the completed DFA-BCC-1 to WVBCCSP who will verify current enrollment in their program. The client's treating physician will fax the completed CDC Certificate of Diagnosis to WVBCCSP.
    - WVBCCSP will then forward the DFA-BCC-1, CDC Certificate of Diagnosis and a Letter of Eligibility stating that the client is enrolled in WVBCCSP to the client's local DOHS Office.

- Once the Worker receives the DFA-BCC-1, CDC Certificate of Diagnosis, and the Letter of Eligibility from WVBCCSP, the Worker must enroll the client into the Presumptive

Phase of BCC, assuming all other BCC requirements are met. Follow the eligibility system instructions for coding BCC using PRD-38. While the client is in the Presumptive Phase of BCC, the Worker will determine if the client is eligible for any mandatory Medicaid coverage groups.

- The Worker must contact the client and arrange for a Medicaid application to be completed and to request any additional information needed to determine eligibility.
- If the Worker determines that the client is NOT eligible for a mandatory Medicaid coverage group, the Worker must disenroll the client from the Presumptive Phase of BCC and enroll them in Regular BCC Medicaid. Follow the eligibility system instructions for coding BCC using PRD-38. Scan documents into the clients case file and make thorough case comments.
- If the client is eligible for a mandatory Medicaid coverage group, disenroll the client from the Presumptive Phase of BCC Medicaid and approve the new Medicaid coverage group. Scan appropriate documents to the client's case and make thorough case comments.
- Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

NOTE: *At application, if a worker receives the DFA-BCC-1 or the CDC Certificate of Diagnosis directly from the client or medical facility, do not approve the client for BCC Medicaid. In the eligibility system, create a Request for Assistance and scan the documents to the client's file. Mail the DFA-BCC-1 and the CDC Certificate to WVBCCSP. If the client is determined eligible for WVBCCSP, WVBCCSP will then fax the completed DFA-BCC-1, the CDC Certificate of Diagnosis, and a Letter of Eligibility to the client's local DOHS office for a Worker to process and determine eligibility for BCC Medicaid.*

NOTE: *To be eligible for BCC, the client must first be a patient of the WVBCCSP. WVBCCSP has separate eligibility guidelines from BCC. While BCC Medicaid does not have an income limit, WVBCCSP has an income limit of 250% FPL. For more information on the West Virginia Breast and Cervical Cancer Screening Program, contact WVBCCSP at 304-558-5388 or 1-800-642-8522.*

1.24.2 REDETERMINATION PROCESS

An annual redetermination for Breast and Cervical Cancer Medicaid (BCC) is required. For the redetermination, the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP), which is managed through the Office of Maternal Child and Family Health (OMCFH), sends the client a blank DFA-BCC-1 Medicaid application and a CDC Certificate of Diagnosis form. The client is responsible for having their doctor complete the blank CDC Certificate of Diagnosis stating the client is still actively receiving cancer treatment. The treating physician will fax the completed CDC Certificate of Diagnosis to WV BCCSP.

If the client remains eligible for WVBCCSP, the completed DFA-BCC-1 application and the CDC Certificate of Diagnosis are then forwarded by WVBCCSP to the client's local DOHS Office. Once the Worker receives the required documents from WVBCCSP, the review process must be completed by the Department. The Worker sends the client a Medicaid application to determine if the client is eligible for one of the mandatory Medicaid coverage groups. The BCC case remains open in Regular BCC while the determination is being made. Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

If determined eligible for a mandatory Medicaid group, the BCC coverage is terminated and takes the Worker approves the client for the appropriate mandatory Medicaid coverage group.

If the client is not eligible for a mandatory Medicaid coverage group, complete the required override for BCC Medicaid and confirm the benefit. The Worker must scan the documents into the client's case record and make appropriate case comments.

If the client needs disenrolled from WVBCCSP due to age, obtaining other insurance, no longer a West Virginia resident, treatment completion or death, the WVBCCSP Case Manager will notify the local DOHS office. The Worker will then need to determine eligibility for any other types of Medicaid before termination.

1.24.3 COMMUNICATIONS WITH THE BREAST AND CERVICAL SCREENING PROGRAM (WVBCCSP)

To ensure that needed services are not delayed after approval for Breast and Cervical Cancer Medicaid (BCC) and that BCC has current information about individuals who are closed or denied, the Worker must follow the procedures outlined below:

- Follow the eligibility system instructions for coding BCC using PRD-38.
- Print the current address screen which must include the applicant's name.
- Write the status of the case on the bottom of the printout. Examples include, but are not limited to approved for BCC, or ineligible for BCC because eligible for another mandatory coverage group.
- Fax the printout along with any other pertinent documentation to the attention of WVBCCSP at 304-558-7164.
- Other avenues of communication with WVBCCSP include:
    - By mail at The Office of Maternal, Child and Family Health, Attn: WVBCCSP, 350 Capitol Street, Room 427, Charleston, WV 25301-3715.
    - By phone at 304-558-5388 or 1-800-642-8522. These phone numbers can be given to the public.
    - WVBCCSP's website has further information about their program. Their web address is https://DoHS.wv.gov/bccsp/Pages/default.aspx.

APPENDIX A: APPLICATION FORMS AND INSTRUCTIONS BY PROGRAM

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
SNAP				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	10 days from the date of the DFA-6 or Verification Checklist.	• If eligible, the client must receive benefits by the 30th day. • If expedited, the client must receive benefits by the seventh day. • If denying for failure to return information, must wait until after the 10th day but no later than the 31st day.
DFA-SNAP-1	SNAP Application	Applicant is only applying for SNAP.		
WV WORKS				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional information must be returned (not to exceed 30 days).	• Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the initial contact. • When the application must be denied because the client has not responded to a DFA-6 or verification checklist, the Worker must wait until after the 10th day but no later than the 31st day to deny the application.
DFA-RFA-1	Request for Assistance	To protect the date of application for proration purposes when the client is in the local office and time does not permit conducting an interview on the date the client wishes to apply for benefits.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
MEDICAID AND OTHER HEALTH COVERAGE PROGRAMS				
Adult Group				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
AFDC-Related Medicaid				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information is due 30 days from the date of application	Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
AIDS Drug Assistance Program (ADAP)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The Worker and the client or his authorized representative decide on a reasonable time for the information to be returned.	• The ADAP eligibility determination must be based on current client circumstances. • From the date of application, defined in Section 1.23, the applicant must return the completed ADAP application to the Worker within 30 days.
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage – Long Form with Supplement	For a single individual applying for health care coverage only.		
DFA-SLA-2 with DFA-SLA-S1	Supplement for Healthcare Coverage - Short Form with Supplement	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
ADAP	ADAP Application	After determined ineligible for all full-coverage Medicaid groups except SSI-Related Medicaid with an unmet spenddown.		
Breast and Cervical Cancer (BCC)				
DFA-BCC-1	BCC Application			
Children Under Age 19				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When an interview is conducted, the Worker and the client decide on a reasonable time for the information to be returned. • When the application is returned by mail, left at the office or submitted by WV PATH and additional information is required, the client must be given at least 10 days after the mailing date of the request for additional information to respond.	• Action must be taken to approve, deny or withdraw the application within 13 business days of the date a complete application is received in the county office. • If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it and to complete the application within 13 business days.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
Continuously Eligible Newborn (CEN) Children				
N/A	N/A	No application required for CEN children who are born to Medicaid eligible women.		
Deemed Parents/Caretaker Relatives				
N/A	N/A	No application required.		
Deemed SSI Recipients				
N/A	N/A	No application required. State Data Exchange (SDX) codes indicate potential eligibility.		
Former West Virginia Foster Children				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Non-Qualified Noncitizens				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application, 90 days if a disability must be established.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Parents/Caretaker Relatives				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Pregnant Women				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When an interview is conducted, the Worker and the client decide on a reasonable time for the information to be returned. • When the application is returned by mail, left at the office or submitted by WV PATH and additional information is required, the client must be given at least 10 days after the mailing date of the request for additional information to respond.	• Action must be taken to approve, deny or withdraw the application within 13 business days of the date a complete application is received in the county office. • If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it and to complete the application within 13 business days.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Qualified Disabled Working Individuals (QDWI)				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.	The Worker must send a copy of the DFA-2 or DFA-MA-1 to the BMS Buy-In Unit within 30 days of the date of application, when the client is eligible for QDWI.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
QMB, SLIMB, QI-1				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When the client visits the office and an interview is conducted, the Worker and client decide on a	Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-QSQ-1	Medicare Assistance Programs Application	When Low Income Subsidy (LIS) files are received from the Social Security Administration (SSA), applicants who are not current Medicare Premium Assistance (MPA) recipients are issued a DFA-QSQ-1 through the eligibility system.	reasonable time for the client to return the information. • When the client mails the application or completes the application in WV PATH or the Marketplace, the Worker then uses the verification checklist or form DFA-6 in inform the client of additional information needed. The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.	For LIS/MPA applicants: • Action must be taken within 30 days of the date the file is received by the eligibility system. • When the eligibility system determines a LIS/MPA applicant is a current MPA recipient, no notice is sent. • The next business day after the eligibility system receives SSA's LIS data, the system issues a DFA-QSQ-1. If the DFA-QSQ-1 is not returned within 31 days from the date the eligibility system received the LIS file, the eligibility system sends a denial notice. No action is required by the Worker
Special Pharmacy				
DFA-SP-1	Special Pharmacy Application	The DFA-SP-1 for Special Pharmacy coverage is completed by the Worker and forwarded to the DFA Medicaid Policy Unit for consideration. This is an interdepartmental form and is not given to or completed by the client.	All information must be submitted with the DFA-SP-1.	The Worker must submit the DFA-SP-1 to the DFA Medicaid Policy Unit within 10 days of completion. DFA must make a decision and notify the Worker of that decision within 30 days from the date the completed DFA-SP-1 is received.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
SSI Recipients				
N/A	N/A	There is no application form. SSI recipients are categorically eligible.	Not applicable.	The Worker must enter the SDX information for approval within 45 days of the date on which the client first appears on the data exchange, or the referral from SSA or the BMS Buy-In Unit is received.
SSI-Related/Aged, Blind and Disabled				
DFA-2 or	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information related to medical bills is due 30 days from the date of application	SSI Age-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application SSI Blind-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application SSI Disability-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 90 days of the date of application
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2 with DFA-SLA-S1	Application for Healthcare Coverage – Short Form with Supplement	For a single individual applying for health care coverage only.		
SSI-Related/Non-Cash Assistance				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information related to medical bills is due 30 days from the date of application.	See SSI-Related Aged, Blind, Disabled above.
DFA-SLA-1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form with Supplement	For a single individual applying for health care coverage only.		
Transitional Medicaid				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
N/A	N/A	There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to hours of employment, amount of employment income.	Not applicable.	Not applicable.
West Virginia Children's Health Insurance Program (WVCHIP)				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Prior to approval for WVCHIP, the client must be determined ineligible for all MAGI Medicaid coverage groups; therefore, the Children Under Age 19 coverage group application procedures apply.	If the Worker decides that additional information is required, the Worker must immediately send a request for the information that includes notification that the application is being held pending receipt of that information and the start date of his WVCHIP coverage may be delayed if he does not respond by the due date.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
OTHER DOHS ASSISTANCE PROGRAMS				
Burial Assistance				
DFA-BU-1	Application for Indigent Burial Benefits	Used in taking applications for payment of burial expenses.	None.	The application must be completed within 30 days of interment or cremation. The completed burial packet must be sent to DFA Policy Unit within three business days of receipt.
DFA-BU-2	Affidavit of Responsible Relative	Required when the applicant is a relative who is liable for the burial costs of the deceased; preferred when the applicant is a relative who is not liable for the burial costs or the applicant is not a relative of the deceased. Used to determine financial ability of those responsible relatives who are liable for the burial costs of the deceased and to determine sufficient ability of other relatives who wish to contribute to the burial costs but are not liable.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
Emergency Assistance (EA)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The Worker must clearly state on the DFA-6 what items must be returned by the applicant, as well as the date by which the information must be returned. The failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the application will be considered failure to provide verification and will result in a denial of the application.	A decision must be made on all applications as soon as possible, if the emergency currently exists, or prior to an imminent emergency but no later than three business days from the date of application.
DFA-EA-1	Emergency Assistance Application	Applicant wishes to be considered for EA only.		
Low Income Energy Assistance Program (LIEAP)				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Applicants must be allowed 15 calendar days to return verification.	Applications ready for processing by the local DOHS office must be sent to that office on a daily basis with a signed and dated list with the name and address of each applicant. Applications held in excess of 30 days by any outside agency are not accepted.
DFA-LIEAP-1	LIEAP Application	Applicant wishes to be considered for LIEAP only.		
DFA-LIEAP-1b	Supplemental LIEAP Form	Applicant is being considered for LIEAP.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
West Virginia School Clothing Allowance (WV SCA)				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained. This date must be within 30 days of the date of application.	As long as the application is made by the last day of July and the applicant returns the requested information in the time frame specified by the Worker, the WV SCA is approved, if the family is otherwise eligible. All applications must be processed by August 31. Because WV SCA benefit expire October 31 of the current year, every effort should be made to process all applications in a timely manner within 30 days of the date of application.
DFA-WVSC-1	SCA Application	Applicant wishes to be considered for WV SCA only.		
WV WORKS School Clothing Allowance (SCA)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	See WV WORKS.	See WV WORKS.

APPENDIX B: GUIDE FOR SELF-SUFFICIENCY PLAN

Identify Goals

Identify Challenges

Identify Support Services or other resources/referrals needed

Assignments/Activities

Target Dates/Completion Dates/Follow-up Dates

MISCELLANEOUS

- Legal Aid
- Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking
- Schedule Date for Orientation
- Schedule Date for In-Depth Assessment (OFA-WVW-3A)
- TABE/Work Keys Testing
- Always Consider Sanctions/Compliance/Non-Compliance
- Always Consider Exemptions from Work Requirements
- Good Cause for Non-Participation
- Mentoring

WORK ACTIVITIES

- Subsidized Employment
- Unsubsidized Employment
- Work Experience (WE), Community Work Experience Program (CWEP), Joint Opportunities for independence (JOIN), and Community Service (CS)
- On the Job Training Employer Incentive Program (EIP)
- Providing childcare to a community service participant (CC)

JOB SEARCH IS:

- Register with the Job Service
- Parenting Classes
- Financial Literacy

- Relationship Education
- Substance Abuse/Mental Health Treatment
- Rehabilitation Activities
- Apply for Governor's Summer Youth Program (GSYP)
- Apply for Work Study Programs (College Students)
- Job Search - Looking for Work

EDUCATIONAL ACTIVITIES

- High School, High School Equivalency (GED), and Adult Basic Education (ABE) Literacy Classes
- English as a Second Language
- College
- Job Skills Training or Education Directly Related to Employment
- Vocational Training

SUPPORT SERVICES

- Child Care
- Transportation
- Tools
- Relocation
- Clothing/Uniforms
- Driver's License
- Professional Licenses
- Collateral Expenses
- Vehicle Repair and Insurance

PRC MANDATORY REQUIREMENTS (for everyone)

- Child Immunizations
- Schedule of Preventive Health Care for Children
- Children must be in School or in Appropriate Child Care

- Obtain Social Security Numbers for all Family Members
- Cooperation with Child Support:
    - Establish Paternity
    - Collection of Child Support

PRC MANDATORY REQUIREMENTS (for Teen Parents)

- Parenting Classes and/or Mentoring
- Living at Home/Adult Supervised Setting Educational Activity:
    - High School
    - Alternative School Setting
    - ABE Classes
    - Vocational Training

MEDICAL

- Medical Testing
- MRT Referral
- Vocational Assessment
- Social Security Administration Referrals
- Dental/Optometry
- Emotion Health Inventory
- Learning Needs Screening

APPENDIX C: EFFECTIVE DATES OF TANF STATE PLANS

State	Effective Date
Alabama	11/96
Alaska	11/96
Arizona	10/96
California	7/97
Colorado	11/96
Connecticut	7/97
Delaware	10/96
District of Columbia	3/97
Florida	3/97
Georgia	10/96
Guam	1/97
Hawaii	7/97
Idaho	7/97
Illinois	7/97
Indiana	7/97
Iowa	10/96
Kansas	1/97
Kentucky	10/96
Louisiana	1/97
Maine	11/96
Maryland	12/96
Massachusetts	9/96
Michigan	9/96
Minnesota	7/97
Mississippi	10/96

State	Effective Date
Missouri	12/96
Montana	12/96
Nebraska	12/96
Nevada	12/96
New Hampshire	10/96
New Jersey	2/97
New Mexico	7/97
New York	12/96
North Carolina	1/97
North Dakota	7/97
Ohio	10/97
Oklahoma	10/97
Oregon	10/96
Pennsylvania	3/97
Puerto Rico	7/97
Rhode Island	5/97
South Carolina	10/96
South Dakota	10/96
Tennessee	10/96
Texas	11/96
Utah	10/96
Vermont	No limit
Virginia	2/97
Virgin Islands	7/97
Washington	1/97
West Virginia	1/97
Wisconsin	9/96
Wyoming	1/97

APPENDIX D: WV WORKS LIST OF LOCAL SERVICES

INSTRUCTIONS

The template contains information in parentheses after each main heading. This information is what is required to be included on the form or discussed with the client. It should not appear on the final form used by Workers.

When the template states to “list” information, it is expected that the local office will type the information on the form. When the template states “discuss” or “tell” it is expected that the Worker will verbally provide information.

When a particular service is not available locally, the local office may list the nearest location where such services are available or may type on the form: “Not Available Locally.” In some locations in the State, there may be more service locations than it is practical to list on the form. When this is true, list all locations on a separate sheet(s) of paper and on the form, refer to the attachment.

Attachment A must be copied exactly as written and included with the WV WORKS List of Local Services provided to the client.

It is recommended that the Worker include the most recent Community Resource Guide or Quick Guide with the WV WORKS List of Local Services.

WV WORKS LIST OF LOCAL SERVICES

Name_____ Case No. or SSN_____

(Please put your initials beside each service as it is discussed with you)

_____ WORKFORCE West Virginia Career Centers/Other Employment Resources
(List addresses and telephone numbers for all available employment resources.)

_____ Activity Placements
(List available types of activities that may be possible to meet a work requirement, such as CWEP, providing childcare. Explain each briefly here and provide more detail in discussion.)

_____ Adult Basic Education Classes/Head Start
(List addresses and telephone numbers for contacting facilities about additional information. Explain what to expect from such classes.)

_____ College/Vocational Training
(List addresses and telephone numbers for colleges and vocational training within commuting distance. List the kinds of vocational training available. Discuss the availability of financial aid and how to apply. List information about how to contact the financial aid officer at each facility. Attach as many pages as necessary and refer to the attachments here).

_____ Statutory Benefits
(List address and telephone number of agencies where application can be made for disability payment, such as SSI, RSDI, VA. Explain MRT process.)

_____ Childcare
(List addresses and telephone numbers for child and adult day care available locally.)

_____ Vision/Dental Services
(Explain the benefits.)

_____ Support Service Payments
(Provide the client with an updated pamphlet describing support services. Tell the client whether or not he will qualify for continued support services if his case is closed due to earnings. Explain the limits and that verification is required.)

_____ Direct Deposit/EBT
(Explain these processes. List telephone numbers to call for problems.)

_____ Medical ID card
(List a contact telephone number for problems with Medical ID cards. Explain how to use one when the family is new to Medicaid and the reason Medicaid is received.)

_____ Fair Hearing Information
(Explain the purpose of a Pre-Hearing Conference and a Fair Hearing, when to request one and how one may be requested.)

_____ Legal Services
(List address and telephone number of available legal services groups. Explain the role such groups play in applying for SSI, in sexual harassment and domestic violence, sexual assault, and stalking situations, in Fair Hearing.)

_____ Home Visits
(Explain that home visits are required, and at which points in their receipt of assistance they will occur. When the client is employed, ask if he can be contacted at work.)

_____ Housing Assistance
(List the address and telephone number to apply for subsidized housing. Include verbal explanation of how to apply.)

_____ Health Department
(List the address and telephone number of local health services. Discuss vaccinations/ immunizations and when to contact a medical professional.)

_____ Mental Health Services
(List the address and telephone number of agencies which provide counseling, substance abuse assistance, parenting skills, etc. Discuss appropriate times to contact these agencies.)

_____ WIC
(List the address and telephone number of the closest WIC location. Discuss the benefits of the Program.)

_____ Family Planning
(List the address and telephone number of agencies/organizations which provide information about family planning and/or supply birth control devices.)

_____ Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking
(List addresses and telephone numbers to obtain information about available services for victims of sexual harassment and domestic violence, sexual assault, and stalking. Discuss: this is offered to everyone even those who have no history of DV {especially important when both parents are present}, confidentiality of information, safety is the first concern, etc.)

_____ Earned Income Tax Credit (EITC)
(Explain that those who file an income tax return may qualify for EITC and how to apply for it. Provide a pamphlet with the information when they are available.)

_____ Transitional Benefit Options
Discuss the two transitional benefit options available to a former WV WORKS participant when the WV WORKS benefit is closed due to employment.

_____ Sexual Harassment
(Worker must provide the attached sexual harassment handout, Attachment A, and briefly discuss with applicant)

_____ Accommodations for Disabilities
(If the client indicates or there is available documentation that he has a mental, physical or learning disability, the Worker must discuss with the client that special accommodations will be made in order for him to participate in the WV WORKS Program.)

WHAT DOES "SEXUAL HARASSMENT" MEAN?

"Sexual harassment" means that someone is bothering you or doing unwanted or unwelcome things of a sexual or gender-related nature. For example, someone who makes unwelcome sexual or gender-related remarks and gestures by:

- Touching you inappropriately
- Making offensive jokes or remarks about women or men
- Making sexual requests or suggestions
- Staring at or making unwelcome comments about your body
- Displaying sexually offensive pictures
- Being verbally abusive to you because of your gender

WHAT CAN YOU DO IF YOU ARE "SEXUALLY HARASSED"?

- Contact your WV WORKS Worker or Supervisor if you are in a WV WORKS employment or training activity.
- Contact the nearest Equal Employment Opportunity Commission (EEOC) representative or call the EEOC office at (800) 669-4000.

WV WORKS List of Local Services – Attachment A

APPENDIX E: WORKER RESPONSIBILITIES

1. Complete NVRA training prior to their first assignment to work with clients. They shall complete NVRA refresher training every six months.

2. Provide a voter registration application (R-28-05) and a declination form at any point a client engages in an application, recertification, or reports a change of address.

3. Provide the red “What happens next card” when a client indicates that they would like to complete a voter registration application. This card informs the client how to fill out the application and how long it will take for their voter registration to be completed. The card also tells the client what to do if they do not receive notification of their registration. The Worker must advise the client that this is an application for voter registration, not a voter registration card.

4. Ensure that no action stated or implied can be interpreted to mean that the client’s decision to complete the voter registration application or declination form could affect the availability of benefits or services.

5. Provide the same quality of assistance to complete the voter registration application as with any other agency form or service while ensuring that no political party preference is conveyed to the customer.

6. Accept completed voter registration applications, declination forms and any uncompleted forms that the client does not use. The Worker shall review all completed forms to ensure all required fields are completed prior to submitting them to the County NVRA Coordinator. The Worker shall assist the customer to complete any incomplete forms when requested by the customer.

7. Complete appropriate eligibility system screen/s to indicate if a client accepted or declined voter registration services.

8. Provide a maximum of four mail-in voter registration application forms for use by other household adults, when requested by the customer. When the client requests more than four applications, the Worker shall make available the contact information to the Secretary of State’s Office. They may contact the elections division staff at (304) 558-6000 or 1-866-767-8683 or by e-mail at http://www.sos.wv.gov.

APPENDIX F: COUNTY COORDINATOR RESPONSIBILITIES

1. Coordinate voter registration services within the local office and the Agency State Coordinator.

2. Ensure that all Workers comply with the registration process.

3. Train designated alternates to assume coordinators duties in the absence of the coordinator.

4. Maintain an office log of registration procedures, supply locations, ordering procedures, contact people and phone numbers.

5. Maintain and secure an office voter registration “date” hand stamp.

6. Ensure that each application is “date” stamped the day it is received in their office.

7. Retain declination forms for 22 months.

8. Completed NVRA applications must be submitted to the Secretary of State’s Office every Friday. The applications must be submitted the next working day when the office is closed on Friday.

9. Maintain a log of all NVRA training completed by Workers. Coordinating with Supervisors and training staff as appropriate to ensure that Workers continue to receive NVRA refresher training every six months. Training may be completed by reviewing the Voter Registration Application Guide located on the Secretary of State’s website at: http://www.sos.wv.gov

10. Maintain confidentiality of applicants.

APPENDIX G: BFA STATE COORDINATOR RESPONSIBILITIES

1. Appoint a current employee as county coordinator of voter registration services for each office or program delivery center.

2. Administer voter registration services in all programs within his or her jurisdiction.

3. Coordinate voter registration services with the Secretary of State.

4. Monitor the county coordinators of his/her delivery programs and reporting assignments.

5. Ensure all coordinators and employees have reviewed all training material and receive periodic updates.

6. Review complaints concerning voter registration activities filed against employees.

7. Notify the Secretary of State within five days of any change of county coordinators.

8. Post all required notices as provided by the Secretary of State.

Chapter 2

Common Eligibility Requirements

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
2.1				
2.2	5/1/18 5/1/19 3/1/20 7/1/22	758 771 782 824	2.2.2.C.3 2.2.3.B.1 2.2.2.A 2.2.1.B	WV WORKS recipients are not considered residents of WV when in Long Term Care in another state. Updated definition of incarcerated individuals Added example Define term as 50%
2.3				
2.4	7/1/18	761	2.4.1 2.4.2	Added section heading to point out that the existing text applies specifically to refusals to cooperate. Added an additional section explaining the process for handling a failure to cooperate. Unlike a refusal, a failure to cooperate with a Quality Control review does not cause the case to close. The worker simply adds case comments to the case
2.5				
2.6				
2.7	10/1/20 5/1/21 5/1/21 5/1/21 11/1/25 12/1/25	794 804 804 804 870 871	2.7.2 2.7.1.B 2.7.1.C 2.7.4 2.7.1.B 2.7.4.B 2.7.4.B	Replaced illegal/ineligible Removes Medicaid Creates section for Medicaid Updates Medicaid time limits and language added 2.7.1.C An individual is given 90 days to provide verification of his/her SSN if it is not provided. An individual is given 90 days to provide verification of his/her SSN. Added a penalty for WV WORKS Caretakers.

2.1 INTRODUCTION

The purpose of this chapter is to show eligibility requirements common to:

- Supplemental Nutrition Assistance Program (SNAP)
- WV WORKS
- Medicaid Programs
- West Virginia (WV) Children's Health Insurance Program (WVCHIP)
- Special Pharmacy
- Acquired Immune Deficiency Syndrome (AIDS) Drug Assistance Program (ADAP)

Details of other requirements vary from program to program, but all these programs share the requirements shown here.

2.2 RESIDENCE

To be eligible to receive benefits, the client must be a resident of West Virginia.

The client must live within the borders of West Virginia for purposes other than vacation. There is no minimum time requirement for how long the client must live or intends to live in West Virginia. The client is not required to maintain a permanent or fixed dwelling.

An individual remains a resident of the former state until he arrives in West Virginia with the intention of remaining indefinitely. Therefore, intent to establish or abandon residency must be known before the state of residence is determined.

The definitions of public and private institution below apply to all programs.

PUBLIC INSTITUTION

Institution that provides shelter, custody, and care, and for which a governmental unit has responsibility or exercises administrative control.

PRIVATE INSTITUTION

Non-governmental institution that provides shelter, custody, and care, and that is required by State law to have a license to operate.

2.2.1 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

2.2.1.A Determining State of Residence/Movement Between States

If the SNAP assistance group (AG) is Categorically Eligible, the residency requirement is considered met. See Section 1.4 for more information about Categorical Eligibility.

When an individual, who received SNAP benefits in another state, establishes residence in West Virginia and applies for benefits, the Worker must determine when SNAP benefits in the other state were stopped. The individual is eligible in West Virginia for the month following the month in which he last received benefits in the former state of residence, if otherwise eligible.

2.2.1.B Institutional Status

An individual must not be a resident of a public or private institution.

An individual is considered a resident of an institution when:

- The institution provides more than 50% of his three daily meals for a 7 day week including weekends (21 total weekly meals), as part of the institution's normal services.

> **Institution Example:** A school dormitory is considered an institution. Therefore, any student who resides in a school dormitory and receives the majority of his meals (21 total weekly meals in a 7 day period), from the institution's meal plan is ineligible to participate in SNAP. This includes, but is not limited to, colleges and military and boarding schools, even when the student returns home for weekends.

Note: A student cannot be denied SNAP benefits simply because the applicant lives on campus and/or participates in a meal plan at an institution of higher education. The worker must determine the scope of an applicant's meal plan to determine SNAP eligibility. The worker must ask the student the details of the meal plan and ask students for clarification if it is unclear how many meals they receive from the plan. If the situation is not questionable, student attestation may be accepted. Refer to section 3.2.1.E.1 regarding Student Eligibility Based on Meal Plans for further guidance.

- The institution has not been authorized to accept SNAP benefits.

The following groups are exempt from this policy:

- Narcotic addicts or alcoholics who reside at a facility or treatment center under the supervision of a drug or alcoholic treatment and rehabilitation program. See Chapter 16 for specific instructions for these groups.
- Individuals who reside in a Group Living Facility (GLF). See Chapter 3 and Chapter 16 for the definition of a GLF and for instructions regarding which residents of a GLF qualify.
- Residents of shelters for battered persons and their children. The facility must be a public or private non-profit facility that:
    - Exclusively serves battered persons and their children;
    - Sets aside a portion of the facility, on a long-term basis, to shelter battered persons and their children; and
    - Is a residence, not simply a place to eat meals. See Chapter 3 and Chapter 16.

- Institution residents who do not receive their meals from the institution, but who purchase and prepare their own food, or participate in a delivered meals program or a communal dining program, are eligible if they meet all other eligibility requirements. This includes those students who reside in school dormitories with optional meal plans and do not receive the majority of their meals from the institution.
- Residents of federally subsidized housing for the elderly, built under either Section 202 of the Housing Act of 1959 or Section 236 of the National Housing Act, qualify if otherwise eligible.
- Residents of public or private non-profit shelters for homeless persons qualify, if otherwise eligible. See Chapter 16.

2.2.1.C Prolonged Absence from the Home

Regardless of the reason for the absence, any person expected to be absent from the home for a full calendar month or more is not eligible to be included in the AG. Shorter absences do not affect eligibility. This policy applies to visiting, obtaining vocational training or education, and obtaining medical care. This policy applies to in-state and out-of-state travel.

Although an individual may meet the residency requirement, he may not be eligible to be included in the AG. Refer to Chapter 3 for specific requirements about who may be included in the AG.

> **SNAP Prolonged Absence Example 1:** A child is residing in West Virginia with his mother and is included in her SNAP AG. On June 22, he goes to Ohio to visit his father and will remain for an undetermined amount of time. As of July 31, he is still in Ohio. Notice is sent to remove him from his mother's AG.
>
> **SNAP Prolonged Absence Example 2:** A divorced man and woman both live in West Virginia. On May 29, the woman reports her oldest child will be visiting his father during summer vacation from June 11 to September 1. After advance notice, the oldest child is removed from the woman's AG for July and August, because he will be absent from the home for those two full calendar months. The father reports the presence of the child on June 10, and requests that he be added to his SNAP benefits. The child is added as of July 1.
>
> **SNAP Prolonged Absence Example 3:** A SNAP AG consists of a man and his wife who reside in West Virginia. His wife goes to Maryland on July 7 to receive medical treatment and is not sure how long she will stay. She returns home on August 29. Her eligibility to remain in the AG is unaffected.

2.2.1.D Students Not Living with a Parent or Other Responsible Adult

The residence of a student is determined as follows:

- When the student under age 18 is under the control of a parent or a person acting as a parent, the state of residence is the residence of the student's parents.
- When the student under age 18 is not under the control of a parent or a person acting as a parent, the state of residence is the location where the student actually lives, including a dormitory or campus housing.
- When the student is age 18 or older, the state of residence is the location where the student actually lives, including a dormitory or campus housing.

2.2.2 WV WORKS

There is a restriction on the amount of time an AG member can be out of the home and still be included in the benefit. See Chapter 3.

2.2.2.A Determining State of Residence/Movement Between States

When an individual who received, or is receiving, cash assistance from another state moves to West Virginia and applies for benefits, the Worker must determine if the case in the other state is closed. Cash assistance received from another state makes that individual ineligible for WV WORKS cash assistance during the same month regardless of the amount received in the other state.

When a client who received cash benefits in another state moves to WV, each month in which benefits were received counts as only one month of benefits toward the client’s lifetime limit on the receipt of cash assistance. Some states count receipt of Temporary Assistance for Needy Families (TANF) in the number of days instead of the number of months. When this occurs, the Worker must request that state to provide the exact months during which it provided cash assistance to the client.

> **WV WORKS Determining State of Residence Example 1:** Mother and children receive TANF benefits in Kentucky for May. On May 15, the family moves to

West Virginia. The household is ineligible to receive WV WORKS benefits until June.

WV WORKS Determining State of Residence Example 2: Father comes in to apply for WV WORKS on May 4. His two children have just moved into his household and they received TANF benefits for May as part of their mother's case in Kentucky. Only the father is eligible to receive WV WORKS benefits for the month of May. The children will be eligible in June.

WV WORKS Determining State of Residence Example 3: A mother comes in to apply for WV Works on May 4 for herself and her two children. She and one of the children received TANF benefits in another state for the application month and closed for ongoing in the other state. One of the children had not received TANF benefits as the child just moved into the household of the mother. For the month of application, the mother and the child who received TANF in the other state would not be eligible for TANF in the application month. Only the child who had not received TANF assistance for May would be eligible for the May benefits as of the date of application. In June, all three would then be eligible for TANF benefits.

NOTE: A child who has not received TANF benefits in another state during the month of application in WV may still receive TANF benefits if all other requirements are met even if the parent applying has received TANF benefits in another state.

2.2.2.B Institutional Status

An individual must not be a resident of a public or private institution as defined above.

A client is eligible while living in an institution under the following circumstances.

2.2.2.B.1 Educational or Training Institution

He is living in an institution for the purpose of securing education or training. Examples include Rehabilitation Services centers, West Virginia Schools for the Deaf and Blind, Mountaineer Challenge Academy, and any college or educational institution.

2.2.2.B.2 General Medical Institution

He is a patient in any section of an institution that has been certified as a medical facility under Medicare or Medicaid standards. Examples include general medical hospitals and licensed nursing facilities.

2.2.2.C Out-of-State Travel

2.2.2.C.1 Visiting

Temporary visits out of state with the intent to return do not affect the client's state of residence as long as the duration is less than 30 days.

2.2.2.C.2 Obtaining Vocational Training or Education

When the Department of Human Services (DOHS) establishes a plan for a client to leave the State to obtain vocational training or education, he continues to be a West Virginia resident.

When the DOHS does not establish a plan, he continues to be a West Virginia resident if he does not meet the residency requirement of the state in which he lives.

2.2.2.C.3 Medical Care

If the client temporarily leaves the State to obtain medical care or treatment, he is considered a West Virginia resident.

Exception: Long term care

2.2.2.D Students Not Living with a Parent or Other Responsible Adult

The state of residence of a student is the specified relative's state of residence.

2.2.3 MEDICAID

2.2.3.A Determining State of Residence/Movement Between States

When an individual receiving Medicaid or WVCHIP from another state moves to West Virginia and applies for Medicaid or WVCHIP, the Worker must determine when payments by the previous state of residence stopped. Medicaid or WVCHIP coverage in West Virginia will begin the month the client establishes residence in West Virginia.

See Chapter 24 for special criteria relating to long term care cases.

SSI-Related Medicaid Groups: For individuals age 21 and older, or emancipated individuals, the state of residence is the state in which the individual is living, with the intent to remain permanently or for an indefinite period. Such an individual has established residence if he is living in a state and entered that state with a job commitment or is seeking employment, even if not currently employed.

2.2.3.B Institutional Status

Medicaid funds may not be used for medical services provided in a public or private institution, as defined above.

Medicaid funds may be used for a resident of an institution under the following circumstances:

- Education or Training Institution

  He is living in an institution for the purpose of securing education or training. Examples include Rehabilitation Services centers, West Virginia Schools for the Deaf and Blind, Mountaineer ChalleNGe Academy, and any college or educational institution.

- General Medical Institution

  He is a patient in any section of an institution that has been certified as a medical facility under Medicare or Medicaid standards. Examples include general medical hospitals and licensed nursing facilities. An institution resident who is incapable to state intent of residence is considered a resident in the state in which he lives.

2.2.3.B.1 Incarcerated Individuals

An individual is an inmate of a public institution, or incarcerated, when serving time for a criminal offense or confined involuntarily in State or federal prisons, jails, detention facilities, or other penal facilities.

Incarcerated individuals who meet all other eligibility criteria may be eligible for limited Medicaid coverage. Payment is only for Medicaid-covered services when the individual is admitted as an inpatient in a medical institution for at least 24 hours. Eligible facilities include, but are not limited to, hospitals, nursing facilities, juvenile psychiatric facilities, and intermediate care facilities.

Incarcerated individuals must have their living arrangements coded correctly in the eligibility system. Information from the eligibility system will notify the claims payment system of the incarcerated status.

Certain "justice involved" individuals are not considered incarcerated and receive Medicaid without the incarceration restrictions on payments. An individual is not considered incarcerated, and would not be coded with the incarcerated living arrangement, when he is:

- On probation or parole, or subject to home confinement;
- Voluntarily residing in a public educational or vocational training institution for purpose of securing an education; or
- Voluntarily residing in a public institution while other living arrangements appropriate to the individual's needs are being made.
- Participating in the Work Release program at one of the following facilities only:
    - Beckley Correctional Center 1501 Eoff Street

NOTE: For MEDICAID, Individuals residing in one of the Correctional Centers and participating in the Residential Substance Abuse Treatment (RSAT) Program are considered incarcerated.

111 S. Eisenhower Drive
Beckley, WV 25801
Phone: 304-256-6780
Fax: 304-256-6782

- Ohio County Correctional Center
  Wheeling, WV 26003
  Phone: 304-238-1007
  Fax: 304-238-1009
- Charleston Correctional Center
  1356 Hansford Street

Charleston, WV 25301
Phone: 304-240-6921
Fax: 304-558-1537

- Parkersburg Correctional Center
  225 Holiday Hills Drive
  Parkersburg, WV 26104
  Phone: 304-420-2443
  Fax: 304-420-2477

2.2.3.B.2 State Psychiatric Hospitals

West Virginia has two State psychiatric hospitals: Mildred Mitchell Bateman Hospital and William R. Sharpe, Jr. Hospital. Individuals residing in these State psychiatric hospitals may receive Medicaid, if otherwise eligible.

An eligibility worker is out-stationed in each of these State psychiatric hospitals. If a family member or authorized representative makes an application at the local office, the application must be forwarded to the out-stationed Worker to verify the patient's status. Normal application and eligibility procedures for these applicants apply.

➢ *Forensic Patients*

Individuals residing in a state facility who are identified as forensic patients may be eligible for Medicaid. However, payment is limited to Medicaid-covered services when admitted as an inpatient in a medical institution – such as a hospital, nursing facility, or intermediate care facility – for at least 24 hours.

Forensic patients must have their living arrangements coded as incarcerated in the data system. Information from the eligibility system will notify the Medicaid Management Information System (MMIS) data system of the Medicaid clients' incarcerated status. All other residents of a state hospital must have their living arrangement coded as hospitalized. These individuals may receive Medicaid coverage when services are provided in the community, if otherwise eligible.

2.2.3.C Out-of-State Travel

2.2.3.C.1 Visiting

Temporary visits out of state with the intent to return do not affect the client's state of residence for Medicaid and WVCHIP

2.2.3.C.2 Obtaining Vocational Training or Education (AFDC-Related)

When the Department of Human Services (DOHS) establishes a plan for a child to leave the State to obtain vocational training or education, he continues to be a West Virginia resident.

When the DOHS does not establish a plan, the child continues to be a West Virginia resident if he does not meet the residence requirement of the state in which he lives.

2.2.3.C.3 Medical Care

If the client temporarily leaves his residence to obtain medical care or treatment, he continues to be considered a West Virginia resident.

See Chapter 24 for exceptions related to long term care.

2.2.3.D Students Not Living with a Parent or Other Responsible Adult

Modified Adjusted Gross Income (MAGI) Group and WVCHIP: The state of residence of a student is the state in which he lives.

EXCEPTION: A full-time student in West Virginia ages 18 to 22 is not considered a West Virginia resident if all the following criteria are met:

- *Neither parent lives in West Virginia;*
- *The student is claimed as a tax dependent by someone in another state; and*
- *The student is applying on his own behalf.*

AFDC-Related: The state of residence of a student is the specified relative's state of residence.

SSI-Related: The state of residence of a student who is age 21 or older, or emancipated, is the state in which the individual is living with the intent to reside.

All Others: The state of residence of a student is the state in which he lives.

2.3 CITIZENSHIP STATUS

To be eligible to receive Supplemental Nutrition Assistance Program (SNAP) benefits, WV WORKS, Medicaid, or WVCHIP the individual must be a resident of the United States, as a citizen or in a qualifying non-citizen status. See Chapter 15 for instructions regarding citizenship, non-citizenship status, and refugees.

2.4 COOPERATION WITH QUALITY CONTROL

A recipient of Supplemental Nutrition Assistance Program (SNAP) benefits and/or Medicaid is required to cooperate with Quality Control (QC) if selected for a QC review.

2.4.1 Refusal to Cooperate

When a client refuses to participate or cooperate in the review, the benefit for which the QC review was attempted must be stopped after advance notice, except for Medicaid coverage for children, pregnant women, and Supplemental Security Income (SSI) clients. A sanction is applied to the pregnant woman after the postpartum period, even when she qualifies for another Medicaid coverage group.

The QC Reviewer advises the local office when a client refuses to cooperate. The memorandum includes the information needed to complete the QC review.

If the client reapplies before the QC review period ends, the Worker must not approve the benefit until the client agrees to cooperate and takes all steps necessary for the QC Reviewer to complete the review. When applicable, the Worker notifies the QC Reviewer that the individual has reapplied and wishes to cooperate in the QC review. Eligibility begins when the client completes the requirements to cooperate with QC.

If the client reapplies after the QC review period expires, the benefit may be approved only if the client supplies all information previously required by QC, as well as all information needed to establish current eligibility.

The QC review periods are as follows:

- SNAP benefits: October through the following September
- Medicaid: October through the following March; April through the following September

For SNAP, if the individual reapplies after 125 days from the end of the annual review period, the client is not required to cooperate with the QC Reviewer.

WV WORKS reviews are completed by the Division of Planning Quality Improvement (DPQI).

2.4.2 Failure to Cooperate

When a client fails to participate or cooperate in the review, benefits are not stopped, but case comments must be added in the case record.

The QC Reviewer notifies the local office when a client fails to cooperate. The memorandum includes the information needed

The case comments must state that the household was randomly selected for a QC review, and that the client needs to contact the reviewer. All contact information provided in the memorandum from the QC Reviewer must be included in the case comments.

NOTE: The decision as to whether a client's actions constitute a failure to cooperate or a refusal to cooperate is made by the QC Reviewer. The memorandum issued by the QC Reviewer will state the determination.

2.5 NON-DUPLICATION OF BENEFITS

A client may only receive benefits in one county and state except as specified below.

In some cases, involving county transfers, different types of benefits may legitimately be received in different counties due to a delay in transferring the case. The Worker must try to avoid this, but the application must not be delayed an unreasonable amount of time.

2.5.1 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

No person may receive SNAP benefits in more than one assistance group (AG) for the same month.

EXCEPTION: Residents of shelters for battered persons. See Section 16.2.3.

2.5.2 WV WORKS

No person may be included in more than one WV WORKS AG for the same month.

2.5.3 MEDICAID AND WVCHIP

No person can receive Medicaid coverage in more than one AG concurrently, unless he receives coverage in one AG and is payee-representative or responsible party only for another AG.

2.6 PENALTY FOR DUPLICATION OF BENEFITS

The Worker must explore the possibility of intentional misrepresentation when the client is receiving benefits of any type in more than one county or state at the same time. See the Department of Human Services (DOHS) Office of Inspector Generals (OIG) Common Chapters Manual for procedures involving misrepresentation.

Program benefits may be affected for those who intentionally receive duplicate benefits. These vary by program, as follows.

2.6.1 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

A client who has made a fraudulent statement or representation about his identity or place of residence in order to receive multiple SNAP benefits simultaneously is ineligible to receive SNAP benefits for a 10-year period. The 10-year period begins on the date the client is found guilty in a federal or state court or in an Administrative Disqualification Hearing (ADH). This applies to multiple benefits received in more than one state or in the same state. Conviction of, or ADH finding of, attempting to receive such multiple benefits carries the same disqualification penalty as actual receipt of the benefits.

2.6.2 WV WORKS

An individual who has made a fraudulent statement or representation about his place of residence in order to receive Temporary Assistance to Needy Families (TANF), WV WORKS, SNAP benefits, Medicaid, or Supplemental Security Income (SSI) benefits simultaneously from two or more states, is ineligible to receive WV WORKS benefits for a 10-year period. The 10-year period begins on the date the individual is convicted in federal or state court. This does not apply when multiple benefits are received in the same state.

2.6.3 MEDICAID AND WVCHIP

There are no disqualification penalties for receipt of duplicate benefits.

2.7 ENUMERATION

2.7.1 THE ENUMERATION REQUIREMENT

2.7.1.A Supplemental Nutrition Assistance Program (SNAP)

The Social Security Number (SSN) must be verified and entered into the eligibility system to satisfy the enumeration requirement.

The enumeration requirement is presumed to be met if the SNAP assistance group (AG) is Categorically Eligible and the AG member is currently receiving a benefit that required the SSN to be verified. If not, the SSN must be verified.

2.7.1.B WV WORKS

The SSN must be provided and entered into the eligibility system to satisfy the enumeration requirement. Verification is not routinely required.

Once the SSN is obtained and verified as required in Chapter 7, the client must not be required to provide or verify it again unless the identity of the individual or the validity of the number is questionable.

At the time of application, or when an individual requests to be added to an existing AG, the Worker must explain both the eligibility requirement of enumeration and the WV WORKS penalty for failure to comply with the requirement.

WV WORKS applicants must not be required to be enumerated as a condition of eligibility prior to approval. Enumeration requirements must be addressed on the Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP).

An individual is given 90 days to provide verification of his/her SSN if it is not provided.

2.7.1.C Medicaid

Enumeration is the procedure by which the Social Security Administration (SSA) assigns and verifies Social Security Numbers. Each individual seeking Medicaid must furnish each of his or her Social Security numbers.

The SSN must be provided and entered into the eligibility system to satisfy the enumeration requirement. Once the SSN is obtained and verified as required in Chapter 7, the client must not be required to provide or verify it again unless the identity of the individual or the validity of the number is questionable.

If an applicant cannot recall his or her SSN or has not been issued an SSN, the agency must:

- Assist the applicant in completing an application for an SSN;
- Obtain evidence required under SSA regulations to establish the age, citizenship or alien status and identity of the applicant; and
- Either send the application to SSA or if the applicant has previously been issued an SSN, request SSA to furnish the number.

The enumeration requirement does not apply to an individual who:

- Is not eligible to receive an SSN; or
- Does not have an SSN and may only be issued an SSN for a valid non-work reason; or
- Refuses to obtain an SSN because of well-established religious objection. Must be a member of a recognized religious sect or division of the sect and adhere to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

Sources of verification include:

- Social security card,
- Correspondence which indicates that the application for an SSN is complete,
- Form SSA-2853, which is a receipt that serves as proof parents have elected to have an SSN assigned to the newborn through the Enumeration process at birth; or
- State On-Line Query (SOLQ)
- SSNs are verified by the Social Security Administration via the Data Exchange process each night. The verification is automatically entered in the eligibility system when verified. The eligibility system sends a daily alert to the Worker showing invalid SSNs.
- For Medicaid and WVCHIP only: SSNs may be verified via the Federal Data Hub (FDH) in real time.

Medicaid applications may not be delayed or denied while the eligible individual verifies his SSN. An individual is given 90 days to provide verification of his/her SSN if it is not provided at application.

2.7.2 WHO MUST BE REFERRED TO APPLY FOR AN SSN?

All individuals included in the SNAP, WV WORKS, Medicaid, or WVCHIP AG must be referred to the Social Security Administration (SSA) for an SSN if:

- A number has never been assigned to the individual; or
- A number was assigned, but the individual does not have the number.

A child eligible for Medicaid as a Continuously Eligible Newborn (CEN) is not required, as a condition of eligibility, to be enumerated. However, the mother should be encouraged to apply for an SSN for the child. The child must have an SSN by his first birthday.

A non-qualified noncitizen who applies for Emergency Medicaid is not required, as a condition of eligibility, to be enumerated. However, a noncitizen who is enumerated must provide his SSN.

2.7.3 REFERRAL PROCEDURES

When necessary, the individual is referred to SSA using either SSA's Enumeration at Birth Project form or a DFA-HS-3, Referral to Social Security Administration.

2.7.3.A Enumeration at Birth Project

When the referral is made through the Enumeration at Birth Project, the application for an SSN is taken while the newborn is still in the hospital. Individuals in this Project receive form SSA-2853, Enumeration at Birth (EAB) Receipt, Message from the Social Security Administration, which states that the SSA is processing the newborn's application for an SSN.

2.7.3.B DFA-HS-3, Referral to SSA

When the referral is made using the DFA-HS-3, the Worker must:

- Complete the DFA-HS-3. A separate form must be completed for each individual who is being referred. The state identification number (510) and case number, eligibility system

or Request for Assistance (RFA) number, if available, must be entered on the form. If there is no case number, the Worker enters seven 9s and the county number.

- Discuss the sources of verification of age, identity, and citizenship, listed on the back of the DFA-HS-3, which the individual must present to the SSA office. If necessary, the Worker assists the individual in obtaining these verifications.
- Ask the individual to hand-deliver the DFA-HS-3 to the SSA office, unless other arrangements have been agreed upon, through consultation between the Community Services Manager of the County Office, or his designee, and the SSA District Office Manager.
- Write a letter to the SSA when the individual being referred is physically unable to visit the SSA office. The letter must list the name and address of the individual being referred and the reason he cannot visit the office. A representative from the SSA office contacts the individual and processes an application for an SSN.
- Record that the DFA-HS-3 was completed.
- Ensure that the referral action is recorded on the local office enumeration log. Each local office must maintain a central log that lists:
    - The date of referral;
    - Case name;
    - Case number; and
    - Name of the individual referred.

  This is necessary to assist in follow-up action.

2.7.4 TIME LIMITS

For SNAP benefits only, the application for the SSN must be made before eligibility is established. Those individuals who have an SSN must provide the number before eligibility is established.

EXCEPTION: Individuals who are eligible for SNAP Expedited Service must apply for or furnish the SSN, whichever is appropriate, before the second issuance.

For WV WORKS, the application for the SSN is part of the PRC/SSP and is not necessarily required before eligibility is established. Those individuals who have an SSN must provide the number as part of the PRC/SSP.

For Medicaid, an application may not be delayed or denied pending issuance or verification of an individual's SSN. Individuals who are not eligible for an SSN, or do not have an SSN and are only eligible for a non-work SSN, or refuse to obtain a SSN because of a well-established religious objection do not need to provide proof of applying for one but must verify the exception. The Worker must assign a Medicaid identification number in lieu of an SSN.

> **Medicaid No SSN Example 1:** A mother and her child apply for Medicaid. Neither has an SSN. After assisting the applicant in completing an application for an SSN; obtaining evidence required under SSA regulations to establish the age, citizenship or alien status and identity of the applicant; and sending the application to SSA, the application must be approved, if otherwise eligible.
>
> **Medicaid No SSN Example 2:** A mother and her child apply for Medicaid and provide their SSNs, but do not provide a copy of their social security card. The application is approved, if otherwise eligible. The eligibility system will request verification from the Social Security Administration using the FDH in real time; or using the Data Exchange process in overnight batch. The eligibility system sends a daily alert to the worker showing invalid SSNs.
>
> **WV WORKS No SSN Example:** A mother applies for Medicaid coverage for a newborn child. The child does not have an SSN as of the date of application. If otherwise eligible, the child should be approved for coverage without delay. The mother should be encouraged to apply for an SSN for the child. The child must have an SSN by his first birthday. **FOLLOW-UP PROCEDURES**

2.7.4.A SNAP

If the client does not report his SSN within 30 days of the first day of the first full month of participation, the Worker must contact him about the status of his SSN.

2.7.4.A.1 Client Has SSN

The Worker obtains the SSN from the client and enters it into the eligibility system. Verification of the SSN is required at the next redetermination if the number is not matched by the eligibility system with the SSA's records.

2.7.4.A.2 Client Does Not Have SSN

➢ Application for SSN Was Not Made

If an individual who is to be included in the AG does not have an SSN, application for one must be made before eligibility is established. If the client can show good cause for not applying for an SSN in a timely manner, that client must be allowed to participate for one month, in addition to the month of application.

If the client is unable to obtain documents required by the SSA, the Worker must assist him in obtaining such documents. The client must show good cause monthly for failure to apply for an SSN to continue to participate.

➢ Individual Applied for SSN, but Has Not Yet Received Number

When the individual has applied for but not yet received the SSN, he may receive benefits.

2.7.4.A.3 Good Cause

The Worker determines monthly if the individual has good cause for not providing the SSN. If good cause exists, the individual remains eligible. Generally, the individual has good cause if, due to his religious beliefs or circumstances beyond his control, he is unable to comply with the requirement.

Good cause includes, but is not limited to:

- Lack of documentary or collateral evidence needed by SSA, as long as the client has made every effort to provide the information; or
- Delay in receipt of an SSN.

Because SSA has provisions for mail-in applications, good cause does not include delays due to:

- Illness
- Lack of transportation or temporary absences

2.7.4.B WV WORKS

When the client does not provide an SSN, or proof of application for an SSN, according to the plan established by the PRC/SSP, and does not have good cause, a sanction is applied after advance notice. The sanction is the same used for all instances of failure to comply with the terms of the PRC/SSP, as found in Chapter 14.

When the client provides proof of application for an SSN, according to the plan established by the PRC/SSP, or good cause, the PRC/SSP is then modified to show the date by which he must provide the SSN to the Worker.

An individual is given 90 days to provide verification of his/her SSN.

When the Caretaker is not included in the WV WORKS benefit, the non-enumerated person without good cause is removed from the WV WORKS benefit group.

2.7.4.C Medicaid

The Worker contacts the client at 30-day intervals until the SSN is received. Because application for an SSN is made before case or individual eligibility is established, any delay in the receipt of the SSN is assumed to be a delay at SSA. After receipt of the SSN, the client is issued a DFA-6 that specifies the length of time in which he is to provide the number. The time limit is 10 days.

The individual has good cause for not complying with the requirement due to his religious beliefs.

2.7.5 ENUMERATION CONTROLS

The eligibility system sends a daily alert to the Worker showing invalid SSNs.

2.7.6 PENALTY FOR FAILURE TO COMPLY WITH ENUMERATION REQUIREMENT

The penalty varies by program, as follows.

2.7.6.A SNAP

If an individual fails, without good cause, to comply with the enumeration requirements, he is excluded from the AG. If a specified relative fails to comply with the requirements for a child, that child only is excluded from the AG. If all AG members are involved, the application is denied, or the case is closed, whichever is appropriate.

The individual may negate the penalty only by providing the SSN to the Department of Human Services (DOHS).

EXCEPTION: If a pregnant woman on Medicaid who is receiving SNAP benefits has a newborn added to the case under the Continuously Eligible Newborn (CEN) Medicaid coverage group, the newborn is not required to be enumerated as a condition of eligibility. However, the mother should be encouraged to apply for an SSN for the child.

The child must be enumerated by the time he reaches age one.

2.7.6.B WV WORKS

See Follow-up Procedures, above.

Chapter 3

Eligibility Determination Groups

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
3.1				
3.2	12/1/17	474	3.2.1.B.2 3.2.1.E	Updating definition of a fleeing felon to include the requirement that law enforcement must be actively seeking to arrest the fleeing felon within 20 days. This is to match requirements of new federal court order (Barry v. Lyon decision).
	7/1/18	761	3.2.1.A.5 3.2.4	Clarified language for the E&D policy Added a detail to Example 5 to clarify that food was purchased separately.
	10/1/18	765	3.2.1.A.3	Added language to clarify when a child under age 18 is considered to be under parental control.
			3.2.1.D.1 3.2.1.E.1	Counties added to counties as Issuance Limited Counties SNAP applicants who are currently enrolled in a vocational/training/educational program through an institution of higher education that is approved through the SNAP E&T program is initially eligible for SNAP benefits. Continued benefits are contingent on the individual participating with SNAP E&T
	6/1/19	772	3.2.1.B.3	Conviction of certain felonies when individuals are out of compliance with the terms of their sentence

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	10/1/19	777	3.2.1.D.3	referral to SNAP E&T voluntary for SNAP participants.
	2/1/20	781	3.2.1.D.1	Updated ILC counties
	4/1/20	784	3.2.1.D.1	Updated ILC counties
	4/1/20	784	3.2.1.D.4	Replaced 15% with discretionary exemption
	6/1/21	805	3.2.1.D.3	Replaced 15% with discretionary exemption
	6/1/21	805	3.2.1.D.3.a	Clarified ABAWD work requirement
	7/1/21	806	3.2.1.D.3	New section ABAWD work requirement
	3/1/22	818	3.2.1.D	ABAWD update Include all 55 counties; removed NILC
	7/1/22	824	3.2.1.A.5	Homeless children under age 18
	7/1/22	824	3.2.1.E.1	Clarify Student Eligibility
	8/1/23	840	3.2.1.D 3.2.1.D.1 3.2.1.D.4	Add expanding target audience. Updated ABAWD age Added/Modified ABAWD exemption categories.
	3/1/23	848	3.2.1.D.4	Reflect that veteran status should only be verified if self-attestation is questionable.
	6/1/24	851	3.2.1.A.7	Added the word separate to AG.
	10/1/24	855	3.2.1.D.1 3.2.1.D.1.A	Ages/birthday for ABAWD has changed. Updating age from 53 to 55. Updating 53rd birthday to 55th. Expanding target audience addition. Added 4th bullet.
	2/1/25	860	3.2.1.D 3.2.1.D.1 3.2.1.D.4 3.2.1.D.6	Clarified when a countable ABAWD month can be assigned by the agency. Updated the definition of a countable ABAWD month. Updated when eligibility workers can verify ABAWD exemptions; removed verbiage related to mandatory exemption verification. Removed a note about veteran status for ABAWD exemptions. Clarified that receipt of Medicaid is a collateral verification for a pregnant ABAWD. Updated the definition of a homeless ABAWD. Clarification of when a countable ABAWD month can be assigned.
	3/1/25	861	3.2.1.D.4	Removed Examples.
	8/1/25	867	3.2.1.E.2	Changed worker to supervisor or senior worker.
	11/1/25	870	3.2.1.D.1 3.2.1.D.1.A 3.2.1.D.4	Changed age 55 to 65 and added NOTE stating individuals age 60, but not yet 65 are not required to register as job seekers with WorkForce WV. Added a bullet regarding age change and exemptions. Updated ABAWD age range, changed dependent child exemption age, removed exemptions for

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				experiencing homelessness, being a U.S. veteran of any military branch, aging out of Foster Care and under age 25. Clarified that exemption changes must occur at the next recertification.
3.3				
3.4	10/23/17	746	3.4.1.B 3.4.4	Added individuals to the list of non-recipient work-eligible individuals for non-cooperation with drug testing. Added example.
3.5				
3.6				
3.7				
3.8				
3.9				
3.10				
3.11				
3.12				
3.13				
3.14				
3.15				
3.16				
3.17				
3.18	10/1/20	794	3.18.1.E 3.18.2	Replaced alien Replaced ineligible
3.19				
3.20	10/1/20 7/1/24	794 853	3.20.1 3.20	Replaced illegal Removed the word illegal, not removed in error from a previous change
3.21				
3.22				
3.23				

3.1 INTRODUCTION

This Chapter contains the policy for Supplemental Nutrition Assistance Program (SNAP) benefits, WV WORKS, and all Medicaid coverage groups. It is used to determine:

- The Assistance Group (AG) - Who receives the benefit;
- The Income Group (IG) - Whose income and assets are counted; and
- The Needs Group (NG) - Whose needs are considered

The total income/assets of all persons in the IG is compared to the income/asset eligibility limits for the number of persons in the NG. This comparison determines if those in the AG are eligible to receive the benefit, and in some instances, the level of benefit for which they are eligible.

3.2 SNAP ELIGIBILITY DETERMINATION GROUPS

3.2.1 THE ASSISTANCE GROUP (AG)

3.2.1.A Who Must Be Included?

The SNAP AG must include all eligible individuals who both live together and purchase food and prepare meals together, with the exception of residents of shelters for battered persons.

An individual cannot be a member of more than one SNAP AG in any month.

EXCEPTION: Residents of shelters for battered persons. See Chapter 16.

When an AG member is absent or is expected to be absent from the home for a full calendar month, he is no longer eligible to be included in the AG and must be removed after advance notice.

The following sub-sections describe how different types of individuals are considered in the composition of a SNAP AG.

3.2.1.A.1 Individuals Living Alone

This is a one-person AG.

3.2.1.A.2 Spouses

Spouses are individuals who are legally married to each other under provisions of state law or those moving to West Virginia from states that recognize their relationship as a legal marriage.

3.2.1.A.3 *Children under Age 18, Not Living with a Parent*

Children under age 18 who live with and are under the parental control of an adult AG member who is not a parent, must be in the same AG as the member who exercises parental control. A child must be considered to be under parental control if he or she is financially or otherwise dependent on a member of the household.

3.2.1.A.4 *Children under Age 22, Living with a Parent*

Natural or adopted children and stepchildren who are under 22 years of age and who live with a parent must be in the same AG as that parent.

There is no required maximum/minimum amount of time the child must spend with a parent for the child to be included in the SNAP AG. If no one is receiving any SNAP benefits for the child, it is assumed that the living arrangements are not questionable, and the child is added to the SNAP AG that wishes to add him. If the child is already listed in another SNAP AG or the other parent wishes to add the child to his SNAP AG, the parents must agree as to where the child "lives" and, ultimately, to which SNAP AG he is added. Where the child receives the majority of his meals, or the percentage of custody, must not be the determining factor for which parent receives SNAP for the child.

3.2.1.A.5 *Homeless Children Under Age 18*

Homeless children under age 18, not under parental control of an adult, are considered an individual living alone and should be afforded the opportunity to apply as a one person household.

3.2.1.A.6 *Individuals or Groups of Individuals Who Purchase and Prepare Together*

A group of individuals who live together, and who customarily purchase food and prepare meals together, is an AG.

"Customarily" means purchasing food and preparing meals more than 50% of the time.

➢ *Elderly and Disabled Individuals*

A group of individuals who live together and purchase food and prepare meals together normally constitute a single AG. If the household contains an individual who meets all the elderly and disabled criteria listed below, that individual, his spouse, and their children under age 22 may form a separate AG, even if they purchase and prepare with others in the household.

The individual must fit the criteria for physical and/or mental disability as defined by Section 13.15.

- The gross countable income of others with whom the elderly and disabled individual resides (excluding the individual's own income and the income of his or her spouse and their children) cannot exceed 165% FPL, which is shown in the E & D" column of Chapter 4, Appendix A. To determine countable income, the following rules apply:
    - Exclude the elderly and disabled individual, his or her spouse, and their children under 22 from the household size for the calculation
    - Gross income for the other members of the household is calculated using the same rules as a standard SNAP application
- At least one AG member is at least 60 years old; and
- Is unable to purchase food and prepare meals because he suffers from either a non-disease related, severe, permanent disability or a disability considered permanent under the Social Security Act (SSA) includes, but is not limited to:
    - 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, except if due to cataracts or detached retina
    - IQ 59 or less, established after attaining age 16
    - Spinal cord or nerve root lesions resulting in paraplegia or quadriplegia
    - Multiple sclerosis in that 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 weakness, 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 that may require dialysis or kidney transplant
- Amputation of a limb, current age 55 or older

NOTE: Refer to the Social Security Administration website for the updated list of conditions for disability.

3.2.1.A.7 Individuals or Groups of Individuals Who Purchase and Prepare Separately

Individuals or groups of individuals living with others, but who customarily purchase food and prepare meals separately, are separate AG's.

"Customarily" means purchasing food and preparing meals more than 50% of the time. An occasional shared meal does not interfere with his separate AG status.

3.2.1.B Who Cannot Be Included?

The following individuals who reside with an AG are not considered AG members or are ineligible to be included in the AG. See The Income Group (IG) below for treatment of these individuals' income.

3.2.1.B.1 Clients in Another State

Individuals may only receive SNAP from one state in any month. Therefore, individuals who have already received or will receive SNAP in another state are ineligible to be included in a SNAP AG in West Virginia for that same month. Exceptions for those in a shelter for battered persons can be found in Chapter 16.

3.2.1.B.2 Enumeration

Persons who fail to meet the enumeration requirements as found in Chapter 2 are ineligible until compliant.

3.2.1.B.3 Individuals Excluded by Law

Persons who are excluded by law and their periods of ineligibility are found below.

➢ *Receipt of Simultaneous Multiple Benefits*

When an individual is determined by an Administrative Disqualification Hearing (ADH) or Conviction in a State or Federal Court, Due to a Fraudulent Statement with Respect to Identity or Place of Residence.

Period of ineligibility: Excluded for 10 years.

➢ *A Fleeing Felon*

The individual is considered to be a fleeing felon only when a federal, state or local law enforcement officer acting in an official capacity:

- Presents an outstanding felony arrest warrant that conforms to one of the following codes from the National Crime Information Center Uniform Offense Classification Codes to obtain information on the client: Escape (4901), Flight to Avoid (prosecution, confinement, etc.) (4902), Flight Escape (4999); and

- States or documents that law enforcement is actively seeking to arrest the fleeing felon within 20 days.

Period of ineligibility: Ineligible while identified in this category.

➢ *A Violator of Probation or Parole*

The individual is considered to be a violator of probation or parole only if both of the following circumstances apply:

- Another agency or court determines that the individual violated a condition of his probation or parole imposed under federal or State law

- Federal, state, or local Law enforcement authorities are actively seeking the individual to enforce the conditions of the probation or parole. In order for the law enforcement authorities to be considered actively seeking the individual to enforce the conditions of the probation or parole, one of the following three criteria must be met:

  1. A federal, state, or local law enforcement agency submits a request for information from the Department of Human Services (DOHS) and informs the DOHS that it intends to arrest an individual for a probation or parole violation within 20 days of the date that the law enforcement agency submitted its request.
  2. A federal, state, or local law enforcement agency presents a felony arrest warrant that conforms to one of the following National Crime Information Center Uniform Offense Classification Codes to obtain information on the client: Escape (4901), Flight to Avoid (prosecution, confinement, etc.) (4902), and Flight-Escape (4999).
  3. The DOHS requests information regarding whether or not an individual is a probation or parole violator from a federal, State, or local law enforcement agency, and that agency states that it intends to arrest the individual for a probation or parole violation within 30 days of the date that the DOHS requested the information.

  The Worker must give the law enforcement agency 20 days to respond to the request. If the law enforcement agency does not respond timely, the client is not considered to be a probation or parole violator until a response is received from the law enforcement agency. If the law enforcement agency states that it does not intend to arrest the individual within 30 days of the date of the DOHS's request, then the client is not considered to be a probation or parole violator. If the law enforcement agency does intend to arrest the client within 30 days, then the Worker will follow up with the law enforcement agency after the 30-day period has expired. If, at that time, the law enforcement agency states that they did attempt to arrest the individual, then the Worker will take appropriate action to deny, decrease, or close the SNAP benefits at that time. If the law enforcement agency, after the 30-day period has expired, has not taken action to arrest the client, then the client is not considered to be a probation or parole violator. The Worker must enter case comments to document that the client had not been arrested.

  The Worker must act on the case timely while awaiting verification of whether a client is a probation or parole violator. If the verification is not received within the processing time frames, the client must not be considered a probation or parole violator. If verification is later received that the individual is a probation or parole violator, then appropriate action would be taken to update the case.

Period of ineligibility: Ineligible while identified in this category.

➢ *Trafficking in SNAP Benefits Prior to 9/22/96, for an Amount Less Than $500*

That resulted in a conviction or agreement which results in a court finding, rather than a conviction or a signed disqualification agreement

Period of ineligibility: Permanent exclusion.

➢ *Convicted After 9/22/96 of Trafficking in SNAP Benefits Involving $500 or More*

Period of ineligibility: Permanent exclusion.

➢ *Convicted of a Felony Offense That Occurred After 8/22/96 Involving a Controlled Substance*

The offense involved one of the following elements due to the possession, use or distribution of a controlled substance as defined by Section 802 (6) of the Controlled Substance Act:

- Misuse of SNAP benefits
- Loss of life
- The causing of physical injury

This does not include convictions which have since been expunged or reduced to lesser convictions as part of a criminal offense reduction program.

House Bill 2459 was passed by the West Virginia Legislature on February 20, 2019. This law requires that individuals with drug felonies, that do not include any of the three elements listed above be eligible for SNAP benefits. This law is effective 90 days from passage. In order for a convicted drug felon to be eligible for SNAP benefits in May 2019, the application must be received on or after May 21, 2019.

Period of ineligibility: Permanent exclusion

There is no period of ineligibility for a drug felony conviction, that does not result in misuse of SNAP benefits, loss of life or the causing of physical injury.

➢ *Conviction of Certain Felonies when Individuals are out of Compliance with the Terms of their Sentence for Conduct Occurring after February 7, 2014*

Effective June 14, 2019, individuals who are convicted of any of the following offenses and are not in compliance with the terms of their sentence are ineligible for SNAP.

- Section 2241 of Title 18, United States Code – Aggravated Sexual Abuse

- Section 1111 of Title 18, United States Code – Murder
- Chapter 110 of Title 18, United States Code – Sexual Exploitation and other Abuse of Children
- Section 40002(a) the Violence Against Women Act of 1994, i.e. sexual assault, gender-based attacks, domestic sex-crimes, sex trafficking
- Any offense under State law determined by the Attorney General to be substantially similar to an offense listed above

Period of ineligibility: Ineligible while identified in this category.

Individuals are required to self-attest at application and redetermination whether they or any other member of their household have been convicted of such crimes and are complying with the terms of their sentence. This self-attestation can be made in writing, verbally, or both. This information must be documented in the case record. The individual should not be required to come to the office solely to self-attest this information. If verification is not received timely, the Agency must process the application without consideration of the individual's felony and compliance.

3.2.1.B.4 Ineligible Noncitizen

Individuals who do not meet the citizenship or eligible noncitizen status are ineligible to participate in SNAP and may not be a separate AG. When an individual indicates inability or unwillingness to provide documentation of noncitizen status, that client is classified as an ineligible noncitizen.

The income of the ineligible noncitizen is deemed and expenses are prorated according to Section 4.4. Eligibility is determined for the remaining eligible AG members. See Chapter 15.

Once the Worker determines the individual is an ineligible noncitizen and would normally be included in the AG, no additional status, such as student, is determined.

> **Ineligible Noncitizen Example:** An ineligible noncitizen lives with her 15-year-old child who was born in the United States (U.S.) and is a citizen. The ineligible noncitizen is attending college and does not meet an exception to the student policy. Her countable income and assets are deemed according to the policy for ineligible noncitizens.

3.2.1.B.5 *Intentional Program Violation (IPV)*

Persons who have been found guilty of an IPV are disqualified as follows:

- First offense: One year
- Second offense: Two years
- Third offense: Permanent

3.2.1.B.6 *Trafficking SNAP Benefits for Controlled Substances*

Persons found by a federal, state, or local court to have exchanged SNAP benefits for a controlled substance, when the trafficking offense does not meet the criteria outlined above as excluded by law, are disqualified as follows:

- First offense: Two years
- Second offense: Permanent

This penalty does not require a court conviction but may also be imposed when there is an agreement that results in a court finding.

3.2.1.B.7 *Unborn Children*

The AG cannot receive SNAP benefits for an unborn child.

3.2.1.B.8 *Work Requirement Penalized Individuals*

This includes persons who have been penalized for failure to comply with SNAP work requirements as found in Chapter 14, even when living with others not affected by the penalty.

3.2.1.C Special Living Situations

3.2.1.C.1 Those Who Do Not Purchase Food and Prepare Meals Together

Other individuals who share living quarters with the AG, but who do not customarily purchase food and prepare meals and are not required to be included in the AG. These individuals may apply as a separate AG.

3.2.1.C.2 Roomer

An individual or group of individuals to whom a household furnishes lodging for compensation, but not meals, is considered a roomer. This individual or group of individuals may be a separate AG.

3.2.1.C.3 Boarder

If the AG so requests, an individual or group of individuals to whom a household furnishes lodging and meals and who pays a reasonable monthly payment for board (lodging and meals), may receive SNAP benefits as part of the AG with which he lives. See below for determining boarder status.

An individual or group of individuals to whom a household furnishes lodging and meals, but who pays less than a reasonable amount is not considered a boarder and is included with the same AG as the person who provides the room and board.

➢ Commercial Boarding Houses

Residents of commercial boarding houses that are licensed to offer meals and lodging for compensation with the intent of making a profit are not eligible to participate in SNAP.

➢ Household Boarding

An individual or group of individuals to whom a household furnishes lodging and meals and who pays a reasonable monthly payment for board, cannot participate in SNAP independently, but may receive SNAP benefits as part of the AG with which he lives, if the AG so requests. If the AG does not wish to include the boarders, they are considered non-AG members, and may not receive benefits as a separate AG.

To be considered a boarder, it is necessary to determine if an individual pays a reasonable monthly payment for board.

A reasonable monthly payment is defined as one of the following:

- More than two meals daily: An amount equal to or exceeding the maximum monthly benefit allotment for the appropriate size of the boarder AG; or
- Two meals or less daily: An amount equal to or exceeding two-thirds of the monthly benefit allotment for the appropriate size of the boarder AG.

➢ *Those Who May Not Be Household Boarders*

The following individuals cannot be considered household boarders and may not constitute a separate AG.

- An individual paying less than a reasonable amount for board must not be considered a boarder but must be considered as a member of the household providing the board, along with a spouse or children living with him.

3.2.1.C.4 Foster Children

Foster child is the designation for a child who is formally placed by a court or state child welfare agency. Foster children and children for whom guardianship payments are made under any state's demonstration project are considered household boarders, regardless of the amount of monthly payment.

These children cannot be a separate AG. The AG in which they reside can choose to include or exclude these children.

3.2.1.C.5 Live-In Attendants

Individuals who reside with an AG to provide medical, housekeeping, childcare, or other similar personal services may be a separate AG. If the live-in attendant is a relative, other than a parent or child who moved in with the AG to provide these services, the individual is considered a live-in attendant. If the relative lived in the home prior to the need for these services or would live with the AG whether or not the services were provided, the attendant is considered a member of the AG.

3.2.1.C.6 *Residents of a Group Living Facility (GLF)*

➢ *Who Is an Eligible Resident?*

A resident of a GLF, as defined in Section 16.2, is eligible when he is:

- Blind; or
- Meets the SNAP definition of disabled found in Section 13.15.2.

Only the SNAP client must meet one of the above requirements, not all of the GLF residents.

If a client receives RSDI, SSI, or any other benefit based on criteria other than disability, and wishes to receive SNAP benefits, he is eligible only if:

- He also meets the definition of disabled found in Section 13.15; or
- It is a requirement that the resident be disabled or blind to reside in the GLF, and the GLF has determined that the aged client meets its definition of disability or blindness; and
- He is a resident of a non-profit Adult Family Care or Personal Care Home approved by the appropriate state licensing division.

➢ *Determining the AG*

The residents of a GLF may each be a separate AG or may be combined in one AG, depending on the wishes of the GLF. When the GLF is the authorized representative, the client must be approved as a one-person AG. See Section 16.2.

3.2.1.D Able-Bodied Adults Without Dependents (ABAWD)

3.2.1.D.1 *Definitions for ABAWD Purposes Only*

ABAWD

ABAWD is a population of individuals who are aged 18 or older but not yet age 65. An individual who turns 18 becomes an ABAWD in the month following their birthday. An individual is no longer an ABAWD in the month of their 65th Birthday.

NOTE: *Individuals aged 60, but not yet 65 are not required to register as job seekers with WorkForce WV.*

ADDITIONAL THREE-MONTH PERIOD

Three consecutive months of SNAP benefits after regaining eligibility by fulfilling the ABAWD work requirement.

COUNTABLE MONTHS

Screened and assigned ABAWD months in which the client receives a full monthly benefit while not exempt or meeting the ABAWD work requirement.

DEPENDENTS

For ABAWD purposes only, any member of the SNAP AG under the age of 14.

FULFILLING THE ABAWD WORK REQUIREMENT

Working and/or participating in an allowable ABAWD work activity for 20 hours per week or 80 hours per month.

IN-KIND SERVICES

In-kind services are defined as any labor that results in an individual receiving an in-kind income/payment as defined in Section 4.2.

ISSUANCE LIMITED COUNTY (ILC)

An issuance limited county is a county with enforced specified time limits for the ABAWD population to be eligible for SNAP benefits. All 55 West Virginia counties are required to enforce the ABAWD time limit rules.

36-MONTH PERIOD

A fixed period for all individuals regardless of client's status or the county or state of residence.

THREE-MONTH LIMIT

First full three months of SNAP benefits received without meeting the ABAWD work requirements or being exempt.

REGAINING ELIGIBILITY

Clients regain eligibility by meeting the ABAWD work requirement for a 30-day period prior to application or meet an exemption.

SNAP EMPLOYMENT AND TRAINING (SNAP E&T)

The SNAP E&T program is to provide SNAP participants with opportunities to gain skills, training, or experience that will improve their employment prospects and reduce reliance on SNAP benefits.

UNPAID WORK

Labor for an individual outside the AG or organization in which a person would traditionally be paid, but the client has chosen not to seek payment.

WORK

For ABAWD purposes only, work is defined as any activity performed for monetary compensation, for in-kind services, or unpaid work.

3.2.1.D.1.a Expanding the Target Audience

- Effective October 1, 2022, all West Virginia counties are required to enforce the ABAWD work requirement per WV state code §9-8-2.
- Effective September 1, 2023, all 50-year-olds receiving SNAP (who are not exempt) must meet the ABAWD work requirement per the Fiscal Responsibility Act of 2023.
- Effective October 1, 2023, all 51-and-52-year-olds receiving SNAP (who are not exempt) must meet the ABAWD work requirement per the Fiscal Responsibility Act of 2023.
- Effective October 1, 2024, all 53-and-54-year-olds receiving SNAP (who are not exempt) must meet the ABAWD requirement per the Fiscal Responsibility Act of 2023.
- Effective November 1, 2025, all individuals up to age 65 (who are not exempt) must meet the ABAWD requirement per the H.R.1 (One Big Beautiful Bill) of 2025.

3.2.1.D.2 ABAWD Eligibility

For SNAP AGs, any individual who meets the definition of an ABAWD and who is normally required to be included in the AG can only receive benefits when he is otherwise eligible and:

- Meets the work requirements outlined below or meets an exemption listed below;
- Is in his first three-month period while not meeting the ABAWD work requirement or being exempt within the 36-month period; or

- Regains eligibility after meeting the ABAWD work requirement and is in his additional three-month period, which must be consecutive months.

For detailed information for each of the bullets above, see below.

3.2.1.D.3 ABAWD Work Requirement

All SNAP work requirements in Chapter 14 also apply to ABAWDs.

An ABAWD must meet the following ABAWD work requirements, in addition to the SNAP work requirements in Chapter 14, to be eligible.

All work hours must be verified, including in-kind services and unpaid work. See Verification Requirements for Work Requirements found in Chapter 7.

As long as an ABAWD is exempt as found in the exemptions below or meets any of the requirements below, he may receive SNAP benefits, if otherwise eligible. Otherwise, he is ineligible once he has received SNAP benefits for three months without being exempt or meeting the ABAWD work requirement. The three months need not be consecutive and includes SNAP benefits received from another state.

The ABAWD work requirement is met by either:

- Working at least 20 hours per week or 80 hours a month;
- Participating in a work program such as, but not limited to: WorkForce Innovation and Opportunity Act (WIOA) Title I programs or a refugee resettlement program, at least 20 hours per week or 80 hours per month; or
- Participating in a SNAP E&T program for the required number of hours. Individuals who do not meet an exemption listed below and who are not participating in another program or working 20 hours per week or 80 hours in a month should be asked if they would like to be referred to the SNAP E&T program.

An ABAWD cannot be assigned any countable month(s) prior to being screened for exemptions. If an ABAWD experiences a change of circumstance during the certification period that results in the loss of their exemption, a worker must address the change at next redetermination.

While a client may choose not to cooperate with the West Virginia's voluntary SNAP E&T program, a client may not opt out of the ABAWD work requirement. A client may choose to cooperate with SNAP E&T at any time.

An ABAWD cannot receive a countable ABAWD month during the month in which the ABAWD is under SNAP E&T provider determination. The next month accrued is the first full month following the SNAP E&T provider determination, where the individual does not meet the ABAWD work requirement or is not exempt. DOHS will remove or add months to the ABAWD based on the information received from the DFA-SNAP-E&T-PD form.

NOTE: Self-directed job search or job search training are not part of the SNAP E&T work program.

3.2.1.D.3.a Good Cause for not meeting the ABAWD Work Requirements

An ABAWD who would have fulfilled the work requirement through working (paid or unpaid), participating in a work program such as SNAP E&T, or a combination of working and participating in a work program, but missed some hours for good cause, would be considered to have fulfilled the work requirement if the absence from work or the work program is temporary. A temporary period is considered less than a one-month period.

Good cause includes circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation.

If an ABAWD is granted good cause in any month for not meeting the ABAWD work requirement, the individual cannot receive a countable ABAWD month in the same period.

It is the responsibility of the ABAWD to report to the agency why they are unable to meet the ABAWD work requirement. The worker must document granting good cause in the case record.

NOTE: If an ABAWD has not completed any required hours during the month in which the ABAWD is claiming good cause, the ABAWD cannot be granted good cause for that month. If a worker needs assistance determining if an ABAWD qualifies for good cause they should consult with the Division of Family Assistance SNAP policy unit.

3.2.1.D.4 Exemptions from ABAWD Time Limits and ABAWD Work Requirements

SNAP benefits received while exempt do not count toward the three-month limit. Eligibility workers must use all available information to verify exemption status, including household attestation. Workers are not required to verify exemption status, unless the situation is questionable. Questionable ABAWD exemption information must be decided on a case-by-case basis. State agencies must apply updated exemptions at certification and recertification. Exemptions cannot be removed unless an individual has been screened.

An individual is exempt if he:

- Is under 18 or is 65 years of age or older.
- Is an Indian, Urban Indian, or California Indian, as those terms are defined in the Indian Health Care Improvement Act.
    - This includes individuals who are members of a federally recognized Indian tribe, band, nation, or Alaska Native village or corporation eligible for federal programs and services provided to Indians; individuals residing in an urban center who meet Indian ancestry or recognition criteria established by the Secretaries of the Interior or Health and Human Services; and individuals of California Indian descent recognized under 25 U.S.C. § 1679(a).
- Receives SNAP benefits in a SNAP AG that contains an individual under the age of 14, even if the household member who is under 14 is not eligible for SNAP himself;
- Is responsible for the care of an incapacitated person, whether or not the person receiving the care resides with the client, and whether or not the incapacitated person is a member of the AG;
    - Caring for an incapacitated person must prevent the client from being able to complete a work activity.
- Is receiving Unemployment Compensation Insurance (UCI). An individual who has applied for but is not yet receiving unemployment compensation is also exempt if he is complying with the unemployment application process, including those applying out of state. This includes persons receiving benefits under the Trade Readjustment Allowance (TRA);
- Is certified as physically or mentally unfit for employment according to the provisions in Section 13.15;
- Is pregnant, regardless of the expected date of delivery. A pregnant person must not be made to verify their pregnancy as an ABAWD if they have already demonstrated their status as pregnant for another program, i.e. Medicaid;

- Is a regular participant in a drug addiction or alcoholic treatment and rehabilitation program;
- Is a student enrolled at least half-time in any recognized school, training program, or institution of higher education. Students enrolled at least half-time in an institution of higher education must still meet the student eligibility requirements found above to be eligible for SNAP;
- Is hired for work at least 30 hours per week;
- Is hired for work paying the equivalent of at least 30 hours times the federal minimum wage per week; or
- Is the recipient of a discretionary exemption through the Division of Family Assistance (DFA). For any month in which a discretionary exemption has been granted, a case comment will be entered into the eligibility system.

These exemptions qualify the individual to participate immediately, if otherwise eligible. These exemptions are only applicable to the ABAWD time limit and ABAWD work requirement and do not automatically exempt the individual from the SNAP work requirements in Chapter 14.

While the individual is exempt, he is not required to regain eligibility by completing any work hours. See below for regaining eligibility.

3.2.1.D.5 Determining the 36-Month Period

For all individuals, regardless of client's status or the county or state of residence, the first 36-month period began January 2016. The 36-month period remains fixed.

Receiving SNAP months without being exempt or meeting the work requirement in another state counts towards the client's three-month limit in West Virginia. The worker must only count such months within the current 36-month period.

3.2.1.D.6 Determining the Three-Month Limit

Months in which the client received prorated benefits do not count toward the three-month limit. When an ABAWD, is no longer meeting an exemption or the work requirement, the first countable month is the first full month after the ABAWD is screened for exemptions.

Mid-Month Job Loss Example: An ABAWD who works 25 hours per week loses his job the second week of February. February is not counted toward his three-month limit.

Prorated Allotment Example: An ABAWD applies on January 15 and is approved for a prorated allotment. January is not counted towards his three-month limit.

3.2.1.D.7 Regaining Eligibility

An individual whose benefits are denied or terminated under the ABAWD policy can become eligible again when:

- He no longer meets the definition of an ABAWD;
- He is currently meeting the ABAWD work requirement; or
- He becomes exempt as specified above.

Individuals who regain eligibility by meeting one of the standards above must maintain eligibility monthly by continuing to meet those standards.

3.2.1.D.8 Qualifying for an Additional Three-Month Period

Once the client has received their first three months and benefits have closed for failure to meet eligibility requirements, eligibility for the additional three months of SNAP is only regained by:

- Having worked 80 hours in a 30-day period; or
- Participating for a month in an employment or training program; and
- Neither is continuing.

The three months must be consecutive, once the period begins, with no break in participation. This is the last time in the 36-month period that he may be eligible without meeting the work requirement or being exempt.

Prorated months do not count toward the three-consecutive-month limit.

The additional three-month period does not begin until the month after the individual is no longer meeting the ABAWD work requirement.

After this additional consecutive three-month limit expires, he may only become eligible again by complying with the requirements to regain eligibility.

Additional Three-Month Period Example 1: An ABAWD individual participated in a SNAP E&T activity for 80 hours in a 30 -day period. The client reapplied March 17 and received a prorated benefit from that date. He continued to meet the ABAWD work requirement with SNAP E&T through June. In July, he did not meet the ABAWD work requirement or an exemption, so the case started the additional three-month period of July through September.

Additional Three-Month Period Example 2: Same situation as above. During the additional three-month period for July through September, the ABAWD failed to complete his August review and the case was closed in August. The ABAWD reapplied on September 10 and currently is not meeting an ABAWD work requirement or an exemption. The application will be denied since there was a break in participation during the additional three consecutive months from July through September.

3.2.1.E Students

A student is an individual who is enrolled at least half time in a recognized school, training program or institute of higher education. A student enrolled at an institute of higher education is ineligible to participate in SNAP unless the individual qualifies for one of the exemptions described below.

- An institution of higher education is defined as a business, technical, trade, or vocational school that normally requires a high school diploma or its equivalent for enrollment in the curriculum, or a college or university that offers degree programs whether or not a high school diploma is required for a particular curriculum.
- For this definition, a college includes a junior, community, two-year, or four-year college.

NOTE: An individual enrolled at least half time in a school or training program that does not meet the definition of an institution of higher education is eligible to participate in SNAP, providing the individual meets all other criteria. Vocational schools which are a substitute for high school are not considered institutions of higher education.

3.2.1.E.1 Student Eligibility Based on Meal Plans

Students who live in a dormitory operated by the school and receive the majority of their meals from the school are ineligible to participate in SNAP regardless of whether they meet an exception to the policy. See Section 2.2.1.

A student cannot be denied SNAP benefits simply because the applicant lives on campus and/or participates in a meal plan at an institution of higher education. The worker must determine the scope of an applicant's meal plan to determine eligibility.

Individuals who receive the majority of their meals (more than 50% of three meals daily) through a meal plan are ineligible for SNAP benefits.

Individuals who DO NOT receive the majority of their meals from a meal plan may be eligible for SNAP, if they meet all other eligibility criteria.

The worker must methodically and comprehensively screen SNAP applicants on a case-by-case basis to determine the scope of the applicant's meal plan.

> **EXAMPLE: An eligibility worker may ask the applicant the number of meals they will receive through a meal plan. The applicant may respond they receive breakfast and lunch every weekday through their meal plan, which is equivalent to 10 meals per week. Though the applicant will receive two of three daily meals through the meal plan on weekdays, the worker will not consider the meal plan to be providing the majority of the applicant's meals because 10 meals per week is less than the majority of 21 total weekly meals (3 meals per day x 7 days per week). 50% of 21 meals per week would be 10.5 meals. If the student receives 10.5 meals or less than 10.5 meals per week, they may be potentially eligible for SNAP.**

The Department recognizes that meal plan structure may vary from institution to institution and the value of a meal plan may be counted by the number of meals, points or dollars included. The worker must fully explore a student's circumstances to determine how to treat such plans. The worker may need to ask students for clarification if it is unclear how many meals they receive from a plan. If there is no clarification, student attestation may be accepted.

The following example illustrates how the worker may evaluate varying meal plan levels.

- Unlimited Plan: Designed for 3 meals a day plus snacks (highest cost) = more than 50%/not SNAP eligible.
- Level 4 Plan: Designed for 3 meals a day (high cost) = more than 50 %/not SNAP eligible.
- Level 3 Plan: Designed for 2 meals every day (moderate cost) = more than 50%/Not

SNAP eligible.

- Level 2 Plan: Designed for about 2 meals a day on weekdays (lower cost) = NOT more than 50%/Potentially SNAP eligible
- Level 1 Plan: Designed for light snacks (lowest cost) = NOT more than 50%/Potentially SNAP eligible.

3.2.1.E.2 Student Exemptions

A student meets an exemption if he is:

- Under age 18;
- Age 50 or over;
- He is physically or mentally unfit for employment. An individual who meets the definition of disability found in **Section 13.15** is considered unfit for employment. Other individuals may be considered unfit for employment if it is verified through a written statement from a licensed medical professional or if it is clearly obvious to the supervisor or senior worker. An individual who meets the definition of unfit for employment, but not disability, should not be coded as disabled in the eligibility system;
- Participating in an on-the-job training program. This does not include the practical experience requirements that may be part of some courses of study, i.e., student teaching, internships, etc.;
    - A person is considered to be participating in on-the-job training, and thus not considered a student, during the period of time that he is being trained by the employer. He is considered a student, only during the period of time that he is attending classes.

    > **On the Job Training Example:** Mr. Azalea is in a program that requires that he attend classes full-time at an institution of higher education for 10 weeks and then be trained by an employer for an additional 10 weeks. Mr. Azalea is considered to be participating in on-the-job training only during the 10-week training period. During the 10-week period Mr. Azalea is only attending classes, he is considered a student.

- Employed at least 20 hours per week or 80 hours a month and is paid for the employment. This average must use a 30-day lookback period to determine if the student meets the 80-hour requirement. The 30-day period should be the same as the minimum lookback period for SNAP income;

  - Unlike normal work registration, a student cannot substitute wages equivalent to 20 times the minimum hourly wage but must actually work at least 20 hours a week or 80 hours a month, regardless of the amount of wages.
  - However, self-employed persons must be employed at least 20 hours per week or 80 hours a month and receive weekly earnings at least equal to the federal minimum wage multiplied by 20 hours or monthly earnings equal to the federal minimum wage multiplied by 80 hours.

- Participating in a state or federally financed College Work Study (CWS) program during the regular school year;
  - Participation means that the student has been approved for CWS during the school term and anticipates actually working during that time.
  - To qualify for this exemption, the student must be approved for CWS at the time of application.
  - The exemption begins with the month in which the school term begins or the month CWS is approved, whichever is later. Once begun, the exemption continues until the end of the month in which the school term ends, or it becomes known that the student refused an assignment. The exemption does not continue between school terms when there are breaks of a full month or longer, unless the student is participating in CWS during the break.
- Included in a WV WORKS benefit;
- Assigned to or placed in an institution of higher education through one of the following:
  - Workforce Innovation and Opportunity Act (WIOA)
  - Section 236 of the Trade Act of 1974
  - An employment and training program for low-income households that is operated by a state or local government when one or more of the program's components is at least equivalent to SNAP E&T

- The SNAP E&T

NOTE: A student enrolled in a program which is approved through the SNAP E&T program and prepares the individual for an occupation listed in the West Virginia State SNAP E&T Plan (see Chapter 17, Appendix B) is initially eligible for SNAP benefits, if otherwise eligible, even if the individual is not currently a participant in SNAP E&T. The student should be referred to SNAP E&T after SNAP approval. If the student meets no other exemption, then the student must be informed during the interview that his ongoing SNAP eligibility is contingent upon his continued participation with SNAP E&T. If the student fails to participate with SNAP E&T and meets no other exemption, then the student becomes ineligible for SNAP after proper advance notice.

If the student is enrolled in a program of study which meets the standards of the SNAP E&T program but does not prepare the individual for an occupation listed in the West Virginia State SNAP E&T Plan, exceptions may be made by the Division of Family Assistance Policy Unit. The worker should pend the case and cooperate with the Policy Unit in obtaining information necessary to approve or disapprove the program for SNAP E&T eligibility.

- Responsible for the care of a child under the age of six;
- Responsible for the care of an AG member who has reached the age of 6 but is under age 12 and adequate child care is not available to enable the student to attend class and satisfy the 20 hour work requirement or participate in a state or federally financed CWS program during the regular school year; or
- Is a single parent (natural, adoptive, or stepparent), regardless of marital status, and is responsible for an AG member under age 12, regardless of the availability of adequate childcare, and is enrolled full-time, as defined by the institution.
    - This applies in situations where only one natural, adoptive, or stepparent, regardless of marital status, is in the same AG with the child.
    - If no natural, adoptive, or stepparent is in the AG with the child, another full-time student in the same AG as the child may qualify for this exemption, if he has parental control over the child.

The following table summarizes the student exemption policy based on the age of the child and the number of parents in the AG.

Age of Child for whom Student is Responsible	Two Parents in the AG	One Parent in the AG
Birth to 6	Eligible – Exemption Met	Eligible – Exemption Met
Who has reached age 6 but is under age 12, adequate childcare not available	Eligible – Exemption Met*	Eligible – Exemption Met*
Who has reached age 6 but is under age 12, adequate childcare is available	Ineligible – Exemption Not Met	Eligible – Exemption Met

*The Worker must determine on a case-by-case basis whether or not the parent who is not a student or the student's spouse who is an AG member is available to provide adequate childcare.

- Paternity does not have to be established to qualify as a father for these purposes. Only when the adults involved do not agree about the paternity of the child is any verification of paternity required.

See Student Exemption Examples below for examples of student AG composition.

3.2.1.E.3 Definition of Enrollment and Participation

A student is considered to be enrolled the day he is scheduled to begin classes at an institution of higher education. Enrollment is defined as continuing during normal periods of class attendance, vacation or recess, unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal term (excluding summer school).

3.2.1.E.4 Examples of Student Exemption AG Composition

> **Student Exemption Example 1:** A WV WORKS mother is a student. She has two children age 13 and age 15. The only income they receive is her WV WORKS benefit. She qualifies for the student exemption because she is a WV WORKS participant.
>
> **Student Exemption Example 2:** In a two-person AG, both the husband and wife are students. They do not have an exemption to student eligibility, so they are ineligible.

Student Exemption Example 3: Mr. and Mrs. Freesia receive WV WORKS and have four children. Cedar, one of Mr. and Mrs. Freesia's children, is a 21-year-old college student who lives at home. Cedar does not meet any of the exemptions to the student policy. Cedar cannot be included in the SNAP AG, but, if they are otherwise eligible, SNAP benefits can be approved for Mr. and Mrs. Freesia and the three other children.

Student Exemption Example 3.1: The situation is the same as the previous example, except Cedar is 17 years old. He is eligible to be included in the SNAP AG because he is under age 18, meeting a student exemption.

Student Exemption Example 4: Iris, who is a student, wants SNAP benefits for herself and her 10-year-old child Jasmine. While Iris is at school, her mother, who lives across town, takes care of Jasmine. Iris has the responsibility for the care of a dependent child between the ages of 6 and 12. Adequate childcare is available, but because Iris is a single parent, she qualifies for an exemption.

Student Exemption Example 5: Mr. Willow, Ms. Holly, and their 10-year-old child Laurel apply for SNAP benefits. Ms. Holly is a student and is responsible for the care of Laurel. While Ms. Holly is in school her mother, who lives across town, takes care of Laurel. Her mother is only willing to keep Laurel while Ms. Holly attends school, but not if she works. Mr. Willow works and there is no other available childcare. Ms. Holly meets the student exemption due to the lack of childcare.

Student Exemption Example 5.1: Same situation as above, except Ms. Holly's mother is willing to keep Laurel if Ms. Holly works. The student exemption is not met; therefore, Ms. Holly is ineligible for SNAP benefits.

Student Exemption Example 6: A SNAP AG consists of a 10-year-old child, his mother, and his stepfather. The stepfather is a full-time student and is responsible for the care of the child due to the mother's disability. The mother is, however, able to look after the child. The stepfather does not qualify for an exemption to the student policy based on caring for a child, since adequate childcare is available.

Student Exemption Example 6.1: Same situation as above except that the mother is not able to look after the child. There is no other childcare available. The stepfather qualifies for an exemption based on having responsibility for the care of a child between 6 and 12 without adequate childcare available.

Student Exemption Example 7: Olive, a married woman, separates from her husband, and she and 10-year-old daughter Myrtle move out of the home. Olive is in college full-time, and her mother cares for Myrtle while Olive goes to school. Because Olive is a single parent enrolled in school full-time, she qualifies for an exemption to the student policy.

3.2.1.F Strikers

When the AG includes an individual who is on strike, the AG is ineligible for the duration of the strike unless:

- The AG was eligible for or receiving SNAP benefits the day prior to the strike; or
- The individual who is participating in the strike is exempt from work requirements for any reason other than employment. Refer to Chapter 14.

To determine if an AG containing a striker is eligible, the Worker must determine pre-strike eligibility and current eligibility. See Section 4.4.4.

3.2.2 THE INCOME GROUP (IG)

The income group includes all AG members and all individuals who live with the AG and would otherwise be included in the AG if not ineligible, disqualified, or excluded by law. This includes ineligible non-citizens, those excluded by law, disqualified due to an IPV or for trafficking SNAP for a controlled substance, and those who fail to meet the enumeration requirement. See Section 4.4 to determine how to count the income and deductions.

Ineligible students and individuals who are ineligible due to receipt in another state are not included in the IG.

3.2.3 THE NEEDS GROUP (NG)

The income limit for the number of eligible individuals in the AG is used to determine eligibility and the amount of the benefit.

Normally, all AG members are included in one case number. However, some SNAP AG members may be eligible for other benefits that, due to eligibility limitations, must be issued in another case number.

3.2.4 EXAMPLES OF AG COMPOSITION

AG Composition Example 1: Miss Cedar, age 20, lives with her parents. She is unmarried, has no children, and is employed. She purchases food and prepares her meals separately. However, because she is under age 22, Miss Cedar must be in an AG with her parents.

AG Composition Example 2: Miss Birch, age 25, lives with her mother. She purchases food and prepares meals separately. Because she is age 22 or over, and purchases food and prepares meals separately, she is a separate AG.

AG Composition Example 2.1: Same situation as the previous example, except Miss Birch purchases food and prepares meals with her mother. Miss Birch and her mother must be in an AG together.

AG Composition Example 3: Miss Oak, age 17, is a high school student who is employed part-time. She lives with her aunt, age 36, who exercises parental control over her. Miss Oak and her aunt must be in the same AG.

AG Composition Example 4: Sage, age 17, and Thyme, age 18, are brothers. Their parents are deceased, and the brothers live together. They purchase food and prepare meals separately. They each qualify as a separate AG as they do not live with a parent or any other adult who exercises parental control.

AG Composition Example 5: Ms. Carnation, age 27, has two children, ages 1 and 2. She moves back in with her parents after she is divorced. The grandmother cares for the children and feeds them their meals. Miss Carnation purchases food for only herself and her two children but works at night and eats separately. Miss Carnation and her children are an AG, but the grandmother wants the children included with her because she feeds them their meals. Children under age 22 and their parents must be in the same AG. The two AGs in the household are as follows: grandmother and grandfather in one; Miss Carnation and her two children in another.

AG Composition Example 6: Mr. Forrest has been laid off. He and his family move in with friends. The friends are providing them all their meals since Mr. Forrest and his family have no income. Mr. Forrest indicates that the only reason they are not purchasing food and preparing their meals separately from their friends is that they have no money. Once Mr. Forrest and his family receive SNAP benefits, they will purchase food and prepare meals separately. Mr. Forrest and his family qualify as a separate AG. The Worker may set a control in the eligibility system to check with the clients after they begin receiving SNAP to confirm the situation.

AG Composition Example 6.1: Same situation as the previous example, except Mr. Forrest indicates his family will continue to purchase food and prepare meals with his friends, even after receipt of SNAP benefits. The Forrest family and their friends must be in the same AG.

AG Composition Example 7: Mr. and Mrs. Geranium, both age 35, live with Mr. Geranium's mother. They purchase food and prepare meals separately from the mother. Separate AG status is approved.

AG Composition Example 8: Mr. and Mrs. Arbor, ages 27 and 30, live with Mrs. Arbor's elderly and disabled mother. They purchase food and prepare meals together. The elderly and disabled requirements are met, so two AGs are established: one for Mr. and Mrs. Arbor, and one for the elderly and disabled mother.

AG Composition Example 8.1: Same situation as the previous example, except the assets of Mr. and Mrs. Arbor exceed the limit. The elderly and disabled mother is still eligible to participate as a separate AG.

AG Composition Example 8.2: Same situation as the previous example, except that the assets and the income of Mr. and Mrs. Arbor exceed the limits. Neither AG is eligible to participate.

AG Composition Example 9: Ms. Marigold reports that she has moved in with her grandson. He has a good job and does not receive SNAP benefits. She states that she purchases food and prepares her meals separately from her grandson. She prepares her meals in the kitchen but takes her meals in her living area. Ms. Marigold customarily purchases food and prepares her meals separate and apart from others. She is a separate AG.

AG Composition Example 9.1: Same scenario as above but Ms. Marigold becomes ill. She can no longer do her own shopping and cooking. She meets the definition of elderly and disabled according to policy. Ms. Marigold must depend on her grandson and his housekeeper to purchase food and prepare meals for her. They use her SNAP benefits and money to purchase her food and they prepare her meals. She continues to take her meals in her living area.

Although Ms. Marigold is now dependent on her grandson and his housekeeper to purchase food and prepare her meals, she can continue to be a separate AG for SNAP purposes, regardless of the grandson's income, because she had previously established that she customarily purchases food and prepares her meals separate and apart from others and she continues to do so.

AG Composition Example 9.2: Same scenario as above, except Ms. Marigold decided that she liked someone else doing the shopping and cooking and she likes spending mealtime with her grandson. Since she no longer purchases food

and prepares her own meals and she takes most of her meals with her grandson, Ms. Marigold no longer meets the criteria of purchasing food and preparing her meals separate and apart from others.

Under this scenario, if Ms. Marigold decides that she wants to receive SNAP under the elderly and disabled policy as a separate household, then the Worker must determine if the grandson`s income exceeds 165% of the FPL. If it does, then Ms. Marigold cannot be considered a separate household for SNAP purposes.

AG Composition Example 10: Mr. Iris, age 25, lives with his parents and pays them a reasonable amount for room and board. Because of the parent/child relationship, Mr. Iris cannot be considered a boarder, even though he is over age 21, nor can he be a separate AG. He may be included in an AG with his parents if they so request.

3.3 DEPENDENT CHILD/SPECIFIED RELATIVE

In order to receive WV WORKS benefits, Parents/Caretaker Relatives Medicaid, or Aid to Families with Dependent Children (AFDC)-Related Medicaid, the dependent child must meet the following requirements.

3.3.1 AGE

3.3.1.A WV WORKS

Children must be under the age of 18, whether or not they are attending school or training. A child who reaches age 18 on the first day of the month is not eligible for benefits for that month.

EXCEPTION: A child over 18 may be included in the benefit group up to age 19 while he:

- *Is full-time student in a secondary school, or the equivalent level of vocational or technical training, including summer breaks; and*
- *Meets all other eligibility requirements.*

A child who reaches age 19 on the first day of the month is not eligible for that month.

3.3.1.B Parents/Caretaker Relatives, AFDC-Related Medicaid

Children must be under the age of 18, whether or not they are attending school or training. A child who reaches age 18 on the first day of the month is not eligible for benefits for that month.

EXCEPTION: A child over age 18 may be included in the AFDC-Related benefit group when he:

- *Is a full-time student in a secondary school, or the equivalent level of vocational or technical training, including summer breaks;*
- *Can be reasonably expected to complete the program before reaching age 19; and*
- *Meets all other eligibility requirements.*

Graduation ceremonies need not take place prior to the child reaching age 19. As long as all courses or training programs are fully completed prior to the child reaching age 19, the child is eligible.

3.3.2 LIVING WITH A SPECIFIED RELATIVE (WV WORKS), OR (PARENTS/CARETAKER RELATIVES MEDICAID, AFDC-RELATED MEDICAID)

The child must be living with a specified relative, who assumes primary responsibility for the child's care, in a place established as the relative's home. In order for an individual to be a caretaker relative, he must be a specified relative. Legal custody or guardianship of a child does not, in itself, qualify a person as a specified relative. A specified relative is any relation by blood, marriage, or adoption who is within the fifth degree of kinship to the dependent child, as shown in the table below.

Degree of Relationship	Natural or Adoptive Parents	Blood Relative	Step Relative
First Degree	Mother; father		Stepfather; stepmother
Second Degree		Brother; sister; grandparent; Half-sister; Half-brother	Stepbrother; stepsister; step-grandparent
Third Degree		Great grandparent; aunt; uncle; nephew; niece	Step-great-grandparent; step-aunt; step-uncle; step-nephew; step-niece
Fourth Degree		Great-great-grandparent; great-aunt; great-uncle; first cousin	Step-great-great-grandparent; step-great-aunt; step-great-uncle; step-first cousin
Fifth Degree		Great-great-great-grandparent; great-great-aunt; great-great-uncle; first cousin once removed (child of first cousin)	Step-great-great-great-grandparent; step-great-great-aunt; step-great-great-uncle; step-first cousin once removed

Under certain circumstances, eligibility continues during periods of separation of the child and the specified relative. Refer to Chapter 2.2.1.

A specified relative is defined as follows:

- Natural or adoptive parents.
    - If a child is living with his natural father and paternity has been legally established, the father is considered a specified relative; a relative of the father of a child born

out-of-wedlock can qualify as a specified relative only if the child's paternity has been established.

- Adoption procedures must be finalized in order for an adoptive parent to qualify as a specified relative.

NOTE: When an adoption is finalized, the ties between the natural parent(s), the natural parent's family, and the child are severed. The natural parent(s) and the natural parent's family do not retain a specified relationship unless the adoptive parent is also related. The specified relationships are then based on the adoptive family.

> **Adoption by a Relative Example:** A set of paternal grandparents legally adopts a grandchild. The father of the child no longer has a specified relationship of parent to the child, but now has a specified relationship as the child's brother.

NOTE: When parental rights have been severed, but no adoption has been finalized, the parent is no longer a specified relative, but all other relationships of the child are unaffected.

> **Severed Parental Rights Example:** A father has all parental rights severed by a court order. The child goes to live with the father's sister. The sister is still an aunt to the child and therefore a specified relative.

- Blood relative: Those of half-blood, brothers or sisters, grandparents, great-grandparents, great-great grandparents, great-great-great grandparents, uncles or aunts, great-uncles or aunts, great-great uncles or aunts, nephews or nieces, first cousins, first cousins once removed.
- Legal stepparent, stepbrother or stepsister, step-grandparents, step-great-grandparents, step-great-great grandparents, step-great-great-great grandparents, step-uncles or aunts, step-great-uncles or aunts, step-great-great uncles or aunts, step-nephews or nieces, step-first cousins, step-first cousins once removed;
- The specified relationship exists even when a marriage terminates in death or divorce. Spouses of stepparents are not specified relatives.

> **Stepparent Example:** A man and his wife have a child from his previous marriage living with them. They get a divorce, and the child continues to live with the wife, and she remarries. She still qualifies as a specified relative, as she is a former stepparent, but her new husband does not.

> **Spouses of Step-relatives Example:** If a step-grandmother has two step-grandchildren living with her and she divorces her husband, she is still the former legal spouse of the children's grandfather, who is a specified relative. She is, therefore, a specified relative. If she were to remarry, her new spouse would not be a specified relative.

NOTE: For WV WORKS, it may be impossible for a relative to establish a home for a child who is in a foster home, or other place, without financial assistance before the child enters his home. The payment can be initiated any time within 30 days prior to the date the child actually goes to live with the specified relative. If DOHS made a Foster Care payment, a WV WORKS payment cannot be initiated for the same period because this results in a duplication of payments.

3.3.3 DEPRIVED OF PARENTAL SUPPORT AND CARE (PARENTS/CARETAKER RELATIVES MEDICAID, AFDC-RELATED MEDICAID)

The definition of a dependent child no longer requires the child to be deprived of parental support and care.

3.3.4 EMANCIPATION

Under West Virginia State law, emancipation occurs when:

- A child has been declared emancipated by a court; or
- A child marries.

3.3.4.A WV WORKS

The definition of dependent child for WV WORKS includes the requirement that any child, included in the AG as a dependent child, be unemancipated.

3.3.4.B Parents/Caretaker Relatives Medicaid, AFDC-Related Medicaid

The emancipation status of a child has no bearing on eligibility for Parents/Caretaker Relatives Medicaid or AFDC-Related Medicaid.

3.4 WV WORKS ELIGIBILITY DETERMINATION GROUPS

3.4.1 THE ASSISTANCE GROUP (AG)

3.4.1.A Who Must Be Included?

Whether or not an individual has income sufficient to meet his own needs or the needs of his dependents is not relevant when determining if the individual must be included in the AG.

A Supplemental Security Income (SSI) recipient, age 18 or over, cannot be included in the AG. See "Who Cannot Be Included" below.

The following individuals must be included in the AG:

- All minor, dependent, blood-related, and adoptive siblings who live in the same household with a specified relative.

  > **Specified Relative Example:** Two children, Rose and Daisy, who have the same mother but different fathers, live with Rose's paternal grandparents. The children are blood-related and would normally be required to be included in the same AG. Rose's grandparents are not specified relatives of Daisy; therefore, Daisy is not eligible for WV WORKS: however, Rose would be.

- The parent(s) of the child(ren) identified in the example above when the parent(s) lives with the child(ren), unless he falls under any of the categories of who must not be included listed below.
- In cases of joint custody, only the custodial parent is included. The custodial parent is the one with whom the child(ren) lives more than 50% of the time in a given month. The custodial parent of any child may change from month to month. If the child lives with each parent exactly 50% of the time, the parents must decide who the custodial parent is.
- Parents who attend school, work, or are looking for work away from home, including those who work out of state, must be included, unless there is a legal separation.
- The legal spouse of the parent described above, regardless of the legal spouse's legal relationship to the child(ren), unless he falls under any of the categories of who must not be included listed below.

NOTE: The stepparent may not choose to be excluded when the parent is in the home.

- All minor, dependent, blood-related, and adoptive children of the legal spouse of the parent, regardless of the relationship of the children to the other children in the home, provided they are living with a specified relative.
- The non-parent caretaker who has chosen to be included by signing the WV WORKS Caretaker Relative Option form (DFA-WVW-10) within the past 12 months.
- The parent(s) of an unemancipated minor parent (mp), even when the mp requests benefits for the child only. This situation would also include the blood-related siblings of the mp. Refer above for the legal spouse of the parent.

NOTE: When an individual is required to be in two or more AGs, the AGs must be combined.

3.4.1.B Who Must Not Be Included?

Individuals who fit in at least one of the following categories are ineligible. When all members of the AG meet any of the criteria listed below, the entire case is ineligible. In addition, when all otherwise eligible children meet any of the criteria listed below, except receipt of foster care, adoption assistance, or SSI benefits for a dependent child is age 18 or over, the AG is ineligible.

NOTE: The caretaker relative may receive WV WORKS when there are no children in the AG if all the children are ineligible for WV WORKS only because:

- *The children are age 18 or over and receive SSI benefits; or*
- *The children receive adoption assistance payments; or*
- *The children receive foster care payments.*

- Individuals who are noncitizens and are ineligible because they have been sponsored by a private or public agency or organization, or because of deeming income from sponsor to noncitizen.
- Individuals who do not meet the citizenship requirements of Chapter 15.
- Individuals, age 18 or over, who are eligible for SSI benefits as determined by the Social Security Administration (SSA).
    - This includes individuals who are approved, but who have not yet received a payment and individuals for whom benefits are temporarily suspended due to overpayment.

- Individuals who are recipients of federal, state, or local foster care maintenance or an adoption assistance payment.
- The child(ren) of a minor parent (mp) when the minor parent (mp) is a recipient of federal foster care payment.
- An unemancipated minor parent (mp).
    - A currently unemancipated parent (whose youngest child is at least 12 weeks old) who has not completed high school, unless the parent(s) participates in, or in the case of an applicant, agrees to participate in: educational activities directed toward attainment of a high school diploma or equivalent; or, an alternative educational or training program.
    - A currently unemancipated parent, under age 18, and the child(ren) of such parent, who do not live with at least one parent of the mp.
    - See Section 3.3 for the definition of emancipation.

NOTE: If the household consists of an adult parent, mp and their child(ren), the adult parent does not need to live in a setting supervised by an adult for the adult parent to receive WV WORKS benefits for himself and the child(ren).

EXCEPTIONS: For the unemancipated mp

- *There is no parent whose whereabouts are known.*
- *No parent allows the unemancipated mp to live in his home.*
- *The unemancipated mp lived apart from the parent for at least one year before the birth of the child or before the WV WORKS application.*
- *The unemancipated mp or child's physical or emotional health would be in jeopardy from residing with a parent.*
- *There is good cause for an unemancipated mp and child(ren) to receive WV WORKS while not living with a parent. Examples include, but are not limited to:*
    - *The unemancipated mp's return to the home of the parent(s) would cause noncompliance with a fixed lease already negotiated by the parent.*
    - *Education or training opportunities may be available and appropriate for the unemancipated mp elsewhere.*

    - When the unemancipated mp demonstrates good cause for not living with a parent, eligibility may be established by living with another adult relative, a legal

guardian, or in an alternative living arrangement that is supervised by an unrelated adult.

- When the alternative living arrangement is a maternity or other group home, the home must be supervised and licensed by the State.
- When the alternative living arrangement involves living with or living in a setting supervised by an unrelated adult, the supervising adult must meet all of the following requirements:
  - Does not receive WV WORKS benefits;
  - Is the same sex as the mp, or the unemancipated mp lives or is supervised by a married couple;
  - Is employed;
  - Is at least 15 years older than the unemancipated mp;
  - Has no Child Protective Services (CPS) Record or has one that contains no substantiated charges; and
  - Has no criminal record, as determined by a Criminal Identification Bureau (CIB) report.

- Non-Recipient Work-Eligible Individuals
  - Non-Recipient Work-Eligible Individuals are parents or stepparents who must sign the application, complete orientation, a Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP) and be participating in a work activity.
  - Neither Non-Recipient Work-Eligible Individuals nor caretaker relatives may be included in the AG if they are:
    - Individuals convicted in federal or state court of having made a fraudulent statement or representation about residence to receive TANF, WV WORKS, Medicaid, SNAP benefits, or SSI. They are ineligible for 10 years from the date of the conviction. The conviction must have occurred after 8/22/96.
    - Individuals who are fleeing to avoid prosecution, or custody/confinement after conviction, for a felony or an attempt to commit a felony.
    - Individuals convicted of a felony under federal or state law when the offense involves the possession, use, or distribution of a controlled substance, as defined in Section 102(6) of the Controlled Substance Act and when the offense occurred after 8/22/96. This does not include convictions which have been expunged or reduced to a lesser charge.

Exception: Individuals who have been convicted of a drug related offense within the last three years and have a negative drug test must be added to the WV WORKS AG.

- Individuals who are violating a condition of probation or parole that was imposed under federal or state law.
- Parents or other included caretakers who do not report that a child is, or will be, out of the home for at least 30 consecutive days. The parents or other caretakers must report the absence within five calendar days of the date that it becomes known to the parents or other caretakers that the child will be absent for at least 30 consecutive days. The individuals who fail to report are permanently removed from the WV WORKS benefit and become non-recipient Work-Eligible Individuals.
- Any individual who has a positive drug test and fails to complete or refuses to participate in the substance abuse treatment and counseling program and job skills program as required is ineligible for the WV WORKS benefit. Ineligibility will continue until the time the individual enrolls and is successfully attending a substance abuse treatment and counseling program and job skills program.
- Any individual who tests positive on a second drug test will be ineligible for the WV WORKS benefit for a period of 12 months or until they have completed both a substance abuse treatment and counseling program and job skills program, whichever is shorter.
- Any individual who tests positive for a third drug test is permanently ineligible for WV WORKS. They must choose a protective payee for the WV WORKS payment for the other members of the WV WORKS AG.

NOTE: Any individual who refuses a Drug Use Questionnaire or a drug test is ineligible for WV WORKS assistance. He becomes a non-recipient work-eligible individual and may still receive WV WORKS for the other members of the household who are otherwise eligible. During the period of ineligibility, he must choose a protective payee who has successfully completed the DFA-WVW-DAST-1 for the WV WORKS benefit for the other members of the WV WORKS AG. Any individual that has had their benefits suspended and has not designated a protective payee for the benefits must be referred to Children & Adult Services.

- Individuals who are recipients of an Independent Living Subsidy through the Division of Children and Adult Services.
- The child(ren) of a parent, when the parent is a recipient of an Independent Living Subsidy through the Division of Children and Adult Services.
- A child who is absent from his home for 30 consecutive days.
    - A child may be absent from his home for more than 30 consecutive days and remain a WV WORKS client only if the reason for the absence is one of the following:
        - Medically substantiated mental or physical illness of a parent or other caretaker necessitates other temporary living arrangements for the child.
        - Medically substantiated mental or physical illness of the child necessitates other temporary arrangements for the child.
        - The child receives education or training at a special needs school and residence outside the home is required to begin or continue such education.
        - A natural disaster forces the child to live apart from the parent(s) or other caretaker(s).
        - The Personal Responsibility Contract/Self-Sufficiency Plan (PRC/SSP) has targeted a family problem that requires the child to be absent from the home for more than 30 consecutive days.

3.4.1.C Who May Choose to Be Included?

The following individuals may choose to be included in the AG:

- Caretaker relatives, who are not natural or adoptive parents, and stepparents when the parent is not in the home. When the caretaker relative is also receiving WV WORKS for his own children, as well as serving as the caretaker relative for other children, he must be included.
    - When the caretaker relative chooses to be included, refer to who must be included above.
- When the parent is not in the home, the stepparent is treated as any other specified relative and may choose to be included or excluded.
- If there is another minor child(ren) in the household who is not required to be included and the caretaker relative requests WV WORKS benefits for him, the caretaker relative

may choose to include him in the AG. A separate case is not established for the child(ren).

Once the choice is made about whether to include the individual in the AG, the decision is binding until the next annual, full-scale redetermination, regardless of changes in the circumstances of the caretaker relative or the child(ren). This must be explained to the caretaker relative at each application and each redetermination.

When the case is closed and reopened before completion of a full-scale redetermination, the last decision is binding until one year from the date the last decision was made. Each decision must be made using the WV WORKS Caretaker Relative Option form (DFA-WVW-10). Refusal or other failure to choose by completing the form results in ineligibility only for the caretaker relative for at least 12 months. Eligibility continues to be denied beyond 12 months, for as long as the caretaker fails to choose.

> **Caretaker Relative Example:** Aster applies for WV WORKS for her five-year-old niece. Aster works and is not applying for her own two children. The case is approved effective February for the niece only; Aster chooses not to be included in the payment. In May, Aster loses her job and applies for WV WORKS for her own children. She is required to be included in the WV WORKS payment for her own children. She and her two children are added to the case for the niece, effective June, and they all receive WV WORKS until September, when Aster finds another job. At that time, Aster and the children are removed from the AG and she continues to receive a payment for the niece only.

3.4.1.D Treatment of the Minor Parent (mp) in the AG

3.4.1.D.1 Unemancipated Minor Parent (mp)

When the mp is unemancipated, a referral to the Bureau for Child Support Enforcement (BCSE) is required to pursue child support from the Major Parent (MP)(s).

The WV WORKS benefit must be made payable to an MP or other adult with whom the mp lives or who supervises the living situation of the mp.

- ***Unemancipated mp Lives with MP(s)***

When an unemancipated mp lives with MP(s), the mp must be included in the AG with:

- The MP(s);
- The MP's child(ren);
- The MP's minor, blood-related, and adoptive siblings, if living with a specified relative;
- The legal spouse of the MP; and
- The blood-related and adoptive siblings who are minor children of the spouse of the MP.

➢ *Unemancipated mp Lives with Adult Other than a Parent*

When an unemancipated mp lives with an adult relative other than a parent, the mp and the child(ren) are a separate AG, as long as the other adult relative does not wish to receive a WV WORKS payment. If the other adult relative wants to receive WV WORKS, he must be a specified relative.

➢ *Unemancipated mp Does Not Live with MP(s)*

When the mp does not live with the MP(s), the amount the MP(s) contribute to the mp is counted as unearned income.

3.4.1.D.2 Emancipated Minor Parent (mp)

When an emancipated mp lives with MP(s), the mp and the child(ren) are a separate AG. See Who Must Be Included above.

When an emancipated mp lives with an adult relative other than a parent, the mp and the child(ren) are a separate AG.

3.4.2 THE INCOME GROUP (IG)

The non-excluded income of all AG members is counted.

The non-excluded income of the ineligible and disqualified non-recipient Work-Eligible Individuals who would normally be required to be included in the AG must be counted when determining eligibility.

See Chapter 4 to determine how the income is counted.

3.4.3 THE NEEDS GROUP (NG)

Countable income is compared to the income limits for the number in the AG to determine eligibility and the amount of the benefit.

Disqualified and excluded SSI individuals are not counted in the NG.

3.4.4 EXAMPLES OF WV WORKS AG COMPOSITION

Example 1: Household consists of a mother and her two dependent children. All are included in the AG.

Example 2: Household consists of a mother who was convicted of a drug felony in 1999, a father, and their two dependent children. Only the father and children are included in the AG, but both the father and mother are required to complete orientation, a PRC/SSP, and be assigned to a work activity or the AG is ineligible for WV WORKS.

Example 3: Household consists of Ms. Birch and her two nephews who are blood-related siblings. Both children are included. Ms. Birch can choose to be either included or excluded. If she is included, her income and assets are counted.

Example 4: Household consists of a married couple and their three children. One of the three children receives SSI. All are included in the AG. The SSI payment is not counted as income for WV WORKS.

Example 5: Household consists of Mr. and Mrs. Pine, Mr. Pine's two children from a previous marriage, and Mrs. Pine's child from a previous marriage. All are included in the same AG.

Example 6: Household consists of Mr. and Mrs. Rosemary, their two children, and Mrs. Rosemary's niece. Mr. and Mrs. Rosemary have applied for benefits for their family and their niece, so all are included in the AG.

Example 7: Household consists of Major mother, minor mother, and minor mother's child. Major mother applies for WV WORKS for minor mother's child. Major mother is considered the supervising adult for both her daughter and grandchild and all must be included in the AG.

Example 8: Household consists of Mother and her two sons who receive WV WORKS. Mother's emancipated daughter returns to the household with her child. The daughter and her child are a separate AG because she is emancipated.

Example 9: Household consists of Mr. Aspen, his wife, and her two children from a previous marriage. Mr. and Mrs. Aspen and her two children must all be included in the AG.

Example 9.1: Mr. Aspen's ex-wife and her two children move into Mr. Aspen's home and apply for WV WORKS. Mr. Aspen is the father of his ex-wife's children. All must be included in the same AG.

Example 10: Household consists of a mother, her daughter, and granddaughter. The mother legally adopts her granddaughter. The mother applies for WV WORKS and the AG consists of the mother and her two daughters.

Example 11: Household consists of Mr. and Mrs. Chestnut and their son. Their divorced minor daughter and her child move back into the home. Mr. and Mrs. Chestnut and their son are included in one AG. A separate AG is established for their divorced daughter and her child because she is legally emancipated.

Example 12: Mrs. Pine and her three children move in with her parents after her divorce. The household consists of Mrs. Pine, her three children, and her parents. The WV WORKS AG consists of Mrs. Pine's and her three children. None of her parents' income is counted.

Example 13: Ms. Birch applies for a WV WORKS benefit for her nephew. She has recently lost her job and chooses to be included in the payment. Two months later Ms. Birch finds another job. Her earnings are excessive, and she tells the Worker she wants to be removed from the payment. The Worker explains that she must still be included, based on her decision at application and closes the case, after proper notice. Eight months later, Ms. Birch is laid off and reapplies. She and her nephew are both included in the payment because one year has not elapsed. The following month, Ms. Birch again finds employment and the case is closed. A year after the original application, she applies for her nephew only and is approved with none of her income counted.

Example 14: Household consists of a married couple and their four minor children. The father and two of the children are SSI recipients. The mother and all of the children are included in the AG. The father is not included in the AG. The SSI payments of the father and the two children are not counted in determining the amount of the WV WORKS benefit.

Example 15: Household consists of Mrs. Pine, her grandson, and his sister. Mrs. Pine's son is the father of the grandson, but not of his sister. The children have the same mother. Mrs. Pine does not choose to be included in the AG. The AG

includes only Mrs. Pine's grandson. His sister does not live with a specified relative and is not otherwise eligible.

Example 16: Ms. Oak has two minor children and is employed full-time. In February, Ms. Oak's sister abandons her five-year-old son and Ms. Oak takes him to live with her. Ms. Oak applies for WV WORKS and signs the DFA-WVW-10 indicating that she does not want to be included in the benefit. The case is approved only for her nephew beginning in February. In July, Ms. Oak loses her job because the business closed. She applies for WV WORKS for herself and her two children. Ms. Oak and her two children are added to the nephew's AG. Even though Ms. Oak signed the DFA-WVW-10 stating that she did not want to be included, she is required to be included when her own children receive benefits.

In September, the father of Ms. Oak's children takes the children out of state to live with him. The only child left in the home is Ms. Oak's nephew. She requests to be included in the benefit because she has no other income. Because she signed the DFA-WVW-10 in February, Ms. Oak cannot be included. The child, however, remains eligible.

Example 17: Ms. Hickory and her minor child apply and are found eligible for WV WORKS in June. In September, Ms. Hickory's minor nephew runs away from home and comes to live with her. Ms. Hickory requests he be added to the WV WORKS case and this is done effective October. In January, Ms. Hickory obtains employment and her salary makes her family ineligible for WV WORKS. However, she wants the benefit to continue for her nephew. At this point, Ms. Hickory must sign an DFA-WVW-10 to indicate whether or not she wants to be included in the payment as a non-parent caretaker relative. This choice is binding from January through December.

Example 18: Household consists of Mr. and Mrs. Maple, their two common children, and Mrs. Maple's child from a previous relationship. Both Mr. and Mrs. Maple were convicted of drug felonies in 2001. The AG includes only the children but both parents must complete a PRC/SSP, orientation, and a work activity.

Example 19: Household consists of two adults who would be included in the WV WORKS benefit and who have completed the Drug Use Questionnaire. One has been referred to testing and has come back with a positive drug test. This individual is enrolled and attending a substance abuse treatment and counseling program and job skills program and is included in the TANF benefit. If he refuses treatment or has another positive drug test, he is not included in the WV WORKS AG. Both individuals are required to complete orientation, a PRC/SSP, and be assigned to a work activity or are ineligible to be included in the WV WORKS benefit.

3.5 MEDICAID – GENERAL ELIGIBILITY

The Medicaid assistance group (AG) is composed of the individual(s) who meet(s) the eligibility requirements for coverage under a specific Medicaid coverage group. However, the income of the AG does not determine financial eligibility for all coverage groups. Some coverage groups require the determination of an income group (IG) to determine countable income and a needs group (NG) for comparison to the appropriate needs standard to determine financial eligibility. The case in which the AG member(s) receives coverage may be composed of eligible AG members of one or more coverage groups.

The AG, IG, and NG information for all of these groups is found in the following sections.

For more information regarding Medicaid eligibility groups, see Chapter 23.

3.6 CHILDREN UNDER AGE 19 MEDICAID

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The Children Under Age 19 coverage group combines coverage for children in the former Aid to Families with Dependent Children (AFDC) Medicaid, Qualified Child, and Poverty-Level Children coverage groups.

3.6.1 ASSISTANCE GROUP

Only the child under age 19 is included.

3.6.2 THE MODIFIED ADJUSTED GROSS INCOME (MAGI) HOUSEHOLD INCOME GROUP (IG) AND NEEDS GROUP (NG)

The methodology for determining the MAGI household's IG and NG is the same as found in Section 3.7.

NOTE: If the child is ineligible for this coverage group, he should be evaluated for West Virginia Children's Health Insurance Program (WVCHIP) eligibility. WVCHIP uses the same eligibility groups as those used for Children under Age 19, except that a pregnant woman is counted as herself, plus the number of unborn children she is expected to deliver. See Chapter 22.

3.7 ADULT GROUP

The Patient Protection and Affordable Care Act, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010, are together referred to as the Affordable Care Act (ACA). The ACA established the categorically mandatory coverage group known as the Adult Group. Effective January 1, 2014, Medicaid coverage is provided to individuals age 19 or older and under age 65 who are not otherwise eligible for and enrolled in another categorically mandatory Medicaid coverage group, and are not entitled to or enrolled in Medicare Part A or B. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

3.7.1 THE ASSISTANCE GROUP (AG)

3.7.1.A Who Must Be Included?

Adults age 19 or older and under age 65.

3.7.1.B Who Cannot Be Included?

- Individuals eligible for these categorically mandatory coverage groups:
  - Supplemental Security Income (SSI)
  - Deemed SSI
  - Parents/Caretakers
  - Pregnant Women
  - Children Under Age 19
  - Former West Virginia Foster Children
- Individuals entitled to or enrolled in Medicare Part A or B
- Parents or other caretaker relatives living with a dependent child under the age of 19, unless the child is also receiving benefits under Medicaid, WVCHIP, or other minimum essential coverage (MEC). See definition in Section 4.2.

If a woman indicates at application or review that she is pregnant, she is not eligible to be included in the Adult Group; she must be evaluated for the Pregnant Women coverage group.

3.7.2 THE MAGI HOUSEHOLD INCOME GROUP (IG)

Income of each member of the individual's MAGI household is counted. The income group is determined using the MAGI methodology established in Section 3.7.3.

EXCEPTION: Income of children, or other tax dependents, who are not expected to be required to file an income tax return is not counted, whether or not the individual actually files a tax return.

NOTE: A reasonable determination as to whether an individual will be required to file a tax return can be made based on the individual's current income for the applicable budget period. Such a determination would be based on information available at the time of application or renewal. Information regarding "Who Must File" a tax return can be found in Appendix G of Chapter 4.

3.7.2.A Examples of Applying the Income Rules for Children and Tax Dependents

Child's Income Excluded Example: A child is 17 years old with a part-time job in the summer and earns $2,100. He is expected to be claimed as a dependent on his parent's tax return. It is determined at application that the child is not expected to be required to file taxes the following year because his income does not exceed the filing requirements established by the IRS. Therefore, the child's income will not be included in the MAGI household or count toward eligibility whether he actually files taxes or not.

Child's Income Included Example: A child is 18 years old and works part time through the summer and after school. He earns $7,200 for the year. It is determined at application that he is expected to be claimed as a dependent on his parent's tax return and will be required to file an income tax return for the year in which Medicaid is being sought. Therefore, this child's income will be included to determine eligibility for any MAGI household for which he is a member.

Tax Dependent's Income Example 1: Blossom is 60 years old and lives with her 40-year-old daughter. Blossom will be claimed as a tax dependent on her daughter's taxes next year. Blossom receives $960 Social Security income per month; she has no other income. Because Blossom has no other income, her Social Security income is not taxable, and she is not required to file taxes. As her daughter's tax dependent, her income does not count toward her daughter's MAGI household.

> **Tax Dependent's Income Example 1.1:** Same situation as above. Blossom is also applying for health coverage. Her MAGI household will include only herself using non-filer MAGI household size rules below. Because Blossom is neither a child nor a tax dependent in her own MAGI household, her income will count toward determining her MAGI eligibility.

3.7.3 THE MAGI HOUSEHOLD NEEDS GROUP (NG)

The needs group is the number of individuals included in the MAGI household size based upon the MAGI rules for counting household members.

To determine the MAGI household size, the following step-by-step methodology is used for each applicant.

For purposes of applying the MAGI methodology:

- Child means natural, adopted, or stepchild;
- Parent means natural, adopted, or stepparent;
- Sibling means natural, adopted, half, or stepsibling.

In the case of married couples who reside together, each spouse must be included in the MAGI household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

The MAGI household of the pregnant woman also includes her unborn child(ren).

This methodology must be applied to each applicant in the MAGI household separately:

STEP 1: IS THE APPLICANT A TAX FILER (and will NOT be claimed as a tax dependent)?

IF NO: Move to **STEP 2**.

IF YES: The applicant's MAGI household includes themselves, each individual he expects to claim as a tax dependent, and his spouse if residing with the tax filer. This is known as the tax filer rule.

STEP 2: IS THE APPLICANT CLAIMED AS A TAX DEPENDENT ON SOMEONE ELSE'S TAXES?

IF NO: Move to **STEP 3**.

IF YES: Test against the three exceptions below. If the answer to any of these exceptions is 'yes', then the applicant's MAGI household size must be calculated using **STEP 3**.

1. The applicant is claimed as a dependent by someone other than a spouse or parent.
2. The applicant is a child under 19 who lives with both parents, but both parents do not expect to file taxes jointly.
3. The applicant is a child under 19 who is claimed as a tax dependent to a non-custodial parent(s).

NOTE: For the purpose of this exception, the custodial parent is established based on physical custody specified in a court order or binding separation, divorce, or custody agreement. If there is no such order or agreement or it is unavailable, or in the event of a shared custody agreement, the custodial parent is the one with whom the applicant spends most nights.

If none of these exceptions are true, then the applicant's Medicaid household consists of the applicant, the tax filer claiming him as a dependent, this could be two people filing jointly, any other dependents in the tax filer's household, and the applicant's spouse if they reside together. This is known as the tax dependent rule.

STEP 3: IF THE APPLICANT IS NOT A TAX FILER, IS NOT CLAIMED AS A TAX DEPENDENT OR MEETS ONE OF THE EXCEPTIONS IN **STEP 2**:

The Medicaid household consists of the applicant and the following individuals as long as they reside with the applicant:

- The applicant's spouse;
- The applicant's child(ren) under age 19;
- For applicants under 19, their parents, and their siblings who are also under 19.

This is known as the non-filer rule.

STEP 4: CASES WHERE APPLICANT CANNOT REASONABLY ESTABLISH TAX DEPENDENT STATUS

If an applicant/tax filer cannot reasonably establish that reported household members will be tax dependents of the applicant for the tax year in which Medicaid is sought, the inclusion of such individual in the MAGI household of the tax filer is determined using rules in **STEP 3**.

Uncertain Tax Status Example: An applicant indicates she is currently separated and seeking a divorce. The living arrangements of the children are to be determined by family court. She is uncertain if the children will remain in her household for the tax year, or whether she will be able to claim them as tax dependents on next year's tax return. Because the tax dependency status of the children cannot be reasonably established on the date of application, inclusion of the children in the applicant's MAGI household is determined using **STEP 3.**

3.7.3.A MAGI HOUSEHOLD SIZE EXAMPLES

Example 1: Moss and Fern are married with two children, Cedar, age 7, and Violet, age 5. Moss and Fern file taxes jointly and claim both children as dependents.

Moss is a tax filer. Using STEP 1, his household includes himself, each of his tax dependents and his spouse – Moss, Fern, Cedar and Violet = Four.

Fern is a joint tax filer. Using STEP 1, her household includes herself, each of her tax dependents and her spouse – Moss, Fern, Cedar and Violet = Four.

Cedar is a tax dependent. Using STEP 2, he does not meet any of the exceptions. James' household includes himself, the tax filers and other tax dependents – Moss, Fern, Cedar and Violet = Four.

Violet is a tax dependent. Using STEP 2, she does not meet any of the exceptions; therefore, her household includes herself, her tax filers, and other tax dependents in the household – Moss, Fern, Cedar and Violet = Four.

Example 2: Oak and Ivy are not married, but have one child together, Acorn, age 9 months. Oak is a tax filer and claims Acorn as his dependent. Ivy is also a tax filer.

Oak is a tax filer. Using STEP 1, his household includes himself and his tax dependent Acorn – Oak and Acorn = Two.

Ivy is a tax filer. Using STEP 1, her household includes herself only – Ivy = One.

Acorn is a tax dependent. Using STEP 2, Acorn meets exception number 2; therefore, her household is determined using STEP 3. Acorn's household includes herself and her parents – Acorn, Oak and Ivy = Three.

Example 3: Elm is a tax filer and claims his 10-year-old son, Birch, as a tax dependent. Elm is the non-custodial parent as Birch lives with his mother.

Elm is a tax filer. Using STEP 1, his household includes himself and his tax dependent Birch – Elm and Birch = Two.

Birch is a tax dependent. Using STEP 2, he meets exception 3; therefore, his household is determined using STEP 3. Birch's household includes himself, the parent, and any siblings with whom he resides. Birch's Medicaid household cannot be determined based on an application submitted by Elm. The parent with whom Birch resides must submit an application on his behalf.

Example 3.1: Holly is a tax filer who lives with her 10-year-old son, Birch. Birch is claimed as a tax dependent by Elm from the example above, his non-custodial parent.

Holly is a tax filer. Using STEP 1, her household includes herself only – Holly = One.

Birch is a tax dependent. Using STEP 2, he meets exception 3; therefore, his household includes himself and his custodial parent Holly – Birch and Holly = Two.

Example 4: Heather is a tax filer and claims her daughter Rose, age 16, and her mother Lily, age 76, as tax dependents. Neither Rose nor Lily is a tax filer.

Heather is a tax filer. Using STEP 1, her household includes herself and her tax dependents Rose and Lily – Heather, Rose, and Lily = Three.

Rose is a tax dependent. Using STEP 2, she does not meet any exceptions; therefore, her household includes herself, Heather, the tax filer claiming her, and Lily the other tax dependent – Rose, Heather, and Lily = Three.

Lily is a tax dependent. Using STEP 2, she meets exception 1; therefore, her household is determined using STEP 3. Lily's household includes herself = one.

Example 5: Daisy is a tax filer and claims her daughter Willow, age 20, and Willow's daughter Poppy, age 1, as tax dependents. Neither Willow nor Poppy is a tax filer.

Daisy is a tax filer. Using STEP 1, her household includes herself and her tax dependents Willow and Poppy – Daisy, Willow, and Poppy = Three.

Willow is a tax dependent. Using STEP 2, she does not meet any exceptions; therefore, her household includes herself; Daisy, the tax filer claiming her; and Poppy, the other tax dependent – Daisy, Willow, and Poppy = Three.

Poppy is a tax dependent. Using STEP 2, she meets exception 1; therefore, her household is determined using STEP 3. Poppy's household includes herself and her mother Willow – Willow and Poppy = Two.

Example 6: Cosmo is a tax filer and claims her 12-year-old grandson, Aspen, as a tax dependent.

Cosmo is a tax filer. Using STEP 1, her household includes herself and her tax dependent Michael – Cosmo and Aspen = Two.

Aspen is a tax dependent. Using STEP 2, he meets exception 1; therefore, his household is determined using STEP 3. Aspen's household includes only himself = One.

Example 7: Jade and Juniper are married and file taxes jointly. Juniper is pregnant.

Jade is a tax filer. Using STEP 1, his household includes himself and his spouse – Jade and Juniper = Two.

Juniper is a tax filer. Using STEP 1, her household includes herself and her spouse Jade. Because Juniper is pregnant her Medicaid household also includes the unborn child – Jade, Juniper, and unborn child = Three.

Example 8: Iris and Crocus are married and have an adopted child named Dahlia. Iris and Crocus file taxes jointly and they both claim Dahlia as a tax dependent.

Iris is a tax filer. Using STEP 1, her household includes herself, each of her tax dependents and her spouse – Iris, Crocus, and Dahlia = Three.

Crocus is a joint tax filer. Using STEP 1, her household includes herself, each of her tax dependents and her spouse – Iris, Crocus, and Dahlia = Three.

Dahlia is a tax dependent. Using STEP 2, she does not meet any of the exceptions. Dahlia's household includes herself and the tax filers claiming her – Iris, Crocus, and Dahlia = Three.

Dahlia lives in the home with both of her parents and is claimed by them. Her AG would be Dahlia, Iris, and Crocus = Three.

Example 9: Rosemary and Sage are married but are on Social Security and do not file taxes. Rosemary's biological grandchildren, Parsley and Basil, live with them as Rosemary has custody of them. Parsley and Basil are first cousins; neither is claimed as a tax dependent by anyone.

Rosemary is a non-tax filer. Using STEP 3, her household includes herself and her spouse – Rosemary and Sage = Two.

Sage is a non-tax filer. Using STEP 3, her household includes herself and her spouse – Sage and Rosemary = Two.

Parsley is neither a tax filer nor a tax dependent. Using STEP 3, her household includes herself only – Parsley = One.

Basil is neither a tax filer nor a tax dependent. Using STEP 3, her household includes herself only – Basil = One.

Example 10: Pine and Fir are married and file taxes jointly. They have one adopted child, Ficus; Pine has a daughter named Orchid; Fir has a daughter name Lavender. All the children live with Pine and Fir and are claimed as their tax dependents.

Pine is a tax filer. Using STEP 1, his household includes himself, each of his tax dependents, and his spouse – Pine, Fir, Ficus, Orchid, and Lavender = Five.

Fir is a joint tax filer. Using STEP 1, his household includes himself, each of his tax dependents, and his spouse – Fir, Pine, Ficus, Orchid, and Lavender = Five.

Ficus is a tax dependent. Using STEP 2, he does not meet any exceptions; therefore, his household includes himself, his tax filers, and other tax dependents in the household – Ficus, Pine, Fir, Orchid, and Lavender = Five.

Orchid is a tax dependent. Using STEP 2, she does not meet any exceptions; therefore, her household includes herself, her tax filers, and other tax dependents in the household – Orchid, Pine, Fir, Ficus, and Lavender = Five.

Lavender is a tax dependent. Using STEP 2, she does not meet any exceptions; therefore, her household includes herself, her tax filers, and other tax dependents in the household – Lavender, Pine, Fir, Ficus, and Orchid = Five.

3.8 PREGNANT WOMEN

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The Pregnant Women coverage group combines former Poverty-Level and Deemed Poverty-Level Pregnant Woman coverage groups.

3.8.1 THE ASSISTANCE GROUP (AG)

Only the pregnant woman is included. The unborn child(ren) is not included.

3.8.2 THE MAGI HOUSEHOLD INCOME GROUP (IG) AND NEEDS GROUP (NG)

The methodology for determining the MAGI household's IG and NG is the same as found in Section 3.7.

The Medicaid IG and NG of the pregnant woman include her unborn child(ren).

3.9 CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN)

3.9.1 THE ASSISTANCE GROUP (AG)

The CEN is the only person who is included.

3.9.2 THE INCOME GROUP (IG)

No income determination is required.

3.9.3 THE NEEDS GROUP (NG)

No need determination is required.

3.10 PARENTS/CARETAKER RELATIVES GROUP

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The Parents/Caretaker Relatives coverage group replaces the former Aid to Families with Dependent Children (AFDC) Medicaid coverage group for parents and other caretaker relatives.

The ACA established a new methodology based on the Internal Revenue Service (IRS) 36B tax rules for determining how income is counted and how household composition and size are determined when establishing financial eligibility, called Modified Adjust Gross Income (MAGI).

To be eligible under this category, the parent or caretaker relative must be living in the household with a dependent child for whom they assume primary responsibility. See Section 3.3 for the definition of a dependent child and specified caretaker relative.

3.10.1 THE ASSISTANCE GROUP (AG)

Only the parent or caretaker relative, and if living with such parent or other caretaker relative, his or her spouse.

3.10.2 THE MAGI HOUSEHOLD INCOME GROUP (IG) AND NEEDS GROUP (NG)

The methodology for determining the Medicaid household's IG and NG is the same as found in Section 3.7.

3.11 DEEMED PARENTS/CARETAKER RELATIVES

3.11.1 EXTENDED MEDICAID

Extended Medicaid clients become eligible based on losing financial eligibility for Parents/Caretaker Relatives Medicaid.

3.11.1.A The Assistance Group (AG)

All individuals, who are members of the Parents/Caretaker Relatives Medicaid AG when the case becomes ineligible, must be included in the AG. When an individual, who would normally be required to be in the AG, returns to the home, the returning individual is added to the Extended Medicaid AG.

3.11.1.B The Income Group (IG)

No other financial test is required.

3.11.1.C The Needs Group (NG)

No needs test is applied.

3.11.2 CHILDREN COVERED UNDER ADOPTION ASSISTANCE

These cases are managed by the Bureau for Children and Families (BCF) Office of Children and Adult Services. When the child also receives Supplemental Security Income (SSI), see Chapter 23.

3.11.3 CHILDREN COVERED UNDER FOSTER CARE

These cases are managed by the BCF Office of Children and Adult Services. When the foster child also receives SSI, see Chapter 23.

3.12 TRANSITIONAL MEDICAID (TM), PHASES I AND II

This coverage group consists of families who lose eligibility for Parents/Caretaker Relatives Medicaid because of earned income. Transitional Medicaid (TM) provides continuing medical coverage and has two phases.

3.12.1 THE ASSISTANCE GROUP (AG)

3.12.1.A Who Must Be Included?

The following persons must be included in the AG:

- All individuals, regardless of WV WORKS receipt, who meet the requirement for TM Phase I or II. See Chapter 23.
- An individual who joins the household during either TM Phase I or II, who is otherwise Parents/Caretaker Relatives Medicaid eligible.

3.12.1.B Who Cannot Be Included?

The following persons cannot be included:

- Supplemental Security Income (SSI) Recipients
- Individuals who are otherwise ineligible for Parents/Caretaker Relatives Medicaid. See Section 3.10.

3.12.2 THE INCOME GROUP (IG)

There is no income test for TM Phase I.

For TM Phase II, the non-excluded income of the AG and sanctioned individuals is used when determining ineligibility for Parents/Caretaker Relatives Medicaid and, therefore, eligibility for TM. The income of the same individuals is used to determine if income exceeds 185% of the Federal Poverty Level (FPL).

3.12.3 THE NEEDS GROUP (NG)

There is no income test for TM Phase I.

For TM Phase II, countable income is compared to the income limit for the number in the AG to determine eligibility.

3.13 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

3.13.1 THE ASSISTANCE GROUP (AG)

Only the Supplemental Security Income (SSI) recipient, or an individual who is otherwise entitled to SSI, is included in the AG. This includes an individual who is otherwise entitled to an SSI payment, but does not receive it due to a repayment.

When the SSI recipient has an essential spouse, see Section 23.11.2.C.

For SSI recipients who are children in foster care, or whose adoptive parents receive adoption assistance, see Section 23.10.8.B.

3.13.2 THE INCOME GROUP (IG)

The Social Security Administration (SSA) determines the income and assets that are counted for SSI. No additional income or asset test is made for Medicaid. For SSI recipients who apply for Long Term Care, see Section 24.4.1.B.3.

3.13.3 THE NEEDS GROUP (NG)

The SSA makes the determination of need for SSI. Receipt of or entitlement to SSI is the only eligibility factor.

3.14 DEEMED SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

3.14.1 PICKLE AMENDMENT COVERAGE (PAC)

3.14.1.A The Assistance Group (AG)

Only the PAC individual is included in the assistance group.

3.14.1.B The Income Group (IG)

3.14.1.B.1 Individual with No Spouse

Count only the individual's income.

3.14.1.B.2 Eligible Spouses

Count the income of both individuals.

3.14.1.B.3 Eligible Individual with Ineligible Spouse

Consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4 for how to determine if the spouse's income is deemed.

3.14.1.B.4 Eligible Individual in a Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) with Eligible/Ineligible Spouse

Count only the individual's income. This applies when the spouse is in the community, in a nursing facility, or in an ICF/IID.

3.14.1.C The Needs Group (NG)

3.14.1.C.1 Individual with No Spouse

The income limit for a single individual is used.

3.14.1.C.2 Eligible Spouses

The income limit for two persons is used.

3.14.1.C.3 Eligible Individual with Ineligible Spouse, No Income Deemed

The income limit for a single individual is used.

3.14.1.C.4 Eligible Individual with Ineligible Spouse, Income Deemed

The income limit for two persons is used.

3.14.1.C.5 Eligible Individual in a Nursing Facility or an ICF/IID with an Eligible/Ineligible Spouse

The income limit for a single individual is used. This applies when the spouse is in the community, in a nursing facility, or in an ICF/IID.

3.14.2 ALL OTHERS

See Chapter 23 for a description of Deemed Supplemental Security Income (SSI) Recipients.

3.14.2.A The AG

Only the Deemed SSI Recipient is included in the AG.

3.14.2.B The IG

The Social Security Administration (SSA) determines income eligibility for these groups.

3.14.2.C The NG

No income test is required.

3.15 QMB, SLIMB, AND QI-1

3.15.1 THE ASSISTANCE GROUP (AG)

When eligible spouses are both members of the AG, they must receive the same level of coverage, QMB, SLIMB, or QI-1.

3.15.1.A Who Must Be Included?

Only the individual or spouses who are eligible for QMB, SLIMB, or QI-1 are included in the AG.

3.15.2 THE INCOME GROUP (IG)

3.15.2.A Eligible Individual with No Spouse

Count only the individual's income.

3.15.2.B Eligible Spouses – No Medicaid Long Term Care (LTC) Services

Count the income of both individuals.

3.15.2.C Eligible Individual with Ineligible Spouse – No Medicaid LTC Services

Consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4 for how to determine if the spouse's income is deemed.

3.15.2.D Eligible Individual – One or Both Spouses Receive Medicaid LTC Services in a Nursing Facility, ICF/IID, or Home and Community-Based Waiver

Count only the individual's income.

3.15.3 THE NEEDS GROUP (NG)

3.15.3.A Individual with No Spouse

The income limit for a single individual is used.

3.15.3.B Eligible Spouses – No Medicaid LTC Services

The income limit for two persons is used.

3.15.3.C Eligible Individual with Ineligible Spouse, No Income Deemed – No Medicaid LTC Services

The income limit for a single individual is used.

3.15.3.D Eligible Individual with Ineligible Spouse, Income Is Deemed – No Medicaid LTC Services

The income limit for two persons is used.

3.15.3.E Eligible Individual – One or Both Spouses Receive Medicaid LTC Services in a Nursing Facility, ICF/IID, or Non-Institutional Home and Community-Based Waiver

The income limit for a single individual is used.

	Receive Medicaid LTC?	Income Group – Income Counted	Needs Group – Income Limit
Eligible Individual	No	Individual	Single individual
Eligible Spouses	No	Both spouses	Two persons
Individual with Ineligible Spouse	No	Individual and spouse, if income is deemable	• Individual is spousal income is not deemed • Both spouses if income is deemed
Eligible Individual - LTC	Yes, individual or spouse	Individual	Single individual

3.16 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

3.16.1 THE ASSISTANCE GROUP (AG)

Only the individual who is eligible for the QDWI coverage is included in the AG.

3.16.2 THE INCOME GROUP (IG)

3.16.2.A Eligible Individual with No Spouse

Count only the individual's income.

3.16.2.B Eligible Spouses

Count the income of both individuals.

3.16.2.C Eligible Individual with Ineligible Spouse

Consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4 for how to determine if the spouse's income is deemed.

3.16.3 THE NEEDS GROUP (NG)

3.16.3.A Individual with No Spouse

The income limit for a single individual is used.

3.16.3.B Eligible Spouses

The income limit for two persons is used.

3.16.3.C Eligible Individual with Ineligible Spouse, No Income Deemed

The income limit for a single individual is used.

3.16.3.D Eligible Individual with Ineligible Spouse, Income Deemed

The income limit for two persons is used.

3.17 SSI-RELATED MEDICAID AND SSI-RELATED/NON-CASH ASSISTANCE

NOTE: The income limits for SSI-Related Medicaid and SSI-Related/Non-Cash Assistance are different. See Chapter 4.

3.17.1 THE ASSISTANCE GROUP (AG)

3.17.1.A Who Must Be Included?

Only the aged, blind, or disabled individual and his eligible aged, blind, or disabled spouse must be included, except when the spouse resides in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

3.17.1.B Who Cannot Be Included?

- SSI Recipients
- The aged, blind, or disabled spouse of a nursing facility or ICF/IID resident cannot be included with the nursing facility or ICF/IID resident and vice versa. The spouse may be in a separate AG.

3.17.2 THE INCOME GROUP (IG)

3.17.2.A Adults

3.17.2.A.1 Individuals with No Spouse

Count only the individual's income.

3.17.2.A.2 Eligible Spouses – No Medicaid Long Term Care (LTC) Services

Count the income of both individuals.

3.17.2.A.3 Eligible Individual with Ineligible Spouse – No Medicaid LTC Services

Consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4 for how to determine if the spouse's income is deemed.

3.17.2.A.4 Eligible Individual – One or Both Spouses Receives Medicaid LTC Services in a Nursing Facility, ICF/IID, or a Home and Community-Based Waiver

Count only the individual's income.

3.17.2.B Child

Count the income of the child and any income deemed from a parent(s). See Chapter 4 for deeming information.

3.17.3 THE NEEDS GROUP (NG)

3.17.3.A Adult

3.17.3.A.1 Individual with No Spouse

The income limit for a single individual is used.

3.17.3.A.2 Eligible Spouses – No Medicaid LTC Services

The income limit for two persons is used.

3.17.3.A.3 Eligible Individual with Ineligible Spouse, No Income Deemed – No Medicaid LTC Services

The income limit for a single individual is used.

3.17.3.A.4 Eligible Individual with Ineligible Spouse, Income Deemed – No Medicaid LTC Services

The income limit for two persons is used.

3.17.3.A.5 Eligible Individual – One or Both Spouses Receives Medicaid LTC Services in a Nursing Facility, ICF/IID, or a Home and Community-Based Waiver

The income limit for a single individual is used.

3.17.3.B Child

The income limit for a single individual is used.

3.18 AFDC-RELATED MEDICAID

Eligibility must be determined for each individual separately. Income and asset eligibility is determined based on the circumstances of the income group (IG) and needs group (NG).

When an individual, not related as a parent, a dependent minor child, or a minor sibling to a member of an AFDC-Related Medicaid assistance group (AG), lives in the household and applies for Medicaid, eligibility is determined separately.

NOTE: Supplemental Security Income (SSI) recipients, whether they are adults or children, are not included in the AG, IG, or NG.

3.18.1 THE ASSISTANCE GROUP (AG)

The process of determining who must be included in the AG begins with the dependent child for whom AFDC-Related Medicaid is sought.

The AFDC-Related Medicaid AG is composed of otherwise eligible dependent children and their parents or another specified relative. Otherwise eligible, for the purpose of this Section only, means the dependent child lives with a specified relative. See Section 3.3 for the definition of dependent child and for the definition of a specified relative.

If any member of the AG is a striker, no member of the AG is eligible for AFDC-Related Medicaid. Eligibility under other coverage groups must be explored.

Those individuals who are required to be included, or who choose to be included to receive AFDC-Related Medicaid, will be in an AG. However, they are not all in the same AG. The following rules apply.

3.18.1.A Parent(s)

Otherwise eligible married parents who live together are in the same AG. However, unmarried, otherwise eligible parents must be in separate AGs. This is necessary to prevent illegal deeming from one unmarried parent to another.

MAJOR PARENT (MP)

The parent of a parent under the age of 18 (minor parent [mp]). The major parent must live in the same household as the mp and his child.

MINOR PARENT (MP)

A parent under the age of 18, regardless of completion of school or training.

3.18.1.B Child, Including the Minor Parent (mp) Who Is a Dependent Child

Each otherwise eligible child is in a separate AG to prevent illegal deeming of one child's income to another.

An mp is a parent under the age of 18, regardless of completion of school or training.

An mp is treated as a dependent child in the AG when:

NOTE: The mp who lives with a spouse cannot be considered a dependent child.

NOTE: When the mp is a dependent child, he must be included in the AG with his dependent blood-related siblings who are otherwise eligible.

- An application is made by a specified relative who has care and control of both the mp and her child.
- An application is made for the mp only by a specified relative who has care and control of the mp.

3.18.1.C Minor Parent (mp) Who Is a Caretaker

The mp is treated as the caretaker anytime he has care and control of his own child. Care and control is defined as providing or making provision for the day-to-day supervision of the child.

The mp and the MP's spouse, who is also the parent of the MP's child, are in the same AG.

The unmarried mp is in a separate AG, even when the child's other parent is in the home. This is necessary to prevent illegal deeming from one unmarried parent to another.

3.18.1.C.1 Minor Parent (mp) Caretaker Examples

> **Example 1:** When the mp and the legal father of the child live together, it is assumed that they are the caretakers of their child.
>
> **Example 2:** When the mp has more than one child and all of the children do not have the same father, the mp is assumed to be the caretaker of all the children, as long as the legal father of one child lives in the home.
>
> **Example 3:** When the mp lives with a spouse who is not the legal father of the child, or any of the children, it is not assumed that the mp is the caretaker of the child.

3.18.1.D Non-Parent Caretaker Who Chooses to Be Included

The non-parent caretaker is in a separate AG. Only one non-parent caretaker may be included.

NOTE: A caretaker relative who is not a natural or adoptive parent cannot be included in the AG when a parent lives in the home.

The caretaker relative, who is otherwise eligible, may choose to be included in the AG when the only dependent child(ren) in the home receives federal, state, or local foster care, adoption assistance payments or Supplemental Security Income (SSI). The needs and income of the child(ren) are not considered when determining the amount of the benefit. The relative is treated like a parent, except he may choose to be excluded at any time.

There are no restrictions on the number of times the individual may choose to be included or excluded.

When an individual in the home, other than the mp, has care and control of the MP's child and applies for AFDC-Related Medicaid for the child, the mp who lives in the home must be included in the AG because he is the parent of the child, not because he is the specified relative. In this situation, the mp is considered to be the non-caretaker parent. The individual who has care and control of the MP's child is the non-parent caretaker of the child.

3.18.1.E Who Cannot Be Included?

The following situations result in ineligibility for the individual who meets at least one of the following criteria. However, when all members of the AG meet any of the criteria listed below the entire case is ineligible. In addition, when all otherwise-eligible children meet any of the criteria listed below, except receipt of SSI, foster care or adoption assistance, the entire case is ineligible.

- Parents and siblings who are SSI recipients. The specified relative may receive AFDC-Related Medicaid when there are no children in the AG, if the children are ineligible for AFDC-Related Medicaid only because they are SSI recipients.
- Parents and siblings who are noncitizens and are ineligible because they have been sponsored by a private or public agency or organization or because of deeming income from sponsor to noncitizen.
- Parents and siblings who are noncitizens and are ineligible because they do not meet the citizenship.
- A child who is a recipient of federal, state or local foster care maintenance payments.
- A child of a minor parent, when the minor parent is a recipient of federal foster care payments.
- A child who is a recipient of federal, state or local adoption assistance, unless the exclusion of the child reduces the amount of payment the AG would have received.

When the child is included in the AG, any portion of the adoption assistance which meets any of the following criteria is excluded:

- The adoption assistance is for a different purpose than the AFDC/U check would have been, i.e., vocational rehabilitation; or
- The adoption assistance is for goods or services not included in the State's Standard of Need, i.e., money for special training or for medical care not provided for recipients of AFDC-Related Medicaid; or
- The adoption assistance makes up the difference between the State's payment standard and the Standard of Need.

NOTE: Any portion of the adoption assistance which is excluded, using the above criteria, is also excluded prior to determining if the AFDC/U benefit would have been reduced if the needs of the adopted child are included.

NOTE: West Virginia's adoption assistance payments do not meet the above criteria.

To determine whether to exclude the adopted child, complete the following steps:

Step 1: Determine the amount of the benefit, excluding the needs of the adopted child.

Step 2: Determine the amount of the benefit, including the needs and non-excluded income of the adopted child.

If the amount in Step 2 is less than the amount in Step 1, the adopted child must be excluded from the AG.

If the amount in Step 2 is greater than the amount in Step 1, the adopted child must be included in the benefit group.

> **Example 1:** Mr. and Mrs. Tulip are eligible for $360 from the former AFDC Program for themselves and their three children. They adopt Sam and he receives $200 non-excluded adoption assistance.
>
> Step 1: $360-AFDC AG of five, excluding Sam
>
> Step 2: Sam's $200 non-excluded adoption assistance reduces the amount of AFDC a six-person AG would receive from $413 to $213.
>
> Because $213 is less than $360, and the benefit is reduced, Sam must be excluded from the AG.
>
> **Example 1.1:** Same as the preceding example, except Sam receives non-excluded adoption assistance of $50.
>
> Step 1: $360 AFDC AG for five, excluding Sam
>
> Step 2: Sam's $50 non-excluded adoption assistance reduces the AFDC six-person AG payment of $413 to $363.
>
> Because $363 is greater than $360, and the benefit is not reduced, Sam is included in the AG.

- Individuals who are ineligible due to failure to fulfill an eligibility requirement. This includes the following individuals:

- The specified relative who fails to cooperate with BCSE medical support requirements without good cause, or who, after assigning rights, fails to cooperate without good cause.
- The individual who fails to meet the enumeration requirement.
- The caretaker relative, who is not a parent of the dependent child and who fails, without good cause, to apply for and accept a potential resource for which he may be eligible.

- Parents and siblings who are ineligible due to receipt of a lump sum

3.18.2 THE INCOME GROUP (IG)

The income counted depends on the AG member. Each member listed shows the income which is counted to determine his eligibility. Only the income of individuals, including non-qualified noncitizens, who live in the home with the AG member is counted.

3.18.2.A Parent(s)

Count the income of:

- The parent(s); and,
- The legal spouse of the parent.

See Chapter 4 for deeming instructions.

3.18.2.B Child, Including the Minor Parent (mp) Who Is a Dependent Child

Count the income of:

- The child; and,
- The parent(s) of the child.

NOTE: The income of a child is never counted for a parent or a sibling.

3.18.2.C Minor Parent (mp) Who Is a Caretaker

Count the income of:

- The mp; and,
- The MPs.

See Chapter 4 for deeming instructions.

3.18.2.D Non-Parent Caretaker Who Chooses to Be Included

Count the income of:

- The non-parent caretaker; and
- The spouse of the non-parent caretaker.

See Chapter 4 for deeming instructions.

3.18.3 THE NEEDS GROUP (NG)

Countable income and assets of the income group are compared to the limit for the number of persons in the NG to determine financial eligibility. The Needs Group is not used to determine whose income to count or whose medical expenses to use to meet the spenddown. See Section 3.18.2 and Chapter 4. The number of persons included in the Needs Group depends on the AG member. Only individuals who reside with the AG member(s) are counted.

NOTE: Recipients of SSI, whether they are adults or children, are not included in the Needs Group.

3.18.3.A Parent(s)

The NG of the parent includes:

- The parent(s);

- The spouse of the parent described above, even when the spouse is not a parent of the children;
- All dependent children of the parent(s), the parent's spouse, and all of the blood-related siblings of the dependent children living in the home; and,
- When the parent is an mp living with his MP, the mp is also included in the NG.

3.18.3.B Child(ren)

The NG of the child includes:

- The dependent child;
- The natural or adoptive parent(s) of the dependent child;
- The blood-related siblings of the dependent child;
- The natural or adoptive parent(s) of the mp; and,
- The following individuals, when a non-parent caretaker of the eligible child is included in the AG:
    - The included non-parent caretaker;
    - The spouse of the included non-parent caretaker; and,
    - All dependent children of the included non-parent caretaker, the non-parent caretaker's spouse, and all of the blood-related siblings of these children who live in the home.

3.18.3.C Non-Parent Caretaker Who Chooses to Be Included

The NG of the non-parent caretaker consists of:

- The non-parent caretaker;
- The spouse of the non-parent caretaker;
- All dependent children of the non-parent caretaker, the non-parent caretaker's spouse, and all of their blood-related siblings who live in the home; and,
- The child(ren) upon whom the non-parent caretaker's eligibility is based.

3.18.3.D A Minor Parent (mp) Living with a Major Parent (MP)

Cases involving an mp require special consideration because there are two parental groups in the family. The first parental unit is the MP(s), and the second is the mp. Any of the following combinations of eligible people are possible:

- mp + MP's child
- MP + mp (Dependent Child) + MP's child
- MP + mp (Caretaker Parent) + MP's child
- MP + mp (Dependent Child)

3.18.3.D.1 AG Includes the mp and the Child

➢ *The MP's NG*

The MP's NG is composed of:

- The MP(s);
- The mp; and
- The MP's child(ren) who live with him.

➢ *The Child's NG*

The Child's NG is composed of:

- The mp;
- The child; and
- The child's blood-related siblings who live with him.

3.18.3.D.2 AG Includes the MP(s), the mp (Dependent Child) and the MP's Child

➢ The MP's NG

The MP's NG composition is determined as found above in Section 3.18.3.A Parents. The mp is included in the MP's NG.

➢ The MP's NG

The MP's NG is composed of:

- The MP(s);
- The mp;
- The MP's blood-related sibling(s) who live with him; and
- The MP's child(ren) who live with him.

➢ The Child's NG

The child's NG is composed of:

- The mp; and
- The child and the child's blood-related siblings who live with him.

3.18.3.D.3 AG Includes the MP(s), the mp (Caretaker) and the MP's Child

➢ The MP(s) NG

The MP(s) NG composition is determined as found above in Section 3.18.3.A Parents, except the mp is not included in the NG.

➢ The MP's NG

The MP's NG is composed of:

- The MP(s);

- The mp; and
- The MP's child.

➢ *The Child's NG*

The child's NG is composed of:

- The mp;
- The child; and
- The child's blood-related siblings who live with him.

3.18.3.D.4 AG Includes the MP(s) and the mp (Dependent Child)

➢ *The MP's NG*

The MP's NG composition is determined as found above in Section 3.18.3.A Parents. The mp is included in the NG.

➢ *The MP's NG*

The MP's NG is composed of:

- The MP(s);
- The mp;
- The blood-related sibling(s) of the mp who live in the home; and
- The MP's child.

NOTE: When the mp is included in the AG only because he must be included as the parent of his child, i.e., another specified relative in the home applies for and has care and control of the mp's child, the mp is treated as an adult in the NG.

3.19 FORMER WEST VIRGINIA FOSTER CHILDREN

The Affordable Care Act (ACA) established the categorically mandatory coverage group called "Former Foster Children" group.

3.19.1 THE ASSISTANCE GROUP (AG)

3.19.1.A Who Must Be Included?

Only a former West Virginia foster child—who was the responsibility of the State and receiving Medicaid on the date he turned 18 years of age, or the date he "aged" out of foster care, up to age 21—is included.

3.19.1.B Who Cannot Be Included?

- Individuals 26 years of age or older.
- Individuals eligible for the following coverage groups:
  - Supplemental Security Income (SSI)
  - Deemed SSI
  - Parents/Caretaker Relatives
  - Pregnant Women
  - Children Under Age 19

NOTE: Individuals eligible for both the Former West Virginia Foster Children group and the Adult group must be enrolled in the Former West Virginia Foster Children group.

3.19.2 THE INCOME GROUP (IG) AND THE NEEDS GROUP (NG)

No financial test is required.

3.20 NON-QUALIFIED NONCITIZENS – EMERGENCY MEDICAID COVERAGE

3.20.1 THE ASSISTANCE GROUP (AG)

Only the non-qualified noncitizen is included in the AG.

3.20.2 THE INCOME GROUP (IG)

The income group is the same as the Medicaid coverage group for which the noncitizen would otherwise be eligible were it not for his immigration status. See the IG and needs group (NG) information in this chapter for the appropriate coverage group.

3.20.3 THE NEEDS GROUP (NG)

The income group is the same as the Medicaid coverage group for which the noncitizen is applying. See the IG/NG information in this chapter for the appropriate coverage group.

3.21 AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The AIDS Drug Assistance Program (ADAP) is not a Medicaid program. ADAP is a different federal program that provides a limited pharmaceutical benefit for clients with HIV/AIDS. These cases are not entered in any data system. The Bureau for Medical Services (BMS) is responsible for providing covered services to these clients.

3.21.1 THE ASSISTANCE GROUP (AG)

Only the individual who meets the eligibility criteria is included in the AG.

3.21.2 THE INCOME GROUP (IG)

The total gross income of the following individuals is used to determine eligibility for the ADAP:

- The ADAP individual;
- The spouse of the ADAP individual; and,
- The natural or adoptive child(ren) of the ADAP individual.

3.21.3 THE NEEDS GROUP (NG)

The total gross income for the number of persons in the IG is compared to 325% of the Federal Poverty Level (FPL) by the BMS to determine financial eligibility.

Chapter 4 – Appendices

Income

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
App A	1/1/18	750		Updated with the maximum SMS and SSI amounts
	3/1/18	754		To update the Federal Poverty Amounts Effective 03-01-18
	5/1/18	755		WV WORKS payment increased by 10%
	6/16/18	759		Changed title of column from “E or D Gross” to “Cat EI Gross.”
	7/1/18	761		Added income limits for the Indigent Burial Program & Updated the minimum SMS and FMA numbers
	10/1/18	765		Update the income limits to the new FPL for FY2019 and to update the utility multipliers to reflect the costs of the utilities.
	1/1/19	768		Updated with the maximum SMS and SSI amounts
	3/1/19	769		Update 2019 increase in income guidelines
	10/1/19	777		Updated SNAP and LIEAP income limits
	1/1/20	780		Updated SMS and SSI amounts

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	3/1/20	783		Updated 2020 income guidelines
	10/1/20	793		Updated income SNAP guidelines
	1/1/21	799		Updated SMS and SSI amounts
	3/1/21	801		Updated guidelines for Burial
	3/1/21	802		Updated 2021 income guidelines
	7/1/21	806		Updated the minimum SMS and maximum FMA numbers
	10/1/21	809		Updated income limits and Maximum allotments for SNAP mass change
	1/1/22	813		Updated new SSI amounts
	3/1/22	817		Updated income guidelines
	3/1/22	818		Updated Burials Amounts
	4/1/22	820		Updated EA amounts
	7/1/22	824		Updated Nursing home
	10/1/22	828		Updated income limits
	1/1/23	830		Updated new SSI amounts
	3/1/23	832		Updated income limits & Burial Amounts
	10/1/23	841		Updated income limits for SNAP
	11/1/23	842		Updated income limits for LIEAP
	12/1/23	844		Corrected/updated the LIEAP 60% SMI limits.
	1/1/24	845		Updated new SSI amounts
	2/1/24	846		Updated minimum SMS and maximum FMA amounts
	3/1/24	848		Updated to reflect the 2024 change in the income guidelines. Indigent Burial Program updated with 2024 133% FPL income limits.
	7/1/24	852		Updated the minimum SMS and maximum FMA amounts.
	10/1/24	855		Updated Maximum Benefit Allotment and SNAP Gross Test amounts due to Snap mass change.
	11/1/24	856		Updated income limits for LIEAP
	1/1/25	859		Updated maximum spousal maintenance standard and SSI amounts.
	3/1/25	861		Updated to reflect the 2025 change in the income guidelines.
	7/1/25	866		Update SMS / FMA amounts.
	7/1/25	868		Correction to Maximum FMA/each. The correct amount

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				is $882.
	10/1/25	869		Updated income limits due to SNAP Mass change.
	11/1/25	870		New income limits for LIEAP and remove the 60% SMI
	1/1/26	872		Updated new SSI amounts.
	3/1/26	874		Updated to reflect the 2026 change in income guidelines. Indigent Burial Program updated with 2026 133% FPL income limits.
App B	10/1/18	765		Update standard deductions and allowances for SNAP
	4/1/19	770		Increased Standard Shelter Allowance (Homeless AGs Only)
	10/1/19	777		Updated amounts for standard deductions, standard utility allowances, shelter/utility cap, and homeless shelter standard
	10/1/20	793		Updated deductions per SNAP COLA
	10/1/21	809		Updated SNAP parameters for SNAP mass change
	10/1/22	828		Updated SNAP parameters for SNAP mass change
	10/1/24	855		Updated SNAP parameters for SNAP mass change.
	10/1/25	869		Updated SNAP parameters for SNAP mass change.
App C	3/1/19	76		Update WVCHIP income limits & enrollment groups
	7/1/19	774		Update WVCHIP income limits & enrollment groups
				Deleted WVCHIP income chart C.1 also found Chapter 22 App B
	10/1/19	777		Removed EBT Issuance Chart
App D				
App E	3/1/19	769		Updated PAC Methods 1 and 2
	3/1/20	783		Updated PAC Methods 1 and 2
	3/1/21	802		Updated PAC Methods 1 and 2
	7/1/21	806		Corrected the term from multiplier to divisor
	3/1/21	817		Updated PAC methods 1 and 2
	3/1/23	832		Updated PAC methods 1 and 2
	3/1/24	848		Updated PAC methods 1 and 2
	3/1/25	861		Updated PAC methods 1 and 2
	3/1/26	874		Updated PAC methods 1 and 2.
App F	8/1/18	462		Updated income amounts for Minimum Gross Income Requirement to new amounts.
	5/1/21	804		Current federal tax filing requirements for dependents

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				on the amounts as to whom is to file taxes.
	3/1/24	848		Updated current Federal Tax Filing requirements for Dependents.
	3/1/25	861		Updated current Federal Tax Filing requirements for Dependents.
	3/1/26	873		Updated current Federal Tax Filing requirements for Dependents.
App G				
App H	1/1/20	780		Added Lottery and Gambling Winnings Chart

APPENDIX A: INCOME LIMITS

Number of Persons	100% FPL	120% FPL	133% FPL	141% FPL	150% FPL	158% FPL	185% FPL	200% FPL	211% FPL	220% FPL	250% FPL	300% FPL	325% FPL	P/C MEDICAID LIMIT	WV WORKS PAYMENT	100 % SON
1	1330	1596	1769	1876	1995	2102	2461	2660	2807	2926	3325	3990	4323	187	417	581
2	1804	2164	2399	2543	2750	2850	3337	3607	3806	3968	4509	5410	5861	252	480	786
3	2277		3028	3211	3415	3598	4212	4554	4804	5009	5692	6830	7400	317	542	991
4	2750		3658	3878	4125	4345	5088	5500	5803	6050	6875	8250	8938	389	612	1196
5	3224		4288	4545	4835	5093	5964	6447	6802	7092	8059	9670	10476	450	670	1401
6	3697		4917	5213	5545	5841	6839	7394	7800	8133	9242	11090	12015	516	734	1606
7	4170		5547	5880	6255	6589	7715	8340	8799	9174	10425	12510	13553	578	793	1811
8	4644		6176	6548	6965	7337	8591	9287	9798	10216	11609	13930	15091	606	811	2016
9	5117		6806	7215	7675	8085	9466	10234	10797	11257	12792	15350	16630	606	811	2221
10	5590		7435	7882	8385	8833	10342	11180	11795	12298	13975	16770	18168	606	811	2426
Each Add. Person	+474*		+631*	+669*	+711*	+749*	+877*	+948*	+1001*	+1043*	+1185*	+1422*	+1541*			

**Actual monthly amount may vary. Monthly amount in the eligibility system must be used for eligibility determination.*

Number of Persons	Maximum Benefit Allotment	Indigent Burial Program 133%	SNAP Gross / Net Test				MNIL		QMB	SLIMB	QI-1	SSI Max	EA	LIEAP
			Gross 130%	Cat EI Gross 200%	Net 100%	E & D 165%	1 Mo.	6 Mos.						
1	298	1769	1696	2610	1305	2152	200	1200	1330	1331-1596	1597-1796	994	861	2454
2	546	2399	2292	3526	1763	2909	275	1650	1804	1805-2164	2165-2435	1491	1281	3209
3	785	3028	2888	4442	2221	3665	290	1740					1316	3965
4	994	3658	3483	5360	2680	4421	312	1872					1366	4720
5	1183	4288	4079	6276	3138	5177	360	2160					1416	5475
6	1421	4917	4675	7192	3596	5934	413	2478					1466	6230
7	1571	5547	5271	8110	4055	6690	461	2766					1516	6372
8	1789	6176	5867	9026	4513	7446	477	2862					1566	6769
9	2007	6806	6463	9944	4992	8203	527	3162					1616	7456
10	2225	7435	7059	10862	5431	8960	577	3462					1666	8144
Add. Person	+ 218	+ 631	+ 596	+ 918	+ 459	+ 757							+ 50	+ 688

Nursing Homes

300% SSI = $2,982

Minimum SMS = $2,643.75
Maximum SMS = $4,066.50
Maximum FMA/each = $882.00

OLE = $175

APPENDIX B: STANDARD DEDUCTIONS AND ALLOWANCES FOR SNAP

Column 1 = Standard Deduction

Column 2 = Standard Utility Allowances

Column 3 = Minimum Medical Expenses – Elderly or Disabled Assistance Group (AG) Members Only

Column 4 = Dependent Care Cap – Non-Elderly/Non-Disabled AGs (separated from Shelter/Utility Cap on May 1, 1986; combined with number six in September 1994) (Dependent Care Cap was removed October 1, 2008).

Column 5 = Dependent Care Cap – Elderly and/or Disabled AGs (separated from Shelter/Utility Cap on May 1, 1986; combined with number five in September 1994) (Dependent Care Cap was removed October 1, 2008).

Column 6 = Shelter/Utility Cap – Non-Elderly/Non-Disabled AGs Only (separated from Dependent Care on May 1, 1986).

Column 7 = Standard Shelter Allowance (Homeless AGs Only)

**Began*

***For Each Dependent*

	1	2	3	4 5	6	7
10/13	1 – 3 AG = $152 4 AG = $163 5 AG = $191 6+ AG = $219	HCS = $347 NHCS = $211 OUS = $57	$35*	Dependent Care Cap Removed	$478	$143
10/14	1 – 3 AG = $155 4 AG = $165 5 AG = $193 6+ AG = $221	HCS = $345 NHCS = $210 OUS = $57			$490	
10/15	1 – 3 AG = $155 4 AG = $168 5 AG = $197 6+ AG = $226	HCS = $397 NHCS = $228 OUS = $72			$504	
10/16	1 – 3 AG = $157 4 AG = $168 5 AG = $197 6+ AG = $226	HCS = $455 NHCS = $246 OUS = $75			$517	
10/17	1 – 3 AG = $160 4 AG = $170 5 AG = $199 6+ AG = $228	HCS = $462 NHCS = $287 OUS = $74			$535	

	1	2	3	4	5	6	7
10/18	1 – 3 AG = $164 4 AG = $174 5 AG = $204 6+ AG = $234	HCS = $421 NHCS = $275 OUS = $74				$552	
5/19							$147.55
10/19	1 – 3 AG = $167 4 AG = $178 5 AG = $209 6+ AG = $240	HCS = $412 NHCS = $267 OUS = $73				$569	$152.06
10/20	1 – 3 AG = $167 4 AG = $181 5 AG = $212 6+ AG = $243	HCS = $428 NHCS = $281 OUS = $76				$586	$156.74
10/21	1 – 3 AG = $177 4 AG = $184 5 AG = $215 6+ AG = $246	HCS = $436 NHCS = $280 OUS = $77				$597	$159.73

	1	2	3	4	5	6	7
10/22	1–4 AG = $193 5 AG = $225 6+ AG = $258	HCS = $435 NHCS = $266 OUS = $74				$624	$166.81
10/23	1-3 AG = $198 4 AG = $208 5 AG = $244 6+ AG = $279	HCS = $496 NHCS = $305 OUS = $79				$672	$179.66
10/24	1-3 AG = $204 4 AG = $217 5 AG = $254 6+ AG = $291	HCS = $504 NHCS = $321 OUS = $86				$712	$190.30
10/25	1-3 AG = $209 4 AG = $223 5 AG = $261 6+ AG = $299	HCS = $518 NHCS = $330 OUS = $88				$744	$198.99

APPENDIX D: SNAP AND WV WORKS PRORATION TABLE

** Shaded numbers on pages D-1 through D-12 are prorated amounts for WV WORKS only.
These numbers remain as "0" for SNAP benefits.

Monthly Allotment	DATE OF APPLICATION																												
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30/31
1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	3	2	2	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0
4	4	3	3	3	3	3	3	3	2	2	2	2	2	2	2	2	1	1	1	1	1	1	1	0	0	0	0	0	0	0
5	5	4	4	4	4	4	4	3	3	3	3	3	3	2	2	2	2	2	2	1	1	1	1	1	1	0	0	0	0	0
6	6	5	5	5	5	5	4	4	4	4	4	3	3	3	3	3	2	2	2	2	2	1	1	1	1	1	0	0	0	0
7	7	6	6	6	6	5	5	5	5	4	4	4	4	3	3	3	3	3	2	2	2	2	1	1	1	1	0	0	0	0
8	8	7	7	7	6	6	6	6	5	5	5	5	4	4	4	4	3	3	3	2	2	2	2	1	1	1	1	0	0	0
9	9	8	8	8	7	7	7	6	6	6	6	5	5	5	4	4	4	3	3	3	3	2	2	2	1	1	1	0	0	0
10	10	9	9	9	8	8	8	7	7	7	6	6	6	5	5	5	4	4	4	3	3	3	2	2	2	1	1	1	0	0
11	11	10	10	9	9	9	8	8	8	7	7	6	6	6	5	5	5	4	4	4	3	3	2	2	2	1	1	1	0	0
12	12	11	11	10	10	10	9	9	8	8	8	7	7	6	6	6	5	5	4	4	4	3	3	2	2	2	1	1	0	0
13	13	12	12	11	11	10	10	9	9	9	8	8	7	7	6	6	6	5	5	4	4	3	3	3	2	2	1	1	0	0
14	14	13	13	12	12	11	11	10	10	9	9	8	8	7	7	7	6	6	5	5	4	4	3	3	2	2	1	1	0	0
15	15	14	14	13	13	12	12	11	11	10	10	9	9	8	8	7	7	6	6	5	5	4	4	3	3	2	2	1	1	0
16	16	15	14	14	13	13	12	12	11	11	10	10	9	9	8	8	7	6	6	5	5	4	4	3	3	2	2	1	1	0
17	17	16	15	15	14	14	13	13	12	11	11	10	10	9	9	8	7	7	6	6	5	5	4	3	3	2	2	1	1	0
18	18	17	16	16	15	15	14	13	13	12	12	11	10	10	9	9	8	7	7	6	6	5	4	4	3	3	2	1	1	0
19	19	18	17	17	16	15	15	14	13	13	12	12	11	10	10	9	8	8	7	6	6	5	5	4	3	3	2	1	1	0
20	20	19	18	18	17	16	16	15	14	14	13	12	12	11	10	10	9	8	8	7	6	6	5	4	4	3	2	2	1	0
21	21	20	19	18	18	17	16	16	15	14	14	13	12	11	11	10	9	9	8	7	7	6	5	4	4	3	2	2	1	0
22	22	21	20	19	19	18	17	16	16	15	14	13	13	12	11	11	10	9	8	8	7	6	5	5	4	3	2	2	1	0
23	23	22	21	20	19	19	18	17	16	16	15	14	13	13	12	11	10	9	9	8	7	6	6	5	4	3	3	2	1	0
24	24	23	22	21	20	20	19	18	17	16	16	15	14	13	12	12	11	10	9	8	8	7	6	5	4	4	3	2	1	0
25	25	24	23	22	21	20	20	19	18	17	16	15	15	14	13	12	11	10	10	9	8	7	6	5	5	4	3	2	1	0

Mon. Allot.	DATE OF APPLICATION																												
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30/31
26	26	25	24	23	22	21	20	19	19	18	17	16	15	14	13	13	12	11	10	9	8	7	6	6	5	4	3	2	1	0
27	27	26	25	24	23	22	21	20	19	18	18	17	16	15	14	13	12	11	10	9	9	8	7	6	5	4	3	2	1	0
28	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0
29	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1	0
30	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
31	31	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
32	32	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	14	13	12	11	10	9	8	7	6	5	4	3	2	1
33	33	31	30	29	28	27	26	25	24	23	22	20	19	18	17	16	15	14	13	12	11	9	8	7	6	5	4	3	2	1
34	34	32	31	30	29	28	27	26	24	23	22	21	20	19	18	17	15	14	13	12	11	10	9	7	6	5	4	3	2	1
35	35	33	32	31	30	29	28	26	25	24	23	22	21	19	18	17	16	15	14	12	11	10	9	8	7	5	4	3	2	1
36	36	34	33	32	31	30	28	27	26	25	24	22	21	20	19	18	16	15	14	13	12	10	9	8	7	6	4	3	2	1
37	37	35	34	33	32	30	29	28	27	25	24	23	22	20	19	18	17	16	14	13	12	11	9	8	7	6	4	3	2	1
38	38	36	35	34	32	31	30	29	27	26	25	24	22	21	20	19	17	16	15	13	12	11	10	8	7	6	5	3	2	1
39	39	37	36	35	33	32	31	29	28	27	26	24	23	22	20	19	18	16	15	14	13	11	10	9	7	6	5	3	2	1
40	40	38	37	36	34	33	32	30	29	28	26	25	24	22	21	20	18	17	16	14	13	12	10	9	8	6	5	4	2	1
41	41	39	38	36	35	34	32	31	30	28	27	25	24	23	21	20	19	17	16	15	13	12	10	9	8	6	5	4	2	1
42	42	40	39	37	36	35	33	32	30	29	28	26	25	23	22	21	19	18	16	15	14	12	11	9	8	7	5	4	2	1
43	43	41	40	38	37	35	34	32	31	30	28	27	25	24	22	21	20	18	17	15	14	12	11	10	8	7	5	4	2	1
44	44	42	41	39	38	36	35	33	32	30	29	27	26	24	23	22	20	19	17	16	14	13	11	10	8	7	5	4	2	1
45	45	43	42	40	39	37	36	34	33	31	30	28	27	25	24	22	21	19	18	16	15	13	12	10	9	7	6	4	3	1
46	46	44	42	41	39	38	36	35	33	32	30	29	27	26	24	23	21	19	18	16	15	13	12	10	9	7	6	4	3	1
47	47	45	43	42	40	39	37	36	34	32	31	29	28	26	25	23	21	20	18	17	15	14	12	10	9	7	6	4	3	1
48	48	46	44	43	41	40	38	36	35	33	32	30	28	27	25	24	22	20	19	17	16	14	12	11	9	8	6	4	3	1
49	49	47	45	44	42	40	39	37	35	34	32	31	29	27	26	24	22	21	19	17	16	14	13	11	9	8	6	4	3	1
50	50	48	46	45	43	41	40	38	36	35	33	31	30	28	26	25	23	21	20	18	16	15	13	11	10	8	6	5	3	1

Mon. Allot.	DATE OF APPLICATION																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30/31
51	51	49	47	45	44	42	40	39	37	35	34	32	30	28	27	25	23	22	20	18	17	15	13	11	10	8	6	5	3	1
52	52	50	48	46	45	43	41	39	38	36	34	32	31	29	27	26	24	22	20	19	17	15	13	12	10	8	6	5	3	1
53	53	51	49	47	45	44	42	40	38	37	35	33	31	30	28	26	24	22	21	19	17	15	14	12	10	8	7	5	3	1
54	54	52	50	48	46	45	43	41	39	37	36	34	32	30	28	27	25	23	21	19	18	16	14	12	10	9	7	5	3	1
55	55	53	51	49	47	45	44	42	40	38	36	34	33	31	29	27	25	23	22	20	18	16	14	12	11	9	7	5	3	1
56	56	54	52	50	48	46	44	42	41	39	37	35	33	31	29	28	26	24	22	20	18	16	14	13	11	9	7	5	3	1
57	57	55	53	51	49	47	45	43	41	39	38	36	34	32	30	28	26	24	22	20	19	17	15	13	11	9	7	5	3	1
58	58	56	54	52	50	48	46	44	42	40	38	36	34	32	30	29	27	25	23	21	19	17	15	13	11	9	7	5	3	1
59	59	57	55	53	51	49	47	45	43	41	39	37	35	33	31	29	27	25	23	21	19	17	15	13	11	9	7	5	3	1
60	60	58	56	54	52	50	48	46	44	42	40	38	36	34	32	30	28	26	24	22	20	18	16	14	12	10	8	6	4	2
61	61	58	56	54	52	50	48	46	44	42	40	38	36	34	32	30	28	26	24	22	20	18	16	14	12	10	8	6	4	2
62	62	59	57	55	53	51	49	47	45	43	41	39	37	35	33	31	28	26	24	22	20	18	16	14	12	10	8	6	4	2
63	63	60	58	56	54	52	50	48	46	44	42	39	37	35	33	31	29	27	25	23	21	18	16	14	12	10	8	6	4	2
64	64	61	59	57	55	53	51	49	46	44	42	40	38	36	34	32	29	27	25	23	21	19	17	14	12	10	8	6	4	2
65	65	62	60	58	56	54	52	49	47	45	43	41	39	36	34	32	30	28	26	23	21	19	17	15	13	10	8	6	4	2
66	66	63	61	59	57	55	52	50	48	46	44	41	39	37	35	33	30	28	26	24	22	19	17	15	13	11	8	6	4	2
67	67	64	62	60	58	55	53	51	49	46	44	42	40	37	35	33	31	29	26	24	22	20	17	15	13	11	8	6	4	2
68	68	65	63	61	58	56	54	52	49	47	45	43	40	38	36	34	31	29	27	24	22	20	18	15	13	11	9	6	4	2
69	69	66	64	62	59	57	55	52	50	48	46	43	41	39	36	34	32	29	27	25	23	20	18	16	13	11	9	6	4	2
70	70	67	65	63	60	58	56	53	51	49	46	44	42	39	37	35	32	30	28	25	23	21	18	16	14	11	9	7	4	2
71	71	68	66	63	61	59	56	54	52	49	47	44	42	40	37	35	33	30	28	26	23	21	18	16	14	11	9	7	4	2
72	72	69	67	64	62	60	57	55	52	50	48	45	43	40	38	36	33	31	28	26	24	21	19	16	14	12	9	7	4	2
73	73	70	68	65	63	60	58	55	53	51	48	46	43	41	38	36	34	31	29	26	24	21	19	17	14	12	9	7	4	2
74	74	71	69	66	64	61	59	56	54	51	49	46	44	41	39	37	34	32	29	27	24	22	19	17	14	12	9	7	4	2
75	75	72	70	67	65	62	60	57	55	52	50	47	45	42	40	37	35	32	30	27	25	22	20	17	15	12	10	7	5	2

Mon. Allot.	DATE OF APPLICATION																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30/31
76	76	73	70	68	65	63	60	58	55	53	50	48	45	43	40	38	35	32	30	27	25	22	20	17	15	12	10	7	5	2
77	77	74	71	69	66	64	61	59	56	53	51	48	46	43	41	38	35	33	30	28	25	23	20	17	15	12	10	7	5	2
78	78	75	72	70	67	65	62	59	57	54	52	49	46	44	41	39	36	33	31	28	26	23	20	18	15	13	10	7	5	2
79	79	76	73	71	68	65	63	60	57	55	52	50	47	44	42	39	36	34	31	28	26	23	21	18	15	13	10	7	5	2
80	80	77	74	72	69	66	64	61	58	56	53	50	48	45	42	40	37	34	32	29	26	24	21	18	16	13	10	8	5	2
81	81	78	75	72	70	67	64	62	59	56	54	51	48	45	43	40	37	35	32	29	27	24	21	18	16	13	10	8	5	2
82	82	79	76	73	71	68	65	62	60	57	54	51	49	46	43	41	38	35	32	30	27	24	21	19	16	13	10	8	5	2
83	83	80	77	74	71	69	66	63	60	58	55	52	49	47	44	41	38	35	33	30	27	24	22	19	16	13	11	8	5	2
84	84	81	78	75	72	70	67	64	61	58	56	53	50	47	44	42	39	36	33	30	28	25	22	19	16	14	11	8	5	2
85	85	82	79	76	73	70	68	65	62	59	56	53	51	48	45	42	39	36	34	31	28	25	22	19	17	14	11	8	5	2
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																													
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Mon. Allot.	DATE OF APPLICATION																											
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Mon. Allot.	DATE OF APPLICATION 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30/31
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																												
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Mon. Allot.	DATE OF APPLICATION																												
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411	411	397	383	369	356	342	328	315	301	287	274	260	246	232	219	205	191	178	164	150	137	123	109	95	82	68	54	41	27	13
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413	413	399	385	371	357	344	330	316	302	289	275	261	247	234	220	206	192	178	165	151	137	123	110	96	82	68	55	41	27	13
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415	415	401	387	373	359	345	332	318	304	290	276	262	249	235	221	207	193	179	166	152	138	124	110	96	83	69	55	41	27	13
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Mon. Allot.	DATE OF APPLICATION																												
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452	452	436	421	406	391	376	361	346	331	316	301	286	271	256	241	226	210	195	180	165	150	135	120	105	90	75	60	45	30	15
453	453	437	422	407	392	377	362	347	332	317	302	286	271	256	241	226	211	196	181	166	151	135	120	105	90	75	60	45	30	15
454	454	438	423	408	393	378	363	348	332	317	302	287	272	257	242	227	211	196	181	166	151	136	121	105	90	75	60	45	30	15
455	455	439	424	409	394	379	364	348	333	318	303	288	273	257	242	227	212	197	182	166	151	136	121	106	91	75	60	45	30	15
456	456	440	425	410	395	380	364	349	334	319	304	288	273	258	243	228	212	197	182	167	152	136	121	106	91	76	60	45	30	15
457	457	441	426	411	396	380	365	350	335	319	304	289	274	258	243	228	213	198	182	167	152	137	121	106	91	76	60	45	30	15
458	458	442	427	412	396	381	366	351	335	320	305	290	274	259	244	229	213	198	183	167	152	137	122	106	91	76	61	45	30	15
459	459	443	428	413	397	382	367	351	336	321	306	290	275	260	244	229	214	198	183	168	153	137	122	107	91	76	61	45	30	15
460	460	444	429	414	398	383	368	352	337	322	306	291	276	260	245	230	214	199	184	168	153	138	122	107	92	76	61	46	30	15
461	461	445	430	414	399	384	368	353	338	322	307	291	276	261	245	230	215	199	184	169	153	138	122	107	92	76	61	46	30	15
462	462	446	431	415	400	385	369	354	338	323	308	292	277	261	246	231	215	200	184	169	154	138	123	107	92	77	61	46	30	15
463	463	447	432	416	401	385	370	354	339	324	308	293	277	262	246	231	216	200	185	169	154	138	123	108	92	77	61	46	30	15
464	464	448	433	417	402	386	371	355	340	324	309	293	278	262	247	232	216	201	185	170	154	139	123	108	92	77	61	46	30	15
465	465	449	434	418	403	387	372	356	341	325	310	294	279	263	248	232	217	201	186	170	155	139	124	108	93	77	62	46	31	15
466	466	450	434	419	403	388	372	357	341	326	310	295	279	264	248	233	217	201	186	170	155	139	124	108	93	77	62	46	31	15
467	467	451	435	420	404	389	373	358	342	326	311	295	280	264	249	233	217	202	186	171	155	140	124	108	93	77	62	46	31	15
468	468	452	436	421	405	390	374	358	343	327	312	296	280	265	249	234	218	202	187	171	156	140	124	109	93	78	62	46	31	15
469	469	453	437	422	406	390	375	359	343	328	312	297	281	265	250	234	218	203	187	171	156	140	125	109	93	78	62	46	31	15
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471	471	455	439	423	408	392	376	361	345	329	314	298	282	266	251	235	219	204	188	172	157	141	125	109	94	78	62	47	31	15
472	472	456	440	424	409	393	377	361	346	330	314	298	283	267	251	236	220	204	188	173	157	141	125	110	94	78	62	47	31	15
473	473	457	441	425	409	394	378	362	346	331	315	299	283	268	252	236	220	204	189	173	157	141	126	110	94	78	63	47	31	15
474	474	458	442	426	410	395	379	363	347	331	316	300	284	268	252	237	221	205	189	173	158	142	126	110	94	79	63	47	31	15
475	475	459	443	427	411	395	380	364	348	332	316	300	285	269	253	237	221	205	190	174	158	142	126	110	95	79	63	47	31	15

Mon. Allot.	DATE OF APPLICATION																												
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483	483	466	450	434	418	402	386	370	354	338	322	305	289	273	257	241	225	209	193	177	161	144	128	112	96	80	64	48	32	16
484	484	467	451	435	419	403	387	371	354	338	322	306	290	274	258	242	225	209	193	177	161	145	129	112	96	80	64	48	32	16
485	485	468	452	436	420	404	388	371	355	339	323	307	291	274	258	242	226	210	194	177	161	145	129	113	97	80	64	48	32	16
486	486	469	453	437	421	405	388	372	356	340	324	307	291	275	259	243	226	210	194	178	162	145	129	113	97	81	64	48	32	16
487	487	470	454	438	422	405	389	373	357	340	324	308	292	275	259	243	227	211	194	178	162	146	129	113	97	81	64	48	32	16
488	488	471	455	439	422	406	390	374	357	341	325	309	292	276	260	244	227	211	195	178	162	146	130	113	97	81	65	48	32	16
489	489	472	456	440	423	407	391	374	358	342	326	309	293	277	260	244	228	211	195	179	163	146	130	114	97	81	65	48	32	16
490	490	473	457	441	424	408	392	375	359	343	326	310	294	277	261	245	228	212	196	179	163	147	130	114	98	81	65	49	32	16
491	491	474	458	441	425	409	392	376	360	343	327	310	294	278	261	245	229	212	196	180	163	147	130	114	98	81	65	49	32	16
492	492	475	459	442	426	410	393	377	360	344	328	311	295	278	262	246	229	213	196	180	164	147	131	114	98	82	65	49	32	16
493	493	476	460	443	427	410	394	377	361	345	328	312	295	279	262	246	230	213	197	180	164	147	131	115	98	82	65	49	32	16
494	494	477	461	444	428	411	395	378	362	345	329	312	296	279	263	247	230	214	197	181	164	148	131	115	98	82	65	49	32	16
495	495	478	462	445	429	412	396	379	363	346	330	313	297	280	264	247	231	214	198	181	165	148	132	115	99	82	66	49	33	16
496	496	479	462	446	429	413	396	380	363	347	330	314	297	281	264	248	231	214	198	181	165	148	132	115	99	82	66	49	33	16
497	497	480	463	447	430	414	397	381	364	347	331	314	298	281	265	248	231	215	198	182	165	149	132	115	99	82	66	49	33	16
498	498	481	464	448	431	415	398	381	365	348	332	315	298	282	265	249	232	215	199	182	166	149	132	116	99	83	66	49	33	16
499	499	482	465	449	432	415	399	382	365	349	332	316	299	282	266	249	232	216	199	182	166	149	133	116	99	83	66	49	33	16
500	500	483	466	450	433	416	400	383	366	350	333	316	300	283	266	250	233	216	200	183	166	150	133	116	100	83	66	50	33	16

Mon. Allot.	DATE OF APPLICATION																												
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502	502	485	468	451	435	418	401	384	368	351	334	317	301	284	267	251	234	217	200	184	167	150	133	117	100	83	66	50	33	16
503	503	486	469	452	435	419	402	385	368	352	335	318	301	285	268	251	234	217	201	184	167	150	134	117	100	83	67	50	33	16
504	504	487	470	453	436	420	403	386	369	352	336	319	302	285	268	252	235	218	201	184	168	151	134	117	100	84	67	50	33	16
505	505	488	471	454	437	420	404	387	370	353	336	319	303	286	269	252	235	218	202	185	168	151	134	117	101	84	67	50	33	16
506	506	489	472	455	438	421	404	387	371	354	337	320	303	286	269	253	236	219	202	185	168	151	134	118	101	84	67	50	33	16
507	507	490	476	456	439	422	405	388	371	354	338	321	304	287	270	253	236	219	202	185	169	152	135	118	101	84	67	50	33	16
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509	509	492	475	458	441	424	407	390	373	356	339	322	305	288	271	254	237	220	203	186	169	152	135	118	101	84	67	50	33	16
510	510	493	476	459	442	425	408	391	374	357	340	323	306	289	272	255	238	221	204	187	170	153	136	119	102	85	68	51	34	17
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513	513	495	478	461	444	427	410	393	376	359	342	324	307	290	273	256	239	222	205	188	171	153	136	119	102	85	68	51	34	17
514	514	496	479	462	445	428	411	394	376	359	342	325	308	291	274	257	239	222	205	188	171	154	137	119	102	85	68	51	34	17
515	515	497	480	463	446	429	412	394	377	360	343	326	309	291	274	257	240	223	206	188	171	154	137	120	103	85	68	51	34	17
516	516	498	481	464	447	430	412	395	378	361	344	326	309	292	275	258	240	223	206	189	172	154	137	120	103	86	68	51	34	17
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519	519	501	484	467	449	432	415	397	380	363	346	328	311	294	276	259	242	224	207	190	173	155	138	121	103	86	69	51	34	17
520	520	502	485	468	450	433	416	398	381	364	346	329	312	294	277	260	242	225	208	190	173	156	138	121	104	86	69	52	34	17
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522	522	504	487	469	452	435	417	400	382	365	348	330	313	295	278	261	243	226	208	191	174	156	139	121	104	87	69	52	34	17
523	523	505	488	470	453	435	418	400	383	366	348	331	313	296	278	261	244	226	209	191	174	156	139	122	104	87	69	52	34	17
524	524	506	489	471	454	436	419	401	384	366	349	331	314	296	279	262	244	227	209	192	174	157	139	122	104	87	69	52	34	17
525	525	507	490	472	455	437	420	402	385	367	350	332	315	297	280	262	245	227	210	192	175	157	140	122	105	87	70	52	35	17

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527	527	509	491	474	456	439	421	404	386	368	351	333	316	298	281	263	245	228	210	193	175	158	140	122	105	87	70	52	35	17
528	528	510	492	475	457	440	422	404	387	369	352	334	316	299	281	264	246	228	211	193	176	158	140	123	105	88	70	52	35	17
529	529	511	493	476	458	440	423	405	387	370	352	335	317	299	282	264	246	229	211	193	176	158	141	123	105	88	70	52	35	17
530	530	512	494	477	459	441	424	406	388	371	353	335	318	300	282	265	247	229	212	194	176	159	141	123	106	88	70	53	35	17
531	531	513	495	477	460	442	424	407	389	371	354	336	318	300	283	265	247	230	212	194	177	159	141	123	106	88	70	53	35	17
532	532	514	496	478	461	443	425	407	390	372	354	336	319	301	283	266	248	230	212	195	177	159	141	124	106	88	70	53	35	17
533	533	515	497	479	461	444	426	408	390	373	355	337	319	302	284	266	248	230	213	195	177	159	142	124	106	88	71	53	35	17
534	534	516	498	480	462	445	427	409	391	373	356	338	320	302	284	267	249	231	213	195	178	160	142	124	106	89	71	53	35	17
535	535	517	499	481	463	445	428	410	392	374	356	338	321	303	285	267	249	231	214	196	178	160	142	124	107	89	71	53	35	17
536	536	518	500	482	464	446	428	410	393	375	357	339	321	303	285	268	250	232	214	196	178	160	142	125	107	89	71	53	35	17
537	537	519	501	483	465	447	429	411	393	375	358	340	322	304	286	268	250	232	214	196	179	161	143	125	107	89	71	53	35	17
538	538	520	502	484	466	448	430	412	394	376	358	340	322	304	286	269	251	233	215	197	179	161	143	125	107	89	71	53	35	17
539	539	521	503	485	467	449	431	413	395	377	359	341	323	305	287	269	251	233	215	197	179	161	143	125	107	89	71	53	35	17
540	540	522	504	486	468	450	432	414	396	378	360	342	324	306	288	270	252	234	216	198	180	162	144	126	108	90	72	54	36	18
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542	542	523	505	487	469	451	433	415	397	379	361	343	325	307	289	271	252	234	216	198	180	162	144	126	108	90	72	54	36	18
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544	544	525	507	489	471	453	435	417	398	380	362	344	326	308	290	272	253	235	217	199	181	163	145	126	108	90	72	54	36	18
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546	546	527	509	491	473	455	436	418	400	382	364	345	327	309	291	273	254	236	218	200	182	163	145	127	109	91	72	54	36	18
547	547	528	510	492	474	455	437	419	401	382	364	346	328	309	291	273	255	237	218	200	182	164	145	127	109	91	72	54	36	18
548	548	529	511	493	474	456	438	420	401	383	365	347	328	310	292	274	255	237	219	200	182	164	146	127	109	91	73	54	36	18
549	549	530	512	494	475	457	439	420	402	384	366	347	329	311	292	274	256	237	219	201	183	164	146	128	109	91	73	54	36	18
550	550	531	513	495	476	458	440	421	403	385	366	348	330	311	293	275	256	238	220	201	183	165	146	128	110	91	73	55	36	18

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552	552	533	515	496	478	460	441	423	404	386	368	349	331	312	294	276	257	239	220	202	184	165	147	128	110	92	73	55	36	18
553	553	534	516	497	479	460	442	423	405	387	368	350	331	313	294	276	258	239	221	202	184	165	147	129	110	92	73	55	36	18
554	554	535	517	498	480	461	443	424	406	387	369	350	332	313	295	277	258	240	221	203	184	166	147	129	110	92	73	55	36	18
555	555	536	518	799	481	462	444	425	407	388	370	351	333	314	296	277	259	240	222	203	185	166	148	129	111	92	74	55	37	18
556	556	537	518	500	481	463	444	426	407	389	370	352	333	315	296	278	259	240	222	203	185	166	148	129	111	92	74	55	37	18
557	557	538	519	501	482	464	445	427	408	389	371	352	334	315	297	278	259	241	222	204	185	167	148	129	111	92	74	55	37	18
558	558	539	520	502	483	465	446	427	409	390	372	353	334	316	297	279	260	241	223	204	186	167	148	130	111	93	74	55	37	18
559	559	540	521	503	484	465	447	428	409	391	372	354	335	316	298	279	260	242	223	204	186	167	149	130	111	93	74	55	37	18
560	560	541	522	504	485	466	448	429	410	392	373	354	336	317	298	280	261	242	224	205	186	168	149	130	112	93	74	56	37	18
561	561	542	523	504	486	467	448	430	411	392	374	355	336	317	299	280	261	243	224	205	187	168	149	130	112	93	74	56	37	18
562	562	543	524	505	487	468	449	430	412	393	374	355	337	318	299	281	262	243	224	206	187	168	149	131	112	93	74	56	37	18
563	563	544	525	506	487	469	450	431	412	394	375	356	337	319	300	281	262	243	225	206	187	168	150	131	112	93	75	56	37	18
564	564	545	526	507	488	470	451	432	413	394	376	357	338	319	300	282	263	244	225	206	188	169	150	131	112	94	75	56	37	18
565	565	546	527	508	489	470	452	433	414	395	376	357	339	320	301	282	263	244	226	207	188	169	150	131	113	94	75	56	37	18
566	566	547	528	509	490	471	452	433	415	396	377	358	339	320	301	283	264	245	226	207	188	169	150	132	113	94	75	56	37	18
567	567	548	529	510	491	472	453	434	415	396	378	359	340	321	302	283	264	245	226	207	189	170	151	132	113	94	75	56	37	18
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569	569	550	531	512	493	474	455	436	417	398	379	360	341	322	303	284	265	246	227	208	189	170	151	132	113	94	75	56	37	18
570	570	551	532	513	494	475	456	437	418	399	380	361	342	323	304	285	266	247	228	209	190	171	152	133	114	95	76	57	38	19
571	571	551	532	513	494	475	456	437	418	399	380	361	342	323	304	285	266	247	228	209	190	171	152	133	114	95	76	57	38	19
572	572	552	533	514	495	476	457	438	419	400	381	362	343	324	305	286	266	247	228	209	190	171	152	133	114	95	76	57	38	19
573	573	553	534	515	496	477	458	439	420	401	382	362	343	324	305	286	267	248	229	210	191	171	152	133	114	95	76	57	38	19
574	574	554	535	516	497	478	459	440	420	401	382	363	344	325	306	287	267	248	229	210	191	172	153	133	114	95	76	57	38	19
575	575	555	536	517	498	479	460	440	421	402	383	364	345	325	306	287	268	249	230	210	191	172	153	134	115	95	76	57	38	19

Mon. Allot.	DATE OF APPLICATION																												
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577	577	557	538	519	500	480	461	442	423	403	384	365	346	326	307	288	269	250	230	211	192	173	153	134	115	96	76	57	38	19
578	578	558	539	520	500	481	462	443	423	404	385	366	346	327	308	289	269	250	231	211	192	173	154	134	115	96	77	57	38	19
579	579	559	540	521	501	482	463	443	424	405	386	366	347	328	308	289	270	250	231	212	193	173	154	135	115	96	77	57	38	19
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581	581	561	542	522	503	484	464	445	426	406	387	367	348	329	309	290	271	251	232	213	193	174	154	135	116	96	77	58	38	19
582	582	562	543	523	504	485	465	446	426	407	388	368	349	329	310	291	271	252	232	213	194	174	155	135	116	97	77	58	38	19
583	583	563	544	524	505	485	466	446	427	408	388	369	349	330	310	291	272	252	233	213	194	174	155	136	116	97	77	58	38	19
584	584	564	545	525	506	486	467	447	428	108	389	369	350	330	311	292	272	253	233	214	194	175	155	136	116	97	77	58	38	19
585	585	565	546	526	507	487	468	448	429	109	390	370	351	331	312	292	273	253	234	214	195	175	156	136	117	97	78	58	39	19
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587	587	567	547	528	508	489	469	450	430	410	391	371	352	332	313	293	273	254	234	215	195	176	156	136	117	97	78	58	39	19
588	588	568	548	529	509	490	470	450	431	411	392	372	352	333	313	294	274	254	235	215	196	176	156	137	117	98	78	58	39	19
589	589	569	549	530	510	490	471	451	431	412	392	373	353	333	314	294	274	255	235	215	196	176	157	137	117	98	78	58	39	19
590	590	570	550	531	511	491	472	452	432	413	393	373	354	334	314	295	275	255	236	216	196	177	157	137	118	98	78	59	39	19
591	591	571	551	531	512	492	472	453	433	413	394	374	354	334	315	295	275	256	236	216	197	177	157	137	118	98	78	59	39	19
592	592	572	552	532	513	493	473	453	434	414	394	374	355	335	315	296	276	256	236	217	197	177	157	138	118	98	78	59	39	19
593	593	573	553	533	513	494	474	454	434	415	395	375	355	336	316	296	276	256	237	217	197	177	158	138	118	98	79	59	39	19
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595	595	575	555	535	515	495	476	456	436	416	396	376	357	337	317	297	277	257	238	218	198	178	158	138	119	99	79	59	39	19
596	596	576	556	536	516	496	476	456	437	417	397	377	357	337	317	298	278	258	238	218	198	178	158	139	119	99	79	59	39	19
597	597	577	557	537	517	497	477	457	437	417	398	378	358	338	318	298	278	258	238	218	199	179	159	139	119	99	79	59	39	19
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599	599	579	559	539	519	499	479	459	439	419	399	379	359	339	319	299	279	259	239	219	199	179	159	139	119	99	79	59	39	19
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Mon. Allot.	DATE OF APPLICATION																												
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603	603	582	562	542	522	502	482	462	442	422	402	381	361	341	321	301	281	261	241	221	201	180	160	140	120	100	80	60	40	20
604	604	583	563	543	523	503	483	463	442	422	402	382	362	342	322	302	281	261	241	221	201	181	161	140	120	100	80	60	40	20
605	605	584	564	544	524	504	484	463	443	423	403	383	363	342	322	302	282	262	242	221	201	181	161	141	121	100	80	60	40	20
606	606	585	565	545	525	505	484	464	444	424	404	383	363	343	323	303	282	262	242	222	202	181	161	141	121	101	80	60	40	20
607	607	586	566	546	526	505	485	465	445	424	404	384	364	343	323	303	283	263	242	222	202	182	161	141	121	101	80	60	40	20
608	608	587	567	547	526	506	486	466	445	425	405	385	364	344	324	304	283	263	243	222	202	182	162	141	121	101	81	60	40	20
609	609	588	568	548	527	507	487	466	446	426	406	385	365	345	324	304	284	263	243	223	203	182	162	142	121	101	81	60	40	20
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612	612	591	571	550	530	510	489	469	448	428	408	387	367	346	326	306	285	265	244	224	204	183	163	142	122	102	81	61	40	20
613	613	592	572	551	531	511	490	469	449	429	408	388	367	347	326	306	286	265	245	224	204	183	163	143	122	102	81	61	40	20
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615	615	594	574	553	533	513	492	471	451	430	410	389	369	348	328	307	287	266	246	225	205	184	164	143	123	102	82	61	41	20
616	616	595	574	554	533	513	492	472	451	431	410	390	369	349	328	308	287	266	246	225	205	184	164	143	123	102	82	61	41	20
617	617	596	575	555	534	514	493	473	452	431	411	390	370	349	329	308	287	267	246	226	205	185	164	143	123	102	82	61	41	20
618	618	597	576	556	535	515	494	473	453	432	412	391	370	350	329	309	288	267	247	226	206	185	164	144	123	103	82	61	41	20
619	619	598	577	557	536	515	495	474	453	433	412	392	371	350	330	309	288	268	247	226	206	185	165	144	123	103	82	61	41	20
620	620	599	578	558	537	516	496	475	454	434	413	392	372	351	330	310	289	268	248	227	206	186	165	144	124	103	82	62	41	20
621	621	600	579	558	538	517	496	476	455	434	414	393	372	351	331	310	289	269	248	227	207	186	165	144	124	103	82	62	41	20
622	622	601	580	559	539	518	497	476	456	435	414	393	373	352	331	311	290	269	248	228	207	186	165	145	124	103	82	62	41	20
623	623	602	581	560	539	519	498	477	456	436	415	394	373	353	332	311	290	269	249	228	207	186	166	145	124	103	83	62	41	20
624	624	603	582	561	540	520	499	478	457	436	416	395	374	353	332	312	291	270	249	228	208	187	166	145	124	104	83	62	41	20
625	625	604	583	562	541	520	500	479	458	437	416	395	375	354	333	312	291	270	250	229	208	187	166	145	125	104	83	62	41	20

Mon. Allot.	DATE OF APPLICATION																													
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626	626	605	584	563	542	521	500	479	459	438	417	396	375	354	333	313	292	271	250	229	208	187	166	146	125	104	83	62	41	20
627	627	606	585	564	543	522	501	480	459	438	418	397	376	355	331	313	292	271	250	229	209	188	167	146	125	104	83	62	41	20
628	628	607	586	565	544	523	502	481	460	439	418	397	376	355	331	314	293	272	251	230	209	188	167	146	125	104	83	62	41	20
629	629	608	587	566	545	524	503	482	461	440	419	398	377	356	335	314	293	272	251	230	209	188	167	146	125	104	83	62	41	20
630	630	609	588	567	546	525	504	483	462	441	420	399	378	357	336	315	294	273	252	231	210	189	168	147	126	105	84	63	42	21
631	631	609	588	567	546	525	504	483	462	441	420	399	378	357	336	315	294	273	252	231	210	189	168	147	126	105	84	63	42	21
632	632	610	589	568	547	526	505	484	463	442	421	400	379	358	337	316	294	273	252	231	210	189	168	147	126	105	84	63	42	21
633	633	611	590	569	548	527	506	485	464	443	422	400	379	358	337	316	295	274	253	232	211	189	168	147	126	105	84	63	42	21
634	634	612	591	570	549	528	507	486	464	443	422	401	380	359	338	317	295	274	253	232	211	190	169	147	126	105	84	63	42	21
635	635	613	592	571	550	529	508	486	465	444	423	402	381	359	338	317	296	275	254	232	211	190	169	148	127	105	84	63	42	21
636	636	614	593	572	551	530	508	487	466	445	424	402	381	360	339	318	296	275	254	233	212	190	169	148	127	106	84	63	42	21
637	637	615	594	573	552	530	509	488	467	445	424	403	382	360	339	318	297	276	254	233	212	191	169	148	127	106	84	63	42	21
638	638	616	595	574	552	531	510	489	467	446	425	404	382	361	340	319	297	276	255	233	212	191	170	148	127	106	85	63	42	21
639	639	617	596	575	553	532	511	489	468	447	426	404	383	362	340	319	298	276	255	234	213	191	170	149	127	106	85	63	42	21
640	640	618	597	576	554	533	512	490	469	448	426	405	384	362	341	320	298	277	256	234	213	192	170	149	128	106	85	64	42	21
641	641	619	598	576	555	534	512	491	470	448	427	405	384	363	341	320	299	277	256	235	213	192	170	149	128	106	85	64	42	21
642	642	620	599	577	556	535	513	492	470	449	428	406	385	363	342	321	299	278	256	235	214	192	171	149	128	107	85	64	42	21
643	643	621	600	578	557	535	514	492	471	450	428	407	385	364	342	321	300	278	257	235	214	192	171	150	128	107	85	64	42	21
644	644	622	601	579	558	536	515	493	472	450	429	407	386	364	343	322	300	279	257	236	214	193	171	150	128	107	85	64	42	21
645	645	623	602	580	559	537	516	494	473	451	430	408	387	365	344	322	301	279	258	236	215	193	172	150	129	107	86	64	43	21
646	646	624	602	581	559	538	516	495	473	452	430	409	387	366	344	323	301	279	258	236	215	193	172	150	129	107	86	64	43	21
647	647	625	603	582	560	539	517	496	474	452	431	409	388	366	345	323	301	280	258	237	215	194	172	150	129	107	86	64	43	21
648	648	626	604	583	561	540	518	496	475	453	432	410	388	367	345	324	302	280	259	237	216	194	172	151	129	108	86	64	43	21
649	649	627	605	584	562	540	519	497	475	454	432	411	389	367	346	324	302	281	259	237	216	194	173	151	129	108	86	64	43	21
650	650	628	606	585	563	541	520	498	476	455	433	411	390	368	346	325	303	281	260	238	216	195	173	151	130	108	86	65	43	21

Mon. Allot.	DATE OF APPLICATION																													
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651	651	629	607	585	564	542	520	499	477	455	434	412	390	368	347	325	303	282	260	238	217	195	173	151	130	108	86	65	43	21
652	652	630	608	586	565	543	521	499	478	456	434	412	391	369	347	326	304	282	260	239	217	195	173	152	130	108	86	65	43	21
653	653	631	609	587	565	544	522	500	478	457	435	413	391	370	348	326	304	282	261	239	217	195	174	152	130	108	87	65	43	21
654	654	632	610	588	566	545	523	501	479	457	436	414	392	370	348	327	305	283	261	239	218	196	174	152	130	109	87	65	43	21
655	655	633	611	589	567	545	524	502	480	458	436	414	393	371	349	327	305	283	262	240	218	196	174	152	131	109	87	65	43	21
656	656	634	612	590	568	546	524	502	481	459	437	415	393	371	349	328	306	284	262	240	218	196	174	153	131	109	87	65	43	21
657	657	635	613	591	569	547	525	503	481	459	438	416	394	372	350	328	306	284	262	240	219	197	175	153	131	109	87	65	43	21
658	658	636	614	592	570	548	526	504	482	460	438	416	394	372	350	329	307	285	263	241	219	197	175	153	131	109	87	65	43	21
659	659	637	615	593	571	549	527	505	483	461	439	417	395	373	351	329	307	285	263	241	219	197	175	153	131	109	87	65	43	21
660	660	638	616	594	572	550	528	506	484	462	440	418	396	374	352	330	308	286	264	242	220	198	176	154	132	110	88	66	44	22
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662	662	639	617	595	573	551	529	507	485	463	441	419	397	375	353	331	308	286	264	242	220	198	176	154	132	110	88	66	44	22
663	663	640	618	596	574	552	530	508	486	464	442	419	397	375	353	331	309	287	265	243	221	198	176	154	132	110	88	66	44	22
664	664	641	619	597	575	553	531	509	486	464	442	420	398	376	354	332	309	287	265	243	221	199	177	154	132	110	88	66	44	22
665	665	642	620	598	576	554	532	509	487	465	443	421	399	376	354	332	310	288	266	243	221	199	177	155	133	110	88	66	44	22
666	666	643	621	599	577	555	532	510	488	466	444	421	399	377	355	333	310	288	266	244	222	199	177	155	133	111	88	66	44	22
667	667	644	622	600	578	555	533	511	489	466	444	422	400	377	355	333	311	289	266	244	222	200	177	155	133	111	88	66	44	22
668	668	645	623	601	578	556	534	512	489	467	445	423	400	378	356	334	311	289	267	244	222	200	178	155	133	111	89	66	44	22
669	669	646	624	602	579	557	535	512	490	468	446	423	401	379	356	334	312	289	267	245	223	200	178	156	133	111	89	66	44	22
670	670	647	625	603	580	558	536	513	491	469	446	424	402	379	357	335	312	290	268	245	223	201	178	156	134	111	89	67	44	22
671	671	648	626	603	581	559	536	514	492	469	447	424	402	380	357	335	313	290	268	246	223	201	178	156	134	111	89	67	44	22
672	672	649	627	604	582	560	537	515	492	470	448	425	403	380	358	336	313	291	268	246	224	201	179	156	134	112	89	67	44	22
673	673	650	628	605	583	560	538	515	493	471	448	426	403	381	358	336	314	291	269	246	224	201	179	157	134	112	89	67	44	22
674	674	651	629	606	584	561	539	516	494	471	449	426	404	381	359	337	314	292	269	247	224	202	179	157	134	112	89	67	44	22
675	675	652	630	607	585	562	540	517	495	472	450	427	405	382	360	337	315	292	270	247	225	202	180	157	135	112	90	67	45	22

Mon. Allot.	DATE OF APPLICATION																												
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677	677	654	631	609	586	564	541	519	496	473	451	428	406	383	361	338	315	293	270	248	225	203	180	157	135	112	90	67	45	22
678	678	655	632	610	587	565	542	519	497	474	452	429	406	384	361	339	316	293	271	248	226	203	180	158	135	113	90	67	45	22
679	679	656	633	611	588	565	543	520	497	475	452	430	407	384	362	339	316	294	271	248	226	203	181	158	135	113	90	67	45	22
680	680	657	634	612	589	566	544	521	498	476	453	430	408	385	362	340	317	294	272	249	226	204	181	158	136	113	90	68	45	22
681	681	658	635	612	590	567	544	522	499	476	454	431	408	385	363	340	317	295	272	249	227	204	181	158	136	113	90	68	45	22
682	682	659	636	613	591	568	545	522	500	477	454	431	409	386	363	341	318	295	272	250	227	204	181	159	136	113	90	68	45	22
683	683	660	637	614	591	569	546	523	500	478	455	432	409	387	364	341	318	295	273	250	227	204	182	159	136	113	91	68	45	22
684	684	661	638	615	592	570	547	524	501	478	456	433	410	387	364	342	319	296	273	250	228	205	182	159	136	114	91	68	45	22
685	685	662	639	616	593	570	548	525	502	479	456	433	411	388	365	342	319	296	274	251	228	205	182	159	137	114	91	68	45	22
686	686	663	640	617	594	571	548	525	503	480	457	434	411	388	365	343	320	297	274	251	228	205	182	160	137	114	91	68	45	22
687	687	664	641	618	595	572	549	526	503	480	458	435	412	389	366	343	320	297	274	251	229	206	183	160	137	114	91	68	45	22
688	688	665	642	619	596	573	550	527	504	481	458	435	412	389	366	344	321	298	275	252	229	206	183	160	137	114	91	68	45	22
689	689	666	643	620	597	574	551	528	505	482	459	436	413	390	367	344	321	298	275	252	229	206	183	160	137	114	91	68	45	22
690	690	667	644	621	598	575	552	529	506	483	460	437	414	391	368	345	322	299	276	253	230	207	184	161	138	115	92	69	46	23
691	691	667	644	621	598	575	552	529	506	483	460	437	414	391	368	345	322	299	276	253	230	207	184	161	138	115	92	69	46	23
692	692	668	645	622	599	576	553	530	507	484	461	438	415	392	369	346	322	299	276	253	230	207	184	161	138	115	92	69	46	23
693	693	669	646	623	600	577	554	531	508	485	462	438	415	392	369	346	323	300	277	254	231	207	184	161	138	115	92	69	46	23
694	694	670	647	624	601	578	555	532	508	485	462	439	416	393	370	347	323	300	277	254	231	208	185	161	138	115	92	69	46	23
695	695	671	648	625	602	579	556	532	509	486	463	440	417	393	370	347	324	301	278	254	231	208	185	162	139	115	92	69	46	23
696	696	672	649	626	603	580	556	533	510	487	464	440	417	394	371	348	324	301	278	255	232	208	185	162	139	116	92	69	46	23
697	697	673	650	627	604	580	557	534	511	487	464	441	418	394	371	348	325	302	278	255	232	209	185	162	139	116	92	69	46	23
698	698	674	651	628	604	581	558	535	511	488	465	442	418	395	372	349	325	302	279	255	232	209	186	162	139	116	93	69	46	23
699	699	675	652	629	605	582	559	535	512	489	466	442	419	396	372	349	326	302	279	256	233	209	186	163	139	116	93	69	46	23
700	700	676	653	630	606	583	560	536	513	490	466	443	420	396	373	350	326	303	280	256	233	210	186	163	140	116	93	70	46	23

Mon.	DATE OF APPLICATION																													
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702	702	678	655	631	608	585	561	538	514	491	468	444	421	397	374	351	327	304	280	257	234	210	187	163	140	117	93	70	46	23
703	703	679	656	632	609	585	562	538	515	491	468	445	421	398	374	351	328	304	281	257	234	210	187	164	140	117	93	70	46	23
704	704	680	657	633	610	586	563	539	516	492	469	445	422	398	375	352	328	305	281	258	234	211	187	164	140	117	93	70	46	23
705	705	681	658	634	611	587	564	540	517	493	470	446	423	399	376	352	329	305	282	258	235	211	188	164	141	117	94	70	47	23
706	706	682	658	635	611	588	564	541	517	494	470	447	423	400	376	353	329	305	282	258	235	211	188	164	141	117	94	70	47	23
707	707	683	659	636	612	589	565	542	518	494	471	447	424	400	377	353	329	306	282	259	235	212	188	164	141	117	94	70	47	23
708	708	684	660	637	613	590	566	542	519	495	472	448	424	401	377	354	330	306	283	259	236	212	188	165	141	118	94	70	47	23
709	709	685	661	638	614	590	567	543	519	496	472	449	425	401	378	354	330	307	283	259	236	212	189	165	141	118	94	70	47	23
710	710	686	662	639	615	591	568	544	520	497	473	449	426	402	378	355	331	307	284	260	236	213	189	165	142	118	94	71	47	23
711	711	687	663	639	616	592	568	545	521	497	474	450	426	402	379	355	331	308	284	260	237	213	189	165	142	118	94	71	47	23
712	712	688	664	640	617	593	569	545	522	498	474	450	427	403	379	356	332	308	284	261	237	213	189	166	142	118	94	71	47	23
713	713	689	665	641	617	594	570	546	522	499	475	451	427	404	380	356	332	308	285	261	237	213	190	166	142	118	95	71	47	23
714	714	690	666	642	618	595	571	547	523	499	476	452	428	404	380	357	332	309	285	261	238	214	190	166	142	119	95	71	47	23
715	715	691	667	643	619	595	572	548	524	500	476	452	429	405	381	357	333	309	286	262	238	214	190	166	143	119	95	71	47	23
716	716	692	668	644	620	596	572	548	525	501	477	453	429	405	381	358	334	310	286	262	238	214	190	167	143	119	95	71	47	23
717	717	693	669	645	621	597	573	549	525	501	478	454	430	406	382	358	334	310	286	262	239	215	191	167	143	119	95	71	47	23
718	718	694	670	646	622	598	574	550	526	502	478	454	430	406	382	359	335	311	287	263	239	215	191	167	143	119	95	71	47	23
719	719	695	671	647	623	599	575	551	527	503	479	455	431	407	383	359	335	311	287	263	239	215	191	167	143	119	95	71	47	23
720	720	696	672	648	624	600	576	552	528	504	480	456	432	408	384	360	336	312	288	264	240	216	192	168	144	120	96	72	48	24
721	721	696	672	648	624	600	576	552	528	504	480	456	432	408	384	360	336	312	288	264	240	216	192	168	144	120	96	72	48	24
722	722	697	673	649	625	601	577	553	529	505	481	457	433	409	385	361	336	312	288	264	240	216	192	168	144	120	96	72	48	24
723	723	698	674	650	626	602	578	554	530	506	482	457	433	409	385	361	337	313	289	265	241	216	192	168	144	120	96	72	48	24
724	724	699	675	651	627	603	579	555	530	506	482	458	434	410	386	362	337	313	289	265	241	217	193	168	144	120	96	72	48	24
725	725	700	676	652	628	604	580	555	531	507	483	459	435	410	386	362	338	314	290	265	241	217	193	169	145	120	96	72	48	24

Mon. Allot.	DATE OF APPLICATION																												
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727	727	702	678	654	630	605	581	557	533	508	484	460	436	411	387	363	339	315	290	266	242	218	193	169	145	121	96	72	48	24
728	728	703	679	655	630	606	582	558	533	509	485	461	436	412	388	364	339	315	291	266	242	218	194	169	145	121	97	72	48	24
729	729	704	680	656	631	607	583	558	534	510	486	461	437	413	388	364	340	315	291	267	243	218	194	170	145	121	97	72	48	24
730	730	705	681	657	632	608	584	559	535	511	486	462	438	413	389	365	340	316	292	267	243	219	194	170	146	121	97	73	48	24
731	731	706	682	657	633	609	584	560	536	511	487	462	438	414	389	365	341	316	292	268	243	219	194	170	146	121	97	73	48	24
732	732	707	683	658	634	610	585	561	536	512	488	463	439	414	390	366	341	317	292	268	244	219	195	170	146	122	97	73	48	24
733	733	708	684	659	635	610	586	561	537	513	488	464	439	415	390	366	342	317	293	268	244	219	195	171	146	122	97	73	48	24
734	734	709	685	660	636	611	587	562	538	513	489	464	440	415	391	367	342	318	293	269	244	220	195	171	146	122	97	73	48	24
735	735	710	686	661	637	612	588	563	539	514	490	465	441	416	392	367	343	318	294	269	245	220	196	171	147	122	98	73	49	24
736	736	711	686	662	637	613	588	564	539	515	490	466	441	417	392	368	343	318	294	269	245	220	196	171	147	122	98	73	49	24
737	737	712	687	663	638	614	589	565	540	515	491	466	442	417	393	368	343	319	294	270	245	221	196	171	147	122	98	73	49	24
738	738	713	688	664	639	615	590	565	541	516	492	467	442	418	393	369	344	319	295	270	246	221	196	172	147	123	98	73	49	24
739	739	714	689	665	640	615	591	566	541	517	492	468	443	418	394	369	344	320	295	270	246	221	197	172	147	123	98	73	49	24
740	740	715	690	666	641	616	592	567	542	518	493	468	444	419	394	370	345	320	296	271	246	222	197	172	148	123	98	74	49	24
741	741	716	691	666	642	617	592	568	543	518	494	469	444	419	395	370	345	321	296	271	247	222	197	172	148	123	98	74	49	24
742	742	717	692	667	643	618	593	568	544	519	494	469	445	420	395	371	346	321	296	272	247	222	197	173	148	123	98	74	49	24
743	743	718	693	668	643	619	594	569	544	520	495	470	445	421	396	371	346	321	297	272	247	222	198	173	148	123	99	74	49	24
744	744	719	694	669	644	620	595	570	545	520	496	471	446	421	396	372	347	322	297	272	248	223	198	173	148	124	99	74	49	24
745	745	720	695	670	645	620	596	571	546	521	496	471	447	422	397	372	347	322	298	273	248	223	198	173	149	124	99	74	49	24
746	746	721	696	671	646	621	596	571	547	522	497	472	447	422	397	373	348	323	298	273	248	223	198	174	149	124	99	74	49	24
747	747	722	697	672	647	622	597	572	547	522	498	473	448	423	398	373	348	323	298	273	249	224	199	174	149	124	99	74	49	24
748	748	723	698	673	648	623	598	573	548	523	498	473	448	423	398	374	349	324	299	274	249	224	199	174	149	124	99	74	49	24
749	749	724	699	674	649	624	599	574	549	524	499	474	449	424	399	374	349	324	299	274	249	224	199	174	149	124	99	74	49	24
750	750	725	700	675	650	625	600	575	550	525	500	475	450	425	400	375	350	325	300	275	250	225	200	175	150	125	100	75	50	25

Mon. Allot.	DATE OF APPLICATION																													
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751	751	725	700	675	650	625	600	575	550	525	500	475	450	425	400	375	350	325	300	275	250	225	200	175	150	125	100	75	50	25
752	752	726	701	676	651	626	601	576	551	526	501	476	451	426	401	376	350	325	300	275	250	225	200	175	150	125	100	75	50	25
753	753	727	702	677	652	627	602	577	552	527	502	476	451	426	401	376	351	326	301	276	251	225	200	175	150	125	100	75	50	25
754	754	728	703	678	653	628	603	578	552	527	502	477	452	427	402	377	351	326	301	276	251	226	201	175	150	125	100	75	50	25
755	755	729	704	679	654	629	604	578	553	528	503	478	453	427	402	377	352	327	302	276	251	226	201	176	151	125	100	75	50	25
756	756	730	705	680	655	630	604	579	554	529	504	478	453	428	403	378	352	327	302	277	252	226	201	176	151	126	100	75	50	25
757	757	731	706	681	656	630	605	580	555	529	504	479	454	428	403	378	353	328	302	277	252	227	201	176	151	126	100	75	50	25
758	758	732	707	682	656	631	606	581	555	530	505	480	454	429	404	379	353	328	303	277	252	227	202	176	151	126	101	75	50	25
759	759	733	708	683	657	632	607	581	556	531	506	480	455	430	404	379	354	328	303	278	253	227	202	177	151	126	101	75	50	25
760	760	734	709	684	658	633	608	582	557	532	506	481	456	430	405	380	354	329	304	278	253	228	202	177	152	126	101	76	50	25
761	761	735	710	684	659	634	608	583	558	532	507	481	456	431	405	380	355	329	304	279	253	228	202	177	152	126	101	76	50	25
762	762	736	711	685	660	635	609	584	558	533	508	482	457	431	406	381	355	330	304	279	254	228	203	177	152	127	101	76	50	25
763	763	737	712	686	661	635	610	584	559	534	508	483	457	432	406	381	356	330	305	279	254	228	203	178	152	127	101	76	50	25
764	764	738	713	687	662	636	611	585	560	534	509	483	458	432	407	382	356	331	305	280	254	229	203	178	152	127	101	76	50	25
765	765	739	714	688	663	637	612	586	561	535	510	484	459	433	408	382	357	331	306	280	255	229	204	178	153	127	102	76	51	25
766	766	740	714	689	663	638	612	587	561	536	510	485	459	434	408	383	357	331	306	280	255	229	204	178	153	127	102	76	51	25
767	767	741	715	690	664	639	613	588	562	536	511	485	460	434	409	383	357	332	306	281	255	230	204	178	153	127	102	76	51	25
768	768	742	716	691	665	640	614	588	563	537	512	486	460	435	409	384	358	332	307	281	256	230	204	179	153	128	102	76	51	25
769	769	743	717	692	666	640	615	589	563	538	512	487	461	435	410	384	358	333	307	281	256	230	205	179	153	128	102	76	51	25
770	770	744	718	693	667	641	616	590	564	539	513	487	462	436	410	385	359	333	308	282	256	231	205	179	154	128	102	77	51	25
771	771	745	719	693	668	642	616	591	565	539	514	488	462	436	411	385	359	334	308	282	257	231	205	179	154	128	102	77	51	25
772	772	746	720	694	669	643	617	591	566	540	514	488	463	437	411	386	360	334	308	283	257	231	205	180	154	128	102	77	51	25
773	773	747	721	695	669	644	618	592	566	541	515	489	463	438	412	386	360	334	309	283	257	231	206	180	154	128	103	77	51	25
774	774	748	722	696	670	645	619	593	567	541	516	490	464	438	412	387	361	335	309	283	258	232	206	180	154	129	103	77	51	25
775	775	749	723	697	671	645	620	594	568	542	516	490	465	439	413	387	361	335	310	284	258	232	206	180	155	129	103	77	51	25

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776	776	750	724	698	672	646	620	594	569	543	517	491	465	439	413	388	362	336	310	284	258	232	206	181	155	129	103	77	51	25
777	777	751	725	699	673	647	621	595	569	543	518	492	466	440	414	388	362	336	310	284	259	233	207	181	155	129	103	77	51	25
778	778	752	726	700	674	648	622	596	570	544	518	492	466	440	414	389	363	337	311	285	259	233	207	181	155	129	103	77	51	25
779	779	753	727	701	675	649	623	597	571	545	519	493	467	441	415	389	363	337	311	285	259	233	207	181	155	129	103	77	51	25
780	780	754	728	702	676	650	624	598	572	546	520	494	468	442	416	390	364	338	312	286	260	234	208	182	156	130	104	78	52	26
781	781	754	728	702	676	650	624	598	572	546	520	494	468	442	416	390	364	338	312	286	260	234	208	182	156	130	104	78	52	26
782	782	755	729	703	677	651	625	599	573	547	521	495	469	443	417	391	364	338	312	286	260	234	208	182	156	130	104	78	52	26
783	783	756	730	704	678	652	626	600	574	548	522	495	469	443	417	391	365	339	313	287	261	234	208	182	156	130	104	78	52	26
784	784	757	731	705	679	653	627	601	574	548	522	496	470	444	418	392	365	339	313	287	261	235	209	182	156	130	104	78	52	26
785	785	758	732	706	680	654	628	601	575	549	523	497	471	444	418	392	366	340	314	287	261	235	209	183	157	130	104	78	52	26
786	786	759	733	707	681	655	628	602	576	550	524	497	471	445	419	393	366	340	314	288	262	235	209	183	157	131	104	78	52	26
787	787	760	734	708	682	655	629	603	577	550	524	498	472	445	419	393	367	341	314	288	262	236	209	183	157	131	104	78	52	26
788	788	761	735	709	682	656	630	604	577	551	525	499	472	446	420	394	367	341	315	288	262	236	210	183	157	131	105	78	52	26
789	789	762	736	710	683	657	631	604	578	552	526	499	473	447	420	394	368	341	315	289	263	236	210	184	157	131	105	78	52	26
790	790	763	737	711	684	658	632	605	579	553	526	500	474	447	421	395	368	342	316	289	263	237	210	184	158	131	105	79	52	26
791	791	764	738	711	685	659	632	606	580	553	527	500	474	448	421	395	369	342	316	290	263	237	210	184	158	131	105	79	52	26
792	792	765	739	712	686	660	633	607	580	554	528	501	475	448	422	396	369	343	316	290	264	237	211	184	158	132	105	79	52	26
793	793	766	740	713	687	660	634	607	581	555	528	502	475	449	422	396	370	343	317	290	264	237	211	185	158	132	105	79	52	26
794	794	767	741	714	688	661	635	608	582	555	529	502	476	449	423	397	370	344	317	291	264	238	211	185	158	132	105	79	52	26
795	795	768	742	715	689	662	636	609	583	556	530	503	477	450	424	397	371	344	318	291	265	238	212	185	159	132	106	79	53	26
796	796	769	742	716	689	663	636	610	583	557	530	504	477	451	424	398	371	344	318	291	265	238	212	185	159	132	106	79	53	26
797	797	770	743	717	690	664	637	611	584	557	531	504	478	451	425	398	371	345	318	292	265	239	212	185	159	132	106	79	53	26
798	798	771	744	718	691	665	638	611	585	558	532	505	478	452	425	399	372	345	319	292	266	239	212	186	159	133	106	79	53	26
799	799	772	745	719	692	665	639	612	585	559	532	506	479	452	426	399	372	346	319	292	266	239	213	186	159	133	106	79	53	26
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Mon. Allot.	DATE OF APPLICATION																													
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802	802	775	748	721	695	668	641	614	588	561	534	507	481	454	427	401	374	347	320	294	267	240	213	187	160	133	106	80	53	26
803	803	776	749	722	695	669	642	615	588	562	535	508	481	455	428	401	374	347	321	294	267	240	214	187	160	133	107	80	53	26
804	804	777	750	723	696	670	643	616	589	562	536	509	482	455	428	402	375	348	321	294	268	241	214	187	160	134	107	80	53	26
805	805	778	751	724	697	670	644	617	590	563	536	509	483	456	429	402	375	348	322	295	268	241	214	187	161	134	107	80	53	26
806	806	779	752	725	698	671	644	617	591	564	537	510	483	456	429	403	376	349	322	295	268	241	214	188	161	134	107	80	53	26
807	807	780	753	726	699	672	645	618	591	564	538	511	484	457	430	403	376	349	322	295	269	242	215	188	161	134	107	80	53	26
808	808	781	754	727	700	673	646	619	592	565	538	511	484	457	430	404	377	350	323	296	269	242	215	188	161	134	107	80	53	26
809	809	782	755	728	701	674	647	620	593	566	539	512	485	458	431	404	377	350	323	296	269	242	215	188	161	134	107	80	53	26
810	810	783	756	729	702	675	648	621	594	567	540	513	486	459	432	405	378	351	324	297	270	243	216	189	162	135	108	81	54	27
811	811	783	756	729	702	675	648	621	594	567	540	513	486	459	432	405	378	351	324	297	270	243	216	189	162	135	108	81	54	27
812	812	784	757	730	703	676	649	622	595	568	541	514	487	460	433	406	378	351	324	297	270	243	216	189	162	135	108	81	54	27
813	813	785	758	731	704	677	650	623	596	569	542	514	487	460	433	406	379	352	325	298	271	243	216	189	162	135	108	81	54	27
814	814	786	759	732	705	678	651	624	596	569	542	515	488	461	434	407	379	352	325	298	271	244	217	189	162	135	108	81	54	27
815	815	787	760	733	706	679	652	624	597	570	543	516	489	461	434	407	380	353	326	298	271	244	217	190	163	135	108	81	54	27
816	816	788	761	734	707	680	652	625	598	571	544	516	489	462	435	408	380	353	326	299	272	244	217	190	163	136	108	81	54	27
817	817	879	762	735	708	680	653	626	599	571	544	517	490	462	435	408	381	354	326	299	272	245	217	190	163	136	108	81	54	27
818	818	790	763	736	708	681	654	627	599	572	545	518	490	463	436	409	381	354	327	299	272	245	218	190	163	136	109	81	54	27
819	819	791	764	737	709	682	655	627	600	573	546	518	491	464	436	409	382	354	327	300	273	245	218	191	163	136	109	81	54	27
820	820	792	765	738	710	683	656	628	601	574	546	519	492	464	437	410	382	355	328	300	273	246	218	191	164	136	109	82	54	27
821	821	793	766	738	711	684	656	629	602	574	547	519	492	465	437	410	383	355	328	301	273	246	218	191	164	136	109	82	54	27
822	822	794	767	739	712	685	657	630	602	575	548	520	493	465	438	411	383	356	328	301	274	246	219	191	164	137	109	82	54	27
823	823	795	768	740	713	685	658	630	603	576	548	521	493	466	438	411	384	356	329	301	274	246	219	192	164	137	109	82	54	27
824	824	796	769	741	714	686	659	631	604	576	549	521	494	466	439	412	384	357	329	302	274	247	219	192	164	137	109	82	54	27
825	825	797	770	742	715	687	660	632	605	577	550	522	495	467	440	412	385	357	330	302	275	247	220	192	165	137	110	82	55	27

Mon. Allot.	DATE OF APPLICATION																													
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826	826	798	770	743	715	688	660	633	605	578	550	523	495	468	440	413	385	357	330	302	275	247	220	192	165	137	110	82	55	27
827	827	799	771	744	716	689	661	634	606	578	551	523	496	468	441	413	385	358	330	303	275	248	220	192	165	137	110	82	55	27
828	828	800	772	745	717	690	662	634	607	579	552	524	496	469	441	414	386	358	331	303	276	248	220	193	165	138	110	82	55	27
829	829	801	773	746	718	690	663	635	607	580	552	525	497	469	442	414	386	359	331	303	276	248	221	193	165	138	110	82	55	27
830	830	802	774	747	719	691	664	636	608	581	553	525	498	470	442	415	387	359	332	304	276	249	221	193	166	138	110	83	55	27
831	831	803	775	747	720	692	664	637	609	581	554	526	498	470	443	415	387	360	332	304	277	249	221	193	166	138	110	83	55	27
832	832	804	776	748	721	693	665	637	610	582	554	526	499	471	443	416	388	360	332	305	277	249	221	194	166	138	110	83	55	27
833	833	805	777	749	721	694	666	638	610	583	555	527	499	472	444	416	388	360	333	305	277	249	222	194	166	138	111	83	55	27
834	834	806	778	750	722	695	667	639	611	583	556	528	500	472	444	417	389	361	333	305	278	250	222	194	166	139	111	83	55	27
835	835	807	779	751	723	695	668	640	612	584	556	528	501	473	445	417	389	361	334	306	278	250	222	194	167	139	111	83	55	27
836	836	808	780	752	724	696	668	640	613	585	557	529	501	473	445	418	390	362	334	306	278	250	222	195	167	139	111	83	55	27
837	837	809	781	753	725	697	669	641	613	585	558	530	502	474	446	418	390	362	334	306	279	251	223	195	167	139	111	83	55	27
838	838	810	782	754	726	698	670	642	614	586	558	530	502	474	446	419	391	363	335	307	279	251	223	195	167	139	111	83	55	27
839	839	811	783	755	727	699	671	643	615	587	559	531	503	475	447	419	391	363	335	307	279	251	223	195	167	139	111	83	55	27
840	840	812	784	756	728	700	672	644	616	588	560	532	504	476	448	420	392	364	336	308	280	252	224	196	168	140	112	84	56	28
841	841	812	784	756	728	700	672	644	616	588	560	532	504	476	448	420	392	364	336	308	280	252	224	196	168	140	112	84	56	28
842	842	813	785	757	729	701	673	645	617	589	561	533	505	477	449	421	392	364	336	308	280	252	224	196	168	140	112	84	56	28
843	843	814	786	758	730	702	674	646	618	590	562	533	505	477	449	421	393	365	337	309	281	252	224	196	168	140	112	84	56	28
844	844	815	787	759	731	703	675	647	618	590	562	534	506	478	450	422	393	365	337	309	281	253	225	196	168	140	112	84	56	28
845	845	816	788	760	732	704	676	647	619	591	563	535	507	478	450	422	394	366	338	309	281	253	225	197	169	140	112	84	56	28
846	846	817	789	761	733	705	676	648	620	592	564	535	507	479	451	423	394	366	338	310	282	253	225	197	169	141	112	84	56	28
847	847	818	790	762	734	705	677	649	621	592	564	536	508	479	451	423	395	367	338	310	282	254	225	197	169	141	112	84	56	28
848	848	819	791	763	734	706	678	650	621	593	565	537	508	480	452	424	395	367	339	310	282	254	226	197	169	141	113	84	56	28
849	849	820	792	764	735	707	679	650	622	594	566	537	509	481	452	424	396	367	339	311	283	254	226	198	169	141	113	84	56	28
850	850	821	793	765	736	708	680	651	623	595	566	538	510	481	453	425	396	368	340	311	283	255	226	198	170	141	113	85	56	28

Mon. Allot.	DATE OF APPLICATION																													
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851	851	822	794	765	737	709	680	652	624	595	567	538	510	482	453	425	397	368	340	312	283	255	226	198	170	141	113	85	56	28
852	852	823	795	766	738	710	681	653	624	596	568	539	511	482	454	426	397	369	340	312	284	255	227	198	170	142	113	85	56	28
853	853	824	796	767	739	710	682	653	625	597	568	540	511	483	454	426	398	369	341	312	284	255	227	199	170	142	113	85	56	28
854	854	825	797	768	740	711	683	654	626	597	569	540	512	483	455	427	398	370	341	313	284	256	227	199	170	142	113	85	56	28
855	855	826	798	769	741	712	684	655	627	598	570	541	513	484	456	427	399	370	342	313	285	256	228	199	171	142	114	85	57	28
856	856	827	798	770	741	713	684	656	627	599	570	542	513	485	456	428	399	370	342	313	285	256	228	199	171	142	114	85	57	28
857	857	828	799	771	742	714	685	657	628	599	571	542	514	485	457	428	399	371	342	314	285	257	228	199	171	142	114	85	57	28
858	858	829	800	772	743	715	686	657	629	600	572	543	514	486	457	429	400	371	343	314	286	257	228	200	171	143	114	85	57	28
859	859	830	801	773	744	715	687	658	629	601	572	544	515	486	458	429	400	372	343	314	286	257	229	200	171	143	114	85	57	28
860	860	831	802	774	745	716	688	659	630	602	573	544	516	487	458	430	401	372	344	315	286	258	229	200	172	143	114	86	57	28
861	861	832	803	774	746	717	688	660	631	602	574	545	516	487	459	430	401	373	344	315	287	258	229	200	172	143	114	86	57	28
862	862	833	804	775	747	718	689	660	632	603	574	545	517	488	459	431	402	373	344	316	287	258	229	201	172	143	114	86	57	28
863	863	834	805	776	747	719	690	661	632	604	575	546	517	489	460	431	402	373	345	316	287	258	230	201	172	143	115	86	57	28
864	864	835	806	777	748	720	691	662	633	604	576	547	518	489	460	432	403	374	345	316	288	259	230	201	172	144	115	86	57	28
865	865	836	807	778	749	720	692	663	634	605	576	547	519	490	461	432	403	374	346	317	288	259	230	201	173	144	115	86	57	28
866	866	837	808	779	750	721	692	663	635	606	577	548	519	490	461	433	404	375	346	317	288	259	230	202	173	144	115	86	57	28
867	867	838	809	780	751	722	693	664	635	606	578	549	520	491	462	433	404	375	346	317	289	260	231	202	173	144	115	86	57	28
868	868	839	810	781	752	723	694	665	636	607	578	549	520	491	462	434	405	376	347	318	289	260	231	202	173	144	115	86	57	28
869	869	840	811	782	753	724	695	666	637	608	579	550	521	492	463	434	405	376	347	318	289	260	231	202	173	144	115	86	57	28
870	870	841	812	783	754	725	696	667	638	609	580	551	522	493	464	435	406	377	348	319	290	261	232	203	174	145	116	87	58	29
871	871	841	812	783	754	725	696	667	638	609	580	551	522	493	464	435	406	377	348	319	290	261	232	203	174	145	116	87	58	29
872	872	842	813	784	755	726	697	668	639	610	581	552	523	494	465	436	406	377	348	319	290	261	232	203	174	145	116	87	58	29
873	873	843	814	785	756	727	698	669	640	611	582	552	523	494	465	436	407	378	349	320	291	261	232	203	174	145	116	87	58	29
874	874	844	815	786	757	728	699	670	640	611	582	553	524	495	466	437	407	378	349	320	291	262	233	203	174	145	116	87	58	29
875	875	845	816	787	758	729	700	670	641	612	583	554	525	495	466	437	408	379	350	320	291	262	233	204	175	145	116	87	58	29

Mon. Allot.	DATE OF APPLICATION																													
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876	876	846	817	788	759	730	700	671	642	613	584	554	525	496	467	438	408	379	350	321	292	262	233	204	175	146	116	87	58	29
877	877	847	818	789	760	730	701	672	643	613	584	555	526	496	467	438	409	380	350	321	292	263	233	204	175	146	116	87	58	29
878	878	848	819	790	760	731	702	673	643	614	585	556	526	497	468	439	409	380	351	321	292	263	234	204	175	146	117	87	58	29
879	879	849	820	791	761	732	703	673	644	615	586	556	527	498	468	439	410	380	351	322	293	263	234	205	175	146	117	87	58	29
880	880	850	821	792	762	733	704	674	645	616	586	557	528	498	469	440	410	381	352	322	293	264	234	205	176	146	117	88	58	29
881	881	851	822	792	763	734	704	675	646	616	587	557	528	499	469	440	411	381	352	323	293	264	234	205	176	146	117	88	58	29
882	882	852	823	793	764	735	705	676	646	617	588	558	529	499	470	441	411	382	352	323	294	264	235	205	176	147	117	88	58	29
883	883	853	824	794	765	735	706	676	647	618	588	559	529	500	470	441	412	382	353	323	294	264	235	206	176	147	117	88	58	29
884	884	854	825	795	766	736	707	678	648	618	589	559	530	500	471	442	412	383	353	324	294	265	235	206	176	147	117	88	58	29
885	885	855	826	796	767	737	708	679	649	619	590	560	531	501	472	442	413	383	354	324	295	265	236	206	177	147	118	88	59	29
886	886	856	826	797	767	738	708	679	649	620	590	561	531	502	472	443	413	383	354	324	295	265	236	206	177	147	118	88	59	29
887	887	857	827	798	768	739	709	680	650	620	591	561	532	502	473	443	413	384	354	325	295	266	236	206	177	147	118	88	59	29
888	888	858	828	799	769	740	710	680	651	621	592	562	532	503	473	444	414	384	355	325	296	266	236	207	177	148	118	88	59	29
889	889	859	829	800	770	740	711	681	651	622	592	563	533	503	474	444	414	385	355	325	296	266	237	207	177	148	118	88	59	29
890	890	860	830	801	771	741	712	682	652	623	593	563	534	504	474	445	415	385	356	326	296	267	237	207	178	148	118	89	59	29
891	891	861	831	801	772	742	712	683	653	623	594	564	534	504	475	445	415	386	356	326	297	267	237	207	178	148	118	89	59	29
892	892	862	832	802	773	743	713	683	654	624	594	564	535	505	475	446	416	386	356	327	297	267	237	208	178	148	118	89	59	29
893	893	863	833	803	773	744	714	684	654	625	595	565	535	506	476	446	416	386	357	327	297	267	238	208	178	148	119	89	59	29
894	894	864	834	804	774	745	715	685	655	625	596	566	536	506	476	447	417	387	357	327	298	268	238	208	178	149	119	89	59	29
895	895	865	835	805	775	745	716	686	656	626	596	566	537	507	477	447	417	387	358	328	298	268	238	208	179	149	119	89	59	29
896	896	866	836	806	776	746	716	686	657	627	597	567	537	507	477	448	418	388	358	328	298	268	238	209	179	149	119	89	59	29
897	897	867	837	807	777	747	717	687	657	627	598	568	538	508	478	448	418	388	358	328	299	269	239	209	179	149	119	89	59	29
898	898	868	838	808	778	748	718	688	658	628	598	568	538	508	478	449	419	389	359	329	299	269	239	209	179	149	119	89	59	29
899	899	869	839	809	779	749	719	689	659	629	599	569	539	509	479	449	419	389	359	329	299	269	239	209	179	149	119	89	59	29
900	900	870	840	810	780	750	720	690	660	630	600	570	540	510	480	450	420	390	360	330	300	270	240	210	180	150	120	90	60	30

*For any monthly allotments greater than $900, use the following formula to calculate the prorated amount:

Monthly allotment X $\frac{(31\text{-date of application})}{30}$ = prorated allotment. Round down to the nearest number.

APPENDIX E: PICKLE AMENDMENT COVERAGE (PAC) ELIGIBILITY – METHOD 1 AND METHOD 2

E.1 PAC ELIGIBILITY METHOD 1

This method is used first to determine PAC eligibility.

Last Supplemental Security Income (SSI) Check Received	Multiplier
2025	973
2024	.949
2023	.920
2022	.846
2021	.799
2020	.788
2019	.776
2018	.755
2017	.740
1/2015 through 12/2016	.738
2014	.726
2013	.715
2012	.703
1/2009 through 12/2011	.678
2008	.641
2007	.627
2006	.607
2005	.583
2004	.568
2003	.556
2002	.548

Last Supplemental Security Income (SSI) Check Received	Multiplier
2001	.534
2000	.516
1999	.504
1998	.497
1997	.487
1996	.473
1995	.461
1994	.449
1993	.437
1992	.425
1991	.409
1990	.388
1989	.371
1988	.357
1987	.342
1986	.338
1985	.328
1984	.317
7/82 through 12/83	.306
7/81 through 6/82	.285
7/80 through 6/81	.256
7/79 through 6/80	.224
7/78 through 6/79	.204
7/77 through 6/78	.192
4/77 through 6/77	.181

Choose from the list the factor for the month in which the client last received SSI. Multiply the current Social Security amount by the appropriate factor.

E.2 PAC ELIGIBILITY METHOD 2

This method must be used when Method 1 results in PAC ineligibility by $20 or less.

Last SSI Check Received	Divisor
2025	1.028
2024	1.025
2023	1.032
2022	1.087
2021	1.059
2020	1.013
2019	1.016
2018	1.028
2017	1.020
2016	1.003
2015	1.000
2014	1.017
2013	1.015
2012	1.017
2011	1.036
1/2009 through 12/2010	1.000
2008	1.058
2007	1.023
2006	1.033
2005	1.041
2004	1.027
2003	1.021
2002	1.014
2001	1.026
2000	1.035

Last SSI Check Received	Divisor
1999	1.025
1998	1.013
1997	1.021
1996	1.029
1995	1.026
1994	1.028
1993	1.026
1992	1.030
1991	1.037
1990	1.054
1989	1.047
1988	1.040
1987	1.042
1986	1.013
1985	1.031
1984	1.035
7/82 through 12/83	1.035
7/81 through 6/82	1.074
7/80 through 6/81	1.112
7/79 through 6/80	1.143
7/78 through 6/79	1.099
7/77 through 6/78	1.065
4/77 through 6/77	1.059

After a determination is made using Method 2, if the client is ineligible for PAC by less than two dollars, refer to Section 4.11.

APPENDIX F: CURRENT FEDERAL TAX FILING REQUIREMENTS FOR DEPENDENTS

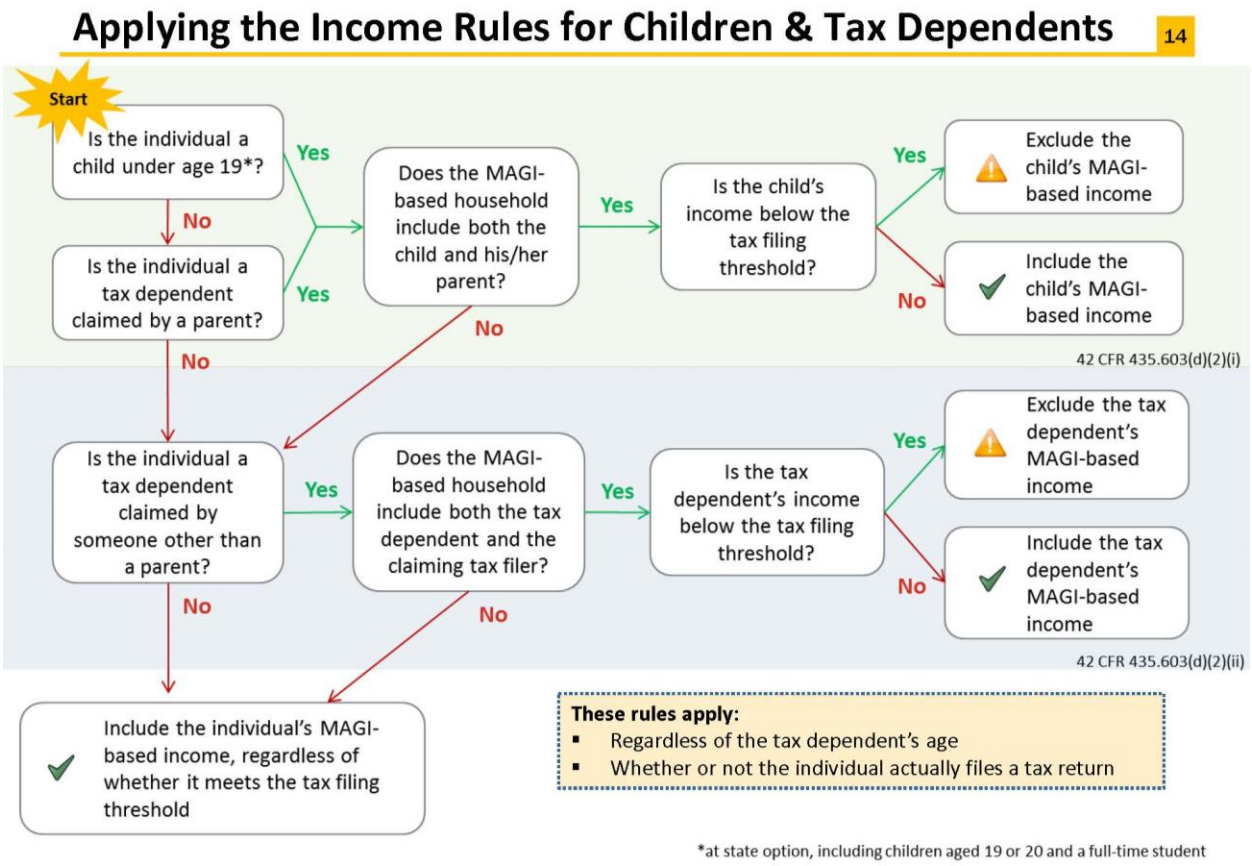
If your dependent is claimed on your tax return, they may still be required to file an income tax return of their own. The requirements vary depending on marital status and age. The minimum income requirements for dependents are listed in the table below.

In this table, unearned income includes taxable interest, ordinary dividends, and capital gain distributions. It also includes unemployment compensation, taxable Social Security benefits, pensions, annuities, and distributions of unearned income from a trust. Earned income includes salaries, wages, tips, professional fees, and taxable scholarship and fellowship grants. Gross income is the total of your unearned and earned income.

Marriage Status	Age	Minimum Gross Income Requirement	Minimum Self-Employment Income Requirement
Single	Under 65 and not blind	More than $15,750 earned or more than $1,350 unearned	$400
	65 or older OR blind	More than $17,750 earned or more than $3,350 unearned	$400
	65 or older AND blind	More than $19,750 earned or more than $5,350 unearned	$400
Married*	Under 65 and not blind	More than $15,750 earned or more than $1,350 unearned	$400
	65 or older OR blind	More than $17,350 earned or more than $2,950 unearned	$400
	65 or older AND blind	More than $18,950 earned or more than $4,550 unearned	$400

*An individual must file a return if their spouse files a separate return and itemizes deductions, and the individual's total income is $5 or more.

APPENDIX G: WHOSE INCOME COUNTS FOR MAGI



APPENDIX H: LOTTERY AND GAMBLING WINNINGS

Lottery and Gambling Winnings:

Months Over Which Income is Counted by Income Increment

From $	Up to $	# Months Counted for Medicaid
1	79,999	1
80,000	89,999	2
90,000	99,999	3
100,000	109,999	4
110,000	119,999	5
120,000	129,999	6
130,000	139,999	7
140,000	149,999	8
150,000	159,999	9
160,000	169,999	10
170,000	179,999	11
180,000	189,999	12
190,000	199,999	13
200,000	209,999	14
210,000	219,999	15
220,000	229,999	16
230,000	239,999	17
240,000	249,999	18
250,000	259,999	19
260,000	269,999	20
270,000	279,999	21
280,000	289,999	22
290,000	298,999	23
300,000	309,999	24
310,000	319,999	25
320,000	329,999	26
330,000	339,999	27
340,000	349,999	28
350,000	359,999	29
360,000	369,999	30
370,000	379,999	31
380,000	389,999	32
390,000	399,999	33
400,000	409,999	34

From $	Up to $	# Months Counted for Medicaid
410,000	419,999	35
420,000	429,999	36
430,000	439,999	37
440,000	449,999	38
450,000	459,999	39
460,000	469,999	40
470,000	479,999	41
480,000	489,999	42
490,000	499,999	43
500,000	509,999	44
510,000	419,999	45
520,000	529,999	46
530,000	539,999	47
540,000	549,999	48
550,000	559,999	49
560,000	569,999	50
570,000	579,999	51
580,000	589,999	52
590,000	599,999	53
600,000	609,999	54
610,000	619,999	55
620,000	629,999	56
630,000	639,999	57
640,000	649,999	58
650,000	659,999	59
660,000	669,999	60
670,000	679,999	61
680,000	689,999	62
690,000	699,999	63
700,000	709,999	64
710,000	719,999	65
720,000	729,999	66
730,000	739,999	67
740,000	749,999	68

750,000	759,999	69
760,000	769,999	70
770,000	779,999	71
780,000	789,999	72
790,000	799,999	73
800,000	809,999	74
810,000	819,999	75
820,000	829,999	76
830,000	839,999	77
840,000	849,999	78
850,000	859,999	79
860,000	869,999	80
870,000	879,999	81
880,000	889,999	82
890,000	899,999	83
900,000	909,999	84
910,000	919,999	85
920,000	929,999	86
930,000	939,999	87
940,000	949,999	88
950,000	959,999	89
960,000	969,999	90
970,000	979,999	91
980,000	989,999	92
990,000	999,999	93
1,000,000	1009,999	94

1,010,000	1,019,999	95
1,020,000	1,029,999	96
1,030,000	1,039,999	97
1,040,000	1,049,999	98
1,050,000	1,059,999	99
1,060,000	1,069,999	100
1,070,000	1,079,999	101
1,080,000	1,089,999	102
1,090,000	1,099,999	103
1,100,000	1,109,999	104
1,110,000	1,119,999	105
1,120,000	1,129,999	106
1,130,000	1,139,999	107
1,140,000	1,149,999	108
1,150,000	1,159,999	109
1,160,000	1,169,999	110
1,170,000	1,179,999	111
1,180,000	1,189,999	112
1,190,000	1,199,999	113
1,200,000	1,209,999	114
1,210,000	1,219,999	115
1,220,000	1,229,999	116
1,230,000	1,239,999	117
1,240,000	1,249,999	118
1,250,000	1,259,999	119
1,260,000		120

Chapter 4

Income

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
4.1				
4.2	6/1/19	772	4.2	Definition of disqualification due to substantial lottery and game winnings
	10/1/19	777	4.2	Added definition of minimum SNAP benefit
	10/1/21	809	4.2	Updated definition of Minimum SNAP Benefit
	10/1/22	828	4.2	Updated definition of Minimum SNAP Benefit
	1/1/24	845	4.2.3	Corrected manual section
	10/1/24	855	4.2	Minimum SNAP benefits of $23 remains the same.
	10/1/25	869	4.2	Definitions - Updated the minimum SNAP allotment amount.
	2/1/26	873	4.2	Added policy regarding an individual who has funds diverted t PASS account that they are receiving SSI or SSI eligible.
4.3	1/1/18	749	4.3.1	Adding ABLE accounts to income chart. Distributions from, contributions to, and earned interest in those accounts is excluded income for Medicaid.
			4.3.2	Adding ABLE accounts distributions used for qualified disability expenses to the list of excluded income sources.
				New SSI amounts
	1/1/18	750	4.3.1	
	2/1/18	751	4.3.1	This change is to match federal clarification that prepaid credit or debit cards given to a member of the AG and any subsequent contributions to the card by non-AG members are considered cash contributions for SNAP income purposes.
	1/1/19	768	4.3.1	New SSI amounts
	5/1/19	771	4.3.2	Updated income and deductions
	1/1/20	780	4.3.2	Chart 2- Lists Qualified Lottery and Gambling Winnings and

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	5/1/20	786	4.2.1	Discharged Student Loans as included sources of income Added a NOTE: the one-time $1,200 per individual, $2,400 per couple, and $500 per dependent child federal stimulus payment will NOT count as income for non-MAGI categories Added a NOTE: the weekly $600 Federal Pandemic Unemployment Compensation payments will not be countable for determining eligibility for Non-MAGI Medicaid categories Added two new income types that are not countable as income for MAGI Medicaid or WVCHIP: $600 weekly Federal Pandemic Unemployment Compensation and federal stimulus payments
	10/20	793	4.3.1	Wages for Census workers
	1/1/2021	799	4.3.1	Updated benefit amount
	2/1/21	800	4.3.1	Census Bureau is excluded for SNAP & WVWORKS
	5/1/21	804	4.3.1 & 2	Update payments not counted as income.
	1/1/22	815	4.3.1.85	Updated fees
	1/1/23	830	4.3.1.53 & 62	Added clarification on how repayments of loans are counted for the lender for SSI-Related Medicaid. Removed section informing about interest paid to lender.
			4.3.1.85	Updated the maximum limit for fees collected by a qualified organization for acting as a representative payee for certain SSI and RSDI recipients. Increased to $52 and $97.
	4/1/23	835	4.3.1.43	Income Tax Refunds: Removed the Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebates/Economic Impact Payments will not count as income.
			4.3.1.92	Unemployment Compensation Insurance: Removed the Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebates/Economic Impact Payments will not count as income.
			4.3.2	Unemployment Benefits: Removed the exemption for $600 weekly Federal Pandemic Unemployment Compensation payments that do not count as income.
	1/1/24	845	4.3	Updated number amounts
	3/1/24	848	4.3.2	Chart 2 - Updated the Countable Sources of Income to reflect an exception to counting income from Alimony
	6/1/24	851	4.3.2	Chart 2 - Clarification is being made for MAGI Coverage Groups that AmeriCorps Living Expense income is not a Countable Source of Income but rather an Excluded Source of Income.
	1/1/25	859	4.3.1.85	Updated the maximum limit for fees collected by a qualified organization for acting as a representative payee for certain SSI and RSDI recipients. Increased to $55 and $103.
	4/1/25	862	4.3.1	Added policy regarding the use of gift cards issued for medical care and services from a federal, state, or local government.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	1/1/26	872	4.3.1.85	Updated the maximum limit for fees collected by a qualified organization for acting as a presentative payee for certain SSI and RSDI recipients. They have increased to $57 and $106.
4.4	2/1/18	751	4.4.2.B.6	This change is to match federal clarification that medical expenses related to the use of an illegal drug under federal law may not be considered deductible for SNAP purposes
			4.4.4.Q.1	This change is to clarify policy regarding the treatment of income received by military personnel deployed to a designated combat zone.
	10/1/19	777		
	3/1/20	781	4.4.3.C	Removed references to Basis of Issuance chart and corrected proration minimum amount
	10/1/20	793	4.4.2.B.5 &4.4.2.B.7	Clarify SNAP shelter verification
	10/1/21	809	4.4.4.R	Removed section for SNAP
	10/1/22	828	4.4.3.C	Updated example of method used to determine benefit amount
	10/1/24	855	4.4.3.C	Updated example of method used to determine benefit amount
	10/1/25	869	4.4.3.C	Updated example of method used to determine the benefit amount.
			4.4.3.C	Updated the benefits computation example.
4.5	3/1/19	769	4.5.4. O	Added payment from Census Bureau
	1/1/20	780	4.5.2.B	Clarified child support for WV WORKS
	1/1/20	780	4.5.3.E	Clarified child support income code
	3/1/20	782	4.5.4.K	Clarified unstated income.
	10/1/20	793	4.5.4.O	Removed section for WORKS
4.6				
4.7	8/1/18	762	4.7.1	Corrected the reference in NOTE from Appendix G to Appendix F, where the information is found.
			4.7.1.A	In example titled “Child’s Income Included”, updated child’s earned income amount to appropriate amount that would be counted under the new rules.
			4.7.2.B	In list, added info to moving expenses that is now a requirement for that deduction, and removed tuition and fees deduction.
	5/1/19	771	4.7.2.B & C	Updated income and deductions
	1/1/20	779	4.7.5.B	Updates exiting policy for pre-existing alimony agreements
			4.7.5.F	Added Exemption policy for Qualified Lottery and Gambling Winnings to include as income for MAGI
	3/1/24	848	4.7.2.B	Updated Language for alimony deductions
	12/1/25	871		Clarifies certain pre-tax deductions are taken prior to the

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			4.7.2.A	countable gross income calculations for MAGI Medicaid. Included common pre-tax deductions and examples.
4.8				
4.9				
4.10				
4.11	3/1/19 3/1/21	769 802	4.11.7. A.2 4.11.7. A.2	Correction to example 3 Updated examples
4.12				
4.13				
4.14	1/1/18 1/1/19 1/1/21 1/1/22 1/1/23 1/1/24 1/1/25 1/1/26	750 768 799 813 830 845 859 872	4.14.2.A-D 4.14.2.A-D 4.14.2.A-D 4.14.2.A 4.14.4.D 4.14.2.A 4.14.4.D 4.14.4.D.3 4.14.2.A.6 4.14.4.D.2 4.14.4.D.3 4.14.2.A.6 4.14.4.D.2 4.14.4.D.3 4.14.2.A.6 4.14.4.D.2 4.14.4.D.3	New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts
4.15				
4.16				
4.17				
4.18	10/1/20	794	4.18	Replaced word illegal
4.19				

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
4.20	6/1/24 7/1/24	851 852	4.20.1 4.20 4.20.1	Updated ADAP income limit to 500%. Updated to ADAP from BMS Updated to ADAP from BMS. Also updated to correct FPL for the ADAP.

4.1 INTRODUCTION

This Chapter contains the income policies and procedures used to determine eligibility and the amount of the benefit for Supplemental Nutrition Assistance Program (SNAP) benefits, WV WORKS, and most Medicaid coverage groups. The income eligibility information for some benefits and eligibility groups can be found in the chapters listed below.

Benefit	Chapter
Medicaid	
Aged and Disabled Waiver (ADW)	Chapter 24
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services	Chapter 24
Intellectual/Developmental Disabilities (I/DD) Waiver	Chapter 24
Medicaid Work Incentive (M-WIN)	Chapter 26
Non-Emergency Medical Transportation (NEMT)	Chapter 27
Nursing Facility services	Chapter 24
Traumatic Brain Injury (TBI) Waiver	Chapter 24
Noncitizens and Refugees	Chapter 15
Other Benefits	
Indigent Burial	Chapter 20
Emergency Assistance	Chapter 20
Low Income Energy Assistance Program (LIEAP)	Chapter 21
Special Pharmacy	Chapter 28
Tele-Assistance/Lifeline Program	Chapter 20
20% Utility Assistance	Chapter 20

The following Medicaid coverage groups require no income eligibility determination by the Worker:

- Adoption Assistance
- Continuously Eligible Newborn Children (CEN)
- Disabled Adult Children (DAC)
- Disabled Widows and Widowers
- Drug Addicts and Alcoholics (DA&A)
- Foster Care

- Former West Virginia Foster Child
- Pass-Throughs
- Supplemental Security Income (SSI) Recipients
- Essential Spouses of SSI Recipients

For more information about these coverage groups, refer to Chapter 23.

This chapter includes charts of sources of income and shows whether or not they are counted for each program. In addition, if an income source is counted, the chart identifies it as earned, self-employment, or unearned income. For each program that requires an income determination by the Worker, there are sections explaining budgeting methods, deductions and disregards, incentives, how to determine countable income, and special situations. Income limits applicable to each benefit are found in Appendix A.

Income is defined as any and all monies received from any source.

The determination of countable income is necessary, because it is, generally, the countable income that is tested against maximum income limits.

The first step in determining countable income is to determine all the incoming monies to the assistance group (AG) and to those whose income is counted for, or deemed to, the AG.

Once all incoming monies have been identified, they are compared to the income exclusions listed in this Chapter, and, if applicable, the income from any excluded source is subtracted.

After all income exclusions have been applied, some of the remaining income may qualify for certain disregards and deductions as outlined in the sections for each specific program.

For Medicaid coverage groups calculated using Modified Adjusted Gross Income (MAGI) Methodology, different steps are required to calculate countable income. See Section 4.7 for a complete discussion of the MAGI income calculation methodology.

4.2 DEFINITIONS

ADJUSTED GROSS INCOME

The amount of taxable income of a household minus specific deductions allowed under federal law. See Section 4.7 for instructions on calculating adjusted gross income.

ADMINISTRATIVE REDETERMINATION

A redetermination process occurring without active participation by the client for Medicaid Groups and the West Virginia Children's Health Insurance Program (WVCHIP). This process is designed to occur electronically or by a pre-populated form, rather than requiring the completion of a blank application.

ADVANCE PREMIUM TAX CREDIT (APTC)

A federal tax credit through Federally Facilitated Marketplace (FFM) that will help make a Qualified Health Plan (QHP) affordable by reducing a taxpayer's out-of-pocket premium when enrolled through the Marketplace.

AFFORDABLE CARE ACT (ACA)

The Patient Protection and Affordable Care Act enacted March 23, 2010, and the Health Care and Education Reconciliation Act enacted March 30, 2010, are collectively referred to as the Affordable Care Act.

AGED

This is also referred to as ELDERLY.

Medicaid: An individual who is at least age 65.

Supplemental Nutrition Assistance Program (SNAP) and WV WORKS: An individual who is at least age 60.

ALLOCATION STANDARD

The difference between the maximum Supplemental Security Income (SSI) payment for one and two persons.

ALLOTMENT

An appropriation of one individual's income diverted to another, such as a military allotment.

SNAP BENEFIT ALLOTMENT

The approved monthly benefit that is deposited into an electronic benefits transfer (EBT) account for the client to purchase food for home preparation or seeds and plants that produce food for home consumption.

AMERICORPS

A national service program administered by the Corporation for National and Community Service (CNCS). Included in the AmeriCorps Network of programs are AmeriCorps USA, AmeriCorps Volunteers in Service to America (VISTA), and AmeriCorps National Civilian Community Corps (NCCC). Closely associated with the AmeriCorps Programs are the Senior Corps, the Youth Corps, and Learn and Serve, which are also administered by CNCS.

ANNUITY

An investment contract or agreement, which gives the right to receive fixed, periodic payments, either for life or a specific term of years.

BASIC NEEDS

The primary needs of individuals or families, such as food, clothing, shelter, and incidentals.

BONA FIDE LOAN

Aid to Families with Dependent Children (AFDC)-Related Medicaid Only: A loan that meets one of the following conditions:

The client has proof that the loan was obtained from an individual or establishment engaged in the business of making loans; or

The client and the lender have completed and signed form ES-AP-75 (Verification of Loan Conditions) to acknowledge the obligation to repay the loan, with or without interest.

> **EXCEPTION:** SSI-Related Medicaid, Children with Disabilities Community Service Program (CDCSP), Pickle Amendment Coverage (PAC), Qualified Disabled Working Individuals (QDWI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB) and Qualified Individual – 1 (QI-1) Only: A loan agreement that is legally valid. This includes oral and written agreements that are binding under state law and which include the borrower's acknowledgement of his obligation to repay, a schedule and plan for repayment and the borrower's express intent to repay with real or personal property or anticipated income.

CHILD

SNAP Only: An individual who is not yet 18, nor the head of a household.

AFDC-Related Medicaid and WV WORKS Only: See Section 3.3 for definition of a dependent child for these programs.

SSI-Related Medicaid, CDCSP, PAC, QDWI, QMB, SLIMB and QI-1 Only: When an individual meets the SSI definition of a child, he may be entitled to additional income disregards or deductions, have income deemed to him or have his needs considered when income is deemed from an ineligible individual to an eligible one.

A Child is:

- A natural or adopted child who lives in a household with one or both parents; and
- Under age 18; or
- Under age 22 and a student; and
- Not married nor head of household

Deeming (defined below) to an eligible child no longer applies beginning the month following the month the child attains age 18 or is over 18 and is no longer a student.

Modified Adjusted Gross Income (MAGI) Coverage Groups: For MAGI Medicaid coverage groups where eligibility is determined based on MAGI methodology, a child is defined an individual under the age of 19.

COLA (COST OF LIVING ADJUSTMENTS)

Adjustments to entitlement benefits, pensions or other retirement income such as Retirement, Survivors, and Disability Insurance (RSDI), Black Lung and Railroad Retirement.

CONVERTING INCOME AND DEDUCTIONS

The method used to change income and deductions paid less often than monthly to a monthly amount.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)

The federal government administers a number of national and community service programs such as, but not limited to, AmeriCorps and the NCCC. In addition, it administers the former ACTION Agency programs created by the Domestic Volunteer Act of 1973. Former ACTION programs include, but are not limited to, AmeriCorps VISTA, University Year of Action, Urban Crime Prevention Program, Retired Senior Volunteer Program (RSVP) and Foster Grandparents.

COUNTABLE INCOME

The amount of income after all allowable exclusions, disregards and deductions have been applied. The eligibility and level of benefit are based on this amount.

MAGI Medicaid Coverage Groups Only: For these groups, eligibility is not based on countable income, it is based on the MAGI calculated as outlined in Section 4.7.

DEDUCTION

A specific amount subtracted from income. Allowable deductions are different, depending upon the program involved.

DEEMING

The process by which the treatment of income of individuals, not included in the assistance group (AG), but living in the home, is counted for the AG, whether or not the income is actually

made available. There are two methods by which this may be accomplished: by treating the deemor's income as if he were included in the AG or by allowing for the needs of the deemor, as well as the needs of others for whom he is financially responsible to be subtracted from the income, and counting the remaining income for the AG. The appropriate method depends on the relationship between the individuals and the program or coverage group involved.

DISQUALIFIED INDIVIDUAL

A person who must normally be included in an AG, but who has been excluded due to his failure to comply with a specific program requirement. This person may also be referred to as a SANCTIONED INDIVIDUAL.

DISREGARD

A portion of income that is not counted when determining countable income. Allowable disregards are different, depending upon the program involved.

DIVIDEND

A share of profits received by a stockholder, stakeholder, or a policy holder.

EARNED INCOME

Income of an individual which is derived, at least in part, from compensation for physical or mental activity as part of a trade or business. Earnings include gross income from employment and gross profit from self-employment.

EARNED INCOME TAX CREDIT (EITC)

An amount by which an individual’s federal income tax obligation is reduced or eliminated. When eligible for the EITC, an individual may receive a federal tax refund which exceeds the original amount withheld or he may receive monthly advance payments.

ELDERLY

This is also referred to as AGED.

Medicaid: An individual who is at least age 65.

SNAP and WV WORKS benefits: An individual who is at least age 60.

EMPLOYMENT

A situation in which a wage, salary or commission is paid to an individual for services rendered. The employer usually takes the responsibility for withholding income taxes and FICA taxes from the wages. However, if this is not done, the employee may pay these taxes himself without affecting his status as an employee. The employer controls such things as hours worked, what is done and where the work is located.

EXCLUDED BY LAW

An individual specifically excluded from the AG by Federal or State law.

EXCLUSION

Income or assets that are treated as if they do not exist.

FEDERAL DATA HUB (FDH)

An electronic Federal data service through which the Department of Human Services (DOHS) will obtain information from federal agencies or other data sources such as the Social Security Administration (SSA), the Department of Treasury and Homeland Security.

FEDERALLY FACILITATED MARKETPLACE (FFM)

This term refers to a State or Federally Facilitated Health Insurance Marketplace and is also referred to as The Marketplace. It is a governmental agency or non-profit entity that makes Qualified Health Plans (QHP) available to qualified individuals. The Marketplace will allow individuals to: compare private health plans; obtain answers to questions about health coverage options; determine if they are eligible for tax credits for private insurance or health programs like Medicaid and WVCHIP; and enroll in a health plan that meets their needs. The Marketplace must have a consumer assistance function, including the navigator program. The Marketplace must provide for operation of a toll-free call center and must maintain an up-to-date Internet website. States must coordinate with the State or Federal Exchange to share eligibility date and eligibility determinations for applicants for Medicaid, WVCHIP or the Marketplace.

GIFT CARD/CERTIFICATE

Representation in paper form as a certificate or other device such as an electronic card that has a dollar value, a merchandise credit, or verification of value where the issuer has received payment for the full face value with the agreement that the card will be redeemed in the future for food, goods, services, credit, or money of at least an equal value. A gift card/certificate must be evaluated to determine if it can be used to purchase food or shelter and if there are any restrictions related to its use.

GROSS INCOME

The amount of monthly income received before any deductions.

GROSS PROFIT

The total gross income from self-employment, less the cost of producing the income.

INCENTIVE PAYMENT

An allowance paid for participation in or successful completion of a training program, or an additional benefit paid.

INCURRED EXPENSES

Monetary liabilities of the client.

IN-KIND INCOME/PAYMENT

Goods or services received or provided by the AG in lieu of a cash payment.

INSURANCE AFFORDABILITY PROGRAM (IAP)

The IAP includes Medicaid, WVCHIP, and coverage in a QHP offered through the Marketplace using advanced payments of premium tax credit or cost-sharing reductions.

LUMP-SUM PAYMENTS

Non-recurring, recurring, or advance payments. This may include, but is not limited to, RSDI, stock dividends paid quarterly, or payments from an income disability insurance plan that cover a previous period, but are delayed for medical reports, etc.

MAGI DISREGARD

An income disregard that equals 5% of the Federal Poverty Level (FPL) for the family size, applicable only to Medicaid Groups and WVCHIP that use MAGI income-based methodologies. See Section 4.7 for further details.

MAGI SCREENING

All applicants will go through a “MAGI Screen” and will have MAGI Medicaid eligibility determined first. If eligible for a MAGI Medicaid coverage group, the applicant should promptly be enrolled into the MAGI coverage group. The applicant may also pursue eligibility for coverage in non-MAGI groups.

MANDATORY PAYROLL DEDUCTIONS

Income withholdings common to all employees of the same employer.

MEANSTESTED PROGRAM

A program for which the client's financial circumstances are considered in determining eligibility and/or benefit level. Also known as NEEDS-BASED PROGRAM.

MINIMUM ESSENTIAL COVERAGE (MEC)

Coverage as defined in Section 5000 (f) of Subtitle D of the Internal Revenue Code. MEC includes, but is not limited to, Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, TRICARE, Veterans Affairs (VA) benefits, Peace Corps, Employee Sponsored Plans and Plans in the individual market.

MINIMUM SNAP BENEFIT

Currently, the minimum SNAP benefit is $24.

MODIFIED ADJUSTED GROSS INCOME (MAGI)

Income figure used to determine eligibility for specific Medicaid eligibility groups and WVCHIP. The MAGI is calculated by making adjustments to the adjusted gross income. See Section 4.7.

NON-AG MEMBER

An individual whose income, resources, needs and/or expenses are not included in the AG of the individual or group of individuals with whom he lives, but who has not been disqualified, sanctioned or excluded by law.

NON-MEANS TESTED PROGRAM

A program that does not take into account income, or an individual's means, without the assistance. However, the benefit has its own rules for eligibility.

ODD JOBS

Small jobs of various types such as, cutting lawns, babysitting or other small jobs for a cash fee. Is not normally listed as a business and has little or no expenses.

PARENTAL LIVING ALLOWANCE

The SSI payment amount for one or two persons, depending on the number of parents in the home.

PLAN TO ACHIEVE SELF-SUPPORT (PASS)

A plan developed by the SSA or the DOHS for a blind or disabled individual to achieve self-support. For a plan through SSA, the individual must receive SSI or qualify for SSI after setting aside income or resources so that they may pursue a work goal.

PAY CARD/PAYROLL CARD/PAYROLL DEBIT CARD

A plastic debit card on which the employer or agency directly deposits the employee or clients earned or unearned income for his use. This card is used in lieu of a paper check or other paper document that indicates payments. An example would be a Direct Express Card.

PRORATION

The process of distributing income received as a single payment, or an expense met by a single payment, equally over the time period it is intended to cover.

QUALIFIED HEALTH PLAN (QHP)

Under the ACA, an insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements. A QHP will have a certification by each Marketplace in which it is sold.

REASONABLE COMPATIBILITY

This term is applicable for Medicaid Groups and WVCHIP. There is considered to be reasonable compatibility when discrepancies between an individual's self-attestation about his non-financial and financial information and the information reported by the FDH, AVS, or other electronic data sources available to the DOHS are within a designated threshold.

REASONABLE COMPATIBILITY STANDARD FOR INCOME ONLY

The Reasonable Compatibility Standard is an acceptable level of variance between self-attested income and income information obtained through electronic data sources. When the difference between the self-attestation and data source income affects eligibility, the reasonable compatibility test is applied by the eligibility system. Refer to 7.2.5.D.

West Virginia's Reasonable Compatibility Standard for MAGI Medicaid coverage groups only is 10%.

REASONABLE COMPATIBILITY STANDARD FOR ASSETS ONLY

The reasonable compatibility standard for assets applies only during the automatic renewal process. Assets are considered verified at automatic redetermination when the value of liquid assets returned by the Asset Verification System plus the value of non-liquid assets previously verified in the case record are below the asset limit. Further verification is not required. When the total of these assets exceeds the asset limit, assets are not considered verified, i.e., discrepant. The client must be mailed a pre-populated redetermination form and be given the opportunity to verify the value of their assets at renewal. See Section 6.3.6.

REIMBURSEMENT

Compensation for past or future expenses.

RELOCATION PAYMENTS

Money received from federal, state or local agencies to cover moving costs, cost of purchasing a home in a new location, or as a rent supplement, when a person or family is displaced by such an agency. Examples of these payments include, but are not limited to, Highway Relocation, Urban Renewal and the Army Corps of Engineers.

ROYALTIES

A share of the profit from the product of an oil or mineral lease. Also, a payment made to an author or composer for each copy of work sold or to an inventor for each article sold under a patent.

SANCTIONED INDIVIDUAL

A person who must normally be included in an AG, but who has been excluded due to his failure to comply with a specific program requirement. This person may also be referred to as a DISQUALIFIED INDIVIDUAL.

SELF-ATTESTATION

Information reported by an individual about financial and non-financial information.

SELF-EMPLOYMENT

A situation in which an individual has an investment in a business, has costs involved in producing income from this business, and could suffer a loss. He is usually responsible for his own income taxes and Federal Insurance Contribution Act (FICA) taxes. A self-employed individual usually has to provide his own equipment, supplies and materials needed to do a job or produce the income. He controls to some extent his hours of work and where the work is done.

SPECIAL NEEDS

Needs other than food, shelter, utilities, clothing and incidentals which are not uniformly shared by all members of the AG.

SPENDDOWN

The amount by which income exceeds the Medically Needy Income Level (MNIL) for the Period of Consideration (POC).

SUBSTANTIAL LOTTERY OR GAMBLING WINNINGS

An amount greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled member that is won in a single game, hand or bet.

THIRD-PARTY LIABILITY (TPL)

TPL refers to the legal obligation of third parties, such as any individual, entity, or other program, to pay part or all of the expenditures for medical assistance; therefore, TPL is the means by which Medicaid payments are reduced or reimbursed by the amount paid by any individual, entity or other program.

THIRD-PARTY PAYMENTS

Payments made on behalf of the AG by an individual who is not a member of the AG. To qualify as a third-party payment, there must be an identifiable payment on behalf of the AG, rather than

on behalf of the payer. Third-party payments are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

TRAINING ALLOWANCE

An allowance paid for participation in a training program. See INCENTIVE PAYMENTS.

TRUST FUND

A legal vehicle which allows money to be held by one individual (the trustee) for the benefit of another (the beneficiary).

UNEARNED INCOME

Income, which is not related, or only indirectly related, to the efforts or activities of the individual. Examples of unearned income are RSDI, SSI, VA benefits, pensions, compensation benefits, interest, royalties, allotments, contributions, and WV WORKS payments.

UNSTATED INCOME

SSI-Related Medicaid and WV WORKS Only: Money that has not been reported, and that is not otherwise known to the DOHS, but is determined to exist because the client's paid living expenses exceed income from known sources.

4.3 CHARTS OF INCOME SOURCES

The following two charts list sources of income and how they are treated for various benefits. Neither list is all inclusive, so all other payments from any source must be evaluated.

In Chart 1, the various programs are listed in the columns. The chart indicates if the source of income is counted and, if so, if the income is earned, self-employment or unearned. If special conditions apply, there is a narrative in the appropriate program column.

For income belonging to or for the benefit of a child, the source must be known, and the chart of income sources consulted for how the income is treated.

Any source of income may be received in a lump-sum payment. For instructions on treatment of a lump-sum payment, refer to the appropriate program section.

Income from Military Personnel while deployed to a designated combat zone may be made available to the assistance group (AG) in various ways. Specific sources are listed in this section. See the appropriate program section for the treatment of this income source.

Chart 1 has columns containing information about four sets of benefits that share criteria:

- Supplemental Nutrition Assistance Program (SNAP)
- Aid to Families with Dependent Children (AFDC)-Related Medicaid (See Section 3.18 for further information)
- Pickle Amendment Coverage (PAC), Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLIMB), Qualified Individual – 1 (QI-1), Qualified Disabled Working Individuals (QDWI), Children with Disabilities Community Service Program (CDCSP), Supplemental Security Income (SSI), SSI-Related Medicaid, and the AIDS Drug Assistance Program (ADAP). See Chapter 23 for further details about these coverage groups.
- WV WORKS and Diversionary Cash Assistance (DCA)

Chart 2 shows income sources used for the calculating the Modified Adjusted Gross Income (MAGI). These income sources are unique to the specific Medicaid coverage groups that utilize MAGI methodology to make eligibility determinations.

Because the calculation of MAGI relies on a base adjusted gross income figure, it is necessary to list the income sources used by the Internal Revenue Service (IRS) to calculate the adjusted gross income. These income sources are the basis of the calculation of the household's MAGI, and therefore apply to the following Medicaid coverage groups: Adult Group, Parents/Caretaker Relatives, Children Under 19, Pregnant Women; and to the West Virginia Children's Health Insurance Program (WVCHIP). Chart 2 should not be considered an exhaustive list of income sources that count towards adjusted gross income.

4.3.1 CHART 1

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
1. AMERICORPS COMMUNITY ENRICHMENT (ACE) AND RELATED PROGRAMS			
See Corporation for National and Community Service (CNCS)	See CNCS	See CNCS	See CNCS
2. ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACCOUNTS			
a. Contributions to (including 3rd party)			
No	No	No	No
b. Distributions from (used for qualified disability expenses)			
No	No	No	No
c. Interest earned in the account			
No	No	No	No
3. ADOPTION ASSISTANCE			
Unearned	Unearned. See Chapter 3.	No	Unearned
4. ADULT FAMILY CARE PROVIDER INCOME			
Earned if an employee; Self-Employment	Earned if an employee; Self-Employment	Earned if an employee; Self-Employment	Earned if an employee; Self-Employment
5. ADVANCE PAY			
See Employment	See Employment	See Employment	See Employment
6. AGRICULTURALSTABILIZATION AND CONSERVATION PROGRAMS			
Unearned	Unearned	Unearned	Unearned
7. ALASKAN NATIVE CLAIMS SETTLEMENT ACT PAYMENTS			
No	No	No	No

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
8. ALLOTMENTS DIVERTED FROM:			
a. Military - See Basic Allowance for Housing			
Unearned. See Section 4.4.4.Q for treatment of allotments from Military Personnel deployed to a designated combat zone.	Unearned	Unearned	Unearned
b. Job Corps			
Unearned	Unearned	Unearned	Unearned
9. ANNUITY PAYMENTS (Payments made from)			
Unearned	Unearned	Unearned	Unearned
10. BASIC ALLOWANCE FOR HOUSING (BAH) Paid to members of Armed Services See Allotments.			
Earned. See Section 4.4.4.Q for treatment of income made available to the AG from Military Personnel deployed to a designated combat zone.	Earned	Earned	Earned
11. CASH CONTRIBUTIONS FROM:			
a. Individuals Not for Shared Household Expenses			
Unearned. Prepaid credit or debit cards given to a member of the AG and any subsequent contributions to the card by non-AG	Unearned	Unearned	Unearned

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
members are considered cash contributions. See Section 4.4.4.Q for treatment of additional contributions from Military Personnel deployed to a designated combat zone.			
b. Individuals for Shared Household Expenses			
No	No	No	No
c. Charitable Organizations NOTE: See In-Kind Payments			
No, unless the amount exceeds $300 in a federal fiscal quarter. If so, the amount over $300 is counted as unearned in the month of receipt. A federal fiscal quarter is defined as a period of three consecutive calendar months beginning with January, April, July or October.	Unearned	Unearned **EXCEPTION:** Cash gifts to or for the benefit of individuals with a life-threatening condition are excluded when the following criteria is met: • Individual is under 18; and • The gift is from a tax-exempt organization under section 501(a) of the Internal Revenue Code; and • The amount of income from the gift(s) to the individual does not exceed $2,000 in a calendar year. Any amount in excess of $2,000 is income.	Unearned

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
		EXCEPTION: A gift used to pay tuition, fees or other necessary educational expenses at any educational institution, including a vocational or technical school, is excluded. This includes any portion of a gift that will be used to pay these expenses in the future. It does not include any portion set aside or used for food, clothing or shelter. During the 9 months following the month of receipt, if the client uses any portion of the gift for some other purpose or no longer intends to use the gift to pay tuition, fees or other necessary educational expenses, the gift is income at the earliest occurrence of either. Also see Section 4.14.4 for gifts used for tuition and fees.	
12. CHILD CARE PAYMENTS FUNDED BY THE CHILD CARE AND DEVELOPMENT BLOCK GRANT ACT			
No	No	No	No
13. CHILD SUPPORT			
a. Current NOTE: Separate entry for Spousal Support.			
Unearned	Unearned	Unearned	Unearned

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
b. Current Child Support for WV WORKS Clients			
When redirected, only the amount forwarded to the client by Bureau for Child Support Enforcement (BCSE) is counted as income.	The first $50 per month of child support is excluded in all steps of the eligibility process. See appropriate program sections.	If the client is a disabled child, 1/3 of child support received is deducted.	Child support up to $100 for one child or up to $200 for two or more children will pass through to families and will be disregarded as income after comparing to 100% Standard of Need (SON). See Section 4.5.4 for special requirements concerning child support for WV WORKS payment. **NOTE:** All child support payments, except pass-through, are income for DCA, but the client is not required to redirect when he is income eligible and receives a payment.
c. Current Child Support for All Others			
Unearned			
d. Arrearages (includes income tax intercept) **NOTE:** See WV WORKS Payments for CSI, Pass-through, and Excess Payments.			
Unearned When redirected, only the amount forwarded to the client by BCSE is counted as income. When not redirected to BCSE, the entire portion is counted as income. For income tax intercepts, see Lump-	Unearned When redirected, only the amount forwarded to the client by BCSE is counted as income. When not redirected to BCSE, the entire portion is counted as income.	Unearned When redirected, only the amount forwarded to the client by BCSE is counted as income. When not redirected to BCSE, the entire portion is counted as income.	Unearned When redirected, only the amount forwarded to the client by BCSE is counted as income. When not redirected to BCSE, the entire portion is counted as income.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
Sum Payments in Section 4.4.4.K.			
14. CHORE SERVICE PROVIDER INCOME			
Earned if an employee; Self-Employment	Earned if an employee; Self-Employment	Earned if an employee; Self-Employment	Earned if an employee; Self- Employment
15. COMMISSIONS			
See Employment	See Employment	See Employment	See Employment
16. COMMUNITY DEVELOPMENT BLOCK GRANTS AND LOANS			
No	No	No	Unearned
17. CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)			
a. Action Programs: Title I (VISTA, AmeriCorps VISTA, ACTION, University Year of Action, Urban Crime Prevent Program)			
Earned **EXCEPTION**: Excluded if the volunteer was eligible for or receiving AFDC/U, TANF, WV WORKS, SNAP or Medicaid at the time he joined. Once a determination is made, temporary interruptions in benefits do not alter the exclusion.	Earned **EXCEPTION**: Excluded if the volunteer was eligible for or receiving AFDC/U, TANF, WV WORKS, SNAP or Medicaid at the time he joined. Once a determination is made, temporary interruptions in benefits do not alter the exclusion.	Earned **EXCEPTION**: Excluded if the volunteer was eligible for or receiving AFDC/U, TANF, WV WORKS, SNAP or Medicaid at the time he joined. Once a determination is made, temporary interruptions in benefits do not alter the exclusion.	Earned **EXCEPTION**: Excluded if the volunteer was eligible for or receiving AFDC/U, TANF, WV WORKS, SNAP or Medicaid at the time he joined. Once a determination is made, temporary interruptions in benefits do not alter the exclusion.
b. Action Programs: Title II Retired Senior Volunteer Program (RSVP) (Foster Grandparents and others)			
No	No	No	No
c. Action Programs: Title III (SCORE and ACE – Administered by the Small Business Administration)			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
No	No	No	No
d. AmeriCorps and Related Programs Living Allowance			
No **NOTE:** AmeriCorps programs are not on-the-job training.	No	No	No
e. AmeriCorps and Related Programs Reimbursements			
No	No	No	No
f. AmeriCorps and Related Programs Summer Youth Programs			
No	No	No	No
18. DAY CARE AND OTHER CARE PROVIDER INCOME (Child and Adult) See Title XIX Medicaid Waiver Payments			
Earned if an employee; otherwise Self-Employment	Earned if an employee; otherwise Self-Employment	Earned if an employee; otherwise Self-Employment	Earned if an employee; otherwise Self-Employment
19. DEATH INSURANCE BENEFITS			
Unearned, lump sum	Unearned, lump sum	Unearned, lump sum	Unearned, lump sum
20. DIVISION OF REHABILITATIVE SERVICES (DRS) FUNDS			
a. Training Allowances • Special training service projects • Incidental personal expenses related to training • Living expenses while living away from home for training			
No	No	No	No
b. Earnings			
Earned	Earned	Earned	Earned
21. DEPOSITS INTO A BANK ACCOUNT (of money belonging to someone other than a member of the AG or disqualified individual) • The Portion of a Deposit Intended for the Use of the AG or Disqualified Person • The Portion of a Deposit Intended for the Use of a Non-AG Group Member			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
a. The Portion of a Deposit Intended for the Use of the AG or Disqualified Person			
Unearned See Section 4.4.4.Q for treatment of additional deposits from Military Personnel deployed to a designated combat zone.	Unearned	Unearned	Unearned
b. The Portion of a Deposit Intended for the Use of a Non-AG Member			
No. However, it must be verified that the money was used as intended.	No. However, verification of ownership of the deposit must be obtained from the depositor.	No	No. However, it must be verified that the money was used as intended.
22. DISABILITY BENEFITS FROM EMPLOYER			
See Sick Benefits	See Sick Benefits	See Sick Benefits	See Sick Benefits
23. DISASTER ASSISTANCE			
No, when it is received for the purpose of replacing or repairing an asset which is lost or damaged. If not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost or damaged. If not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost or damaged. If not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost or damaged. If not used for the above purpose, it is counted as a lump-sum payment.
24. DIVIDENDS			
Unearned, whether or not the AG actually collects them.	Unearned	Unearned **EXCEPTION:** Dividends earned from a counted asset or from an asset excluded under federal law are excluded as income. See specific assets in	Unearned, whether or not the AG actually collects them.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
		Section 5.5 for federal law exclusions.	
25. DOMESTIC VOLUNTEER ACT OF 1973			
See CNCS	See CNCS	See CNCS	See CNCS
26. EARNED INCOME TAX CREDIT (EITC)			
No	No	No	No
27. EDUCATIONAL INCOME			
a. Funded Under Title IV of the Higher Education Act or Bureau of Indian Affairs (BIA)			
No	No	No	No
b. College Work Study (CWS) Apprenticeships or Fellowships with a Work Requirement (Funded from Other Than Title IV or BIA)			
No	Earned, unless used for educational expenses.	Earned, unless used for educational expenses. See Section 4.14.4.	No
c. Other than CWS, or Apprenticeships or Fellowships with a Work Requirement (Funded from Other Than Title IV or BIA)			
No	Unearned.	Unearned, unless used for educational expenses. See Section 4.14.4.	No
d. Veteran's Educational Benefits			
No	See Veteran's Benefits	See Veteran's Benefits and Section 4.14.4.	No
28. EMERGENCY ASSISTANCE FROM DOHS			
No	No	No	No
29. EMERGENCY CHILD CARE PROVIDER INCOME			
a. Monthly Payment for Beds Maintained			
Self-Employment	Self-Employment	Self-Employment	Self-Employment
b. Per Diem Rate for Each Child Placed in Shelter			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
No	No	No	Self-Employment
30. EMPLOYMENT			
a. Advance Pay (Compensation as an Employee)			
Earned	Earned	Earned	Earned
b. Commissions (Compensation as an Employee)			
Earned	Earned	Earned	Earned
c. Military Pay When Serving in a Combat Zone (Compensation as an Employee)			
See Section 4.4.4.Q.	Earned	No. Any pay specified for combat, hostile fire, or imminent danger is excluded.	Earned
d. Profit Sharing from Employer or Former Employer (Compensation as an Employee)			
Earned, if still employed by the company providing the income; otherwise, unearned.	Earned, if still employed by the company providing the income; otherwise, unearned.	Earned, if still employed by the company providing the income; otherwise, unearned.	Earned, if still employed by the company providing the income; otherwise, unearned.
e. Recurring Bonuses (Compensation as an Employee)			
Earned	Earned	Earned	Earned
f. Salaries (Compensation as an Employee)			
Earned	Earned	Earned	Earned
g. Vacation Pay When Employment is Terminated – Received in More Than One Installment (Compensation as an Employee)			
Earned, if payroll taxes are withheld; unearned, if payroll taxes are not withheld.	Earned if payroll taxes are withheld; unearned, if payroll taxes are not withheld.	Earned, if payroll taxes are withheld; unearned, if payroll taxes are not withheld.	Earned
h. Vacation Pay When Employment is Terminated – Not Withdrawn (Compensation as an Employee)			
No	No	No	Earned

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
i. Vacation Pay When Employment is Terminated – Received in a Lump Sum (Compensation as an Employee)			
Unearned, treated as a lump-sum payment.	Unearned, treated as a lump-sum payment.	Unearned, treated as a lump-sum payment.	Earned, treated as a lump-sum payment
j. Wages (Compensation as an Employee)			
Earned	Earned	Earned	Earned
k. Wages Paid Directly by Private Employers Who Contract With the Census Bureau (Compensation as an Employee)			
Earned	Earned	Earned	Earned
l. Wages Paid Directly by the Census Bureau for Census Related Activities (Compensation as an Employee)			
Excluded	Earned	Earned	Excluded
m. Income Earned from Work Supplementation or Supported Work Program			
Earned	Earned	Earned	Earned
n. WV WORKS Benefit (Income Earned from Work Supplementation or Supported Work Program)			
See WV WORKS	See WV WORKS	See WV WORKS	See WV WORKS
o. Non-WV WORKS Benefit (Income Earned from Work Supplementation or Supported Work Program)			
Earned	Earned	Earned	Earned
p. Self-Employment			
Earned, including the proceeds from the sale of capital goods and equipment. See Section 4.4.1 and Section 4.4.4.	Earned	Earned	Earned
q. **EXCEPTIONS** for all Types of Employment			
EXCEPTIONS: NOT COUNTED AS INCOME IF: • Under 18 years	**EXCEPTIONS:** NOT COUNTED AS INCOME IF: • Dependent child and	**EXCEPTIONS:** NOT COUNTED AS INCOME IF: • Under 22; and	**EXCEPTIONS:** NOT COUNTED AS INCOME IF: • Child or parent under

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
old; and **NOTE:** Income is not counted until the month following in which the child turns 18. • Resides with a natural, adoptive or stepparent, as a member of the same AG or as a separate AG; or resides under the parental control of an adult AG member other than a parent. • Is enrolled in elementary or secondary school or a program for completion of a high school equivalency diploma at least half-time, as defined by the school.	• Full-time student For a half-time student, earned income is included in the 185% and 100% of Need tests, when applicable. However, once the Needs tests are passed, all earned income of a child included in the AG is excluded when the child is a half-time student who is employed less than 30 hours per week. Monthly hours are divided by 4.3. A half-time student is defined as being enrolled in and attending school or training at least half-time as defined by the institution.	**NOTE:** Income is not counted until the month following the month in which the individual becomes 22. • Blind or disabled; and • Regularly attending school designed to prepare client for gainful employment	age 18; and • Is enrolled in secondary school or a program for completion of a high school equivalency diploma. **NOTE:** Income is not counted until the month following the month in which the individual becomes 18 or is no longer enrolled in school or high school equivalency program.
31. ENERGY ASSISTANCE PAYMENTS OTHER THAN LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)			
Unearned **EXCEPTIONS**: Federal energy assistance and one-time payments/ allowances under a	No	No	No

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
federal or state law for the costs of weatherization or emergency repair/ replacement of unsafe/ inoperative furnaces or other heating/cooling devices.			
32. FACTOR VIII OR IX CONCENTRATE BLOOD PRODUCTS LITIGATION, MDL 986, NO. 93-C- 7452, ND OF ILLINOIS			
See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS
33. FEDERAL HOUSING ADMINISTRATION (FHA)			
No	No	No	No
34. FILIPINO VETERANS EQUITY COMPENSATION FUND For certain veterans and the spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during World War II			
No	No	No	No
35. FOSTER CARE PAYMENTS			
Unearned. The AG has the choice of including the foster child or not. If the foster child is included, the income is unearned. If the foster child is not included, income is excluded.	No	No	No
36. FOSTER GRANDPARENTS PROGRAM			
See CNCS	See CNCS	See CNCS	See CNCS

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
37. GIFT CARD/CERTIFICATE			
No	Yes Unearned income in the month received when the gift card/certificate can be used to purchase food or shelter; OR can be resold or redeemed for cash. **NOTE:** These are considered to be resellable unless evidence is presented to the contrary. **EXCEPTIONS**: No, if there are restrictions on its usage or the owner is legally or otherwise prohibited from selling or transferring the gift card/certificate; AND it cannot be used to purchase food or shelter. Gift cards/certificates issued as federal disaster assistance are excluded. Gift cards issued for medical care and services from a federal, state, or local government program, such as, Medicare Advantage Flex Card funds.	Yes Unearned income in the month received when the gift card/certificate can be used to purchase food or shelter; OR can be resold or redeemed for cash. **NOTE:** These are considered to be resellable unless evidence is presented to the contrary. **EXCEPTIONS:** No, if there are restrictions on its usage or the owner is legally or otherwise prohibited from selling or transferring the gift card/certificate AND it cannot be used to purchase food or shelter. Gift cards/certificates issued as federal disaster assistance are excluded. Gift cards issued for medical care and services from a federal, state, or local government program, such as, Medicare Advantage Flex Card funds.	No Gift cards/certificates are not counted unless the card/certificate can be converted to cash or sold. The amount received from cashing or selling of the gift card/certificate is counted as unearned income the month it is converted.
38. GOVERNOR'S SUMMER YOUTH PROGRAM (GSYP)			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
See WIOA	See WIOA	See WIOA	See WIOA
39. GUARDIANSHIP PAYMENTS (Paid by Title IV-E of the Social Security Act to persons who agree to become a legal guardian of child under age 18, but not foster care or adoption).			
Treated as Foster Care Payments. See Foster Care.	No	No	No
40. HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS			
a. Factor VIII or IX Concentrate Blood Products Litigation, MDL 986, No. 93-C- 7452, ND of Illinois			
No, see Lump-Sum Payments in Section 4.4.4.K.	No	No	Unearned, see Lump-Sum Payments in Section 4.5.4.H.
b. Ricky Ray Hemophilia Funds			
No, see Lump-Sum Payments in Section 4.4.4.K.	No	No	Unearned, see Lump-Sum Payments in Section 4.5.4.H.
c. Walker v. Bayer Settlements			
No, see Lump-Sum Payments in Section 4.4.4.K.	No **NOTE:** Exclusion applies to payments made as a result of an individual release of claims, instead of a class settlement, when the agreement is signed by all affected parties on or before the later of 12/31/97, or the date that is 270 days after the date on which the release is first sent to the persons to whom the payments is to be made.	No **NOTE:** Exclusion applies to payments made as a result of an individual release of claims, instead of a class settlement, when the agreement is signed by all affected parties on or before the later of 12/31/97, or the date that is 270 days after the date on which the release is first sent to the persons to whom the payments is to be made.	Unearned, see Lump-Sum Payments in Section 4.5.4.H.
41. HOUSING AND URBAN DEVELOPMENT (HUD) See YouthBuild Program			
No	No	No	No. When a rent or

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
			utility supplement is paid directly to the client, it is unearned income.
42. INCOME PROTECTION INSURANCE			
Unearned	Unearned	Unearned	Unearned
43. INCOME TAX REFUNDS			
No	No	No	No
44. INDEPENDENT LIVING SUBSIDY (Paid through the Office of Children and Adult Services)			
Unearned	No	No	No. A recipient of an Independent Living Subsidy cannot be included in the WV WORKS AG. See Section 3.4.1.
45. INDIAN SETTLEMENT INCOME Payments to the following groups of Indians under various public laws: • Apache Tribe of the Mescalero Reservation • Arizona • Assiniboine • Chippewas • Confederate • Grand River Band of Ottawa Indians • Grosventre • Houlton Band of Maliseet-Blackfeet • Lake Superior • Mississippi • Montana • Papago • Passamaquoddy • Tribe Penobscot Nation • Puyallup Tribe • Red Lake Band • Saginaw			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
• Seneca Nation • Turtle Mountain Band • White Earth Band • Tribes and Bands of the Yakima Indian Nation			
No	No	No	No
46. INDIVIDUAL DEVELOPMENT ACCOUNTS (IDA) - CONTRIBUTIONS TO			
a. TANF- or Assets for Independence Act (AFIA) – Funded			
Earned	Earned	No	No
b. Non-TANF- or AFIA-Funded (See Definition in Section 5.1)			
Earned	Earned	Earned, unless the IDA is limited to use for a PASS and approved by the Social Security Administration.	No
47. IN-KIND PAYMENTS			
No	No	No **EXCEPTION:** In-kind gifts to or for the individual with a life-threatening condition, are excluded when the criteria outlined for Cash Contributions from a Charitable Organization are met, unless converted to cash. If converted to cash, the total amount is income in the month the conversion occurs.	No
48. INSURANCE PROCEEDS			
See Personal Injury Awards or Replacement of Property	See Personal Injury Awards or Replacement of Property	See Personal Injury Awards or Replacement of Property	See Personal Injury Awards or Replacement of Property

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
49. INTEREST INCOME			
Unearned, including the amount left to accumulate	Unearned, including the amount left to accumulate.	Unearned, including the amount left to accumulate. **EXCEPTION:** Interest earned from a counted asset or from an asset excluded under federal law is excluded as income. Accumulated interest which becomes part of excluded burial funds is also excluded. See specific assets in Section 5.5 for federal law exclusions.	Unearned, including the amount left to accumulate.
50. JAPANESE-AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS			
No	No	No	No
51. JOB CORPS **NOTE:** Job Corps is a WIOA program. See WIOA.			
a. Living or Readjustment Allowance			
See WIOA	See WIOA	Earned	See WIOA
b. Bonuses or Incentive Payments			
See WIOA	See WIOA	Earned	See WIOA
c. Clothing or Transportation Allowances			
See WIOA	See WIOA	No	See WIOA
52. JURY DUTY			
Earned **NOTE:** Payments received for expenses incurred as a result of required attendance at jury duty, e.g. mileage or childcare, meals and lodging are	Earned **NOTE:** Payments received for expenses incurred as a result of required attendance at jury duty, e.g. mileage or childcare, meals and lodging are considered	Unearned **NOTE:** Payments received for expenses incurred as a result of required attendance at jury duty, e.g. mileage or childcare, meals and lodging are considered	Earned The payments received for attendance are considered earned income in the month received or may be prorated over the period of time they are

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
considered reimbursements, see REIMBURSEMENTS.	reimbursements, see REIMBURSEMENTS.	reimbursements, see REIMBURSEMENTS.	intended to cover. **NOTE:** Payments received for expenses incurred as a result of required attendance at jury duty, e.g. mileage or childcare, meals and lodging are considered reimbursements, see REIMBURSEMENTS.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
53. LOANS AND REPAYMENTS (Includes credit card advances and reverse mortgages)			
No, if there is a written or verbal agreement to repay, regardless of payment status. Otherwise, unearned. See Section 4.4.4 for educational loans.	No, for the borrower, if the definition of a Bona Fide Loan is met, regardless of payment status. Otherwise, unearned. Interest paid to the lender is income, regardless of whether or not the loan is Bona Fide. If the loan is not Bona Fide, the principal payments are income. See Section 5.5 for loans as an asset.	No, for the borrower, if the definition of a Bona Fide Loan is met, regardless of payment status. Otherwise, unearned. For the lender: • When the loan agreement is an excluded asset for the lender, count the principal and interest payments received as unearned income. • When the loan agreement is a countable asset for the lender, the principal payments do not count as income for the lender. Interest paid to the lender is unearned income. See Section 5.5 for loans as an asset.	Unearned, unless it is used: • To repair or replace an asset; or • To purchase a home in which to reside, when no other home is owned; or means of transportation to and from work when no other operable means is owned by the income group. • For educational expenses. There must be a written agreement to repay.
54. LOW-INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)			
No	No	No	No
55. MEDICAL INSURANCE REIMBURSEMENTS (For Out-of-Pocket Medical Expenses)			
No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
Group.			
56. NAZI PERSECUTION VICTIMS PAYMENTS This may include, but is not limited to: • Austrian Social Insurance Payments • German Reparations Payments • Netherlands WUV Payments			
No	No	No	No
57. NORTH VIETNAM – DEPARTMENT OF DEFENSE (DOD) PAYMENTS TO CERTAIN PERSONS CAPTURED OR INTERNED			
No	No	No	No
58. OLDER AMERICANS ACT - COMMUNITY SERVICE EMPLOYMENT (CSEP) UNDER TITLE V			
No	Earned	Earned	No
59. PENSIONS			
Unearned. Count gross.	Unearned. Count balance after subtracting mandatory payroll deductions.	Unearned. Count gross.	Unearned. Count gross.
60. PERSONAL CARE PROVIDER INCOME			
Earned if an employee; Self-Employment	Earned if an employee; Self-Employment.	Earned if an employee; Self-Employment	Earned if an employee; Self-Employment.
61. PERSONAL INJURY AWARDS (Insurance settlements and other compensation)			
No, treated as a lump-sum payment. See Section 4.4.4.K.	Unearned, treated as a lump-sum payment. See program sections. **EXCEPTION:** See Hemophilia/AIDS Funds and Settlements.	Unearned, treated as a lump-sum payment. See Section 4.14.4.F. **EXCEPTION:** See Hemophilia/AIDS Funds and Settlements.	Unearned, treated as a lump-sum payment. See Section 4.5.4.H.
62. PROMISSORY NOTES AND REPAYMENTS			
No, if there is a written or verbal agreement to repay, regardless of	No, for the borrower, if the definition of a Bona Fide Loan is met,	No, for the borrower, if the definition of a Bona Fide Loan is met,	Unearned, unless it is used: • To repair or replace

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
payment status. Otherwise, unearned. See Interest Section 4.4.4 for educational loans.	regardless of payment status. Otherwise, unearned. Interest paid to the lender is income, regardless of whether or not the loan is Bona Fide. If the loan is not Bona Fide, the principal payments are income. See Section 5.5 for promissory notes as an asset.	regardless of payment status. Otherwise, unearned. For the lender: • When the loan agreement is an excluded asset for the lender, count the principal and interest payments received as unearned income. • When the loan agreement is a countable asset for the lender, the principal payments do not count as income for the lender. Interest paid to the lender is unearned income. See Section 5.5 for promissory notes as an asset. See Section 24.8.2 for promissory notes as a transfer of resources for Long Term Care.	an asset; or • To purchase a home in which to reside, when no other home is owned; or means of transportation to and from work when no other operable means is owned by the income group. • For educational expenses. There must be a written agreement to repay.
63. RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS			
No	No	No	No
64. RAILROAD RETIREMENT			
Unearned **NOTE:** See SSI for exclusion of fees collected by some	Unearned	Unearned	Unearned

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
organizations. Applies only when Railroad Retirement is based upon a disability.			
65. REIMBURSEMENTS (For past or future expenses) Including, but not limited to, reimbursements for travel or job-related expenses.			
No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group.	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group.	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group.	No, as long as they do not exceed actual expenses or represent a gain or benefit to the Income Group.
66. RELOCATION PAYMENTS			
No	No	No	No
67. RENT AND/OR UTILITY SUPPLEMENTS			
No, unless a rent or utility supplement is paid directly to the client. If so, it is unearned income.	No	No	No, unless a rent or utility supplement is paid directly to the client. If so, it is unearned.
68. RENTAL INCOME (Also see Roomer/Boarder Provider Income)			
a. Non-business (Not self-employed in the rental business)			
Unearned, unless a member of the Income Group is actively engaged in managing the rental property at least an average of 20 hours per week. Even when unearned, it is considered self-employment. See program section.	Earned, unless the rental property is managed by a rental agency, and the client receives only the profit. If so, unearned income.	Unearned. Even when unearned, it is considered self-employment to determine gross profit. See program section.	Earned, unless the rental property is managed by a rental agency, and the client receives only the profit. If so, unearned income. See program section.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
b. Business			
Earned. See Section 4.4.4.	Earned, unless the rental property is managed by a rental agency and the client receives only the profit. If so, unearned income. See program sections.	Earned. See Section 4.14.4.	Earned, unless the rental property is managed by a rental agency and the client receives only the profit. If so, unearned income. See Section 4.5.4.
69. RENTER'S INSURANCE PROCEEDS			
See Replacement of Property	See Replacement of Property	See Replacement of Property	See Replacement of Property
70. REPLACEMENT OF PROPERTY BENEFITS (From insurance companies, federal or state agencies, public or private organizations or other individuals.)			
No, when it is received for the purpose of replacing or repairing an asset which is lost, stolen or damaged. If it is not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost, stolen or damaged. If it is not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost, stolen or damaged. If it is not used for the above purpose, it is counted as a lump-sum payment.	No, when it is received for the purpose of replacing or repairing an asset which is lost, stolen or damaged. If it is not used for the above purpose, it is counted as a lump-sum payment.
71. RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)			
See CNCS	See CNCS	See CNCS	See CNCS
72. RETIREMENT BENEFITS			
Unearned Count gross.	Unearned Count balance after subtracting mandatory payroll deductions.	Unearned Count gross.	Unearned Count gross.
73. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI)			
Unearned Count the amount of the client's entitlement.	Unearned Count the amount of the client's entitlement.	Unearned Count the amount of the client's entitlement.	Unearned Count the amount of the client's entitlement.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
This includes any amount deducted for Medicare, if applicable. **NOTE:** See SSI for exclusion of fees collected by some organizations. Applies only when RSDI is based on disability.	This includes any amount deducted for Medicare, if applicable.	This includes any amount deducted for Medicare, if applicable.	This includes any amount deducted for Medicare, if applicable.
74. RICKY RAY HEMOPHILIA FUND PAYMENTS			
See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS	See HEMOPHILIA/ AIDS FUNDS AND SETTLEMENTS
75. ROOMER/BOARDER PROVIDER INCOME			
Earned, Self-employment	Earned, Self-employment	Earned, Self-employment	Earned, Self-employment
76. ROYALTIES			
Unearned	Unearned	Unearned	Unearned
77. RURAL DEVELOPMENT RENTAL ASSISTANCE PROGRAM ~~RURAL HOUSING SERVICE~~ (RHS) (Formerly FARMERS HOME ADMINISTRATION)			
No, unless a rent or utility supplement is paid directly to the client. If so, it is unearned income.	No	No	No
78. SALE OF PROPERTY – INCOME FROM			
No, unless received in periodic installments; if so, it is unearned income.	The interest is unearned income. See Section 5.5 for land sale contracts as an asset.	The interest is unearned income. See Section 5.5 for land sale contracts as an asset.	No, unless received in periodic installments; if so, it is unearned income.
79. SCORE			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
See CNCS	See CNCS	See CNCS	See CNCS
80. SICK BENEFITS FROM EMPLOYER			
Earned, if received while still employed. Unearned, if received after employment is terminated. Count gross.	Earned **EXCEPTION:** Any portion attributed to the employee's own contribution is unearned income.	Unearned **EXCEPTION:** Sick pay received from an employer or third party, within the first 6 months of the last day worked, is earned income. However, any portion of the above sick pay that is attributed to the employee's own contribution is considered unearned income.	Earned
81. SNAP BENEFITS			
No	No	No	No
82. SOCIAL SECURITY PAYMENTS			
Unearned. See RSDI.	Unearned. See RSDI.	Unearned. See RSDI.	Unearned. See RSDI.
83. SPOUSAL SUPPORT OR ALIMONY NOTE: Separate entry for Child Support			
Unearned	Unearned	Unearned	Unearned
84. STRIKE BENEFITS			
Unearned	Unearned	Unearned	No An individual receiving striker benefits makes the entire WV WORKS AG ineligible. See Section 4.5.4.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
85. SUPPLEMENTAL SECURITY INCOME (SSI)			
Unearned. Fees collected by a qualified organization for acting as the client's representative payee are excluded. To qualify, the organization must be a community-based, non-profit social agency, bonded or licensed by the State. Exclusion is limited to the lesser of 10% of the SSI benefit or $57/month, except Drug Addicts & Alcoholics (DA & As). For DA & As, the limit is the lesser of 10% or $106/month. **EXCEPTION FOR DEDICATED ACCOUNT:** When SSA requires the establishment of a dedicated account for past due monthly SSI payments, the amount in the dedicated fund is not counted as income. Disbursements from the account are not counted as income. Interest on the account is unearned income in the month	No	No	No **EXCEPTION FOR DEDICATED ACCOUNT:** When the SSA requires the establishment of a dedicated account for past due monthly SSI payments, the amount in the dedicated fund is not counted as income. Disbursements from the account are not counted as income. Interest on the account is not income. This applies when the amount requires SSA to deposit the funds directly in the dedicated account and when funds are deposited there at the discretion of the representative payee.

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
received. This applies when the amount requires SSA to deposit the funds directly in the dedicated account and when funds are deposited there at the discretion of the representative payee. **EXCEPTION FOR LUMP-SUM PAYMENTS:** When the client is eligible for a lump sum SSI payment which equals or exceeds three times the maximum SSI benefits, SSA requires that it be issued in not more than three lump sum installments which are made at six-month intervals. These payments are excluded. Any other recurring SSI lump-sum payments, such as those for a DA&A, are unearned income.			
86. TANF PAYMENTS (From another state. For West Virginia, see WV WORKS)			
a. Corrective and Retroactive Payments			
Unearned	Unearned	No	No
b. Ongoing Payments			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
No, except a payment received in the month for which it is intended.	No	No	No Cash assistance received from another state results in ineligibility for WV WORKS for that same month.
87. THIRD-PARTY PAYMENTS			
No, except when the payments are made from funds normally payable to the AG. **EXCEPTION:** Vendor payments for transitional housing for the homeless are unearned. **Example:** A woman's ex-husband is court-ordered to make the house payment directly to the bank. The amount he is court-ordered to pay is not income.	No This includes the Department of Commerce Digital Television Converter Box Coupons which are provided to assist households with the cost of conversion boxes needed when television signals are no longer transmitted in an analog format.	No This includes the Department of Commerce Digital Television Converter Box Coupons which are provided to assist households with the cost of conversion boxes needed when television signals are no longer transmitted in an analog format.	No This includes the Department of Commerce Digital Television Converter Box Coupons which are provided to assist households with the cost of conversion boxes needed when television signals are no longer transmitted in an analog format.
88. TITLE XIX MEDICAID WAIVER PAYMENTS (To care for another individual)			
Earned if an employee; otherwise Self-Employment.	Earned if an employee; otherwise Self-Employment.	Earned in an employee; otherwise Self-Employment.	Earned if an employee; otherwise Self-Employment.
89. TRUST ACCOUNT DISBURSEMENTS			
Unearned	Unearned	Unearned	Unearned
90. U.S. ACTION AGENCY (Payments to Volunteers)			
See CNCS	See CNCS	See CNCS	See CNCS

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
91. U.S. SAVINGS BONDS			
No	No	Unearned, when the bond can be cashed, and it was received as a gift. Otherwise, no.	No
92. UNEMPLOYMENT COMPENSATION INSURANCE (UCI)			
Unearned	Unearned	Unearned	Unearned
93. UNIFORM GIFTS TO MINORS ACT (Income Disbursements)			
Unearned	Unearned	Unearned	Unearned
94. UNIVERSITY YEAR OF ACTION			
See CNCS	See CNCS	See CNCS	See CNCS
95. UNSTATED INCOME (See Definitions)			
No	No	Unearned. See program sections.	Unearned. See program sections.
96. URBAN CRIME PREVENTION PROGRAM			
See CNCS	See CNCS	See CNCS	See CNCS
97. VACATION PAY			
See Employment	See Employment	See Employment	See Employment
98. VETERAN'S BENEFITS			
a. Allowance under 38 U.S.C., Chapter 18, to a Child of a Vietnam Veteran. This includes: • Individual with spina bifida who is the child of a Vietnam veteran • Individual with a covered birth defect(s) who is the child of a female Vietnam veteran			
No	No	No	No
b. Compensation or Pension			
Unearned **EXCEPTION:** Any portion of the VA benefit which is paid as Housebound or Unusual Medical Expense allowance/	Unearned .	Unearned Some VA payments are based on need, and are, therefore, not subject to the SSI $20 income disregard. They are excluded from	Unearned .

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
reimbursement is excluded.		income which is deemed. See Section 4.14.2 and Section 4.14.4. Payments based on need are: • Pensions paid to veterans, except by an act of Congress or to a Medal of Honor recipient • Compensation paid to a surviving parent Payments not based on need are compensation payments to a veteran, spouse, child or widow(er). **EXCEPTION:** Any portion of the VA benefit which is paid as Aid and Attendance, Housebound or Unusual Medical Expense allowance is excluded.	
c. Educational Benefits			
No	Unearned. See Educational Income in program section.	Unearned, unless used for educational purposes. See Section 4.14.4. **EXCEPTION:** VA educational benefits paid as part of a vocational rehabilitation program, or that represent a	No

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
		withdrawal of a veteran's own contributions are excluded.	
99. VICTIM COMPENSATION PAYMENTS			
No	No, when the application for Medicaid is due in whole or in part to a crime committed against a member of the Income Group.	No **EXCEPTION:** Interest earned on retained funds is unearned.	No, when the application for WV WORKS or DCA is due to in whole or in part to a crime committed against a member of the Income Group.
100. VISTA AND AMERICORPS VISTA			
See CNCS	See CNCS	See CNCS	See CNCS
101. WAGES PAID DIRECTLY BY THE CENSUS BUREAU FOR CENSUS RELATED ACTIVITIES (COMPENSATION AS AN EMPLOYEE)			
No	Yes	Yes	No
102. WALKER V. BAYER SETTLEMENTS			
See Hemophilia/ AIDS Funds and Settlements.	See Hemophilia/AIDS Funds and Settlements.	See Hemophilia/AIDS Funds and Settlements.	See Hemophilia/AIDS Funds and Settlements.
103. WINNINGS (Prizes, Awards, Lottery, Bingo, Gambling, etc.)			
Unearned	Unearned, treated as a lump-sum payment.	Unearned, treated as a lump-sum payment.	Unearned, treated as a lump-sum payment.
104. WOMEN, INFANTS AND CHILDREN (WIC)			
No	No	No	No
105. WORKERS' COMPENSATION			
Unearned	Earned, unless for a permanent, total disability, then unearned.	Unearned	Earned, unless for a permanent, total disability, then unearned.
106. Workforce Innovation Opportunity Act (WIOA) (Replaced WIA)			
a. Money Paid By: • WIOA • WIOA and Employer			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
Earned, if for on-the-job training, otherwise excluded. **EXCEPTION:** Not counted as earned/ unearned income if participant is: • Under age 19, and; • Under parental control of another adult AG member.	No	Earned	No
b. Summer Youth Programs			
No	No	Earned	No
c. Training Allowances, Reimbursements and Incentive Payments			
No	No	Earned, unless a reimbursement	No
107. WEST VIRGINIA LOCAL HOUSING AUTHORITIES (HUD payments distributed for rent/utilities)			
No, unless a rent or utility supplement which is not funded by HUD is paid directly to the client or the utility provider. If so, it is unearned income.	No	No	No, unless a rent or utility supplement is paid directly to the client. If so, it is counted as unearned income.
108. WV WORKS PAYMENTS (See TANF Payments for payments from another state)			
a. Child Support Excess Payment			
Unearned	Unearned	Unearned	Unearned
b. Child Support Incentive (CSI) and Pass-Through Payment			
Unearned	No	No	No
c. Corrective and Retroactive Payments			

SNAP	AFDC-RELATED MEDICAID	PAC, QMB, SLMB, QI-1, QDWI, CDCSP, ADAP, SSI-RELATED MEDICAID	WV WORKS, DCA ELIGIBILITY
Unearned	No	No	No
d. DCA Payments			
No. See Lump-Sum Payments in Section 4.4.4.K.	No	No	No
e. Incentive Payments, Allowances: • Work-Related Expenses or Supportive Services Payments • Human Resource Development Foundation (HRDF)			
No **EXCEPTION:** Payments to the client for clothing, other than uniforms, or for grooming expenses is unearned income.	No	No	No
f. Monthly Cash Assistance Payments			
Unearned	No	No	No Cash assistance received from another state results in ineligibility for WV WORKS during the same month.
g. WV WORKS Employment Assistance Program Payments			
Unearned	No	No	No
109. YOUTHBUILD PROGRAM (HUD)			
See WIOA	See WIOA	See WIOA	See WIOA

4.3.2 CHART 2

Applicable MAGI Coverage Groups	• Adult Group • Children Under Age 19 • Parents/Caretaker Relatives • Pregnant Women • WVCHIP

Countable Sources of Income
This list is not all inclusive, payments from any source must be evaluated. Please contact the BMS Policy Unit.
	• Alimony ONLY if the alimony agreements are finalized prior to January 2019
	EXCEPTION: Alimony is not countable if the divorce or separation agreement is modified after December 31, 2018, and the modification states the alimony or separate maintenance payments are not includable in the income of the receiving spouse.
	• Census Bureau Income
	• Net Farming/Fishing
	• Net Rental Income
	• Pensions and Annuities
	• Retirement Accounts and Profit-Sharing Plans
	• Self-Employment and Business Income
	• Social Security Benefits
	• Unemployment Benefits
	• Wages, Salaries, and Tip Income
	• **Other:**
	  ○ Accrued Leave Payment
	  ○ Advance Commission
	  ○ Allowances and Reimbursements
	  ○ Back Pay Awards
	  ○ Bartering Income
	  ○ Bonuses and Awards
	  ○ Child Care Provider Income
	  ○ College Work Study Program (this is considered taxable income under IRS rules and therefore cannot be excluded from the MAGI calculation.)
	  ○ Court Awards and Damages
	  ○ Disability Pension Plans Paid by Employer
	  ○ Discharged Student Loan Debt, unless the student is deceased or determined as permanently and totally disabled.

	○ Dividends and Other Stock Gains ○ Earnings for Clergy ○ Employee Achievement Awards ○ Fringe Benefits ○ Gambling Income and Losses ○ Government Cost-of-Living Allowances (COLA) ○ Interest Income Reported on a 1099 ○ Most Cancelled Debts ○ National Guard Differential Wage Payments ○ Non-Qualified Deferred Compensation Plans ○ Prize Payments ○ Qualified Lottery and Gambling Winnings. See Section 4.7.5.F Exception. ○ Railroad Retirement Benefits ○ Railroad Sick Pay ○ Royalties ○ Severance Pay ○ Sick Pay ○ Stock Appreciation Rights
Excluded Income Sources *This list is not all inclusive, payments from any source must be evaluated. Please contact the BMS Policy Unit.*	• ABLE Account distributions that are used for qualified disability expenses • Adoption Assistance • American Indian/Alaska Native Specific Income Sources: ○ Distributions from Alaska Native Corporations and Settlement Trusts ○ Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior ○ Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from: ▪ Rights of ownership or possession in any lands described in paragraph (3)(b) of this section; or ▪ Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources. • AmeriCorps Living Expenses • Black Lung Benefits

- Cash Support

  EXCEPTION: For individuals who expect to be claimed as a tax dependent by a grandparent, another relative, or another individual who is not a parent or stepparent, their household income includes cash support provided by the person claiming them as a tax dependent if over $50 per month.

- Child Support
- Educational Scholarships and Fellowship Grants including AmeriCorps Education Expenses (See Section 4.7.5.C)
- Federal Tax Credits
- Foster Care Payments
- Gifts and Loans
- Parent Mentor Compensation
- Supplemental Security Income (SSI)
- TANF Assistance
- Title XIX Medicaid Waiver Payments:
  - Medicaid Waiver Payments made to an applicant if they live in the home full-time with the waiver client.
- Veteran Benefits (Disability, Pension, other):
  - Disability compensation and pensions payments for disabilities paid either to veterans or their families.
  - Grants for homes designed for wheelchair living.
  - Grants for motor vehicles for veterans who lost their sight or the use of their limbs.
  - Veterans' insurance proceeds and dividend paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.
  - Interest on insurance dividends left on deposit with the VA.
  - Benefits under a dependent care assistance program.
  - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.
  - Any bonus payment by a state or political subdivision because of service in a combat zone.
- Worker's Compensation

4.4 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

4.4.1 BUDGETING METHOD

Eligibility is determined and benefits are issued on a monthly basis; therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. The following information applies to earned and unearned income.

For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the assistance group (AG). Income is projected; past income is used only when it reflects the income the client reasonably expects to receive during the certification period. There is one exception, which requires use of actual income instead of conversion or proration. See Section 4.4.1.E below.

When the amount of an anticipated income source is determined by use of an income tax return, it is not necessary to change the method by which that income source is anticipated at each redetermination prior to the next tax return, unless the anticipated income from that source for the upcoming certification period is expected to change.

4.4.1.A Methods for Reasonably Anticipating Income

There are two methods for reasonably anticipating the income the client expects to receive. One method uses past income and the other method uses future income. Both methods may be used for the same AG for the same certification period. The method used depends on the circumstances of each source of income.

Use past income only when both of the following conditions exist for a source of income:

- Income from the source is expected to continue into the certification period; and
- The amount of income from the same source is expected to be more or less the same. For these purposes, the same source of earned income means income from the same employer, not just the continued receipt of earned income.

Use future income when either of the following conditions exist for a source of income:

- Income from a new source is expected to be received during the certification period. For these purposes, a new source of earned income means income from a different employer; or

- The rate of pay or the number of hours worked for an old source is expected to change during the certification period. Income that normally fluctuates does not require use of future income. Future income is used for old sources only when the hourly, weekly, monthly, etc. rate of pay changes or the number of hours worked during a pay period increases or decreases permanently.

> **Fluctuating Work Hours Example:** The Thorn family members have the following income: Mr. Thorn has earnings that fluctuate greatly from week to week. He expects no change in his earnings. Mrs. Thorn was earning a substantial monthly salary but was laid off last week. She will begin work next week at a job that pays $9.00 per hour. She does not know how many hours she will work, but her employer has told her she will work a minimum of 20 hours per week. Mr. Thorn's income is anticipated by using his past income as an indication of what he can expect to receive during the certification period. Mrs. Thorn's income from an old source cannot be used because it will not be received during the upcoming certification period. Instead, the Worker must anticipate what her future earnings will be based on the best information available at the time. Mr. Thorn's source of income meets the requirements for using past income to anticipate the future income, but Mrs. Thorn's source is new and must be projected.

4.4.1.B Consideration of Past Income

The Worker must consider information about the client's income sources before deciding which income to use.

The Worker must follow the steps below for each old income source.

Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application/redetermination date, or interview date when the interview is completed on a different day than when the application is received.

The appropriate time period is determined by counting back 30 days beginning with the calendar day prior to the date of application/redetermination. However, if the interview is completed on a different day than when the date the application/redetermination is received, the 30-day look-back period could begin the day before the interview date. The income from this 30-day period is the minimum amount of income that must be considered. When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period of time, the Worker considers income for the time

period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a longer period of time, all of the income received from that source during that time period must be considered. All pay periods during the appropriate time period must be considered and must be consecutive.

If the client provided sufficient income verification on the date the application/redetermination is received, then additional verification is not required at interview.

The year-to-date amounts on check stubs may only be used when the client has verification of all payment amounts whether used or not but is missing one.

Determination of Payments Example 1: Application/interview date is June 1.

Paid weekly on Fridays.

Pays in last 30 days are:

- May 28
- May 21
- May 14
- May 7

Determination of Payments Example 2: Application/interview date is December 6.

Paid weekly on Mondays.

Pays in last 30 days are:

- November 29
- November 22
- November 15
- November 8

Determination of Payments Example 3: Application date is October 8. Interview date is October 20.

Paid weekly on Fridays.

Pays in last 30 days (prior to application) are:

- October 1
- September 24
- September 17
- September 10

OR

Pays in last 30 days (prior to interview) are:

- October 15
- October 8
- October 1
- September 24

Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period.

If it is not expected to continue, the income from this source is no longer considered for use in the new certification period.

If it is expected to continue, determine if the amount is reasonably expected to be more or less the same. If so, the income source is used for the new certification period and treated according to Section 4.4.1.D below. If it is not expected to continue at more or less the same amount, the income source is used for the new certification period and treated according to Section 4.4.1.C below.

Step 3: Record the results of Step 2, including the amount of income, why the source is or is not being considered for the new certification period, the client's statement about continuation of the income from this source, the time period used, and, if more than the previous 30 days, the reason additional income was considered.

Once the Worker has determined all of the old sources of income to consider and the time period for which they are considered, he must then determine if any source should be considered for future income.

4.4.1.C Consideration of Future Income

This section applies only when the client reasonably expects to receive income from a new source during the new certification period, or when the amount of income from an old source is expected to change. In that case, the Worker must consider the income that can be reasonably expected to be received.

NOTE: When self-employment income is anticipated, proceeds from the sale of capital goods and equipment must be anticipated also. See Section 4.4.4 for capital goods and equipment.

NOTE: When the amount of income or the date of receipt cannot be reasonably anticipated, income from that source is not considered until the necessary information can be obtained. See Step 2 below.

Step 1: Determine if the IG expects to receive income from a new source, or expects a different amount from an old source, in the new certification period.

If not, none of the following steps are necessary. However, the Worker must record the client's statement that he does not expect income from a new source.

Step 2: Determine the amount of income the client reasonably expects to receive from the new source, or the new amount from the old source.

If the amount of income is not reasonably anticipated, the income from that source is not counted. If it is possible to reasonably anticipate a range of income, the minimum amount that is anticipated is used.

The Worker will record case comments for the client's statement concerning this income and will also record why it cannot be reasonably anticipated.

Step 3: Determine the date the client reasonably expects to receive the income from the new source, or the new amount from the old source.

If the date the income will be received is not reasonably anticipated, the income from that source is not counted.

The Worker will record case comments for the client's statement concerning the date and will also record why it cannot be reasonably anticipated.

Step 4: When the amount and date of receipt can be anticipated, the Worker treats the income according to Section 4.4.1.D below.

The Worker must record how the amount and date of receipt were projected.

4.4.1.D How to Use Past and Future Income

After the Worker determines all of the income sources that are to be considered for use, the Worker determines the amount of monthly income, based on the frequency of receipt and whether the amount is stable or fluctuates. This is described in the following table.

When the Frequency of Receipt is:	When the Amount is Stable	When the Amount Fluctuates (See Note Below)
Monthly	Use **actual** monthly amount.	Use **average** monthly amount. (See note below)
More often than monthly (such as weekly, biweekly, semimonthly)	**Convert** amount per period to monthly amount.	Find **average** amount per period and **convert** to monthly amount. (See note below)
Less often than monthly (such as quarterly, semiannually, annually)	**Prorate** to find amount for intended period. If not monthly, **convert or prorate** amount.	**Prorate** to find amount for intended period. If monthly, **convert or prorate** amount.

NOTE: The purpose of finding an average amount of fluctuating income is to even out the highs and lows in the amount of income. The client is not, then, required to report fluctuating income each pay period and the Worker is not required to change income monthly. See Section 10.4.2 for SNAP reporting requirements. Sometimes the client receives higher benefits than he would if actual income were used and sometimes he receives lower benefits. Therefore, when the Worker has averaged fluctuating income based on the best information available and the client's income does not match the monthly amount used by the Worker, there is no repayment when the client receives higher benefits and no supplemental issuance when the client receives lower benefits. Should the client report fluctuations in the amount of income, the Worker is only required to recalculate the countable income when, in his judgment, the fluctuation will significantly impact the benefit amount. All changes reported by the client must be considered, but not necessarily used. Reported changes must be recorded and the Worker must record why the reported income was or was not used.

Conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semi-monthly amount (twice/month) x 2

Proration of income to determine a monthly amount is accomplished by dividing the amount received by the number of time periods it is intended to cover as follows:

- Bimonthly amount (every two months) ÷ 2
- Quarterly amount (every three months) ÷ 3
- Semi-annual amount (twice/year) ÷ 6
- Annual amount ÷ 12
- Six-week amount ÷ 6 converted to monthly amount by using x 4.3
- Eight-week amount ÷ 8 converted to monthly amount by using x 4.3

> **Actual Income Example:** Ms. Poppy begins working on the second Monday of a month. She earns $200 per week and is paid every Friday. Her average weekly pay is $200. For the first month Ms. Poppy has earnings, she expects to be paid three times. Her income for the month is $200 x 3 = $600. A change must be made for the anticipated income from the second month of her employment.
>
> **Proration, Conversion, Fluctuation, and Multiple Sources of Income Example:** The Calla family is a family of four consisting of Mr. Calla, his wife, Lily, his mother, and his son. Mr. Calla works and earns a monthly salary of $300. His wife, Lily, works part-time and is paid weekly. Lily earns $9 per hour, but the number of hours she works fluctuates each week. His mother receives $150 every three months from the mineral rights to some property she owns out of state. His son just received a disability insurance check in the amount of $420 for the past six weeks. Income is determined as follows:
>
> For Mr. Calla, Monthly Pay, Amount Stable = $300 Salary = Monthly Amount
>
> For Lily, More Often, Amount Fluctuates = $9 per hour x Average Number of Hours per Week x 4.3 = Monthly Amount
>
> For his mother, Less Often = $150 ÷ 3 Months = Monthly Amount
>
> For his son, Less Often = $420 ÷ 6 Weeks x 4.3 Weeks = Monthly Amount

4.4.1.E Exception for Use of Actual Income

There is one exception to the rules in items A - D above. It applies to both applicants and clients and requires use of actual income instead of conversion or proration of income.

4.4.1.E.1 Applicants

When:

- The first month of eligibility meets the definition of an initial month, (i.e. the first month following any period of time in which the AG was not participating); and
- An income source terminates in the month of application or in the 30 days prior to the date of application. The Worker must calculate the income for the month of application for the terminated source by adding the actual amount already received in the month of application, plus the amount expected to be received later in the month of application. Income from this source for the past 30 days, or from the month of application, must not be used to convert the terminated income to a monthly amount.

> **Applicant Exception Example:** Mr. Maple applies on September 10. His job ended on August 31. He was paid on that date, but still has another pay due to him on September 15. Because the income is from a terminated source, the income from this source cannot be converted. Instead, the amount already received in the month of application ($0), plus the amount expected to be received on September 15, are used to determine his eligibility and benefit level for the month of application.

4.4.1.E.2 Clients

When:

- He reports the beginning or ending of a source of income; and
- The client is not expected to receive a full month's income. Income from this source must not be converted to a monthly amount.

Instead, the Worker must use the actual amount of income. If income from the source is ending, no income from the source is counted in future months.

If the income from the source is beginning, the income is added as actual amounts for each month until the client would receive a full month of income from the new source, at which time the income is converted to a monthly amount.

4.4.1.F Anticipated Income Examples

The following are examples of methods to anticipate income, based on several different situations. The Worker must always base anticipated income on the individual situation, not solely on the information contained in the examples below.

> **Example 1:** An application is made on June 22. The client indicates he is paid biweekly and he does not expect any change in his income. The Worker requests that the client provide information about pay received in the 30 days prior to June 22 and uses this income to anticipate income for the certification period. The Worker records the client's statement about expecting no changes, as well as how the income was verified, and the method used to convert the income to a monthly amount.
>
> **Example 2:** Same situation as previous example, except that the client indicates that his pay fluctuates each pay day and he expects this pattern to continue without any change in status, rate or source of income. After a discussion with the client, the Worker and client agree that two additional pay periods prior will provide enough information to reasonably anticipate income for the certification period. The Worker records the results of the discussion with the client, how the income was verified, and the method used to convert the income to a monthly amount.
>
> **Example 3:** A redetermination is received on July 7. The client indicates that he is paid weekly, and his income fluctuates because his hours of work are unpredictable. The client also indicates that beginning the following month, he will receive an increase in his hourly rate. The Worker requests that the client provide income for the 60 days prior to the redetermination date in order to anticipate the average number of hours the client works. Income from the last 60 days is requested because it provides a good indication of the fluctuations in the client's income. The Worker uses the average weekly number or hours the client worked during the last 60 days but uses the new hourly pay rate to anticipate income for the new certification period. The Worker records why income from the last 60 days was requested, how the average weekly hours were determined, how the new pay rate was verified, and how the anticipated income was calculated.
>
> **Example 4:** An application is made July 8. The client indicates that he began a new job two weeks prior to making application. He is paid weekly and has received two pays. He indicates that his employer has told him that, although his hourly rate will not increase in the near future, he can expect an increase in his hours after his training period is finished in two weeks. However, the increase in

hours is dependent upon how much work is available and the increased number of hours is unpredictable. The Worker requests all income that the client has received from the new job prior to the date of application. This actual amount of income from the new source is counted for July. Because the number of increased hours cannot be anticipated, the minimum number of hours, (i.e., the amount he has worked each week for the first two weeks), is used to anticipate income for the certification period or period of consideration (POC). The Worker records how the income was verified and determined for the month of application, as well as how the income was calculated for the months following the month of application.

Example 5: An application is made June 26 and the client indicates that he began a new job the week prior to application. He is going to be paid biweekly and has not received a pay yet. He states that he will work 35 hours per week and receive $12.75 per hour. The client does not expect any changes in hours or rate of pay. The Worker requests a statement from the client's employer for the number of hours and hourly rate of pay and anticipates income for the certification period as follows:

$12.75	hourly rate
x 70	hours for two weeks
$892.50	Anticipated biweekly pay
$892.50	
x 2.15	
$1,918.88	Anticipated monthly pay

The Worker records the client's statement about no expected changes in income and his lack of pay to date, as well as how the income was verified and calculated.

Example 6: An application is made September 13, and the client states that he is self-employed. He grows and sells Christmas trees. Most of his income for the year is earned during the months of November and December. In addition, he sells the leftover trees to the local city government to use for mulch. He receives some income each month from the leftover trees and the amount fluctuates during the year. He states that he anticipates that his earnings will be less from Christmas sales this year because many of his trees were damaged in a fire last spring. He estimates he lost at least half of the trees that he planned to sell this year. He is unable to determine at this time if his sale of trees to the city will be affected after Christmas, but currently his income from this source has not changed. The Worker requests that the client provide income received in the previous year from his sales to the city, and his Christmas tree sale earnings for the previous season.

Anticipated income is based on an average of monthly sales to the city and half of the previous year's Christmas tree sales. The Worker records the client's situation in detail, how past income was verified, and the method used to anticipate income for the new certification period.

Example 7: Ms. Daisy applies on March 2. She does not work, and her only source of income is child support from three absent parents. Income from Absent Parent A is regularly received, but the amount varies.

Income from Absent Parent B is always the same amount, but she never knows when she will receive it.

Absent Parent C pays regularly, and the amount is more or less the same.

The Worker requests verification as follows: A's payments for the last six months; B's payments for the last six months; C's payments for the last three months. She reports and verifies the following income from the three sources:

Parent A:

- March 1 $450
- February 1 $75
- January 1 $123
- December 1 $850
- November 1 $170
- October 1 $100

Parent B:

- February 14 $250
- January 10 $250
- November 20 $250

Parent C:

- February 20 $300
- January 20 $300
- December 20 $300

The Worker finds the average monthly payment made by Parent A and projects the income to continue. The Worker and the client cannot reasonably anticipate that any payments will be received in the new certification period or POC from Parent B, so no income is counted from this source. Parent C pays the same amount at the same time, so $300 per month is counted from Parent C.

The Worker records details about payments and payment dates from each of the absent parents, how the payments were verified, whether or not any income was counted from each source and, if so, how the amount was determined.

Example 8: Same situation as above, except the client indicates she also receives child support arrearages, as well as ongoing child support.

The client states that the arrearage payments from Parent A are received regularly, but the amount varies.

She states that she seldom receives arrearage payment from Parent B, and she cannot anticipate any payments.

Parent C makes arrearage payments regularly, and the amount is usually the same.

The Worker requests the following verifications: Parent A's payments for the last six months; Parent B's payments for the last six months; and Parent C's payments for the last three months.

The client reports and verifies the following child support arrearage payments from the three parents:

Parent A:

- March 1 $200
- February 1 $100
- January 1 $50
- December 1 $75
- November 1 $300
- October 1 $25

Parent B:

- February 14 $80

Parent C:

- February 20 $50
- January 20 $50
- December 20 $50

The Worker determines the average monthly arrearage payment made by Parent A and anticipates that amount to continue. The Worker and client cannot reasonably anticipate that any arrearage payments will be received from Parent B during the certification period, so no arrearage amount from him is counted.

Because Parent C pays the same arrearage amount regularly, $50 a month is counted.

The Worker records the details about the payments and dates received from each parent. He also records how the payments were verified, whether or not any income was counted from each parent, and, if counted, how the amount was determined.

Example 9: A waitress, Mrs. Pine, applies on December 7. She is paid twice a month and provides pay stubs with the following information:

Date	Number of Hours	Wages	Tips
September 15	35 hours	$180.25 wages	$88.00 tips
September 30	60 hours	$309.00 wages	$130.00 tips
October 15	32 hours	$164.80 wages	$83.00 tips
October 30	35 hours	$180.25 wages	$88.00 tips
November 15	12 hours	$61.80 wages	$32.00 tips
November 30	35 hours	$180.25 wages	$88.00 tips

Mrs. Pine provides the following additional information: She earns $9 per hour. She does get some tips, but rarely the amount shown on her paystubs. She says the employer determines the amount shown as tips by some formula that she does not understand because he is required by the Internal Revenue Service (IRS) to report them. She does not have to share her tips with any other employee, and they do not share tips with her. She says that during a “good” week, she makes about $20 in tips. The employer never sees her tips, she does not report the amount to him, and is not required to do so. The Worker pends the case for verification of the way the employer determines the amount of tips shown on her paystubs and reported to the IRS.

The client provides the following note from the employer:

To Whom It May Concern:
Mrs. Pine works for me at the Dew Drop Inn as a waitress. I pay her $7.25 for every hour she works. She does make some in tips, but I don’t know how much. The IRS makes me figure her tips, so I do it according to how much food she sells. I don’t think she really gets that much. None of my waitresses do, but the IRS makes me do it.
Very truly yours,
Lilly Rose

> There is no third-party, independent verification available for the amount of Mrs. Pine's tips. However, she does state that she receives tips, so income from the tips cannot be disregarded. The only way to verify the amount of tips is to accept her statement as to the amount. There is no other source of verification available, so the Worker must accept her statement. The Worker must record that the employer confirmed the tips shown on the paystubs do not necessarily reflect the amount she actually receives, that this is the best information that can be provided to verify the situation, and that the client's statement is accepted as verification.

4.4.2 INCOME DISREGARDS AND DEDUCTIONS

Certain items may be allowed as income deductions to arrive at an AG's countable income, (even if the payment is made from assets). To receive a deduction, the expense must:

- Not be an educational expense;
- Be billed or be due during the certification period in which the deduction is claimed;
- Be obligated to be met by the AG's own resources; and
- Be owed to an individual not included in the AG to receive a deduction.

To convert an expense to a monthly amount, multiply by an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semi-monthly (twice/month) x 2

4.4.2.A Effective Date of Deduction

Some expenses cannot be anticipated or occur too late in the month to use as deductions in the following month. They are used as deductions for the first month for which a change can be made effective.

At initial application, expenses paid during previous months are not used. Expenses paid or due during the month of application are used. In some situations, expenses from previous months are used to anticipate ongoing expenses.

When a client fails to report household expenses that would normally result in a deduction, the AG loses their entitlement to that deduction. They have a right to the expense, once it is reported and verified, if required by policy. See Section 10.4.

In addition, any SNAP AG may choose to have fluctuating expenses averaged, except for educational expenses. Expenses are averaged by dividing the expenses over the number of months they are intended to cover. When expenses are prorated, they are prorated over the certification period, or the remainder of the certification period, as appropriate.

Expenses regularly billed as a single monthly payment, and that are used as a deduction, are used in the month the expense is intended to cover. An expense does not have to be paid to be a deduction.

4.4.2.B Allowable Disregards and Deductions

The following are the only allowable disregards and deductions for the SNAP. They apply to the income of the AG members and any individual sanctioned/penalized due to enumeration, Intentional Program Violation (IPV), failure to comply with a work requirement, or disqualified by law. See Deeming in Section 4.4.4.H.

4.4.2.B.1 Earned Income Disregard

Twenty percent (20%) of gross countable earned income, including gross profit from self-employment, is disregarded. This disregard is applied to the combined earnings of all members of the AG and to those persons whose income is counted or deemed. It is intended to cover those expenses incidental to employment or training, such as transportation, meals away from home, special clothing, and payroll deductions.

4.4.2.B.2 Standard Deduction

A Standard Deduction is applied to the total non-excluded income counted for the AG, after application of the Earned Income Disregard. The amount of the Standard Deduction is found in Appendix B.

4.4.2.B.3 Dependent Care Deduction

A deduction is allowed for payment for the care of a child or other dependent, when the expense is necessary for an IG member to accept, continue or seek employment or training, or pursue education that is preparatory to employment. Persons enrolled in an institution of post-secondary education, in a course of study designed to lead to any degree, are considered to be pursuing education that is preparatory to employment. Persons taking only elective classes or some specialized classes, or who do not have a declared major, do not qualify for this deduction.

Dependent care expenses are deducted from educational funds to the extent that they are earmarked and/or used for such expenses. See Educational Income in Section 4.4.4.G. Dependent care expenses deducted from educational funds are deducted from these funds last, after all other allowable educational expenses, so that the client may then use any excess dependent care expenses as a Dependent Care Deduction.

When third-party payments are made for dependent care, no deduction is given for the amount paid by the third party.

4.4.2.B.4 Child Support Deduction

A deduction is allowed for legally obligated child support actually paid by an AG member or disqualified individual to an individual not residing in the same household.

In the State of West Virginia, legally obligated means the child support is the result of a circuit or magistrate court order, an order issued by administrative process, or a legally enforceable separation agreement. For orders issued in other states, any order that would be upheld by a Judge in a court of law is considered legally obligated.

Legally obligated child support includes cash or in-kind payments, payments on arrearages, and payments for medical insurance premiums to cover the dependent child. If the dependent child is included in the parent's medical coverage at no extra cost, no deduction is allowed. If the parent must also enroll in order to cover the child, the total premium amount is used as a deduction. Alimony, spousal support, and payments made in accordance with a property settlement are not deducted.

A deduction is allowed based only on payments actually made, not the legally obligated amount, and may not exceed the legal obligation.

Child support paid to a child support agency and retained by the agency is deducted, even when the individual who pays the support resides with the person to whom the payment would customarily be paid. When the AG member pays the support to the agency and it is forwarded to an individual who resides in the same household, a deduction is not given.

➢ *Child Support Examples*

Example 1: An AG member has a court order to pay $150 per month child support and he verifies only $50 per month in payments. His child support deduction is $50.

Example 2: An AG member has a court order to pay $100 per month child support and to provide medical coverage available through his employer. He did not make a payment for 10 months and owes $1,000 in arrearages. His employer deducts $100 per month child support, $50 per month for arrearages, and $25 per month for medical insurance for the child. His child support deduction is $175.

Example 3: Same situation as above, except the order requires $50 per month alimony and $100 per month rent to his ex-wife's landlord, which the court order stipulates is part of his child support obligation. The child support deduction is $275. No deduction is given for the alimony.

When the child support amount paid each month varies, a minimum three-month total is averaged to project payments over the certification period.

When the payment record is less than three months, the deduction is based on anticipated payments, including arrearage.

For child support paid by disqualified individuals, see Deeming in Section 4.4.4.H.

4.4.2.B.5 Homeless Shelter Standard Deduction

This deduction may be applied when a homeless AG incurs any shelter/utility expenses for the month. Homeless AGs that receive free housing and utilities throughout the month are not eligible for the deduction. However, if they incur any shelter or utility expense, regardless of the amount, any time during the month, they qualify for the Homeless Shelter Standard Deduction. See Appendix B. Any shelter expenses reported by the homeless individual must be verified at a minimum at application and redetermination, or when a change of shelter is reported.

> **Homeless Shelter Deduction Example 1:** A homeless family applies for SNAP. They have been living in their car until the Department of Human Services (DOHS) paid for them to stay in a motel for a week. Now they reside at a homeless shelter. This family does not qualify for the deduction because none of its own money was used for shelter.
>
> **Homeless Shelter Deduction Example 2:** A family becomes homeless while participating in SNAP. They are living first with one relative and then another, paying a token amount for their keep. This family qualifies for the deduction because it has incurred expenses for shelter.

If the AG incurs, shelter and/or utility costs in excess of the Homeless Shelter Standard Deduction amount, the AG may use the actual shelter and/or the appropriate utility standard, if eligible. An AG must not receive the homeless shelter standard deduction and either a deduction for actual shelter costs and/or the Standard Utility Allowance (SUA) in the same month. See Shelter/Utility Deduction below for allowable expenses.

NOTE: If all avenues of verification have been exhausted and the homeless individual is unable to provide the agency with this information, client attestation with all necessary information is acceptable. This information should be documented in writing with the individual's signature as well as documented in the case record.

4.4.2.B.6 Medical Expenses

Medical expenses in excess of $35 must be allowed as a medical deduction for AG members who are elderly, which is at least age 60, or disabled, as defined in Section 13.15. Once the medical expenses of all such AG members have been totaled, the amount of the total in excess of $35 is used as a medical deduction. Thirty-five dollars ($35) is deducted from the total amount of expenses for the AG, not $35 from each person's expenses. There is no maximum dollar limit for a medical deduction.

➢ *Allowable Expenses*

Only medical costs that are not reimbursable through a third party (insurance, Medicaid, etc.) are deducted. The deduction cannot be granted until the reimbursable portion of the expense is known.

- The cost of any medical goods or services related to the use of an illegal substance under federal law, including medicinal marijuana, may not be deducted.
- Medical and dental care, including psychotherapy and rehabilitation services provided by a qualified health professional.
- Prescription and over-the-counter drugs, if prescribed by a qualified health professional. This includes postage and handling costs paid for mail-order prescription drugs.
- Medical supplies and equipment, if prescribed by a qualified health professional. Items may be either purchased or rented.
- Hospital or outpatient costs, nursing care, and nursing facility care. This is also allowable if paid on behalf of an individual who was a member of the AG immediately prior to admission to a facility. The facility must be recognized by the State.
- Health and hospitalization insurance premiums, including long-term care, vision, and dental insurance.

  When the individual(s) who qualifies for a medical deduction has medical insurance under a policy that benefits other individuals who do not qualify for a medical deduction, only the portion of the insurance premium assigned to the qualifying individual(s) is considered. If specific information is not available about the eligible individual's premium amount, the premium is prorated among those covered by the insurance.
- Medicare premiums, except when the DOHS is paying the premium.
- Medical support service systems, if prescribed by a qualified health professional. Allowable costs are related to the purchase, rental, and maintenance of the system. Examples of medical support service systems include, but are not limited to, Lifeline Personal Response, Life Alert, etc.
- Dentures
- Hearing aids and batteries
- Purchase and maintenance of prosthetic devices
- Purchase and maintenance of a trained service animal which is required for a physical or mental disability and is prescribed by a doctor. This includes the cost of food and veterinarian bills for the service animal. Trained service animals may include seeing or hearing dogs, therapy animals to treat depression, animals used by persons with other

disabilities such as epilepsy, paraplegia, etc. When the supervisor is unable to determine whether or not an animal meets the applicable criteria or an animal-related expense is an appropriate deduction, he must contact the Division of Family Assistance (DFA) Economic Services Policy Unit for clarification.

- Prescription eyeglasses
- Reasonable cost of transportation and lodging to obtain medical treatment or services. If a client can verify that a charge was made for transportation, but the transportation provider will not state the amount, the current state mileage rate is allowed as a medical deduction.
- Maintaining an attendant, homemaker, home health aide, housekeeper, or childcare services necessary due to age, infirmity, or illness. If the AG provides the majority of the attendant's meals, an amount equal to the maximum monthly SNAP allotment for one person is also used as a medical deduction.
- Any cost-sharing or spenddown expense incurred by Medicaid clients.

NOTE: When attendant care costs qualify for both Dependent Care Deduction and medical deduction, it must be considered a medical expense.

NOTE: Special diets and dietary supplements are not allowable medical expenses.

➢ *Timing Considerations Related to Medical Bills*

The client is only required to report medical expenses at the time of application and redetermination. He may choose to report changes in expenses during the certification period, and such changes must be acted on.

Medical bills that are overdue when reported cannot be considered. The date the expense is incurred is not the deciding factor, but rather, the date the expense is billed or otherwise due.

The AG may elect to have one-time only costs deducted in a lump sum or prorated over the certification period. If, at application or redetermination, a client anticipates and verifies that he will incur an expense during the certification period, it may be prorated over the entire certification period. If he reports an expense during the certification period, it may be prorated over the remainder of the certification period.

When the medical bill or expense is paid by a credit card, it must be treated as a one-time only cost. The medical bill or expense may be deducted in a lump sum or prorated over the

certification period. The actual monthly payment to the credit card company is not an allowable medical expense.

An AG that is certified for 24 months may elect to have one-time only costs deducted as follows:

- Costs reported during the first 12 months of the certification period may be:
  - Deducted for one month;
  - Averaged over the remainder of the first 12 months; or
  - Averaged over the remainder of the 24-month certification period.
- Costs reported after the twelfth month may be:
  - Deducted for one month; or
  - Averaged over the remainder of the certification period.

➢ *Estimated and Actual Medical Expenses*

Clients may choose to use a combination of estimated and actual expenses.

▪ *Estimated Expenses*

The client may claim a medical deduction by providing a reasonable estimate of medical expenses for the certification period. Such expenses may include current verified medical expenses, anticipated changes in ongoing expenses, an anticipated new ongoing expenses, or an anticipated one-time only expense. The client must verify that his estimate is reasonable.

Information used to determine that an estimate is reasonable may include, but is not limited to:

- Current verified medical expenses
- Statement from a physician, dentist, or other healthcare professional to establish the need for and/or date of an anticipated procedure, course of treatment, etc. The Worker and/or Supervisor may establish need based upon knowledge of the client's current or prior circumstances, or information in the client's record.
- Cost estimate from the provider of an anticipated procedure, course of treatment, etc.
- Information about third-party coverage, including Medicaid, for current and/or anticipated expenses

Once the client provides a reasonable estimate of expenses for the certification period, he is not required to report further, even if the estimated expenses increase, decrease, or are not incurred. However, changes reported by the AG must be acted on.

Changes reported or information received from a source other than the AG, such as information received from a medical provider for a Medicaid client, must be acted on only when the information is verified by the outside source and contact with the AG is not necessary for additional information or verification. Otherwise, such information is acted on at the next redetermination or when the client reports and verifies it.

▪ *Actual Expenses*

The client may claim a medical deduction by using actual expenses. Once he reports his actual expenses at application or redetermination, he is not required to report further, even if his expenses increase or decrease during the certification period. However, reported changes must be acted on.

Monthly payments toward medical expenses are allowable as a deduction only when a monthly payment schedule is negotiated prior to the due date of the bill. If the client must renegotiate the payment schedule for any reason, only the amount that is not past due, and for which the client has not already received a deduction, is an allowable expense.

> **Renegotiated Payment Example:** The AG agrees in January to make monthly payments of $100 for 10 months on a $1,000 bill. They make timely payments in January and February. In March and April, they make no payment due to a change in circumstances, but they do receive the deduction. In May, they renegotiate the payments to pay the balance of $800 at $80 a month for 10 months. Because the AG has already received a total deduction of $400, and the amount of $200 for March and April is overdue, the client may only receive a deduction for $600. He may receive the $80 a month deduction only until the $600 is paid.

When a bill becomes overdue during the certification period, the deduction continues until the end of the certification period, unless the client reports the overdue bill.

Ongoing medical expenses that are regularly incurred on a weekly, biweekly or semi-monthly basis must be converted to a monthly amount using the following conversion figures:

- Weekly - Multiply by 4.3
- Biweekly - Multiply by 2.15
- Semi-monthly - Multiply by 2

➢ *Medical Deduction for Residents of Group Living Facilities (GLF)*

Allowable medical expenses that can be identified apart from food and shelter payments are deducted. See Section 16.2.

➢ *Categorically Eligible, Retroactive SSI Approvals*

When all of the following conditions are met, the AG must have benefits restored to compensate the client for a medical deduction he did not receive:

- The AG becomes Categorically Eligible due to retroactive approval of SSI benefits; and
- The individual approved for Supplemental Security Income (SSI) is entitled to a medical deduction; and
- The client started receiving SNAP benefits prior to being found eligible for SSI.

Benefits must be restored for the period starting the date the individual was authorized to receive SSI benefits or the date of the SNAP application, whichever is later.

4.4.2.B.7 Shelter/Utility Deduction

After all other exclusions, disregards, and deductions have been applied, 50% of the remaining income is compared to the total monthly shelter costs and the appropriate SUA. If the shelter costs/SUA exceed 50% of the remaining income, the amount in excess of 50% is deducted. The deduction cannot exceed the shelter/utility cap found in Appendix B.

EXCEPTION: The cap on the shelter/utility deduction does not apply when the SNAP AG includes an individual who is elderly or disabled, as defined in Section 13.15.

The Worker must allow the expense only if the AG is obligated to pay with the AG's excluded or non-excluded resources. There is no time limit during the certification period for deciding when an AG is no longer allowed a deduction for the bill. The AG is no longer allowed the deduction when the expense is no longer billed or is no longer due. An expense does not have to be paid to be a deduction. In order to receive a shelter deduction, the expense/obligation must be verified at a minimum of application and redetermination, or when the AG reports a change in shelter expense.

NOTE: If all avenues of verification have been exhausted and the individual is unable to provide the agency with this information client attestation with all necessary information is acceptable. This information should be documented in writing with the individual's signature as well as documented in the case record. If an individual fails to submit verification of shelter, the SNAP application or redetermination will be processed without giving a shelter deduction.

When the AG is providing an in-kind payment instead of a cash payment, a deduction is only allowed when the original obligation is a cash payment. The AG must be otherwise obligated to make a cash payment, if the in-kind payment is not provided.

> **In-Kind Payment Example 1:** An AG is renting a house that needs repairs. The house normally rents for $450 a month. The landlord has agreed to allow the AG to make repairs to the home in lieu of making a rent payment for six months. The AG is entitled to a $450 rent deduction for six months.
>
> **In-Kind Payment Example 2:** Same situation as above, except that the landlord has agreed to allow the AG to make repairs to the home in lieu of part of the rent for 12 months. The AG must make a cash payment of $225 a month and make repairs for the remaining $225 a month. The AG is entitled to a $450 rent deduction for 12 months.
>
> **In-Kind Payment Example 3:** An AG is renting a room in an elderly woman's home. In exchange for rent, the AG is expected to provide housekeeping, lawn care, and meal preparation for the woman. No cash value was assigned to this obligation. The AG is not required to make a cash payment in lieu of these responsibilities. The AG is not entitled to a shelter deduction because the only rental obligation is an in-kind payment.
>
> **Shelter Deduction Example 1:** An eligible college student uses a portion of his educational grants and loans in August to pay his rent through the end of the semester. His rent is used as a shelter deduction as it would be due during the certification period.
>
> **Shelter Deduction Example 2:** An eligible college student's parents pay his rent during the school term. His rent is not used as a deduction because he is not obligated to pay it. His parents do not pay his rent during the summer. He may receive a deduction during the summer because he is obligated to pay the rent.

The AG may still be eligible for a deduction if the home is not occupied by the SNAP AG because of employment or training away from home, illness, or disaster/casualty loss of an AG or non-AG member. The deduction is allowed, if the AG remains responsible for the shelter and/or utility costs, and the home is not leased or rented during this time. The AG must intend to return to the home, and the current occupants of the house, if any, must not be claiming the shelter costs for SNAP purposes.

Homeless AGs who use the Homeless Shelter Standard Deduction are not eligible for the SUA and an additional shelter deduction.

AGs with shelter expenses, (i.e., rent and mortgage), for both occupied and unoccupied homes may use the obligations for both homes as a deduction.

When the client claims expenses for his home as a self-employment expense, the deduction can be either a shelter deduction or a cost of doing business, but the total deduction given must not exceed the actual expense. See Ineligibility for The Heating/Cooling Standard (HCS) below.

4.4.2.C Shelter Expenses

Items considered in arriving at shelter expenses are the continuing amounts of:

- Rent. Security or damage deposits are not shelter expenses.
- Mortgage payments. This includes second mortgages and home equity loans and any other loans for which the dwelling is used as collateral.

NOTE: A shelter cost paid in advance, but billed and/or due during the certification period, is used as a deduction.

- Interest on mortgage payments.
- Condominium and association fees, regardless of purpose for the fees.
- Payments to an escrow account established to pay property taxes and homeowner's insurance.
- Property taxes and special tax assessments on the structure and lot required by State or local law. This does not include assessments such as police and fire fees, unless the fee is based on property valuation.
- Insurance on the structure and lot. This does not include insurance on furniture or personal belongings. If the insurance cost on the structure and the cost on the personal belongings/furniture cannot be identified separately, the entire insurance payment is allowed.
- Cost of repairing the home that was damaged or destroyed due to a natural disaster or misfortune including, but not limited to, fire, flood, or freezing temperatures. This does not include charges that will be or have been reimbursed from any source such as insurance, private agency, etc.
- A car payment when a homeless AG lives in their vehicle.
- Insurance on the vehicle itself when a homeless AG lives in their vehicle.

➢ *Rent Subsidies*

A rent subsidy paid directly to the client's landlord is not counted as income and the amount of the subsidy is not used as a shelter deduction.

A rent subsidy paid directly to the client or any other entity other than the client's landlord is counted as income and the amount of rent payment actually made from the client's income is used as a shelter deduction.

A rent subsidy paid directly to the client or to the utility provider is counted as income, and the amount of the rent payment actually made from the AG's income, including income counted due to direct receipt of a rent subsidy, is used as a shelter deduction.

When the United States Department of Housing and Urban Development (HUD) is recovering an overpayment by withholding money for current and future subsidies, the client's contribution increases. Such an increase is not counted as an increase in shelter costs.

➢ *Residents of Group Living Facilities (GLF)*

The portion of the payment made to the GLF, which can be identified as being for shelter or utilities, is used as a shelter deduction.

If it is not possible to identify the portion of the payment that is for shelter, the Worker subtracts the maximum monthly benefit for the number of persons in the AG from the total monthly payment actually made from the AG's income. The remainder is used as the shelter expense.

4.4.2.C.1 Standard Utility Allowance (SUA)

SUAs are fixed deductions that are adjusted yearly to allow for fluctuations in utility expenses. AGs with utility expenses for both occupied and unoccupied homes may only use the SUA for one home of his choice.

These deductions are the Heating/Cooling Standard (HCS), the Non-Heating/Cooling Standard (NHCS), and the One Utility Standard (OUS). The current SUA amounts are found in Appendix B.

AGs that are obligated to pay from their resources a utility expense that is billed separately from their shelter expenses are eligible for an SUA deduction. AGs that are not obligated to pay any utility expense are ineligible for the SUA, even if other residents pay utility expenses. Eligibility

for the SUA must be evaluated at certification, redetermination, and when the AG reports a change in utilities that may affect its eligibility for a deduction.

Items that are considered utilities include, but are not limited to:

- Water, including well installation and maintenance
- Liquefied Petroleum Gas (LP or LPG) or natural gas
- Wood, wood pellets, coal, and heating oil
- Electricity
- Sewage, including septic tank system installation and maintenance
- Garbage collection
- The basic rate for one telephone, either landline or cellular service, but not both. Basic rates include, but are not limited to, taxes, wire maintenance fees, subscriber line charges, relay center surcharges, and 911 fees. It does not include extra services such as, call-waiting, caller ID, etc.

Items not considered utilities include, but are not limited to:

- Cable/digital/satellite television service
- Internet service
- Utility deposits
- Pre-paid cell phones

SHARED RESIDENCE EXCEPTION: When an AG shares a residence with another AG or non-AG and shares any utility expense, the AG is eligible to receive the appropriate SUA based on all the utilities of the residence.

> **Shared Residence Example:** A SNAP client shares a home with another individual. The utilities for the home are electric, gas, water, and telephone. The SNAP client pays the water, and the other individual pays the electric, gas, and telephone. The SNAP client is eligible for an SUA deduction based on the utilities of the residence, which are the electric, gas, water, and telephone.

➢ *Heating/Cooling Standard (HCS)*

To be eligible for the HCS, the AG must meet the following criteria.

▪ *Heating or Cooling Costs*

AGs that are obligated to pay a heating or cooling expense that is billed on a regular basis are eligible for the HCS. There does not have to be a monthly bill for heating or cooling throughout the year, just a regular bill for heating or cooling during the appropriate season.

To qualify for the HCS, the heating or cooling expenses must be for the primary source of heating or cooling.

Heating expenses include, but are not limited to, the cost of electricity, gas, oil, coal, wood, wood pellets, and kerosene. Heating costs include only the fuel, and not related costs. Related expenses are those necessary to obtain the fuel or to operate the unit, such as electricity to run a gas furnace.

Cooling expenses for the operation of air conditioning systems or room air conditioners are allowable expenses. Fans are not considered air conditioners and are not an allowable expense.

> **Primary Heating Source Example:** The use of electric space heaters by an AG whose primary source of heat is free gas, does not qualify the AG for the HCS.
>
> **Related Expense Example:** A client uses free firewood for heat but must pay for delivery. The delivery expense alone does not qualify the AG for the HCS.

▪ *Separate Billing*

The expense for heating or cooling costs must be billed separately from the rent or mortgage, even if the AG combines those payments.

This includes the following:

- Residents of a private rental housing who are billed by the landlord for a heating or cooling cost based on actual use or charged a flat rate separately from the rent.
- AGs that live in separate residences but share a single meter.
- AGs that rent different residences in the same building and share utility meters, and one is billed for heating and one is billed for another utility.
- Residents of public housing with shared utility meters who are billed for excess heating or cooling costs.
- AGs that have utilities included in their rent and/or shelter payments but are billed separately for a heating or cooling cost are eligible for the HCS.

▪ *Low-Income Energy Assistance Program (LIEAP)*

AGs that receive LIEAP or share a residence and utility costs with a LIEAP client are eligible to receive the HCS. LIEAP payments must be received in the current month or preceding 12 months of determining eligibility, regardless of any changes in the AG's address.

▪ *Ineligibility for the HCS*

The AG, unless a LIEAP client, is not eligible for the HCS when any of the following situations exist:

- The heating or cooling costs are included in the shelter obligation and are not billed separately; or
- The AG receives an excluded utility supplement and does not have utility costs in excess of the amount of the excluded supplement.

A homeless AG may choose to use the Homeless Shelter Standard Deduction or the HCS, if otherwise eligible.

➢ *Non-Heating/Cooling Standard (NHCS)*

AGs that do not qualify for the HCS, but incur two or more utility expenses or at least one utility expense when sharing a residence that has two or more utilities, are eligible for the NHCS if the AG meets the following criteria:

▪ *Separate Billing*

The utility costs must be billed separately from the rent or mortgage payment for the residence.

This includes the following:

- Residents of private rental housing who are billed by the landlord based on actual use or charged a flat rate separately from the rent.
- AGs that live in separate residences but share a single meter.
- AGs that rent different residences in the same building, and one is billed for one utility and the other is billed for the other utility.
- Residents of public housing with shared utility meters who are billed excess costs for two or more utilities.

- AGs that have utilities included in their rent and/or shelter payment but are billed separately for two or more utility expenses are eligible for the NHCS.

▪ *Ineligibility for the NHCS*

The AG is not eligible for the NHCS when any of the following situations exist:

- All the utility costs are included in the shelter payment and none are billed separately
- The AG receives an excluded utility supplement and does not have utility costs greater than the excluded supplement

A homeless AG may choose to use the Homeless Shelter Standard Deduction or the NHCS, if otherwise eligible.

➢ *One Utility Standard (OUS)*

AGs that do not qualify for the HCS or the NHCS, but incur one utility expense, are eligible for the OUS if the AG meets the following criteria:

▪ *Separate Billing*

The utility cost must be billed separately from the rent or mortgage payment of the residence.

This includes the following:

- Residents of a private rental housing who are billed by the landlord based on actual use or are charged a flat rate separately from the rent.
- AGs that live in separate residences but share a single meter.
- AGs that rent different residences in the same building, and only one is billed for the one utility.
- Residents of public housing with a shared utility meter who are billed excess cost of a single utility.
- AGs that have a utility or multiple utilities included in their rent and/or shelter payment, but are billed separately for one utility expense are eligible for the OUS.

- ***Ineligibility for the OUS***

An AG is not eligible for the OUS when any of the following situations exist:

- All the utility costs are included in the shelter payment and none are billed separately.
- The AG receives an excluded utility supplement and does not have utility costs in excess of the amount of the excluded supplement.

A homeless AG may choose to use the Homeless Shelter Standard Deduction or the OUS if otherwise eligible.

4.4.3 DETERMINING ELIGIBILTY AND BENEFIT LEVEL

The following information describes situations encountered in determining eligibility for most AGs; however, there are situations that require special treatment. See Special Situations in Section 4.4.4.

The process of determining eligibility and the amount of the benefit differs when an AG member is elderly or disabled.

4.4.3.A Determining Eligibility

- When no AG member is elderly or disabled, the gross income must be equal to, or less than, the gross income limit in Appendix A. If so, the AG qualifies for the disregards and deductions.

  If the gross income exceeds the amount in Appendix A, the AG is ineligible.
- When at least one AG member is elderly, which is at least age 60, or disabled as specified in Section 13.15, eligibility is determined by comparing the countable income to the maximum net monthly income found in Appendix A. There is no gross income test.
- When the AG is Categorically Eligible as defined in Chapter 1, the gross income test is presumed to be met.

4.4.3.B Determining Countable Income

SNAP certification for residents of shelters for battered persons and their children are based on the income, assets, and expenses of the client and their children. See Sections 5.6 and 16.2.

The following steps are used to determine countable income for cases meeting the eligibility tests above.

Step 1: Combine monthly gross countable earnings and monthly gross profit from self-employment.

Step 2: Deduct 20% of Step 1.

Step 3: Add the gross countable unearned income, including the WV WORKS benefit and any amount reduced or being repaid to WV WORKS due to failure to comply with a program requirement. See Section 4.4.4.

Step 4: Subtract the Standard Deduction found in Appendix B.

Step 5: Subtract allowable Dependent Care Expenses.

Step 6: Subtract the amount of legally obligated child support actually paid.

Step 7: Subtract the Homeless Shelter Standard Deduction found in Appendix B.

Step 8: Subtract allowable medical expenses in excess of $35.

Step 9: Calculate 50% of the remaining income and compare it to the actual monthly shelter/SUA amount.

Step 10:

	No One Elderly or Disabled	At Least One Person Elderly or Disabled
Shelter/SUA Equal to Or Less Than Step 9	No further computation is needed. The amount from Step 8 is the countable income.	No further computation is needed. The amount from Step 8 is the countable income.
Shelter/SUA Greater Than Step 9	The amount in excess of 50%, not to exceed the shelter/utility cap, in Appendix B is deducted to arrive at countable income.	The amount in excess of 50% is deducted, without regard to the shelter/utility cap, in Appendix B to arrive at countable income.

Step 11: Compare the countable income to the maximum net income in Appendix A for the AG size. This net income test does not apply to Categorically Eligible AGs. See Chapter 1.

4.4.3.C Determining the Amount of the Benefit

To determine the SNAP allotment, find the countable income and the maximum benefit allotment for the AG in Appendix A. One- and two-person AGs who meet the gross and net income test or who are categorically eligible, as defined in Section 1.4.17.C automatically receive the minimum SNAP benefit, unless it is a prorated benefit. See Appendix D, SNAP and WV WORKS Proration Table. No benefits are issued to any AG eligible for an initial, prorated amount less than $10. See Chapter 1 for proration requirements.

The Worker will determine the benefit amount by using the following method. The eligibility system also uses this method.

Computation of Benefit Amount	Example
Multiply net income by 30% (Round up)	$ 554 Net monthly income X .30 **$166.20 = $167**
Subtract 30% of net income as calculated above from the maximum monthly benefit for the AG size	$994 Maximum allotment for four - 167 30% of net income **$827 SNAP benefit for a full month**

4.4.4 SPECIAL SITUATIONS

4.4.4.A Categorical Eligibility

Although there is no gross or net income test, countable SNAP income for the purposes of determining level of benefit is calculated the same way it is for all other SNAP AGs. See Chapter 1 for Categorical Eligibility information.

4.4.4.B Expedited Service

After eligibility for Expedited Service is determined, the income calculations are the same as for any other AG.

Destitute AGs receive special income calculations, whether they are expedited or not. See item C below.

4.4.4.C Destitute AGs

NOTE: This provision applies only to migrant or seasonal farm worker AGs.

4.4.4.C.1 Definition of Destitute

The AG's only income for the month was prior to the date of application and is from a terminated source or the AG will receive no more than $25 in income from a new source within 10 days after the date of application.

NOTE: A migrant or seasonal farm worker's source of income is the grower for whom they are working and not the crew chief.

Households may receive both income from a terminated source and income from a new source and still be considered destitute.

Travel advances from a new employer are not considered the first pay from the new source and do not prevent the AG from being destitute.

- ***Income from a Terminated Source***

Income is considered to be from a terminated source when:

- If it is received on a monthly or more frequent basis and will not be received again from that source for the remainder of the month of application or the month following the month of application; or

- If it is received less often than monthly and will not be received for the month in which the next payment would normally be received.

➢ *Income from a New Source*

Income is considered to be from a new source when:

- If it is received on a monthly or more frequent basis and no more than $25 was received within 30 days prior to the application date; or
- If it is received less often than monthly and no more than $25 was received within the last normal interval between payments.

4.4.4.C.2 Determination of Destitute

Migrant and seasonal farm workers that are determined destitute are entitled to:

- Expedited Service procedures
- Special income calculations used for the first month of the certification period.

4.4.4.C.3 Special Income Calculations

Those AGs determined destitute have only the income received between the first of the month of application (or redetermination) and the date of application (or redetermination) used in the income calculations for the first month of certification (or recertification). All other SNAP income policy and procedures apply.

4.4.4.D Income from Self-Employment

When an AG member or a disqualified individual(s) receives income from self-employment, the instructions below must be used to arrive at the gross profit which is used to calculate countable income.

Contract income that is not intended to cover a 12-month period and is not paid on an hourly or piecework basis is prorated over the period it is intended to cover.

4.4.4.D.1 Determining Gross Income

Gross income includes the net proceeds from the sale of capital goods or equipment.

The method used to determine monthly gross income from self-employment varies with the nature of the enterprise. It is necessary to determine which of the following types of self-employment applies to the client's situation. Once the pattern of self-employment has been determined, the instructions below are used to determine how the income is counted.

➢ Person Receiving Regular Income

Persons who receive income as profit on a more or less regular schedule (weekly, monthly, etc.), or receive a specific amount from the business each week or month and/or receive the balance of profit from the enterprise at the end of the business year.

This income is converted to a monthly amount, according to the Budgeting Method in Section 4.4.1.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ Persons Receiving Irregular Income

Many persons derive income from short-term seasonal self-employment. This seasonal enterprise may be the major source of income for the year, or only for the period of time the person is actually engaged in this enterprise, with other sources of income being available during the remainder of the year. Persons who are seasonally self-employed include vendors of seasonal commodities (produce, Christmas trees, etc.), or other seasonal farmers.

Cash-crop and some seasonal farmers and other persons with similar irregular self-employment income receive their annual income from self-employment in a short period of time and budget their money to meet their living expenses for the next 12 months.

Because the income is seasonal, it must be averaged over the period of time it is intended to cover, even if it is the major source of income for the year. However, if the averaged amount of past income does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income is calculated based on anticipated earnings.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ *New Business*

AGs with a new business that has been in existence less than a year have their income and incurred business expenses averaged over the amount of time the business has been in operation. From this, the monthly amount is projected for the coming year. However, if the averaged amount of past income and/or expenses does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income and/or expenses is calculated based on anticipated earnings.

4.4.4.D.2 Determining Gross Profit

Gross profit from self-employment is the income remaining after deducting any identifiable costs of doing business from the gross income.

➢ *Deductions*

Examples of allowable deductions include, but are not limited to:

- Employee labor costs, including wages paid to an AG member and any salary the client pays himself. When paid to an AG member, the income must be considered according to the provisions in Section 4.3.
- Stock and supplies
- Raw material
- Seed
- Fertilizers
- Repair and maintenance of machinery and/or property
- Cost of rental space used for conducting the business
- Payments on the principal and interest of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods
- Insurance premiums and taxes paid on the business and income-producing property
- The utilities, principal, interest, and taxes for the client's residence which is used in part to produce income. This is applicable only if the expenses on the portion of the home used in the self-employment enterprise can be identified separately. See Shelter/Utility

Deduction above. The total deduction given for shelter and/or expense of doing business must not exceed the actual expense.

- Advertising costs
- Utilities
- Office expenses, (i.e., stamps, stationery, etc.)
- Legal costs
- Net Loss from self-employment farming. See item D below.

Do not deduct the following:

- Federal, State, or local income taxes
- Money set aside for retirement
- Travel from home to a fixed place of business and return
- Depreciation
- Amounts claimed as a net loss, except loss from farming self-employment. See item D below.

➢ *Rental Income Deductions*

In addition to the deductions listed in item A above, the following expenses are deducted from rental income:

- Utility bills paid for tenants
- Property tax and insurance on the rental property
- Repair and upkeep of the property
- Interest and principal on necessary purchases made in installments, such as the purchase of a new furnace

NOTE: The following deductions apply to both business and non-business rental income even when the non-business rental income is counted as unearned income.

➢ *Deductions from Boarder Income*

When the household is not a commercial boarding house, the deduction for the cost of doing business is:

- The documented cost of providing rooms and meals, if the cost exceeds the maximum SNAP allotment equal to the number of boarders. However, this amount cannot exceed the actual payment the AG receives from the boarder; or
- The maximum SNAP allotment for the number of boarders.

➢ *Offsetting Farming Losses*

Offsetting losses from farm self-employment activities is accomplished as follows:

NOTE: Losses from farming self-employment are only offset for the AG containing the person directly involved in the agricultural activity and, then, only when the farmer receives or expects to receive annual gross income of $1,000 or more from the farming enterprise.

Step 1: Determine gross monthly farm self-employment income.

Step 2: Determine monthly farm business costs, prorated over the same period used to prorate income.

Step 3: Subtract the business costs from the gross farm income to determine the negative number that is the net monthly loss.

Step 4: Determine gross non-farm, self-employment income.

Step 5: Subtract monthly business costs for the non-farm, self-employment enterprise from the result of Step 4.

Step 6: Subtract the result of Step 3 (losses due to farm self-employment) from the result of Step 5

Step 7: If the result of Step 6 is $0 or greater, offsetting the farm loss is complete. The result is used as the total self-employment income for the AG. If the result of Step 6 is negative, the difference between the amount of farm loss and the amount of non-farm self-employment income is used as the net farm loss amount. Proceed to Step 8.

Step 8: Add together the total gross earned income (excluding the result from Step 5) and total unearned income of the AG.

Step 9: Subtract the net farm loss (Step 7) from the total arrived at in Step 8. This is the final gross monthly income for use in the gross income test. If the final gross monthly income is negative, 0 (zero) is used as the income.

Farm and Other Self-Employment Income Example: The Jade family has $2,400 per year gross income from farming. In addition, Mrs. Jade is self-employed and earns $600 per year. One child receives $25 per month child support and Mr. Jade has gross earnings of $400 per month.

Step 1: Gross monthly farm self-employment income is $200 per month.

Step 2: Monthly farm business costs are $300 per month.

Step 3: $200 Farm self-employment income

	-$300	Monthly farm business costs
	$-100	**Net monthly farm loss**
Step 4:	Gross non-farm, self-employment income is $50 per month	
Step 5:	Monthly business costs for non-farm, self-employment is $20 per month, leaving $30 per month as gross profit from non-farm, self-employment.	
Step 6:	$30	Month gross profit from non-farm, self-employment
	-$100	Net monthly farm loss
	$- 70	**New net monthly farm loss**
Step 7:	Because the result of Step 6 is a negative figure, proceed to Step 8. The new net farm loss = -$70.	
Step 8:	$25	Child support
	+$400	Earnings
	$425	
Step 9:	$425	Total gross income
	$- 70	Farm loss
	$355	**Gross income minus farm losses**

The gross income test is passed.

4.4.4.E Migrant Farm Laborers with Seasonal Employment

See Section 4.4.4.C above.

4.4.4.F Annual Contract Employment

This section applies to any person employed under a yearly contract, such as school employees, including bus drivers, cooks, janitors, aides, and professional staff. This item does not apply to migrant workers or substitute employees.

These individuals have their annual income prorated over a 12-month period. Additional earnings, such as for summer work, are added to the prorated amount during the time additional earnings are received.

Although a person may not have signed a new annual contract, he is still considered employed under an annual contract when the contract is automatically renewable, or when he has implied renewal rights. Implied renewal rights are most commonly associated with school contracts.

This item does not apply during strike and disaster situations when the other party to the contract cannot fulfill it; or when labor disputes interrupt the flow of earnings specified in the contract.

4.4.4.G Educational Income

All student financial assistance, including grants, scholarships, fellowships, work study, educational loans on which payment is deferred, and veterans' educational benefits are entirely excluded.

Unless used for living expenses, income from stipends is excluded.

4.4.4.H Deeming

Income is deemed from individuals who are ineligible, disqualified, and excluded by law and from certain income sources as found below.

NOTE: This does not apply to students who are ineligible due to the SNAP general eligibility provisions in Section 3.2, individuals who are ineligible due to receipt of SNAP in another state and individuals who are ineligible due to the institution residence provision in Section 2.2.

See Sections 15.6 for deeming from ineligible noncitizens and from sponsors of ineligible noncitizens.

4.4.4.H.1 Deeming from Disqualified and Ineligible Individuals

Income treatment differs, based on the reason for the disqualification or ineligibility as follows.

➢ *Ineligible AG Members*

The following individuals are ineligible to be included in the AG and are not counted as AG or Needs Group members when determining eligibility and the benefit level. See Section 3.2.

- Individuals subject to an enumeration penalty
- Ineligible noncitizens
- Individuals who are found to be ineligible Able-Bodied Adults Without Dependents (ABAWD)

The income is deemed as follows:

Step 1: The total countable income of the ineligible individual is divided by the number of persons in the AG, plus the ineligible individual(s). This is each individual's pro rata share.

Step 2: Subtract the disqualified individual(s') share from his total countable income. The remaining amount is counted as income to the AG.

The Earned Income Disregard is applied only to the portion deemed to the AG.

The portion of the AG's allowable child support payments, shelter, and dependent care expenses, which is billed to and/or paid by the ineligible individual is prorated as described above.

NOTE: No portion of an AG's SUA is prorated due to the ineligibility of an AG member.

Ineligible Individual Example: The household consists of father, mother, and three children. The father has earnings of $500 per month and is an ineligible individual. There is no other income in the home and the father pays the $250 rent.

Income for the AG is calculated as follows:

Step 1: $500 ÷ 5 = $100 Pro rata income share for each person

Step 2:

$500	Father's income
-$100	Father's pro rata share
$400	**Deemed to AG as earned income**

The shelter expense is calculated as follows:

Step 1: $250 ÷ 5 = $50 Pro rata rent share for each person

Step 2:

$250	Rent paid by father
-$50	Father's pro rata share
$200	**Used as shelter expense for AG**

➢ *Disqualified Individuals*

The income of the following disqualified and excluded individual(s) is counted as if he were a member of the AG.

- An individual who is in a SNAP penalty for failure to comply with SNAP work requirements. See Section 14.5.
- An individual who is excluded by law. See Section 3.2.
- An individual who has been found guilty of an Intentional Program Violation (IPV). See Section 3.2.

All applicable exclusions, disregards, and deductions apply to the individual(s) income; however, the individual is not included in the AG when determining eligibility or benefit level.

NOTE: The benefit level cannot increase when an individual is disqualified and all other case circumstances remain the same. Should this happen, please notify the DFA Policy Unit.

NOTE: An individual who wins a substantial lottery or gambling winning is not a disqualified individual; the entire AG is then disqualified until the AG meets the allowable resource and income guidelines.

4.4.4.H.2 Failure to Comply with WV WORKS Requirements

SNAP benefits will not increase due to a repayment or the loss of WV WORKS when the repayment or loss is due to the client's failure to comply with a requirement of WV WORKS. The client must be receiving a SNAP benefit at the time of the failure to comply.

➢ *Nature of the Deeming Process*

The amount of the WV WORKS benefit prior to the repayment or loss continues to be counted as income, even though the client no longer receives it.

> **AG Separation Example:** Mr. and Mrs. Crocus have four children and are notified that a third sanction will be imposed, and the benefit amount will be reduced from $460 to $0. The WV WORKS amount counted for SNAP benefits is $460. The AG separates; Mr. and Mrs. Crocus each will then have $230 of the

WV WORKS benefit counted for the SNAP benefits in their separate AGs. If they reconcile before the end of the sanction period, $460 WV WORKS benefit will be counted for their SNAP benefit.

➢ *Deeming Period*

The duration of the WV WORKS sanction is not affected by a break in SNAP certification. For WV WORKS sanctions, the income is deemed during the entirety of the sanction period.

➢ *Client Notification*

The fact that benefits do not increase based on a decrease in income, does not constitute an adverse action. Client notification is required.

➢ *SNAP Fair Hearing*

The AG is not entitled to a separate SNAP Fair Hearing on the issue of failure to comply.

A SNAP Fair Hearing may be held on the issue of not increasing SNAP benefits when WV WORKS income has decreased.

4.4.4.I Strikers

4.4.4.I.1 Definition of a Striker

A striker is an individual involved in a strike or concerted work stoppage by employees, or any slowdown or concerted interruption of operation by employees.

An individual who is a part of the striking union or concerted work stoppage is considered a striker, even if he voted against the strike or concerted work stoppage, and even if he does not actively engage in strike-related activity, such as walking in a picket line. Sympathy strikers are considered strikers.

4.4.4.I.2 Determining Striker Eligibility

To determine if an AG containing a striker is eligible, it is necessary to determine pre-strike eligibility and current eligibility. When the SNAP AG includes an individual who is on strike, the AG is ineligible for the duration of the strike unless:

- If the AG was eligible and receiving SNAP benefits the day prior to the strike, pre-strike eligibility is assumed. If not, it is necessary to determine if the AG would have been eligible the day prior to the strike, had they applied. If the AG would not have been eligible prior to the strike, they are ineligible for current SNAP benefits.
- The individual who is participating in the strike is exempt from work requirements for any reason other than employment. Refer to Chapter 14.

4.4.4.I.3 Who Is Not a Striker?

The following persons are not considered strikers:

- An individual who is not a part of the striking union or concerted work stoppage;
- An employee who is not working because of a lock-out by the employer;
- Employees who are laid off or for whom there is no work because of a strike;
- An employee who is not a member of a striking union, but who cannot cross a picket line because of fear of personal injury or death. Any person, who is prohibited by his union's by-laws from crossing a union picket line may feel he faces the possibility of personal injury if he does cross the picket line of the union that is striking or conducting a concerted work stoppage. The DFA Policy Unit must be contacted before a decision is made on these cases. The DFA Policy Unit will determine if each member of the non-striking union does face the possibility of personal injury by crossing the picket line of the striking group. The DFA Policy Unit will determine if the entire non-striking union may be considered non-strikers, or if the decision about the possibility of harm must be made on a case-by-case basis, after consultation with the Food and Nutrition Service of the United States Department of Agriculture (FNS).

4.4.4.I.4 Striker Criteria

The following points are considered in determining whether or not to consider an individual a striker:

- If both the union and the company consider the work stoppage to be a strike, the individual is a striker.
- If both the union and the company consider the work stoppage to be a lockout, the individual is not a striker.

- The fact that a person receives unemployment compensation insurance (UCI) benefits does not necessarily mean that the individual is not a striker.
- Employees who participate in sympathy or support strikes are considered to be strikers.
- All non-working members of the bargaining unit, which is on strike are strikers, even if they are not members of the union, regardless of their fear of crossing a picket line. Members of the bargaining unit who are working are not considered strikers.
- If the company fires the employee while he is on strike, the employee is no longer considered a striker.
- If the employee officially resigns from his job while on strike, the employee is no longer considered a striker.
- If an individual obtains other employment while on strike, but he does not resign, the individual is still a striker.
- If the company hires permanent replacements for the individuals who are striking, the individuals are no longer considered strikers.
- If the company does not allow the individuals who are striking to return to their old jobs, but offers them different ones, the individuals are no longer considered strikers. Employees must be able to return to the same jobs they left when the strike began to be considered strikers.
- If an employee was locked out by the company the day before the strike, the employee is not considered a striker.
- If the union calls off the strike and tells the individuals who are striking to go back to work, and they do not, the individuals are considered strikers until the individuals go back to work, are fired, or quit.
- If the company lays off, furloughs, or otherwise notifies employees who are not part of the bargaining unit that no jobs are available because of the strike, these employees are not considered strikers.
- If an individual was laid off when the strike began, the individual is not considered a striker.
- Self-employed persons, such as independent long-distance truckers, are not considered strikers.
- The fact that the company has applied for Chapter 11 bankruptcy does not mean that the individuals are not considered strikers.

4.4.4.I.5 Determining Current Eligibility

Current eligibility is determined as for any other AG, except for calculating the striker's countable income, which is determined as follows:

- Determine what the striker's monthly countable income would have been, if he had applied the day prior to the strike, and, if the strike had not occurred.
- Determine the striker's current monthly countable income.
- The higher of these two amounts is counted as the striker's income.
- Add the determined amount to the current non-excluded income of the non-striking AG members. Eligibility and benefit level are determined as for any other AG and all appropriate deductions apply.
- Eligible strikers are subject to the work registration requirements detailed in Chapter 14, unless exempt for some reason other than employment.

4.4.4.J Irregular Income

Any income in the certification period that is received too infrequently, or irregularly, to be reasonably anticipated, but not in excess of $30 per quarter, is excluded.

However, should an AG's receipt of irregular income continue over time, it must be anticipated, and a determination of a countable amount be made according to the budgeting method outlined in Section 4.4.1.

4.4.4.K Lump-Sum Payments

Recurring lump-sum payments, received by an applicant in the month of application or by a client, are treated as unearned income and prorated over the period of time they are intended to cover.

Non-recurring lump-sum payments are excluded as income but are counted as assets. Refer to Chapter 5.

4.4.4.L Withheld Income

4.4.4.L.1 From Earned Income

Earnings withheld to repay an advance payment are excluded, if they were counted in the month received. If not counted in the month received, the withheld earnings are considered income.

No other earned income is excluded from consideration just because it is withheld by the employer. This includes income garnishments, such as child support. See Section 4.4.2, Income Disregards and Deductions, above for allowable deductions.

4.4.4.L.2 From Unearned Income

Treatment of unearned income depends on the reason it is being withheld and the government program, if any, involved.

- ***Repayment***

NOTE: Although Retirement, Survivors, and Disability Insurance (RSDI) and SSI are both paid by the Social Security Administration (SSA), they are separate programs and not treated as from the same source for this policy. This applies to both means-tested and non-means tested programs.

- ***Means-tested Programs***

Means-tested programs include, but are not limited to, WV WORKS, SSI, HUD, and Pell educational grants.

When a client's benefits under a federal or State means-tested program are reduced due to the client's intentional misrepresentation, the amount being recouped from current benefits is counted as income.

When intentional misrepresentation cannot be documented by the means-tested program, the income is not counted. The Worker must accept the determination of the program issuing the

benefit that was reduced, suspended, or terminated as the final authority for the determination of intentional misrepresentation. If the determination is not specifically identified and documented by the other program, the policy in this section is not applied. The Worker must not make a judgment about whether or not the client's actions constitute intentional misrepresentation.

If the Worker is unable to obtain information from another program outside DOHS, the policy in this section must not be applied. The Worker must document efforts to obtain such information, including information received from the client or copies of appropriate correspondence, if any, filed in the case record. This is necessary to avoid Quality Control (QC) errors for non-compliance with the policy.

When means-tested income is SSI, the agency must not contact the SSA to obtain information about SSI recipients who had withholding from their payments due to an overpayment of SSI benefits.

Any other recoupment is not counted as income when voluntarily or involuntarily withheld to repay a prior overpayment received from that same source, if the income was counted or would have been counted in the month received.

- ***Non-means Tested Programs***

Unearned income sources that are not-means tested include, but are not limited to, RSDI and Workers' Compensation.

Any recoupment is not counted as income when voluntarily or involuntarily withheld to repay a prior overpayment received from that same source, if the income was counted or would have been counted in the month received.

> **Example:** The client is eligible for $450 from RSDI; however, $50 a month is withheld by the SSA to repay a previous RSDI overpayment. The countable RSDI is $400.

- ***Garnishment***

Income that is withheld for any reason not listed above including, but not limited to, child support or legal fees is counted. See Income Disregards and Deductions above for allowable deductions.

> **Garnishment Example:** The client is eligible for $450 from RSDI; however, $50 a month is withheld by the SSA and sent to the Bureau for Child Support Enforcement (BCSE) to pay child support arrears. The countable income is $450 and $50 is given as a child support deduction.

4.4.4.M Funds Diverted to a Plan to Achieve Self-Support (PASS)

Funds diverted to a PASS account are excluded only when the PASS is established by the SSA for an SSI recipient.

4.4.4.N Unstated Income

There is no provision for counting unstated income.

4.4.4.O Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.4.4.P Income Received for a Non-Income Group Member

Income received by a member of the IG, that is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility or benefit level of the payee's AG, is excluded as income.

This includes SSI payees and other protective payees. This does not include child support payments and/or arrearages received by an AG member for a child who is not in the AG. In this situation, the child support is counted for the AG that receives the income, even when it is forwarded to, and/or used, for the child.

4.4.4.Q Income Received from Military Service Personnel Deployed to a Designated Combat Zone

Use the following steps for both applicants and clients to determine the amount of income to count for the AG when funds are provided by military service personnel while serving in a designated combat zone. A list of designated combat zones is available online at the FNS website.

Step 1: Determine the amount of the military person's pay that was actually available to the household prior to deployment to a combat zone as follows:

- If the military person was a member of the SNAP AG or IG prior to deployment, the amount is his net military pay.
- If the military person was not a member of the SNAP AG or IG prior to deployment, the amount is the amount the person actually made available to the SNAP AG prior to deployment.

Step 2: Determine the amount of military pay the person makes available to the SNAP group while deployed to a combat zone.

Step 3: Use the lesser of the Step 1 and Step 2 results.

4.4.4.Q.1 Military Income Examples

> **Example 1:** A member of the Air National Guard (ANG) receives notice that her unit has been activated and will be deployed. This is her only source of income and increases by $1,600 per month from her traditional ANG pay of $400 per month to her new federalized pay of $2,000 per month. She reports this change and her SNAP benefits are adjusted accordingly. She is then deployed to a designated combat zone and is expected to be away for at least six months. Her husband reports this change, and she is removed from the AG due to her anticipated absence from the home. He also reports that she is making her entire income available to the AG and now grosses an additional $1,000 per month.
>
> Step 1: The soldier's net income before deployment was $2,000 per month.
>
> Step 2: The amount made available to the household after deployment, including the additional income is now $3,000 per month.

Step 3: Because the amount made available to the AG after deployment is more, the additional amount is excluded. The $2,000 determined in Step 1 is counted as unearned income for the AG.

Example 2: A member of the ANG receives notice that her unit has been activated and will be deployed. She is sent to Oklahoma for training. She is expected to be deployed to a combat zone but has not been told when. Her husband applies for SNAP when she leaves for training in March. She is expected to be gone for at least a year. The application is approved without her in the AG. She sends the AG a $1,200 military allotment monthly and this is counted as unearned income. The husband is also employed, and the AG is certified for 12 months.

At the next redetermination, the husband reports that the wife was deployed to a designated combat zone sometime in the last four months and is now sending a $1,700 military allotment to the AG. The AG was not required to report this change during the certification period as the total income made available to the AG does not exceed the 130% of the Federal Poverty Level (FPL). The $1,700 is compared to the $1,200 and the additional $500 is excluded. The pre-deployment military allotment amount of $1,200 is still counted as unearned income.

Example 3: An AG receives a military allotment of $700 from her son who is stationed in Delaware. Once he is deployed to a designated combat zone, he decreases the military allotment to $600. Because the amount after deployment is less, the $600 is counted as unearned income for the AG.

4.5 WV WORKS

This section contains specific instructions for determining countable income and the benefit level for WV WORKS.

4.5.1 BUDGETING METHOD

Eligibility is determined, and benefits are issued on a monthly basis; therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. The following information applies to earned and unearned income.

For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the assistance group (AG). For all cases, income is projected; past income is used only when it reflects the income the client reasonably expects to receive during the certification period. There is one exception that requires use of actual income instead of conversion or proration; see Section 4.5.1.E below.

When the amount of an anticipated income source is determined by use of an income tax return, it is not necessary to change the method by which that income source is anticipated at each redetermination prior to the next tax return, unless the anticipated income from that source for the upcoming certification period is expected to change.

4.5.1.A Methods for Reasonably Anticipating Income

There are two methods for reasonably anticipating the income the client expects to receive. One method uses past income and the other method uses future income. Both methods may be used for the same AG for the same certification period. The method used depends on the circumstances of each source of income.

Use past income only when both of the following conditions exist for a source of income:

- Income from the source is expected to continue into the certification period; and
- The amount of income from the same source is expected to be more or less the same. For these purposes, the same source of earned income means income from the same employer, not just the continued receipt of earned income.

Use future income when either of the following conditions exist for a source of income:

- Income from a new source is expected to be received during the certification period. For these purposes, a new source of earned income means income from a different employer; or
- The rate of pay or the number of hours worked for an old source is expected to change during the certification period. Income that normally fluctuates does not require use of future income. Future income is used for old sources only when the hourly, weekly, monthly, etc. rate of pay changes or the number of hours worked during a pay period increases or decreases permanently.

> **Fluctuating Work Hours Example:** The Thorn family members have the following income: Mr. Thorn has earnings that fluctuate greatly from week to week. He expects no change in his earnings. Mrs. Thorn was earning a substantial monthly salary but was laid off last week. She will begin work next week at a job that pays $9 per hour. She does not know how many hours she will work, but her employer has told her she will work a minimum of 20 hours per week. Mr. Thorn's income is anticipated by using his past income as an indication of what he can expect to receive during the certification period. Mrs. Thorn's income from an old source cannot be used because it will not be received in the upcoming certification period. Instead, the Worker must anticipate what her future earnings will be based on the best information available at the time. Mr. Thorn's source of income meets the requirements for using past income to anticipate the future income, but Mrs. Thorn's source is new and must be projected.

4.5.1.B Consideration of Past Income

The Worker must consider information about the client's income sources before deciding which income to use.

The Worker must follow the steps below for each old income source.

Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application/redetermination date, or interview date when the interview is completed on a different day than the application is received.

The appropriate time period is determined by counting back 30 days beginning with the calendar day prior to the date of application/redetermination. However, if the interview is completed on a different day than the date the

application/redetermination is received, the 30-day look-back period could begin the day before the interview date. The income from this 30-day period is the minimum amount of income that must be considered. When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period of time, the Worker considers income for the time period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a longer period of time, all of the income received from that source during that time period must be considered. All pay periods during the appropriate time period must be considered and must be consecutive.

If the client provided sufficient income verification on the date the application/redetermination is received, then additional verification is not required at time of interview.

The year-to-date amounts on check stubs may only be used when the client has verification of all payment amounts whether used or not but is missing one.

Determination of Payments Example 1: Application/interview date is June 1.

Paid weekly on Fridays.

Last pay date is May 28.

Pay dates in last 30 days are:

- May 28
- May 21
- May 14
- May 7

Determination of Payments Example 2: Application/interview date is December 6.

Paid weekly on Mondays.

Last pay date is December 6. Because he provided sufficient documentation, the December 6 pay is not required.

Pay dates in last 30 days are:

- November 29
- November 22
- November 15
- November 8

Determination of Payments Example 3: Application date is October 8. Interview date is October 20.

Paid weekly on Fridays.

Last pay date at application is October 8.

Last pay date at interview is October 15.

Pay dates in last 30 days (prior to application) are:

- October 1
- September 24
- September 17
- September 10

OR

Pay dates in last 30 days (prior to interview) are:

- October 15
- October 8
- October 1
- September 24

Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period.

If it is not expected to continue, the income from this source is no longer considered for use in the new certification period.

If it is expected to continue, determine if the amount is reasonably expected to be more or less the same. If so, the income source is used for the new certification period and treated according to Section 4.5.1.D below. If it is not expected to continue at more or less the same amount, the income source is used for the new certification period and treated according to Section 4.5.1.C below.

Step 3: Record the results of Step 2, including the amount of income, why the source is or is not being considered for the new certification period, the client's statement about continuation of the income from this source, the time period used, and, if more than the previous 30 days, the reason additional income was considered.

Once the Worker has determined all of the old sources of income to consider and the time period for which they are considered, he must then determine if any source should be considered for future income.

4.5.1.C Consideration of Future Income

This section applies only when the client reasonably expects to receive income from a new source during the new certification period, or when the amount of income from an old source is expected to change. In that case, the Worker must consider the income that can be reasonably expected to be received.

NOTE: When self-employment income is anticipated, proceeds from the sale of capital goods and equipment must be anticipated also.

NOTE: When the amount of income or the date of receipt cannot be reasonably anticipated, income from that source is not considered until the necessary information can be obtained. See Step 2 below.

Step 1: Determine if the IG expects to receive income from a new source, or expects a different amount from an old source, in the new certification period.

If not, none of the following steps are necessary. However, the Worker must record the client's statement that he does not expected income from a new source.

Step 2: Determine the amount of income the client reasonably expects to receive from the new source, or the new amount from the old source.

If the amount of income is not reasonably anticipated, the income from that source is not counted. If it is possible to reasonably anticipate a range of income, the minimum amount that is anticipated is used.

> **Example:** A client is scheduled to start work in February, the month following the month of application. He knows he will earn $9 per hour but is not sure how many hours he will work. The Worker verifies through the employer that he will work 30-40 hours per week. The Worker anticipates the income by using 30 hours, the minimum number of hours he is expected to work.

The Worker will record case comments for the client's statement concerning this income and will also record why it cannot be reasonably anticipated.

Step 3: Determine the date the client reasonably expects to receive the income from the new source, or the new amount from the old source.

If the date the income will be received is not reasonably anticipated, the income from that source is not counted.

The Worker will record case comments for the client's statement concerning the date and will also record why it cannot be reasonably anticipated.

Step 4: When the amount and date of receipt can be anticipated, the Worker treats the income according to Section 4.5.1.D below.

The Worker must record how the amount and date of receipt were projected.

4.5.1.D How to Use Past and Future Income

After the Worker determines all of the income sources that are to be considered for use, the Worker determines the amount of monthly income, based on the frequency of receipt and whether the amount is stable or fluctuates. This is described below.

When the Frequency of Receipt is:	When the Amount is Stable	When the Amount Fluctuates (See Below)
Monthly	Use **actual** monthly amount.	Use **average** monthly amount. (See below)
More often than monthly	**Convert** amount per period to monthly amount.	Find **average** amount per period and **convert** to monthly amount. (See below)
Less often than monthly	**Prorate** to find amount for intended period. If not monthly, **convert or prorate** amount.	**Prorate** to find amount for intended period. If monthly, **convert or prorate** amount.

NOTE: The purpose of finding an average amount of fluctuating income is to even out the highs and lows in the amount of income. The client is not, then, required to report fluctuating income each pay period and the Worker is not required to change income monthly. Sometimes, the client receives higher benefits than he would if actual income were used and sometimes he receives lower benefits. Therefore, when the Worker has averaged fluctuating income based on the best information available and the client's income does not match the monthly amount used by the Worker, there is no repayment when the client receives higher benefits and no supplemental issuance when the client receives lower benefits. Should the client report fluctuations in the amount of income, the Worker is only required to recalculate the countable income when, in his judgment, the fluctuation will significantly impact the benefit amount. All changes reported by the client must be considered, but not necessarily used. Reported changes must be recorded and the Worker must record why the reported income was, or was not, used.

Conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semi-monthly (twice/month) x 2

Proration of income to determine a monthly amount is accomplished by dividing the amount received by the number of time periods it is intended to cover as follows:

- Bimonthly amount (two months) ÷ 2
- Quarterly amount (three months) ÷ 3
- Semi-annual amount (twice/year) ÷ 6
- Annual amount ÷ 12
- Six-week amount ÷ 6 converted to monthly amount by using x 4.3
- Eight-week amount ÷ 8 converted to monthly amount by using x 4.3

> **Actual Income Example:** Ms. Poppy begins working on the second Monday of a month. She earns $200 per week and is paid every Friday. Her average weekly pay is $200. For the first month Ms. Poppy has earnings, she expects to be paid three times. Her income for the month is $200 x 3 = $600. A change must be made for the anticipated income from the second month of her employment.
>
> **Proration, Conversion, Fluctuation, and Multiple Sources of Income Example:** The Calla family is a family of four consisting of Mr. Calla, his wife, Lily, his mother, and his son. Mr. Calla works and earns a monthly salary of $300. His wife Lily works part-time and is paid weekly. Lily earns $9 per hour, but

the number of hours she works fluctuates each week. His mother receives $150 every three months from the mineral rights to some property she owns out of state. His son just received a disability insurance check in the amount of $420 for the past six weeks. Income is determined as follows:

For Mr. Calla, Monthly Pay, Amount Stable = $300 Salary = Monthly Amount

For Lily, More Often, Amount Fluctuates = $9 per hour x Average Number of Hours per Week x 4.3 = Monthly Amount

For his mother, Less Often = $150 ÷ 3 Months = Monthly Amount

For his son, Less Often = $420 ÷ 6 Weeks x 4.3 Weeks = Monthly Amount

4.5.1.E Exception for Use of Actual Income

There is one exception to the rules in items A – D above. It applies to both applicants and clients and requires use of actual income instead of conversion or proration of income.

4.5.1.E.1 Applicants

When:

- The first month of eligibility meets the definition of an initial month (i.e. the first month following any period of time in which the AG was not participating); and
- An income source terminates in the month of application or in the 30 days prior to the date of application. The Worker must calculate the income for the month of application for the terminated source by adding the actual amount already received in the month of application plus the amount expected to be received later in the month of application. Income from this source for the past 30 days or from the month of application must not be used to convert the terminated income to a monthly amount.

Applicant Exception Example: A client applies on September 10. His job ended on August 31. He was paid on that date, but still has another pay due to him on September 15. Because the income is from a terminated source, the income from this source cannot be converted. Instead, the amount already received in the month of application ($0) plus the amount expected to be received on September 15, are used to determine his eligibility and benefit level for the month of application.

4.5.1.E.2 Clients

When:

- He reports the beginning or ending of a source of income; and
- The client is not expected to receive a full month's income. Income from this source must not be converted to a monthly amount.

Instead, the Worker must use the actual amount of income. If income from the source is ending, no income from the source is counted in future months.

If the income from the source is beginning, the Worker must use income already received from the source plus the amount expected to be received from this source later in the month. This is the amount used as income for the month following the change. Income from this first month must not be used to convert the income to a monthly amount until the second month following the change.

4.5.1.F Anticipated Income Examples

The following are examples of methods to anticipate income, based on several different situations. The Worker must always base anticipated income on the individual situation, not solely on the information contained in the examples below.

> **Example 1:** An application is made on June 22. The client indicates he is paid biweekly and he does not expect any change in his income. The Worker requests that the client provide information about pay received in the 30 days prior to June 22 and uses this income to anticipate income for the certification period. The Worker records the client's statement about expecting no changes, as well as how the income was verified, and the method used to convert the income to a monthly amount.
>
> **Example 2:** Same situation as previous example, except that the client indicates that his pay fluctuates each pay day and he expect this pattern to continue without any change in status, rate or source of income. After a discussion with the client, the Worker and client agree that two additional pay periods prior will provide enough information to reasonably anticipate income for the certification period. The Worker records the results of the discussion with the client, how the income was verified, and the method used to convert the income to a monthly amount.

Example 3: A redetermination is received on July 7. The client indicates that he is paid weekly, and his income fluctuates because his hours of work are unpredictable. The client also indicates that beginning the following month, he will receive an increase in his hourly rate. The Worker requests that the client provide income for the 60 days prior to the redetermination date in order to anticipate the average number of hours the client works. Income from the last 60 days is requested because it provides a good indication of the fluctuations in the client's income. The Worker uses the average weekly number or hours the client worked during the last 60 days but uses the new hourly pay rate to anticipate income for the new certification period. The Worker records why income from the last 60 days was requested, how the average weekly hours were determined, how the new pay rate was verified, and how the anticipated income was calculated.

Example 4: An application is made July 8. The client indicates that he began a new job two weeks prior to making application. He is paid weekly and has received two pays. He indicates that his employer has told him that, although his hourly rate will not increase in the near future, he can expect an increase in his hours after his training period is finished in two weeks. However, the increase in hours is dependent upon how much work is available and the increased number of hours is unpredictable. The Worker requests all income that the client has received from the new job prior to the date of application. This actual amount of income from the new source is counted for July. Because the number of increased hours cannot be anticipated, the minimum number of hours, i.e., the amount he has worked each week for the first two weeks, is used to anticipate income for the certification period or POC. The Worker records how the income was verified and determined for the month of application, how the income was calculated for the months following the month of application.

Example 5: An application is made June 26 and the client indicates that he began a new job the week prior to application. He is going to be paid biweekly and has not received a pay yet. He states that he will work 35 hours per week and receive $12.75 per hour. The client does not expect any changes in hours or rate of pay. The Worker requests a statement from the client's employer for the number of hours and hourly rate of pay and anticipates income for the certification period as follows:

$12.75	hourly rate
x 70	hours for two weeks
$892.50	Anticipated biweekly pay
$892.50	
x 2.15	
$1,918.88	Anticipated monthly pay

The Worker records the client's statement about no expected changes in income and his lack of pay to date, as well as how the income was verified and calculated.

Example 6: An application is made September 13 and the client states that he is self-employed. He grows and sells Christmas trees. Most of his income for the year is earned during the months of November and December. In addition, he sells the leftover trees to the local city government to use for mulch. He receives some income each month from the leftover trees and the amount fluctuates during the year. He states that he anticipates that his earnings will be less from Christmas sales this year because many of his trees were damaged in a fire last spring. He estimates he lost at least half of the trees that he planned to sell this year. He is unable to determine at this time if his sale of trees to the city will be affected after Christmas, but currently his income from this source has not changed. The Worker requests that the client provide income received in the previous year from his sales to the city and his Christmas tree sale earnings for the previous season.

Anticipated income is based on an average of monthly sales to the city and half of the previous year's Christmas tree sales. The Worker records the client's situation in detail, how past income was verified, and the method used to anticipate income for the new certification period.

Example 7: A woman applies on March 2. She does not work, and her only source of income is child support from three absent parents. Income from Absent Parent A is regularly received, but the amount varies.

Income from Absent Parent B is always the same amount, but she never knows when she will receive it.

Absent Parent C pays regularly, and the amount is more or less the same.

The Worker requests verification as follows: A's payments for the last six months; B's payments for the last six months; C's payments for the last three months. She reports and verifies the following income from the three sources:

Parent A:

- March 1 $450
- February 1 $75
- January 1 $123
- December 1 $850
- November 1 $170
- October 1 $100

Parent B:

- February 14 $250
- January 10 $250
- November 20 $250

Parent C:

- February 20 $300
- January 20 $300
- December 20 $300

The Worker finds the average monthly payment made by Parent A and projects the income to continue. The Worker and the client cannot reasonably anticipate that any payments will be received in the new certification period or period of consideration (POC) from Parent B, so no income is counted from this source. Parent C pays the same amount at the same time, so $300 per month is counted from Parent C.

The Worker records details about payments and payment dates from each of the absent parents, how the payments were verified, whether or not any income was counted from each source and, if so, how the amount was determined.

Example 8: A waitress, Mrs. Pine, applies on December 7. She is paid twice a month and provides pay stubs with the following information:

Date	Number of Hours	Wages	Tips
September 15	35 hours	$180.25 wages	$88.00 tips
September 30	60 hours	$309.00 wages	$130.00 tips
October 15	32 hours	$164.80 wages	$83.00 tips
October 30	35 hours	$180.25 wages	$88.00 tips
November 15	12 hours	$61.80 wages	$32.00 tips
November 30	35 hours	$180.25 wages	$88.00 tips

She earns $9.00 per hour. She does get some tips, but rarely the amount shown on her paystubs. She says the employer determines the amount shown as tips by some formula that she does not understand because he is required by the Internal Revenue Service (IRS) to report them. She does not have to share her tips with any other employee, and they do not share tips with her. She says that during a “good” week she makes about $20 in tips. The employer never sees her

tips, she does not report the amount to him, and is not required to do so. The Worker pends the case for verification of the way the employer determines the amount of tips shown on her pay stubs and reported to the IRS.

The client provides the following note from the employer:

To Whom It May Concern:

Mrs. Pine works for me at the Dew Drop Inn as a waitress. I pay her $7.25 for every hour she works. She does make some in tips, but I don't know how much. The IRS makes me figure her tips so I do it according to how much food she sells. I don't think she really gets that much. None of my waitresses do, but the IRS makes me do it.

Very truly yours,
Lily Rose

There is no third-party, independent verification available for the amount of Mrs. Pine's tips; however, she does state that she receives tips, so income from the tips cannot be disregarded. The only way to verify the amount of tips is to accept her statement as to the amount. There is no other source of verification available, so the Worker must accept her statement. The Worker must record that the employer confirmed the tips shown on the paystubs do not necessarily reflect the amount she actually receives, that this is the best information that can be provided to verify the situation and that the client's statement is accepted as verification.

4.5.2 INCOME DISREGARDS AND DEDUCTIONS

The following disregards and deductions are applied to income.

4.5.2.A Earned Income

The client must report new employment within 10 days of the date an AG member or disqualified person begins the employment unless there is good cause for not reporting. The earned income disregards and deductions are not applied to any month's income for which earnings were not reported. These same disregards and deductions are not applied to any

earnings received during the time the employment is unreported. In addition, when new employment is not reported, as required by the Personal Responsibility Contract (PRC), the appropriate sanction is applied. See Section 14.8.

The earned income of a child or parent, under age 18, who is enrolled in secondary school or equivalent, is disregarded at all steps of the eligibility determination process.

4.5.2.A.1 Earned Income Disregard

The gross earned income of all IG members is reduced by 40%. The remaining amount is the countable earned income.

4.5.2.A.2 Dependent Care Deduction

When the employed AG member or disqualified person must pay for dependent child or incapacitated adult care to accept or continue employment or training, a deduction from income must be allowed. There is not a maximum allowable amount for this deduction. The dependent need not be receiving WV WORKS for the deduction to apply.

Only payments made from the person's own funds are deductible. Clients with these expenses must be offered a referral to the Division of Children and Adult Services for help in meeting these expenses. However, there is no penalty for failure to accept these services.

4.5.2.B Unearned Income

The only unearned income disregard or deduction is child support that is redirected to the Bureau for Child Support Enforcement (BCSE) of up to $100 per month for families with one child and up to $200 for families with more than one child eligible for Temporary Assistance for Needy Families (TANF). This deduction does not apply until after the 100% Standard of Need (SON) test has been met.

Special consideration must be given to applicants as follows:

- If the client is receiving child support payments at the time of application, and the application is approved, it may not be possible or practical for him to redirect the support payment received during the effective month of approval. The child support system will send all child support to the caretaker during the month of approval.

- Child support that has already been redirected to BCSE will be released to the client during the initial benefit month. In these situations, up to $100 per month for families with one child and up to $200 for families with more than one child eligible for TANF is disregarded and the remainder is counted as income.

The above situations may also occur when a review is completed during the last week of the month.

Child Support Example 1: Ms. Birch applies for WV WORKS on July 10 and has been receiving regular child support payments from the absent parent. The Worker explains that once she begins receiving WV WORKS, her child support will now be retained by the State and she will receive the pass-through and Child Support Incentive (CSI) payments instead. She will continue to receive any child support payments that are received for the month of July. The child support will be retained for the month of August, then the pass-through and CSI payments will be issued for September.

Child Support Example 2: Ms. Elm applies for WV WORKS on May 20 and has been receiving regular child support payments from the absent parent. The Worker explains that once she begins receiving WV WORKS, her child support will now be retained by the State and she will receive the pass-through and CSI payments instead. Due to the need for additional information before her case could be approved, her case is not confirmed until May 27.

The eligibility system may not have enough time to notify the child support system that WV WORKS has been opened in this case before June 1. Because of this, the Worker will anticipate that the child support will be forwarded to Ms. Elm for the month of June at the time of confirmation. The Worker must set an alert in the eligibility system to check the child support system on June 1 to see if the case type has changed. If the case type has changed, then the child support will be retained, and the Worker will need to issue an auxiliary for WV WORKS. Once the child support has been retained for a full month, then the pass-through and CSI payments will be issued the following month. Subsequently, the worker should anticipate the pass-through and CSI payment to continue for one month after WV WORKS closure. See the child support system desk guide for anticipating CSI and pass-through payments.

The client is not considered out of compliance with the redirection requirement if he fails to redirect when:

- The child support payment is received during the effective month of approval of the application. The Worker must consider the non-redirected child support payment in

excess of the maximum pass-through listed below as income only in the month of application.

- Any overpayment is recovered through the TANF repayment process. All child support must be redirected, unless only a Diversionary Cash Assistance (DCA) payment is received.

Number of Children	Maximum Pass-Through
1	$100
2 or more	$200

Once the recipient begins receiving child support after WV WORKS approval, the Case Manager takes the unearned income disregard into consideration and enters the child support into the system to close the WV WORKS benefit due to income, if appropriate. When Case Managers have knowledge of receipt of child support in excess of the WV WORKS benefit before the excess refund is issued, this action is taken.

4.5.3 DETERMINING ELIGIBILITY AND BENEFIT LEVEL

The following information describes situations encountered in determining eligibility and benefit level for the AG. However, there are situations that require special treatment.

To determine eligibility for DCA, see Section 1.5. Countable income is used to determine eligibility only. It is not used to determine the amount of DCA.

For child support payments, the income is coded to the children in the eligibility system. If there is more than one child, the amount should be evenly divided among the children in the AG.

4.5.3.A Determining Eligibility – 100% of the SON Test

The AG is ineligible in any month that the countable monthly gross income exceeds 100% of the SON. The income of the disqualified person(s) is included in determining the amount of income available to the AG. However, the needs of the disqualified person(s) are not considered in any step of the eligibility determination process.

The test is applied as follows:

Step 1: Add together the total countable gross earned income, the gross profit from self-employment, and the countable gross unearned income of the AG and any disqualified person(s).

Step 2: Determine the 100% of the SON amount in Appendix A for the appropriate AG size, excluding the disqualified person(s).

Step 3: If the amount in Step 1 is greater than the amount in Step 2, the AG is ineligible.

Step 4: If the amount in Step 1 is equal to or less than the amount in Step 2, the AG is eligible for further determinations.

4.5.3.B Determining Countable Income and the Benefit Amount

Once the 100% of the SON test is met, the following steps are taken.

Step 1: Add together the countable gross earned income of the AG and/or any disqualified person(s).

Step 2: Subtract 40% of Step 1 (Earned Income Disregard).

Step 3: Subtract the allowable Dependent Care Deduction.

This resulting amount is the Total Countable Earned Income.

Step 4: Total all child support received by the AG and/or disqualified person(s).

Step 5: Subtract the child support pass-through amount of up to $100 or $200 for children eligible for TANF. See below for determining the child support pass-through amount.

Step 6: Add all other countable unearned income of the AG and/or any disqualified person(s).

The resulting amount is the countable unearned income.

Step 7: Add together the total countable earned and unearned income.

The resulting amount is the total monthly countable income.

Step 8: Determine the maximum WV WORKS benefit amount for the AG size, using Appendix A.

Step 9: If the total countable income exceeds the maximum WV WORKS benefit amount, the AG is ineligible.

If the total countable income is less than the maximum WV WORKS benefit amount, the AG is income eligible.

Step 10: Subtract the total countable income from the maximum WV WORKS benefit amount.

The resulting amount is the WV WORKS benefit amount.

4.5.3.C Child Support Pass-Through

A child support payment of up to $100 for families with one child or $200 for families with more than one child of child support collected on behalf of a family receiving WV WORKS will be passed through to the family. This payment is referred to as the child support pass-through. Pass-through payment amounts will depend on the amount of child support collected by the BCSE but must not exceed the $100 or $200 limits. This payment will not be issued until the month following the month that the BCSE retains the child support collected. This is a monthly payment as long as the child support is collected.

The child for whom the support was paid must be a WV WORKS client for the collection month to receive the pass-through payment.

The pass-through is excluded as unearned income for WV WORKS, DCA, and Employment Assistance Program (EAP). This payment is in addition to the CSI and will be issued in conjunction with the CSI.

4.5.3.D Child Support Incentive (CSI)

A $25 benefit increase is provided to any WV WORKS AG when child support, in any amount, is collected for a child in the AG. This payment is in addition to the child support pass-through. The CSI is applicable, even when the family is eligible for the maximum WV WORKS payment.

The CSI is available on approximately the 20th calendar day of the month. The client receives a notice of the deposit and the month for which the CSI is being paid.

4.5.3.D.1 Conditions to Receive the CSI

To receive the CSI, the following conditions must be met:

- Child support is redirected to the BCSE.
- The redirected amount is current child support**.

- The child support payment codes for the CSI and pass-through are arrearages with court order, grace period, and assigned and retained.
- The child for whom the support was paid is a WV WORKS client for the collection month.

**Current support is child support for a month that the CSI is automatically issued.

When an applicant receives child support in the month of WV WORKS approval, either directly from the absent parent, or from the BSCE, no CSI is issued for the month of approval. For all clients, the CSI is effective the month following the month child support is redirected. If child support is not paid to the BCSE for a given month, no CSI is issued for that month in the following month.

> **CSI Example 1:** Ms. Cedar has one child and she receives WV WORKS cash assistance of $301. Child support collected for this month is $175. Because of the pass-through, Ms. Cedar will receive $125 next month in addition to her normal WV WORKS benefits. The $125, which is the sum of the pass-through and the CSI, will not be counted as income for her WV WORKS eligibility.
>
> **CSI Example 2:** Ms. Mulberry has two children and she receives WV WORKS cash assistance in the amount of $340. Child support collected for this month is $195. Because of the pass-though, Ms. Mulberry will receive the $220 next month in addition to her normal WV WORKS benefits. The maximum amount of pass-through is $200 for two or more children eligible for TANF. The $220 will not be counted as income for her WV WORKS eligibility and is her $195 pass-through and $25 CSI payment.

4.5.3.D.2 CSI Issuance

CSI payments are automatically issued for the current month (the month of receipt by the BCSE). When there is a child support payment received that is intended to cover the three prior months, the CSI payments are issued for the three months immediately preceding the current month.

> **CSI Issuance Example:** A redirected child support payment is received by the BCSE in April, for the April child support obligation. The current month for the eligibility system's CSI purposes is April. A CSI is automatically issued for April child support during the month of May. If the payment received in April included payment for January, February, and/or March, CSI payments are automatically issued for those months also.

4.5.3.D.3 Supplemental CSI

If the client did not receive a CSI payment for the month they were eligible for such payment, a supplemental CSI payment is required. All supplemental CSI payments require written approval from the Division of Family Assistance (DFA) Family Support Policy Unit.

The following information must be provided to the DFA Family Support Policy Unit:

- Case number
- Case name
- The month in question
- A brief explanation of why the client should have received a CSI payment

After approval is received from the DFA Family Support Policy Unit, eligibility system staff will evaluate the reported problem and advise the local office of any required action. No approval will be granted unless this process is used. In addition, eligibility system staff consult with the BCSE State Office staff to correct sequence number mismatches.

EXCEPTION: The Worker may issue a supplemental CSI payment without prior approval only when the case number is written to the CSI Payments Not Issued Report.

Adverse action notice requirements do not apply when a CSI will not be paid. However, they do apply when receipt of the CSI affects another benefit.

4.5.3.D.4 CSI Payments After WV WORKS Closure

When a WV WORKS case is closed, and child support is received by the BCSE in the effective month of closure, a CSI is issued in the month after closure for the child support received in the effective month of closure.

> **CSI Payment After Closure Example:** A WV WORKS AG is closed effective August for excessive earned income. The last month of receipt of a WV WORKS benefit is August, and child support is received by the BCSE in August. A $25 CSI is issued in September for August.

4.5.3.D.5 CSI Repayment

When received in error, the CSI is subject to repayment. See Section 11.3. Received in error includes, but is not limited to, BCSE credited a payment to the wrong case, or the client failed to report income and received a WV WORKS benefit in error.

4.5.3.E Child Support Excess Payment

When the absent parent has no remaining state debt from previous TANF receipt and makes a payment to the BCSE that is in excess of the current WV WORKS payment, any amount that exceeds the benefit is distributed to the custodial parent by the BCSE. This payment is coded as a monthly excess refund in the eligibility system.

When the Worker receives an alert that a payment has been sent to client, he must code the excess payment as unearned income, then determine if the new countable income exceeds the WV WORKS benefit amount as described above. The child support excess payment is coded to the children for whom it is intended.

When the countable income exceeds the WV WORKS benefit amount, then the Worker must close the WV WORKS benefit. No disregards or deductions are applied to this payment.

NOTE: The child support excess payment does not have to be reasonably anticipated to continue in order to be considered as unearned income.

> **Excess Refund Payment Example 1:** Ms. Oak's TANF AG consists of herself and her two children. The Worker receives an alert that a child support excess refund payment has been sent. The Worker checks the eligibility system and the child support excess payment amount is listed as $20 for the month. She has no other income. The $20 does not exceed the WV WORKS benefit amount of $340, so the Worker adds the $20 as unearned income. Following adverse action deadlines, the WV WORKS and SNAP benefits will reduce.
>
> **Excess Refund Payment Example 2:** Ms. Pine's TANF AG consists of herself and her son. The Worker receives an alert that a child support excess refund payment has been sent. The Worker checks the eligibility system and the child support excess payment amount is listed as $305 for the month. She has no other income. The $305 exceeds the WV WORKS benefit amount of $301, so the Worker closes the WV WORKS AG and reduces the SNAP benefits following adverse action guidelines. The following month, her entire child support payment would be redirected to her.

4.5.4 SPECIAL SITUATIONS

4.5.4.A Income from Self-Employment

When an AG member or a disqualified individual(s) receives income from self-employment, the instructions below must be used to arrive at the gross profit that is used to calculate countable income. This is determined by subtracting allowable business expenses from the gross income.

4.5.4.A.1 Determining Gross Income

The method used to determine monthly gross income from self-employment varies with the nature of the enterprise. It is necessary to determine which of the following types of self-employment applies to the client's situation. Once the pattern of self-employment has been determined, the instructions below are used to determine how the income is counted.

- ***Person Receiving Regular Income***

Persons receiving regular income are persons who receive income as profit on a more or less regular schedule (weekly, monthly, etc.), or receive a specific amount from the business each week or month and/or receive the balance of profit from the enterprise at the end of the business year.

This income is converted to a monthly amount, according to Section 4.5.1.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

- ***Persons Receiving Irregular Income***

Many persons derive income from short-term seasonal self-employment. This seasonal enterprise may be the major source of income for the year, or only for the period of time the person is actually engaged in this enterprise, with other sources of income being available during the remainder of the year. Persons who are seasonally self-employed include vendors of seasonal commodities (produce, Christmas trees, etc.), or other seasonal farmers.

Cash crop and some seasonal farmers and other persons with similar irregular self-employment income receive their annual income from self-employment in a short period of time and budget their money to meet their living expenses for the next 12 months.

Because the income is seasonal, it must be averaged over the period of time it is intended to cover, even if it is the major source of income for the year. However, if the averaged amount of past income does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income is calculated based on anticipated earnings.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ *New Business*

AGs with a new business that has been in existence less than a year have their income and incurred business expenses averaged over the amount of time the business has been in operation. From this, the monthly amount is projected for the coming year. However, if the averaged amount of past income and/or expenses does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income and/or expenses is calculated based on anticipated earnings.

Incurred business expenses are also averaged over the amount of time the business has been in operation. However, if the averaged amount of past expenses does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the expenses are calculated based on anticipated costs.

4.5.4.A.2 Determining Gross Profit

Gross profit from self-employment is the income remaining after deducting any identifiable costs of doing business from the gross income.

➢ *Deductions*

Examples of allowable deductions are:

- Employee labor costs, including wages paid to an AG member and any salary the client pays himself. When paid to an AG member, the income must be considered according to the provisions in Section 4.3.

- Stock and supplies.
- Raw material.
- Seed.
- Fertilizers.
- Repair and maintenance of machinery and/or property.
- Cost of rental space used for conducting the business.
- Insurance premiums and taxes paid on the business and income-producing property.
- Interest and taxes, but not the principal, paid on installment payments to purchase capitol assets, such as real estate, machinery, equipment, etc.
- The utilities, principal, interest, and taxes on the client's residence that is used in part to produce income. This is applicable only if the expenses on the portion of the home used in the self-employment enterprise can be identified separately.
- Advertising costs.
- Utilities.
- Office expenses (stamps, stationery, etc.).
- Legal costs.

Do not deduct the following:

- Money paid to purchase capital assets, such as real estate, machinery, equipment, etc. Interest is deducted, if paid in installments.

  > **Deductions Example:** The cost of purchasing a new furnace is a capital expenditure and only the interest on installment payments is deducted. A repair of a furnace is a routine repair and is deducted in its entirety.

- Federal, state, or local income taxes.
- Money set aside for retirement.
- Travel from home to a fixed place of business and return.
- Depreciation.
- Principal of real estate mortgages on income-producing property.
- Amounts claimed as a net loss.

➢ *Rental Income Deductions*

In addition to the deductions in Deductions above, the following expenses are deducted from rental income:

- Utility bills paid for tenants
- Property tax and insurance on the rental property
- Repair and upkeep of the property
- Interest, but not the principal, on necessary purchases made in installments, such as the purchase of a new furnace

4.5.4.B Migrant Farm Laborers with Seasonal Employment

Income of migrant farm laborers is treated the same as the income of any other applicant or client.

4.5.4.C Annual Contract Employment

This section applies to any person employed under a yearly contract, such as school employees, including bus drivers, cooks, janitors, aids, and professional staff. This item does not apply to substitute employees.

These individuals have their annual income prorated over a 12-month period. Additional earnings, such as for summer work, are added to the prorated amount during the time additional earnings are received.

Although a person may not have signed a new annual contract, he is still considered employed under an annual contract when the contract is automatically renewable, or when he has implied renewal rights. Implied renewal rights are most commonly associated with school contracts.

NOTE: This section does not apply during strike and disaster situations when the other party to the contract cannot fulfill it; or, when labor disputes interrupt the flow of earnings specified in the contract.

4.5.4.D Educational Income

All educational income, including loans for education, is excluded, regardless of the source. Educational expenses may include, but are not limited to, tuition, books, lab fees, living expenses, and other expenses necessary to attend an educational program.

4.5.4.E Deeming

4.5.4.E.1 Income

The income of a disqualified individual(s), who would otherwise be required to be included in the AG, is counted in its entirety. The same exclusions, disregards, and deductions are applied. However, the disqualified individual is not included in the AG and is not considered in determining eligibility or benefit level. He is subject to the same reporting requirements applicable to the AG.

4.5.4.E.2 Lump-Sum Payment

When a disqualified individual(s), who would otherwise be required to be included in the AG, receives a lump-sum payment, it is counted as if he were in the AG. However, he is not included in the number of eligibles when determining the appropriate Federal Poverty Level (FPL) to use for prorating the lump-sum payment. See Lump-Sum Payments and Related Periods of Ineligibility below.

4.5.4.F Strikers

When an individual, who must be included, or who would otherwise be required to be included in the WV WORKS AG, is a striker, the entire AG is ineligible for WV WORKS. See Section 4.4.4.I for the definition of a striker.

4.5.4.G Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

4.5.4.H Lump-Sum Payments and Related Periods of Ineligibility

The lump-sum payment policy applies to applicants, when the lump sum is received in the month of application. This policy also applies to clients when a lump sum is received during any month a case is active. Both include lump-sum payments received by a disqualified person(s) who would otherwise be required to be included in the AG. See Section 4.5.4.E.2 above.

The DFA-RR-1 (Rights and Responsibilities) notifies all applicants, clients, and disqualified persons, who would otherwise be required to be included in the AG, of the lump-sum payment policy. The Worker must also advise the client of the lump-sum payment policy when the client notifies the Worker of receipt, or the possibility of receipt, of a lump-sum payment.

Assets converted from one form to another are not counted as lump-sum payments. See Chapter 5.

4.5.4.H.1 Determining Countable Amount

The total amount of the lump-sum payment is counted, except for the following:

- Lump-sum payments that are earmarked and used for the purpose for which they are intended (e.g., monies for back medical bills resulting from injury, or funeral and burial costs) are deducted. In addition, lump-sum payments that are intended and used for replacement or repair of an asset (e.g., monies to replace a defective automobile) are deducted.
- Any of the lump-sum funds, obligated and used for legal fees as a result of the efforts of the attorney to obtain the lump-sum payment, are deducted.

> **Replacement of an Asset Example:** A client's home is destroyed by fire. He receives an insurance settlement of $16,500. With $10,000 of this settlement, he purchases a mobile home. Only $6,500 is counted as a lump-sum payment.

4.5.4.H.2 Computing the Period of Ineligibility

Given that the client is expected to use the lump sum for general living expenses, a period of ineligibility must be calculated as directed below.

After applying appropriate exclusions, disregards and deductions to other income received for the month, add the lump-sum payment to all other monthly income. When the total amount is less than the payment amount for the number of people in the WV WORKS AG, the lump-sum payment is counted as income in its entirety for one month.

When the total amount is less than the FPL for the number in the AG, but more than the benefit amount for the AG found in Appendix A, the case is ineligible for one month. The amount in excess of the benefit amount is not counted as income for the following month.

When the total amount is greater than the appropriate 100% of the FPL, divide the lump-sum payment by the appropriate 100% of the FPL for the AG size. The AG is ineligible for the full number of months equal to the result of the division. Ineligibility begins the month of receipt.

For any partial month remaining after the division, the amount of the lump-sum payment that remains is counted as income. The number of months the case is ineligible, because of the receipt of the lump-sum payment, and the amount of income counted for any remaining partial month, is determined as follows:

- Multiply the 100% of the FPL by the number of full months the case has been determined ineligible.
- Subtract this figure from the total lump sum.
- The remaining amount is counted as income in the month after the last month of ineligibility.

The persons in the AG when the lump-sum payment is received remain ineligible for the period regardless of any changes that may occur, unless the period of ineligibility is shortened as found below in Section 4.5.4.H.3.

When an individual is born or returns to a family whose members are ineligible due to receipt of a lump-sum payment, the individual is treated as a separate AG. If all other eligibility factors are met, the individual is eligible. None of the lump-sum amount is counted for the new family member. All other policy and procedures for counting income apply. Only the new family member(s) is included in the AG that is used when determining the appropriate eligibility limits.

> **Newborn Example:** A child is born to a family whose members are ineligible due to the prior receipt of a lump-sum payment. A separate case is established for the child. The child is eligible for a WV WORKS benefit.

4.5.4.H.3 Shortening the Period of Ineligibility

The lump-sum payment is treated as described above, even if it is spent in a shorter time period, unless the period of ineligibility can be shortened as found below.

➢ Reasons

When all or part of the lump-sum payment becomes unavailable to the AG, due to circumstances beyond its control, as specified below, the period of ineligibility is shortened. This may be done at any point between the time the lump-sum payment is received, and the period of ineligibility expires. Once the period of ineligibility expires, no consideration is given to shortening the time period retroactively.

The lump-sum amount is considered unavailable only in the following situations:

- The lump-sum payment was, totally or in part, destroyed by fire, flood, or other natural disaster.

  This refers to destruction of the money itself, not the goods purchased with it or destruction of replaceable checks or bonds.

- The lump-sum payment was, totally or in part, stolen from the AG. This refers to the money itself, not the theft of goods purchased with it or the theft of replaceable checks or bonds.

- A member of the AG, or an individual who would otherwise be required to be included, gained access to all or part of the lump-sum payment, abandoned the remaining AG members and left them without access to the funds. The loss of all or part of the lump sum in this way refers to the loss of the money itself or checks, bonds, etc., when payment cannot be stopped, not the taking of goods purchased with it. Moving to another place of residence, with the family relationship still intact, is not sufficient to justify shortening the period of ineligibility.

  When the AG member or other individual who left with all or part of the lump sum returns to the home, the period of ineligibility resumes the month he returns and continues until the month the original period of ineligibility was due to expire.

- The lump-sum payment has been or will be expended, totally or in part, to address a life-threatening situation. To meet this criterion for shortening the period of ineligibility, it must be shown that the funds in question were used or will be used to avert a life-and-death situation for an AG member or a situation that is seriously detrimental to the health of an AG member.

  For cases involving life-threatening situations, the DFA Policy Unit must be contacted in writing. The memorandum must fully explain the situation and include how the money was

or will be spent, the date spent or to be spent, and the nature of the life-threatening situation. The final decision is made by the DFA Policy Unit. If the Worker has any doubt about referring a case to the DFA Policy Unit, he must make the referral.

➢ *Procedures*

The period of ineligibility is shortened as follows:

Step 1: Determine the original amount of the lump-sum payment.

Step 2: Subtract the amount unavailable due to circumstances beyond the control of the AG.

The result is the new lump-sum payment amount.

Step 3: Calculate the length of the new period from the original first month of the ineligibility using the new lump-sum payment amount.

If the family becomes eligible as a result of the recomputations, it is treated like any other applicant. Benefits are prorated from the date of application. Retroactive or corrective payment is not made for any period between the time the lump sum became unavailable and the date eligibility is reestablished.

It is the unavailability of the lump-sum payment amount itself that is explored, not the loss of goods purchased with the lump sum.

> **Control of Use of Funds Example:** A WV WORKS family of four receives a lump-sum payment in April. It is determined that they are ineligible for six months. In June, they report to the local office that they used most of the lump-sum amount to pay back money owed to the wife's parents who made trailer payments for them for several months so they would not lose the trailer. Because the use of the money was under the control of the AG, the period of ineligibility is not shortened.
>
> **Birth Example:** Same situation as above except that the family used most of the lump sum to pay for the birth of a new baby. The use of the money was under the control of the AG, so the period of ineligibility cannot be shortened for this reason. However, the case must be submitted to the DFA Policy Unit for consideration as a life-threatening situation.
>
> **Trust Fund Example:** A WV WORKS family receives a lump-sum payment of $12,000. The client sets up a trust fund for each of his children in the amount of $4,000 each. The trust funds stipulate that the children may not receive any of the money until they turn 21 years of age. Use and control of the lump-sum

amount belonged to the AG when the trust funds were set up, so the period of ineligibility is not shortened.

Fire Destruction Example: A WV WORKS family of three received a lump-sum payment of $2,600 in July. They were determined ineligible for two months, with $60 counted as income in the third month. In July, they purchased a new television and a new refrigerator. The remainder of the money, $150, was kept in the house. In August, the client reports that the house and all the contents were destroyed by fire. The period of ineligibility is redetermined as follows:

$2,600	Original lump-sum amount
- $150	Amount destroyed
$2,450	New lump-sum amount

The family remains ineligible for July and August.

Stolen Funds Example 1: A WV WORKS family of four receives a lump-sum payment of $4,500 in December. They are determined ineligible for December, January, and February with $87 counted as income in March. In February, the client reports that $2,700 was stolen early in February. He reapplies on February 10 and is found eligible on that date.

The recomputation is as follows:

$4,500	Original lump-sum amount
-$2,700	Amount stolen
$1,800	New lump-sum amount

The recalculated period of ineligibility is December and $329 is counted as income in January. The family is eligible for a prorated benefit for February.

Stolen Funds Example 2: Same situation as above except that the money was stolen on January 10. The result is the same as above because the client did not reapply until February 10.

4.5.4.I Withheld Income

4.5.4.I.1 From Earned Income

Earnings withheld to repay an advance payment are disregarded, if they were counted in the month received. If not counted in the month received, the withheld earnings are considered

income. No other earned income is excluded from consideration just because it is withheld by the employer.

4.5.4.I.2 From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine WV WORKS eligibility.

4.5.4.J Funds Diverted to a Plan for Achieving Self-Support (PASS)

Funds diverted to a PASS account are counted as earned or unearned income, depending on the source.

4.5.4.K Unstated Income

Unstated income is income that has not been reported by the household, and is not otherwise known to the agency, but is determined to exist because the client's paid living expenses exceed income from known sources.

The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

When the information in the client's record, including statements of the client or third parties, indicates that paid expenses exceed the stated income, the existence of unstated income must be explored.

If insufficient or conflicting evidence exists, the Worker must question the client about the possibility of unstated income and allow him the opportunity to explain how his expenses are met. This may include but is not limited to a family member, a friend or other agencies helping with the client's past, current and ongoing living expenses. Use the best source of verification available. If the client provides a satisfactory explanation, the Worker records the explanation.

If the client's explanation of how the expenses are met is inadequate, the Worker makes a recording of the explanation and then determines the amount of unstated income to count.

To determine the amount of unstated income to count, the Worker compares the usual amount of monthly living expenses with the client's reported income. The difference is unstated income and is counted as unearned income.

Under no circumstances should an application not be taken or denied based on verification of unstated income as client attestation can be accepted. A recording of the conversation must be documented in case comments.

4.5.4.L Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.5.4.M Income Received for a Non-Income Group Member

Income received by a member of the IG, that is intended and used for the care and maintenance of an individual whose income is not used in determining eligibility or the benefit level of the payee's AG, is excluded.

4.5.4.N Income Received from Military Service Personnel Deployed to a Designated Combat Zone

There is no provision for excluding income received as a result of service in a designated combat zone.

4.6 GENERAL INCOME INFORMATION FOR MEDICAID COVERAGE GROUPS

The following sections contain income information about most Medicaid coverage groups.

Adult and Disabled Waiver (ADW), Traumatic Brain Injury (TBI), and Intellectually and Developmentally Disabled (I/DD) Waiver cases are included in Chapter 24, along with information about individuals receiving nursing home and Intermediate Care Facilities /Individuals with Intellectual Disabilities (ICF/IID) services.

Also not found in the following sections is income information about children who receive Adoption Assistance or Foster Care payments. These cases are the responsibility of the Bureau for Children and Families (BCF) Office of Children and Adult Services.

4.6.1 BUDGETING METHOD

The following method is used to determine income for the certification period or period of consideration (POC), unless information to the contrary is shown in the remaining sections of this chapter.

Eligibility is determined on a monthly basis. Therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. The following information applies to earned and unearned income.

For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the assistance group (AG). For all cases, income is projected*; past income is used only when it reflects the income the client reasonably expects to receive during the certification period.

**NOTE: There are two exceptions to this. They are found below in Section 4.6.1.E, Exceptions for Use of Actual Income.*

When the amount of an anticipated income source is determined by use of an income tax return, it is not necessary to change the method by which that income source is anticipated at each redetermination prior to the next tax return, unless the anticipated income from that source for the upcoming certification period or POC is expected to change.

4.6.1.A Methods for Reasonably Anticipating Income

There are two methods for reasonably anticipating the income the client expects to receive. One method uses past income and the other method uses future income. Both methods may be used for the same AG for the same certification period. The method used depends on the circumstances of each source of income.

Use past income only when both of the following conditions exist for a source of income:

- Income from the source is expected to continue into the certification period or POC.
- The amount of income from the same source is expected to be more or less the same. For these purposes, the same source of earned income means income from the same employer, not just the continued receipt of earned income.

Use future income when either of the following conditions exist for a source of income:

- Income from a new source is expected to be received in the certification period or POC. For these purposes, a new source of earned income means income from a different employer.
- The rate of pay or the number of hours worked for an old source is expected to change during the certification period or POC. Income that normally fluctuates does not require use of future income.

> **Fluctuating Work Hours Example:** The Thorn family members have the following income: Mr. Thorn has earnings that fluctuate greatly from week to week. He expects no change in his earnings. Mrs. Thorn was earning a substantial monthly salary but was laid off last week. She will begin work next week at a job that pays $9.00 per hour. She does not know how many hours she will work, but her employer has told her she will work a minimum of 20 hours per week. Mr. Thorn's income is anticipated by using his past income as an indication of what he can expect to receive in the certification period. Mrs. Thorn's income from an old source cannot be used because it will not be received in the upcoming certification period. Instead, the Worker must anticipate what her future earnings will be based on the best information available at the time. Mr. Thorn's source of income meets the requirements for using past income to anticipate the future income, but Mrs. Thorn's source is new and must be projected.

4.6.1.B Consideration of Past Income

The Worker must consider information about the client's income sources before deciding which income to use.

The Worker must follow the steps below for each old income source.

NOTE: The year-to-date amounts on check stubs may only be used when the client has verification of all payment amounts whether used or not, but is missing one.

Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application/redetermination date.

The appropriate time period is determined by counting back 30 days beginning with the calendar day prior to the date of application/redetermination. The income from this 30-day period is the minimum amount of income that must be considered. When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period of time, the Worker considers income for the time period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a longer period of time, all of the income received from that source during that time period must be considered. All pay periods during the appropriate time period must be considered and must be consecutive.

Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period or POC.

If it is not expected to continue, the income from this source is no longer considered for use in the new certification period or POC.

If it is expected to continue, determine if the amount is reasonably expected to be more or less the same. If the income is expected to continue, the income source is used for the new certification period or POC and treated according to How to Use Past and Future Income below. If it is not expected to continue at more or less the same amount, the income source is used for the new certification period or POC and treated according to Consideration of Future Income below.

Step 3: Record the results of Step 2, including the amount of income, why the source is or is not being considered for the new certification period or POC, the client's statement about continuation of the income from this source, the time period used, and, if more than the previous 30 days, the reason additional income was considered.

Once the Worker has determined all the old sources of income to consider and the time period for which they are considered, he must then determine if any source should be considered for future income.

4.6.1.C Consideration of Future Income

This section applies only when the client reasonably expects to receive income from a new source during the new certification period or POC, or when the amount of income from an old source is expected to change. In that case, the Worker must consider the income that can be reasonably expected to be received.

NOTE: When the amount of income or the date of receipt cannot be reasonably anticipated, income from that source is not considered until the necessary information can be obtained. See Step 2 below.

Step 1: Determine if the IG expects to receive income from a new source, or expects a different amount from an old source, in the new certification period or POC.

If not, none of the following steps are necessary. However, the Worker must record the client's statement that he does not expect income from a new source.

Step 2: Determine the amount of income the client reasonably expects to receive from the new source, or the new amount from the old source.

If the amount of income is not reasonably anticipated, the income from that source is not counted. If it is possible to reasonably anticipate a range of income, the minimum amount that is anticipated is used.

The Worker will record case comments for the client's statement concerning this income and will also record why it cannot be reasonably anticipated.

> **Example:** A client is scheduled to start work in February, the month following the month of application. He knows he will earn $9 per hour but is not sure how many hours he will work. The Worker verifies through the employer that he will work 30 – 40 hours per week. The Worker anticipates the income by using 30 hours, the minimum number of hours he is expected to work.

Step 3: Determine when the client can be reasonably expected to receive income from the new source or the changed amount from the old source.

If the date of receipt cannot be reasonably anticipated, income from this source is not considered. The Worker must record the client's statement that he expects income from a new source or a change in the amount from an old source. In addition, the Worker must record why the date of receipt cannot be anticipated and information about attempts made to determine the date of receipt.

Step 4: When the amount and date of receipt can be anticipated, the Worker treats the income according to How to Use Past and Future Income below.

The Worker must record how the amount and date of receipt were projected.

4.6.1.D How to Use Past and Future Income

After the Worker determines all of the income sources that are to be considered for use, the Worker determines the amount of monthly income, based on the frequency of receipt and whether the amount is stable or fluctuates. This is described below.

When the Frequency of Receipt is:	When the Amount is Stable	When the Amount Fluctuates (See Note)
Monthly	Use **actual** monthly amount.	Use **average** monthly amount. (See Note)
More often than monthly	**Convert** amount per period to monthly amount.	Find **average** amount per period and **convert** to monthly amount. (See Note)
Less often than monthly	**Prorate** to find amount for intended period. If not monthly, **convert or prorate** amount.	**Prorate** to find amount for intended period. If monthly, **convert or prorate** amount.

**NOTE: The purpose of finding an average amount of fluctuating income is to even out the highs and lows in the amount of income. The client is not, then, required to report fluctuating income each pay period and the Worker is not required to change income monthly. Should the client report fluctuations in the amount of income, the Worker is only required to recalculate the countable income when, in his judgment, the fluctuation will affect eligibility. All changes reported by the client must be considered, but not necessarily used. Reported changes must be recorded and the Worker must record why the reported income was or was not used.*

Conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semimonthly (twice/month) x 2

Proration of income to determine a monthly amount is accomplished by dividing the amount received by the number of time periods it is intended to cover as follows:

- Bimonthly amount (two months) ÷ 2
- Quarterly amount (three months) ÷ 3
- Semi-annual amount (twice/year) ÷ 6
- Annual amount ÷ 12
- Six-week amount ÷ 6 and converted to monthly amount by using x 4.3
- Eight-week amount ÷ 8 and converted to monthly amount by using x 4.3

> **Actual Income Example:** Ms. Poppy begins working on the second Monday of a month. She earns $200 per week and is paid every Friday. Her average weekly pay is $200. For the first month Ms. Poppy has earnings, she expects to be paid three times. Her income for the month is $200 x 3 = $600. A change must be made for the anticipated income from the second month of her employment.
>
> **Proration, Conversion, Fluctuation, and Multiple Sources of Income Example:** The Calla family is a family of four, consisting of Mr. Calla, his wife Lily, his mother, and his son. Mr. Calla works and earns a monthly salary of $300. His wife Lily works part-time and is paid weekly. Lily earns $9 per hour, but the number of hours she works fluctuates each week. His mother receives $150 every three months from the mineral rights to some property she owns out of state. His son just received a disability insurance check in the amount of $420 for the past six weeks. Income is determined as follows:
>
> For Mr. Calla, Monthly Pay, Amount Stable = $300 Salary = Monthly Amount
>
> For Lily, More Often, Amount Fluctuates = $9 Per Hour x Average Number of Hours Per Week x 4.3 = Monthly Amount
>
> For his mother, Less Often = $150 ÷ 3 Months = Monthly Amount
> For his son, Less Often = $420 ÷ 6 Weeks x 4.3 Weeks = Monthly Amount

4.6.1.E Exceptions for Use of Actual Income

There are two exceptions to the rules in items A – D above for applicants.

4.6.1.E.1 Terminated Income

When an income source terminates in the month of application or in the 30 days prior to the date of application, the Worker must calculate the income for the month of application for the terminated source by adding the actual amount already received in the month of application plus the amount expected to be received later in the month of application. Income from this source for the past 30 days or from the month of application must not be used to convert the terminated income to a monthly amount.

> **Terminated Income Example:** A client applies on September 10. His job ended and he was paid on August 31. He has another payment due to him on September 15. Because the income is from a terminated source, the income from this source cannot be converted. Instead, the amount already received in the month of application ($0) plus the amount expected to be received on September 15 are used to determine his eligibility for the month of application.

4.6.1.E.2 Backdated Eligibility Requested

When backdated Medicaid eligibility is requested, the actual income received in the month(s) prior to the month of application is used to determine eligibility. Income for the month of application and any months thereafter is determined according to the policy in items A – D above.

4.6.1.F Anticipated Income Examples

The following are examples of methods to anticipate income, based on several different situations. The Worker must always base anticipated income on the individual situation, not solely on the information contained in the examples below.

Example 1: An application is made on June 22. The client indicates he is paid biweekly and he does not expect any change in his income. The Worker requests that the client provide information about pay received in the 30 days prior to June 22 and uses this income to anticipate income for the certification period. The Worker records the client's statement about expecting no changes, as well as how the income was verified, and the method used to convert the income to a monthly amount.

Example 2: Same situation as previous example, except that the client indicates that his pay fluctuates each pay day and he expect this pattern to continue without any change in status, rate, or source of income. After a discussion with the client, the Worker and client agree that two additional pay periods prior will provide enough information to reasonably anticipate income for the certification period. The Worker records the results of the discussion with the client, how the income was verified, and the method used to convert the income to a monthly amount.

Example 3: A redetermination is received on July 7. The client indicates that he is paid weekly, and his income fluctuates because his hours of work are unpredictable. The client also indicates that beginning the following month, he will receive an increase in his hourly rate. The Worker requests that the client provide income for the 60 days prior to the redetermination date in order to anticipate the average number of hours the client works. Income from the last 60 days is requested because it provides a good indication of the fluctuations in the client's income. The Worker uses the average weekly number or hours the client worked during the last 60 days but uses the new hourly pay rate to anticipate income for the new certification period. The Worker records why income from the last 60 days was requested, how the average weekly hours were determined, how the new pay rate was verified, and how the anticipated income was calculated.

Example 4: An application is made July 8. The client indicates that he began a new job two weeks prior to making application. He is paid weekly and has received two pays. He indicates that his employer has told him that, although his hourly rate will not increase in the near future, he can expect an increase in his hours after his training period is finished in two weeks. However, the increase in hours is dependent upon how much work is available and the increased number of hours is unpredictable. The Worker requests all income that the client has received from the new job prior to the date of application. This actual amount of income from the new source is counted for July. Because the number of increased hours cannot be anticipated, the minimum number of hours (i.e., the amount he has worked each week for the first two weeks) is used to anticipate income for the certification period or POC. The Worker records how the income

was verified and determined for the month of application, and how the income was calculated for the months following the month of application.

Example 5: An application is made June 26 and the client indicates that he began a new job the week prior to application. He is going to be paid biweekly and has not received a pay yet. He states that he will work 15 hours per week and receive $12.75 per hour. The client does not expect any changes in hours or rate of pay. The Worker requests a statement from the client's employer for the number of hours and hourly rate of pay and anticipates income for the certification period as follows:

$12.75	hourly rate
x 30	hours for two weeks
$382.50	Anticipated biweekly pay
$382.50	
x 2.15	
$822.375	Anticipated monthly pay

The Worker records the client's statement about no expected changes in income and his lack of pay to date, as well as how the income was verified and calculated.

Example 6: An application is made September 13 and the client states that he is self-employed. He grows and sells Christmas trees. Most of his income for the year is earned during the months of November and December. In addition, he sells the leftover trees to the local city government to use for mulch. He receives some income each month from the leftover trees and the amount fluctuates during the year. He states that he anticipates that his earnings will be less from Christmas sales this year because many of his trees were damaged in a fire last spring. He estimates he lost at least half of the trees that he planned to sell this year. He is unable to determine at this time if his sale of trees to the city will be affected after Christmas, but currently his income from this source has not changed. The Worker requests that the client provide income received in the previous year from his sales to the city and his Christmas tree sale earnings for the previous season.

Anticipated income is based on an average of monthly sales to the city and half of the previous year's Christmas tree sales. The Worker records the client's situation in detail, how past income was verified, and the method used to anticipate income for the new certification period.

Example 7: A woman applies on March 2. She does not work, and her only source of income is child support from three absent parents. Income from Absent Parent A is regularly received, but the amount varies. Income from Absent Parent B is always the same amount, but she never knows when she will receive it. Absent Parent C pays regularly, and the amount is more or less the same. The Worker requests verification as follows: A's payments for the last six months; B's payments for the last six months; C's payments for the last three months. She reports and verifies the following income from the three sources:

Parent A:

- March 1 $100
- February 1 $75
- January 1 $123
- December 1 $100
- November 1 $100
- October 1 $100

Parent B:

- December 14 $45
- January 10 $35
- November 20 $50

Parent C:

- February 20 $75
- January 20 $75
- December 20 $75

The Worker finds the average monthly payment made by Parent A and projects the income to continue. The Worker and the client cannot reasonably anticipate that any payments will be received in the new certification period or POC from Parent B, so no income is counted from this source. Parent C pays the same amount at the same time, so $75 per month is counted from Parent C.

The Worker records details about payments and payment dates from each of the absent parents, how the payments were verified, whether or not any income was counted from each source and, if so, how the amount was determined.

Example 8: A waitress, Mrs. Beech, applies on December 7. She is paid twice a month and provides pay stubs with the following information:

Date	Number of Hours	Wages	Tips
September 15	20 hours	$145.00 wages	$40.00 tips
September 30	25 hours	$181.65 wages	$52.00 tips
October 15	17 hours	$123.25 wages	$35.00 tips
October 30	20 hours	$145.00 wages	$42.00 tips
November 15	7 hours	$50.75 wages	$7.00 tips
November 30	25 hours	$181.25 wages	$60.00 tips

Mrs. Beech provides the following additional information: She earns $7.25 per hour. She does get some tips, but rarely the amount shown on her pay stubs. She says the employer determines the amount shown as tips by some formula that she does not understand because he is required by the Internal Revenue Service (IRS) to report them. She does not have to share her tips with any other employee, and they do not share tips with her. She says that during a “good” week she makes about $20 in tips. The employer never sees her tips; she does not report the amount to him and is not required to do so. The Worker pends the case for verification of the way the employer determines the amount of tips shown on her pay stubs and reported to the IRS.

The client provides the following note from the employer:

To Whom It May Concern:

Mrs. Beech works for me at the Dew Drop Inn as a waitress. I pay her $7.25 for every hour she works. She does make some in tips, but I don’t know how much. The IRS makes me figure her tips so I do it according to how much food she sells. I don’t think she really gets that much. None of my waitresses do, but the IRS makes me do it.

Very truly yours,
Lily Rose

There is no third-party independent verification available for the amount of Mrs. Beech’s tips. However, she does state that she receives tips, so income from the tips cannot be disregarded. The only way to verify the amount of tips is to accept her statement as to the amount. There is no other source of verification available, so the Worker must accept her statement. The Worker must record that the employer confirmed the tips shown on the pay stubs do not necessarily reflect

> the amount she actually receives, that this is the best information that can be provided to verify the situation, and that the client's statement is accepted as verification.

4.6.2 UNCOMPENSATED TRANSFERS OF INCOME

When any Medicaid client is receiving nursing home or ICF/IID services or is a member of an ADW, TBI, or I/DD Waiver AG (See Chapter 24), a penalty may be applied for an uncompensated transfer of resources, including income or a stream of income. The policy and procedures related to this process are explained in Chapter 24.

4.7 MAGI METHODOLOGY – PARENTS/CARETAKER RELATIVES; PREGNANT WOMEN; CHILDREN UNDER AGE 19, AND ADULT GROUP (Categorically Needy, Mandatory)

The Modified Adjusted Gross Income (MAGI) methodology is used to determine financial eligibility for the following Medicaid eligibility groups:

- Parents and Other Caretaker Relatives
- Pregnant Women
- Children Under 19
- Adult Group

NOTE: MAGI methodologies are also used to calculate eligibility for the West Virginia Children's Health Insurance Program (WVCHIP). Additional eligibility requirements for WVCHIP can be found in Chapter 22.

4.7.1 DETERMINING INCOME COUNTED FOR THE MAGI HOUSEHOLD

Income of each member of the individual's MAGI household is counted. The MAGI household is determined using the MAGI methodology established in Chapter 3.

EXCEPTION: Income of children, or other tax dependents, who are not expected to be required to file an income tax return is excluded from the MAGI household income.

NOTE: A reasonable determination as to whether an individual will be required to file a tax return can be made based on the individual's current income for the applicable budget period. Such a determination would be based on information available at the time of application or renewal. Information regarding "Who Must File" a tax return can be found in Appendix F.

4.7.1.A Examples of Applying the Income Rules for Children and Tax Dependents

Child's Income Excluded: A child is 17 years old with a part-time job in the summer and earns $2,100 annually. He is expected to be claimed as a dependent on his parent's tax return. It is determined at application that the child is not expected to be required to file taxes the following year because his income does not exceed the filing requirements established by the Internal Revenue Service (IRS). Therefore, the child's income will NOT be included in the MAGI household nor count toward eligibility, whether he actually files taxes or not.

Child's Income Included: A child is 18 years old and works part-time through the summer and after school. He earns $12,500 for the year. It is determined at application that he is expected to be claimed as a dependent on his parent's tax return and will be required to file an income tax return for the year in which Medicaid is being sought. Therefore, this child's income WILL be included for determining eligibility for any MAGI household for which he is a member.

Tax Dependent's Income Excluded: Mrs. Basswood is 60 years old and lives with her 40-year-old daughter. Mrs. Basswood will be claimed as a tax dependent on her daughter's taxes next year. Mrs. Basswood receives $960 Social Security income per month; she has no other income. Because Mrs. Basswood has no other income, her Social Security income is not taxable, and she is not required to file taxes. As her daughter's tax dependent, her income does not count toward her daughter's MAGI household.

Applicant's Income Included: Same situations as above. Mrs. Basswood is also applying for health coverage. Her MAGI household will include only herself, using non-filer MAGI household size rules in Chapter 3. Because Mrs. Basswood is neither a child nor a tax dependent in her own MAGI household, her income will count toward determining her MAGI eligibility.

4.7.2 CALCULATING MAGI (WHAT INCOME IS COUNTED)

MAGI-based income includes:

- Adjusted gross income (taxable income less deductions/adjustments), excluding:
  - Certain taxable American Indian/Alaska Native income
  - Taxable scholarships/awards used for educational purposes

- Non-taxable Social Security benefits
- Tax-exempt interest
- Foreign earned income

NOTE: Supplemental Security Income (SSI) is never counted in MAGI.

To calculate the MAGI, determine the adjusted gross income amount for each member of the MAGI household whose income will count, for the current month. The MAGI differs from the adjusted gross income, because MAGI accounts for additions and adjustments. The Worker uses the budgeting method established in Section 4.6.1, Budgeting Method, to anticipate future income amounts, consider past income sources, and build monthly income amounts based upon the applicant's reported income.

4.7.2.A Step 1 – Determine the Income

Taxable income is the portion of your gross income that is subject to federal, state, and local taxes. The calculation starts with your total annual earnings and then subtracts any eligible deductions to arrive at the final taxable amount.

In some situations, pre-tax deductions must also be deducted from MAGI gross income. Pre-tax deductions are taken from an employee's paycheck before any taxes are withheld. Pre-tax deductions can be tax-deferred or tax-exempt amounts that are deducted from the gross amount shown on an individual's pay stub but will not be shown on the W-2 or IRS form 1040. When an individual has a pre-tax deduction, federally taxable wages will be less than gross wages on the pay stub.

Pre-tax deductions include, but are not limited to:

- Premiums for health, dental, vision and life insurance
- Contributions to flexible spending accounts and health savings accounts
- Contributions to certain 410 (k) and other retirement accounts
- Short-term disability insurance

> **Example 1:** Rosebud's pay stub shows weekly earnings of $400, and a tax-deferred 401K contribution of $24 per week. You start with the gross weekly pay and subtract the tax-deferred 401K contribution. $400 - $24 = $376. The amount counted as income for MAGI Medicaid is $376 per week.
>
> **Example 2:** Elmer's pay stub shows a weekly salary of $550. His employer automatically deducts a pre-tax amount of $35 for his health insurance premium. You start with the gross weekly pay and subtract the non-taxable health

insurance premium. $550 - $35 = $515. The amount counted as income for MAGI Medicaid is $515 per week.

Example 3: Kale is paid bi-weekly and has a gross pay of $1,300 per paycheck. She has two pre-tax deductions: $70 for her 401(k) contribution and $50 for her Flexible Spending Account (FSA). You start with the gross bi-weekly pay and subtract all pre-tax deductions. $1,300 - $70 - $50 = $1,180. The amount counted as income for MAGI Medicaid is $1,180 per bi-weekly paycheck.

NOTE: Contributions to designed Roth 401(k)s and Roth IRAs are not pre-tax deductions, because they are made with after tax earnings.

The Worker next adds all of the individual's income from any of the income sources listed in "Countable Sources of Income" of Section 4.3, Chart 2 and exclude income listed in "Excluded Sources of Income" of Section 4.3, Chart 2.

4.7.2.B Step 2 – Make the Adjustments/Deductions

After the income has been determined in Step 1, determine if any adjustments/deductions are applicable and subtract them from the income determined in Step 1. The Worker must incorporate allowable deductions (also known as adjustments) in the calculation of MAGI-based income. These adjustments/deductions can be found on page one of IRS form 1040.

Different methodologies, as shown in the table below, may be used to incorporate different types of adjustments/deductions into the income determined in Step 1.

Deduction Type	Examples	Deduction Methodology
Consistent, monthly deduction	• Alimony paid • Student loan interest	• Deduct the monthly expense from current monthly income.
Lump-sum deduction	• Certain educator expenses • Certain moving expenses	• Deduct the full amount of the expense from current monthly income in the month in which the expense was incurred. • Divide the total expense by 12 and deduct that amount from current monthly income.

Deduction Type	Examples	Deduction Methodology
Annualized deduction	• Net operating loss carryover • Deductible part of self-employment tax	• Divide the total projected expense by 12 and deduct that amount from current monthly income.

The following items are subtracted from the individual's income:

- Educator expenses
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health savings account deductions
- Moving expenses (Only for active duty members of the military who are ordered to move or change duty station).
- Deductible part of self-employment tax
- Self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees (SIMPLE), and qualified plans
- Self-employed health insurance deductions
- Penalty on early withdrawal of savings
- Alimony paid ONLY if the alimony agreements are finalized prior to January 2019. Any pre-existing agreements modified after December 31, 2018 are not deductible.
- IRA deductions
- Student loan interest deductions

NOTE: The adjustments/deductions are capped at the same amount set by the IRS.

> **Example 1:** Mr. Oak, an elementary school teacher, has one tax dependent child, Hazel. He spends $240 on supplies for his classroom in August. That same month, Mr. Oak applies for Medicaid for Hazel. Hazel's MAGI-based household will include herself and her father, Mr. Oak. Because it is an educator expense, Mr. Oak can choose to annualize the expense or use it as a lump-sum deduction. To annualize the deduction, first divide the expense by 12 (240 divided by 12 = $20). Then, subtract the $20 from Hazel's household income for the month of August.
>
> **Example 2:** Same situation as above, except Mr. Oak chooses to use a lump-sum deduction for his $240 educator expense. To calculate the lump-sum deduction, subtract the total amount of the expense ($240) from Hazel's MAGI-

based income for the month of August. Hazel's household income for succeeding months will be higher when the lump-sum approach is used.

4.7.2.C Step 3 – Required Additions

Add the following income sources to the income determined in Step 2:

- Foreign earned income and housing costs as defined in 26 USC §911.
- Any interest received that would normally be excluded from taxes.
- The portion of the individual's Title II Social Security benefits typically excluded from taxation, as described in 26 USC §86(d).
- Self-employment/farming income, after accounting for depreciation and operating losses. In cases where the business or farm operated at a loss, the Worker must subtract the amount of the loss from the income calculation. See the methodology established in Section 4.7 for calculating self-employment income.
- For individuals who expect to be claimed as a tax dependent by a grandparent, another relative, or another individual who is not a parent or stepparent, their household income includes cash support provided by the person claiming them as a tax dependent, if over $50 per month.
- Lump-sum income must be included, but it must only be counted in the month that it is received.

4.7.3 MAGI-BASED INCOME DISREGARD

The only allowable income disregard is an amount equivalent to five percentage points of 100% of the Federal Poverty Level (FPL) for the applicable MAGI household size.

The 5% FPL disregard is not applied to every MAGI eligibility determination and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

4.7.3.A MAGI-Based Income Disregard Examples

Pregnant Woman Example 1: A pregnant woman has MAGI household income at 135% of the FPL. The 5% FPL disregard will not be applied because the highest income limit of the MAGI Medicaid coverage group for which she may be eligible is 185% of the FPL for the Pregnant Women coverage group.

Pregnant Woman Example 2: A pregnant woman has MAGI household income at 190% of the FPL. The 5% FPL disregard would be applied to bring her income to below 185% of the FPL.

Adult Group Example 1: A client has MAGI household income at 137% of the FPL. The 5% FPL disregard would be applied to bring his income below 133% of the FPL for the Adult Group.

4.7.4 DETERMINING ELIGIBILITY

The applicant's household income must be at or below the applicable MAGI standard for the MAGI coverage groups.

Step 1: Determine the MAGI-based gross monthly income for each MAGI household income group (IG).

Step 2: Convert the MAGI household's gross monthly income to a percentage of the FPL by dividing the current monthly income by 100% of the FPL for the household size. Convert the result to a percentage.

If the result from Step 2 is equal to or less than the appropriate income limit, no disregard is necessary, and no further steps are required.

Step 3: If the result from Step 2 is greater than the appropriate limit, apply the 5% FPL disregard by subtracting five percentage points from the converted monthly gross income to determine the household income.

Step 4: After the 5% FPL income disregard has been applied, the remaining percent of FPL is the final figure that will be compared against the applicable modified adjusted gross income standard for the MAGI coverage groups.

4.7.4.A MAGI Screening

Applicants with income below the MAGI standard and determined eligible for coverage in a MAGI coverage group, i.e., the Adult group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19 group or WVCHIP, should be promptly enrolled into the MAGI coverage group. The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group. See Section 23.8.2

NOTE: If the household income of an applicant using MAGI methodologies results in financial ineligibility for Medicaid, and the tax household income of the applicant used to determine eligibility for advance premium tax credits (APTC) through the Marketplace is below 100% FPL resulting in ineligibility for APTC, eligibility for Medicaid will be determined using the tax household methodologies.

4.7.4.B Eligibility Determination Examples

Example 1: Cedar and Holly are married and live together with their son Ash, age 6. Cedar and Holly file a joint tax return, with Ash claimed as a tax dependent. The family applies for health coverage for all three family members. Cedar works and earns $1,500 per month and Holly receives SSA benefits in the amount of $450 per month. Ash has no income.

1. *Determine the MAGI Household Size for Each Applicant:*

- Cedar is a tax filer. Using STEP 1 in Section 4.7.2.A, his MAGI household consists of his spouse Holly, and his tax dependent, Ash, resulting in a MAGI household size of three – Cedar + Holly + Ash.
- Holly is also a tax filer; therefore, both her spouse, Cedar, and her tax dependent, Ash, count in her MAGI household, resulting in a MAGI household size of three – Cedar + Holly + Ash.
- Ash is a tax dependent and does not meet any of the exceptions in STEP 2 in Section 4.7.2.B; therefore, his MAGI household is the same as Cedar, the tax filer claiming him as a dependent, resulting in a MAGI household size of three – Cedar + Holly + Ash.

2. *Determine the MAGI for each Household:*

Income of each member of the applicant's MAGI household is counted unless identified as not being counted in Section 4.7.2 above.

- Neither Cedar nor Holly are the child or expected tax dependent of another member of the MAGI household; therefore, their income will count.
- Ash is the child and expected tax dependent of another member of the MAGI household. However, he is not expected to be required to file a tax return. Any income of Ash's would not be counted.

In this example, because each applicant's MAGI household is the same – Cedar + Holly + Ash, each applicant has the same MAGI household income. Cedar, Holly, and Ash's total MAGI household income = Cedar and Holly's income = $1,500 + $450 = $1,950.

3. *Determining Eligibility:*

Cedar, Holly, and Ash: Convert the gross monthly income for each applicant's MAGI household to a percentage of the FPL. Because each applicant in this example has the same MAGI household, the same income conversion calculation will apply to all three applicants. Each applicant's MAGI household's total gross monthly income equals $1,950.

To convert household income to a percentage of FPL and determine eligibility, follow these steps:

- Determine gross monthly income: $1,950.
- Determine MAGI household size: three.
- Determine 100% of the FPL for the household size of three: $1,702.
- Divide gross monthly income by 100% of the FPL for the household size: $1,950/$1,702 = 1.1457.
- Move decimal point two places to the right: 1.1457 = 114.57% of the FPL.
- Compare 114.57% of the FPL to the income threshold for each coverage group.
- The 5% FPL disregard is not required because the applicants are eligible for a MAGI Medicaid coverage group.

In this case Cedar, Holly, and Ash all fall under an income threshold for Medicaid eligibility. Cedar and Holly qualify under the Adult Group and Ash qualifies under the Children Under Age 19 Group.

Example 2: Birch and Lily live together but they are not married. They have one child together named Ginger, who is two years old. Birch is the custodial parent of his son Aspen, from a prior marriage, who lives with him full time. Birch and Lily are both tax filers and file taxes separately. Birch claims Aspen and Ginger as tax dependents. Birch earns $1,400 per month in wages. Lily earns $1,300 per month in wages. Neither child has income.

1. *Determine the MAGI Household Size for each applicant:*

- Birch is a tax filer. Using STEP 1 in Section 4.7.2.A above Birch's MAGI household size equals three – Birch + his tax dependents Aspen and Ginger.
- Lily is a tax filer. She has no tax dependents. Lily's MAGI household size equals one - Lily.
- Ginger is a tax dependent. She meets an exception in STEP 2 in Section 4.7.2.B because she is living with both parents, but they will not file a joint tax return; therefore, her MAGI household is determined by STEP 3. Ginger's MAGI household size equals four – Ginger + her parents Birch and Lily + sibling Aspen.
- Aspen is a tax dependent, but he does not meet an exception in STEP 2. Therefore, his MAGI household is the same as Birch, the tax filer claiming him. Aspen's MAGI household size is also three – Aspen + Birch + Ginger.

2. *Determine MAGI for each Household:*

Income of each member of the applicant's MAGI household is counted unless identified as not being counted in Section 4.7.1 above.

- Birch is not the child or expected tax dependent of another member of this MAGI household; therefore, his income will count. Ginger and Aspen are the child and/or expected tax dependent of another member of the MAGI household. However, neither is expected to be required to file a tax return. Any of their income would not be counted.

  Birch and Aspen's MAGI household income = Birch's income = $1,400.
- Lily is neither the child nor expected tax dependent of another member of her MAGI household; therefore, her income will count.

  Lily's MAGI household income = $1,300.
- Ginger's MAGI household includes both of her parents, Birch and Lily.

  Ginger's MAGI household income = Birch and Lily's income = $2,700.

3. Determining Eligibility:

Convert the gross monthly income for each applicant's MAGI household to a percentage of the FPL.

To convert MAGI household income to a percentage of the FPL and determine eligibility, follow these steps:

Birch and Aspen: Birch and Aspen's MAGI household income would be converted using the following steps:

- Determine gross monthly income: $1,400.
- Determine MAGI household size: Three.
- Determine 100% FPL for the household size of three: $1,702.
- Divide gross monthly income by 100% of the FPL for the household size: $1,400/$1,702 = .82256.
- Move decimal point two places to the right: .82256 = 82.26% FPL.
- Compare 82.26% FPL to the income threshold for each coverage group.
- The 5% FPL disregard is not required because the applicants are eligible for a MAGI Medicaid coverage group.

Birch and Aspen's MAGI household income is below the Medicaid income limit; therefore, both will be eligible for Medicaid.

Lily: Lily's MAGI household income would be converted using the following steps:

- Determine gross monthly income: $1,300.
- Determine MAGI household size: one.
- Determine 100% FPL for the household size of one: $1,005.
- Divide gross monthly income by 100% of the FPL for the household size: $1,300/$1,005 = 1.2935.
- Move decimal point two places to the right: 1.2935 = 129.35% FPL.
- The 5% FPL disregard is not required because the applicant is eligible for a MAGI coverage group.

Lily's MAGI household income exceeds the income standard for the Adult Group. Her electronic account will be referred to the Marketplace to be evaluated for financial assistance with purchasing health insurance using APTC.

Ginger: Ginger's MAGI household income would be converted using the following steps:

- Determine gross monthly income: $2,700.
- Determine MAGI household size: Four.
- Determine 100% FPL for the household size of four: $2,050.
- Divide gross monthly income by 100% of the FPL for the household size: $2,700/$2,050 = 1.3170.
- Move decimal point two places to the right: 1.3170 = 131.70% FPL.
- Compare 140.55% FPL to the income threshold for each coverage group.
- The 5% FPL disregard is not required because the applicant is eligible for a MAGI Medicaid coverage group.

Ginger's MAGI household income is below the Medicaid income standard for children age one to five. Therefore, Ginger will be eligible for Medicaid.

4.7.5 SPECIAL SITUATIONS

4.7.5.A Income from Self-Employment

When a member of the MAGI household IG receives self-employment income, the instructions below must be used to arrive at the gross profit, which is used to calculate countable income. Countable income is determined by subtracting allowable business expenses from the gross income.

4.7.5.A.1 Determining Gross Income

The method used to determine monthly gross income from self-employment varies with the nature of the enterprise. It is necessary to determine which of the following types of self-employment applies to the client's situation. Once the pattern of self-employment is determined, the instructions below are used to determine how the income is counted.

➢ *Persons Receiving Regular Income*

Persons receiving regular income are persons who receive income on a more or less regular schedule (weekly, monthly, etc.), or receive a specific amount from the business each week or month and/or receive the balance of profit from the enterprise at the end of the business year.

This income is converted to a monthly amount according to the Budgeting Method in Section 4.6.1.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ *Persons Receiving Irregular Income*

Many persons derive income from short-term seasonal self-employment. This seasonal enterprise may be the major source of income for the year, or only for the period of time the person is actually engaged in this enterprise, with other sources of income being available during the remainder of the year. Persons who are seasonally self-employed include vendors of seasonal commodities (e.g., produce, Christmas trees, etc.), or other seasonal farmers.

Cash crop and some seasonal farmers and other persons with similar irregular self-employment income receive their annual income from self-employment in a short period of time and budget their money to meet their living expenses for the next 12 months.

Because the income is seasonal, it must be averaged over the period of time it is intended to cover, even if it is the major source of income for the year. However, if the averaged amount of past income does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income is calculated based on anticipated earnings.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ *New Business*

AGs with a new business that has been in existence less than a year have their income and incurred business expenses averaged over the amount of time the business has been in operation. From this, the monthly amount is projected for the coming year. However, if the averaged amount of past income and/or expenses does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income and/or expenses is calculated based on anticipated earnings.

4.7.5.A.2 Determining Gross Profit

Gross profit from self-employment is the income remaining after deducting any identifiable costs of doing business from the gross income. The instructions below must be used to arrive at the gross profit, which is used to calculate countable income.

These instructions are based upon the IRS Forms used by self-employed individuals to file federal taxes on their self- employment income.

Income from self-employment is calculated by totaling the following items, as described on the IRS Forms:

- Add payment cards and third-party network transactions.
- Add gross receipts or sales (separate from items reported above).
- Add income that results from “Statutory Employee” status. If an individual’s income results from such a status, they would receive a W-2 for the year that has the “Statutory Employee” box checked.
- Add any other form of income received by the business.
- Subtract returns, allowances, and other adjustments.
- Subtract the cost of goods sold, calculated using the following methodology:
    - Add value of inventory at the beginning of the period under consideration.
    - Add purchases (disregarding cost of items withdrawn for personal use).
    - Add labor costs (disregarding amounts paid to oneself).
    - Add materials and supplies.
    - Add other costs.
    - Subtract value of inventory at the end of the period under consideration.
- Subtract the expenses related to the business’ operations. The following expenses can be deducted:
    - Advertising
    - Car and truck expenses
    - Commissions and fees
    - Contract labor
    - Depletion
    - Depreciation and section 179 expense deduction
    - Employee benefit programs

- Insurance (not including health insurance)
- Interest (mortgage and from other loans)
- Legal and professional services
- Office expenses
- Pension and profit-sharing plans
- Rent or lease (includes vehicles, machinery, equipment, and other business property)
- Repairs and maintenance
- Supplies
- Taxes and licenses
- Travel, meals, and entertainment
- Utilities
- Wages
- Any other business-related expenses

- Subtract the business' expenses from its income to arrive at the self-employment income profit or loss for the individual.

4.7.5.B Annual Contract Employment

This section applies to any person employed under a yearly contract, such as school employees, including bus drivers, cooks, janitors, aides, and professional staff.

These individuals have their annual income prorated over a 12-month period. Additional earnings, such as for summer work, are added to the prorated amount during the time additional earnings are received.

Although a person may not have signed a new annual contract, he is still considered employed under an annual contract when the contract is automatically renewable, or when he has implied renewal rights. Implied renewal rights are most commonly associated with school contracts.

This item does not apply during strike and disaster situations when the other party to the contract cannot fulfill it, or when labor disputes interrupt the flow of earnings specified in the contract.

4.7.5.C Educational Income

All student financial assistance, funded in whole or in part under Title IV of the Higher Education Act or the Bureau of Indian Affairs, is excluded in its entirety.

Treatment of educational income and expenses depends upon the source of income and the intended use.

4.7.5.C.1 Sources That Are Totally Excluded

Funds from the following sources are totally excluded:

- Federal Pell Grants.
- Federal Supplemental Educational Opportunity Grants (FSEOG).
- Guaranteed Student Loans, including William D. Ford Federal Direct Loan Program and Federal Direct PLUS Loans, Supplemental Loans for Students, and Federal Family Education Loan (FFEL) Program Loans.
- Leveraging Educational Assistance Partnership (LEAP) and Special Leveraging Educational Assistance Partnership (SLEAP) Programs, formerly known as State Student Incentive Grants.
- Federal Perkins Loans.
- Federal Stafford Loans.
- Robert C. Byrd Honors Scholarship.
- Loans for educational expenses that meet the definition of a bona fide loan, as found in Section 4.2, Definitions.

4.7.5.C.2 College Work Study (CWS) Program

Income received from CWS Programs, funded in whole or in part under Title IV of the Higher Education Act, is excluded.

Income received from CWS Programs not funded under Title IV that is needed for the educational program or course of study is excluded. Any portion specifically earmarked for

shelter, utilities, clothing, or incidentals not needed for the educational program or the course of study is considered income.

Because income is usually paid to the student on the basis of work performed, not in one lump sum, its treatment is different than that of other educational benefits. Treatment of this income depends upon whether or not the amount to be earned in one semester is known at the beginning of the semester.

➢ *Earnings Known at Beginning of Semester*

When the amount of the earnings, or maximum amount that can be earned, is known at the beginning of the semester, the Worker prorates any portion, specifically earmarked for shelter, utilities, food, clothing, or incidentals, not needed for the program or course of study, over the period of time it is intended to cover.

➢ *Earnings Unknown at Beginning of Semester*

When the amount of the earnings is not known at the beginning of the semester, any portion of the CWS income specifically earmarked for shelter, utilities, food, clothing, or incidentals, not needed for the program or course of study, is treated as earned income and converted to a monthly amount according to Section 4.6. All earned income disregards and deductions apply.

4.7.5.C.3 Other Sources

Educational funds from any source, other than those listed in Section 4.7.5.A.1 and Section 4.7.5.A.2 above, are totally excluded as being earmarked for educational purposes, unless any portion of the funds is specifically earmarked for shelter, utilities, food, clothing, or incidentals not needed for the program or course of study.

Any of the funds specifically earmarked for shelter, utilities, food, clothing, or incidentals, not needed for the program or course of study, are counted as unearned income and prorated over the period of time they are intended to cover.

4.7.5.D Deeming

The MAGI methodology described in this section is used to determine the MAGI household and whose income will be counted.

4.7.5.E Irregular Income

Regardless of the source, irregular income is not counted because it cannot be anticipated.

4.7.5.F Lump-Sum Payments

Lump-sum payments are counted as unearned income only in the month received.

EXCEPTION: Qualified lottery and gambling winnings and qualified lump sum income in the amount of $80,000 or more on or after January 1, 2020 are counted not only in month received, but over a period of up to, but not to exceed, 120 months regardless of the state in which they were won.

Non-cash prizes are not considered qualified lottery and gambling winnings and continue to be counted as lump sum income in the month in which they are received only.

Although there are circumstances in which gambling losses may be deducted from income for federal income taxes, gambling losses are not deducted from winnings for this period.

The months over which qualified lottery and gambling winnings income is counted is found in Chapter 4 Appendix H-Lottery and Gambling Winnings: Months over which Income Is Counted by Income Increment.

To calculate the monthly income used for eligibility add the verified income and the additional income from the lottery and gambling winnings. Once the winning's income is exhausted only use the verified income. The requirement to count qualified winnings over multiple months applies only to the individual(s) receiving such winnings.

Notices of the income period must be provided to affected individual(s) and include:

- The date on which qualified winnings will no longer be counted;
- Opportunity to apply for a hardship exemption;
- And information on applying to enroll in a qualified health plan on the Exchange.

Example 1: Daisy is enrolled in Medicaid with MAGI-based household income of $1.200 per month. She is single and has no dependents. On January 4, 2020, Daisy wins $192,000 playing roulette. Using the chart in Chapter 4 Appendix H, we see that Daisy winnings of $192,000 are counted in her MAGI-based income for 13 months, including the month in which she receives the winnings. They are counted in January 2020 through January 2021. An equal amount of $14,769 is counted in each month ($192,000/13 months = $14,769 per month). Daisy's MAGI-based monthly income for January 2020 through January 2021 is $15,969 ($14,769 gambling winnings plus $1,200 other MAGI-based income) assuming no changes to her other MAGI-based income. Because Daisy's income exceeds the state's MAGI-based income standard, the agency would provide Daisy with a notice alerting her that she is no longer eligible for Medicaid and her coverage will be terminated following the advance notice period. The notice will also tell Daisy that beginning January 1, 2020, her gambling winnings will no longer be counted in her MAGI-based income.

Example 2: Rose is a single parent who lives with her son, Rowan, who is age 7. Rose and Rowan have monthly MAGI-based income of $2,000 from Rose's job. On April 14, 2020, Rose submits a Medicaid application for Rowan. The following week Rose wins the state lottery and receives a lump sum payment of $755,000.

For the month of April, Rowan's MAGI-based household income will be calculated as $755,000 in lottery and gambling winnings, plus $2,000 in the other MAGI-based income, for a total monthly income of $757,000 for a family of two. For the month of May, Rowan's income will be $2,000. Rose's lottery winnings would court toward Medicaid, using the chart, her winnings if $755,000 would be counted in her MAGI-based income for 69 months (or, 5 years and 9 months), beginning in the month in which she receives the winnings. Rose's winnings would be counted in her MAGI-based income in April 2020 through December 2025. An equal amount of $10,942 would be counted in each month ($755,000/69 months = $10,942 per month).

If a Medicaid or WVCHIP applicant or beneficiary incurred winnings from lottery or gambling multiple times, in amounts over $80,000, the lottery and gambling winnings are counted concurrently (each instance beginning and ending per the formula) and applied separately to each instance of winning.

4.7.5.G Withheld Income

All withheld income is counted, unless an amount is being withheld to repay income that was previously used to determine Medicaid eligibility. No other earned income is excluded just because it is withheld by the employer.

4.7.5.H Funds Diverted to a Plan to Achieve Self-Support (PASS)

Funds diverted to a PASS account are treated as earned or unearned income, depending on the source.

4.7.5.I Unstated Income

There is no provision that allows for counting unstated income.

4.7.5.J Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.7.5.K Income Received for a Non-Income Group Member

Income received by a member of the IG, which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility of the payee's Medicaid household, is excluded as income.

4.7.5.L Income Belonging to or for the Benefit of a Child

The source of the income must be known, and Section 4.3 consulted for how the income is treated.

4.8 MEDICAID FOR CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN) (CATEGORICALLY AND MEDICALLY NEEDY, MANDATORY)

There is no income test for the CEN. See Section 23.10.6.

NOTE: The spenddown provision does not apply to CEN.

4.9 TRANSITIONAL MEDICAID (TM) (Categorically Needy, Mandatory)

This coverage group consists of families that lose eligibility for Parents/Caretaker Relatives Medicaid because of earned income. TM provides continuing medical coverage after Parents/Caretaker Relatives Medicaid eligibility ends and occurs in two phases.

NOTE: The spenddown provision does not apply to TM.

4.9.1 FINANCIAL REQUIREMENTS FOR PHASE I TM

There is no maximum income test for Phase I TM. The onset or increase of earned income must cause Parents/Caretaker Relatives Medicaid ineligibility. See Section 23.10.1.

4.9.2 DETERMINING ELIGIBILITY FOR PHASE II TM

In order to be eligible for Phase II TM, the income must not exceed 185% of the Federal Poverty Level (FPL) based on the steps below.

To determine eligibility for Phase II coverage, the following procedure is used:

Step 1: Determine the total countable income of all assistance group (AG) members.

Step 2: Deduct the Dependent Care Deduction. See Section 4.16.

Step 3: Compare the remaining amount to the 185% of the FPL amount for the Needs Group found in Appendix A.

NOTE: Self-employment income and Annual Contract Employment income is determined using the same methodology outlined in Section 4.7.5.

4.10 MEDICAID FOR INDIVIDUALS APPROVED FOR OR RECEIVING SSI (Categorically Needy, Mandatory)

Income eligibility calculations are performed by the Social Security Administration (SSA). The Worker has no responsibility in this process. See Section 23.11.1.

NOTE: The spenddown provision does not apply to Medicaid clients approved for or receiving SSI.

4.11 MEDICAID FOR DEEMED SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS (Categorically Needy, Mandatory)

Income eligibility is determined by the Social Security Administration (SSA) for the following coverage groups: Disabled Adult Children (DAC), Blind, Disabled – Substantial Gainful Activity (SGA), Essential Spouses, Pass-Throughs, Disabled Widows/Widowers and Drug Addicts/Alcoholics. See Section 23.11.2.

Only one Deemed SSI Recipient coverage group requires income calculations. Those eligible for Pickle Amendment Coverage (PAC) are addressed in this section.

NOTE: The spenddown provision does not apply to Deemed SSI recipients.

4.11.1 DISABLED ADULT CHILDREN

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.2 BLIND, DISABLED – SGA

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.3 ESSENTIAL SPOUSES

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.4 PASS-THROUGHS

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.5 DISBALED WIDOWS/WIDOWERS

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.6 DRUG ADDICTS/ALCOHOLICS

Income eligibility calculations are performed by the SSA. The Worker has no responsibility in this process. See Section 23.11.2.

4.11.7 PAC

4.11.7.A Determining Eligibility

There are two methods by which income eligibility as a PAC may be determined. Method 1 is used first. If Method 1 results in ineligibility by $20 or less, the Worker must use Method 2. When calculations using Method 2 result in an individual's ineligibility by less than two dollars, the Worker contacts the SSA to confirm the PAC eligibility decision.

4.11.7.A.1 Method 1

Step 1: Determine the last month and year in which the client received Supplemental Security Income (SSI) and Retirement, Survivors, and Disability Insurance (RSDI) in the same month.

NOTE: An individual who received SSI and was found retroactively eligible for RSDI is considered to have received SSI and RSDI in the same month. RSDI payments are received the month following the month of entitlement. For example the RSDI entitlement for December is received in January.

Step 2: Using Appendix E, find the percentage that applies to that year and multiply the current RSDI amount for the client and/or his financially responsible parent or spouse by that percentage. Round down to the nearest dollar.

Step 3: Add any other current countable income using the budgeting methods in Section 4.6.1.

Step 4: Apply the disregards and deductions from Section 4.14.2 for SSI-Related Medicaid.

If the remaining amount is less than the current SSI maximum payment, the client is income eligible.

➢ *PAC Method 1 Examples*

Example 1: Mr. Daffodil received RSDI and SSI at the same time for several years until his SSI stopped in December 2012. His current RSDI amount is $909, and he has no other income. Using the 2012 multiplier found in Appendix E, $909 X .880 = $799. After applying the $20 disregard, the countable income is $779, which is less than the current SSI payment rate of $794. He is income eligible as a PAC.

Example 2: Ms. Aster, age 55 and single, has assets of less than $2,000. Her current RSDI amount is $913 and she has no other income. She first applied for RSDI and SSI in October 2008. She was approved and paid for SSI beginning October 2008 through December 2008. In December 2008, she received her first RSDI check that resulted in the loss of SSI payments. Using the multiplier for 2008 found in Appendix E, $913 X .802 = $732. Ms. Aster qualifies for PAC.

Example 3: Mrs. Rose lives with her husband, Sam Rose. He is 75 years old and receives $880 RSDI. He did not previously receive SSI. Mrs. Rose is 70 years old and receives $700 RSDI. The couple's total combined monthly income is $1,580, which exceeds the current SSI amount of $1,191 for a couple. Mrs. Rose received both RSDI and SSI until she married Sam in 2006. Her SSI was terminated after the marriage due to excessive income for a couple. To determine PAC eligibility, the combined RSDI income of $1,580 is multiplied by .760, the amount for 2006 found in Appendix E for Method 1. The result is $1,200, which is their countable RSDI income. After applying the $20 disregard, the total countable income is $1,180, which is less than the current SSI amount for a couple of $1,191. Mrs. Rose qualifies for PAC coverage. Her husband is not PAC eligible because he did not receive SSI.

NOTE: If the client is ineligible by $20 or less, Method 2 must be used as the final eligibility determination.

4.11.7.A.2 Method 2

To determine an individual's financial eligibility under Method 2, the Worker must determine the cumulative RSDI Cost of Living Adjustments (COLA) of the applicant and/or his financially responsible parent or spouse, which were received because SSI eligibility was lost.

Step 1: Divide the current RSDI benefit amount by the percentage amount of the previous year's COLA. This percentage is found in Appendix E. This procedure determines the individual's RSDI benefit level prior to the most recent COLA.

Step 2: Repeat the process in Step 1 for each COLA received because the individual lost SSI eligibility. This produces the RSDI amount the client and/or his financially responsible parent or spouse received when he lost SSI eligibility.

COLA Example: For the 2018 RSDI amount, use the 2017 COLA information from Appendix E, Method 2 Chart. $856 ÷ 1.020 = $840, the RSDI amount before 1/18 COLA.

Resulting RSDI amount before 1/18 COLA, $840 ÷ 1.003 = $838, the RSDI amount before 1/17 COLA.

Resulting RSDI amount before 1/17 COLA, $838 ÷ 1.000 = $838, the RSDI amount before 1/16 COLA.

Step 3: Add the client's current countable income using the budgeting methods in Section 4.6.1

Step 4: Apply appropriate disregards and deductions from Section 4.14.2 for SSI-Related Medicaid.

If countable income is less than the current maximum SSI payment amount, the client is income eligible.

4.11.7.B Special Situations

4.11.7.B.1 Income from Self-Employment

Gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16. After gross profit is determined, it is treated as SSI-Related earned income.

4.11.7.B.2 Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.11.7.B.3 Educational Income

Educational income is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.11.7.B.4 Deeming

Income is deemed from an ineligible financially responsible spouse or parent the same way it is deemed for SSI-Related Medicaid cases. See Section 4.14. The COLA disregard is applied to any RSDI received by an ineligible spouse or financially responsible parent, and which is subject to deeming.

4.11.7.B.5 Irregular Income

Regardless of the source, irregular income is not counted because it cannot be anticipated.

4.11.7.B.6 Lump-Sum Payments

Lump-sum payments are counted as unearned income in the month received.

4.11.7.B.7 Withheld Income

Withheld income is treated the same way it is for SSI-Related Medicaid. See Section 4.14.

4.11.7.B.8 Funds Diverted to a Plan to Achieve Self-Support (PASS)

Funds diverted to a PASS account are excluded.

4.11.7.B.9 Unstated Income

There is no provision that allows for counting unstated income.

4.11.7.B.10 Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.11.7.B.11 Income Received for a Non-Income Group Member

Income received by a member of the income group (IG), which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility of the payee's assistance group (AG), is excluded as income.

4.11.7.B.12 Income Belonging to or for the Benefit of a Child

The source of the income must be known, and Section 4.3 consulted, for how the income is treated.

4.12 MEDICAID FOR QMB, SLIMB, QI-1 (Categorically Needy, Mandatory)

The spenddown provision does not apply for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), or Qualifying Individuals (QI-1).

4.12.1 DETERMINING ELIGIBILITY

Countable income is determined by subtracting any allowable disregards and deductions from the total countable gross income. Deemed income is addressed in Section 4.12.2 below.

NOTE: Recipients of federal benefits such as Retirement, Survivors, and Disability Insurance (RSDI) may receive periodic cost of living adjustments (COLA). For QMB, SLIMB, and QI-1, the RSDI COLAs are disregarded in determining income eligibility for January and any subsequent months prior to the effective month of the state's Federal Poverty Level (FPL) updates for the year. RSDI and Supplemental Security Income (SSI) increases are handled in accordance with instructions in Chapter 10, Appendices A and B.

Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 2: Determine the total countable gross earned income and subtract the appropriate disregards and deductions. See Section 4.14.2.

Step 3: Add the results from Step 1 and Step 2 to achieve the total monthly countable income.

Step 4: Compare the amount in Step 3 to the QMB, SLIMB, or QI-1 income levels for the appropriate number of persons. See Section 4.14 for SSI-Related deeming procedures.

If the amount is less than or equal to the QMB, SLIMB, or QI-1 income levels, the client(s) is eligible.

Eligibility for these coverage groups is determined as follows:

- QMB – Income is less than or equal to 100% FPL.
- SLIMB – Income is greater than 100% FPL, but less than or equal to 120% FPL.

- QI-1 – Income is greater than 120% FPL, but less than or equal to 135% FPL.

See Appendix A.

4.12.2 SPECIAL SITUATIONS

4.12.2.A Self-Employment

Gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16.

4.12.2.B Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.12.2.C Educational Income

Educational income is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.12.2.D Deeming

See Section 4.14.4 for SSI deeming procedures.

4.12.2.E Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

4.12.2.F Lump-Sum Payments

Lump-sum payments are counted as unearned income in the month received.

4.12.2.G Withheld Income

Withheld income is treated the same way it is for SSI-Related Medicaid. See Section 4.14.

4.12.2.H Unstated Income

There is no provision that allows for counting unstated income.

4.12.2.I Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.12.2.J Income Received for a Non-Income Group (IG) Member

Income received by a member of the IG, which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility of the payee's AG, is excluded as income.

4.13 MEDICAID FOR QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI) (CATEGORICALLY NEEDY, MANDATORY)

NOTE: The spenddown provision does not apply to QDWI.

4.13.1 DETERMINING ELIGIBILITY

Countable income is determined the same way it is for Supplemental Security Income (SSI)-Related Medicaid. See Section 4.14.3. The same disregards and deductions used for SSI-Related Medicaid are applied. See Section 4.14.2.

Once countable income is determined, it is compared to 200% of the Federal Poverty Level (FPL), rather than the Medically Needy Income Level (MNIL), to determine financial eligibility. If the countable income exceeds 200% of the FPL, the client is ineligible as a QDWI.

4.13.2 SPECIAL SITUATIONS

The special situations and procedures for SSI-Related Medicaid are found in Section 4.14.4 and apply to QDWI cases.

4.14 SSI-RELATED MEDICAID (Medically Needy, Categorically Need, Optional)

NOTE: Spenddown provisions apply to Supplemental Security Income (SSI)-Related.

4.14.1 BUDGETING METHOD

In addition to the information in Section 4.6, some Medically Needy cases may have other considerations, because Medically Needy cases have a fixed Period of Consideration (POC) and the total income for the six-month POC is used to determine the spenddown amount.

Therefore, the Worker must take the following steps when the income is expected to change during the POC.

Step 1: Determine the specific months that will constitute the POC.

Step 2: Determine the anticipated earned income for each of the six months, according to Section 4.6.

Step 3: Determine the anticipated unearned income for each of the six months, according to Section 4.6.

Step 4: Take the result from Step 2 and divide by six to determine the average anticipated earned income for the POC.

NOTE: When there is no earned income in a month, use $0 as income for that month, but always divide by six.

Step 5: Take the result from Step 3 and divide by six to determine the average anticipated unearned income for the POC.

NOTE: When there is no unearned income in a month, use $0 as income for that month, but always divide by six.

4.14.2 INCOME DISREGARDS AND DEDUCTIONS

The following disregards and deductions are applied, if applicable.

4.14.2.A Earned Income

Disregards and deductions apply only to earned income. Any unused portion of the disregards or deductions is not applied to unearned income.

4.14.2.A.1 SSI $20 Disregard

The remainder of the $20 income disregard.

See Unearned Income below.

4.14.2.A.2 SSI Earned Income Disregard

$65 and half of the remainder are subtracted from earned income and from gross profit from self-employment earnings. See Section 4.14.3 below.

4.14.2.A.3 SSI Impairment-Related Work Expenses

Expenses for items or services that are directly related to enabling a person with a disability to work and that are necessarily incurred by the individual due to a physical or mental impairment. The individual must be:

- Disabled, but not blind; and
- Under age 65; or
- Received SSI or SSI-Related Medicaid as a disabled individual for the month before becoming age 65.

In addition, the severity of the impairment must require the individual to purchase or rent items and services in order to work and the expense must be reasonable and not reimbursable from another source, such as, but not limited to, Medicare or private insurance. The payment must be made with income received for a month in which the person both worked and received the services or used the item, or the payment may be made before the earned income is received when the person is working.

Examples of SSI impairment-related work expenses include, but are not limited to:

- Attendant care services, both at home and at work
- Drugs, medical supplies, and devices
- Federal, state, and local income taxes and Federal Insurance Contributions Act (FICA) taxes
- Fees, such as union dues
- Guide dogs
- Mandatory contributions, such as pensions
- Meals consumed during work hours
- Physical therapy
- Prosthesis
- Structural modifications to the person's home
- Transportation to and from work, and vehicle modification
- Work-related equipment or services

4.14.2.A.4 SSI Work-Related Expenses (Blind Persons Only)

A deduction for impairment-related expenses necessary for employment is allowed, such as a guide dog, cane training, purchase of special equipment needed to perform or advance on the job, etc.

4.14.2.A.5 Earnings Diverted to a Plan to Achieve Self-Support (PASS)

Any earnings diverted to a PASS account are deducted from income.

4.14.2.A.6 SSI Student Child Earned Income Disregard

$2,410 per month, but no more than $9,730 in a calendar year, is disregarded when the child meets the following criteria:

- Is under age 22, unmarried, and not head of a household; and
- Takes one or more courses of study and attends classes as follows:
    - In a college or university at least eight hours a week; or
    - In grades 7-12 at least 12 hours a week; or
    - In a course of training to prepare for a paying job for at least 15 hours a week, if shop practice is involved, or 12 hours a week, if shop practice is not involved; or
    - For less than the amount of time indicated above for reasons beyond the student's control, such as illness, if circumstances justify a reduced load or attendance.

This applies to homebound students when a disability requires home school and a home visitor or tutor from school directs the study.

4.14.2.B Unearned Income

4.14.2.B.1 SSI $20 Disregard

A $20 disregard is applied to the total gross unearned income. If unearned income is less than $20, the remainder is subtracted from earned income, prior to the application of any other earned income disregards and deductions.

NOTE: The SSI $20 disregard is not applied to any unearned income received that is based on need. This includes, but is not limited to, Veterans Affairs (VA) benefits based on need. See VA Benefits in Section 4.3.

4.14.2.B.2 Unearned Income Diverted to a PASS

Any unearned income diverted to a PASS account is deducted from income.

4.1.1.A.1 For SSI-Related Children Only

One-third of the child support intended for the SSI-Related child is disregarded.

4.14.2.B.3 Death Benefits

The portion of a lump-sum payment received as a result of the death of an individual, which is used to pay the expenses of the last illness and burial of that individual, is deducted.

4.14.3 DETERMINING ELIGIBILITY

Countable income is determined by subtracting any allowable disregards and deductions in the Budgeting Method section above from the total countable gross income. Deemed income is addressed in Public Assistance Maintenance Income below.

NOTE: When income is deemed from an ineligible spouse, the income is added to the client's income in Steps 1 and 2. When income is deemed from a parent(s), the predetermined deemed amount is added to the child's unearned income in Step 1.

Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the $20 disregard, if applicable.

Step 2: Determine the total countable earned income. Subtract the following in order:

- Remainder of SSI $20 disregard
- SSI $65 earned income disregard
- SSI impairment-related expenses

- One-half of remaining earned income
- SSI work-related expense deductions (blind persons only)
- Earnings diverted to a PASS
- SSI student child earned income disregard

Step 3: Add the result from Step 1 to the result from Step 2.

Step 4: Subtract unearned income diverted to a PASS account, the Death Benefits deduction and, for children, the child support disregard.

The result is the total monthly countable income.

Step 5: Compare the amount in Step 4 to the SSI Maximum Payment Level, indicated in Appendix A for the appropriate number of persons.

If the net countable monthly income is equal to or less than the appropriate SSI Maximum Payment Level, the assistance group (AG) is eligible and no further steps are necessary.

If the net countable monthly income is above the appropriate SSI Maximum Payment Level, continue with Step 6.

Step 6: Compare the amount in Step 4 to the Medically Needy Income Level (MNIL) for the appropriate number of persons. See Public Assistance Maintenance Income in Section 4.14.4.D.1 below.

If the net countable monthly income is equal to or less than the appropriate MNIL, the AG is eligible without a spenddown. If it is in excess of the appropriate MNIL, the AG must meet a spenddown. See Section 4.14.4.J.

4.14.4 SPECIAL SITUATIONS

4.14.4.A Income from Self-Employment

Gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16. The gross profit may be earned or unearned income. See Section 4.3.

4.14.4.B Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.14.4.C Educational Income

4.14.4.C.1 Title IV Educational Assistance

All student financial assistance, funded in whole or in part, under Title IV of the Higher Education Act or the Bureau of Indian Affairs, is excluded in its entirety.

Examples of Title IV educational assistance are:

- Federal Pell Grants
- Federal Supplemental Educational Opportunity Grants (FSEOG)
- Guaranteed Student Loans, including William D. Ford Federal Direct Loan Program and Federal Direct PLUS Loans, Supplemental Loans for Students, and Federal Family Education Loan (FFEL) Program Loans
- Leveraging Educational Assistance Partnership (LEAP) and Special Leveraging Educational Assistance Partnership (SLEAP) Programs, formerly known as State Student Incentive Grants
- Federal Perkins Loans
- Federal Stafford Loans
- Federal Work-Study
- Robert C. Byrd Honors Scholarship

Examples of educational assistance that are NOT funded under Title IV are:

- West Virginia Promise Scholarships
- West Virginia Higher Education Grant, also known as West Virginia Grant
- Non-Title IV College Work Study

4.14.4.C.2 Other Educational Assistance

Any grant, scholarship, fellowship, gift, or portion of a gift that is used to pay tuition and other educational expenses at any educational institution, including technical or vocational schools, is excluded. Any portion used or set aside for food or shelter is counted as income in the month received. See Section 5.5 for the asset policy for those educational assistance sources when retained into the month following the month of receipt. Any portion set aside for educational expenses that is used to pay non-educational expenses is income in the month it is used for another expense.

4.14.4.D Deeming

When determining income to be deemed to an eligible individual, certain income sources are not deemed. These sources are outlined in Section 4.14.4.D.1 and Section 4.14.D.2 below.

NOTE: For the definition of eligible child or ineligible child, see Section 4.2.

4.14.4.D.1 Public Assistance Maintenance Income

As defined by the Social Security Administration (SSA), public assistance maintenance income of the spouse or parent from whom income is deemed is excluded from the deeming process; therefore, it is not deemed. In addition, any income, which was considered (counted or excluded) in computing the amount of such income maintenance payments, is also excluded.

These public assistance income maintenance payments are:

- Needs-based payments resulting from the Refugee Act of 1980
- Payments from the Disaster Relief and Emergency Assistance Act
- Payments from general assistance programs of the Bureau of Indian Affairs
- Payments from the VA programs when such payments are based on need. See Section 4.3.
- SSI
- State or local government assistance programs based on need. *(Earned income tax credits (EITC) payments and tax refunds are not considered to be based on need.)*
- WV WORKS

4.14.4.D.2 Other Excluded Income Sources

Other excluded sources are:

- Any portion of a grant, scholarship, fellowship, or gift used to pay tuition and fees
- Money received for providing foster care to an ineligible child
- The value of Supplemental Nutrition Assistance Program (SNAP) benefits or Department of Agriculture donated foods
- Home produce for personal consumption
- Tax refunds on income, real property, or food purchased by the family
- Income used to fulfill an approved PASS
- Income used to comply with the terms of court-ordered support or support payments enforced under Title IV-D
- Periodic payments made by a state under a program established before July 1,1973 and based solely on duration of residence and attaining age 65. Only that State of Alaska makes such payments.
- Infrequent or irregular income
- Work expenses of a blind individual
- Income of the ineligible individual or parent that is paid under a federal, state, or local program to provide chore, attendant, or homemaker services to the eligible individual
- Home energy assistance
- The earned income of a student child, up to $2,410 a month, but not more than $9,730 per year, is excluded from the income of an ineligible child for purpose of determining the ineligible child allocation

When the ineligible spouse's non-excluded income, as shown above and in Section 4.3, minus only the needs of ineligible children in the home, is greater than the Allocation Standard, the ineligible spouse's income is added to the eligible spouse's income. These are the SSI deeming provisions, which also require use of the couple income limit to determine eligibility for the individual when income is deemed. If the SSI-Related individual is a child, the income of the parent(s) is also deemed, and the above exclusions are applied to their income.

NOTE: The income of separated spouses is not counted or deemed beginning in the month following the month in which the couple separates.

4.14.4.D.3 Deeming from Ineligible Spouse to SSI-Related Spouse

The deeming calculations are as follows:

Step 1: Determine the ineligible spouse's total countable unearned income.

Step 2: Subtract the needs of all ineligible dependent children. See Section 4.2 for the definition of ineligible child.

The need of each ineligible child is determined separately by subtracting the child's income from the Allocation Standard. The difference, if any, represents the child's needs.

> **Need of Each Ineligible Child Example:** SSI payment level for one person is $994 and the level for two persons is $1,491.
>
> The Allocation Standard is $499. Child #1's income is $498. Because the child's income exceeds $498, there is no deduction for Child #1's needs. Child #2's income is $140. The allocation for this child's needs is $358.
>
> After a separate determination is made for each ineligible child, the allocations are added together and then subtracted from income.

Step 3: Determine the ineligible spouse's total gross countable earned income.

Step 4: Subtract the remainder of the needs of all ineligible children who could not be subtracted in Step 2.

Step 5: Add together the ineligible spouse's remaining earned and unearned income.

Step 6: Compare the amount from Step 5 to the Allocation Standard.

When the remaining amount is less than the Allocation Standard, no income is deemed from the ineligible spouse and the individual income limit is used.

When the remaining amount is in excess of the Allocation Standard, the ineligible spouse's remaining earned income from Step 4 is added to the SSI-Related spouse's earned income, and the ineligible spouse's remaining unearned income from Step 2 is added to the SSI-Related spouse's unearned income. The income limit for two persons is used, even though only one spouse is in the AG.

4.14.4.D.4 Deeming from Parent(s) to SSI-Related Child(ren)

See Section 4.2 for the definition of child.

The deeming calculations are as follows:

Step 1: Determine the total countable gross unearned income of the eligible and ineligible parents.

Step 2: Subtract the needs of all ineligible children. The need of each ineligible child is determined separately by subtracting the child's own income from the Allocation Standard.

After a separate determination is made for each ineligible child, the allocations are added together and then subtracted from income.

Step 3: Determine the total countable gross earned income of the eligible and ineligible parents.

Step 4: Subtract the needs of the ineligible children, which were not subtracted in Step 2.

Step 5: Subtract the SSI $20 disregard from the amount in Step 2.

Step 6: Subtract any remainder of the SSI $20 disregard from the amount in Step 4.

Step 7: Apply the SSI $65, plus half of the earned income disregard, to the amount remaining from Step 6.

NOTE: When the person from whom income is deemed receives Retirement, Survivors, and Disability Insurance (RSDI) based on disability or received that benefit prior to becoming age 65, SSI Impairment-Related Work Expenses, if appropriate, are deducted after the $65, but prior to deducting the remaining half. See Earned Income in Section 4.14.2.A.

Step 8: Add together the amounts from Steps 5 and 7.

Step 9: Subtract the Parental Living Allowance. See Section 4.2, Definitions.

The remaining amount is deemed to the SSI-Related child as unearned income. If there is more than one SSI-Related child, divide the remaining amount equally among the SSI-Related children.

4.14.4.D.5 Deeming from Ineligible Spouse and Eligible/Ineligible Parent to SSI-Related Spouse and SSI-Related Child

The deeming calculations are as follows:

Step 1: Determine the ineligible spouse's total gross countable unearned income.

Step 2: Subtract the needs of all ineligible children. The needs are determined separately by subtracting the child's own income from the Allocation Standard.

After a separate determination is made for each child, the allocations are added together and then subtracted from income.

Step 3: Determine the ineligible spouse's total countable gross earned income.

Step 4: Subtract the needs of the ineligible children, which were not subtracted in Step 2.

Step 5: Add the remaining amount from Step 2 to the remaining amount from Step 4.

NOTE: If the amount in Step 5 is equal to or less than the Allocation Standard, no income is deemed to the spouse or child. If it is greater, continue.

Step 6: Add the SSI-Related spouse's unearned income to the amount in Step 2.

Step 7: Subtract the SSI $20 disregard from the Step 6 amount.

Step 8: Add the SSI-Related spouse's earned income to the amount in Step 4.

Step 9: Subtract the amount of the SSI $20 disregard that was not subtracted in Step 7.

Step 10: Apply the SSI $65, plus half of the earned income disregard, to the amount in Step 9.

NOTE: When the person from whom income is deemed receives RSDI based on disability or received that benefit prior to becoming age 65, SSI Impairment-Related Work Expenses, if appropriate, are deducted after the $65, but prior to deducting the remaining half. See Earned Income in Section 4.14.2.A.

Step 11: Add the amounts from Steps 7 and 10.

NOTE: If the amount from Step 11 is equal to or less than the maximum SSI payment for a couple, no income is deemed to the SSI-Related Child. If it is greater, continue.

Step 12: Subtract the maximum SSI payment for a couple from the Step 11 amount.

The amount remaining after Step 12 is deemed to the SSI-Related child as unearned income. If there is more than one SSI-Related child, divide the amount equally among the SSI-Related children.

4.14.4.E Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

4.14.4.F Lump-Sum Payments

Lump-sum payments are treated as unearned income in the month received.

4.14.4.G Withheld Income

4.14.4.G.1 From Earned Income

Earnings withheld to repay an advance payment are disregarded if they were counted in the month received. If not counted in the month received, the withheld earnings are income.

No other earned income is excluded just because it is withheld by the employer.

4.14.4.G.2 From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine Medicaid eligibility.

4.14.4.H Funds Diverted to a PASS

Funds diverted to a PASS account are disregarded.

4.14.4.I Unstated Income

Unstated income is income that has not been reported by the household, and is not otherwise known to the agency, but is determined to exist because the client's paid living expenses exceed income from known sources.

The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

When the information in the client's record, including statements of the client or third parties, indicates that paid expenses exceed the stated income, the existence of unstated income must be explored. The client must complete form ES-IN-1, Statement of Monthly Living Expenses.

If insufficient or conflicting evidence exists, the Worker must question the client about the possibility of unstated income and allow him the opportunity to explain how his expenses are met. If the client provides a satisfactory explanation, the Worker records the explanation.

If the client's explanation of how the expenses are met is inadequate, the Worker makes a recording of the explanation and then determines the amount of unstated income to count. To determine the amount of unstated income to count, the Worker compares the usual amount of monthly living expenses with the client's reported income, taking into consideration any other reasonable explanations the client provides. The difference is unstated income and is counted as unearned income.

4.14.4.J Spenddown

To be eligible for Medicaid, the Income Group’s (IG) monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the six-month POC, until the income is at, or below, the MNIL for the Needs Group (NG) size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

4.14.4.J.1 Procedures

The Worker must determine the amount of the client’s spenddown at the time of application based on information provided by the client. The spenddown amount may have to be revised if

the verified income amount differs from the client's statement. The Worker must also explain the spenddown process to the client.

A DFA-6A is attached to the verification checklist (DFA-6) that notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses. The DFA-6 must also contain any other information the client must supply in order to determine eligibility.

The following procedures are required for the spenddown process.

- The Worker prepares the DFA-6, attaches a DFA-6A and gives them to the client or mails them. The DFA-6A notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses.

  The DFA-6 must also contain any other information the client must supply in order to determine eligibility.

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally, or emotionally unable to verify his medical expenses.
- The client is requested to provide proof of his medical expenses, date incurred, type of expense and amount, and to submit them to the Worker by the application processing deadline.
- Medical bills are entered and tracked in the eligibility system as they are received. When the bills or verification are received, the Worker reviews the information to determine:
  - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.
  - The individual(s) who received the medical service is one of the persons described in Section 4.14.4.J.2 below.
  - The expenses are for medical services and are appropriate to use to meet a spenddown. See Section 4.14.4.J.3 below.
- The Worker must enter the pertinent information about expenses received from the client in the eligibility system. This information includes:
  - The date of service
  - The provider of the service
  - The total amount of the bill
  - The third-party liability amount

- Medical Processing in the Bureau for Medical Services (BMS) accesses the eligibility system to determine the date on which the spenddown is met. Additional electronic notification to BMS is required only when a change is necessary to add additional medical expenses after the spenddown is met and will result in an earlier period of eligibility (POE). The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

NOTE: Although eligibility begins on the date of service of the medical bills that bring the spenddown amount to $0, expenses incurred on that date that are used to meet the spenddown, as indicated in the eligibility system, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied.

The application is denied when the applicant indicates there are no medical bills or anticipated medical expenses in the 30-day application period that may be used to meet the spenddown for the Medicaid AG member(s).

4.14.4.J.2 Whose Medical Expenses Are Used

The medical bills of the following persons who live with the AG member(s) are used to meet the spenddown. There is no limit on the amount of one individual's bills that can be used to meet another individual's spenddown.

- The aged, blind, or disabled individual
- The spouse of the eligible individual who lives with him
- The children under age 18 of the eligible individual and spouse, when the children live in the home with them

NOTE: The past medical bills of any of the individuals listed that were incurred while the individual lived with an AG member(s) may be used for spenddown, even if the individual no longer lives with the AG member, is deceased, or is divorced from the AG member.

The AG member must be responsible for the bill at the time it was incurred and remain responsible for payment.

Because the individuals whose medical expenses are used to meet a spenddown may be in separate AGs, the same medical bill is used to meet the spenddown in each AG containing one of the persons identified above.

4.14.4.J.3 Allowable Spenddown Expenses

The following medical expenses, which are not subject to payment by a third party, and for which the client will not be reimbursed, are used to reduce or eliminate the spenddown.

- A current payment on, or the unpaid balance of an old bill, incurred outside the current POC, is used as long as that portion of the bill was not used in a previous POC during which the client became eligible. No payment or part of a bill that is used to make a client eligible may be used again. Old unpaid bills, which are being collected by an agency other than the medical provider, may be used when the expense is still owed to the provider. If the expense has been written off by the provider, it is no longer considered the client's obligation, and is, therefore, not an allowable spenddown expense.

  Medical bills that were previously submitted, but were not sufficient to meet the spenddown, are used again in a new POC. When only a portion of the old bill, incurred outside the current POC, is used to meet spenddown, any remaining portion of the bill for which the client is still liable may be used to meet spenddown in a new POC.

  In addition, when the client submits an old bill and then withdraws his application, the old bill may be used again if he reapplies.
- Health insurance premiums, including Medicare or the enrollment fee for a Medicare-approved drug discount card
- Medicaid co-pays
- Medicare co-insurance, deductibles, and enrollment fees
- Necessary medical or remedial care expenses. This includes, but is not limited to:
  - Office visits to a physician
  - Hospital services, inpatient and outpatient
  - Emergency room services
  - Prescriptions
  - Over-the-counter drugs prescribed by a physician
  - Eye examinations
  - Eyeglasses
  - Dental services
  - Therapy prescribed by a physician
  - Chiropractic services
  - Prosthetic devices

- Durable medical equipment prescribed by a physician
- Rental of sickroom supplies
- Cost of in-home care
- Services of other licensed practitioners of the healing arts

Do not deduct any expenses that are included in a package of services, prior to the date services are rendered, such as, charges for prenatal care and delivery services or orthodontia.

- Expenses for personal care services are defined as: services provided in a client's home that are prescribed by a physician, delivered in accordance with a plan of treatment and provided by a qualified person who is not a member of the client's family, under the supervision of a registered nurse. For these purposes, home is defined as the client's full-time residence, but does not include a hospital, nursing facility, intermediate care facility, or any other setting in which nursing services are, or could be, made available.
  - Family member for these purposes is defined as:
    - A spouse
    - A parent or stepparent of a minor child
    - A parent of an adult child
    - An adopted child or adoptive parent of a client
  - An adult sibling or stepsibling of a minor child
  - An adult sibling residing with an adult sibling client
  - An adult child of an adult client

  The services must fall into any of the following general groups. Each general group shown below is further defined by examples but is not limited to only the examples shown.
  - Personal Hygiene/Grooming: care of hair; nails; teeth; mouth; shaving; bathing; toilet assistance; dressing; laundry, when related to incontinence.
  - Non-Technical Physical Assistance: routine bodily functions; routine skin care, including application of non-prescription skin care products; change of simple dressings; repositioning or transferring into and out of bed, on and off seats; walking, with or without equipment; assist in administration of medication; following directions of a professional for use of medical supplies.
  - Nutritional Support: meal preparation; feeding; assisting with special nutritional needs, including preparation of special formulas, prescribed feedings or special diets.
  - Environmental: housecleaning, dusting and vacuuming; laundry; ironing and mending; making and changing beds; dishwashing; food shopping; payment of

bills; essential errands; activities and transportation necessary to move the client from place to place; other similar activities of daily living.

Expenses billed to the client for the personal care services shown above must, at a minimum, specify the amount billed for each general group of services.

Ongoing or one-time-only medical expenses are not projected. They must be used no earlier than actually incurred. Those persons who are billed for their care at intervals longer than monthly are to have the expenses used to meet spenddown on the date services are performed, not on the date billed. Such expenses are not incurred prior to receipt of services.

4.14.4.K Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.14.4.L Income Received for a Non-Income Group Member

Income received by a member of the Income Group, which is intended and used for the care and maintenance of an individual, whose income is not used in determining the eligibility or benefit level of the payee's AG, is excluded as income.

4.14.4.M Income Received from Military Service Personnel Deployed to a Designated Combat Zone

Military pay received while serving in a combat zone is excluded. Only pay which is specified for combat, hostile fire, or imminent danger is excluded. All other military pay is counted.

Pay for a member of the uniformed services is determined by using the individual’s Leave and Earnings Statement (LES), which is received at the beginning of the month. The LES shows the earnings for services performed in the prior month. See Section 7.3.

4.14.4.N Income Belonging to or for the Benefit of a Child

The source of the income must be known, and Section 4.3 consulted for how the income is treated.

4.15 SSI-RELATED NON-CASH ASSISTANCE MEDICAID (Categorically Needy, Optional)

Spenddown provisions do not apply to Supplemental Security Income (SSI)-Related Non-cash assistance Medicaid.

4.15.1 BUDGETING METHOD

The budgeting method in Section 4.6.1 is used for this coverage group.

4.15.2 INCOME DISREGARDS AND DEDUCTIONS

The following disregards and deductions are applied, if applicable.

4.15.2.A Earned Income

These disregards and deductions apply only to earned income. Any unused portion of the disregards or deductions is not applied to unearned income.

4.15.2.A.1 SSI $20 Disregard

The remainder of the $20 income disregard.

See Section 4.15.2.B, Unearned Income, below.

4.15.2.A.2 SSI Earned Income Disregard

$65 and half of the remainder are subtracted from earned income and from gross profit from self-employment earnings. See Section 4.15.3 below.

4.15.2.A.3 Impairment-Related Work Expenses

Impairment-related work expenses are expenses for items or services that are directly related to enabling a person with a disability to work and that are necessarily incurred by the individual due to a physical or mental impairment. The individual must:

- Be disabled, but not blind; and
- Be under age 65; or
- Have received SSI or SSI-Related Medicaid as a disabled individual for the month before becoming age 65.

In addition, the severity of the impairment must require the individual to purchase or rent items and services in order to work, and the expense must be reasonable and not reimbursable from another source, such as, but not limited to, Medicare or private insurance. The payment must be made with income received for a month in which the person both worked and received the services or used the item, or the payment may be made before the earned income is received when the person is working.

Examples of SSI impairment-related work expenses include, but are not limited to:

- Attendant care services, both at home and at work
- Drugs and medical supplies and devices
- Federal, state, and local income taxes and Federal Insurance Contributions Act (FICA) taxes
- Fees such as union dues
- Guide dogs
- Mandatory contributions such as pensions
- Meals consumed during work hours
- Physical therapy
- Prosthesis
- Structural modifications to the person’s home
- Transportation to and from work and vehicle modification
- Work-related equipment or services

4.15.2.A.4 SSI Work-Related Expenses (Blind Persons Only)

A deduction for impairment-related expenses necessary for employment is allowed, such as a guide dog, cane training, purchase of special equipment needed to perform or advance on the job, etc.

4.15.2.A.5 Earnings Diverted to a Plan to Achieve Self-Support (PASS)

Any earnings diverted to a PASS account are deducted from income.

4.15.2.A.6 SSI Student Child Earned Income Disregard

$1,790 per month, but no more than $7,200 in a calendar year, is disregarded when the child meets the following criteria:

- Is under age 22, unmarried, and not head of a household; and
- Takes one or more courses of study and attends classes as follows:
    - In a college or university at least eight hours a week; or
    - In grades 7 – 12 at least 12 hours a week; or
    - In a course of training to prepare for a paying job for at least 15 hours a week, if shop practice is involved, or 12 hours a week, if shop practice is not involved; or
    - For less than the amount of time indicated above for reasons beyond the student's control, such as illness, if circumstances justify a reduced load or attendance.

This applies to homebound students when a disability requires home school and a home visitor or tutor from school directs the study.

4.15.2.B Unearned Income

4.15.2.B.1 SSI $20 Disregard

A $20 disregard is applied to the total gross unearned income. If unearned income is less than $20, the remainder is subtracted from earned income, prior to the application of any other earned income disregards and deductions.

NOTE: The SSI $20 disregard is not applied to any unearned income received that is based on need. This includes, but is not limited to, Veterans Affairs (VA) benefits based on need. See VA Benefits in Section 4.3.

4.15.2.B.2 Unearned Income Diverted to a PASS

Any unearned income diverted to a PASS account is deducted from income.

4.15.2.B.3 For SSI-Related Children Only

One-third of the child support intended for the SSI-Related child is disregarded.

4.15.2.B.4 Death Benefits

The portion of a lump-sum payment received as a result of the death of an individual, which is used to pay the expenses of the last illness and burial of that individual, is deducted.

4.15.3 DETERMINING ELIGIBILITY

Countable income is determined by subtracting any allowable disregards and deductions in the Budgeting Method in Section 4.6.1 from the total countable gross income. Deemed income is addressed in Public Assistance Maintenance Income below.

NOTE: When income is deemed from an ineligible spouse, the income is added to client's income in Steps 1 and 2. When income is deemed from a parent(s), the predetermined deemed amount is added to the child's unearned income in Step 1.

Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the $20 disregard, if applicable.

Step 2: Determine the total countable earned income. Subtract the following in order:

- Remainder of SSI $20 disregard
- SSI $65 earned income disregard
- SSI impairment-related expenses
- One-half of remaining earned income
- SSI work-related expense deductions (blind persons only)
- Earnings diverted to a PASS

Step 3: Add unearned income from Step 1 above.

Step 4: Subtract unearned income diverted to a PASS account, the Death Benefits deduction and, for children, the child support disregard.

The result is the total monthly countable income.

Step 5: Compare the amount in Step 4 to the SSI Maximum Payment Level, indicated in Appendix A, for the appropriate number of persons.

If the net countable monthly income is equal to or less than the appropriate SSI Maximum Payment Level, the assistance group (AG) is eligible.

4.15.4 SPECIAL SITUATIONS

4.15.4.A Income from Self-Employment

Gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16. The gross profit may be earned or unearned income. See Section 4.3.

4.15.4.B Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.15.4.C Educational Income

4.15.4.C.1 Title IV Educational Assistance

All student financial assistance, funded in whole or in part, under Title IV of the Higher Education Act or the Bureau of Indian Affairs, is excluded in its entirety.

Examples of Title IV educational assistance are:

- Federal Pell Grants
- Federal Supplemental Educational Opportunity Grants (FSEOG)
- Guaranteed Student Loans, including William D. Ford Federal Direct Loan Program and Federal Direct PLUS Loans, Supplemental Loans for Students, and Federal Family Education Loan (FFEL) Program Loans
- Leveraging Educational Assistance Partnership (LEAP) and Special Leveraging Educational Assistance Partnership (SLEAP) Programs, formerly known as State Student Incentive Grants
- Federal Perkins Loans

- Federal Stafford Loans
- Federal Work-Study
- Robert C. Byrd Honors Scholarship

Examples of educational assistance that are NOT funded under Title IV are:

- WV Promise Scholarships
- WV Higher Education Grant, also known as WV Grant
- Non-Title IV College Work Study

4.15.4.C.2 Other Educational Assistance

Any grant, scholarship, fellowship, gift, or portion of a gift that is used to pay tuition and other educational expenses at any educational institution, including technical or vocational schools, is excluded. Any portion used or set aside for food or shelter is counted as income in the month received. See Section 5.5 for the asset policy for those educational assistance sources when retained into the month following the month of receipt. Any portion set aside for educational expenses that is used to pay non-educational expenses is income in the month it is used for another expense.

4.15.4.D Deeming

When determining income to be deemed to an eligible individual, certain income sources are not deemed. These sources are outlined in Section 4.15.4.D.1 and Section 4.15.D.2 below.

NOTE: For the definition of eligible child or ineligible child, see Section 4.2.

4.15.4.D.1 Public Assistance Maintenance Income

As defined by the Social Security Administration (SSA), public assistance maintenance income of the spouse or parent from whom income is deemed is excluded from the deeming process; therefore, it is not deemed. In addition, any income that was considered (counted or excluded) in computing the amount of such income maintenance payments is also excluded.

These public assistance income maintenance payments are:

- Needs-based payments resulting from the Refugee Act of 1980.
- Payments from the Disaster Relief and Emergency Assistance Act.
- Payments from general assistance programs of the Bureau of Indian Affairs.
- Payments from the VA programs when such payments are based on need. See Section 4.3.
- SSI.
- State or local government assistance programs based on need. Earned income tax credits (EITC) payments and tax refunds are not considered to be based on need.
- WV WORKS.

4.15.4.D.2 Other Excluded Income Sources

Other excluded sources are:

- Any portion of a grant, scholarship, fellowship, or gift used to pay tuition and fees.
- Money received for providing foster care to an ineligible child.
- The value of Supplemental Nutrition Assistance Program (SNAP) benefits or Department of Agriculture-donated foods.
- Home produce for personal consumption.
- Tax refunds on income, real property or food purchased by the family.
- Income used to fulfill an approved PASS.
- Income used to comply with the terms of court-ordered support or support payments enforced under Title IV-D.
- Periodic payments made by a state under a program established before 7/1/73 and based solely on duration of residence and attaining age 65. Only Alaska makes such payments.
- Infrequent or irregular income.
- Work expenses of a blind individual.
- Income of the ineligible individual or parent that is paid under a federal, state, or local program to provide chore, attendant, or homemaker services to the eligible individual.
- Home energy assistance.

- The earned income of a student child, up to $1,790 a month, but not more than $7,200 per year, is excluded from the income of an ineligible child for purposes of determining the ineligible child allocation.

When the ineligible spouse's non-excluded income, as shown above and in Section 4.3, minus only the needs of ineligible children in the home, is greater than the Allocation Standard, then the ineligible spouse's income is added to the eligible spouse's income. These are the SSI deeming provisions, which also require use of the couple income limit to determine eligibility for the individual when income is deemed. If the SSI-Related individual is a child, the income of the parent(s) is also deemed, and the above exclusions are applied to their income.

NOTE: The income of separated spouses is not counted or deemed beginning in the month following the month in which the couple separates.

4.15.4.D.3 Deeming from Ineligible Spouse to SSI-Related Spouse

The deeming calculations are as follows:

Step 1: Determine the ineligible spouse's total countable unearned income.

Step 2: Subtract the needs of all ineligible dependent children. See Section 4.2 for the definition of ineligible child.

The need of each ineligible child is determined separately by subtracting the child's income from the Allocation Standard. The difference, if any, represents the child's needs.

> **Need of Each Ineligible Child Example:** SSI payment level for one person is $735 and the level for two persons is $1,103.
>
> The Allocation Standard is $367. Child #1's income is $400. Because the child's income exceeds $367, there is no deduction for Child #1's needs. Child #2's income is $125. The allocation for this child's needs is $242.
>
> After a separate determination is made for each ineligible child, the allocations are added together and then subtracted from income.

Step 3: Determine the ineligible spouse's total gross countable earned income.

Step 4: Subtract the remainder of the needs of all ineligible children who could not be subtracted in Step 2.

Step 5: Add together the ineligible spouse's remaining earned and unearned income.

Step 6: Compare the amount from Step 5 to the Allocation Standard.

When the remaining amount is less than the Allocation Standard, no income is deemed from the ineligible spouse and the individual income limit is used.

When the remaining amount is in excess of the Allocation Standard, the ineligible spouse's remaining earned income from Step 4 is added to the SSI-Related spouse's earned income, and the ineligible spouse's remaining unearned income from Step 2 is added to the SSI-Related spouse's unearned income. The income limit for two persons is used, even though only one spouse is in the AG.

4.15.4.D.4 Deeming from Parent(s) to SSI-Related Child(ren)

See Section 4.2 for the definition of child.

The deeming calculations are as follows:

Step 1: Determine the total countable gross unearned income of the eligible and ineligible parents.

Step 2: Subtract the needs of all ineligible children. The need of each ineligible child is determined separately by subtracting the child's own income from the Allocation Standard.

After a separate determination is made for each ineligible child, the allocations are added together and then subtracted from income.

Step 3: Determine the total countable gross earned income of the eligible and ineligible parents.

Step 4: Subtract the needs of the ineligible children that were not subtracted in Step 2.

Step 5: Subtract the SSI $20 disregard from the amount in Step 2.

Step 6: Subtract any remainder of the SSI $20 disregard from the amount in Step 4.

Step 7: Apply the SSI $65 plus half of the earned income disregard to the amount remaining from Step 6.

NOTE: When the person from whom income is deemed receives Retirement, Survivors, and Disability Insurance (RSDI) based on disability or received that benefit prior to becoming age 65, SSI Impairment-Related Work Expenses, if appropriate, are deducted after the $65, but prior to deducting the remaining half. See Earned Income in Section 4.15.2.A.

Step 8: Add together the amounts from Steps 5 and 7.

Step 9: Subtract the Parental Living Allowance. See Section 4.2, Definitions.

The remaining amount is deemed to the SSI-Related child as unearned income. If there is more than one SSI-Related child, divide the remaining amount equally among the SSI-Related children.

4.15.4.D.5 Deeming from Ineligible Spouse and Eligible/Ineligible Parent to SSI-Related Spouse and SSI-Related Child

The deeming calculations are as follows:

Step 1: Determine the ineligible spouse's total gross countable unearned income.

Step 2: Subtract the needs of all ineligible children. The needs are determined separately by subtracting the child's own income from the Allocation Standard.

After a separate determination is made for each child, the allocations are added together and then subtracted from income.

Step 3: Determine the ineligible spouse's total countable gross earned income.

Step 4: Subtract the needs of the ineligible children that were not subtracted in Step 2.

Step 5: Add the remaining amount from Step 2 to the remaining amount from Step 4.

NOTE: If the amount in Step 5 is equal to or less than the Allocation Standard, no income is deemed to the spouse or child. If it is greater, continue.

Step 6: Add the SSI-Related spouse's unearned income to the amount in Step 2.

Step 7: Subtract the SSI $20 disregard from the Step 6 amount.

Step 8: Add the SSI-Related spouse's earned income to the amount in Step 4.

Step 9: Subtract the amount of the SSI $20 disregard that was not subtracted in Step 7.

Step 10: Apply the SSI $65 plus half of the earned income disregard to the amount in Step 9.

NOTE: When the person from whom income is deemed receives RSDI based on disability or received that benefit prior to becoming age 65, SSI Impairment-Related Work Expenses, if appropriate, are deducted after the $65, but prior to deducting the remaining half. See Earned Income in Section 4.15.2.A.

Step 11: Add the amounts from Steps 7 and 10.

NOTE: If the amount from Step 11 is equal to or less than the maximum SSI payment for a couple, no income is deemed to the SSI-Related Child. If it is greater, continue.

Step 12: Subtract the maximum SSI payment for a couple from the Step 11 amount.

The amount remaining after Step 12 is deemed to the SSI-Related child as unearned income. If there is more than one SSI-Related child, divide the amount equally among the SSI-Related children.

4.15.4.E Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

4.15.4.F Lump-Sum Payments

Lump-sum payments are treated as unearned income in the month received.

4.15.4.G Withheld Income

4.15.4.G.1 From Earned Income

Earnings withheld to repay an advance payment are disregarded if they were counted in the month received. If not counted in the month received, the withheld earnings are income.

No other earned income is excluded just because it is withheld by the employer.

4.15.4.G.2 From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine Medicaid eligibility.

4.15.4.H Funds Diverted to a PASS

Funds diverted to a PASS account are disregarded.

4.15.4.I Unstated Income

Unstated income is income that has not been reported by the household, and is not otherwise known to the agency, but is determined to exist because the client's paid living expenses exceed income from known sources.

The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

When the information in the client's record, including statements of the client or third parties, indicates that paid expenses exceed the stated income, the existence of unstated income must be explored. The client must complete form ES-IN-1, Statement of Monthly Living Expenses.

If insufficient or conflicting evidence exists, the Worker must question the client about the possibility of unstated income and allow him the opportunity to explain how his expenses are met. If the client provides a satisfactory explanation, the Worker records the explanation.

If the client's explanation of how the expenses are met is inadequate, the Worker makes a recording of the explanation and then determines the amount of unstated income to count. To determine the amount of unstated income to count, the Worker compares the usual amount of monthly living expenses with the client's reported income, taking into consideration any other reasonable explanations the client provides. The difference is unstated income and is counted as unearned income.

4.15.4.J Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.15.4.K Income Received for a Non-Income Group Member

Income received by a member of the Income Group, which is intended and used for the care and maintenance of an individual, whose income is not used in determining the eligibility or benefit level of the payee's AG, is excluded as income.

4.15.4.L Income Received from Military Service Personnel Deployed to a Designated Combat Zone

Military pay received while serving in a combat zone is excluded. Only pay that is specified for combat, hostile fire, or imminent danger is excluded. All other military pay is counted.

Pay for a member of the uniformed services is determined by using the individual’s Leave and Earnings Statement (LES), which is received at the beginning of the month. The LES shows the earnings for services performed in the prior month. See Section 7.3.

4.15.4.M Income Belonging to or for the Benefit of a Child

The source of the income must be known, and Section 4.3 consulted for how the income is treated.

4.16 AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)-RELATED MEDICAID (MEDICALLY NEEDY, MANDATORY FOR CHILDREN AND OPTIONAL FOR PARENTS)

NOTE: Spenddown provisions apply to AFDC-Related Medicaid.

4.16.1 BUDGETING METHOD

In addition to the information in Section 4.6, some Medically Needy cases may have other considerations, because Medically Needy cases have a fixed Period of Consideration (POC). The total income for the six-month POC is used to determine if the spenddown provisions apply.

Therefore, the Worker must take the following steps when the income is expected to change during the POC.

Step 1: Determine the specific months that will constitute the POC.

Step 2: Determine the anticipated earned income for each of the six months, according to Section 4.6. If there is no earned income in a month, use $0 for that month.

Add all of the earned income and divide by 6 to determine the average anticipated earned income for the POC.

Step 3: Determine the anticipated unearned income for each of the six months, according to Section 4.6. If there is no unearned income in a month, use $0 for that month.

Add all of the unearned income and divide by 6 to determine the average anticipated unearned income for the POC.

4.16.2 INCOME DISREGARDS AND DEDUCTIONS

The following disregards and deductions are applied, if applicable.

4.16.2.A Earned Income

- AFDC-Related Medicaid Standard Work Deduction: A standard deduction of $90 is applied to the earnings of each working person. The amount deducted must not exceed the amount of each person's earned income.
- AFDC-Related Medicaid Dependent Care Deduction: When the employed member(s) of the Income Group (IG) must pay for care for a dependent child or incapacitated adult to accept or continue employment or training, a deduction is allowed. The amount is allowed as paid, up to the maximum amounts shown below for each dependent. The dependent is not required to be in the Assistance Group (AG), IG, or Needs Group (NG) to allow the deduction.

Age of Dependent	Maximum Monthly Deduction
Under Age 2	$200
Age 2 or Over	$175

Only payments made from the client's own funds are deductible. Clients with these expenses must be offered a referral to the Child Care Services for help in meeting these expenses. However, there is no penalty for failure to accept these services.

4.16.2.B Unearned Income

Child Support Disregard: The first $50 of child support is disregarded. This is the only disregard of unearned income.

When more than one child in the NG receives child support, the disregard amount is divided by the number of children in the NG who receive support. The resulting amount is deducted from each child's support amount to determine each child's countable child support.

4.16.2.B.1 Child Support Disregard Examples

Example 1: Four blood-related siblings live in the same home and receive the following amounts of child support: Child A receives $200 per month; Child B receives $150; Child C receives $50; Child D receives $100. The $50 disregard is divided by 4 and each child receives a disregard of $12.50.

Child A	
$200.00	Child Support
-$ 12.50	Disregard
$187.50	Countable Child Support
Child B	
$150.00	Child Support
-$ 12.50	Disregard
$137.50	Countable Child Support
Child C	
$50.00	Child Support
-$12.50	Disregard
$37.50	Countable Child Support
Child D	
$100.00	Child Support
-$ 12.50	Disregard
$87.50	Countable Child Support

Example 2: Mrs. Evergreen applies for Medicaid for her four grandchildren who live with her. Paul and John are blood-related siblings and are the children of Mrs. Evergreen's daughter, Samantha. They receive $200 child support. George and Ringo are blood-related siblings and are the children of Mrs. Evergreen's other daughter, Virginia. George receives $150 child support and Ringo receives none. Because all of Mrs. Evergreen's grandchildren are not blood-related siblings, two NGs are established: one for Paul and John; and one for George and Ringo. Each NG then receives the $50 disregard.

The countable child support for each child is as follows:

Paul and John

The child support amount of $200 is divided between the children and each child's amount is $100. The $50 disregard is divided between the two children as they are both in the NG and each receives a $25 disregard.

$100.00	Child Support Per Child
-$25.00	Disregard
$75.00	Countable Child Support Per Child

George

Because Ringo receives no child support and George is the only child in the NG who receives child support, he receives the entire $50 disregard.

$150.00	Child Support
-$50.00	Disregard
$100.00	Countable Child Support

4.16.3 DETERMINING ELIGIBILITY

Countable income is determined by applying the income disregards and deductions in Section 4.16.2 above to the countable gross income of the IG. To determine who is included in the IG, see Chapter 3. The remaining income is then compared to the Medically Needy Income Level (MNIL) for the appropriate NG size. An AFDC-Related Medicaid application is not denied solely on the basis of excess income. Instead, the spenddown provision is applied.

The following steps are used to determine the countable income of the IG.

Step 1: Determine the IG's countable gross earned income. Do not count the income of a child's sibling or count any child's income for his parent(s).

Step 2: Subtract the AFDC-Related Medicaid Standard Work Deduction for each working person.

Step 3: Subtract the AFDC-Related Medicaid Dependent Care Deduction up to the maximum allowable amounts.

Step 4: Add the countable gross unearned income of the IG to the amount remaining from Step 3. This includes the child's countable child support. Do not count the income of a child's sibling or count any child's income for his parent(s).

Step 5: Determine the appropriate MNIL for the NG. See Appendix A.

Step 6: Compare the result of Step 4 to the amount in Step 5.

If the net countable monthly income is less than or equal to the appropriate MNIL, the AG is eligible without a spenddown. If it is in excess of the appropriate MNIL, the AG must meet a spenddown. See Spenddown in Section 4.16.4.J below.

4.16.4 SPECIAL SITUATIONS

4.16.4.A Income from Self-Employment

When the AG member receives self-employment income, the instructions below must be used to arrive at the gross profit, which is used to calculate countable income. This is determined by subtracting allowable business expenses from the gross income.

4.16.4.A.1 Determining Gross Income

The method used to determine monthly gross income from self-employment varies with the nature of the enterprise. It is necessary to determine which of the following types of self-employment applies to the client's situation. Once the pattern of self-employment is determined, the instructions below are used to determine how the income is counted.

- ***Persons Receiving Regular Income***

For persons who receive income on a more or less regular schedule (weekly, monthly, etc.)—or who receive a specific amount from the business each week or month and/or receive the balance of profit from the enterprise at the end of the business year—the income is converted to a monthly amount according to item A above.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

- ***Persons Receiving Irregular Income***

Many persons receive income from short-term seasonal self-employment. This seasonal enterprise may be the major source of income for the year, or only for the period of time the

person is actually engaged in this enterprise, with other sources of income being available during the remainder of the year. Persons who are seasonally self-employed include vendors of seasonal commodities (produce, Christmas trees, etc.), or other seasonal farmers.

Cash crop and some seasonal farmers and other persons with similar irregular self-employment income receive their annual income from self-employment in a short period of time and budget their money to meet their living expenses for the next 12 months.

Because the income is seasonal, it must be averaged over the period of time it is intended to cover, even if it is the major source of income for the year. However, if the averaged amount of past income does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income is calculated based on anticipated earnings.

Business expenses may be computed on a monthly basis or prorated over a 12-month period, at the client's option.

➢ *New Business*

AGs with a new business that has been in existence less than a year will have their income and incurred business expenses averaged over the amount of time the business has been in operation. From this, the monthly amount is projected for the coming year. However, if the averaged amount of past income and/or expenses does not accurately reflect the anticipated monthly circumstances because of a substantial increase or decrease in business, the income and/or expenses is calculated based on anticipated earnings.

4.16.4.A.2 Determining Gross Profit

Gross profit from self-employment is the income remaining after deducting any identifiable costs of doing business from the gross income.

➢ *Deductions*

Examples of allowable deductions include, but are not limited to:

- Advertising costs.
- Cost of rental space used for conducting the business.
- Employee labor costs.

- Fertilizers.
- Insurance premiums and taxes paid on the business and business property.
- Interest and taxes, but not the principal, paid on installment payments to purchase capital assets, such as real estate, machinery, equipment, etc.
- Interest and taxes on the client's residence that is used in part to produce income. This is applicable only if the costs on the portion of the home used in the self-employment enterprise can be identified separately.
- Legal costs.
- Office expenses (stamps, stationery, etc.).
- Raw material.
- Repair and maintenance of machinery and/or property.
- Seed.
- Stock and supplies.
- Utilities.

Do not deduct the following:

- Amounts claimed as a net loss.
- Depreciation.
- Federal, state, or local income taxes.
- Money paid to purchase capital assets, such as real estate, machinery, equipment, etc. Interest is deducted, if paid in installments.

  > **Example:** The cost of purchasing a new furnace is a capital expenditure and only the interest on installment payments is deducted. A repair of a furnace is a routine repair and is deducted in its entirety.

- Money set aside for retirement.
- Principal of real estate mortgages on income-producing property.
- Travel from home to a fixed place of business and return.

➢ *Rental Income Deductions*

In addition to the deductions above, the following expenses are deducted from rental income:

- Interest, but not the principal, on necessary purchases made in installments, such as the purchase of a new furnace

- Property tax and insurance on the rental property
- Repair and upkeep of the property
- Utility bills paid for tenants

4.16.4.B Annual Contract Employment

This section applies to any person employed under a yearly contract, such as school employees—including bus drivers, cooks, janitors, aids, and professional staff.

These individuals have their annual income prorated over a 12-month period. Additional earnings, such as for summer work, are added to the prorated amount during the time additional earnings are received.

Although a person may not have signed a new annual contract, he is still considered employed under an annual contract when the contract is automatically renewable, or when he has implied renewal rights. Implied renewal rights are most commonly associated with school contracts.

NOTE: This section does not apply during strike and disaster situations when the other party to the contract cannot fulfill it, or when labor disputes interrupt the flow of earnings specified in the contract.

4.16.4.C Educational Income

All student financial assistance, funded in whole or in part under Title IV of the Higher Education Act or the Bureau of Indian Affairs, is excluded in its entirety.

Treatment of educational income and expenses depends upon the source of income and the intended use.

4.16.4.C.1 Sources That Are Totally Excluded

Funds from the following sources are totally excluded:

- Federal Pell Grants.
- Federal Supplemental Educational Opportunity Grants (FSEOG).

- Guaranteed Student Loans, including William D. Ford Federal Direct Loan Program and Federal Direct PLUS Loans, Supplemental Loans for Students, and Federal Family Education Loan (FFEL) Program Loans.
- Leveraging Educational Assistance Partnership (LEAP) and Special Leveraging Educational Assistance Partnership (SLEAP) Programs, formerly known as State Student Incentive Grants.
- Federal Perkins Loans.
- Federal Stafford Loans.
- Robert C. Byrd Honors Scholarship.
- Loans for educational expenses that meet the definition of a bona fide loan, as found in Section 4.2, Definitions.

4.16.4.C.2 College Work Study (CWS) Program

Income received from CWS Programs, funded in whole or in part under Title IV of the Higher Education Act, is excluded.

Income received from CWS Programs not funded under Title IV that is needed for the educational program or course of study is excluded. Any portion specifically earmarked for shelter, utilities, clothing, or incidentals not needed for the educational program or the course of study is income.

Because income is usually paid to the student on the basis of work performed, and not in one lump sum, its treatment is different than that of other educational benefits. Treatment of this income depends upon whether or not the amount to be earned in one semester is known at the beginning of the semester.

➢ *Earnings Known at Beginning of Semester*

When the amount of the earnings, or maximum amount that can be earned, is known at the beginning of the semester, the Worker prorates any portion, specifically earmarked for shelter, utilities, food, clothing, or incidentals not needed for the program or course of study, over the period of time it is intended to cover.

➢ *Earnings Unknown at Beginning of Semester*

When the amount of the earnings is not known at the beginning of the semester, any portion of the CWS income specifically earmarked for shelter, utilities, food, clothing, or incidentals not needed for the program or course of study is treated as earned income and converted to a monthly amount according to Section 4.16.1. All earned income disregards and deductions apply.

4.16.4.C.3 Other Sources

Educational funds from any source, other than those listed in Section 4.16.4.C.1 and Section 4.16.4.C.2 above, are totally excluded as being earmarked for educational purposes, unless any portion of the funds is specifically earmarked for shelter, utilities, food, clothing, or incidentals not needed for the program or course of study.

Any of the funds specifically earmarked for shelter, utilities, food, clothing, or incidentals not needed for the program or course of study, are counted as unearned income and prorated over the period of time they are intended to cover.

4.16.4.D Deeming

The following types of income are excluded from the deeming process:

- Needs-based payments resulting from the Refugee Act of 1980.
- Payments from the Disaster Relief and Emergency Assistance Act.
- Payments from general assistance programs of the Bureau of Indian Affairs.
- Payments from the U.S. Department of Veterans Affairs (VA) programs, when such payments are based on need. VA pensions are based on need, but not payments made for service-connected disabilities.
- State or local government assistance programs based on need. Earned income tax credits (EITC) payments and tax refunds are not considered to be based on need.
- Supplemental Security Income (SSI).
- WV WORKS.

4.16.4.D.1 Financial Responsibility

In order to deem income correctly, it is necessary to determine who in the home is financially responsible for each household member.

The Social Security Act limits financial responsibility for Medicaid purposes to legal spouses and legal parents. Persons related to or associated with a dependent child as a stepparent, grandparent, noncitizen sponsor, legal guardian, or in any way other than as a parent, are not financially responsible for the child. When income is deemed to a parent from a stepparent, no portion of the amount deemed to the parent is deemed to the children. Only if there is financial responsibility from one person to another or others can that person's income be deemed.

Legal spouses are defined in Section 5.1. Legal parents are natural or adoptive parents.

4.16.4.D.2 General Deeming Instructions

Deeming is most often accomplished by including the income of financially responsible persons in the total income of the Income Group (IG) and applying the AFDC-Related Medicaid disregards and deductions to that income. However, some case situations require a different method of deeming, as described below.

4.16.4.D.3 Deeming When There Is No Stepparent, Caretaker Relative Other Than a Parent or Major Parent (MP)

NOTE: A Major Parent (MP) is the parent of a parent under the age of 18 (minor parent (mp). The MP must live in the same household as the mp and his child.

- **When No Dependent Child Has Income**

The non-excluded income of the parent(s) is the only income counted. This income is then subject to the AFDC-Related Medicaid disregards and deductions, unless the parent, or one of the parents, is an SSI-Related Medicaid client. In this case, the SSI-Related Medicaid disregards and deductions are applied to his income and the remainder is added to the income of the other parent, after the AFDC-Related Medicaid disregards and deductions have been applied to the other parent's income.

➢ When at Least One Dependent Child Has Income

For children in the home with income, add together the non-excluded income of the child and the parent(s), unless one of the parents is an SSI-Related Medicaid client. In this case, the SSI-Related Medicaid disregards and deductions are applied to his income and the remainder is added to the income of the other parent and the child, after the AFDC-Related Medicaid disregards and deductions have been applied to the income of the other parent and child.

4.16.4.D.4 Deeming When There Is a Stepparent, Caretaker Relative Other Than a Parent or a MP

NOTE: Throughout this item, if any of the individuals from whom income is deemed is an SSI-Related Medicaid client, then the SSI-Related Medicaid income exclusions, disregards, and deductions are applied to his own income only, and are applied prior to deeming the income, even when he is a parent of the child. The deemed income is added to that of other members of the IG after the AFDC-Related Medicaid disregards and deductions have been applied to their income.

The following procedures are used to deem income when there is a stepparent, caretaker relative other than a parent or a MP.

➢ When There Is a Stepparent

The stepparent's income is deemed only to the parent. When deeming from the parent to the children, none of the amount deemed from the stepparent is deemed to the children.

▪ Determining the Income Used for the Parent

The parent's countable income is added to the stepparent's countable income.

▪ Determining the Child's Countable Income

The child's own countable income is added to the parent's own countable income. Do not include any of the amount deemed for the parent from the stepparent.

➢ When There Is A Caretaker Relative Other Than a Parent

▪ Determining the Income Used for the Caretaker Relative Other Than a Parent

The caretaker relative's own countable income is added to his spouse's countable income.

▪ Determining the Income Used for the Child

The child's own countable income is the only income counted for the child.

➢ When There Is a mp Living With a MP

Cases involving a mp require special consideration, only because a variable, not present in other AGs, exists (i.e., there are two parental groups in the family). The first parental unit is the MP(s), and the second is the mp. Any of the following combinations of eligible people are possible.

NOTE: A mp is a parent under the age of 18, regardless of completion of school or training.

- mp + child
- MP + mp + child
- MP + mp

See Chapter 3 to determine the appropriate AG. However, no matter who is included, the MP(s) is still financially responsible for the mp, and the mp is financially responsible for the child.

▪ When the AG Includes the mp and the Child

Determining the income used for the mp:

- The MP’s countable income is added to the MP(s) countable income.

Determining the income used for the child:

- The child's own countable income is added to the MP’s own countable income. When deeming from the mp, none of the income deemed to the mp from the MP(s) is counted for the child.

- ***When the AG Includes the MP(s), mp, and Child***

Determining the income used for the MP(s):

- If there is only one MP in the home, the MP's own countable income is added to that of the MP's spouse, who is not a parent of the mp, to determine eligibility.
- If there are two MPs in the home, their countable income is added together.

Determining the income used for the mp:

- The MP's own countable income is added to that of the MP(s). When income has been deemed to the MP from the MP's spouse, who is not a parent of the mp, none of the amount deemed to the MP is counted for the mp.

Determining the income used for the child:

- The child's own countable income is added to the MP's own countable income. None of the amount deemed from the MP(s) to the mp is counted for the child.

- ***When the AG Includes Only the MP(s) and the mp***

Determining the income used for the MP(s): See Determining the income used for the MP(s) in When the AG Includes the MP(s), mp, and Child above.

Determining the income used for the mp:

- The MP's own countable income is added to that of the MP(s). When income has been deemed to the MP from the MP's spouse, who is not a parent of the mp, none of the amount deemed to the MP is counted for the mp.

4.16.4.E Irregular Income

Regardless of the source, irregular income is not counted because it cannot be anticipated.

4.16.4.F Lump-Sum Payments

Lump-sum payments are counted as unearned income in the month received.

4.16.4.G Withheld Income

4.16.4.G.1 From Earned Income

Earnings withheld to repay an advance payment are disregarded if they were counted in the month received. If not counted in the month received, the withheld earnings are considered income.

No other earned income is excluded from consideration just because it is withheld by the employer.

4.16.4.G.2 From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine eligibility for AFDC-Related Medicaid.

4.16.4.H Funds Diverted to a Plan to Achieve Self-Support (PASS)

Funds diverted to a PASS account are treated as earned or unearned income, depending on the source.

4.16.4.I Unstated Income

There is no provision for counting unstated income.

4.16.4.J Spenddown

To be eligible for Medicaid, the IG's monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the

income for the six-month POC, until the income is at or below the MNIL for the NG size. The spenddown process applies only to AFDC-Related and SSI-Related Medicaid.

4.16.4.J.1 Procedures

The Worker must determine the amount of the client's spenddown at the time of application based on information provided by the client. The spenddown amount may have to be revised if the verified income amount differs from the client's statement. The Worker must also explain the spenddown process to the client.

The following procedures are required for the spenddown process.

- The Worker prepares the verification checklist (DFA-6), attaches a DFA-6A and gives them to the client or mails them. A DFA-6A is attached to the DFA-6, which notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses.

  The DFA-6 must also contain any other information the client must supply in order to determine eligibility.

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally, or emotionally unable to verify his medical expenses.
- The client is requested to provide proof of his medical expenses, date incurred, type of expense, and amount, and to submit them to the Worker by the application-processing deadline.
- Medical bills are entered and tracked in the eligibility system as they are received. When the bills or verification are received, the Worker reviews the information to determine:
  - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.
  - The individual(s) who received the medical service is one of the persons described in Whose Medical Expenses Are Used below.
  - The expenses are for medical services and are appropriate to use to meet a spenddown. See Allowable Spenddown Expenses below.
- The Worker must enter the pertinent information about expenses received from the client in the eligibility system. This information includes:
  - The date of service

- The provider of the service
- The total amount of the bill
- The third-party liability amount

- Medical Processing in the Bureau for Medical Services (BMS) accesses the eligibility system to determine the date on which spenddown is met. Additional electronic notification to BMS is required only when a change is necessary to add additional medical expenses after the spenddown is met and will result in an earlier Period of Eligibility (POE). The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

NOTE: Although eligibility begins on the date of service of the medical bills that bring the spenddown amount to $0, expenses incurred on that date that are used to meet the spenddown, as indicated in the eligibility system, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application-processing deadline, the application is denied.

  The application is denied when the applicant indicates there are no medical bills or anticipated medical expenses in the 30-day application period that may be used to meet the spenddown for the Medicaid AG member(s).

NOTE: An AG that meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individuals is an AG member.
• A member(s) of the IG experiences an increase in income; or
• An individual(s) with income is added to the IG; or
• An individual(s) is removed from the NG.

4.16.4.J.2 Whose Medical Expenses Are Used

The medical bills of the following persons who live with the AG member(s) are used to meet the spenddown. There is no limit on the amount of one individual's bills that can be used to meet the client’s spenddown.

NOTE: The past medical bills of any of the individuals listed below that were incurred while the individual lived with an AG member(s) may be used for spenddown, even if the individual no longer lives with the AG member, is deceased, or is divorced from the AG member. The AG member must be responsible for the bill at the time it was incurred and remain responsible for payment.

➢ *Meeting the Spenddown of Adults*

Use the bills of:

- The adult(s) who is the parent(s) or other caretaker relative
- The spouse of the parent or other caretaker relative
- The dependent children and their blood-related siblings of the parent or other caretaker relative
- The dependent children and their blood-related siblings of the spouse of the parent or other caretaker relative

➢ *Meeting the Spenddown of Children*

Use the bills of:

- The child
- The parent(s). Do not use the bills of the caretaker relative other than a parent.
- The stepparent
- The blood-related siblings of the child
- The dependent children of the stepparent and their blood-related siblings in the home.

Because the individuals whose medical expenses are used to meet a spenddown may be in separate AGs, the same medical bill is used to meet the spenddown in each AG containing one of the persons identified above.

➢ *Meeting the Spenddown Examples*

> **Example 1:** A mother and her two children apply for Medicaid. Also, in the home is the mother's husband, who is the stepfather of the children. His medical bills are used to meet the spenddown of his wife and of both children.

> **Example 2:** A mother applies for Medicaid for herself and her two children. Also, in the home are her husband and his two children, who are also applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddowns of his wife and stepchildren as well as his own and his children's spenddown.
>
> **Example 3:** Same situation as above, except the husband and his children are not applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddown of the mother and her children.
>
> **Example 4:** A man and woman live together but are not married. They each have two children from previous marriages, and all are applying for Medicaid. The medical bills of the woman and her two children are used to meet their own spenddowns, but not those of the man and his two children. The medical bills of the man and his two children are used to meet their own spenddowns, but not those of the woman and her two children.

4.16.4.J.3 Allowable Spenddown Expenses

The following medical expenses, which are not subject to payment by a third party, and for which the client will not be reimbursed, are used to reduce or eliminate the spenddown.

- A current payment on or the unpaid balance of an old bill, incurred outside the current POC, is used as long as that portion of the bill was not used in a previous POC during which the client became eligible. No payment or part of a bill that is used to make a client eligible may be used again. Old unpaid bills, which are being collected by an agency other than the medical provider, may be used when the expense is still owed to the provider. If the expense has been written off by the provider, it is no longer considered the client's obligation, and is, therefore, not an allowable spenddown expense.

  Medical bills that were previously submitted, but were not sufficient to meet the spenddown, are used again in a new POC. When only a portion of the old bill, incurred outside the current POC, is used to meet spenddown, any remaining portion of the bill for which the client is still liable may be used to meet spenddown in a new POC.

  In addition, when the client submits an old bill and then withdraws his application, the old bill may be used again if he reapplies.
- Health insurance premiums, including Medicare or the enrollment fee for a Medicare-approved drug discount card.
- Medicare co-insurance, deductibles, and enrollment fees.
- Necessary medical or remedial care expenses. This includes, but is not limited to:

- Office visits to a physician
- Inpatient and outpatient hospital services
- Emergency room services
- Prescriptions
- Over-the-counter drugs prescribed by a physician
- Eye examinations
- Eye glasses
- Dental services
- Therapy prescribed by a physician
- Chiropractic services
- Prosthetic devices
- Durable medical equipment prescribed by a physician
- Rental of sickroom supplies
- Cost of in-home care
- Services of other licensed practitioners of the healing arts

Do not deduct any expenses that are included in a package of services, prior to the date services are rendered, such as charges for prenatal care and delivery services or orthodontia.

- Expenses for personal care services defined as: services provided in a client's home that are prescribed by a physician, delivered in accordance with a plan of treatment and provided by a qualified person who is not a member of the client's family, under the supervision of a registered nurse. For these purposes, home is defined as the client's full-time residence, but does not include a hospital, nursing facility, intermediate care facility, or any other setting in which nursing services are, or could be, made available.
  - Family member for these purposes is defined as:
    - A spouse
    - A parent or stepparent of a minor child
    - A parent of an adult child
    - An adopted child or adoptive parent of a client
    - An adult sibling or stepsibling of a minor child
    - An adult sibling residing with an adult sibling client
    - An adult child of an adult client

  The services must fall into any of the following general groups. Each general group shown below is further defined by examples but is not limited to only the examples shown.

- Personal Hygiene/Grooming: care of hair, nails, teeth, mouth; shaving; bathing; toilet assistance; dressing; laundry, when related to incontinence.
- Non-Technical Physical Assistance: routine bodily functions; routine skin care, including application of non-prescription skin care products; change of simple dressings; repositioning or transferring into and out of bed, on and off seats; walking, with or without equipment; assist in administration of medication; following directions of a professional for use of medical supplies.
- Nutritional Support: meal preparation; feeding; assisting with special nutritional needs, including preparation of special formulas, prescribed feedings, or special diets.
- Environmental: housecleaning, dusting and vacuuming; laundry; ironing and mending; making and changing beds; dishwashing; food shopping; payment of bills; essential errands; activities and transportation necessary to move the client from place to place; other similar activities of daily living.

Expenses billed to the client for the personal care services shown above must, at a minimum, specify the amount billed for each general group of services.

Ongoing or one-time-only medical expenses are not projected. They must be used no earlier than actually incurred. Those persons who are billed for their care at intervals longer than monthly are to have the expenses used to meet spenddown on the date services are performed, not on the date billed. Such expenses are not incurred prior to receipt of services.

4.16.4.K Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.16.4.L Income Received for a Non-IG Member

Income received by a member of the IG, which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility of the payee's AG, is excluded as income.

4.16.4.M Income Belonging to or for the Benefit of a Child

The source of the income must be known, and Section 4.3 consulted for how the income is treated.

4.17 FORMER WEST VIRGINIA FOSTER CHILDREN (CATEGORICALLY NEEDY, MANDATORY)

There is no income test for the Former West Virginia Foster Children coverage group. See Section 23.10.5.

4.18 MEDICAID FOR NON-QUALIFIED NONCITIZENS (CATEGORICALLY NEEDY, MANDATORY)

A non-qualified noncitizen, eligible for emergency Medicaid coverage, must meet the income requirements of any coverage group for which he is eligible, with the exception of the long-term care groups.

See the income policy and procedures used to determine eligibility for the appropriate coverage group in this chapter.

A non-qualified noncitizen who is a dependent child or the parent of a dependent child is income eligible if, after using all income policy, income is below the limit. Only the family member with the emergency medical need is eligible for Medicaid, even though it is necessary to determine the family's eligibility.

A non-qualified noncitizen, who is aged, blind, or disabled, is income eligible if—after using all Supplemental Security Income (SSI)-Related Medicaid income policy, except for the spenddown provision in Section 4.14—income is below the maximum SSI payment for an individual or a couple, if applicable.

4.19 MEDICAID FOR CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM (CDCSP) (CATEGORICALLY NEEDY, OPTIONAL)

The spenddown provision does not apply to CDCSP.

4.19.1 DETERMINING ELIGIBILITY

The Worker determines the child's own total income from all sources and compares it to 300% of the Supplemental Security Income (SSI) payment level. No income disregards or deductions are applied to the child's income. If income is less than or equal to 300% of the SSI payment level, the child is income eligible.

If income-eligible, the Worker sends income information to Bureau for Medical Services (BMS). BMS determines the annual cost of institutionalization, the annual cost of in-home care under CDCSP, and the cost of the type of services necessary for the child to decide the cost-effectiveness of the proposed in-home plan.

4.19.2 SPECIAL SITUATIONS

4.19.2.A Self-Employment

Gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16. No other disregards and deductions are applied.

4.19.2.B Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.19.2.C Educational Income

Educational income is counted the same way it is for AFDC-Related Medicaid. See Section 4.16.

4.19.2.D Deeming

Income is not deemed to the CDCSP child from any financially responsible person.

4.19.2.E Irregular Income

Regardless of the source, irregular income is not counted because it cannot be anticipated.

4.19.2.F Lump-Sum Payments

Lump-sum payments are counted as unearned income in the month received.

4.19.2.G Withheld Income

Withheld income of the CDCSP child is treated the same way it is for SSI-Related Medicaid. See Section 4.14.4.

4.19.2.H Funds Diverted to a Plan to Achieve Self-Support (PASS)

Funds diverted to a PASS account are counted as earned or unearned income, depending on the source.

4.19.2.I Unstated Income

There is no provision that allows for counting unstated income.

4.19.2.J Unavailable Income

Income intended for the client but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

4.19.2.K Income Received for a Non-Income Group Member

Income received by a member of the Income Group, which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility of the payee's Assistance Group (AG), is excluded as income.

4.20 AIDS DRUG ASSISTANCE PROGRAM (ADAP) (CATEGORICALLY NEEDY, OPTIONAL)

The ADAP is a Bureau of Public Health (BPH) pharmacy program contracted by the Bureau for Medical Services (BMS) to administer medical services. The eligibility decision is made by ADAP, rather than the Worker.

4.20.1 DETERMINING ELIGIBILITY

Income eligibility is determined by ADAP. The Worker must include income information for the individual, his spouse, and dependent children who live with him and are listed on the application, regardless of the source or amount. The income limit is 500% of the Federal Poverty Level (FPL).

4.20.2 INCOME BELONGING TO OR FOR THE BENEFIT OF A CHILD

The source of the income must be known, and Section 4.3 consulted for how the income is treated.

4.20.3 SPECIAL SITUATIONS

There are no special situations.

Chapter 5

Assets

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
5.1				
5.2				
5.3	2/1/22	816	5.3.4	Added details regarding asset accessibility for Medicaid
5.4	3/1/19	769	5.4	Updated Asset Limits
	1/1/21	799	5.4	Updated Asset Limits
	10/1/21	809	5.4	Updated maximum allowable assets for SNAP due to mass change
	3/1/22	817	5.4	Updated Asset Limits
	10/1/22	828	5.4	Updated Asset Limits
	3/1/23	838	5.4	Updated Asset Limits
	1/1/24	845	5.4	Updated Asset Limits
	10/1/24	855	5.4	Updated maximum allowable assets for SNAP due to mass change
	1/1/25	859	5.4	Updated to reflect the 2025 Maximum Allowable Assets for QMB, SLMB and QI-1
	1/1/26	872	5.4	Updated the resource standards for single and married QMB's, SLMB's, QI's.
5.5	1/1/18	749	5.5.1	Adding ABLE accounts to the list of assets, along with a description and explanation of exclusion.
			5.5.45.C	Adding new policy to existing text that the individual can establish their own trust on or after December 13, 2016.
	2/1/18	751	5.5.7	This change is to match federal requirements that pre-paid credit and pre-paid debit cards are considered cash on hand for SNAP

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	5/1/19	771	5.5.46.C	Updated excluded trusts
	5/1/20	786	5.5.22	A Note was added explaining that the federal $1200 stimulus payments will not be counted as an asset for 12 months following the month of receipt
	2/15/23	834	5.5.12	Added policy to clarify COVID-19 pandemic-related classified as disaster assistance are permanently excluded as income and excluded as an asset.
			5.5.22	Removed language relating to the 12-month exclusion of assets during the COVID-19 Public Health Emergency.
	2/1/24	846	5.5.12	Added language to the Note for COVID-19 Pandemic-related Disaster Assistance Funds.
	8/1/25	867	5.5.30	Added policy for the asset exclusion of Medicare premium refunds for individuals eligible for DoHS buy-in.
5.6	6/1/19	772	5.6.1.D.2	Losing categorical eligibility due to substantial lottery and gaming winnings.
	12/1/19	779	5.6.1.H	How an AG becomes disqualified due to receipt of substantial lottery and gaming winnings. Clarified lottery winnings
	10/1/20	794	5.6.3.A	Replaced word illegal/ineligible
5.7	10/1/21	809	5.7.1.D	Updated Length of Disqualification for SNAP
	10/1/22	828	5.7.1.D	Updated Length of Disqualification for SNAP
	10/1/24	855	5.7.1.D	Updated Length of Disqualification for SNAP
App A				
App B				
App C				

5.1 DEFINITIONS

AMORTIZATION SCHEDULE

The schedule of payments for paying off a loan.

ASSETS

Total real and personal property the client has available to meet financial needs, including the value of assets assigned from certain individuals. Assets may be liquid or non-liquid.

ACCESSIBILITY OF ASSETS

A client may not have access to certain assets. In order to be considered an asset, the asset must be owned by, or available to, the client. If the client cannot legally dispose of the asset, it is not treated as an asset.

ANNUITY

An investment contract or agreement, which gives the right to receive fixed, periodic payments, either for life or a specific term of years.

BENEFICIARY

A person to whom benefits are payable.

BONDS

United States (U.S.) Government, municipal, or corporate.

BURIAL FUNDS

Burial funds include revocable burial contracts, revocable and irrevocable burial trusts, cash, savings bonds, and any other separately identifiable assets that an individual states are intended for expenses connected with burial, cremation, or other funeral arrangements.

BURIAL CONTRACT

An agreement in which a provider of funeral services and burial items agrees to provide burial services or other final arrangements.

BURIAL INSURANCE

Insurance with terms specifically stating that the proceeds can be used only to pay burial expenses for the insured individual.

BURIAL SPACES

Conventional gravesites, crypts, mausoleums, urns, vaults, or other repositories that are customarily and traditionally used for the remains of deceased persons.

Burial spaces include the following:

- Headstones, markers, or plaques;
- Burial containers for caskets;
- Arrangements for opening and closing the gravesite; and
- Reasonable maintenance of such spaces.

BURIAL TRUST FUNDS

Assets placed in a trust fund for burial expenses.

CASH SAVINGS

The amount of savings or cash-on-hand held by the client or for him by another person.

CASH SURRENDER OR CASH-IN VALUE

The amount of cash received by the owner of the policy, if redeemed before death of the insured.

See LIFE INSURANCE, FACE VALUE, TERM INSURANCE, and WHOLE LIFE INSURANCE.

CATEGORICALLY ELIGIBLE SNAP ASSISTANCE GROUP (AG)

An AG that is automatically eligible for the SNAP without application of the usual eligibility tests.

CERTIFICATE OF DEPOSIT (CD)

Funds held in an account that specifies a maturity date.

COMMUNITY SPOUSE

A spouse living in the community whose spouse is an institutionalized individual. This definition is used when one spouse is applying for long-term care (LTC) benefits and the other spouse is not and is used in conjunction with the definition of institutionalized spouse.

CONDITIONAL ELIGIBILITY

WV WORKS Only: The period of time during which eligibility is allowed, even though assets exceed the maximum allowable asset limit.

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)

A residential community, also known as a life care community, which offers services for the remainder of an individual's life, with a choice of services and living situations, based on changing needs at each point in time. Individuals that enter these communities sign a long-term contract that includes housing, services, and nursing care, usually provided in one location, enabling seniors to remain in a familiar setting as they age. These service and housing packages parallel independent living, assisted living, and skilled nursing facilities. Seniors who are independent may live in a single-family home, apartment, or condominium within the

continuing care retirement complex. If they begin to need assistance with activities of daily living, (i.e., mobility, eating, bathing, dressing, etc.), they may be transferred to an assisted living or skilled nursing facility on the same site.

CONTRACT BENEFICIARY

Any entity that is named in a contract as the beneficiary.

CONTRACT BUYER

A person who purchases goods or services as specified in a contract.

CONTRACT SELLER

A person, his agent, or his employee who sells, makes available, or provides contracts.

CONVERSION OR SALE OF AN ASSET

The sale or exchange of an asset from liquid to non-liquid or non-liquid to liquid.

CREDITOR

The owner of an agreement (i.e., promissory note) or a property agreement (i.e., land sale contract). A creditor or lender is the seller of the property or holder of a promissory note.

CURRENT MARKET VALUE (CMV)

The amount an asset can be expected to sell for on the open market, in the particular geographic area. Market conditions are reflected in an asset's CMV.

DEBT

Any form of legal indebtedness against an asset, such as mortgages, liens, loans, purchase contracts, and security interests. For purposes of establishing equity value, a debt must be legally recognized as binding on the individual who holds the asset.

DEDICATED ACCOUNT

An SSI recipient, who is under age 18 and has a representative payee, may have a dedicated account, so that back SSI payments can be deposited directly into the account. Social Security Administration (SSA) regulations require that certain such payments be directly deposited. Other payments of the same type are not required to be deposited directly into the account but may be deposited in the dedicated account at the discretion of the representative payee. SSA places certain restrictions on the use of the funds deposited into these accounts. SSI representative payees receive notification from SSA that a dedicated account must be established and also receive notification when an SSI back payment amount is directly deposited.

ELDERLY

- For SNAP and WV WORKS: Age 60 and over
- For Medicaid: Age 65 and over

ENDOWMENT FOR PERPETUAL CARE

A contract for care and maintenance of a gravesite.

EXCESSIVE HOME EQUITY

This definition is used in the determination of eligibility for LTC for Medicaid. Excessive home equity can result in a denial of payment for LTC or waiver services when the equity in the homestead exceeds the current allowable maximum. This amount changes every year.

A denial for excessive home equity is subject to the Undue Hardship Provision.

EXCLUDED

Assets that are not considered when determining asset eligibility.

FACE VALUE

The specified amount payable on death of the insured, usually listed on the front of the policy, is the amount guaranteed and premium terms agreed upon via contract at the time of purchase. When the premium payment specified in the contract has been fulfilled and premium payments continued to be made resulting in additional paid-up insurance, the policy's death benefit, (i.e., face value), has increased and the current amount counted.

See LIFE INSURANCE, CASH SURRENDER OR CASH-IN VALUE, TERM INSURANCE, and WHOLE LIFE INSURANCE.

HOMESTEAD PROPERTY

The dwelling and land on which the dwelling rests, which is not separated by intervening property owned by others. This property does not have to be part of the original purchase. This includes the life estate interest, when it is the life estate holder's home.

IMMEDIATE FAMILY

SSI-Related Medicaid Only: The SSI-Related Medicaid individual's immediate family includes: parents, or adoptive parents; minor or adult children, including minor or adoptive and stepchildren; siblings, including adoptive and stepsiblings. Immediate family also includes the spouse of the above relatives.

INCOME-PRODUCING PROPERTY

Property that is annually producing income consistent with its CURRENT MARKET VALUE.

INDIVIDUAL DEVELOPMENT ACCOUNT (IDA)

An IDA is a special bank account that helps an individual save for his education, the purchase of a first home, or to start a business. The funds are matched by a government or non-profit agency.

INSTITUTIONALIZED SPOUSE

An individual who is institutionalized .and has a spouse living in the community who is not receiving LTC benefits. This definition is used when one spouse is applying for LTC benefits and the other spouse is not and is used in conjunction with the definition of community spouse.

IRREVOCABLE

Impossible to retract, revoke, or annul.

IRREVOCABLE ARRANGEMENTS

Assets that are available for burial and held in an irrevocable burial contract or irrevocable burial trust. Irrevocable contracts and trusts are those that cannot be changed and that do not allow the client access to the assets.

See BURIAL TRUST FUNDS.

JOINTLY OWNED PROPERTY

An asset owned by two (2) or more individuals.

LAND SALE CONTRACT

A contract whereby a landowner enters into a legal agreement to sell property to another person by installment payments. The buyer is entitled to possession and equitable title to the property. The seller or creditor holds legal title until the buyer completes the required payments to fulfill the contract.

LIFE ESTATE

Under a life estate, an individual who owns property and transfers ownership of the property to another individual, while retaining certain rights to it for the rest of his life, or the life of another person. Generally, a life estate entitles the owner of the life estate to possess, use, and obtain profits from the property for as long as he lives. However, actual ownership of the property has been transferred.

LIFE ESTATE HOLDER

The person who benefits from the life estate.

LIFE INSURANCE

A contract whereby one party insures his own life, or the life of another party, for a specified amount of money.

LIQUID ASSETS

Those that are cash or payable in cash on demand, including financial instruments that can be converted to cash.

- Supplemental Security Income (SSI) Medicaid Groups: Liquid assets are those that are cash or that can be converted into cash within 20 working days. National, state, and local holidays are not working days.

See ASSETS and NON-LIQUID ASSETS.

LUMP-SUM PAYMENTS

Non-recurring, recurring, or advance payments. This may include, but is not limited to, Retirement, Survivors, and Disability Insurance (RSDI), stock dividends paid quarterly, or payments from an income disability insurance plan that cover a previous period, but are delayed for medical reports, etc.

MUTUAL FUNDS

A pool of assets managed by an investment company that buys and sells securities and other investments.

NEGOTIABLE AGREEMENT

An agreement whereby the ownership of the instrument itself and its face value can be transferred, (e.g., sold), from one person to another.

NON-EXCLUDED

Assets that are considered when determining asset eligibility.

See EXCLUDED.

NON-HOMESTEAD PROPERTY

Real property, other than the homestead, that the client owns or is purchasing.

NON-LIQUID ASSETS

Those that can be converted, or sold, for cash.

- SSI Medicaid Groups: Non-liquid assets are those that cannot be converted to cash within 20 working days.

See ASSETS and LIQUID ASSETS.

PERSONAL INCOME-PRODUCING PROPERTY

Movable belongings, exclusive of land and buildings, which are annually producing income consistent with their CURRENT MARKET VALUE.

See REAL INCOME-PRODUCING PROPERTY.

PRINCIPAL PLACE OF RESIDENCE

The dwelling the client considers his fixed, established home. The principal place of residence must be a home in which the individual has lived.

PROCEEDS FROM SALE OF HOME

Net amount received by the seller, after satisfaction of all encumbrances and sale expenses.

PROMISSORY NOTE

A written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time, or on demand to another party. It may be given in return for goods, money loaned, or services rendered.

PURE SNAP AGS

Every person included in the SNAP AG receives TANF-funded benefits, SSI, or is authorized to receive information and referral services. Pure SNAP AGs are categorically eligible for SNAP benefits.

REAL INCOME-PRODUCING PROPERTY

Fixed property, including land and buildings, that is annually producing income consistent with its CURRENT MARKET VALUE.

See PERSONAL INCOME-PRODUCING PROPERTY.

REBUTTAL

The process whereby the client refutes the Department of Human Services' (DOHS) presumption of unrestricted access to resources.

RECREATIONAL VEHICLES AND EQUIPMENT

May include, but is not limited to, boats, snowmobiles, campers, camper-trailers, airplanes, and similar equipment that do not meet the definition of a vehicle. Also includes ATVs and similar vehicles that do not require licensing, even though they may be licensed. This does not include sporting equipment or toys.

RESOURCES

Income and assets.

RETIREMENT FUNDS

Funds in an individual account, pension fund, or retirement plan, (i.e., Individual Retirement Account, Keogh Plan, 401(k), Simplified Employee Pension plan, and employer plans).

REVOCABLE

Capable of being revoked, retracted or annulled.

SPOUSES

Persons legally married to each other, under the provisions of West Virginia State law, or those moving to West Virginia from states that recognize their relationship as a legal marriage.

There is no provision in West Virginia State law regarding common-law marriage. Any individual that establishes this type of relationship in a state that recognizes common-law marriages is considered married for DOHS purposes.

The states and cities that recognize common-law marriages are:

Alabama	Colorado	District of Columbia	Iowa	Kansas	Montana
Oklahoma	Rhode Island	South Carolina	Texas	Utah	

Common law marriages are recognized in the following states if established by the date shown.

Ohio	October 1, 1991
Idaho	January 1, 1996
Georgia	January 1, 1997
Pennsylvania	January 1, 2005

Effective October 8, 2014, same-sex marriage is a legal marriage in the state of West Virginia. Same-sex couples legally married after this date are defined as legal spouses for the West Virginia DOHS program purposes. Same-sex couples who move to West Virginia and are legally married under the laws of jurisdiction in which the marriage was celebrated, are recognized as spouses. This includes a civil union, or domestic partnership, only if recognized as legal marriage under the state law where such union was entered into.

STOCKS

A security representing a share of ownership in a business or corporation.

TERM INSURANCE

Insurance policies that do not have a cash surrender value.

See LIFE INSURANCE, CASH SURRENDER OR CASH-IN VALUE, FACE VALUE, and WHOLE LIFE INSURANCE.

TIME DEPOSIT

Any type of account that has a maturity date.

TRUST

Any arrangement in which a grantor transfers property to a trustee(s) with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

- For SSI Medicaid Groups, the term trust also includes any legal instrument or device that is similar to a trust.

Legal Instrument or Device Similar to a Trust: Any legal instrument, device, or arrangement that may not be called a trust under State law, but that is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This may include, but is not limited to, escrow accounts, investment accounts, pension funds, and other similar entities managed by an individual or entity with fiduciary obligations.

TRUSTEE

Person or institution that holds legal title to property for the benefit or use of another.

UNCOMPENSATED VALUE

The CMV, less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of compensation received by the AG.

UNDUE HARDSHIP

Applies to Medicaid LTC groups only. This condition exists with the application of one or more of the following asset policies:

- Excessive home equity;
- Transfer to a non-permissible trust; and/or
- A transfer of assets penalty results in the denial of payment of LTC services and causes the individual to be deprived of medical care to the extent that the individual's health or life would be endangered, or his food, clothing, shelter, or other necessities of life are at severe risk.

When there has been a transferred asset, in order to meet Undue Hardship requirements, the individual must have exhausted all means, legal and otherwise, to receive CMV for and/or to regain the transferred asset. All means, legal or otherwise, refers to action through the court system and/or the voluntary return or recovery of the asset or item. Undue Hardship does not exist when the denial causes the individual inconvenience or might restrict his lifestyle but would not put him at risk of serious deprivation.

UNDUE HARDSHIP COMMITTEE

A standing committee comprised of representatives from West Virginia Bureau for Medical Services (BMS) Policy Unit that determines if an individual's denial for Medicaid LTC Services should be waived due to the individual's Undue Hardship condition as defined above.

UNDUE HARDSHIP PROVISION

This provision only applies to individuals who are denied Medicaid LTC Services due to the application of the excessive home equity, transfer of asset to a non-permissible trust, and/or a transfer of assets penalty. The individual must be *otherwise* eligible for LTC Services.

UNIFORM GIFTS TO MINORS ACT (UGMA)

The State law that allows an irrevocable gift of money or property, made to a minor, to be tax-free. This may also be referred to as Uniform Transfer to Minors Act (UTMA).

VEHICLE

A car, truck, motorcycle, motor scooter, or a camper when the living section of the camper is a permanent part of the motorized section. To be considered a vehicle, it must require licensing to operate on public roadways, not necessarily be licensed. ATVs are treated as recreational vehicles, not as vehicles.

WHOLE LIFE INSURANCE

Insurance policies that have a cash surrender value.

See LIFE INSURANCE, CASH SURRENDER OR CASH-IN VALUE, FACE VALUE, and TERM INSURANCE.

5.2 INTRODUCTION

This chapter contains the policies for determining asset eligibility for Supplemental Nutrition Assistance Program (SNAP), WV WORKS, Aid to Families with Dependent Children (AFDC)-Related Medicaid, and most other Medicaid coverage groups. Instructions for determining the value of assets are included.

The following Medicaid coverage groups have no asset test:

- Parents/Caretaker Relatives
- Deemed Parents/Caretaker Relatives
- Transitional Medicaid
- Extended Medicaid
- Continuously Eligible Newborns
- Supplemental Security Income (SSI) and Deemed (SSI) Recipients, except Pickle Amendment Coverage (PAC) and Pass-Throughs
- Pregnant Women
- Children Under Age 19
- Adult Group
- Breast and Cervical Cancer
- Former West Virginia (WV) Foster Children
- Acquired Immune Deficiency Syndrome (AIDS) Drug Assistance Program

In addition, West Virginia Children's Health Insurance Program (WVCHIP) has no asset test.

Social Security Administration (SSA) determines income and asset eligibility for the following Medicaid coverage groups:

- SSI Recipients
- Deemed SSI Recipients
    - Disabled Adult Children
    - Blind, Disabled – Substantial Gainful Activity (SGA)
    - Essential Spouses of SSI Recipients
    - Disabled Widows and Widowers
    - Drug Addicts and Alcoholics (DA&A)

5.3 COMMON INFORMATION

5.3.1 ESTABLISHING DATE OF ASSET ELIGIBILITY

5.3.1.A Supplemental Nutrition Assistance Program (SNAP)

The asset determination must be made as of the date of application.

If the assistance group (AG) is not determined categorically eligible, and the AG's countable assets exceed the limit on the date of application, the application must be denied. However, the application may subsequently be approved beginning with the date the AG is determined asset eligible, providing all other eligibility requirements are also met as of that date. The Worker must record the reason for denial and any subsequent approval.

5.3.1.B Supplemental Security Income (SSI) Medicaid Groups

The SSI Medicaid Groups include: SSI-Related Medicaid, CDCSP, PAC, QDWI, QMB, SLIMB, and QI1.

The asset eligibility determination for these applications must be made as of the first moment (defined as 12:00 a.m. of the first day) of the month of eligibility.

The client is not eligible for any month in which countable assets are in excess of the limit, as of the first moment of the month. Increases in countable assets during one month do not affect eligibility unless retained into the first moment of the following month.

> **SSI Medicaid Asset Eligibility Determination Example 1:** Mr. Rose applies for SSI-Related Medicaid on April 21. On April 1, he had a savings account of $1,500 and two automobiles: a vehicle that he used for obtaining medical treatment and a second vehicle valued at $575. His total assets on April 1 were $2,075. He advises the Worker that on April 10, he withdrew $125 from his savings account to pay for automobile repairs. Even though on April 10 his assets decreased to $1,950, which is under the $2,000 asset limit, his assets as of the first moment of the month were in excess of the asset limit; therefore, he is not eligible.

If the applicant's assets, as of the first moment of the month, are within the asset limit, and during the month his assets increase to above the asset limit, he is still eligible for that month.

The Worker may use any of the following items to determine first-of-the-month account balances:

- Printed or online bank statements and passbooks;
- The applicant's check register or any bank-issued document. This includes, but is not limited to, ATM transaction receipts and/or deposit and/or withdrawal receipts; and/or
- The account transaction history on a bank's automated telephone customer service line that provides complete transaction information, (i.e., deposits, withdrawals, cleared checks, and transfers to/from the account with transaction dates).

When the applicant states that a check has not cleared the bank, the Worker may use any of the means listed above to verify that the funds are legally obligated.

> **SSI Medicaid Asset Eligibility Determination Example 2:** Mr. Oak's bank statement shows a checking account balance of $1,350 as of May 1, which combined with other countable assets is $2,250 as of the first of the month. Mr. Oak states the statement balance includes his April rent check of $500 to his landlord, but his landlord has not cashed the check. The Worker finds an entry for check number 1345 for $500 written on April 25. He finds that check 1346 is cleared on the bank statement. The Worker also sees that Mr. Oak has written a $500 check for rent on the 25th of each month for the last six months. Because Mr. Oak wrote the check and legally obligated the funds in his account, and his records provide a complete and consistent picture of the account, the Worker deducts the amount of the uncashed check from the May 1 first-of-the-month balance as an encumbrance. The new checking account balance as of May 1 is $850 and Mr. Oak is asset eligible.

5.3.1.C WV WORKS and AFDC-Related Medicaid

The asset determination must be made as of the date of application.

For AFDC-Related Medicaid, when medical coverage is backdated, the asset determination must be made from the first day of the month for which eligibility is being determined. All other eligibility requirements must also be met as of that date.

When there is an increase in countable assets that exceeds the limit, the AG is closed.

5.3.2 WHEN INCOME BECOMES AN ASSET

Money counted as income when received becomes an asset if retained within the month after the month of receipt.

EXCEPTION: The proceeds from the sale of an excluded home are treated according to Section 5.3.5 below.

5.3.3 DETERMINATION OF THE VALUE OF COUNTABLE ASSETS

Only the client's equity, or portion of actual ownership, is considered, unless otherwise specified in Section 5.5 or 5.6.

Equity is determined only as follows:

- Determine the CMV of the asset.
- Multiply the number of installment payments remaining by the amount of the installment payment.
- Subtract the result of the calculation from the CMV. The remainder is the equity value.

When the Worker determines that the equity value of an asset, or of several assets, will increase to above the asset limit before the next redetermination, he must set an eligibility system alert to recheck asset eligibility.

When the client disagrees with the Department of Human Services-determined (DOHS) value of an asset, it is his responsibility to provide verification of the actual value.

5.3.4 ACCESSIBILITY OF ASSETS

A client may not have access to some assets. To be considered an asset, the item must be owned by, or available to, the client and available for disposition. If the client cannot legally dispose of the item, it is not his asset.

Examples of inaccessibility include, but are not limited to, the following:

- Legal proceedings such as, probate, liens (other than those required for financing the asset). Items encumbered, or otherwise unavailable, due to litigation are not considered

assets until the court proceedings are completed and a court decision is reached. The DOHS is required to follow the dictates of the court order.

For Medicaid only: Assets may be marked as inaccessible for clients who are currently declared incapacitated by a physician and have no legal financial power of attorney.

- If a petition for conservatorship has not been filed with a court, assets must be excluded as inaccessible as of the first day of the month of application, for a period not to exceed 30 days. Assets must also be excluded up to three months prior to the month of application, when requested, but not prior to the date of the physician-declared incapacity.

- If a petition for conservatorship is filed with a court, assets must be excluded as inaccessible until the court appoints a conservator or denies the petition for conservatorship

Verification of the physician declaration of incapacity and/or petition filed must be provided prior to entering the asset exclusion. Advanced notice of adverse action is required after an asset accessibility exclusion period ends.

- Property sold with a land sale contract. The property does not belong to the seller as long as a legal contract is in effect.
- Homestead/non-homestead property being purchased by a land sale contract. The property does not have equity value for the buyer until the terms of the contract are fulfilled.
- Acting as the authorized agent of an organization, such as the Treasurer of a church or the President of a community group or town council.
- Joint ownership: The meaning of such ownership may be indicated in one of the following ways:
    - AND - Joint ownership indicated by "and" between the names of the owners. Unless there is evidence to the contrary, each owner is assumed to own an equal, fractional share of the jointly owned asset.

      If the fractional share of the asset is not available to either owner without the consent of the other, and such consent is withheld, the asset is excluded as being inaccessible.

        - <u>For SNAP only</u>: The consent must be withheld by an individual(s) who is not a member of the applicant's AG in order for the asset to be considered inaccessible.

    - OR - Joint ownership indicated by "or" between the names of the owners. The asset is available to each owner in its entirety.

- AND/OR - Joint ownership indicated by “and/or” between the names of the owners. The asset is available to each owner in its entirety.

NOTE: For SNAP, see Section 5.6 for bank accounts jointly owned with deployed service persons.

5.3.5 CONVERSION OR SALE OF AN ASSET

Assets may be either liquid or non-liquid. An asset is converted from one form to another by sale or exchange. In addition, assets may be exchanged for assets of the same form.

5.3.5.A General Instructions

When assets are converted, the Worker must determine if the result of the conversion is an excluded or non-excluded asset. The result of the sale of an asset is never counted as income or as a lump-sum payment to the client. The only exception is when payment is received in installments, rather than in a lump sum. See Chapter 4. Instead, the new or converted asset must be evaluated as any other asset to determine continuing eligibility.

> **Asset Conversion Example:** In July, Miss Redwood becomes disabled and is no longer able to continue the operation of a dress shop in her home. Her home is excluded as homestead property. She applies for SSI-Related Medicaid and becomes eligible in September. Her only assets are those associated with the business (i.e., a cash register, showcases, and mannequins), which were estimated to have a CMV of $1,400 at the time of application. In October, she liquidates these tangible assets and converts them to liquid assets totaling $1,295. The value of the cash is a countable asset, but she is still eligible because it is within the asset limit when considered with other countable assets; it has only changed form, from a non-liquid to a liquid asset.
>
> **Asset Conversion Example:** A WV WORKS client sells a vehicle that is an excluded asset. She receives $1,500 from the sale. She has $700 in other assets, so her assets now total $2,200. She is ineligible for WV WORKS. Even though the vehicle was excluded, the money received in exchange for the vehicle is not excluded and must be counted as an asset.

5.3.5.B Exceptions for Sale of an Excluded Asset

For SSI Medicaid Groups: The proceeds from the sale of an excluded home are excluded if they are used or obligated to purchase and occupy another home by the last day of the third full month following the month of receipt.

> **Example:** If the proceeds from the sale are received January 13, they must be used or obligated by April 30.

The proceeds from the sale of a home are the net payments received by the seller, after satisfaction of all encumbrances and sale expenses.

- Encumbrances include, but are not limited to, mortgages, liens, and any other enforceable claims against the home or seller that must be, and are satisfied to, finalize the sale.
- Sale expenses are all expenses that must be paid by the seller in connection with the sale. They include, but are not limited to:
    - Broker fees;
    - Broker commissions;
    - Legal fees;
    - Mortgage-related fees, such as "points" paid by the seller;
    - Inspection and settlement fees; or
    - Transfer taxes and other accrued taxes paid by the seller.

NOTE: Interest earned on the proceeds from the sale is not excluded.

Treatment of the proceeds depends on whether or not the client intends to purchase another home.

5.3.5.B.1 Client Intends to Purchase Another Home

When the client sells his excluded home and states that he intends to purchase another home, the exclusion applies. The Worker must record that the client has stated this intent and set an alert for the third month following the month in which the client received the proceeds from the sale to verify that the proceeds are obligated or used to purchase another home. The client's statement of intent is sufficient to qualify for the exclusion, unless questionable.

The exclusion does not apply to the portion of the proceeds that exceeds the costs of the purchase and occupancy of another home. Allowable costs need not actually be paid to qualify for the exclusion. However, the individual must have legally obligated himself to pay the costs at some future time in connection with the purchase of another home. Examples of allowable costs of purchase include, but are not limited to, the following:

- Down payments
- Settlement costs
- Loan processing fees and points
- Moving expenses
- Costs of necessary repairs or replacements to the new home's existing structure or fixtures, (i.e., furnace, plumbing, or built-in appliances)
- Mortgage payments on the new home for the time prior to occupancy

NOTE: Mortgage payments made on the new home after occupancy are not excluded.

When an individual has already received the proceeds from the sale of a home when he applies, the proceeds must be used or obligated by the last day of the third full month following the month of receipt.

When the exclusion period expires, the Worker must contact the client to verify the dates and amounts of costs for the new home. Count retained proceeds, not used or contracted before expiration of the exclusion period, are counted as an asset, beginning with the month following the month the exclusion period ends. The period cannot be extended for any reason.

5.3.5.B.2 Client Does Not Intend to Purchase Another Home

If the client indicates he has sold a home and does not intend to purchase another home, the Worker must record the contact and count the net proceeds from the sale as an asset beginning with the month following the month of receipt.

If the client initially does not intend to purchase a new home but changes his mind before the end of the third full month following the month of receipt, the exclusion is applied based on the original three-month period.

5.3.6 COMPENSATION FOR LOSS OR DAMAGE

Settlements for lost or damaged assets or insurance proceeds earmarked for medical expenses, burial costs, replacement, or repair of assets are excluded, provided the client use the money, as intended, in a reasonable period of time. Reasonable is defined as being used in the month of receipt or the month following receipt.

EXCEPTION: For SNAP: Any governmental payments that are designated for the restoration of a home damaged in a disaster are excluded, as long as the AG is subject to a legal sanction if the funds are not used as intended.

> **Example 1:** Ms. Basil receives an insurance settlement of $8,000 as a result of an automobile accident. Of the payment amount, $1,250 is used for medical expenses and $6,000 is used to replace the vehicle destroyed in the accident. Because the insurance settlement has been used as intended, for replacement of the lost asset and reimbursement of medical expenses, only $750 remains as a lump-sum payment.
>
> **Example 2:** A payment of $30,000 from a utility company, due to the loss of Mr. Rose's home through the company's negligence, includes $28,000 for the home and household goods and $2,000 for personal injury. In this case, only the $28,000 can be subject to this exclusion. The $2,000 for personal injury is treated as a lump sum.

EXCEPTION: For SSI Medicaid Groups: Cash or in-kind items received from any source, such as, but not limited to, insurance companies, federal or State agencies, public or private organizations or other individuals, to replace or repair an excluded asset that is lost, stolen, or damaged, and any interest earned on such cash payments, are not counted as an asset for nine months, beginning with the month the cash or in-kind item is received, as long as the client states he intends to replace the asset. If he does not intend to replace the asset, the proceeds received are counted as an asset the month following the month of receipt. Any of the cash and interest that has not been used to repair or replace the excluded asset, after the nine-month period expires, is counted as an asset beginning the following month.

The initial nine-month period may be extended up to an additional nine months, for a total of up to 18 months, if it can be determined the client had good cause for not replacing or repairing the asset. The client is determined to have good cause when circumstances beyond his control prevented the repair, replacement, or the contracting for the repair or replacement of the asset. When an extension is allowed, the unused cash and interest are counted as assets, beginning the month after the good cause extension period ends.

In the event of a presidentially-declared disaster, the 18-month period can be extended for up to an additional 12 months, for a maximum asset exclusion period of 30 months, if:

- *The excluded asset is geographically within the disaster area as defined in the presidential order;*
- *The individual intends to repair or replace the excluded asset; and*
- *The individual presents evidence of good cause as defined above.*

When the client changes his intent to repair or replace the excluded asset, funds previously held for replacement or repair must be counted as an asset effective the first moment of the month following the month the client reports the change of intent.

The cash or in-kind item(s) that is received to replace or repair non-excluded assets, or for personal injury or other purposes, is not excluded, even if the cash or in-kind item is received in conjunction with, and/or from, the same source as the cash or in-kind item intended to replace or repair an excluded asset.

5.4 MAXIMUM ALLOWABLE ASSETS

To be eligible for programs listed below the total amount of countable assets cannot exceed the amounts that are listed in the following chart.

<table>
<tr><th></th><th>SNAP</th><th>WV WORKS</th><th colspan="2">SSI Medicaid, AFDC-Related, Medicaid, PAC, CDCSP</th><th colspan="2">QDWI</th><th colspan="2">QMB, SLMB, QI-1</th></tr>
<tr><td rowspan="2">Size of AG</td><td rowspan="3">$3,000 – all AGs except as below.
$4,500 – at least one Assistance Group (AG) member is age 60 or over, or is disabled, according to Section 1.16 regardless of the size of the AG.</td><td rowspan="3">$2,000 – regardless of the number in the AG.</td><td>1</td><td>2</td><td>1</td><td>2</td><td>1</td><td>2</td></tr>
<tr><td>Asset Limit</td><td>$2,000</td><td>$3,000</td><td>$4,000</td><td>$6,000</td><td>$9,950</td><td>$14,910</td></tr>
<tr><td rowspan="2"></td><td colspan="2" rowspan="2"><u>For AFDC- Related Medicaid</u>: Use the asset limit for the appropriate Needs Group size. Add $50 to the asset maximum for each additional Needs Group member
<u>For SSI Medicaid Groups</u>: In cases involving spouses who are living together, only one of whom is eligible, the asset limit for two persons is used for their combined non-excluded assets.</td><td colspan="4" rowspan="2">NOTE: In cases involving spouses who are living together, only one of whom is eligible, the asset level for two persons is used for their combined non-excluded assets, except when one spouse is a long-term care recipient.</td></tr>
<tr><td>NOTE: For categorically eligible AGs, the asset test is presumed to be met.</td></tr>
</table>

5.5 LIST OF ASSETS

The following alphabetical list identifies items that are considered in determining asset eligibility. Beside each item, there are three boxes. The yes or no in the boxes indicates if the item is an asset for the programs as listed below:

Box 1: Supplemental Nutrition Assistance Program (SNAP)

Box 2: WV WORKS, AFDC-Related Medicaid (Aid to Families with Dependent Children)

Box 3: Supplemental Security Income (SSI) Medicaid Groups: SSI-Related Medicaid, Medicaid Work Incentive (M-WIN), Children with Disabilities Community Service Program (CDCSP), Pickle Amendment Coverage (PAC), Qualified Disabled Working Individuals (QDWI), Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), and Qualified Individual-1 (QI-1)

Example:

Box 1	**Box 2**	**Box 3**
SNAP	WVW, AFDC-Related Medicaid	SSI Medicaid Groups
Yes/No	Yes/No	Yes/No

When a “Yes” or “No” in the box shows an asterisk (*) beside it, special conditions apply, and the narrative must be consulted.

Unless specified in the narrative or marked with an asterisk (*), the comments apply to all programs listed.

For the purposes of Section 5.5, “SSI Medicaid Groups” includes M-WIN, CDCSP, PAC, QDWI, QMB, SLIMB, and QI-1.

NOTE: SSI Medicaid Groups: Liquid assets used in a trade or business are excluded as property essential to self-support.

NOTE: See Chapter 24 for special procedures related to Long Term Care (LTC) Programs. For any program not listed, see Section 5.2. See Chapter 7 for verification information.

5.5.1 ABLE Accounts

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

These tax-exempt savings accounts are available to persons with disabilities to use for qualified disability expenses such as education, transportation, housing, medical, dental care, community-based supports services, employment training and assistive technology. The accounts are only available to individuals who have blindness or a disability that occurred before the age of 26, and they are a recipient of Supplemental Security Insurance (SSI) or Social Security Disability Insurance (SSDI). Individuals can have only one ABLE account, but that account can be established in any State.

Funds in these accounts, including those from 3rd party contributions, are excluded.

Any funds taken out of an ABLE account and placed in another account or held by the client continue to be excluded, and they can be kept by the client and maintain exclusion indefinitely.

5.5.2 AGENT ORANGE COMPENSATION

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

All payments from the Agent Orange Settlement fund, or any other fund established pursuant to the settlement, are excluded by federal law.

5.5.3 ANNUITIES

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	No*	Yes*

SNAP:

The annuity must be accessible to an Assistance Group (AG) member.

AFDC-Related Medicaid and SSI Medicaid Groups:

The amount counted depends upon the status of the annuity and when it was purchased.

5.5.3.A Annuities Purchased Prior to November 1, 2008

The annuity must be revocable or assignable to be an asset.

- Revocable annuity: The value is the amount the purchaser will receive if he cancels the annuity.
- Assignable annuity: The value is the amount for which the annuity can be sold on the open market.
- Irrevocable or unassignable: The value is not an asset.

5.5.3.B Annuities Purchased on or after November 1, 2008

The value of the annuity is as follows.

- Revocable annuity: The value is the amount the purchaser will receive if he cancels the annuity.
- Assignable annuity: The value is the amount for which the annuity can be sold on the open market.
- Irrevocable or unassignable annuity: The value is the amount for which the current or future stream of payments can be sold on the open market.

See Section 24.8 for annuities as a transfer of resources.

LTC MEDICAID ONLY: When an individual is approved for LTC Medicaid and has an excluded annuity described above, for which Medicaid must be the beneficiary, the Worker must fax a copy of the trust document and the Medicaid recipient's name, case number, and name of the recipient's Power of Attorney or legal representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Chapter 24, Appendix E.

5.5.4 BANK ACCOUNTS AND CERTIFICATES OF DEPOSIT (CDs)

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	Yes*	Yes*

5.5.4.A Savings Accounts, Christmas Clubs, Checking Accounts, CDs

For CDs, the amount deposited, plus any accrued interest, minus any penalties imposed for early withdrawal, is counted as an asset.

Some funds held in CDs cannot be withdrawn prior to maturity under any circumstances. In this situation, the certificate is not an asset until the first month after it matures.

For a joint checking or savings account, or jointly owned time deposit, refer to the jointly owned assets section under each program of assistance.

The current month's income deposited in accounts is not counted as an asset for that month. See Section 5.3. Checks dated or posted before the usual check receipt date are treated as if they were received in the usual month of receipt.

SNAP:

- When excluded funds are kept in a bank account with non-excluded money, the normally non-excluded funds are excluded for six months from the date they were placed in the account. After six months, the exclusion ends and all money in the account is an asset.
- Educational funds are excluded for SNAP, even when co-mingled with other funds.
- When a non-AG member deposits his own money, for his own use, into the account of an AG member, the amount remaining in the account on the first day of the next calendar month is counted as an asset for the SNAP AG.

SSI Medicaid Groups:

- See Section 5.5.13 below for educational funds set aside for tuition and other educational expenses.
- Bank accounts and CDs used in a trade or business are excluded as property essential to self-support.

5.5.4.B Dedicated Account for SSI Recipient

WV WORKS and SSI Medicaid Groups:

- When the SSI recipient is under age 18 and the Social Security Administration (SSA) requires the establishment of a dedicated account for past due monthly SSI payments, the amount in the dedicated account is excluded as an asset. This applies when the back-payment amount is deposited by SSA directly in the account and when it is deposited there at the discretion of the representative payee. These accounts may include checking, savings, and money market accounts. The exclusion continues until all funds in the account are depleted, or until SSA determines the account no longer meets

the SSA criteria for a dedicated account. The exclusion continues after the SSI recipient reaches age 18, as long as the account remains a dedicated account.

- If the funds are commingled with any other funds, except accumulated earnings or interest from the account, the exclusion does not apply to any portion of the account.

For SNAP see Section 5.6.1.

5.5.4.C HUD FSS Escrow Accounts and Individual Development Accounts (IDA)

Funds in either a Housing and Urban Development (HUD) Family Self-Sufficiency (FSS) Escrow Accounts or an IDA, as well as any disbursements made prior to program completion, are excluded.

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	No*

Any disbursement made upon completion of the program is treated as a lump-sum payment.

5.5.4.D TANF-Funded and Demonstration Project IDAs

Both Temporary Assistance for Needy Families (TANF)-funded and demonstration project IDAs are excluded by federal law for all programs.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.5 BONDS – U.S. SAVINGS

The cash-in value is counted.

SNAP	WVW, AFDC-Related	SSI Groups
Yes	Yes	Yes*

SSI Medicaid Groups:

A U.S. Savings Bond is not an asset during its six-month minimum retention period. As of the first moment of the seventh month, the bond is considered an asset. If an individual receives a bond as a gift, see Section 4.3, U.S. Savings Bonds.

5.5.6 BURIAL FUNDS AND PLOTS

5.5.6.A Burial Funds

Money set aside to pay for funerals and related expenses may be counted as an asset. When set up as a trust, prepaid burials can be paid for by cash, insurance policies, or annuities.

SNAP	WVW, AFDC-Related	SSI Groups
See Section 5.6		

For treatment of burial funds by program, see Section 5.6.

5.5.6.B Burial Plots

SNAP, WV WORKS, and AFDC-Related Medicaid:

One burial space, regardless of the type, per AG member is excluded.

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	No*

SSI Medicaid Groups:

Burial spaces that are intended for the use of the client, spouse, or any member of the immediate family, are excluded.

The immediate family includes:

- Parents, including adoptive parents;
- Minor or adult children, including adoptive, and stepchildren; and
- Siblings, including adoptive and stepsiblings.

Immediate family also includes the spouse of the above relatives. If the relative's relationship to the client is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply.

> **Burial Spaces Example:** An individual owns burial spaces, two of which are for his brother and sister-in-law. Two years after he purchases the spaces, his brother and sister-in-law divorce. The space originally intended for the sister-in-law is no longer excluded.

5.5.7 BUSINESS AND NON-BUSINESS PERSONAL PROPERTY

5.5.7.A Business Personal Property

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes	No*

SNAP:

- Excluded if used in a business. If not excluded as business property, the equity value is an asset.
- This exclusion continues during periods of unemployment due to physical inability to work as long as the individual intends to return to work when physically able.
- Vehicles and recreational vehicles/equipment are excluded regardless of use.

SSI Medicaid Groups:

The following are excluded as business personal property, regardless of the rate of return:

- Property currently used in a trade or business
- Property used by an individual as an employee for work
- Property required by an employer for work. Examples include, but are not limited to: tools, safety equipment, and uniforms.

The property must be in current use or has been in use, with a reasonable expectation that the use will resume within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition. Verification of the condition is not required. The exclusion ends as of the date the person changes his intent to resume the self-support enterprise or employment for which he uses the property.

> **Excluded Property Example 1:** Ms. Dahlia has a small business in her home making hand-woven rugs. The looms and other equipment used in the business have a CMV of $7,000. Her equity is $5,500 because she owes $1,500 on the looms. The $5,500 equity is excluded because the equipment is used in a business.
>
> **Excluded Property Example 2**: Mr. Woods owns a commercial fishing permit granted by the State Commerce Commission, a boat, and fishing tackle. The boat and tackle have an equity value of $6,500. The $6,500 equity is excluded because the boat and tackle are used in a business.

5.5.7.B Non-Business Personal Property

5.5.7.B.1 Income Producing

SNAP:

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes	No*

Property that is annually producing income consistent with its CMV is excluded. Vehicles and recreational vehicles/equipment are excluded regardless of use. This includes vehicles used as a taxi, truck or a fishing boat. Equipment used by someone who live on a farm and uses the equipment for self-employment is also excluded.

SSI Medicaid Groups:

Up to $6,000 of an individual's equity in personal or real income-producing property is excluded, if it produces a net annual income of at least 6% of the excluded equity.

The minimum amount of net annual income the property must produce is $360.

If the individual's equity is greater than $6,000, only the amount that exceeds $6,000 is counted toward the asset limit, when the net annual income requirement of 6% is met on the excluded equity.

- Net annual income is the gross income from the enterprise, less the cost of doing business for a one-year period.
- If the activity produces less than a 6% return, due to circumstances beyond the individual's control, such as crop failure or illness, and there is a reasonable expectation that the individual's activity will again produce a 6% return, the property is excluded.
- If the individual owns more than one piece of property, and each produces income, each has the 6% rule applied. Then, the individual's equity in all of the properties producing 6% is totaled to determine if the total equity is $6,000 or less. The equity in those properties that do not meet the 6% rule is counted as an asset. If the individual's total equity in the properties producing 6% income is over the $6,000 equity limit, the amount of equity exceeding $6,000 is counted as an asset.

The procedure to determine if the property is excluded is as follows:

- Step 1: Add together the equity value of all personal and real business properties used in one enterprise.

- Step 2: If the Step 1 amount is less than $6,000, multiply that amount by .06. If the Step 1 amount is $6,000 or greater, multiply $6,000 by .06.
- Step 3: Compare the Step 2 amount to the net annual income. If the net annual income is equal to or greater than the amount in Step 2, subtract $6,000 from total equity value of the property(s). The remainder is an asset. If the net annual income is less than the amount arrived at in Step 2, the total equity of the property(s) is an asset.

> **Income Producing Example:** Mr. Aster owns a mobile home, which is not his residence that has a CMV and equity value of $3,000. He owns other property that has a CMV and equity value of $2,000. The mobile home produces a net annual rental income of $750, and the other property produces less than $50 a year. Because the mobile home produces more than a 6% return, its equity value is excluded. Because the other property produces less than a 6% return, its equity value is counted.

EXCEPTION: Property that represents the authority granted by a governmental agency to engage in an income-producing activity is excluded if it is:

- *Used in a trade, business, or non-business income-producing activity; or*
- *Not used due to circumstances beyond the individual's control (i.e., illness), and there is a reasonable expectation that the use will resume.*

5.5.7.B.2 Necessary for Self-Support

SNAP:

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes	No *

Vehicles, recreational vehicles/equipment, and mobile homes are excluded regardless of use.

SSI Medicaid Groups:

Non-business personal and real property is considered essential for an individual and/or his spouse's self-support if it is used to produce goods or services necessary for his daily activities. This property includes real property, (i.e., land), which is used to produce vegetables or livestock for personal consumption only, (i.e., corn, tomatoes, chickens, cattle). Vehicles used solely in a non-business self-support activity (i.e., garden tractor, boat used for subsistence fishing) are included under this policy, but not vehicles as defined in Section 5.5.48 below. Property used to produce goods or services or property necessary to perform daily functions is

excluded, if the individual's equity in the property does not exceed $6,000. The amount of equity in excess of $6,000 is counted toward the asset limit.

> **Necessary for Self-Support Example:** Mr. Crocus owns a small unimproved lot several blocks from his home. He uses the lot, which is valued at $4,800, to grow vegetables and fruit, only for his own consumption. Because his equity in the property is less than $6,000, the property is excluded as necessary to self-support.

5.5.8 CASH ON HAND CASH SAVINGS

SNAP	WVW, AFDC-Related	SSI Groups
Yes	Yes	Yes*

This is a countable asset, except when any portion of it is the current month's income. Once the amount of cash, including cash benefits in an Electronic Benefits Transfer (EBT) account, the balance of unearned or earned income remaining on a pay card or debit card, savings, or cash benefits in an EBT account is determined, any remainder is an asset.

NOTE: For SNAP, pre-paid credit and pre-paid debit cards are considered cash on hand.

SSI Medicaid Groups:

Grants, scholarships, fellowships, gifts, or portions of gifts set aside to pay tuition and other necessary educational expenses are excluded for nine months following the month of receipt. Any portion of these funds used to pay expenses, other than those related to education, is counted as income in the month it is used to pay another expense. See Section 4.14.4.C.

Liquid assets used in a trade or business are excluded as property essential to self-support.

5.5.9 COLLECTIONS

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes	Yes

Goods and personal effects of unusual value such as, but not limited to, expensive china, silver, artwork, antiques, or gun and coin collections.

5.5.10 CONTINUING CARE RETIREMENT COMMUNITY (CCRC)

SNAP:

Admission or entrance fees are countable if refunded at the time the individual leaves the CCRC.

SNAP	WVW, AFDC-Related	SSI Groups
No*	WV WORKS - No AFDC Groups - Yes	Yes

AFDC-Related Medicaid and SSI Medicaid Groups:

Any admission or entrance fee paid to a CCRC, or life care community, is considered an asset if:

- The individual can use the entrance fee to pay for care when other income or assets are insufficient; and
- The individual is eligible for a refund at death or upon leaving the CCRC; and
- The fee does not confer an ownership interest in the CCRC. See Section 5.1 for the definition of a CCRC.

NOTE: The admission or entrance fee is the full amount paid to become a resident of the CCRC.

5.5.11 CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.12 DISASTER ASSISTANCE

Assistance provided as a result of a federally declared disaster. See Section 5.3.6.

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	No*

NOTE: Any pandemic related payment received under the declaration of a public health emergency (COVID-19) is classified as disaster assistance and will not be counted as an asset for the purposes of Medicaid. See 7.3.76 COVID-19 Pandemic-related Disaster Assistance.

5.5.13 EDUCATIONAL FUNDS

5.5.13.A Grants, Loans, and Scholarships

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	No*

When funds are excluded as income, they are also excluded as assets. However, funds that are not used for the intended purpose and are allowed to accumulate beyond the time they were intended to cover, are assets.

SSI Medicaid Groups:

Grants, scholarships, fellowships and gifts or portions of gifts set aside to pay tuition and other necessary educational expenses are excluded for nine months following the month of receipt. Any portion of these funds used to pay expenses, other than those related to education, is counted as income in the month it is used to pay another expense. See Section 4.14.4.C.

5.5.13.B SMART 529 Plan and Pre-Paid College Tuition Plans

SNAP	WVW, AFDC-Related	SSI Groups
No	WVW - No AFDC Groups - Yes	Yes

The cash value of the account, minus any penalty for non-qualified withdrawals, is counted as an asset for the account owner, not the student beneficiary.

5.5.13.C Coverdell Education Savings Accounts

An Individual Retirement Account (IRA) type of account designed to pay education expenses. The cash value of the account, minus any penalty for non-qualified withdrawals, is counted as an asset for the account owner, not the student beneficiary.

SNAP	WVW, AFDC-Related	SSI Groups
No	WVW - No AFDC Groups - Yes	Yes

5.5.14 EITC (EARNED INCOME TAX CREDIT)

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	No*

SNAP:

EITC payments are excluded for 12 months from the date of receipt, if the recipient of the EITC is an AG member at the time of receipt and participates continuously during the 12-month period. AGs that temporarily do not participate for administrative reasons, (i.e., redetermination), but who are otherwise eligible, do not lose the exclusion.

WV WORKS:

EITC payments are excluded in the month of receipt and the following month only. This applies when received as part of the person's pay or as one payment at end of the year.

SSI Medicaid Groups:

Remaining portions of EITC payments are excluded for 9 months following the month of receipt. This applies when received as part of the person's pay or as one payment at the end of the year.

5.5.15 EQUIPMENT ESSENTIAL FOR EMPLOYMENT

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes	No*

SNAP:

Property, such as the tools of a tradesman or the machinery of a farmer, which is essential to the employment or self-employment of an AG member, is excluded. This exclusion continues during periods of unemployment due to physical inability to work as long as the individual intends to return to work when physically able. Property essential to the self-employment of an AG member engaged in farming is excluded for one year from the date he terminates his farming self-employment. Vehicles and recreational vehicles/equipment are excluded regardless of use.

SSI Medicaid Groups:

Property that is required by the individual's employer is excluded, regardless of value, as long as the individual is employed. Examples of this type of equipment include tools, uniforms, safety equipment, and other similar equipment.

Also see Business and Non-Business Personal Property, and Real Property.

5.5.16 FACTOR VIII OR IX BLOOD PRODUCTS LITIGATION, MDL 986, NO. 93-C-7452, ND OF ILLINOIS

See HEMOPHILIA/AIDS SETTLEMENTS AND FUNDS

5.5.17 FILIPINO VETERANS EQUITY COMPENSATION FUND

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.18 GIFT CARDS/CERTIFICATES

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

AFDC-Related Medicaid and SSI Medicaid Groups:

Any unspent balance remaining on a gift card or gift certificate is an asset beginning the month following the month the gift card or certificate is received by the individual UNLESS:

- The individual does not have the right, authority or power to convert or sell the gift card/certificate for cash; AND
- The card or certificate cannot be used to purchase food or shelter.

WV WORKS:

Gift cards are not counted unless the card can be converted to cash or sold. The cash or sale value is considered an asset the month following the month of receipt.

5.5.19 HEMOPHILIA/AIDS SETTLEMENTS AND FUNDS

All payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No*

5.5.19.A Factor VIII or IX Concentrate Blood Products Litigation, MDL 986, No. 93-C-7452, ND of Illinois

SSI Medicaid Groups Only:

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No*

Other assets purchased with funds, such as a home or vehicle, are considered according to the policy for that asset. See Section 5.5.46 for Trusts established with these funds. See Chapter 24 for Transfers of Resources.

5.5.19.B Ricky Ray Hemophilia Funds

SSI Medicaid Groups Only:

SNAP	WVW, AFDC-Related	SSI Groups
No	WVW - No AFDC Groups - No*	No*

Other assets purchased with the funds, such as a home or vehicle, are considered according to the policy for that asset. See Section 5.5.46 for Trusts established with these funds. See Chapter 24 for Transfers of Resources.

5.5.19.C Walker v. Bayer, et al. Settlements

Medicaid Groups Only:

SNAP	WVW, AFDC-Related	SSI Groups
No	WVW - No AFDC Groups - No*	No*

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et at. are excluded. Payments made as a result of an individual release of claims, instead of the class settlement, are excluded when the agreement is signed by all affected parties on or before the later of

December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the persons to whom the payment is to be made.

Other assets purchased with the funds, such as a home or vehicle, are considered according to the policy for that asset. See Section 5.5.46 for Trusts established with these funds. See Chapter 24 for Transfers of Resources.

5.5.20 HIGHWAY RELOCATION ASSISTANCE PAYMENTS AND URBAN RENEWAL RELOCATION PAYMENTS

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.21 HOUSEHOLD FURNISHINGS, PERSONAL EFFECTS, AND PETS

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

Furniture, appliances, personal effects such as clothing, jewelry, and pets are excluded. Certain livestock may also be considered family pets. The Worker and Supervisor must determine on a case-by-case basis whether or not the livestock reasonably qualifies as a pet, taking into account the number of livestock/pets and their usage.

5.5.22 INCOME TAX REFUNDS AND REBATES

SNAP	WVW, AFDC-Related	SSI Groups
Yes	Yes	Yes*

SSI Medicaid Groups:

Refunds for the Child Care Tax Credit are excluded for the SSI-Related groups. Also see EITC.

5.5.23 INDIAN LANDS AND TRUST FUNDS

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	Yes*	Yes*

See Appendix C of this chapter.

5.5.24 INSURANCE SETTLEMENTS

Treated as lump-sum payments, or compensation for loss or damage.

See Chapter 4 and Section 5.3.6

5.5.25 JAPANESE-AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.26 LAND SALE CONTRACT

WV WORKS, AFDC-Related and SSI Medicaid Groups:

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

The property is considered to belong to the buyer or purchaser as long as a legal contract is in effect but has no equity value until the terms of the contract are fulfilled. See Section 5.5.39 below for the Homestead exclusion when the buyer lives on the property.

When an individual holds a land sale contract as a creditor, the outstanding balance of principal payments is an asset unless there is a legal bar to the sale of the contract.

NOTE: If the buyer defaults on the contract, the property is considered to belong to the seller again. The buyer only has equity value in the property after the terms of the contract are fulfilled.

Property sold with a land sale contract is not considered to belong to the seller as long as a legal contract is in effect.

Land Sale Contract Example 1: Mr. Birch sold property with a land sale contract to Mr. Pine. Mr. Birch applies for SSI-related Medicaid and the property is not considered his asset because he has a legal contract in effect.

Land Sale Contract Example 2: Same situation as above, except Mr. Pine defaulted on the contract when he failed to make three payments by the terms of the contract. The property is now considered an asset for Mr. Birch because there is no legal contract in effect.

5.5.27 LIFE INSURANCE (CASH SURRENDER VALUE)

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes	Yes*

SSI Medicaid Groups:

If the face value of all life insurance policies for one individual totals $1,500 or less, the cash surrender values are not counted as an asset. If the face value of all life insurance policies for an individual is in excess of $1,500, the cash surrender values are counted as an asset. The life insurance policy must be owned by the client or by a person whose assets are deemed to him to be counted. If the consent of another individual is needed to surrender a policy for its full cash surrender value, and the consent cannot be obtained, the policy is not an asset. Assignment of a life insurance policy to another individual means consent of that individual is required before it can be cashed.

NOTE: Endowment Life Insurance Policies are considered balloon annuities and subject to a transfer penalty for LTC Services. See Section 24.8.

5.5.28 LIEAP (LOW-INCOME ENERGY ASSISTANCE PROGRAM) AND ENERGY CRISIS INTERVENTION PAYMENTS

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.29 LOANS, NON-EDUCATIONALS

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	Yes*	Yes*

SNAP:

Loans for which there is a verbal or written agreement to repay are excluded.

AFDC-Related Medicaid:

- Loans that meet the definition of Bona Fide loans, as found in Chapter 4, are excluded as assets.
- When an individual holds a loan as a creditor, the outstanding balance of principal payments is an asset unless there is a legal bar to the sale of the loan agreement.

WV WORKS:

- Loans are normally counted as income. However, when a loan is excluded from consideration as income and has not been used for the intended purpose within three months of the date the money is received, the funds remaining at the end of three months are counted as an asset. The remaining amount of a loan that was counted as income in the month of receipt becomes an asset in the month following the month of receipt.
- When an individual holds a loan as a creditor, the outstanding balance of principal payments is an asset unless there is a legal bar to the sale of the loan agreement.

SSI Medicaid Groups:

- Loans received under conditions that preclude their use for living expenses are excluded.
- When an individual holds a loan as a creditor, the outstanding balance of principal payments is an asset unless there is a legal bar to the sale of the loan agreement.

5.5.30 LUMP-SUM PAYMENTS

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	No*	No*

Lump-sum payments are not counted as assets when counted as income.

When a lump-sum payment is received prior to the month of application, the amount remaining during the month of application is an asset. When a lump-sum payment is received by someone being added to an active AG, the amount retained during his month of application is an asset.

SNAP:

Non-recurring lump-sum payments are counted as assets. For recurring lump-sum payments, see Section 4.4.4.

WV WORKS:

- When the SSI recipient is under age 18 and SSA requires the establishment of a dedicated account for past-due monthly SSI payments, any lump-sum SSI back payment amount deposited in the dedicated account is excluded as an asset.
- If the funds are commingled with any other funds, except accumulated earnings or interest from the account, the exclusion does not apply to any portion of the account.

SSI Medicaid Groups:

➢ *SSI Dedicated Accounts*

When an SSI recipient is under age 18 and SSA requires the establishment of a dedicated account for past-due monthly SSI payments, any lump-sum SSI back payment amount deposited in the dedicated account is excluded as an asset. If the funds are commingled with any other funds, except accumulated earnings or interest from the account, the exclusion does not apply to any portion of the account.

➢ *Retirement, Survivors and Disability Insurance (RSDI) and SSI Underpayments*

The payments are excluded for nine months following the month of receipt.

➢ *RSDI and SSI Restitution Payments for Misuse by a Representative Payee*

The payments are excluded for nine months following the month of receipt.

➢ *Medicare Premium Refunds for Individuals Eligible for DoHS Buy-In*

The payments are excluded for nine months following the month of receipt. Effective for refunds issued after June 1, 2025.

5.5.31 MUTUAL FUNDS

SNAP	WVW, AFDC-Related	SSI Groups
Yes	Yes	Yes

5.5.32 NAZI PERSECUTION VICTIMS PAYMENTS

These payments excluded by federal law are made to individuals because of their status as victims of Nazi persecution and may include, but are not limited to:

- Austrian Social Insurance Payments
- German Reparations Payments
- Netherlands WUV Payments

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.33 NORTH VIETNAM – DEPARTMENT OF DEFENSE (DOD) PAYMENTS TO PERSONS CAPTURED AND INTERNED

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.34 PLAN FOR ACHIEVING SELF-SUPPORT (PASS) ACCOUNT

SNAP:

Any PASS account developed for an SSI recipient by SSA is excluded.

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	Yes	No

5.5.35 PENSION AND OTHER RETIREMENT FUNDS

5.5.35.A Cash Value of Pension Funds

SNAP, WV WORKS and AFDC-Related Medicaid:

The cash value of these accounts is excluded, unless removed from the account.

SNAP	WVW, AFDC-Related	SSI Groups
No*	No*	Yes*

SSI Medicaid Groups:

The amount counted is the total cash value of the account or plan, minus the amount of the penalty, if any, that would be applied for the early withdrawal of the entire amount.

Pensions or other retirement funds of spouse's ineligible to be included in the SSI-related Medicaid category because they are not aged, blind, or disabled are not deemed, nor are those belonging to parents or spouses of parents. Once removed from the pension or retirement account, the fund(s) is counted according to the policy for the asset to which it is converted (e.g., bank account, CD).

5.5.35.B 401(k) Plans

SNAP:

The cash value of these accounts is excluded, unless removed from the account.

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes*	Yes*

WV WORKS and AFDC-Related Medicaid:

The amount counted is the total cash value of the account or plan, minus the amount of the penalty, if any, that would be applied for the early withdrawal of the entire amount.

SSI Medicaid Groups:

The amount counted is the total cash value of the account or plan, minus the amount of the penalty, if any, that would be applied for the early withdrawal of the entire amount.

Pensions or other retirement funds of spouse's ineligible to be included in the SSI-related Medicaid category because they are not aged, blind, or disabled are not deemed, nor are those belonging to parents or spouses of parents. Once removed from the pension or retirement account, the fund(s) is counted according to the policy for the asset to which it is converted (e.g., bank account, CD).

5.5.35.C IRA, Keogh, Simplified Employer Pension Plan, or Similar Plans

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes *	Yes *

SNAP:

The following are excluded:

- Tax-preferred retirement accounts such as, but not limited to:
  - Simple 401(k)
  - 501(c)
  - 18, 403(b) plan
  - 457 plan
- Federal Employee Thrift Savings plan
- Keogh plan
- IRA
- Roth IRA
- SIMPLE IRA
- Simplified Employer plan
- Profit sharing plan
- Pension or traditional defined-benefit plan, or
- Cash Balance plans

WV WORKS and AFDC-Related Medicaid:

IRAs, Simplified Employer Pension Plans (SEPs), which are considered to be IRAs, and funds held in Keogh plans that do not involve the AG member in a contractual relationship with individuals who are not AG members, are counted as assets. The amount counted is the total cash value of the account or plan, minus the amount of the penalty, if any, that would be applied for the early withdrawal of the entire amount.

If the KEOGH Plan is such that individual participants may make withdrawals without affecting in any way other parties who are not AG members, the AG member's funds in the KEOGH Plan, minus any penalty affecting him only, are counted as an asset. The exclusion of the Keogh plan

involving more than one person does not apply if the other persons involved in the Plan are members of the AG.

SSI Medicaid Groups:

The amount counted is the total cash value of the account or plan, minus the amount of the penalty, if any, that would be applied for the early withdrawal of the entire amount.

Pensions or other retirement funds of spouse's ineligible to be included in the SSI Medicaid Group category because they are not aged, blind, or disabled are not deemed, nor are those belonging to parents or spouses of parents. Once removed from the pension or retirement account, the fund(s) is counted according to the policy for the asset to which it is converted (e.g., bank account, CD).

5.5.36 PRODUCE AND LIVESTOCK FOR HOME CONSUMPTION

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.37 PROMISSORY NOTES

The outstanding principal balance of a promissory note is not an asset.

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes *	Yes *

WV WORKS, AFDC-Related and SSI Medicaid Groups:

The outstanding principal balance in the month eligibility is determined is an asset, unless the client submits verification of a legal bar to the sale of the agreement or an estimate from a knowledgeable source that shows the CMV of the agreement is less than the outstanding principal balance. Knowledgeable sources include anyone in the business of making such estimates, including, but not limited to, banks or other financial institutions, private investors, and real estate brokers. The estimate must show the name, title, and address of the source. See Section 24.8.2 for promissory notes as a possible transfer of resources for long term care.

5.5.38 RADIATION EXPOSURE COMPENSATION FUND

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.39 REAL PROPERTY

Also see BUSINESS and NON-BUSINESS PERSONAL PROPERTY

SNAP	WVW, AFDC-Related	SSI Groups
No*	No	No

See Section 5.3.5 CONVERSION OR SALE OF AN ASSET; COMPENSATION FOR LOSS OR DAMAGE

SNAP:

All real property, mobile homes and timber rights are excluded, regardless of use.

5.5.39.A Homestead Property

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

The client's homestead is the property on which he lives, and which is owned, or is being purchased by him. It is the dwelling and the land on which the dwelling rests, which is not separated by intervening property owned by others. Public rights-of-way that run through the surrounding property and separate it from the home do not affect this exclusion. Any additional property acquired and not separated from the original acquisition by intervening property owned by others is also excluded.

The value of structures on the property, other than the client's dwelling, is included in the exemption whether or not they are income producing, except for mobile homes.

WV WORKS, AFDC-Related and SSI Medicaid Groups:

The value of any mobile home on the homestead property, if it is not the client's dwelling, is considered an asset, unless it is income-producing property. See below.

SSI Medicaid Groups:

Only one dwelling is established as the client's principal place of residence, and only the principal place of residence is excluded. See Section 5.1 for the definition of principal place of residence. When an individual leaves his principle place of residence for any reason, but intends to return to it, the home is excluded. The exclusion is based solely on the individual's intent to return, even if the home is vacant or rented. The individual need not have the ability to return to the home but must simply have the intent.

If an individual leaves the principal place of residence with no intent to return due to domestic abuse, the home continues to be excluded until the individual establishes a new principal place of residence or otherwise takes action rendering the home no longer excludable.

When an individual is institutionalized, his home remains his principal place of residence, regardless of his intent to return, as long as a spouse or dependent relative lives in the home. For purposes of the homestead exclusion only, a dependent relative is one who is dependent financially, medically, or as otherwise determined, upon the institutionalized person. The following are considered relatives of the institutionalized person: child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, including relations of step or half; cousin or in-law.

NOTE: Property being purchased with a land sale contract is considered homestead property if the buyer lives on the property. See Section 5.5.26 above for the equity value of land sale contracts.

When the client has only a life estate interest in his principal place of residence, the value of the life estate interest is excluded. For more information, see below. Temporary absences from the home for trips, visits, hospitalizations, or institutionalization do not affect the homestead exclusion.

5.5.39.B Non-Homestead Property

Treatment of non-homestead property as an asset depends on its use.

SNAP	WVW, AFDC-Related	SSI Groups

No	Yes	No*

5.5.39.B.1 Income-Producing Non-Homestead Property

SSI Medicaid Groups:

➢ Real Property Used in a Business or Trade

All real property currently used in a trade or business is excluded, regardless of value or rate of return.

The property must be in current use or been in use, with a reasonable expectation that the use will resume within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition. Verification of the condition is not required. The exclusion ends as of the date the person changes his intent to resume the self-support enterprise or employment for which he uses the property.

➢ Real Property Not Used in a Business or Trade

See Section 5.5.7.B Non-Business Personal Property above.

➢ Necessary for Self-Support

See Section 5.5.7.B Non-Business Personal Property above.

5.5.39.B.2 Other Non-Homestead Property

The equity in property, not otherwise excluded, is an asset.

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

WV WORKS:

Any non-excluded real property that the AG is making a good faith effort to sell is excluded for six months. A good faith effort means that the property is currently available for sale through a real estate agent or through publication.

The only time this exclusion applies is when the client has agreed in writing, using a DFA-22, to dispose of the property within the six-month exclusion period. Any TANF payments made to the

AG during this disposition period must be repaid to the Department once the client disposes of the asset.

If, for any reason, the client fails to dispose of the property, or the case is closed during the exclusion period, all of the payments made to the AG must be repaid. If, at the end of the six-month period, the client has failed to dispose of the property, it must be counted as an asset.

AFDC-Related Medicaid:

The equity in real property, other than homestead property, is an asset.

SSI Medicaid Groups:

When the client's non-excluded real property is not used in a trade or business or does not meet the $6,000 or the $6,000/6% limitation, the equity in the property is an asset.

5.5.39.C Life Estates

SNAP	WVW, AFDC-Related	SSI Groups
No*	Yes*	Yes*

When the client establishes a life estate with his own property, the property itself is no longer an asset to him because ownership has been transferred. However, the value of the life estate is treated as an asset when it is not the client's principal place of residence. The value is determined as follows:

- Step 1: Determine the CMV of the property.
- Step 2: Determine the age of the life estate holder, as of his last birthday and the life estate factor for that age found in Appendix A. The table contained in the WV State Code is not used; only Appendix A is used.
- Step 3: Multiply the CMV by the life estate factor determined in Step 2.

The resulting amount is counted as an asset for the life estate holder.

If the client believes the life estate is worth less than the determined value, he must provide proof of a lower value.

NOTE: For long-term care cases, a penalty may be applied for transferring property when retaining a life estate or for purchasing a life estate interest in another individual's home. See Chapter 24.

When property is transferred to a client by someone who retains a life estate interest in the property, the transferred property is counted as an asset, unless the client cannot legally dispose of it.

5.5.39.D Real Property Related to Vehicle Maintenance

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes	Yes

5.5.40 RECREATIONAL EQUIPMENT

Recreational equipment is considered personal property. The current market value (CMV) must be used when determining equity. See Section 5.3.3.

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

5.5.41 RECREATIONAL VEHICLES

Recreational vehicles are considered personal property. The current market value (CMV) must be used when determining equity. See Section 5.3.3.

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

EXCEPTION: When the individual lives in his recreational equipment, it is considered his home and is excluded as long as he lives in it.

5.5.42 RICKY RAY HEMOPHILIA FUNDS

See HEMOPHILIA/AIDS SETTLEMENTS AND FUNDS

5.5.43 STOCKS

SNAP	WVW, AFDC-Related	SSI Groups
Yes *	Yes *	Yes *

To establish the CMV of a stock for applicants, the Worker must use the closing stock market price as of the last business day of the prior month. For clients who purchase stocks, the purchase price is used. All policies applicable to stocks also apply to preferred stocks, as well as warrants, rights, and options to purchase stocks.

EXCEPTION: Shares of stock in an Alaskan Native Regional or Village Corporation are excluded for all programs.

NOTE: The par value or stated value shown on some stock certificates is not the market value of the stock.

5.5.44 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

This includes SNAP benefits in an EBT account.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.45 SWIMMING POOLS

- Above-ground

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes	Yes

- In-ground: Excluded if considered part of the homestead

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

5.5.46 TRUST FUNDS

In general, if the client has unrestricted access to the principal of the trust, it must be counted as an asset.

SNAP	WVW, AFDC-Related	SSI Groups
Yes*	Yes*	Yes*

SNAP:

Any funds in a trust or transferred to a trust, and any income produced by that trust, are considered inaccessible to the AG and excluded if:

- The trust arrangement is not likely to cease before the next redetermination and no AG member has the power to revoke the trust arrangement or change the name of the beneficiary before the next redetermination; and
- The trustee administering the funds is either:
  - A court, or an institution, corporation, or organization that is not under the direction or ownership of any AG member, or
  - An individual appointed by the court who has court-imposed limitations placed on his use of the funds that meet all other fund requirements found in this item; and

- Trust investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction, influence of an AG member; and
- The funds held in irrevocable trust are either:
    - Established from the AG's own funds, if the trustee uses the funds solely to make investments on behalf of the trust or to pay education or medical expenses of any person named by the AG creating the trust, or
    - Established from non-AG funds by a non-AG member.

When withdrawals are made from a trust fund, see Chapter 4 for policy about treatment of the withdrawal as income.

Dividends that the AG has the option of either receiving as income or reinvesting in the trust are not assets. See Chapter 4 for treatment of dividends.

A client cannot be required to petition the court for the use of the trust. In addition, this fund cannot be presumed to be available to the client.

WV WORKS, AFDC-Related and SSI Medicaid Groups:

For SSI Medicaid, AFDC-Related and SSI Medicaid Groups, M-WIN, CDCS, PAC, QDWI, QMB, SLIMB, and QI-1, this section applies to any trust established on or after August 11, 1993. For trusts prior to August 11, 1993, see Appendix B of this chapter.

- For WV WORKS, this item applies to any trust established on or after January 1, 1997. Trusts established prior to January 1, 1997, are not counted as assets.

Generally, all trusts are counted as assets, regardless of their purpose, restrictions on distributions, or on the trustee's discretion to distribute the funds, whether acted on or not. There are exceptions to this general rule and there is a difference in the treatment of trusts established by a will and those not established by a will. In addition, sometimes revocable and irrevocable trusts are treated differently. Details are found below.

If a trust is made up of the client's resources and those of one or more other persons, only the amount established with the client's resources is counted.

For purposes of this item, the terms "individual" or "client" include:

- The client
- His spouse
- Any person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse
- Any person, including a court or administrative body, acting at the direction of, or upon the request of, the individual or the individual's spouse

5.5.46.A Trust Established by Will

A trust is treated as an asset only to the extent that it is available to the client. Clauses included in a trust that limit the trustee's use of the funds (e.g., exculpatory clauses) are recognized and the amount of funds affected by such exculpatory clauses is excluded. Irrevocable trusts are excluded, regardless of the amount. There is no penalty for the placement of funds in an irrevocable trust.

5.5.46.B Trusts Not Established by Will

When the following two conditions are met, the trust policy contained below in this item is applied. If the two conditions are not met, the fund is treated as any other bank account.

1. An individual has established a trust when his resources were used to form all or part of the corpus of the trust.
2. Any of the following persons established the trust for the individual by any vehicle other than by will:
    - Individual
    - Individual's spouse
    - A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse
    - A person, including any court or administrative body, acting at the direction of, or upon the request, of the individual or the individual's spouse.

5.5.46.C Excluded Trusts

In the following four trust situations, the trust is totally excluded. In addition, establishment of these trusts is not treated as an uncompensated transfer of resources, as defined in Chapter 24 and Section 5.7.

For excluded trusts 1 and 2 below, the SSA definition of disability is used. Therefore, any person medically approved for or receiving SSI, based on disability, meets the definition, as well as persons who have been determined disabled by the Medical Review Team (MRT). If no

disability determination has been made, the case must be submitted for an MRT decision. See Section 13.8.

1. A trust containing the assets of an individual, under age 65, who is disabled, and which is established for his benefit by a parent, grandparent, legal guardian, or a court. The individual may establish the trust for himself on or after December 13, 2016. The exception continues even after the individual becomes age 65, as long as he continues to be disabled. This is commonly known as a special needs trust. To qualify for the exception, a trust must contain a provision that the State will receive all amounts remaining in the trust upon the death of the individual, up to the total Medicaid payments made on his behalf.
2. A trust that contains the assets of an individual who is disabled and that meets all of the following conditions:
    - The trust is established and managed by a non-profit association;
    - A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools the funds in these accounts;
    - Accounts in the trusts are established solely for the benefit of the disabled individual; and,
    - Accounts in the trusts are established by the individual, his parent, grandparent, legal guardian or by a court.
    - The trust must include a specific provision that amounts remaining in the individual's account that are not retained by the trust upon the client's death, must be used to reimburse the State for Medicaid and/or WV WORKS payments which were made on the individual's behalf.

NOTE: When an individual is approved for Medicaid and/or WV WORKS and has an excluded trust, the State must be the beneficiary. The Worker must fax a copy of the trust document and the client's name, case number and the name of the power-of-attorney or representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Chapter 24, Appendix E.

3. Burial trusts that meet all of the following conditions:
    - The individual signs a contract with the funeral director promising prepayment in return for specific funeral merchandise and services.
    - The contract is irrevocable.

- The individual pays the agreed-upon amount to the funeral director in the form of a direct cash payment, purchase, or transfer of a life insurance policy or annuity that is assigned to the funeral director.
- The funeral director, in turn, places the pre-need payment or device into a trust or escrow account that the funeral director establishes himself. If the client establishes the trust or other device himself, the amount may be considered a transfer of resources. See Chapter 24 and Section 5.7.

4. A trust established with a settlement or funds received from the following:
    - Factor VIII or IX Concentrate Blood Products Litigation, MDL 986, No. 93-C-7452, ND of Illinois
    - Ricky Ray Fund
    - Walker v. Bayer Settlement

5.5.46.D Revocable Trusts

Once the Worker determines that the trust was not established by a will and is not determined to be an excluded trust, the following rules apply:

- The corpus of the trust is considered an available asset.
- Payments from the trust to the client or for his benefit are counted as income.

5.5.46.E Irrevocable Trusts

Once the Worker determines the trust was not established by a will and does not meet one of the exceptions above, the following rules apply:

- If there are any circumstances under which payments from the trust could be made to the client or for his benefit, that portion of the corpus, or the interest, is an asset.
- If payments are made from the available corpus, or interest, to the client or for his benefit, the amount is treated as income.

5.5.46.E.1 Payment for the Client's Benefit

Throughout the Irrevocable Trusts section "payments made on behalf of the client" or "for his benefit" means payments of any kind to another entity, such that the client derives some benefit

from the payment. This may include, but is not limited to, clothing; television; payments for services or care rendered, whether medical or personal; payments to maintain a home, etc. Any payment for the benefit of the client is counted, even if it is not customarily counted in determining Medicaid and/or WV WORKS eligibility.

In determining whether payments can or cannot be made from a trust, take into account any restrictions on payments, such as use restrictions, exculpatory clauses, limits on trustee discretion, etc., that may be included in the trust.

> **Payment for the Client's Benefit Example 1:** A trust provides that the trustee can disburse only $1,000 out of a $20,000 trust. Only the $1,000 is treated as a payment that could be made to the client or for his benefit. The remaining $19,000 is treated as an amount that cannot, under any circumstances, be paid to, or for the benefit of the individual.

In determining whether payments can or cannot be made from a trust, the Worker must take into account restrictions included in the trust on how payments can be made; the Worker must not take into account when payments can be made. When a trust provides, in some manner, that a payment can be made, even though that payment may be sometime in the future, the trust must be treated as providing that payment can be made from the trust.

> **Payment for the Client's Benefit Example 2:** A trust contains $50,000 that the trustee can disburse only in the event that the grantor needs a heart transplant. The full amount is payment that could be made under some circumstances, even though the likelihood of payment is remote if the client does not have heart problems.

5.5.46.F Undue Hardship Caused by Trust

There is a hardship provision for LTC Medicaid that allows the DOHS to exclude a trust when counting it results in undue hardship for the client. All decisions about undue hardship are made by the Undue Hardship Waiver Committee. Any requests for such a determination are submitted in writing and must show complete details about the undue hardship that will result. See "UNDUE HARDSHIP" in Section 5.1 and Section 24.8.

5.5.47 UNIFORM GIFTS TO MINORS ACT FUNDS

SNAP	WVW, AFDC-Related	SSI Groups
Yes	Yes	No

5.5.48 VEHICLES

SNAP	WVW, AFDC-Related	SSI Groups
No	Yes*	Yes*

The owner of a vehicle is generally the individual to whom it is titled. However, when the title of a vehicle is not in the client's name, but the client states he is the owner, the vehicle is counted as the client's asset. If the title is in the client's name, and he indicates the vehicle no longer belongs to him, and the name on the title has not been changed, the vehicle is presumed to be his, unless he can prove otherwise. Only those vehicles of members of the AG, individuals who are disqualified or excluded by law and who would otherwise be required to be included, are considered when determining vehicle assets.

A leased vehicle, in which the individual has no equity and which he cannot sell, is excluded.

The trade-in value is usually used as the CMV for AFDC-Related, SSI Medicaid Groups, and WV WORKS.

See Sections 5.5.40 and 5.5.41 for RECREATIONAL VEHICLES and EQUIPMENT.

The trade-in value is not increased by adding the value of low-mileage or other factors, such as optional equipment or special equipment for the disabled.

Possible sources for obtaining the trade-in value are listed in Section 7.3. Throughout the following items, the term “listed value” refers to the value obtained from one of the sources in Section 7.3.

5.5.48.A SNAP

All vehicles, including recreational vehicles and equipment, as defined in Section 5.1, are excluded for SNAP.

5.5.48.B WV WORKS

For WV WORKS, equity is not a factor in any step of the process to determine countable vehicle assets.

- Step 1: Exclusion of One Vehicle as defined in Section 5.1 per Work-Eligible Individual in the household

  One (1) vehicle per Work-Eligible Individual in the household is excluded regardless of value.

- Step 2: Determining Current Market Value of All Non-Excluded Vehicles

  The listed trade-in value of the vehicle is used, unless one of the following conditions exists:

  - *The client disagrees with the listed value.*

  The client is responsible for obtaining one estimate on form DFA-V-1, Vehicle Estimate. The Department assumes any expense incurred in obtaining this estimate, using form BA-67. If the Department has no objection to the client's estimate, it is accepted as the CMV. The listed value is not used once an estimate of the value has been obtained.

  If the Department determines that the estimate obtained by the client is unreasonable, a second estimate is obtained by the Worker from a qualified appraiser of the Department's choice. Form BA-67 is used to pay for the second estimate. This estimate and the client's estimate are averaged to arrive at the CMV.

  - *The vehicle is not listed.*

  In this situation, the client's statement of the value of the vehicle(s) is accepted unless it appears incorrect. If the client's statement appears incorrect, the Worker requires that the client obtain one estimate. A DFA-V-1 is used, and payment, when required, is made by the Department, using a BA-67.

  If the vehicle is listed as junk with the Department of Motor Vehicles, as indicated on the title of the vehicle, a sale value of $25 is assigned to it, and that amount used as the value.

- Step 3: Determining Asset Value of All Non-Excluded Vehicles

  The CMV as determined in Step 2 above, of all non-excluded vehicles, is counted in its entirety, regardless of the client's equity.

  For child-only cases with SSI adults, one vehicle is excluded.

5.5.48.C AFDC-Related and SSI-Related Medicaid

The following steps are used to determine asset value for AFDC-Related Medicaid:

AFDC-Related Medicaid:

- Step 1: When the AG Has Only One Vehicle

  One vehicle is excluded, provided the equity does not exceed $1,500. When the equity of the vehicle is greater than $1,500, the excess amount is an asset. If the client disagrees with the value or the value cannot be obtained, procedures in Step 2 are followed to determine equity.

- Step 2: Determining Equity in All Vehicles

  The listed trade-in value of the vehicle is used, unless one of the following conditions exists:

  - *The client disagrees with the listed value.*

  The client is responsible for obtaining one estimate on form DFA-V-1, Vehicle Estimate. The DOHS assumes any expense incurred in obtaining this estimate, using form BA-67. If the Department has no objection to the client's estimate, it is accepted as the value used in determining equity. The listed value is not used once an estimate has been obtained.

  If the DOHS determines that the estimate obtained by the client is unreasonable, a second estimate is obtained by the Worker from a qualified appraiser of the Department's choice. Form BA-67 is used to pay for the estimate. This estimate and the client's estimate are averaged to arrive at a value used in determining countable equity.

  - *The vehicle value is not listed.*

  In this situation, the client's statement of the value of the vehicle(s) is accepted unless it appears incorrect. If the statement appears incorrect, the Worker requires that the client obtain one estimate. Form DFA-V-1 is used, and payment, when required, is made by the DOHS, using a BA-67. If the vehicle is listed as junk with the Department of Motor Vehicles (DMV), as indicated on the title of the vehicle, a sale value of $25 is assigned to it, and that amount used as the CMV.

  In determining the countable value of the vehicle(s), only the equity is counted. Once the CMV is determined, the amount of the periodic installment payment is multiplied by the number of payments remaining. The result is subtracted from the CMV to determine the equity. Only when the client indicates he intends to pay off the vehicle

in a lump sum is the pay-off amount used instead of the amount of remaining payments.

- Step 3: Determining Asset Value of All Vehicles

  After equity is determined for each vehicle, $1,500 is subtracted from the one with the highest equity. Any amount in excess of the $1,500 is an asset for that vehicle. In addition, the equity in all other vehicles is counted in its entirety. See Step 1 above.

AFDC-Related Medicaid Vehicle Asset Value Example: A client has three (3) vehicles. The listed values are:

Vehicle A	Vehicle B	Vehicle C
$2,500	$1,500	$1,750

The client disagrees with the listed values of Vehicles B and C. He obtains estimates for Vehicles B and C as follows:

Vehicle B	Vehicle C
$900	$1,200

The DOHS disagrees with the estimate obtained for Vehicle B and obtains another estimate of $1,100.

The values used to determine countable equity are found by using the listed value for Vehicle A, accepting the client-obtained estimate for Vehicle C and by averaging the two estimates for Vehicle B. Therefore, the countable equity is determined as follows:

Vehicle A	Vehicle B	Vehicle C
$2,500	$1,000	$1,200
-300 Owed	-400 Owed	-500 Owed
$2,200 Equity	$600 Equity	$700 Equity

Vehicle A is the vehicle with the highest equity; Vehicle A receives the $1,500 exclusion.

Vehicle A	Vehicle B	Vehicle C
$2,200	$600	$700
-1,500		
700		

Counted toward the asset limit.	Counted toward the asset limit.	Counted toward the asset limit.

Total Vehicle Asset Value = $2,000. The case is asset eligible.

SSI Medicaid Groups:

One vehicle is excluded as an asset for these coverage groups regardless of value, when it is used for transportation of the AG or a member(s) of the AG's household. For SSI-related policy, vehicles used for transportation include, but are not limited to, cars, trucks, motorcycles, boats, snowmobiles, animal-drawn vehicles, and animals. A temporarily disabled vehicle, normally used for transportation, also meets the criteria. The following do not meet the definition of a vehicle for SSI-related Medicaid groups:

- A vehicle with a junked title
- A vehicle only used for recreational purposes, such as a boat or snowmobile

When there is more than one vehicle, the vehicle exclusion is always applied in a manner that benefits the AG. The car with the highest value may not be the vehicle used for transportation; however, it may be excluded for that reason, if it is to the AG's advantage.

SSI-Related Medicaid Vehicle Asset Example: Mr. Pine owns a first vehicle with a CMV of $18,000 and his equity is $1,000. He also owns a second vehicle with equity value of $3,640. This amount exceeds the asset limit. Mr. Pine states he uses the first vehicle for transportation. Based on Mr. Pine's statement, the first car would be excluded for transportation and the equity in the second vehicle would be an asset. However, because the equity in the first vehicle is only $1,000, the second vehicle is excluded for transportation because it is more advantageous to Mr. Pine.

- Step 1: Exclusion Based on Use

  One vehicle is totally excluded, regardless of its value, when it is used for transportation of the AG or a member(s) of the AG's household.

- Step 2: Determining CMV of all non-excluded vehicles.

  The equity value of any other vehicle(s) that is not excluded in Step 1 is an asset, unless the vehicle(s) is excluded by other policy, such as property essential to self-support.

The listed trade-in value of the vehicle is used to determine equity value, unless one of the following conditions exist:

- The client disagrees with the listed value.
- The vehicle value is not listed.

In either of these situations, the client is responsible for obtaining one estimate at his expense on form DFA-V-1, Vehicle Estimate, or providing similar documentation that contains the necessary information to establish CMV. If the DOHS has no objection to the client's estimate, it is accepted as the value used in determining equity. The listed value is not used once an estimate has been obtained.

5.5.49 VIETNAM VETERAN – CHILD BENEFIT

The payments are excluded by federal law.

SNAP	WVW, AFDC-Related	SSI Groups
No	No	No

An allowance under 38 U.S.C., Chapter 12, to a Child of a Vietnam Veteran. This includes:

- Individual with spina bifida who is the child of a Vietnam veteran
- Individual with a covered birth defect(s) who is the child of a female Vietnam veteran

5.5.50 VICTIM COMPENSATION PAYMENTS

SSI Medicaid Groups Only: The payment is excluded for nine months, beginning with the month following the month of receipt.

SNAP	WVW, AFDC-Related	SSI Groups
Yes	WVW - No AFDC-Related - No	No*

5.5.51 WALKER V. BAYER, ET AL. SETTLEMENTS

See HEMOPHILIA/AIDS SETTLEMENTS AND FUNDS

5.6 ASSETS OF PERSONS IN SPECIAL CIRCUMSTANCES

5.6.1 SNAP

The countable assets of the AG include all assets of the AG members and any individuals excluded by law or disqualified, including ineligible noncitizens. See Chapter 3. For information about the assets of non-citizens, see Chapter 15.

When an asset is deemed, the full equity value is deemed with no disregards or deductions applied.

5.6.1.A Assets of Those Disqualified, Ineligible, or Excluded by Law

The assets of non-AG members are not counted in determining the AG's eligibility.

However, ineligible noncitizens, disqualified individuals, and individuals excluded by law must have their assets deemed to the AG. See Section 3.2.1.B for a list of disqualified individuals and those excluded by law.

The same asset exclusions that apply to AG members also apply to ineligible noncitizens and those who are disqualified or excluded by law.

5.6.1.B Assets of Ineligible Students

If a student is found ineligible to participate in Supplemental Nutrition Assistance Program (SNAP) because he does not meet the criteria for student eligibility, his assets are excluded. See Section 3.2.1.E for student eligibility information.

5.6.1.C Jointly Owned Assets

The treatment of jointly owned assets becomes significant when all the joint owners are not included in the AG. An asset is considered jointly owned when the client has an investment in it, or his name appears on it. Also see Section 5.2.

5.6.1.C.1 All Joint Owners Are in the AG

When all joint owners are in the AG, the total equity is counted, unless one of the joint owners is a WV WORKS or Supplemental Security Income (SSI) recipient. See 5.6.1.D.

5.6.1.C.2 All Joint Owners Are Not in the AG

If all of the joint owners are not in the AG, the asset owned jointly is considered available in its entirety to the AG, unless it can be demonstrated that such assets are inaccessible. If the AG can demonstrate that it has access to only a portion of the asset, the value of that portion is counted as an asset.

NOTE: When a client cannot dispose of his share of an asset without the consent of the other owner(s), and the consent is withheld, the asset is excluded as inaccessible.

EXCEPTION: Bank accounts that are jointly owned with deployed service persons are considered inaccessible as long as the AG can document that the access is for the sole purpose of attending to the service person's affairs and cannot be used for the AGs own purposes. See Section 7.3 for verification. If the funds are used for the AG, the account is considered accessible.

All Joint Owners Are Not in the AG Example 1: Three people own a racehorse valued at $20,000. One of them applies for SNAP. The horse cannot be sold without the consent of all three owners and each person may sell his interest only to the other two owners. The other two owners do not want to buy the applicant's interest in the property at this time. The asset is excluded.

All Joint Owners Are Not in the AG Example 2: Same situation as above, except that the agreement does not stipulate that only the other two owners may buy the interest in the asset. One-third of the equity in the property is assigned to the client as an asset.

5.6.1.C.3 Residents of Shelters for Battered Persons

Assets are considered inaccessible to persons residing in shelters for battered persons when:

- The assets are jointly owned with persons they lived with prior to entering the shelter; and
- The shelter resident's access is dependent upon the agreement of a joint owner who still resides in the former household.

5.6.1.D Special Considerations Depending on the AG Composition

5.6.1.D.1 Categorical Eligibility

SNAP AGs that meet the requirements for Categorical Eligibility found in Section 1.4.17, are not required to meet an asset eligibility test.

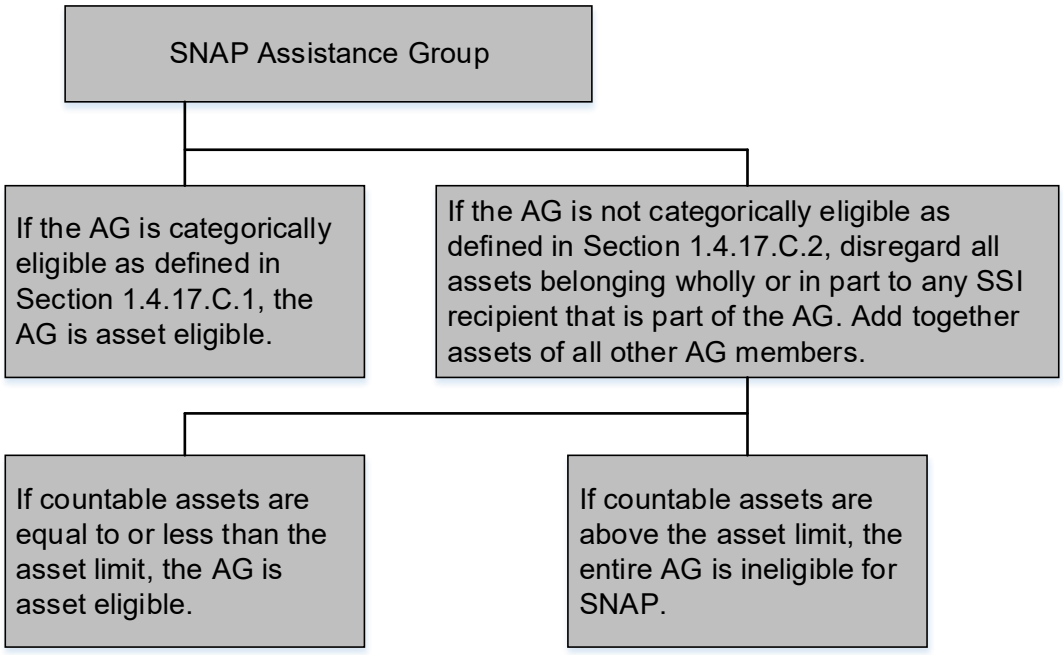
5.6.1.D.2 AGs Not Categorically Eligible

Clients who are included in an AG that has at least one person that is disqualified due to an IPV, or ineligible due to the striker provisions, or is in a penalty for transfer of asset, must meet an asset eligibility test. See Section 1.4.17.

NOTE: An AG who was previously disqualified due to receiving a substantial lottery or gaming winning is not categorically eligible and must meet an asset eligibility test for SNAP.

5.6.1.D.3 Asset Determination Based on AG Composition

The diagram below summarizes the process of determining asset eligibility for SNAP AGs:



NOTE: The asset limits for SNAP, as found in Section 5.6, apply.

5.6.1.E Retroactive Payments

These monies are counted as an asset when retained into the month following the month of receipt.

EXCEPTION: When the Social Security Administration (SSA) requires the establishment of a dedicated account for past-due monthly SSI payments, the amount in the dedicated fund is an excluded asset. This applies, when based on the amount, SSA is required to deposit the funds directly in the dedicated account and when funds are deposited there at the discretion of the representative payee. See Chapter 4 for treatment of disbursements from the dedicated account.

NOTE: This provision does not apply to stocks, bonds, and negotiable financial instruments.

5.6.1.F Low Profit from the Sale of an Asset

In addition to assets that may be considered inaccessible according to the provisions above, an asset that meets one of the following criteria is considered inaccessible and is, therefore, excluded because it cannot be sold for a significant return:

- The asset has an expected sale price of $1,500 or less; or
- The cost of selling the asset will likely result in a return of $1,500 or less. The AG's ownership interest must also be considered when determining the potential return.

This applies to a single asset, not to a combination of assets.

NOTE: An asset cannot be subdivided solely to obtain an exclusion as inaccessible.

5.6.1.G Burial Funds

The value of one funeral agreement per AG member is excluded. In addition, any burial funds in an irrevocable trust are excluded.

5.6.1.H Substantial Lottery and Gaming Winnings

Effective June 14, 2019, an AG who receives an amount greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled member from any single hand, bet or ticket won from any lottery or gaming establishment is ineligible for SNAP. A SNAP recipient is required to report this information within 10 days of the end of the month in which the assistance group received the winnings. All unearned income should count toward the AGs eligibility before taxes and withholdings are taken out. The AG remains ineligible until it meets both the allowable income and asset limits.

NOTE: If multiple individuals shared in the purchase of a ticket, hand or bet, only the portion of the winnings are allocated to the member of the SNAP AG in determining eligibility.

5.6.2 WV WORKS AND AFDC-RELATED MEDICAID

When an asset is deemed, the full countable value is deemed with no disregards or deductions applied.

5.6.2.A Assets of Disqualified/Ineligible Individuals

5.6.2.A.1 AFDC-Related Medicaid

The countable assets used for the AG include all assets of the members of the Income Group, except that the assets of a child are not counted for his sibling(s) or for his parent(s).

Assets of the ineligible stepparent are deemed to the parent, but never to the stepchildren.

The asset limit used for the AG is based on the size of the Needs Group. See Chapter 3 for determining Needs Group composition. Assets of all the members of the Income Group are counted, except that the assets of a child are never counted for his sibling(s) or for his parents.

> **Stepparent Asset Limit Example:** A mother and three children are included in the AFDC-Related Medicaid AG. Her husband, who is the stepfather of the recipient children, and his two dependent children are in the home. The asset limit for the mother is the asset limit for a seven-person Needs Group. The asset limit for the children is the asset limit for a four-person Needs Group.

5.6.2.A.2 WV WORKS

The countable assets of the AG include all assets of the AG members and of individuals excluded by law or disqualified, who would otherwise be required to be included.

The assets of disqualified individuals, those excluded by law, and excluded SSI recipients age 18 or over, who would otherwise be required to be included in the AG, are counted as if they were members of the AG. The WV WORKS asset exclusions are applied, and the remainder is counted. Assets of other ineligible persons are not deemed. For jointly owned assets, see below.

➢ *WV WORKS Individuals Excluded by Law or Disqualified*

Individuals convicted in federal or state court of having made a fraudulent statement or representation about residence to receive TANF, WV WORKS, Medicaid, SNAP, or SSI are ineligible for 10 years from the date of the conviction. The conviction must have occurred on or after August 23, 1996.

Individuals who are fleeing to avoid prosecution, or custody/confinement after conviction, for a felony or an attempt to commit a felony.

An individual convicted of a felony under federal or state law when the offense involves the possession, use or distribution of a controlled substance, as defined in Section 102(6) of the Controlled Substance Act and when the offense occurred on or after August 23, 1996.

Individuals who are violating a condition of probation or parole which was imposed under federal or state law.

A parent(s) or other included caretaker who does not report that a child is, or will be, out of his home for at least 30 consecutive days.

5.6.2.B Jointly Owned Assets

Also see Section 5.4.

5.6.2.B.1 AFDC-Related Medicaid

Treatment of jointly owned assets becomes significant when all the joint owners are not included in the AG.

➢ *All Joint Owners in the AG*

If all joint owners are in the AG, the total equity in the asset is counted as an asset for the AG.

➢ *All Joint Owners Not in the AG*

If all joint owners are not in the AG, the following general rules apply:

- If a non-SSI recipient parent is in the home and is not included in the AG, his assets are available to his spouse and children in their entirety.
- The assets available to the AG from the ineligible parent are:
    - The value of the assets owned solely by the ineligible parent; and
    - The asset value assigned to him as a result of joint ownership.
- The assets considered available to the AG from the ineligible spouse, who is not a parent of the dependent children, is the asset value assigned to the eligible spouse as a result of this joint ownership.
- The assets considered available to the AG from other joint ownership is the countable asset value assigned to the AG member as a result of the joint ownership plus any other assets owned solely by AG members.

> **Asset Example 1:** A woman receives AFDC-Related Medicaid for herself and her children from a previous marriage. She is now remarried and living with her husband. She and her current husband jointly own all their assets (John Oak or Mary Oak). Their countable assets total $3,000. All of this amount is counted as an asset because the woman is in the AG, and because the jointly owned assets are considered available to her in their entirety.
>
> **Asset Example 2:** Same situation as above except that the woman is not included in the AG. Because the jointly owned assets are considered hers in their entirety, and her children are in the AG, all of the $3,000 in assets is counted.
>
> **Asset Example 3:** A woman, separated from her husband, receives AFDC-Related Medicaid for herself and her children. She and her husband jointly owned property and neither can sell his interest in it. Her husband refuses to sell the property and divide the money. The property is excluded, as long as she is unable to sell her interest.
>
> **Asset Example 4:** A woman and her three children apply for AFDC-Related Medicaid. The woman owns her homestead property and another piece of land valued at $600. In addition, she and her sister jointly own property valued at $750. The deed shows the owners as Betty and Wilma Pine. They are trying to sell the property. The value assigned to the applicant is $975, i.e., the total value of the land she owns alone plus ½ of the value of the jointly owned property.

5.6.2.B.2 Assets Jointly Owned by an AFDC-Related Medicaid Client and an SSI Recipient

Treatment of assets jointly owned with an SSI recipient depends on the type of asset.

➢ *Bank Accounts*

When the joint owner, who is an SSI recipient, does not successfully rebut the presumption of ownership through SSA, all account funds are considered to belong totally to the SSI recipient. Otherwise, the portion that SSA determines not be his due to his successful rebuttal is considered to belong to the other joint owner(s).

➢ *Other Assets*

For assets other than bank accounts, unless there is evidence to the contrary, assume that each owner owns only his fractional interest of the shared asset.

5.6.2.B.3 WV WORKS

Treatment of jointly owned assets becomes significant when all the joint owners are not included in the AG.

➢ *All Joint Owners in the AG*

If all joint owners are in the AG, the total countable value of the asset is counted as an asset for the AG.

➢ *All Joint Owners Not in the AG*

If all joint owners are not in the AG, the following general rules apply:

- The non-excluded assets of an individual who is excluded by a law or disqualified, who would otherwise be required to be included, are available to his spouse and children in their entirety.
- The assets available to the AG from the disqualified individual are:
    - The value of the assets owned solely by the disqualified individual; and
    - The asset value assigned to the disqualified individual as a result of joint ownership.
- The assets considered available to the AG from other joint ownership is the countable asset value assigned to the AG as a result of the joint ownership, plus any other assets owned solely by AG members.

All Joint Owners Not in the AG Example 1: A WV WORKS AG consists of a mother, her 2 children, and her husband, who is a stepparent to the children. The mother and her husband are convicted of selling drugs but receive probation. The mother owns a vehicle with a current market value (CMV) of $18,000 and a piece of property she owns jointly with her brother with a total value of $400. Her husband owns a vehicle valued at $700. Even though neither adult qualifies to be included in the AG, their assets are counted for the children as follows: $200 for ½ the value of the mother's jointly owned property. The mother's and husband's vehicles are excluded.

All Joint Owners Not in the AG Example 2: A woman receives WV WORKS for herself and her child. Her husband, who is the child's stepfather, is disqualified. The woman and her husband own a piece of property in Ohio. They own this property jointly with the woman's brother, who currently lives in a trailer on the property. Each owns an equal share of the property that has a CMV of $1,550. Each person's share of the CMV of the property is $516.66. The woman's share is counted as an asset because she is included in the AG. The stepfather is disqualified, but his share still counts for the AG because he would normally be required to be included in the AG. The woman's brother's share is not counted as an asset; he does not live with the AG, is not included and is not required to be included. The total amount counted as an asset from this property for the AG is $1,033.32 or $1,033.

5.6.2.C Special Considerations Depending on AG Composition

For AFDC-Related Medicaid Only: Assets of a child are never counted for sibling(s) or for a parent(s), even though the child is included in the Needs Group of his sibling(s) and parent(s).

5.6.2.D Retroactive Payments

Retroactive payments are counted as an asset when retained into the month following the month of receipt.

5.6.2.E Burial Funds

5.6.2.E.1 WV WORKS

Burial funds of up to $1,500 for each AG member may be excluded, provided any amount in an irrevocable burial trust is excluded in its entirety first. This limits the amount of other excludable burial funds.

- If the irrevocable trust is $1,500 or more, no other burial funds may be excluded.
- If the irrevocable trust is less than $1,500, the difference between $1,500 and the irrevocable trust may be excluded.

To qualify for all or a portion of the $1,500 exclusion, burial funds must be formal agreements, such as burial contracts, burial trusts, or other funeral arrangements. Bank accounts, money set aside for burial and the cash surrender value of life insurance policies are not considered burial funds; they are countable assets.

5.6.2.E.2 AFDC-Related Medicaid

See Section 5.6.3.D below. For these coverage groups, the $3,000 limit on burial funds applies to each member of the AG.

5.6.3 SSI MEDICAID GROUPS

When an asset is deemed, the full equity value is deemed with no disregards or deductions applied.

5.6.3.A Assets of Disqualified/Ineligible Individuals

Assets of disqualified/ineligible individuals are deemed. The method of deeming depends on whether the individual is an adult or a child.

5.6.3.A.1 Adults

To determine the countable assets of the AG, the assets of spouses, including non-qualified noncitizens, who are living together are combined.

Assets of an SSI Medicaid Group recipient and his spouse who lives with him are added together and compared to the asset level for two.

5.6.3.A.2 Children

When the child lives with one parent, including a non-qualified non-citizen, and there is no stepparent, all assets of the parent that exceed the asset limit for one person are deemed to the child. The child's assets are then compared to the asset limit for one.

When the child is living with both parents, or a parent and stepparent, including a non-qualified noncitizen, assets of the parent(s) and/or stepparent that exceed the limit for two are deemed to the child. The child's assets are compared to the asset limit for one.

> **Child Asset Example:** An application for a 10-year-old child is submitted for SSI-Related Medicaid. He is living with his mother, his stepfather, and two minor dependent sisters, none of whom are Medicaid eligible. The child's assets are $500. The combined assets of the mother and stepfather are $4,000. The asset limit for 2 is $3,000. Assets of $1000 are deemed to the child whose total assets are now $1500. The asset limit for one person is used to determine the child's asset eligibility.

For CDCSP, only the child’s own assets are counted.

5.6.3.B Jointly Owned Assets

The treatment of jointly owned assets depends upon the relationship of the joint owners and whether or not all the joint owners are included in the AG.

5.6.3.B.1 Joint Ownership by Spouses

For spouses, joint ownership is not the deciding factor.

➢ *Spouses Who Live Together*

For spouses who live together, the assets of one spouse are counted in their entirety for the other spouse. The asset limit for two is used.

➢ *Spouses Who Do Not Live Together*

For spouses who do not live together, only the jointly owned assets that are accessible to the applicant are counted toward the asset limit. The asset limit for one is used.

When one spouse is institutionalized, assets are treated as though they live together, even if they lived apart prior to institutionalization. See Chapter 24 for long term care applicants.

5.6.3.B.2 Joint Ownership with an SSI Recipient

Treatment of assets jointly owned with an SSI recipient depends on the type of asset.

➢ *Bank Accounts*

When the joint owner, who is an SSI recipient, does not successfully rebut the presumption of ownership through SSA, all account funds are considered to belong totally to the SSI recipient. Otherwise, the portion that SSA determines not to be his due to his successful rebuttal is considered to belong to the other joint owner(s).

➢ *Other Assets*

For assets other than bank accounts, unless there is evidence to the contrary, assume that each owner owns only his fractional interest of the shared asset.

5.6.3.B.3 Joint Ownership with Other SSI Medicaid Group Clients

When the joint owners include more than one applicant or client of an SSI Medicaid Group who are not spouses, the equity value of the asset is divided by the number of SSI Medicaid, M-WIN, CDCS, PAC, QDWI, QMB, SLIMB, or QI-1 clients, regardless of the number of other joint owners. The result is counted as an asset for each client.

5.6.3.B.4 Joint Ownership by Others

When all of the following conditions apply, jointly owned assets are counted in their entirety for each owner.

- Joint ownership is indicated by use of the word “OR.” See Section 5.3.4.
- The joint owners are not spouses.
- One of the joint owners is not an SSI recipient.
- The joint owners are not SSI Medicaid, M-WIN, CDCSP, PAC, QDWI, QMB, SLIMB, or QI-1 clients.
- The client has not successfully rebutted the presumption of full ownership.

5.6.3.B.5 Rebuttal When Client Denies Ownership of Assets

When the client has unrestricted access to assets, his ownership is presumed even though he does not consider himself an owner. He must be allowed to rebut the Department's presumption of ownership.

5.6.3.B.6 Evidence Necessary for Rebuttal

The client must provide the following evidence to rebut the presumption of ownership:

- A statement written by the client giving his explanation of ownership of the asset and the reason the asset is not accessible to him. In addition, when the asset is a bank account or certificate of deposit, the Worker must document who made deposits to and withdrawals from the account and who benefited from the funds.
- Corroborating statements from the other owners. However, if the joint owner is incompetent or a minor, it is not necessary to obtain a corroborating statement.
- Proof of change in the asset ownership designation that removes the client's name as an owner or restricts his access to the asset.

5.6.3.C Retroactive Payments

These are counted as an asset when retained as of the first moment of the month following the month of receipt, with the exception of the following.

- ***Retirement, Survivors and Disability Insurance (RSDI) and SSI Underpayments***

The payments are excluded for nine months following the month of receipt.

- ***RSDI and SSI Restitution Payments for Misuse by a Representative Payee***

The payments are excluded for nine months following the month of receipt.

5.6.3.D Burial Funds

A client may retain a maximum of $3,000 in burial funds for himself. He may also retain the same amount for his spouse. These funds may be in the form of money set aside for burial (maximum of $1,500, not comingled with other funds), face value of life insurance policies, revocable or some irrevocable burial trusts or prepaid funeral contracts, etc.

Burial trusts are treated like any other trust funds, unless all of the following conditions are met:

- The individual signs a contract with the funeral director promising prepayment in return for specific funeral merchandise and services. Such goods and services must be listed.
- The contract is irrevocable.
- The individual pays the agreed-upon amount to the funeral director in the form of a direct cash payment, purchase, or transfer of a life insurance policy or annuity that is assigned to the funeral director.
- The funeral director, in turn, places the pre-need payment or device into the trust or escrow account that the funeral director establishes himself. If the client establishes the trust or other device himself, the amount may be considered a transfer of resources. See Chapter 24.
- The client is expected to receive goods and services with a total CMV at least equal to the amount he paid.

When all of these conditions are met, burial funds are excluded in their entirety for the client and/or his spouse.

The exclusion is determined by the following method, with irrevocable burial funds being used for the exclusion before any other funds.

- Step 1: $3,000 Maximum Burial Exclusion
- Step 2: Subtract irrevocable burial trusts, irrevocable burial contracts, or any other irrevocable burial agreements.
- Step 3: Subtract face value of all life insurance policies whether or not these policies are also counted as assets.
- Step 4: Subtract revocable burial trusts and any other revocable burial agreements; money set aside for burial (maximum of $1,500, not comingled with other funds).
- Step 5: This is the remaining amount of other assets that may be excluded for burial.

Burial Fund Example 1: An unmarried man applies for Medicaid. He has $1,800 set aside for burial and he has just established an irrevocable pre-need burial trust, in the amount of $2,000. This totals $3,800 in burial funds. Because he cannot access any of the money in the pre-need burial trust, it is excluded first as part of the $3,000 burial exclusion. Of the $1,800 in funds set aside for burial, only $1,000 is excluded. The remaining $800 is counted as an asset and must be removed from the account so that it is not comingled with the burial fund.

Step 1:	$3,000	Maximum burial exclusion
Step 2:	-2,000	Irrevocable burial fund exclusion
	$1,000	Remaining burial exclusion
Step 3:	- 0	Face value of all life insurance
	$1,000	
Step 4:	- 1,800	Money set aside for burial
	-$800	Counted as asset, must not be co-mingled

Burial Fund Example 2: A married couple purchased an irrevocable pre-need funeral trust for $20,000 from a funeral home. The director of the funeral home placed the funds in an irrevocable arrangement of $10,000 for each person. Because each irrevocable trust exceeds the $3,000 burial fund exclusion, no additional funds are excluded. The excess $7,000 in each irrevocable trust is not an asset.

In addition, each has $1,500 set aside for burial. However, the $1,500 set aside for burial for each person cannot be excluded because the irrevocable burial trust meets and exceeds the maximum allowable exclusion. The couple, therefore, has countable assets of $3,000.

Burial Fund Example 3: Same as example above except each person placed $10,000 in an irrevocable trust for burial purposes that do not meet the standard for a pre-need burial trust. The $3,000 maximum burial fund exclusion is excluded from the $10,000 irrevocable burial fund for each. The remaining excess $7,000 in each irrevocable trust is not an asset, because it is not accessible to him.

5.7 TRANSFER OF ASSETS

5.7.1 SNAP

There is a penalty when an Assistance Group (AG) member or an individual excluded by law or disqualified, knowingly transfers assets for the purpose of qualifying for the Supplemental Nutrition Assistance Program (SNAP). Supervisory approval is required before notification of disqualification is sent to the client.

5.7.1.A Permissible Transfers

Eligibility is not affected by transfers of assets when:

- Would otherwise not affect eligibility, such as personal effects, any item excluded in Section 5.5, etc.; or
- The household meets the requirements for categorical eligibility; or
- Are sold or traded at or near the Current Market Value (CMV); or
- Are transferred for other purposes, other than to qualify for SNAP; or
- Are transferred between members of the SNAP AG.

> **Permissible Transfers Example:** Placing funds in an irrevocable burial trust fund.

NOTE: The assets of a Supplemental Security Income (SSI) recipient are excluded in a mixed SNAP AG. See Section 5.5. Therefore, a transfer from a non-SSI recipient to an SSI recipient could be a transfer of assets and any such transfer must be explored.

5.7.1.B Applicants

If the applicant has transferred assets within the three-month period immediately preceding the date of application with the intent to qualify for SNAP, the AG is disqualified from participation in SNAP for up to one year from the date the transfer is discovered.

5.7.1.C Clients

If a client transfers an asset, the AG is disqualified from participation for up to one year from the date the transfer is discovered.

5.7.1.D Length of Disqualification

The length of the disqualification period is based on the amount by which the client's total retained assets and those transferred exceed the appropriate asset limit.

The chart below is used to determine the disqualification period:

Amount in Excess of the Asset Limit	Disqualification Period
0 – 249.99	1 month
250 – 999.99	3 months
1,000 – 2,999.99	6 months
3,000 – 4,999.99	9 months
5,000 – and up	12 months

> **Length of Disqualification Example 1:** If a one-person AG, with a bank account of $2,175, transfers bonds with a cash value of $1,000. The $2,175 bank account plus $1,000 in bonds equals $3,175. Subtract the $3,000 asset limit from this amount to arrive at $175. Use the $175 to determine the disqualification period.

The disqualification period begins as follows:

- Application: The month of application.
- Active Case: With the first issuance after discovery, or the following month after the adverse action period.
- Closed Case: If the transfer occurs prior to closure, disqualification begins when the AG reapplies and is found otherwise eligible. If the transfer occurs after closure, the client is treated the same as any other applicant upon reapplication.

> **Length of Disqualification Example 2:** A one-person AG has $3,250 in a savings account. He transfers $600 to qualify for SNAP. To determine his disqualification period, consider the total asset value of $3,250. The countable asset of $3,250 less the $3,000 asset limit, equals the amount in excess of the asset limit or $250. The disqualification period is three months.

5.7.2 WV WORKS

A transfer of asset penalty may be imposed if the client gives away or transfers assets without receiving CMV.

For purpose of WV WORKS, the following information applies.

CURRENT MARKET VALUE (CMV)

The amount an asset can be expected to sell for on the open market, in the particular geographic area. Market conditions are reflected in an asset's CMV.

> **CMV Example:** A transfer for love and consideration is not considered a transfer for CMV. Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free, at the time, were intended to be provided without compensation. Therefore, a transfer to a relative for care provided in the past normally is not a transfer of assets for CMV. However, an individual may rebut this presumption.

FOR THE SOLE BENEFIT OF

A transfer is considered to be for the sole benefit of a spouse, disabled child, or a disabled individual under age 65 if the transfer is arranged in such a way that no individual, except the spouse, child or individual, can benefit from the transferred asset(s) in any way, either at the time of the transfer, or at any time in the future, except when the Department of Human Services (DOHS) is named as the primary beneficiary. The agreement must be in writing.

Similarly, a trust is considered to be established for the sole benefit of one of these individuals if the trust benefits no one but the individual, either at the time of the establishment of the trust, or any time in the future, except when the Department is named as the primary beneficiary. However, the trust may provide for reasonable compensation for a trustee to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

If a beneficiary is named to receive the funds remaining in a trust upon the individual's death, the transfer is considered made for the sole benefit of the individual if the Department is named as the primary beneficiary for up to the amount paid in benefits to the individual. The designated beneficiary receives any remaining amount.

LOOK-BACK DATE

The look-back date is the earliest date for which a penalty for transferring assets for less than CMV can be applied. Penalties can be applied for transfers that take place on or after the look-back date. Penalties cannot be applied for transfers that take place prior to the look-back date.

When an individual applies more than once (e.g., he applies and is denied due to excess assets and applies again later), the look-back date is based on the first date on which the individual applied for WV WORKS.

The look-back date establishes the look-back period.

5.7.2.A Look-Back Period

The length of time for which the Worker looks back for any asset transfers depends upon whether or not a trust fund was involved.

5.7.2.A.1 Trust Amounts Treated as Uncompensated Transfers

The look-back period is 60 months for amounts in revocable or irrevocable trusts that are considered transferred. The time period begins the month the client applies for WV WORKS.

Irrevocable agreements may result in an asset becoming inaccessible to the client.

5.7.2.A.2 Other Transfers

The look-back period is 36 months. The time period begins the month the client applies for WV WORKS.

5.7.2.B Permissible Transfers

The following transfers do not result in a penalty for transferring assets. See Section 5.5.46.

5.7.2.B.1 Transfer to a Trust

When an AG member transfers assets to a trust that is excluded from consideration as an asset, no penalty is applied.

5.7.2.B.2 Transferred Assets Returned

When all assets transferred for less than CMV have been returned to the client, no penalty is applied. However, if a penalty has already been applied or has already started, a retroactive adjustment back to the beginning of the penalty period is required. The client is not necessarily asset-eligible once the resources are returned.

If parts of such assets are returned, the penalty period is adjusted accordingly.

5.7.2.B.3 Client Intended CMV or Other Value Consideration

When the client can demonstrate that he intended to dispose of the asset for CMV or for other valuable consideration, no penalty is applied.

5.7.2.B.4 Transfer Was Not to Qualify for WV WORKS

When the asset(s) was transferred exclusively for a purpose other than to qualify for WV WORKS, no penalty is applied.

5.7.2.C Transfers That Are Not Permissible

All transfers not specifically permissible as stated above result in the application of a penalty. This also applies to jointly owned assets.

The jointly owned asset, or the affected portion of it, is considered transferred by the client when any action is taken that reduces or eliminates the client's ownership or control of the resource.

5.7.2.D Transfer with Retention of a Life Estate

A transfer of property with the retention of a life estate interest is treated as an uncompensated transfer.

To determine if a penalty is assessed and the length of the penalty, the Worker must compute the value of the transferred asset and of the life estate, then calculate the difference between the two.

- Step 1: To determine the value of the transferred asset, subtract any loans, mortgages or other encumbrances from the CMV of the transferred asset.
- Step 2: Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Appendix A of this chapter. Multiply the CMV of the transferred asset by the life estate factor. This is the value of the life estate.
- Step 3: Subtract the Step 2 amount from the Step 1 amount. The result is the uncompensated value of the transfer.
- Step 4: Divide the Step 3 amount by 100% current federal poverty level (FPL) for the AG size. The result is the number of months the penalty covers.

5.7.2.E Transfer to Purchase an Annuity

Establishment of an annuity is sometimes treated as a transfer of assets, depending on whether or not the annuity is actuarially sound. The average number of years of expected life remaining for the individual who benefits from the annuity must coincide with the life of the annuity for it to be actuarially sound and, thus, not treated as an uncompensated transfer of assets.

If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive CMV. The annuity is not, then, actuarially sound and a transfer of assets for less than CMV has taken place.

The transfer is considered to have occurred at the time the annuity was purchased. Only the amount that is not actuarially sound is treated as an uncompensated transfer. Life Expectancy Tables are found in Chapter 24, Appendix D.

> **Annuity Example 1:** A 30-year-old father who won $500,000 in the lottery, purchases a $500,000 annuity that is to be paid over 40 years. His life expectancy, according to Chapter 24, Appendix D, is 44.06 years. The annuity is actuarially sound, so no transfer of resources has taken place.

> **Annuity Example 2:** A 60-year-old grandmother, who is the caretaker for her grandchildren, requests to be included in the payment. She purchases a $50,000 annuity to be paid over 25 years. According to Chapter 24, Appendix D, her life expectancy is only 22.86 years. Therefore, the amount that will be paid out by the annuity for 2.14 years is considered an uncompensated transfer of assets that took place at the time the annuity was purchased.

5.7.2.F Transfer Penalty

The transfer of assets penalty is ineligibility for a WV WORKS payment.

5.7.2.F.1 Calculating Length of Penalty

The penalty period lasts for the number of whole months determined by the following calculation:

$$\frac{Total\ amount\ transferred\ during\ the\ look-back\ period}{100\%\ of\ the\ current\ FPL\ for\ the\ AG\ size}$$

When the amount of the transfer is less than the FPL amount, no penalty is applied until a series of transfers totals more than the FPL amount.

The penalty runs continuously from the first day of the penalty period, whether or not the client continues to receive benefits.

There is no maximum or minimum number of months a penalty may be applied.

5.7.2.F.2 Start of the Penalty

The penalty period starts the month in which the asset is transferred, as long as that month does not occur in any other period of ineligibility due to a transfer of assets penalty. If the month the asset is transferred falls into another such penalty period, the penalty period begins the month after the previous penalty period ends.

When a single asset is transferred, or a number of assets are transferred at the same time, the penalty period is determined by adding together the total uncompensated value of the asset(s) and dividing as shown below. When resources are transferred at different times, the following general guidelines are used.

➢ *When Penalty Periods Would Overlap?*

When assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the value of all assets transferred, and divide by 100% FPL for the AG size. This produces a single penalty period that begins on the first day of the month in which the first transfer was made.

> **Penalty Calculation Example:** An individual transfers $10,000 in January, $10,000 in February, and $10,000 in March. Calculated individually, based on a 100% FPL of $1,111 a month, the penalty for the first transfer is from January through September, the second is from February through October, and the third is from March through November. Because these periods overlap, the Worker must calculate the penalty periods by adding the transfers together (a total of $30,000) and dividing by the FPL ($1,111). The penalty period is 27 months, beginning in January.

➢ *When Penalty Periods Would Not Overlap?*

When multiple transfers are made in such a way that the penalty periods for each would not overlap, the Worker must treat each transfer as a separate event, with its own penalty period.

All penalties for transferred assets run consecutively.

5.7.2.F.3 Who Is Affected by the Penalty?

The WV WORKS AG is affected by any transfer described above when any AG member, disqualified individual or any entity acting on behalf of, or at the discretion of, a member or a disqualified individual transfers an asset.

When the AG splits into two or more groups, the remaining penalty period is divided equally between the adults included in the WV WORKS benefit. A recording in each affected case must specifically explain the division of the penalty period.

Penalty Example 1: Mr. and Mrs. Birch received WV WORKS for themselves, Mrs. Birch's 3 children from a previous marriage and Mr. Birch's nephew. Mr. Birch transferred an asset for less than CMV, and a 10-month penalty was imposed from February through November. Mr. Birch leaves the home in April and Mrs. Birch reapplies for WV WORKS. Mrs. Birch continues to be ineligible.

However, because Mr. and Mrs. Birch no longer live together, they each carry one-half of the remaining penalty period with them. Mrs. Birch remains ineligible through July. There are eight months remaining in the penalty period. Both have already been ineligible as a unit for February and March. Mrs. Birch becomes ineligible beginning in April for four additional months. If Mr. Birch reapplies, he will also be determined ineligible through July. If the children begin living with other adults, no part of the transfer penalty follows them, unless they live in the home with Mr. and/or Mrs. Birch.

NOTE: When the number of months remaining in the penalty period does not divide evenly by the number of adults who were included in the AG, a portion of the appropriate 100% FPL is counted as income after the penalty months have been served.

Penalty Example 2: Same situation as in the above example except that seven months are remaining in the penalty period when Mr. Birch leaves. The AGs containing Mr. Birch and Mrs. Birch are both ineligible for three months. In addition, $1,373.50 (100% FPL = $2,747 ÷ 2) is counted as income for each of the adults in the fourth month.

5.7.2.G Treatment of Jointly Owned Assets

Jointly owned assets include assets held by an individual in common with at least one other person by joint tenancy, tenancy in common, joint ownership or any similar arrangement. Such an asset is considered to be transferred by the individual when any action is taken, either by the individual or any other person who reduces or eliminates the individual's ownership or control of the asset.

Under this policy, merely placing another person's name on an account or asset as a joint owner might not constitute a transfer of assets, depending upon the specific circumstances involved. In such a situation, the client may still possess ownership rights to the account or asset and, thus, have the right to withdraw all of the funds at any time. The account, then, still belongs to the client.

However, actual withdrawal of funds from the account, or removal of all or part of the asset by another person, removes the funds or property from the control of the client, and, thus, is a transfer of assets. In addition, if placing another person's name on the account or asset actually limits the client's right to sell or otherwise dispose of it, the addition of the name constitutes a transfer of assets.

If either the client or the other person proves that the funds withdrawn were the sole property of the other person, the withdrawal does not result in a penalty.

5.7.3 MEDICAID

There is no transfer of assets penalty for Medicaid, except when a Medicaid client, who receives Medicaid under a coverage group that requires an asset test, applies for or receives long-term care services. See Chapter 24.

APPENDIX A: LIFE ESTATE TABLE

Age	Life Estate Factor	Age	Life Estate Factor	Age	Life Estate Factor	Age	Life Estate Factor	Age	Life Estate Factor
0	.97188	23	.96986	46	.87863	69	.62086	92	.25771
1	.98988	24	.96841	47	.87137	70	.60522	93	.24692
2	.99017	25	.96678	48	.86374	71	.58914	94	.23728
3	.99008	26	.96495	49	.85578	72	.57261	95	.22887
4	.98981	27	.96290	50	.84743	73	.55571	96	.22181
5	.98938	28	.96062	51	.83674	74	.53862	97	.21550
6	.98884	29	.95813	52	.82969	75	.52149	98	.21000
7	.98822	30	.95543	53	.82028	76	.50441	99	.20486
8	.98748	31	.95254	54	.81054	77	.48742	100	.19975
9	.98663	32	.94942	55	.80046	78	.47049	101	.19532
10	.98565	33	.94608	56	.79006	79	.45357	102	.19054
11	.98453	34	.94250	57	.77931	80	.43659	103	.18437
12	.98329	35	.93868	58	.76822	81	.41967	104	.17856
13	.98198	36	.93460	59	.75675	82	.40295	105	.16962
14	.98066	37	.93026	60	.74491	83	.38642	106	.15488
15	.97937	38	.92567	61	.73267	84	.36998	107	.13409
16	.97815	39	.92083	62	.72002	85	.35359	108	.10068
17	.97700	40	.91571	63	.70696	86	.33764	109	.04545
18	.97590	41	.91030	64	.69352	87	.32262		
19	.97480	42	.90457	65	.67970	88	.30859		
20	.97365	43	.89855	66	.66551	89	.29526		
21	.97245	44	.89221	67	.65098	90	.28221		
22	.97120	45	.88558	68	.63610	91	.26955		

APPENDIX B: TREATMENT OF MEDICAID ASSETS PRIOR TO 8/11/93

Medicaid for Aid to Families with Dependent Children (AFDC) Recipients: A trust is treated as an asset to the extent that it is available to the client or for his benefit. Clauses included in a trust that limits the trustee's use of the funds (i.e., exculpatory clauses) are recognized and the amount of funds affected by such exculpatory clauses, excluded as an asset. Irrevocable trusts are also excluded, regardless of the amount. There is no penalty for the placement of funds in an irrevocable trust.

SSI-Related Medicaid Only: An irrevocable trust, i.e., a trust that is recognized by State law and cannot be legally revoked is excluded as an asset.

Any trust agreement that restricts the client's access to the trust funds (e.g., only the trustee or court, etc., can invade the principal), the principal does not count as an asset. This is true even when the trust arrangement: (a) can be revoked by someone other than the client; (b) provides a regular specified payment from the principal to the client for the use of the client; (c) designates a representative payee or legal guardian as the trustee for treatment of bank accounts that use the form of "in trust for". When payments are made to the client from the trust, these payments are counted as income and not an asset.

In general, if the client has unrestricted access to the principal of the trust, it is an asset.

Trusts containing exculpatory clauses are treated as if the exculpatory clauses were not contained in the trust. Exculpatory clauses are those that in any way limit the trustee's discretion to disburse funds for services or items covered by Medicaid or any other government aid or assistance program.

The following examples illustrate the type of clauses disregarded when examining a trust fund:

- It is the intention of the Grantor that no trust income or principal shall be paid to or be expended for the benefit of . . . so long as there are sufficient monies available to them for their care, comfort and welfare from federal, state and local government agencies and departments.
- It is the intention of the Grantor that in no event should trust income or principal be paid to or for the benefit of a governmental agency or department, and the trust estate shall at all times be free of the claims of such governmental bodies.
- The Trustee shall pay, apply, or expend so much of the net income and so much of the principal of the trust to or for the use and benefit of however, that such Trustee shall first take into consideration any other resources available to them including any benefits from federal, state, and local governmental agencies and departments.

- The authority of the Trustee to distribute income and principal is expressly restricted to purchasing goods and services that are not available free from any federal, state, and local government agencies and departments.

APPENDIX C: INDIAN LANDS AND TRUSTS EXCLUDED FROM INCOME AND ASSETS

C.1 PER CAPITA DISTRIBUTION PAYMENTS

- Indian Judgment Funds Distribution Act - Public Law (P.L.) 93-134
- Distribution of Indian Judgment Funds – P.L. 97-458

This includes interest and investment income accrued while funds are held in trust. Initial purchases made with distributed judgment funds are excluded from assets.

- Per Capita Act - P.L. 97-64

Local tribal funds (e.g., tribally managed gaming revenues) that have not been held in trust by the Secretary of the Interior are not excluded from income and assets under this provision.

- Distribution of Per Capita Funds - P.L. 85-794

Per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber or the Red Lake Reservation.

- Distribution of Judgment Funds
    - P.L. 92-254 - Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members that resulted from judgment funds to the tribes.
    - P.L. 94-189 - Sac and Fox Indian Nation members
    - P.L. 94-540 - Grand River Band of Ottawa Indians
    - P.L. 95-433 - Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation
    - P.L. 96-318 - Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma
    - P.L. 97-403 - Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana)
    - P.L. 97-408 - Gros Ventre and Assiniboine Tribes of Fort Belknap Indian Community, and the Papago Tribe of Arizona

- P.L. 97-436 - Up to $2,000 of per capita distribution of judgment funds to member of the Confederated Tribes of Warm Springs Reservation
- P.L. 98-124 - Assiniboine Tribe of the Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana
- P.L. 98-602 - Wyandotte Tribe of Oklahoma and the Absentee Wyandottes
- P.L. 99-130 - Sanee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, and the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota
- P.L. 99-146 & P.L. 99-377 - Chippewas of Lake Superior and the Chippewas of the Mississippi
- P.L. 100-383 - Per capita restitution payments made to eligible Aleuts who were located or interned during World War II
- P.L.100-411 - Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana
- P.L. 100-580 - Hoopa Valley Indian Tribe and the Yurok Indian Tribe
- P.L. 101-277 - Members of the Seminole Nation of Oklahoma, the Seminole Tribes of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida
- P.L. 101-618 - Per capita distribution of settlement funds under the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990

C.2 JUDGEMENT FUNDS/LANDS HELD IN TRUST

- P.L. 97-458 - Distribution of Indian Judgment Funds

This includes interest and investment income accrued while funds are held in trust. Initial purchases made with distributed judgment funds are excluded from assets.

- P.L. 100-241 – Alaska Native Claims Settlement Act (ANCSA) An interest in a settlement trust is excluded from assets.
- P.L. 103-66 - Payments from Individual Interests in Trust or Restricted Lands

Interests of individual Indians in trust or restricted lands are excluded from assets.

- P.L. 94-189 - Distribution of Judgment Funds

Judgment funds held in trust for members of the Sac and Fox Indian Nation are excluded from income and assets.

- P.L. 94-540 - Distribution of Judgment Funds

Judgment funds and the availability of these funds, held in trust for members of the Grand River Band of Ottawa Indians are excluded from income and assets.

- P.L. 99-146 and P.L. 99-377 - Distribution of Judgment Funds

Funds held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi are excluded from income and assets.

- P.L. 100-581 - Distribution of Judgment Funds

Judgment funds held in trust by the United States distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi), including accruing interest and investment income of such funds, are excluded from income and assets.

- P.L. 101-277 - Distribution of Judgment Funds

Judgment funds and accruing interest and investment income held in trust for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida, and the availability of those funds are excluded from income and assets.

- P.L. 103-436 - Distribution of Settlement Funds

Settlement funds held in trust, including interest and investment income accruing on such funds, for members of the Confederated Tribes of the Colville Reservation under the Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act are excluded form income and assets.

C.3 DISTRIBUTION PAYMENTS, RECEIPTS, TRANSFERS, PAYMENTS, INCOME, INTEREST, LAND, AND FUNDS MADE AVAILABLE FOR PROGRAM

- P.L. 97-458 - Distribution of Indian Judgment Funds

Initial purchase made with distribution Indian judgment funds are excluded from resources.

- P.L. 100-241 – Alaska Native Claim Settlement Act (ANCSA)

Items excluded from income and resources when received from a native corporation:

- Cash, including cash individuals or stock received from a native corporation to the extent it does not exceed $2,000/individual/year
- Stock, including stock issued or distributed by a native corporation as a dividend or distribution on stock
- A partnership interest
- Land or an interest in land, including land or an interest in land received from a native corporation as a dividend or distribution on stock

Up to $2,000 in retained distributions from a native corporation may be excluded from assets for each year.

- P.L. 103-66 – Payments from Individual Interests in Trust or Restricted Lands

Up to $2,000/year received by Indians that is derived from restricted lands is excluded income.

Interest of individual Indians in restricted lands is excluded from assets.

- P.L. 93-531 and P.L. 96-305 – Settlement Fund Payments

Settlement fund payments to members of the Hopi and Navajo Tribes, and the availability of such funds, are excluded from income and assets.

- P.L. 94-114 – Receipts from Lands Held in Trust for Indian Tribes

Receipts derived from the following trust lands and distributed to members of designated Indian tribes are excluded from income and assets.

Indian Group	Conveyance Statute	State
Seminole Indians	P.L. 84-736 (70 Stat 581) (July 20, 1956)	Florida
Pueblos of Zia and Jemez	P.L. 84-926 (70 Stat 941) (August 2, 1956)	New Mexico
Stockbridge Munsee Indian Community	P.L. 92-480 (86 Stat 795) (October 9, 1972)	Wisconsin
Burns Indian Colony	P.L. 92-488 (86 Stat 806) (October 13, 1972)	Oregon

Indian Group	Reservation	Lands Conveyed by P.L. 94-114	State
Assiniboine and Sioux Tribe	Fort Peck	LI-MT 6 Fort Peck	Montana
Bad River Band of the Lake Superior Tribe of Chippewa Indians	Bad River	LI-WI 8 Bad River	Wisconsin
Blackfeet Tribe of Montana	Blackfeet	LI-MT 9 Blackfeet	Montana
Cherokee Nation of Oklahoma	None	LI-OK 4 Delaware LI-OK 5 Adair	Oklahoma
Cheyenne River Sioux Tribe	Cheyenne River	LI-SD 13 Cheyenne Indian	South Dakota
Crow Creek Sioux Tribe	Crow Creek	LI-SD 10 Crow Creek	South Dakota
Devil's Lake Sioux Tribe	Fort Totten	LI-ND 11 Fort Totten	North Dakota
Fort Belknap Indian Community	Fort Belknap	LI-MT 8 Fort Belknap	Montana
Keweenaw Bay Indian Community	L' Anse	LI-MI 8 L' Anse	Michigan
Lac Courte Oreilles Band of Lake Superior Chippewa Indians	Lac Courte Oreilles	LI-WI 9 Lac Courte	Wisconsin
Lower Brule Sioux Tribe	Lower Brule	LI-SD 10 Lower Brule	South Dakota
Minnesota Chippewa Tribe	White Earth	LI-MN 6 Twin Lakes LI-MN 15 Flat Lake	Minnesota
Navajo Tribe	Navajo	LI-NM 18 Gallup Two Wells	New Mexico
Oglala Sioux Tribe	Pine Ridge	LI-SD 7 Pine Ridge	South Dakota

Indian Group	Reservation	Lands Conveyed by P.L. 94-114	State
Rosebud Sioux Tribe	Rosebud	LI-SD 8 Cutmeat LI-SD 9 Antelope	South Dakota
Shoshone-Bannock Tribe	Fort Hall	LI-ID 2 Fort Hall	Idaho
Standing Rock Sioux Tribe	Standing Rock	LI-ND 10 Standing Rock LI-SD 10 Standing Rock	North Dakota South Dakota

- P.L. 95-498 - Receipts from Lands Held in Trust

Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe are excluded from income and assets.

- P.L. 95-499 - Receipts from Lands Held in Trust

Receipts derived from trust lands awarded to the Pueblo of Zia and distributed to members of that tribe are excluded from income and assets.

- P.L. 96-318 - Distributed of Judgment Funds

Any judgment funds made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma are excluded from income and assets.

- P.L. 96-420 - Maine Indians Claims Settlement Act (MICS)

All funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds, are excluded from income and assets.

- P.L. 97-95 - Distribution of Judgment Funds

Any distribution of judgment funds to members of the San Carlos Tribe of Arizona are excluded from income and assets.

- P.L. 97-371 - Distribution of Judgment Funds

Any distribution of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma are excluded from income and assets.

- P.L. 97-372 - Distribution of Judgment Funds

Any distribution of judgment funds to members of the Shawnee Tribe of Indians (absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band Shawnee descendants) are excluded from income and assets.

- P.L. 97-376 - Distribution of Judgment Funds

Judgment funds made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana are excluded from income and assets.

- P.L. 97-402 - Distribution of Judgment Funds

Distribution of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians) are excluded from income and assets.

- P.L. 97-403 - Distribution of Judgment Funds

Judgment funds made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana) are excluded from income and assets.

- P.L. 98-123 - Distribution of Judgment Funds

Judgment funds distributed to the Red Lake Band of Chippewa Indians are excluded from income and assets.

- P.L. 98-124 - Distribution of Judgment Funds

Family interest payments for members of the Assiniboine Tribe of the Fort Belknop Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana are excluded from income and assets.

- P.L. 98-432 - Distribution of Claims Settlement Funds

Judgment funds and income therefrom distributed to members of the Shoalwater Bay Indian Tribe are excluded from income and assets.

- P.L. 98-500 - Distribution of Claims Settlement Funds

All distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act are excluded from income and assets.

- P.L. 98-602 - Distribution of Judgment Funds

Judgment funds made available for any tribal program for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes are excluded from income and assets.

- P.L. 99-130 - Distribution of Judgment Funds

Dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, and the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota are Band of Chippewa Indians of Montana) are excluded from income and assets.

- P.L. 99-264 - Distribution of Claims Settlement Funds

Distributions of claims settlement funds to members of the White Earth Band Chippewa Indians as allottees, or their heirs, are excluded from income and assets.

- P.L. 99-346 - Distribution of Judgment Funds

Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan are excluded from income and assets.

- P.L. 100-139 - Distribution of Judgment Funds

Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians are excluded from income and assets.

- P.L. 100-581 - Distribution of Judgment Funds

Judgment funds made available for programs to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) are excluded from income and assets.

- P.L. 101-41 - Distribution of Money and Land

All funds, assets, and income from the trust fund transferred to members of the Puyallup Tribe under the Puyallup Tribe of Indians Settlement Act of 1989 are excluded from income and assets.

- P.L. 101-277 - Distribution of Judgment Funds

Judgment funds made available for programs for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida are excluded from income and assets.

- P.L. 101-503 - Distribution of Settlement Funds

Payments, funds, distributions or income derived from these sources under the Seneca Nation Settlement Act of 1990 are excluded from income and assets.

- P.L. 103-116 - Distribution of Settlement Funds

Settlement funds, assets, income, payments, or distributions from Trust Funds to members of the Catawba Indian Tribe under the Catawba Indian Tribe of South Carolina Land Claims Settlement Act of 1993 are excluded from income and assets.

- P.L. 103-444 - Distribution of Settlement Funds

Payments made or benefits granted by the Crow Boundary Settlement Act of 1994 are excluded from income and assets.

C.4 PROCEDURES

If there is an allegation or other indication that an individual received excluded judgment funds or settlement fund distributions, per capita payments, land or receipts from land, follow these procedures.

C.4.1 Verification of Tribe Membership

As necessary, verify that the individual is a member of the relevant tribe by contact with the Board of Indian Affairs (BIA) or tribal authorities or use of a precedent file.

C.4.2 Payment/Distribution Development

Develop the identity and the amount of excludable payment or distribution by contact with BIA or tribal authorities or use of a precedent file. Trust Property Income (TPI) reports may also be available from BIA, which list to whom restricted individual Indian property is assigned and show if lease is grazing right payments are not paid through BIA or the tribe. If land is distributed, identify the location of the land as reported by deed or other legal conveyance. Additional contacts with the Bureau of Land Management may be necessary to develop land information.

C.4.3 Documentation

Document the case file by using the method or methods below as needed:

- A report of contact for verifications made over the phone with the tribal authorities or the BIA area office.
- An income report or comparable document from the BIA, the tribe's governing body, or its official financial representative.
- A signed statement from tribal authorities, the BIA area offices, or the Bureau of Land Management.
- A copy of pertinent local precedent.

Chapter 6

Data Exchanges

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Change History Log

Section	Date of Change	Change Number	Sub-Section(s) Changed	Description of Change
6.1				
6.2	6/1/19 9/1/20	772 792	6.2.4 6.2.4	Substantial lottery and gaming data matches DOHS & WV Lottery now partners
6.3	8/1/18 5/1/19 6/1/19 4/1/20 12/1/23 2/1/24 6/1/24 1/1/26	762 771 772 784 844 846 851 872	6.3.6 6.3.6 6.3.4.A.6 6.3.3.C 6.3.3. A 6.3.3. B 6.3.3. C 6.3.4.A.6 6.3.3.B 6.3.3.C 6.3.2 6.3.4.A.2 6.3.4.A.6 6.3.5 6.3.3.B 6.3.4	Added section 6.3.6 for the AVS. Revised AVS Prisoner matches of certain felonies. OIG is considered verification. Note added to clarify responsibility for Federal Matches. Note added referencing for the agency to allow an individual an opportunity to explain a PARIS Match Note added to clarify responsibilities for VA matches. Added clarification to Prison Match Data Exchange. Clarified in the note for the Interstate Match to include WVCHIP along with Medicaid. Clarified in the note for the Veterans Affairs Match to include WVCHIP along with Medicaid. Added Notice of Match Results information. Added a SNAP note about Notice of Match Results. Added bullet for death match.
6.4	1/1/26	872	6.4.4	Added Notice of Match Results into Independent Verification instructions; Also changed examples to include Notice of Match Results process.
6.5				
App A				
App B				
App C				

6.1 INTRODUCTION

There are two main electronic sources that provide verifications to the Department of Human Services (DOHS). These are the Federal Data Hub (FDH) and the Income and Eligibility Verification System (IEVS). The IEVS is a computerized information system that performs data matches against several agency databases to verify certain types of income and/or assets. The information provided by these two main sources overlaps in some areas. The Worker accesses all information through the eligibility system.

In general, the two sources are used in the following ways:

- When the Worker evaluates for Medicaid eligibility, he tests for Modified Adjusted Gross Income (MAGI) coverage groups first. That requires a check of results primarily from the Hub.
- If the test fails for a MAGI coverage group, the Worker evaluates for Non-MAGI coverage groups, which uses data exchange information from IEVS.
- Data exchange information available at both application and review may also be used by the Worker to evaluate discrepancies in the client's statement when it disagrees with Hub data.
- For determination of eligibility for benefits other than MAGI Medicaid, Hub data may be used only if it was obtained when trying to determine MAGI Medicaid eligibility. Otherwise, it is not used. It is never used to determine Supplemental Nutrition Assistance Program (SNAP) benefits.

6.1.1 FEDERAL DATA HUB (FDH)

The FDH is the primary source the Worker uses to verify reported information for MAGI Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP). When no information is returned from the Hub or when discrepancies exist that are not reasonably compatible, the Worker must utilize all sources available before requesting verification from the client. See Section 7.2.

An electronic data match with the Hub will be triggered when eligibility is being determined for MAGI Medicaid or WVCHIP. When no one in the case is found eligible for MAGI Medicaid or WVCHIP, information returned by the Hub is not used for eligibility purposes for other programs.

NOTE: The Federally Facilitated Marketplace (FFM) utilizes the same FDH used by the DOHS.

6.1.2 IEVS DATA EXCHANGES

The IEVS provides the DOHS with additional sources of information for use in determining eligibility and the amount of the benefit for applicants and clients. This information is provided to the Worker through data exchanges.

Through the eligibility system, DOHS staff receive information obtained through data exchanges with other governmental agencies. The IEVS procedures ensure that appropriate Internal Revenue Service (IRS) privacy and procedural safeguards are applied in the use of the information. The same precautions with privacy and procedural safeguards apply to information received through the FDH.

Information obtained through IEVS is used for the following purposes:

- To verify the eligibility of the assistance group (AG)
- To verify the proper amount of benefits
- To determine if the AG received benefits to which it was not entitled
- To obtain information for use in criminal or civil prosecution based on receipt of benefits to which the AG was not entitled. Federal regulations require use of the following data exchanges that are provided using the IEVS:
    - WorkForce West Virginia – Wage and unemployment compensation information (UCI) data is available.
    - Internal Revenue Service (IRS) – Unearned income data is available.
    - Social Security Administration (SSA) – Retirement, Survivors and Disability Insurance (RSDI), Supplemental Security Income (SSI), and net earnings from self-employment data are available.

NOTE: Federal Medicaid regulations require the utilization of the following IEVS data sources when nothing is returned from the Hub or when discrepancies exist that are not reasonably compatible: WorkForce WV, IRS and SSA.

The Social Security Number (SSN) of each applicant and client of SNAP benefits, WV WORKS, and Medicaid is used to obtain IEVS information.

A data exchange in the eligibility system occurs:

- When a new case is created;
- When a new person is added to a benefit;
- When a person's demographic information is changed; and,

- On a periodic basis for all individuals in the eligibility system, depending on the type of benefit being received

The Worker must check eligibility system information as to the availability of data exchange information. In some instances, but not all, the eligibility system sends an alert to the Worker.

6.2 STATE DATA EXCHANGES

6.2.1 WORKFORCE WEST VIRGINIA

6.2.1.A Wage Information

Wage information is available around the fifth working day of each quarter for the previous quarter. Information received includes:

- Employer name and address;
- Dates of employment; and
- Wages for individuals whose actual earnings are $225 or greater per quarter than the income used for the assistance group (AG) for the same quarter.

This information is not considered verified upon receipt for Supplemental Nutrition Assistance Program (SNAP) and is subject to independent verification for all programs.

NOTE: Workforce WV wage information is obtained electronically by the data system in real-time for Medicaid and WVCHIP applications and reviews. The Worker does not need to manually check Workforce WV wage information at initial application or review for Medicaid and WVCHIP. The reasonable compatibility process described in Section 7.2.5 is applied automatically by the data system to Workforce WV wage information.

6.2.1.B Unemployment Compensation Income (UCI)

UCI information is available around the third working day of each month. Information received includes unemployment and low-earnings benefits.

This information is considered verified upon receipt for SNAP and is not subject to independent verification for any program.

6.2.2 OFFICE OF CHILDREN AND ADULT SERVICES

6.2.2.A Provider Income

Provider income information is available the first working day after the second Friday of each month. Information received includes adoption, foster care, day care, and demand payments for the previous month.

This information is considered verified upon receipt for SNAP and is not subject to independent verification for all programs.

6.2.2.B Client Detail

The adult and child information is available around the tenth calendar day of each month. Information received includes:

- Client income;
- Assets;
- Placement;
- Demographics; and,
- Address.

This information is considered verified upon receipt for SNAP and is not subject to independent verification for all programs.

6.2.3 BUREAU FOR CHILD SUPPORT ENFORCEMENT (BCSE)

New hire information is available each Monday. Information received includes:

- Names and addresses of employers, and
- Start and end dates of employment.

BCSE collects the new hire information from employers. Employers do not report consistently, and even when they do provide information, the information may include applicants who were never hired.

The Worker must follow up on this information, as it is not considered verified upon receipt. It is considered information from a third-party source for SNAP and is subject to independent verification for all programs.

6.2.4 Substantial Lottery and Gaming Data Matches

Data exchanges will be received from all gaming/lottery institutions currently in cooperative agreement with the DOHS.

- WV Lottery Commission: sent in a secured file by the 10th of each month

6.3 FEDERAL DATA EXCHANGES

Regulations require that the Department of Human Services (DOHS) take the necessary steps to safeguard information received from data exchanges with the Internal Revenue Service (IRS), Prisoner Match, the Beneficiary and Earnings Data Exchange (BENDEX), and the Beneficiary Earnings Exchange Record System (BEERS) by restricting access to it. See Section 6.4.

For individuals applying for MAGI Medicaid and WVCHIP, the primary data source used by the Worker is the Hub. When the Hub returns no information or when discrepancies exist between an individual's self-attestation and Hub information, the Worker seeks verification from other electronic sources including those listed below. The reasonable compatibility provision applies to financial information. See Section 7.2.5.

6.3.1 DEPARTMENT OF HOMELAND SECURITY

Through the FDH Systematic Alien Verification for Entitlements (SAVE), information related to citizenship/immigration may be returned.

6.3.2 INTERNAL REVENUE SERVICE (IRS)

The Affordable Care Act (ACA) provides specific authority at Internal Revenue Code (IRC) Sec. 6103(l)(21) for the IRS to provide individual tax information for use in determining eligibility for MAGI Medicaid and WVCHIP through the FDH. This IRS information may include:

- The taxpayer identity;
- Filing status;
- Family size;
- Modified Adjusted Gross Income (MAGI); and
- The tax year to which any such information relates, or that no information is available.

Through the federal data exchange that is used in place of the Hub for programs other than MAGI Medicaid and WVCHIP, the IRS unearned interest income is available on or around the 15th of each month. Information received includes:

- Asset and income information reported to IRS;
- Income type;

- Payee name; and
- Income amount.

This information is not considered verified upon receipt for Supplemental Nutrition Assistance Program (SNAP) and is subject to independent verification for all programs.

For SNAP, the agency must provide the household with the Notice of Match Results (NCHZ) and the matched individual must be given 10 days to contest the findings.

The IRS information received is subject to the special procedural requirements in this chapter.

6.3.3 PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS)

The PARIS data match occurs quarterly. There are three types of PARIS matches on income and medical benefits: Federal, Interstate and Veterans Affairs. PARIS conducts matches on income and health coverage information. Verification is received through data exchange and is compared to the information in the case record. The client's Social Security Number (SSN) is used to retrieve the information.

6.3.3.A Federal Match

A return on this match is initiated from the Department of Defense (DoD) and the Office of Personnel Management (OPM). The match indicates an individual is receiving income, and includes records for active and retired federal civilian and military personnel. Healthcare coverage eligibility is also available in the federal match (civilian health coverage or TriCare, formerly Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]).

Workers have access to the federal match directly and must follow up on information obtained. This information is not verified upon receipt and is subject to independent verification for all programs.

6.3.3.B Interstate Match

A return on this match indicates an individual is enrolled for benefits in two or more states. Automatic disenrollment for the West Virginia program occurs for the matched individuals. If the individual is the primary person in the entire case, it will close.

This process is administered by the Office of Inspector General's (OIG) Investigations and Fraud Management Unit. When the OIG determines worker action is necessary, it will notify the worker. The information received from OIG is considered verified upon receipt. The worker has 10 days to take the action specified.

NOTE FOR MEDICAID AND WVCHIP COVERAGE GROUPS ONLY: Eligibility cannot be denied/terminated based solely on a data match from PARIS. If the information obtained from any third-party data source is inconsistent with approving eligibility or suggests a change in circumstances for a current enrollee impacting eligibility, the agency must provide the individual opportunity to provide an explanation or other documentation prior to closure. If no alternative documentation or explanation is provided, the agency must deny or terminate eligibility.

NOTE FOR SNAP ONLY: The agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

6.3.3.C Veterans Affairs (VA) Match

A return on this match indicates an individual is receiving income and/or medical assistance payments from VA. Compensation and pension data are provided along with third-party liability information.

NOTE FOR MEDICAID AND WVCHIP COVERAGE ONLY: Workers have access to the VA match directly and must follow up on information obtained. This information is not verified upon receipt and is subject to independent verification.

The process is administered by the Office of Inspector General's (OIG) Investigations and Fraud Management Unit. When the OIG determines Worker action is necessary, it will notify the Worker. Workers have access to the VA match directly and must follow up on information obtained. The information received from OIG is considered verified upon receipt for SNAP. The Worker has 10 days to take the action specified.

6.3.4 SOCIAL SECURITY ADMINISTRATION (SSA)

Through the FDH, the SSN is considered verified for MAGI Medicaid and WVCHIP. Other information received from the Hub may be:

- Citizenship;
- Identity status;

- Incarceration data; and
- Receipt of Title II Social Security income.

Through data exchange, SSA provides the DOHS with information on:

- Pensions;
- Earnings;
- Net earnings from self-employment;
- Retirement, Survivors and Disability Insurance (RSDI);
- Supplemental Security Income (SSI); and
- Other related benefit information received through SSA.

When the data exchange received through SSA indicates that an individual is deceased, the worker must verify this information through a secondary source. If the data exchange indicating an individual is deceased cannot be independently verified, then the Worker must follow up on this information by sending a verification checklist to the SNAP assistance group. If the assistance group does not respond or fails to supply sufficient information, then the Worker shall remove the individual found in the SSA match from the SNAP assistance group after proper

NOTE: When a data exchange is received and indicates an individual is deceased, SNAP cannot be decreased or closed solely with information received from SOLQ/SSA. A worker may use IPACT as a secondary source of verification. If information received from IPACT is unclear or inconclusive and the worker is unable to verify through another source, the worker must send a verification checklist to the individual.

notice. If the case is closed due to the client not providing verification that the client is still alive, the case must be reopened without a new application if, during the first calendar month following the closure, the client provides verification that re-establishes eligibility. The SNAP benefits would be prorated from the date the client returns the required information demonstrating the client is not deceased.

For SNAP, the agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

6.3.4.A System Generated

6.3.4.A.1 Beneficiary and Earnings Data Exchange (BENDEX)

The BENDEX data exchange occurs daily. Information received includes RSDI amounts and Medicare eligibility and premiums.

This information is considered verified upon receipt for SNAP and is not subject to independent verification for any program.

Data exchanges include discrepancies between the eligibility system and SSA files and individuals who may also be receiving benefits in another state.

6.3.4.A.2 Beneficiary Earnings and Exchange Record System (BEERS)

The BEERS wage-match data exchange occurs daily. Information received includes

- Wages;
- Pensions; and
- Self-employment income.

West Virginia employment is not included in this match. See Section 6.2 for this data exchange.

This information is not considered verified upon receipt for SNAP and is subject to independent verification for all programs.

For SNAP, the agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

6.3.4.A.3 Social Security Number (SSN) Verification Details

Verified SSNs are automatically indicated in the eligibility system daily. Errors are identified and detailed information is available to the Worker in the eligibility system.

This information is considered verified upon receipt for all programs and is not subject to independent verification.

6.3.4.A.4 State Data Exchange (SDX)

➢ SDX to Open a Medicaid Application

This match identifies individuals who receive SSI, but who do not receive Medicaid, or who must be enrolled in a different Medicaid coverage group as a result of their SSI eligibility.

➢ SDX to Evaluate Alternate Medicaid Eligibility

This match identifies individuals whose SSI is being terminated, suspended, or closed. When SSI Medicaid is closed based on this information, the assistance group (AG) must be evaluated for all other Medicaid coverage groups. The match will also indicate whether the individual is eligible for Deemed SSI coverage groups, which guides the Worker's evaluation of eligibility for other coverage groups. See Section 10.14.

➢ SDX Change

This match identifies individuals who have had a change in their benefit amounts, payee name, or addresses.

State Data Exchange (SDX) information is considered verified upon receipt for all programs and is not subject to independent verification.

6.3.4.A.5 Forty (40) Qualifying Quarters of Coverage Data Exchange

See Section 15.4 for the Alien Qualifying Quarters policy.

The Qualifying Quarters data exchange occurs daily. Information is automatically requested for persons included in the AG whose work quarters can be counted. The Worker must initiate requests for persons who are not in the AG, but whose work history can be used to qualify the alien for SNAP benefits.

This information is considered verified upon receipt for SNAP and is not subject to independent verification.

6.3.4.A.6 Prisoner Match Data Exchange

The Prisoner Match is available around the third working day of each month. Information received from federal and state prisons may include:

- Length of detention;
- Correctional facility name; and
- Release date.

When disclosure is prohibited by SSA, no details are provided.

This information is not considered verified upon receipt for any program and is subject to independent verification for all programs. The Worker must not take any action based only on the data received from this source.

The Worker requests verification of the information through the prison system if the prison is identified. The verification request must clearly explain the information the Worker has and allow 30 calendar days for a response.

If the prison is not identified or if the Prisoner Match cannot be independently verified, then the Worker must send a verification checklist to the SNAP assistance group requesting information related to the data exchange. If the assistance group does not respond or fails to supply sufficient information, then the Worker shall remove the individual found in the prisoner match from the SNAP assistance group after proper notice.

If a SNAP applicant or recipient presents themselves at the SNAP local office with the appropriate identification, it is reasonable for the worker to consider this sufficient verification that the person is not in prison and can clear the match result.

The worker can also make phone contact with the household to verify that the member is or is not incarcerated. The worker will need to speak with the person the prisoner match is on. When making phone contact, the worker should use all efforts to verbally verify the identification of the person they are speaking with that they are in fact talking to the correct household member to verify this information. The conversation must be documented in case comments to include that the identity of the individual was established.

For SNAP, the agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

NOTE: Prisoner matches do not contain relevant information to determine whether an individual convicted of certain felonies is complying with the terms of their conviction.

6.3.4.A.7 State Verification Exchange System (SVES)

Information about new applicants for Medicaid and WVCHIP is submitted to SSA through SVES. A response from SSA confirms whether or not the data submitted by the State is consistent with SSA data regarding citizenship. An alert will generate on a daily basis to inform the Worker if citizenship is inconsistent with SSA data.

6.3.4.B Worker Requested Verification – State On-Line Query (SOLQ)

SOLQ provides direct access to SSA's databases. The Worker must initially use the Hub for evaluating eligibility for MAGI Medicaid and WVCHIP coverage groups, the Income and Eligibility Verification System (IEVS) data exchange for all other programs, and SOLQ last. Information received includes SSN verification, as well as SSI and RSDI details. Requests can be made only for individuals known to the eligibility system within the previous five years.

This information is considered verified upon receipt for SNAP and is not subject to independent verification.

6.3.5 NATIONAL DIRECTORY OF NEW HIRES

Through a monthly data exchange, the National Directory of New Hires provides unverified employment information. This information must be reviewed before determining eligibility for SNAP and WV WORKS at application and review. WV WORKS must also act on any NEHR alert received during the certification period.

This information is not considered verified upon receipt for SNAP and is subject to independent verification.

For SNAP, the agency must provide the household with the Notice of Match Results (NCHZ), and the matched individual must be given 10 days to contest the findings.

For WV WORKS, match results are required to be verified. Results from the last application or review to the current information must be reviewed with the participant.

NOTE: The National Directory of New Hires is not used for Medicaid unless the Worker takes action on SNAP or Temporary Assistance for Needy Families (TANF) based on verified information from the National Directory of New Hires. The resulting information must be acted on for Medicaid purposes as SNAP or TANF data.

6.3.6 Asset Verification System (AVS)

The Asset Verification System (AVS) must be used to verify assets for Medicaid applicants and clients who qualify based on being aged, blind or disabled.

NOTE: The eligibility process is not delayed for AVS verification when the client verified the appropriate reported assets.

These categories include:

Aged, Blind, Disabled Medicaid	Long Term Care Medicaid	Medicare Premium Assistance
• SSI-Related (Spenddown) • SSI-Related/Non-Cash Assistance • M-WIN	• Nursing Facility Group • SSI-Related/Monthly Spenddown Group • Intermediate Care Facility/Individuals with Intellectual Disability • Traumatic Brain Injury Waiver • Aged and Disabled Waiver • Intellectual/Developmental Disability Waiver • Children with Disabilities Community Service Program	• Qualified Medicare Beneficiary • Specified Low Income Medicare Beneficiary • Qualified Individual • Qualified Disabled Working Individuals

Aged, Blind, Disabled Medicaid	Long Term Care Medicaid	Medicare Premium Assistance

AVS is used at initial application, redetermination and a client reported change during the certification period. AVS must not be accessed at any other time, or for any Medicaid category not listed above.

Authorization to use AVS to verify assets is a condition of eligibility for Medicaid and is part of the Rights and Responsibilities. Failure to give consent and authorize the release of information results in Medicaid denial/closure.

Bank account information received from the AVS is considered verified for the Medicaid program. However, when information received in the AVS results in ineligibility, the client must be afforded the opportunity to rebut the AVS information prior to any negative case action.

Real property and vehicle information received from AVS is not considered verified for the Medicaid program and will require the worker to follow-up with the client to verify the availability and value of the asset if this has not already been provided by the client.

6.4 SPECIAL REQUIREMENTS FOR SAFEGUARDING INFORMATION

Income and Eligibility Verification System (IEVS) regulations mandate specific requirements for safeguarding Internal Revenue Service (IRS) information, as outlined below.

6.4.1 EMPLOYEE AWARENESS

As with all information obtained about applicants and clients, all Department of Human Services (DOHS) staff must hold Internal Revenue Service (IRS) data confidential. Additionally, the IRS Code requires that all employees who have access to IRS data be informed of all the penalties for unauthorized disclosure of IRS data.

The Supervisor must provide each Worker with a copy of the applicable sections of the IRS Code. In addition, the Worker must sign form DFA-IE-01, IRS Disclosure Notice Log, to indicate he received the IRS Code Notices. IRS Code Notices are found in Appendices B and C.

6.4.2 EMPLOYEE TRAINING

In addition to employee awareness, new Worker training must include IRS safeguards/security procedures and penalties for unauthorized disclosure of IRS data. Training will include testing and exercises that measure Worker knowledge of the requirement to report improper inspection and/or disclosure of Federal Tax Information (FTI). Annually, all tenured DOHS Workers with IRS access will complete the Bureau of Children and Families Information, Technology and Training (BCF-ITT-FA) 301 IRS Web Ct course with an 80% score or higher, print the course certificate, endorse it, and give it to their Supervisor. Certificates are retained in the local office for tracking and monitoring compliance with the IRS requirements.

6.4.3 CLIENT NOTICE OF IEVS REQUIREMENTS

All applicants and clients must be notified in writing of the IEVS requirements and the use of information obtained through IEVS. A statement is included in the Rights and Responsibilities Form (DFA-RR-1).

6.4.4 INDEPENDENT VERIFICATION

Independent verification is necessary in some situations, depending upon the program and the source of information (i.e., any data exchange that is not considered “verified upon receipt”). Independent verification is used if there is a discrepancy between information reported by the IEVS sources and that reported by the client.

The Worker must not take any case action based only on IRS and/or Prisoner Match data until the following information has been independently verified:

- The amount of the income or asset involved;
- If the client actually has, or had, access to the income or asset; and
- The time period(s) when the individual had the income or asset.

The Worker may request the independent verification by requesting that the client obtain information from the financial institution or source of the unearned income/asset. The Worker uses form DFA-6, Request for Additional Information, the eligibility system verification checklist, to request that the client obtain the information. The information may be requested by letter directly from the financial institution or source of the income/asset.

Any correspondence to the client, financial institution, community partner, or other income/asset source that contains the IRS-provided information must be safeguarded according to the procedures in Safeguarding Information, below. All DOHS staff are subject to the same IRS safeguards regardless of performing their duties in a DOHS-sanctioned work site, an out-stationed work site, or other alternative work site. Verification provided separately from the financial institution or income/asset source from its own records, which does not contain any of the IRS-provided information, is independently verified only and does not require the safeguarding procedures in Safeguarding Information, below.

Note: When the agency receives a Notice of Match Results from the Income Eligibility Verification System that conflicts with case information, and the agency cannot resolve it internally, the client is required to provide independent verification to clarify or confirm the information.

The Notice of Match Results (NCHZ) will be used when the agency receives information from a third-party source (see 10.4.2.B.3 Third Party Sources). The data may include wages, death, new hire, Internal Revenue Service (IRS), prisoner, and Federal Public Assistance Reporting Information System (PARIS).

Independent Verification Example 1: The worker receives IRS information about interest on a bank account and completes a DFA-6 or eligibility system request for verification. The verification request includes all the information obtained from the IRS report.

The following steps occur:

- The client takes the verification request to the bank.
- A bank official independently verifies the information by comparing it with the bank's official records.
- If the bank records confirm the IRS-reported data, the official documents the information and signs the verification request.
- The client then returns the completed verification to the worker.

Because the IRS-provided information is still included in the returned verification, it remains subject to the safeguarding procedures described in Safeguarding Information, below.

Independent Verification Example 2: Same situation but rather than completing the DFA-6 or verification request form, the bank official provides the following:

- A bank generated account statement or printout, covering all relevant transactions and account details for the past three years.
- The printout is signed and certified by the bank official and contains sufficient information to confirm the interest income reported by the IRS.
- The client returns only the bank-issued printout the to the worker. In this case, the bank documentation constitutes independent verification obtained directly from the financial institution and does not contain IRS-provided information.
- The returned documentation is not subject to the safeguarding requirements outlined under Safeguarding Information.

6.4.5 SAFEGUARDING INFORMATION

IRS, Prisoner Match, Beneficiary and Earnings Data Exchange (BENDEX), and Beneficiary Earnings Exchange Record System (BEERS) regulations require that the DOHS take the necessary steps to safeguard the data by restricting access. The following safeguards apply DOHS-wide and to staff performing their duties in a DOHS-sanctioned work site, an out-

stationed work site, or other alternative work site. Only those Workers/Supervisors who have been assigned to the case are permitted access. User information is tracked in the eligibility system.

The following procedures apply to all sources of FTI, not just information provided through IEVS, and include all documentation provided by the client or on his behalf that includes FTI.

6.4.5.A Paper, Electronic, and Facsimile Documents

FTI is never to be faxed or sent electronically.

The Data Incident Report for Improper Inspection and/or Disclosure of FTI (DFA-FTI-1) coversheet must be attached to all case files that contain FTI to ensure that only authorized personnel view FTI.

Paper documents, such as screen prints from the eligibility system or any documents—such as, but not limited to, requests that are sent to financial institutions and, when returned, contain IRS information as described in Section 6.4.3 above—must be destroyed by shredding. If the office does not have access to a shredder, the documents are sent to the Division of Family Assistance (DFA) for shredding. Prior to disposal, all printed documents must be maintained in a locked file cabinet to which only a Supervisor has access.

All file cabinets that contain FTI and FTI Data Incident Reports must be labeled. Labels are available upon request from the DFA. All hard copies of FTI must be removed from the case record before archiving.

Any violation related to improper inspection and/or disclosure of FTI must be reported immediately, but no later than 24 hours after discovery, to the staff's Supervisor, who will follow the guidelines in Appendix A for contact and/or reporting information.

6.4.5.B IRS Safeguard Log

The local office must designate an IRS Safeguard Manager to maintain the IRS Safeguard Log.

Paper documents of eligibility system screen prints, electronic mail, or facsimiles must be attached to an IRS Safeguard Log, DFA-IE-02. These log sheets provide a format in which to record:

- The date received,

- Document description,
- Employee signature, supervisor signature, and
- Distribution date.

The IRS Safeguard Log is returned to the Safeguard Manager, who maintains a record of the Log sheets and documents the destruction of all safeguarded documents. The Safeguard Manager then signs and files the documents.

NOTE: IRS, Prisoner Match, BENDEX, and BEERS information in the eligibility system must not be routinely printed. However, if it is necessary to print a screen that contains FTI or Prisoner Match information, the office must comply with the safeguard instructions for the destruction of printed documents. The document must also be secured as stated in Paper, Electronic, and Facsimile Documents, above.

6.5 REQUEST AND USE OF INFORMATION

The following describes the method of matching Income and Eligibility Verification System (IEVS) information and the Worker's responsibilities.

The Worker evaluates the Department of Health and Human Resource's (DOHS) data exchanges for Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP). Workers must utilize all electronic and other sources available before requesting verification from the client.

6.5.1 APPLICANTS

The DOHS requests IEVS information on all applicants for Supplemental Nutrition Assistance Program (SNAP), Medicaid, WVCHIP, and WV WORKS programs. IEVS regulations apply only to those Supplemental Security Income (SSI) recipients who receive SNAP benefits.

Information received must be used in determining eligibility and/or the amount of the benefit, if the information is received before the client is notified of the action on his application. If the information is received after client notification, it must be used within the time limit explained below in Section 6.5.2 and according to policy for the specific benefits received.

The DOHS must not delay action on the application solely because IEVS information has not been received, unless the information reported by the applicant is questionable. The time limit for acting on applications is not extended for situations that involve IEVS.

6.5.2 CLIENTS

The Worker receives information about clients through the eligibility system data exchange.

The Worker must act on the information within 10 days of the date it is received to ensure action is completed within 45 days of receipt. This means that within 45 days, the Worker must send notification to the client or make an entry in the case record that no action is necessary.

- SNAP-Only: Action does not have to be initiated within 10 days; however, the action must be completed within 45 days of receipt.

EXCEPTION: The completed action may be delayed beyond 45 days when:

- *The Worker initiated the action within 10 days of the date the information is received;*
- *The reason action cannot be completed is non-receipt of requested verification from a third party; and*
- *Action is completed promptly when the third-party verification is received or at the next contact or redetermination, whichever occurs first.*

6.5.3 SPECIAL REQUIREMENTS FOR DISCLOSING CERTAIN DATA RECEIVED FROM THE FEDERAL DATA HUB (FDH)

6.5.3.A Disclosure of Data Obtained From the FDH at Application

The following data received via the FDH must not be disclosed to an application filer, or an individual who is identified on the application as assisting the application filer (agent, broker, certified application counselor, in-person assistor, or Navigator) during the application process:

- Federal Tax Information (FTI) obtained from the IRS
- Title II SSA income benefits (Retirement, Survivors and Disability Insurance – RSDI) obtained from the Social Security Administration (SSA)
- The number of quarters of coverage obtained from SSA
- Current income data obtained from Equifax Workforce Solutions

Such information will be disclosed only to the requesting Marketplace, Medicaid, or CHIP agency. The data will be used by those entities for the purposes of conducting verifications, and in the eligibility determination process; the data must be safeguarded in accordance with applicable regulations and Internal Revenue Service (IRS) publication 1075 (for FTI).

A receiving entity may not disclose such data received via the Hub on an eligibility notice, or in response to a customer service inquiry.

6.5.3.B Customer Service Inquiries

If an application filer contacts the Marketplace, Medicaid, or CHIP agency and requests information obtained via the Hub regarding FTI, Title II SSA income benefits, the number of quarters of coverage obtained from SSA, or current income data obtained from Equifax Workforce Solutions, which was used in processing his or her application, the DOHS will explain how to resolve any open verification issue, if appropriate, but may not provide the underlying data. The Worker must inform the applicant that reported information could not be electronically verified and notify the applicant of information or verification he must supply to establish eligibility.

If the applicant is still interested in information obtained via the Hub that was used in processing his or her application, then the Marketplace, Medicaid, or CHIP agency should provide instructions to the applicant on how to locate the data in tax and Social Security benefit documents he already has, or how to interact directly with the IRS or SSA. The agency should also direct such an individual to Equifax Workforce Solutions to obtain the source information, if necessary.

6.5.3.C Eligibility Appeals

If an individual appeals his or her eligibility determination and needs access to FTI, Title II SSA income benefits, the number of quarters of coverage obtained from SSA, or current income data obtained from Equifax Workforce Solutions, then the Marketplace, Medicaid, or CHIP agency will collect a handwritten signature (either an original or a copy) from the adult application filer to authorize the disclosure. If an application includes more than one tax household, the agency will collect handwritten signatures from every adult listed on the application to authorize the disclosure. These signatures can be mailed or uploaded to the Marketplace, Medicaid, or CHIP agency, or sent via facsimile.

6.5.3.D Data That May Be Disclosed

Any information provided on an application by an application filer may be displayed as part of the application, eligibility notice, and electronic account. Income and household size as a percentage of the federal poverty level (FPL), which is calculated by the Marketplace, Medicaid, or CHIP agency based on multiple sources of data, may be disclosed as part of the eligibility and enrollment process.

APPENDIX A: IMPORTANT NOTICE

THESE PROVISIONS APPLY TO ALL DEPARTMENT OF HUMAN SERVICES (DOHS) STAFF WITH ACCESS TO IRS INFORMATION

IMPORTANT NOTICE

The Deficit Reduction Act of 1984 mandates that each state develop and implement an Income and Eligibility System (IEVS) to make accurate eligibility determinations and benefit payments by exchanging information with other agencies and by obtaining unearned income data from the Internal Revenue Service (IRS).

As with all information obtained by the DOHS, the agency is required to ensure the confidentiality of the information and restrict its use to the administration of the appropriate programs.

However, additionally, the IEVS regulations mandate that each employee having access to IRS information be informed of the IRS safeguarding/security requirements and penalties for unauthorized disclosure.

Appendix B contains information from the Internal Revenue Code (IRC) relating to unauthorized disclosure and damages for unauthorized disclosure. Please read Section 7213 in Appendix B and Section 7431 in Appendix C carefully.

Provisions of IRC Section 7213 make unauthorized disclosure of federal returns or return information a crime that may be punishable by a $5,000 fine, five (5) years imprisonment, or both.

In addition, provisions of IRC Section 7431 permit a taxpayer to bring suit for civil damages in a United States district court for unauthorized disclosure of returns and return information. This section allows for punitive damages in case of willful disclosure or gross negligence, as well as the cost of action.

These civil and criminal penalties apply even if the unauthorized disclosures were made after employment with the agency is terminated.

Any violation related to improper inspection and/or disclosure of Federal Tax Information (FTI) must be reported to the staff's Supervisor. Both physical and electronic violations must be reported. The Supervisor or the office's designee completes an incident report using form Data Incident Report for Improper Inspection and/or Disclosure of FTI (DFA-FTI-1). The breached FTI information is not submitted with the report. The form and any other attachments are sent immediately, but no later than 24 hours from the date of discovery, to both of the following agencies in the format designated below:

In writing or by telephone:	In encrypted electronic mail:
U.S. Treasury Inspector General for Tax Administration Office (TIGTA): Ben Franklin Station P. O. Box 589 Washington, DC 20044-0589 Hotline: 1-800-366-4484 Alternate: 1-800-589-3718	SafeguardReports@IRS.gov

A copy of the form and any attachments must be filed in the FTI file cabinet according to the policy in Section 6.4.

Any issues regarding the proper procedures for reporting improper inspection and/or disclosure of FTI are discussed with the staff's Supervisor.

APPENDIX B: IRC SECTIONS 7213 and 7213A

THESE PROVISIONS APPLY TO ALL DEPARTMENT OF HUMAN SERVICES STAFF WITH ACCESS TO IRS INFORMATION

IRS Publication 1075, September 2016

IRC SEC. 7213 UNAUTHORIZED DISCLOSURE OF INFORMATION

(a) RETURNS AND RETURN INFORMATION

(1) FEDERAL EMPLOYEES AND OTHER PERSONS – It shall be unlawful for any officer or employee of the United States or any person described in section 6103(n) (or an officer or employee of any such person), or any former officer or employee, willfully to disclose to any person, except as authorized in this title, any return or return information [as defined in section 6103(b)]. Any violation of this paragraph shall be a felony punishable upon conviction by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution, and if such offense is committed by any officer or employee of the United States, he shall, in addition to any other punishment, be dismissed from office or discharged from employment upon conviction for such offense.

(2) STATE AND OTHER EMPLOYEES—It shall be unlawful for any person [not described in paragraph (1)] willfully to disclose to any person, except as authorized in this title, any return or return information [as defined in section 6103(b)] acquired by him or another person under subsection (d), (i)(3)(B)(i), (1)(6), (7), (8), (9), (10), (12), (15) or (16) or (m)(2), (4), (5), (6), or (7) of section 6103. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(3) OTHER PERSONS – It shall be unlawful for any person to whom any return or return information [as defined in section 6103(b)] is disclosed in a manner unauthorized by this title thereafter willfully to print or publish in any manner not provided by law any such return or return information. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(4) SOLICITATION – It shall be unlawful for any person willfully to offer any item of material value in exchange for any return or return information [as defined in 6103(b)] and to receive as a result of such solicitation any such return or return information. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(5) SHAREHOLDERS – It shall be unlawful for any person to whom return or return information [as defined in 6103(b)] is disclosed pursuant to the provisions of 6103(e)(1)(D)(iii) willfully to disclose such return or return information in any manner not provided by law. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

IRC SEC. 7213A. UNAUTHORIZED INSPECTION OF RETURNS OR RETURN INFORMATION

(a) PROHIBITIONS

(1) FEDERAL EMPLOYEES AND OTHER PERSONS – It shall be unlawful for

(A) any officer or employee of the United States, or

(B) any person described in section 6103(n) or an officer willfully to inspect, except as authorized in this title, any return or return information.

(2) STATE AND OTHER EMPLOYEES – It shall be unlawful for any person [not described in paragraph (l)] willfully to inspect, except as authorized by this title, any return information acquired by such person or another person under a provision of section 6103 referred to in section 7213(a)(2).

(b) PENALTY

(1) IN GENERAL – Any violation of subsection (a) shall be punishable upon conviction by a fine in any amount not exceeding $1000, or imprisonment of not more than 1 year, or both, together with the costs of prosecution.

(2) FEDERAL OFFICERS OR EMPLOYEES – An officer or employee of the United States who is convicted of any violation of subsection (a) shall, in addition to any other punishment, be dismissed from office or discharged from employment.

(c) DEFINITIONS – For purposes of this section, the terms “inspect” “return” and “return information” have respective meanings given such terms by section 6103(b).

APPENDIX C: IRC SECTION 7431

THESE PROVISIONS APPLY TO ALL DEPARTMENT OF HUMAN SERVICES STAFF WITH ACCESS TO IRS INFORMATION

IRS Publication 1075, September 2016

IRC SEC. 7431 CIVIL DAMAGES FOR UNAUTHORIZED INSPECTION OR DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) In general

(1) Inspection or Disclosure by employee of United States

If any officer or employee of the United States knowingly, or by reason of negligence, inspects or discloses any return or return information with respect to a taxpayer in violation of any provision of section 6103, such taxpayer may bring a civil action for damages against the United States in a district court of the United States.

(2) Inspection or disclosure by a person who is not an employee of United States

If any person who is not an officer or employee of the United States knowingly, or by reason of negligence, inspects or discloses any return or return information with respect to a taxpayer in violation of any provision of section 6103 or in violation of section 6104 (c), such taxpayer may bring a civil action for damages against such person in a district court of the United States.

(b) Exceptions

No liability shall arise under this section with respect to any inspection or disclosure-

(1) which results from good faith, but erroneous, interpretation of section 6103, or

(2) which is requested by the taxpayer.

(c) Damages

In any action brought under subsection (a), upon a finding of liability on the part of the defendant, the defendant shall be liable to the plaintiff in an amount equal to the sum of–

(1) the greater of –

(A) $1,000 for each act of unauthorized inspection or disclosure of a return or return information with respect to which such defendant is found liable, or

(B) the sum of –

(i) the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure, plus

(ii) in the case of a willful inspection or disclosure or an inspection or disclosure which is the result of gross negligence, punitive damages, plus

(2) the cost of the action.

(d) Period for Bringing Action

Notwithstanding any other provision of law, an action to enforce any liability created under this section may be brought, without regard to the amount in controversy, at any time within 2 years after the date of discovery by the plaintiff of the unauthorized inspection or disclosure.

(e) Notification of Unlawful Inspection and Disclosure

If any person is criminally charged by indictment or information with inspection or disclosure of a taxpayer's return or return information in violation of –

(1) paragraph (1) or (2) of section 7213 (a),

(2) section 7213A (a), or

(3) subparagraph (B) of section 1030(a)(2) of Title 18, United States Code, the Secretary shall notify such taxpayer as soon as practicable of such inspection or disclosure.

(f) Definitions

For purposes of this section, the terms “inspect”, “inspection”, “return” and “return information” have the respective meanings given such terms by section 6103 (b).

(g) Extension to information obtained under section 3406

For purposes of this section –

(1) any information obtained under section 3406 (including information with respect to any payee certification failure under subsection (d) thereof) shall be treated as return information, and

(2) any inspection or use of such information other than for purposes of meeting any requirement under section 3406 or (subject to the safeguards set forth in section 6103) for purposes permitted under section 6103 shall be treated as a violation of section 6103.

For purposes of subsection (b), the reference to section 6103 shall be treated as including a reference to section 3406.

Chapter 7

Verification

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
7.1	4/1/23	835	7.1	Removed from the Introduction the note which waived certain verifications. Specifically for the Aged and Disabled Waiver applications only.
7.2	10/1/20	794	7.2.3	Replaced ineligible
	5/1/21	804	7.2.5.C	Updated examples of allowable self-attested verifications.
	6/1/22	822	7.2.4	Changed Domestic Violence to sexual harassment & domestic violence, sexual assault, and stalking.
	6/1/24	851	7.2.3	Removed the words Modified Adjusted Gross Income (MAGI).
			7.2.5	Removed the words MAGI and ONLY from the title.
			7.2.5.A	Updated language to clarify that the Reasonable Compatibility Standard for income. Added new Reasonable Compatibility Standard for Assets.
			7.2.5.B	Added language to clarify Reasonable Compatibility Policy is for only income and asset information received from electronic data sources.
	1/1/26	872	7.2.4	Added note about worker responsibilities for Notice of Match Results.
7.3	10/23/17	746	7.3	Verification requirements added Participation Hours in a Substance Abuse Treatment and Counseling Program and a Job Skills Program and Prescription.

	1/1/18	749	7.3	Adding verification requirements for ABLE accounts to chart. Should only verify once, either when the new account is reported or application prior to exclusion, to ensure it is an ABLE account.
	2/1/18	751	7.3	This change is to match federal requirements that an individual must provide verification of deployment to a designated combat zone prior to exempting additional earnings.
				When and how to verify certain felonies
				Change INS to USCIS
	6/1/19	772	7.3	Added Qualified Lottery
	6/1/19	772	7.4.3.A&B	Clarify SNAP shelter expenses
	1/1/20	779	7.3	Verification of Lottery & Gaming
	3/1/20	782	7.3	
	9/1/20	792	7.3	Changed language to clarify assets
	10/1/20	794	7.3.8	Changed wording
	2/1/21	800	7.3.24	Updated verification of age within Medicaid and CHIP
	5/1/21	804	7.3	Updated reporting requirements for SNAP
	10/1/21	809	7.3.41 & 42	Updated reporting requirements for SNAP
	12/1/21	813	7.3.25	Updated shelter verification
	1/1/22	814	7.3.75	Updated verification for Workforce WV
	6/1/22	822	7.3.18	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	1/1/23	830	7.3.28	Client attestation is verification of former foster care status.
	2/1/24	846	7.3	Added clarification on how retained COVID-19 Pandemic-related Disaster Assistance Funds can be verified for Medicaid.
	3/1/24	848	7.3.75	Added options for verifying veteran status for ABAWD policy
			7.3.76	New numbered order to make space for the new 7.3.75
	6/1/24	851	7.3.9	Added the Asset Verification System (AVS) as a possible source of verification.
			7.3.12	Updated to clarify that citizenship is verified through the FDH when available at initial application or when a change is reported.
			7.3.41	Removed the word MAGI from the chart.
			7.3.42	Removed the word MAGI from the chart.
			7.3.49	Removed the word MAGI and ONLY from the chart.
				Removed SNAP references from verification type Pregnancy

	2/1/25 4/1/25 6/1/25 8/1/25	860 862 864 867	7.3 7.3.50 7.3.9 7.3	Work Exemption. Removed Veteran Status (ABAWD exemption) from 7.3 Added BMS Third Party Insurance Verification Vendor as a source of verification for WVCHIP. Clarify AVS is for Medicaid programs with an asset test only. The discretionary decision must be clearly obvious to the supervisor or senior worker.
7.4	6/1/18 10/1/20 5/1/21	760 794 804	7.4.3.A 7.4.2&7.4.3 7.4.3.A	Removed NOTE in Social Security Administration (SSA/State Eligibility System (SVES) Data Match to clarify current Medicaid recipients need not document ongoing citizenship and identity. Replaced word illegal Clarify Medicaid verification
App A				

7.1 INTRODUCTION

This chapter describes the general verification process and requirements for the Supplemental Nutrition Assistance Program (SNAP), WV WORKS, the West Virginia Children's Health Insurance Program (WVCHIP), and most Medicaid coverage groups. Program-specific information is contained in program-specific chapters.

7.2 VERIFICATION PROCESS

7.2.1 WHEN VERIFICATION IS REQUIRED

Verification of a client's statement is required when:

- Policy requires routine verification of specific information.
- The information provided is questionable. To be questionable, it must be:
    - Inconsistent with other information provided; or
    - Inconsistent with the information in the case file; or
    - Inconsistent with information received by the Department of Human Services (DOHS) from other sources; or
    - Incomplete; or
    - Obviously inaccurate; or
    - Outdated.
- Past experience with the client reveals a pattern of providing incorrect information or withholding information. A case recording must substantiate the reason the Worker questions the client's statement.
- The client does not know the required information.

7.2.2 WHEN VERIFICATION IS NOT REQUIRED

Verification is not required from the individual when:

- It is known that the individual does not have access to the requested information.
- The information is known, or available to the Department of Human Services (DOHS).
- The client's response is a negative statement, unless his statement is questionable. An example of a negative statement is when a client reports that he has no bank account. His negative statement is not verified unless there is a valid reason to question it.
- A change reported during the Supplemental Nutrition Assistance Program (SNAP) certification period results in a decrease in benefits, unless the reported change is a new source of income.

For Medicaid Coverage Groups and West Virginia Children's Health Insurance Program (WVCHIP) Only: Being homeless, a victim of a natural disaster, or a victim of an emergency situation are all considered as limiting an individual's compliance with obtaining verifications. Once citizenship and non-citizen status are verified, an eligibility decision is made for these individuals on available information alone.

7.2.3 CLIENT RESPONSIBILITIES

The primary responsibility for providing verification rests with the client.

It is an eligibility requirement that the client cooperate in obtaining necessary verifications, with an exception being that a client must never be asked to provide verification that he is or is not either a fleeing felon or a probation/parole violator. The client is expected to provide information to which he has access and to sign authorizations needed to obtain other information.

Failure of the client to provide necessary information or to sign authorizations for release of information results in denial of the application or closure of the active case, provided the client has access to such information and is physically and mentally able to provide it.

For Medicaid Coverage Groups and WVCHIP Only:

- Client self-attestation is verified by electronic data sources.
- The client must not be required to provide verification unless information cannot be obtained electronically or self-attestation, and electronic data sources are not reasonably compatible. See Section 7.2.5 below.

Refusal to cooperate, failure to provide necessary information, or failure to sign authorizations for release of information, provided the client has access to such information and is physically and mentally able to provide it, may result in one of the following:

- Denial of the application
- Closure of the assistance group (AG)
- Determination of ineligibility
- Disallowance of an income deduction or an incentive payment

No case may be determined ineligible when a person outside the AG or income group (IG) fails to cooperate with verification. The following individuals are not considered part of the AG or IG but must provide verification:

- Ineligible student (SNAP – verification only required for student status)
- Non-qualified non-citizens (all programs)

- Persons who fail to attest to or verify citizenship or non-citizen status (requirements vary by program)
- Disqualified persons (WV WORKS and SNAP)
- Supplemental Security Income (SSI) recipients who would be required to be included in the WV WORKS AG, except for receipt of SSI

7.2.4 WORKER RESPONSIBILITIES

The Worker has the following responsibilities in the verification process:

- At application, redetermination, and anytime a DFA-6 is used, the Worker must list all required verification known at the time. The Worker should only request additional verification if information provided is incomplete or additional information is necessary to determine eligibility.
- If the client is unsuccessful in obtaining information, or if physical or mental limitations prevent his compliance, and there is no one to assist him, the Worker must document attempts to obtain the verification.
- The Worker must accept any reasonable documentary evidence as verification and must not require a specific kind or source of verification. Verification may be submitted in person, by mail, by fax, or electronically.
- The Worker must not request verification if the case record or other documentation shows that verification has previously been supplied. It may, however, be requested if the verification provided or shown in the Department's records is incomplete, inaccurate, outdated, or inconsistent with recently reported information.
- If the client requests a receipt for verification, one must be provided.
- When the client alleges sexual harassment and domestic violence, sexual assault, and stalking, the Worker, in order to ensure the safety of the individual, must never contact the abuser, his relatives, or friends. See Section 7.3.16 for acceptable method of verification in sexual harassment and domestic violence, sexual assault, and stalking situations.

NOTE: For SNAP, home visits are made only on a case-by-case basis and not because an AG fits an error prone or other profile. A home visit is used for verification only when documentary evidence cannot be obtained or is insufficient to make an eligibility or benefit level determination.

- When the Worker must make collateral contact, such as but not limited to, a client's employer, the Worker must not disclose the client's status as an applicant/client of a DOHS program.
- When the Worker receives information about the SNAP AG during the certification period that requires additional clarification or verification, the Worker may send a DFA-6 or may request, but not require, the client report to the office for an interview.
- When the agency receives a Notice of Match Results from the Income Eligibility Verification System that conflicts with case information, and the agency cannot resolve it internally, the client is required to provide independent verification to clarify or confirm the information.

7.2.5 REASONABLE COMPATIBILITY – MEDICAID COVERAGE GROUPS AND WVCHIP ONLY

7.2.5.A Definitions

These definitions and provisions apply to all Medicaid and WVCHIP coverage groups.

REASONABLE COMPATIBILITY

Reasonable compatibility means that information provided by an applicant through self-attestation does not vary significantly, or in a way that is meaningful for eligibility when compared to information obtained through electronic data sources.

Under reasonable compatibility, the Worker can require verification documentation only when the difference between the attestation and data source affects eligibility.

REASONABLE EXPLANATION

The applicant must be given an opportunity to provide an explanation for discrepancies between self-attested information, and information reported by an electronic data source. The Worker must determine if the client's explanation is reasonable.

REASONABLE COMPATIBILITY STANDARD FOR INCOME ONLY

The Reasonable Compatibility Standard is an acceptable level of variance between self-attested income and income information obtained through electronic data sources. When the difference between the self-attestation and data source incomes affects eligibility, the reasonable compatibility test is applied by the eligibility system. Refer to 7.2.5.D.

West Virginia's Reasonable Compatibility Standard for MAGI Medicaid coverage groups only is 10%.

REASONABLE COMPATIBILITY STANDARD FOR ASSETS ONLY

The reasonable compatibility standard for assets applies only during the automatic renewal process. Assets are considered verified at automatic redetermination when the value of liquid assets returned by the Asset Verification System plus the value of non-liquid assets previously verified in the case record are below the asset limit. Further verification is not required.

When the total of these assets exceeds the asset limit, assets are not considered verified, i.e., discrepant. The client must be mailed a pre-populated redetermination form and be given the opportunity to verify the value of their assets at renewal. See Section 6.3.6.

7.2.5.B Reasonable Compatibility Policy

Eligibility determinations for Medicaid and WVCHIP will be based, to the maximum extent possible, on applicant self-attestation verified by information obtained from electronic data sources.

- When income and asset information obtained through electronic data sources is reasonably compatible with an applicant's attestation, the self-attested information is considered verified.
    - Self-attestation information and information from data sources are reasonably compatible when any difference or discrepancy between the two sources does not impact the eligibility of the application.
- If income and asset information obtained through electronic data sources is not reasonably compatible with an applicant's attestation, additional documentation may be required.
- Under reasonable compatibility, the Worker can require verification documentation only when the difference between the self-attestation and data source income and asset information affects eligibility.
- The applicant must be given an opportunity to provide an explanation for discrepancies between self-attested information and income and asset information reported by an electronic data source. The Worker must determine if the client's explanation is reasonable.

7.2.5.C Applying Reasonable Explanation

Eligibility determination begins with the applicant's self-attestation regarding his non-financial and financial information. When available, applicant information is matched by the Federal Data HUB (FDH) or other electronic data source.

The majority of eligibility factors are subject to the reasonable compatibility assessment when there is a discrepancy between the applicant's statement and information in the FDH or other electronic data source.

Self-attestation is accepted without further verification for certain factors including residency, household composition, and pregnancy.

The Worker must reconcile discrepancies in information using this process:

- The Worker must give the applicant the chance to provide an explanation for the differences. If the client explains the differences and the Worker accepts the explanation as reasonable, no further verification is necessary. The Worker can use the self-attested information.
- If the applicant's explanation is questionable and the Worker does not accept it as reasonable, the Worker must check all other electronic databases first, as well as any other information available to the Department, such as the client record, before requesting verifications from the applicant.
- If, after checking other available sources and requesting and reviewing verification from the applicant, the Worker cannot reconcile the self-attested information with information received from an electronic data source as reasonably compatible, then additional information is requested.

EXCEPTION: Citizenship and immigration status must be verified regardless of the applicant's explanation of discrepancies.

7.2.5.D Applying Reasonable Compatibility to Income

The Worker must accept self-attestation of income information when the applicant's attestation and information obtained through an electronic data sources are reasonably compatible, meaning any difference in income information does not impact eligibility.

The following table identifies the one situation when the difference in income information impacts eligibility and the Reasonable Compatibility Test must be applied.

Attested Income (including 5% disregard, if applicable)	Income from Electronic Data Source	Can Attested Income be Used?	Outcome	Is Reasonable Compatibility Test Required?
Is below, or equal to, the income eligibility threshold	Is below the income eligibility threshold	Yes	Applicant is income eligible	No
Is below, or equal to, the income eligibility threshold	Is above the income eligibility threshold	No	Income information is not reasonably compatible	Yes See Section 7.2.5.E
Is below, or equal to, the income eligibility threshold	Is not available	No	Request additional verification	No
Is above the income eligibility threshold	Is above the income eligibility threshold	Yes	Applicant is ineligible	No
Is above the income eligibility threshold	Is below the income eligibility threshold	Yes	Applicant is ineligible	No
Is above the income eligibility threshold	Is not available	Yes	Applicant is ineligible	No

7.2.5.E Applying the Reasonable Compatibility Test

When the applicant's self-attested income is below or equal to the income eligibility threshold, and the electronic data source is above the income eligibility threshold, Reasonable Compatibility is applied, and a determination is made to determine whether or not additional verification is required.

The Reasonable Compatibility Test has two steps:

- **Step 1**: Calculate the percentage difference between the self-attested income and the income reported by the electronic data source.

$$\frac{\text{Electronic Data Source Income} - \text{Self-attested Income}}{} \times 100$$

Self-attested Income

- **Step 2**: If the percentage difference between the self-attested income and electronic data source income is less than or equal to 10%:
  - The two figures are considered reasonably compatible.
  - No additional verification is required.
  - The self-attested income is used to determine eligibility.

7.2.5.F Reasonable Compatibility Examples

Reasonable Compatibility Example 1: Ms. Violet applied for Medicaid as a single adult. She states her income is $1,200 per month. The electronic data source returns income of $1,280 per month. The allowable income limit is $1,238. No further explanation or verification is required.

Reasonable Compatibility Test Step	Calculation	Result
STEP 1: Calculate the percentage difference between the self-attested income and the income reported by the electronic data source.	$\frac{\$1280 - \$1200}{\$1200} \times 100$	6.6%
STEP 2: Compare the income difference to the Reasonable Compatibility Standard (10%).	6.7% is less than 10%; therefore, the amounts are reasonably compatible. The Worker must use the self-attested income to determine eligibility.	

Reasonable Compatibility Example 2: Mr. Clover applied for Medicaid as a single adult. He states his income is $1,200 per month. The electronic data source returns income of $1,340 per month. The allowable income limit is $1,238. The Worker asks Mr. Clover to explain the difference, but he cannot. The income difference affects eligibility, so the Reasonable Compatibility Test must be applied.

NOTE: If the percentage difference between the self-attested income and electronic data source income is greater than 10%:

- *The two figures are not reasonably compatible.*
- *Additional verification is required.*

Reasonable Compatibility Test Step	Calculation	Result

STEP 1: Calculate the percentage difference between the self-attested income and the income reported by the electronic data source.	$\frac{\$1340 - \$1200}{\$1200} \times 100$	11.6%
STEP 2: Compare the income difference to the Reasonable Compatibility Standard (10%).	11.6% is greater than 10%; therefore, the amounts are not reasonably compatible. The Worker must check other available data sources known to the Department. If he cannot verify the self-attested income, he must request income verification from the applicant.	

7.3 VERIFICATION REQUIREMENTS

See Section 7.2 for additional verification requirements including, but not limited to, when the information is questionable. The table below identifies items to be verified, which programs require verification, when information must be verified, and possible sources of verification.

NOTE: SNAP ONLY: Verification of assets is not required when an assistance group (AG) is categorically eligible for benefits. A Worker is still required to update the eligibility system with all available asset information reported.

Program	When to Verify	Possible Sources of Verification
1. 24-Month Time Limit		
WV WORKS	Prior to initial approval	Eligibility system; case record information; contact with other states; Department of Human Services (DOHS) printouts or other records
2. 60-Month Lifetime Limit		
WV WORKS	Prior to initial approval	Eligibility system; case record information; contact and obtain written verification from other states using the DFA-WVW-Verif-1; DOHS printouts or other records
3. Ability to Sell an Annuity or the Annuity's Stream of Income		
All Medicaid coverage groups with an asset test	Prior to approval or when an annuity is purchased	Letters or documents from companies that purchase annuities or a stream of income from annuities

Program	When to Verify	Possible Sources of Verification
4. Achieving a Better Life Experience (ABLE) Account		
All Programs	Only once to verify the account itself prior to exclusion; at application or when new account is reported	Financial institution forms or account statement Client attestation is acceptable for account balance, contributions to, or distributions from the account, as well as for amount spent for qualified disability expenses
5. Age (Date of Birth)		
Medicaid and WVCHIP	Prior to initial approval	Social Security Administration through the FDH or SVES, IPACT, Birth Certificate If verification exists electronically, no further verification is required, and case worker will make a comment as to the verified source. If no verification exists from electronic sources, paper verification may be requested from the client to satisfy the requirement; or, the State may reach out to the individual for reasonable explanation.
6. Value of an Annuity		
All Medicaid coverage groups with an asset test	Prior to approval or when an annuity is purchased, or other action taken that would affect the annuity value	Statement or document verifying the value from the financial entity or company that issued or holds the annuity
7. Application for Potential Resources		
WV WORKS Medicaid, except as specified in Chapter 8	Prior to initial approval, when an AG member appears to be eligible for a benefit which would reduce or eliminate the client's need for public assistance	Written statement from agency which accepted the client's application, telephone contact with such agency
8. Adult – Supervised Living Arrangement		
WV WORKS	Prior to initial approval; at each redetermination; when a change is reported	Contact with the supervising adult; written statement from the supervising adult; collateral contacts; home visit
9. Bank Accounts, Certificates of Deposit (CDs), and Other Liquid Assets		

Program	When to Verify	Possible Sources of Verification
All programs and coverage groups subject to an asset test	At application and redetermination; or when client reports an increase SNAP Only: To determine if used solely for a deployed service person's benefit	Bank statements; the CD; stock market prices; whole life insurance policies; statement of stockbroker; Asset Verification System (AVS). AVS is for Medicaid applicants and clients who qualify based on being aged, blind, or disabled only. SNAP Only: Written statement from the service person or the financial institution, such as a detailed account record
10. Bona Fide Loan		
Aid to Families with Dependent Children (AFDC)-Related Medicaid SSI-Related Medicaid groups	At application; at redetermination; when client reports he has a loan	Written statement; loan documents
11. Certain Felony Convictions and Sentence Compliance		
SNAP	At application and redetermination or when the client reports he is not complying with his conviction.	Original conviction document or information obtained from law enforcement with appropriate jurisdiction and knowledge of non-compliance.
12. Citizenship		
Medicaid and WV CHIP	At initial application and when a change is reported.	See Section 7.4 for specific documentation requirements and exemptions. The FDH will verify citizenship when information is available. Additional documentation may be requested if citizenship cannot be verified through the FDH.
13. Compliance with Personal Responsibility Contract (PRC) and Self Sufficiency Plan (SSP) Requirements		
WV WORKS	At time limits established in the (PRC) and/or the (SSP)	Contact with other agency or institution; written notice of compliance from the entity with whom the client was required

Program	When to Verify	Possible Sources of Verification
		to participate; copies of official documents from other agency or institution
14. Criminal Offense Reduction of a Felony to a Misdemeanor		
SNAP and WV WORKS	Prior to approval or adding a previously disqualified individual to the household	A legal court order granting the criminal offense reduction; collateral contact
15. Dedicated Account for SSI Recipient Under Age 18		
WV WORKS	Prior to exclusion	Social Security Administration (SSA) letters to payee which inform individual of need to establish account or which verify a deposit into such account; statement from SSA that dedicated account meets SSA definition
16. Deployment to a Designated Combat Zone		
SNAP	Prior to approval.	The Leave and Earnings Statement (LES); orders issued to the military person; public records; local base financial office; the internet. A list of designated combat zones is available online at the FNS website. Use the best source of verification available. When there is absolutely no other source of verification, the client's statement must be used.
17. Disability, Blindness		
SSI-Related Medicaid CDCSP SNAP	Prior to approval; when the Medical Review Team (MRT) or the Bureau for Medical Services (BMS) requires re-evaluation SNAP Only: See Section 13.15	Receipt of Retirement, Survivors, and Disability Insurance (RSDI); the MRT decision; the BMS decision SNAP Only: See Section 13.15
18. Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking		
WV WORKS	When the applicant or client alleges sexual harassment and domestic violence, sexual assault, and stalking and requests an exemption from	Protective orders; hospital records; statements from legal services or domestic violence counseling or shelter staff or witnesses; paperwork from law enforcement agencies, (i.e., criminal

Program	When to Verify	Possible Sources of Verification
	work participation requirements or program time limits	charges). *NOTE: To ensure the safety of the client, the Worker must never contact the abuser, his relatives, or friends in an attempt to verify sexual harassment and domestic violence, sexual assault, and stalking.*
19. Educational Funds		
Medicaid WVCHIP	Prior to initial approval; at application; at redetermination; and when the client reports the onset or a change	Verify the source amount and amount earmarked for educational purposes Statement from educational institution; financial aid office or other grantor; receipts; knowledge of public transportation costs; commuting distances and gasoline prices; statement of reasonable estimate of expenses
20. Employment Offer or Guarantee of Employment or Other Income		
WV WORKS	Prior to approval of Diversionary Cash Assistance (DCA) payment	Contact with future employer or entity from which the income is expected
21. Child Support Expense for Child Support Income, see Unearned Income.		
SNAP	At application; at redetermination or when the client reports a change in the legally obligated amount or amount actually paid	Verify the legally obligated amount and the amount actually paid, including the value of any in-kind payments Court order or legal separation agreement; cancelled checks; the child support data system; pay stubs showing wage withholding; signed receipt or statement from the custodial parent
22. Dependent Care Expenses		
SNAP WV WORKS AFDC-Related Medicaid	SNAP Only: Only when information provided is questionable WV WORKS and AFDC-Related Medicaid Only: Prior to initial approval, at redetermination or when the client reports a change	Day care bills; receipts; written estimates of anticipated costs from the provider; child care program certification letters showing client liability

Program	When to Verify	Possible Sources of Verification
23. Medical Expenses		
SNAP SSI-Related Medicaid AFDC-Related Medicaid	SNAP Only: At application; at redetermination; and when the client reports a change of more than $25 in total medical expenses or anticipated medical expenses SSI and AFDC-Related Medicaid Only: Prior to using the expense for spenddown	Verify amount owed by the client which will not be reimbursed by a third party Medical bills; medical receipts; written estimates of anticipated costs from the medical provider; health insurance Explanation of Benefits (EOB); billing staff in hospital or doctor's office; shipping invoices for mail-order prescription drugs and their shipping costs
24. Out-of-Pocket Medical Expenses		
Medicaid	When the Department causes a delay in Medicaid coverage, and the client incurs medical expenses, which would have been paid by Medicaid, had the Department acted timely.	Original bills from the medical provider and proof of payment by the client; receipts from the medical provider
25. Shelter Expenses		
SNAP	At each application and redetermination, or when an individual reports a change of shelter expense.	Acceptable verification must include the name and phone number of the landlord, the obligation amount, and the actual paid amount. Shelter expense verifications do not require a landlord's signature. Acceptable verification is not limited to any single type of document and is obtained from the household or other source. When the customer cannot obtain information from a primary source of verification, the worker can then accept a secondary source. When a customer cannot obtain any verification of shelter expense, it is necessary for the worker to obtain a shelter attestation form from the customer. If a lease or rental agreement provided by the customer is older than 1 year, the customer must also

Program	When to Verify	Possible Sources of Verification
		complete a shelter attestation form. The worker must provide or mail the shelter attestation form to the customer to complete and must record why the shelter attestation form was used. **Primary Sources of Verification**: • Current lease/rental agreements within 1 year of the application/review date. • Document on official letterhead from an office or agency. This includes offices or agencies working on behalf of the landlord. • HUD contracts/renewals **Secondary Sources of Verification** • Handwritten notes/letters • Rent receipts/Money Orders
26. Substantial Lottery or Gambling Lottery		
SNAP	Anytime an individual receives winnings greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled individual during any single game, hand or bet.	Information received from the WV Lottery Commission. Tax ticket, receipts, bills of sale. The AG must meet the allowable asset and income limits before being eligible for SNAP.
27. Utility Expenses for Standard Utility Allowance (SUA) Standards		
SNAP	Only when information provided is questionable	Current bills or receipts; landlord statements; lease agreements
28. Former Foster Care Status		
Former Foster Care Medicaid Group	Accept Client self-attestation, post-eligibility, if questionable.	Client statement Child Welfare Information System
29. Funds Received for Replacement or Repair of an Asset		
All programs with an asset test	When client reports receipt of such funds	Verify: amount, source, date received, how much used to repair or replace an asset Award letter; statement from provider

Program	When to Verify	Possible Sources of Verification
		of funds; copy of check; receipts for repair or replacement; estimates; signed contracts
30. Funds Received from Sale of an Excluded Home		
SSI-Related Medicaid Pickle Amendment Coverage (PAC) CDCSP Qualified Disabled Working Individuals (QDWI) Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB) Qualified Individual–1 (QI-1)	When excluded home is sold	Verify: amount, source, date received, how much used to purchase a different home Purchase agreement; statement from buyer; statement from seller; statement from real estate agent
31. Gift Card / Certificate Value		
All Medicaid coverage groups WV WORKS	Prior to initial approval; at redetermination; and when the client reports receipt	Signed attestation from the individual. If questionable, verification with the issuer, the card itself, a purchase receipt, vendor, or vendor's website.
32. Good Cause for Leaving or Refusing Employment		
SNAP WV WORKS	When good cause is claimed for work requirements SNAP Only: Good cause is determined at redetermination and application.	Employer's statement; grievance board decisions; statements of witnesses; WorkForce West Virginia decision; employee associations; union representatives WV WORKS Only: Statement from school or educational facility of enrollment and/or attendance in a full-time educational activity
33. Good Cause for Refusal To Cooperate With the Bureau for Child Support Enforcement (BCSE)		
WV WORKS	When the custodial parent or caretaker relative does not cooperate and claims good cause.	Police reports; collateral statements from persons knowledgeable about the client's situation; domestic violence shelter staff documentation;

Program	When to Verify	Possible Sources of Verification
		counselor's reports; medical records
34. Good Cause for Voluntarily Quitting Employment		
SNAP WV WORKS	SNAP Only: When an applicant quits employment within 60 days prior to the application date or a client quits a job. Good cause is determined at redetermination and application. WV WORKS Only: When an applicant quits employment within 45 days prior to the application date or a client quits a job at any time	Employer's statement; grievance board decisions; statements of witnesses; WorkForce West Virginia decision. WV WORKS Only: Statement from school or educational facility of enrollment and/or attendance in a full-time educational activity
35. Good-Faith Effort to Sell Real Property		
WV WORKS	Prior to exemption of real property	Newspaper ads; statement of realtor; other media notices; DFA-22
36. Hours Worked		
SNAP	Prior to exemption when an AG member is a student or an Able-Bodied Adults Without Dependents (ABAWD)	Pay stubs; written statement from employer; work record sheet; DFA-17
37. Identity		
SNAP SNAP Only: This includes authorized representatives. WV WORKS	Prior to initial approval. *NOTE: Verification of identity is not waived for SNAP Expedited Service cases.*	Including but not limited to: driver's license; school ID cards or records; marriage records; library card; credit cards; Employment Services registration card; Social Security card; written statements from neighbors; police records; employment ID or records; voters registration card, military discharge papers; selective service card; state ID card; passport; military identification card; State Verification Eligibility System (SVES) data match
38. Illness, Impairment, or Unfit for Work		
SNAP WV WORKS	SNAP Only: Prior to exempting the individual from work and/or ABAWD requirements when the	Joint decision by Worker and Supervisor when supported by definitive medical information; MRT decision for WV

Program	When to Verify	Possible Sources of Verification
	illness, impairment or unfit for work is not clearly obvious to a supervisor or senior worker. Exemption status must be re-evaluated at redetermination. WV WORKS Only: Prior to temporarily exempting the individual from meeting the work participation requirement, and prior to determining good cause for failure to meet the 24-month work requirement	WORKS The DFA-DIMA-1 may be utilized for both SNAP and WV WORKS. It is the preferred method of verification.
39. Individual Needed in the Home to Care for an Ill, Handicapped, or Disabled Person		
SNAP WV WORKS	Prior to exempting the individual from participation and at redetermination *NOTE: For SNAP, the individual who needs care is not required to reside with the AG.*	Definitive statement from physician; licensed psychologist; MRT decision for WV WORKS
40. Immigration Status		
MAGI Medicaid groups WVCHIP	At application, or at redetermination if changes occur regarding immigration status.	Department of Homeland Security. This information will be obtained from the FDH electronically. If a match is not available, the agency must contact Systematic Alien Verification for Entitlement Program (SAVE) Coordinator.
41. Earned Income		
All programs with an income test	All Programs: Prior to initial approval, at application, at redetermination. *NOTE: All income used in calculating eligibility and the amount of the benefit must be verified. However, income considered, but not used, need not be verified.* SNAP Only: During the certification period, when there is a change in employment or a change in earnings of $125 or more.	Verify source and amount. Pay stubs; written statement from employer; self- employment records; Work Record Sheet DFA-17; military LES. The amount of earnings received on a pay card may also be verified electronically via text message, calling the number on the debit card or accessing the employer's website. *NOTE: The military LES is received at the beginning of the month and shows earnings for services performed in the*

Program	When to Verify	Possible Sources of Verification
	Medicaid and WVCHIP Only: When a change in the amount is reported. WV WORKS Only: When a change is reported in rate of pay, or number of hours, verify the change. When a change is reported in the source, verify rate of pay, number of hours and source.	*prior month.* *NOTE: The year-to-date amounts on pay stubs may be used when the client has verification of all pay amounts whether used or not but is missing one.* Use the best source of verification available. When there is absolutely no other source of verification, the client's statement must be used. Medicaid and WVCHIP Only: See Section 7.2 for Federal Data Hub and certain emergency circumstances when verifications are not available to the client.
42. Unearned Income		
All programs	Prior to approval; at redetermination; when a change in the source or amount is reported *NOTE: All income used in calculating eligibility and the amount of the benefit must be verified. However, income considered, but not used, need not be verified.* SNAP Only: The change in the income amount must be more than $125 for verification to be required. MAGI Medicaid and WVCHIP Only: See Section 7.2	Verify source and amount. Award letter; computer matches; written statement from source; BCSE information; written statement from contributor; eligibility system data exchanges The amount of unearned income received on a pay card may also be verified electronically via text message, calling the number on the debit card or accessing the source's website. *NOTE: The year-to-date amounts on check stubs may only be used when the client has verification of all payment amounts whether used or not but is missing one.* Use the best source of verification available. When there is absolutely no other source of verification, the client's statement must be used. Medicaid and WVCHIP Only: Federal Data Hub, see Section 7.2
43. Indian Lands and Trust Funds		
All Medicaid coverage groups with	See Chapter 5, Appendix C	See Chapter 5, Appendix C

Program	When to Verify	Possible Sources of Verification
an asset test		
44. Proceeds or Distributions from Indian Lands and Trust Funds		
All Medicaid coverage groups	See Chapter 5, Appendix C	See Chapter 5, Appendix C
45. Insurance Premium Payment		
SNAP: For medical expenses only Medicaid WVCHIP	Prior to approval; at redetermination or whenever a change is reported	Statement from insurance company or pay stub when insurance premium payment is an expense.
46. Joint Custody, Which Parent Will Receive Benefits for Child		
SNAP WV WORKS	Prior to initial approval; at redetermination; when a change is requested by parents SNAP Only: Only verify when questionable	Statements from parents; collateral statements from friends, neighbors, family; court order
47. Long Term Care Insurance Partnership (LTCIP) Asset Disregard		
Medicaid - Aged, blind, or disabled, institutionalized individuals with income equal to, or less than 300% of the SSI payment for one	Prior to approval and any time an individual indicates assets in excess of the allowable maximum asset amount but has a Qualified LTCIP Policy that has paid insurance benefits to or on behalf of the individual	The DFA-LTCIP-1; the Qualified LTCIP Policy; letter from the issuing state's insurance commissioner or other governmental agency that regulates insurance; or verification from the issuing insurance agency indicating compliance of the Policy with Section 1917(b)(5)(A) of the Social Security Act
48. Lottery and Gambling Winnings		
MAGI-based Medicaid	When the client reports the receipt of a lump sum payment	Copy of the tax ticket, IRS/tax, lottery forms, media stories, bank deposits, or data exchange
49. Lump Sum Payment		
All programs with an income test	At application; at redetermination; when the client reports the receipt of a lump sum payment Medicaid and WVCHIP: Only verified if received in the month of application	Verify amount used to meet life-threatening situation or amount unavailable Media stories; statement of knowledgeable person; police reports; hospital reports; physician's statement
50. Medical Insurance Information		

Program	When to Verify	Possible Sources of Verification
Medicaid WVCHIP	Prior to approval for WVCHIP; at redetermination; when new insurance or a change in insurance is reported	Medical insurance card or coverage verification letter from insurance company; BMS Third Party Insurance Verification Vendor
51. Medicare Enrollment – Parts A and B		
Medicaid	Prior to initial approval and at redetermination	Federal Data Services Hub; award letter from Social Security (SSA); Medicare card; SSA referral form
52. Participation Hours in Employment and Training Activities		
SNAP WV WORKS WV WORKS Support Payments	Monthly	SNAP Only: DFA-17 WV WORKS Only: Time sheets; verbal confirmation over the phone from training or volunteer site may be accepted but must be followed up with receipt of a signed timesheet. For employment, phone confirmation by employer followed with written, signed employer statement, or pay stubs, electronic records, such as e-mails. WV WORKS Support Payments: Participation hours may be recorded based on employment hours, but no support services may be issued without appropriate verification or signed time sheet or the appropriate submitted request.
53. Participation Hours in a Substance Abuse Treatment and Counseling Program and a Job Skills Program		
WV WORKS WV WORKS Support Payments	Weekly for Participation Monthly for WV WORKS Support Payments	Participation: Time sheets, verbal confirmation by phone from a Substance Abuse Treatment and Counseling Treatment Programs and a Job Skills Program site, or faxes and electronic records, such as e-mails. Support Payments: Time sheet, or the appropriate submitted request.
54. Personal Care Contract, Personal Care Agreement, Personal Service Contract		
Medicaid	When an applicant or client states	The legal, written agreement; letter from

Program	When to Verify	Possible Sources of Verification
	he transferred funds, property or resources to a relative or friend as payment of personal care services	an attorney that contains all the terms of the personal care contract.
55. Plan for Achieving Self-Support (PASS) Account		
SNAP SSI-Related Medicaid PAC CDCSP QDW QMB SLIMB QI-1	Prior to exclusion; at application; at redetermination SNAP Only: Prior to exclusion, verify that PASS was developed through SSA	Copy of plan
56. Pregnancy		
Medicaid WVCHIP	This is not routinely verified. Prior to approval; only when pregnancy is questionable due to age of applicant; history of multiple pregnancies in a short time or pregnancies not resulting in a status such as birth, abortion or miscarriage, etc.	Accept self-attestation. Statement from attending physician, physician's assistant, nurse practitioner or other person medically qualified to diagnose pregnancy
57. Pregnancy Work Exemption		
WV WORKS	Prior to WV WORKS good cause determination	Written statement from physician, physician's assistant, nurse practitioner or other licensed health care provider, which shows the expected date of delivery.
58. Prescription		
WV WORKS	Within 24 hours following a positive drug test	A valid prescription, current prescription bottle or written verification by a healthcare provider who has the authority to prescribe the controlled substance in question.
59. Promissory Notes and Outstanding Principal Balance		
All Medicaid coverage groups with an asset test	At application and redetermination or when a promissory note is obtained or held	A copy of the agreement/promissory note. If the individual claims the Fair Market Value (FMV) is less than the outstanding

Program	When to Verify	Possible Sources of Verification
		principal balance, he may present documentation from a bank or other financial institution, private investor or real estate broker. The estimate must show the name, title, and address of the source. To determine the outstanding principal balance, an amortization schedule can be used to determine the outstanding principal balance and interest income, if the terms of the agreement are known, (i.e., interest rate, payment period, original principal amount, etc.).
60. Replacement of Destroyed Food Purchased with SNAP Benefits		
SNAP	Request for food replacement. *EXCEPTION: During a mass power outage, no verification is required.*	Collateral contact; community agency; utility company; landlord; home visit
61. Residence		
SNAP Medicaid and WVCHIP	Prior to initial approval Medicaid and WVCHIP Only: Only if questionable	Rent or mortgage receipts; landlord's statement; written statements from neighbors; employment records
62. Savings Bond		
All programs subject to an asset test	**When bond is at least six months old:** Prior to initial approval, or when client reports additional bonds **If bond is not six months old:** Verify six months from date of issue	Verify date of purchase and cash- in value Bond; financial institution
63. Social Security Number (SSN) Application		
All programs, except Medicaid Continuously Eligible Newborn (CEN) group	Prior to initial approval; prior to adding the individual to the AG WV WORKS Only: After completion of the PRC/SSP	SSA/DHS-3; written statement from SSA; for newborns only, SSA Form 2853 Enumeration at Birth form
64. SSN		
All programs, except Medicaid CEN group	Prior to initial approval; prior to adding an individual to the AG. SNAP Only: At redetermination if individual without SSN is referred to	Social Security Card; written statement from SSA; data system Medicaid and WVCHIP Only: FDH

Program	When to Verify	Possible Sources of Verification
	SSA WV WORKS Only: After completion of the PRC/SSP	
65. Specified Relationship		
AFDC-Related Medicaid Parents/Caretaker Relatives Medicaid WV WORKS	WV WORKS Only: Prior to initial approval AFDC-Related Medicaid and Parents/Caretaker Relatives Medicaid Only: Only if questionable.	Birth certificates; statements of physicians or midwives who attended the birth; family Bible; wills or deeds which specify paternity; records of social services agencies; DOHS records; hospital records; juvenile court records; school records; income tax returns In the absence of any documentary proof, the relative's statement about the reason there is no proof, and at least one notarized statement from a person knowledgeable about the situation is acceptable. The notarized statement must describe the relationship and explain how the individual knows it to be true.
66. Termination Appeal of SSI - No Longer Disabled		
SSI Medicaid	Prior to case closure and evaluation for other Medicaid coverage groups	Letters to client from SSA; written statement from SSA
67. Tax-Exempt Status of Group Living Facility (GLF)		
SNAP	Prior to approval of benefits for residents of GLFs	Copy of State certification or other authorization to operate the facility; written statement from IRS
68. Tax Filer Status or the Tax Filing Status		
MAGI Medicaid WVCHIP	Prior to approval; at redetermination; or when a change is reported	Accept self-attestation or, if questionable, IRS returns, or court documents.
69. Tax Household Group		
MAGI Medicaid WVCHIP	At application; at redetermination; when a change to the tax household group is reported	FDH; client statement; court order. See Section 7.2
70. Trust Fund or Other Similar Device, Including Burial Trusts		
All Programs subject to an asset test	At application; prior to initial approval; when client reports	Written agreement

Program	When to Verify	Possible Sources of Verification
	establishment of a trust	
71. Uniform Gifts to Minors Act Funds		
SNAP WV WORKS AFDC-Related Medicaid	At application; at redetermination; when client reports having such funds; prior to exclusion	Written agreement must specifically state that such funds are part of the Uniform Gifts to Minors Act.
72. Value of Business Equipment and Livestock		
All programs subject to an asset test	Prior to initial approval; at redetermination; and when ownership of different or additional equipment or livestock is reported	Tax receipts; Assessor's records; Realtor's statement
73. Vehicles		
WV WORKS Non-MAGI Medicaid coverage groups subject to an asset test	Prior to initial approval; at redetermination and when ownership of a different or additional vehicle is reported. WV WORKS Only: When there is more than one vehicle per work-eligible individual in the household.	Verify ownership and value. Vehicle title; registration; legal contract; National Automobile Dealers Association (NADA) book; DFA-V-1; DFA-RV-1; statement from a knowledgeable source; acceptable websites: NADA.com, CarPrices.com, AutoPricing.com, Intellichoice.com, Edmunds.com, and the Kelley Blue Book at kbb.com
74. Vehicles, Recreational		
WV WORKS Non-MAGI Medicaid coverage groups subject to an asset test	Prior to initial approval; at redetermination and when ownership of a different or additional vehicle is reported	Verify ownership and value. Vehicle title; registration; legal contract; NADA book; DFA-V-1; DFA-RV-1; statement from a knowledgeable source; acceptable websites: NADA.com, CarPrices.com, AutoPricing.com, Intellichoice.com, Edmunds.com and the Kelley Blue Book at kbb.com
75. WorkForce West Virginia Registration		
SNAP	When the individual is required to register and does not meet an exemption. See Section 14.2 for a list of exemptions.	Information received through the Workforce WV registration screen in the eligibility system, information received from the Workforce WV data system, or any documentation

Program	When to Verify	Possible Sources of Verification
		received from Workforce WV.
76. COVID-19 Pandemic-related Disaster Assistance		
Medicaid	Prior to initial approval, at redetermination, and when funds reported as received.	Bank statements, award letters, other sources to identify funds. Assume, due to the length of time since the COVID-19 pandemic-related disaster assistance has been received, that the funds have been exhausted. If it is reported funds are retained, thorough documentation of the client's allegation is required. Compare current account balances to COVID-19 funds received with provided verification. In the event it is reported funds are still available, always assume when withdrawals are made from an account with commingled funds in it, that the non-excluded funds are withdrawn first, leaving as much of the excluded COVID-19 pandemic-related disaster funds in the account as possible. Note: COVID-19 pandemic-related funds are permanently excluded as an asset for Medicaid. See: 5.5.12 Disaster Assistance.

7.4 CITIZENSHIP AND IDENTITY REQUIREMENTS FOR MEDICAID AND WVCHIP

Section 6036 of the Deficit Reduction Act of 2005 (DRA) enacted on February 8, 2006, requires individuals who claim United States (U.S.) citizenship to provide documentary evidence of citizenship or nationality and identity when initially applying for Medicaid or upon a client's first Medicaid redetermination on, or after, July 1, 2006. This provision does not affect individuals who have declared they are non-citizens in a satisfactory immigration status. Section 6036 requires evidence of both citizenship and identity and specifies forms of acceptable evidence of citizenship or nationality and identity.

Section 211 of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 mandated citizenship documentation for CHIP applicants beginning January 1, 2010. West Virginia implemented this provision effective March 1, 2010.

7.4.1 ESTABLISHING U.S. CITIZENSHIP AND IDENTITY

To establish U.S. citizenship the document must show:

- A U.S. place of birth; or
- That the person is a U.S. citizen.

To establish identity a document must show:

- Evidence that provides identifying information that relates to the person named on the document.

All documents are not required to be an original. They may be photocopied, faxed or scanned. The Worker must file a copy of the verification in the case record. Verification of citizenship is required only once, unless later evidence makes it questionable. There is no requirement that the verification be submitted in person.

NOTE: Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens.

7.4.2 EXEMPTIONS

The following applicants and clients are exempt from the requirement to provide documentary evidence of citizenship and identity:

- Current Supplemental Security Income (SSI) recipients.
- Retirement, Survivors and Disability Insurance (RSDI) recipients when receipt is based on disability.
- Medicare enrollees, or those eligible to enroll in Medicare.
- Individuals covered under Title IV-B child welfare services or Title IV-E foster care or adoption services.
- A child born in the U.S. to a woman who was eligible for, and receiving, Medicaid on the date of the child's birth. This includes a child born to a non-qualified non-citizen who received Medicaid for the birth only.

7.4.3 DOCUMENTS WHICH ESTABLISH U.S. CITIZENSHIP AND IDENTITY

The following sections list acceptable evidence of U.S. citizenship and/or identity. The sections establish a hierarchy of citizenship documents and the instructions specify when a document of lesser reliability may be acceptable.

- If a client presents documents from the Primary Documents list, no other information is required.
- If a client does not present documents from Primary Documents list, an identity document must also be presented.

NOTE: See Section 7.4.3.E below for additional identity documents which may be used when a child is age 16 or younger.

7.4.3.A Primary Documents to Establish U.S. Citizenship

Primary documents to establish both citizenship and identity are outlined in the table below. Primary evidence conclusively establishes that the person is a U.S. citizen. The Worker should obtain primary evidence of citizenship and identity before using secondary evidence.

NOTE: Persons born in American Samoa, including Swain's Island, are generally U.S. non-citizen nationals. There is no difference in terms of Medicaid eligibility.

Applicants or clients born outside the U.S., who were not citizens at birth, must submit a document listed under primary evidence of U.S. citizenship.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by United State Citizenship and Immigration Services (USCIS).

Primary Documents	Explanation
U.S. Passport	The Department of State issues U.S. passports. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. ***EXCEPTION:*** *For an individual born in Puerto Rico, applying November 1, 2010, or later, an expired U.S. Passport is not accepted as proof of citizenship or identity.* ***NOTE:*** *Before 1980, spouses and children were sometimes included on one passport. The citizenship and identity of any included person can be established with this passport.* ***EXCEPTION:*** *The Worker should not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.*
Certificate of Naturalization (N-550 or N-570)	The DHS issues certificates of naturalization for naturalization.
Certificate of Citizenship (N-560 or N-561)	The DHS issues certificates of citizenship to individuals who derive citizenship through a parent.
Documentation from a Federally Recognized Tribe	This includes an Indian Tribal enrollment document/card, or certificate of degree of Indian blood. If the Tribe has an international border, and the membership includes non-U.S. citizens, the Tribal enrollment/membership document is used.
Social Security Administration (SSA) / State Verification Eligibility System (SVES) Data Match/ FDH	Information about new applicants for Medicaid and WVCHIP is submitted to SSA through the FDH and SVES. A response from SSA that confirms the data submitted by the state is consistent with SSA data, including citizenship or nationality, is considered equivalent to a primary document.

In addition to the documents outlined in the chart above, a child born in the U.S. to a woman who was eligible for and receiving Medicaid on the date of the child's birth is exempt from the requirement to provide citizenship and identity documentation. This includes a child born to a non-qualified non-citizen who received Medicaid for the birth only.

7.4.3.B Secondary Documents to Establish U.S. Citizenship

Secondary evidence of citizenship is used when primary evidence of citizenship is not available. In addition, a document which establishes identity must also be presented as described in Section 7.4.3.E.

The Worker must accept any of the documents listed in the chart below as secondary evidence of U.S. citizenship, if the document meets the criteria and there is no indication that the person is not a U.S. citizen.

Immigrants and non-citizens must submit a document listed under primary evidence of U.S. citizenship.

Naturalized citizens may submit primary or secondary evidence of citizenship. In rare circumstances, a naturalized citizen can submit a written affidavit to verify citizenship. See Section 7.4.3.D below. The remaining documents in the third and fourth levels are not applicable for naturalized citizens because they require the document to show a U.S. place of birth.

Secondary Documents	Explanation
A U.S. public birth record showing birth in: • One of the 50 U.S. States; • District of Columbia; • American Samoa; • Swain's Island; • Puerto Rico, if born on or after January 13, 1941; • Virgin Islands of the U.S., if born on or after January 17, 1917; • Northern Mariana Islands if born on or after November 4, 1986, (NMI local time); or	The birth record document may be recorded by the State, Commonwealth, territory, or local jurisdiction. It must have been recorded before the person was five years of age. ***NOTE:*** *For applicants born on or after November 1, 2010, birth certificates issued by the Commonwealth of Puerto Rico must have an issuance date of July 1, 2010, or later. This provision does not apply to reapplications when citizenship and/or identity has already been established. The Worker can request a transcript of a birth certificate through an electronic transmission at no charge at: Registrodemografico@salud@gov.pr.* A delayed birth record document that is recorded after five years of age is considered fourth level evidence of citizenship. See Section 7.4.3.D below. ***NOTE:*** *The online records of WV Vital Registration, obtained from the IPACT system, may be used to verify citizenship for*

Secondary Documents	Explanation
• Guam, if born on or after April 10,1899	*persons born in West Virginia. The IPACT print screen must be filed in the case record.* ***NOTE:** If the document shows the individual was born in Puerto Rico, the Virgin Islands or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. Please note the additional requirements for Collective Naturalization.*
Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (OS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this and can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
Certification of Birth Abroad (FS-545)	Before November 1, 1990, Department of State consulates also issued Form FS-545, along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue form FS-545. Treat an FS-545 the same as the DS-1350.
U.S. Citizen Identification Card, I-197, or the prior version, I-179	United States Citizenship and Immigration Services (USCIS) issued the I-179 from 1960 until 1973, revised, and renumbered it as Form I-197. USCIS issued the I-197 from 1973 until April 7, 1983. USCIS issued Form I-179 to naturalized U.S. citizens living near the Canadian or Mexican for frequent border crossings. Neither form is currently issued but is still valid.
American Indian Card, I-872	DRS issued this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification' code "KIC" and a statement on the back denote U.S. citizenship.
Northern Mariana Card, I-873	USCIS issued the 1-873 to a collectively naturalized citizen who was born in the NMI before November 4, 1986. The card is no longer issued but is still valid.

Secondary Documents	Explanation
Final adoption decree	The adoption decree must show the child's name and U.S. place of birth. If the adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency showing the child's name and U.S. place of birth is acceptable. The adoption agency must state that the place of birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976.
Official military record of service	The document must show a U.S. place of birth.
Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Program	The SAVE Coordinator has access to the SAVE Program for verification of naturalized citizens.

7.4.3.C Third Level Documents to Establish U.S. Citizenship

Third level evidence is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used only when primary evidence cannot be obtained and secondary evidence does not exist or cannot be obtained, and the applicant or client alleges being born in the U.S. In addition, a second document establishing identity must be presented as described in Section 7.4.3.E.

The Worker must accept any of the documents listed in the chart below as third level if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is no indicator that the person is not a U.S. citizen.

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth.

The place of birth on the non-government document and the application must agree.

Third Level Documents	Explanation
Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least five years before the initial application date and indicates a U.S. place of birth	Do not accept a souvenir birth certificate issued by the hospital. ***NOTE:*** *For children under 16, the document must have been created near the time of birth or at least five years before the date of application.*
Life or health or other insurance record showing a U.S. place of birth and was created at least five years before the initial application date	Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Religious record created within three months after the birth	The document, such as a baptismal certificate, must show a U.S. place of birth and either the date of birth or age at the time the record was created. This does not include entries in a family Bible.
Early school record showing a U.S. place of birth	The school record must show the admission date, the date of birth or age at the time the record was made, a U.S. place of birth, and the name(s) and place(s) of the birth of the applicant's parents.

7.4.3.D Fourth Level Documents to Establish Citizenship

Fourth level evidence of U.S. citizenship is of the lowest reliability. This level of evidence is only used when primary evidence is not available, or both secondary and third level evidence do not exist or cannot be obtained, and the applicant alleges a U.S. place of birth or naturalized citizenship status. In addition, a second document establishing identity must be presented as described in Section 7.4.3.E.

The Worker must accept any of the documents listed in the chart below as fourth level evidence if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is no indication that the person is not a U.S. citizen.

Fourth level evidence consists of documents established for a reason other than to establish U.S. citizenship and which show a U.S. place of birth. The U.S. place of birth on the document and the application must agree. The written affidavit is used only when unable to secure evidence of citizenship listed in any other chart.

Fourth Level Documents	Explanation
Federal or state census record showing U.S. citizenship or a U.S. place of birth.	The census record must also show the applicant's age. ***NOTE:*** *Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, client, or the Worker should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." The application should also include the purpose is for Medicaid eligibility. This form requires a fee.*
Other document as listed in the explanation that was created at least five years before the application for Medicaid or WVCHIP	This document must be one of the following and show a U.S. place of birth: • Seneca Indian tribal census record • Bureau of Indian Affairs tribal census records of the Navaho Indians • U.S. State Vital Statistics official notification of birth registration • An amended U.S. public birth record that is amended more than five years after the person's birth • Statement signed by the physician or midwife who was in attendance at the time of birth
Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least five years before the initial application date and indicates a U.S. place of birth	Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical clinic, doctor or hospital record that was created at least five years before the initial application date and indicates a U.S. place of birth	Medical records generally show biographical information for the person including place of birth; record can be used to establish U.S. citizenship when it shows a U.S. place of birth. ***NOTE:*** *An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.* ***NOTE:*** *For children under 16, the document must have been created near the time of birth or five years before the date of application.*
Roll of Alaska Natives	Individuals were required to demonstrate U.S. Citizenship as part of the application process to be included on the Roll. It contains individuals who were born prior to December 17, 1971.
Written Affidavit	Affidavits may only be used in rare circumstances. An affidavit by at least two individuals, one of whom is not related

Fourth Level Documents	Explanation
	to the applicant/client and who has personal knowledge of the event(s), would establish the applicant's or client's claim of citizenship. The person(s) making the affidavit must be able to provide proof of his own citizenship and identity for the affidavit to be accepted. If the affiant has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. It must also be signed under penalty of perjury by the person making the affidavit. A second affidavit from the applicant/client or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested. ***NOTE:*** *Naturalized citizens can submit an affidavit to verify citizenship if this information cannot be found in the SAVE database.*

7.4.3.E Evidence of Identity

When primary evidence of citizenship described above is not available, a lower-level form of evidence may be presented, if accompanied by an identity document from the list in the table below.

NOTE: To establish identity, a document must show evidence that provides identifying information that relates to the person named on the document.

Recently expired identity documents are acceptable when there is no reason to believe the document does not match the individual.

Documents to Establish Identity	Explanation
Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.	Acceptable if the document carries a photograph of the applicant or client, or has other personal identifying information relating to the individual. See Section 7.4.3.A for members of a federally-recognized Indian Tribe.
Any identity document described in Section 274A(b)	The following are acceptable documents for Medicaid:

Documents to Establish Identity	Explanation
(1) (D) of the Immigration and Nationality Act	• Driver's license issued by a state or territory, either with a photograph or other identifying information of the individual such as name, age, sex, race, height, weight, or eye color • School identification card with a photograph of the individual • School records, such as report cards. These must be verified with the issuing school. • U.S. military card or draft record • Identification card issued by the federal, state, or local government with the same information included on driver's licenses • Military dependent's identification card • Native American Tribal document • U.S. Coast Guard Merchant Mariner card • Three or more corroborating documents to prove identity, such as a marriage license, divorce decree, high school, or college diploma, death certificate, employer ID card or property deed/title. • Clinic, doctor or hospital records ***NOTE:*** *For children under age 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian and states the date and place of the birth of the child. An affidavit may be used for an individual under age 18 when both school photo ID cards and drivers' licenses are not available in that area until that age.* ***NOTE:*** *Disabled individuals in residential care facilities may use identity affidavits made by the residential care facility director or administrator.* ***EXCEPTION:*** *A voter's registration card or Canadian driver's license cannot be used.*

7.4.4 COLLECTIVE NATURALIZATION

The following documents establish U.S. citizenship for collectively naturalized individuals.

7.4.4.A Puerto Rico

- Evidence of birth in Puerto Rico on or after April 11, 1899, and the applicant's statement that he was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or
- Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917, and that he did not take an oath of allegiance to Spain.

NOTE: Birth certificates issued by the Commonwealth of Puerto Rico must have an issuance date of July 1, 2010, or later.

7.4.4.B U.S. Virgin Islands

- Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or
- The applicant’s statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917, and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.

7.4.4.C Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)

- Evidence of birth in the NMI, TIPI citizenship and residence in the NMI, the U.S., or a U.S. possession or territory on November 3, 1986, (NMI local time) and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or
- Evidence of TIPI citizenship, continuous residence in the NMI since before November 3, 1981, (NMI local time), voter registration prior to January 1, 1975, and the applicant's

statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

- Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

NOTE: If a person entered the NMI as a non-immigrant and has lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

7.4.5 DRIVER'S LICENSE DOCUMENTATION TO ESTABLISH BOTH CITIZENSHIP AND IDENTITY

Chapter 6036(a)(3)(B)(iv) of the DRA permits the use of a valid state-issued driver's license or other identity document described in Chapter 274A(b)(I)(O) of the Immigration and Nationality Act, only if the state issuing the license or such document requires proof of U.S. citizenship before issuance of such license or obtains a Social Security Number from the applicant and verifies, before certification, that such number is valid and assigned to the applicant who is a citizen. West Virginia does not have these processes in place at this time. The West Virginia driver’s license is valid for identity verification only.

7.4.6 REASONABLE OPPORTUNITY

At the time of application or upon redetermination of benefits, all applicants and clients must be given a reasonable opportunity period to provide documents to establish U. S. citizenship or nationality and identity.

7.4.6.A Applicants

The reasonable opportunity period for applicants to provide documentation of citizenship is 90 days from the date the notice is received by the client. The assistance group (AG) is initially approved for Medicaid or WVCHIP, if otherwise eligible, pending receipt of State Verification

Eligibility System (SVES) match information. A SVES data match confirming the data submitted by the state is consistent with SSA data is considered equivalent to a primary document verifying citizenship or nationality. If the SVES data match results in an inconsistency, the Worker should make a reasonable effort to identify and correct possible errors, e.g., misspellings or transposed numbers in the SSN, name, or date of birth, so the data can be resubmitted to SSA. If the inconsistency still cannot be resolved, the applicant must be notified and provided 90 days from the date the notice is received to provide satisfactory documentation of citizenship, or to resolve the inconsistency with SSA's information. The applicant remains eligible for Medicaid or WVCHIP during this 90-day period. If citizenship documentation is not supplied within the reasonable opportunity period, Medicaid or WVCHIP is stopped after advance notice.

7.4.6.B Clients

Current Medicaid clients continue to receive benefits until determined ineligible. Medicaid is closed only after the client is given a reasonable opportunity period of 45 days to present evidence. This is the reasonable opportunity period for clients. The Worker may make an exception to the time limit when a client is making a good faith effort to provide the verification but is unable to do so. The extension period may not exceed 45 days. Any exception must be recorded thoroughly in the eligibility system. The Worker must assist the client to secure verification if necessary.

NOTE: Individuals who are ineligible for Medicaid coverage due to failure to supply citizenship/identity documentation cannot be approved for WVCHIP. These are individuals who qualify for Medicaid financially and otherwise, but lack the required documentation.

7.4.7 APPLICANTS OR CLIENTS WHO REQUIRE ASSISTANCE

If the applicant or client is homeless, an amnesia victim, mentally impaired, or physically incapacitated and lacks someone who can act for the individual, and cannot provide evidence of U.S. citizenship or identity, the Worker should assist the applicant or client to document U.S. citizenship and identity.

7.4.8 NOTIFICATION AND FAIR HEARINGS

An applicant or client who fails to cooperate with presenting documentary evidence of citizenship may have benefits stopped after advance notice. Current notification procedures and appeal rights must be given if the individual fails to cooperate with the requirement to provide documentary evidence of citizenship.

APPENDIX A – PUBLIC FORMS

FORM NUMBER	FORM TITLE
DFA-ID-1	Identity Declaration
DFA-V-1	Vehicle Estimate
DFA-RV-1	Recreational Vehicle Estimate

Chapter 8

Resource Development (Medicaid and WV WORKS Only)

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8.6.11 CHILD SUPPORT....25

Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
8.1	6/1/25	864	8.1	Removed Medicaid from introduction.
8.2	4/1/18 6/1/25	755 864	8.2.2 8.2.2 8.2.3 8.2.4	Reformatted for clarity. Added penalty for failure to enroll in Medicare if eligible. Update Medicare Buy-in email address. Removed section. Removed Medicaid exceptions and updated Works exceptions to exclude Medicaid.
8.3	6/1/25	864	8.3.2	Removed wording for penalty section.
8.4	4/1/18 6/1/25	755 864	8.4.2.D 8.4 8.4.1 8.4.2 8.4.2.A 8.4.2.B 8.4.2.C 8.4.2.D	Added policy to clarify MAGI Medicaid groups are required to cooperate with Medicare Enrollment. Removed wording. Removed sections.
8.5	4/1/18 6/1/25	755 864	8.5 8.5	Corrected Manual citations to IMM 8.2.2 Removed wording.
8.6	4/1/18 10/1/20	755 794	8.6.2.F 8.6.2.E 8.6.2	Updated the worker process to reflect the initial 64 years and 9 months report notice is issued automatically by the eligibility system. Corrected Manual citations to IMM 8.2.2 Replace word alien

8.1 INTRODUCTION

The resource development process is designed to enable WV WORKS and Medicaid clients to achieve financial independence.

The Worker assists clients in developing alternate or additional sources of income to reduce or eliminate the need for WV WORKS. Sections 8.2 – 8.5 contain the procedures and requirements that are applicable to the resource development process. Section 8.6 contains a description of the benefits for which a client may qualify, and referral instructions.

8.2 RESOURCE DEVELOPMENT AS AN ELIGIBILITY REQUIREMENT

It is a condition of eligibility for WV WORKS and some Medicaid coverage groups that clients take necessary steps to develop resources that may be available to them.

8.2.1 CHILD SUPPORT (WV WORKS AND MEDICAID)

This includes financial support for WV WORKS. Financial and medical support are among the services provided by the Bureau for Child Support Enforcement (BCSE) free of charge and on a voluntary basis for Medicaid.

See Chapter 18 and Chapter 23.3.

8.2.2 ENROLLMENT IN MEDICARE, PART A AND PART B (MEDICAID ONLY)

All applicants for and clients of Medicaid, who qualify for Medicare Buy-In, must enroll in Medicare, Parts A and B, unless an exemption to enrollment is met. Exemptions include, but are not limited to:

- No established record of birth, or
- The individual has other creditable health insurance and will be disadvantaged by Medicare enrollment.

See Section 8.6.2 for Medicare eligibility requirements and Section 25.2 for Medicaid coverage groups subject to Department of Human Services (DOHS) buy-in.

Failure, without an exemption, to enroll in Medicare for the Medicaid applicants or clients who qualify for Medicare Buy-In results in denial of Medicaid or exclusion from the Medicaid assistance group (AG). When the individual is the only Medicaid AG member, Medicaid is closed. The individual remains ineligible until he enrolls.

For Supplemental Security Income (SSI) recipients not Medicare-enrolled, but who appear eligible, see Section 25.3.2.A.

Individuals who meet all other Qualified Medicare Beneficiary (QMB), Supplementary Medical Insurance Benefits (SLIMB), and Qualified Individual (QI-1) eligibility requirements, but who are not yet enrolled in Part B, must be referred to the Bureau for Medical Services (BMS) Medicare Buy-In Unit by sending an email to BMSmedicarebuyin@wv.gov. The message must contain the

applicant's name, address, date of birth, and Social Security number (SSN). The Buy-In Unit contacts Social Security to facilitate enrollment. This avoids any late enrollment penalty that may apply to the individual and permits enrollment outside the yearly open enrollment period.

8.2.3 WV WORKS EXCEPTIONS

WV WORKS clients are expected to take the necessary steps to develop resources that may be available to them. The development of such resources is part of the Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP).

As such, the application is not held pending until the client initiates development of the resource. WV WORKS clients must apply for and/or accept SSI benefits.

If the client has appealed a disability decision, he is not expected to accept a reduced amount of disability compensation pending completion of the appeal process.

The Veteran's and Survivor's Improvement Act of 1978 provided Veterans Affairs (VA) pensioners receiving a pension in December 1978 the option of choosing to receive a higher "improved" pension after December 31, 1978. Some pensioners who chose this option lost Aid to Families with Dependent Children (AFDC) cash assistance eligibility due to higher income. Those who lived in states without a Medically Needy Program also lost Medicaid eligibility. To remedy this, Section 1133 of the Social Security Act allowed these pensioners to revert to their previous pension level to regain their benefits. Therefore, these VA pensioners who elected lower pensions cannot be required to reapply for the improved pension as a condition of eligibility, even if the receipt to the improved pension did not or would not render them ineligible for the Department of Human Services (DoHS) benefit.

8.3 WORKER RESPONSIBILITIES

The responsibilities of the Worker in the resource development process includes the following.

8.3.1 IDENTIFICATION OF POTENTIAL BENEFITS

The Worker makes the determination of potential eligibility as appropriate, but at least at application and redetermination.

8.3.2 PROCEDURES AFTER IDENTIFICATION

The Worker must:

- Explain to the client how to apply for the benefit
- Explain to the client the consequences of failure to develop the resource
- Initiate the referrals to potential resources when appropriate
- Record case comments in the eligibility system for all actions taken in the process of developing potential resources
- Aid the client who needs help with the referral
- Monitor the client's progress and take any indicated action
- Apply the penalty when the client fails, without good cause, to pursue the resource

8.4 PENALTY FOR FAILURE TO APPLY FOR OR RETAIN BENEFITS WITHOUT GOOD CAUSE

The penalties apply only when development and retention are a condition of eligibility. See Section 8.2.

The penalty imposed depends upon the source of the potential resource and who fails to meet the requirement, as follows.

Note: For WV WORKS benefits, a client who fails, without good cause, to develop and retain potential resources as identified in the Personal Responsibility Contract (PRC) or Self-Sufficiency Plan (SSP), has failed to adhere to the terms of his PRC/SSP.

For ongoing cases, failure to comply without good cause will result in a sanction being imposed.

8.5 GOOD CAUSE FOR FAILURE TO APPLY FOR OR RETAIN BENEFITS

Good cause for failure of an individual to take the necessary steps to develop or retain a resource exist when the individual is unable to take the indicated action because of circumstances beyond his control, such as, but not limited to, illness, lack of transportation, etc.

8.6 POTENTIAL RESOURCES

The following describes potential resources for which the client may be eligible.

8.6.1 SOCIAL SECURITY ADMINISTRATION (SSA) BENEFITS

8.6.1.A Supplemental Security Income (SSI)

8.6.1.A.1 Requirements for Coverage

To meet eligibility requirements for SSI, the client must meet all of the following:

- Be age 65 or over, or blind, or disabled
- Be a United States (U.S.) citizen or a legally admitted noncitizen
- Not be residing in a public institution
- Have income and assets that are within SSI limits

8.6.1.A.2 Who Should Be Referred for SSI Benefits

Any adult or child who appears to meet the above criteria may be referred.

8.6.1.B Retirement, Survivors, and Disability Insurance (RSDI)

8.6.1.B.1 Requirements for Coverage

The RSDI program refers to retirement, survivors, and disability benefits paid to workers, their dependents, and survivors.

The wage earner must have credit for a certain amount of work under Social Security (i.e., the wage earner must meet a work requirement). Types of RSDI benefits and other eligibility requirements are as follows.

➢ *Retirement Benefits*

Retired wage earner must be age 62 or over.

➢ *Disability Benefits*

Wage earner must be under his full-retirement benefit age. This is based on his year of birth. He must meet the SSA definition of disability.

➢ *Dependent and Survivor Benefits*

- Age 60 or over – widow or widower of the deceased worker.
- Age 62 or over – spouse of a disabled or retired worker.
- Age 62 or over – former spouse of wage earner when not remarried.
- Age 50 or over – disabled widow or widower of the deceased wage earner.
- Disabled adult child of the wage earner – child must be unmarried, age 18 or over, and have a severe disabled that began before age 22. In order for the disabled adult child to receive benefits, his wage earner parent must be deceased or receiving retirement or disability benefits.
- Family benefits – a widow, widower, or spouse of a retiree can receive benefits at any age if the person takes care of a child who is under age 16 or disabled and receives benefits on the record of the retired or deceased individual.

  To receive benefits from a retired or deceased parent, a child must be unmarried and under age 18, or under age 19 and a full-time elementary or secondary school student, or age 18 or older and have a disability that began before age 22. Eligible children include natural or adopted children, stepchildren, or dependent grandchildren.

8.6.1.B.2 Who Must Be Referred for RSDI Benefits

Clients who appear to meet the above criteria.

8.6.1.C Federal Black Lung Benefits

8.6.1.C.1 Requirements for Coverage

Federal Black Lung benefits are available to a wage earner who is totally disabled by Black Lung Disease as a result of exposure to coal dust while working in the coal mining industry in the U.S. and to certain dependents or survivors. More specifically, benefits may be available for:

- The wage earner.
- The spouse and unmarried children who are under the age of 18 (or under age 23 if in school).
- The wage earner's widow or widower (regardless of age) and surviving dependent children (under age 18 or under 23 if in school) of the wage earner who was entitled to Black Lung benefits at the time of his death or who dies of Black Lung Disease.

Claims for Black Lung benefits are filed at the local SSA office. However, since 1973, the U.S. Department of Labor (DOL)'s Office of Workers' Compensation has been responsible for administering the program, which includes making an eligibility decision and issuing the benefit payments once the local SSA office forwards the claim to the DOL. Because the local SSA office has no knowledge of the decision as to eligibility for the benefit, the Worker must follow up with the client to learn the outcome.

8.6.1.C.2 Who Must Be Referred for Black Lung Benefits

Clients who appear to meet the above criteria.

Clients who are referred to the SSA office for Black Lung benefits should be referred to the State Workers' Compensation Fund to apply for Occupational Pneumoconiosis (State Black Lung benefits). See Section 8.6.5.A for details.

Additional information about Black Lung benefits may be found at the DOL's website.

8.6.2 MEDICARE

Medicare is a health insurance program that is available to individuals who meet the following criteria.

The individual:

- Is a U.S. citizen or lawfully admitted non-citizen who has resided in this country for five consecutive years; and
- Is age 65 or over; or
- Has received RSDI benefits based on a disability for 24 consecutive months, regardless of age; or
- Has received Railroad Disability Benefits based on total and permanent disability for 24 consecutive months. Railroad Disability Benefits based on occupational disability do not qualify the individual for Medicare; or
- Has End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare, managed by Centers for Medicare and Medicaid Services (CMS), consists of three parts as follows.

8.6.2.A Medicare Part A – Hospitalization Insurance Benefits

To qualify for "premium free" Medicare Part A, the individual must meet a work coverage requirement or must be the surviving spouse of the individual. If the individual does not qualify for Medicare Part A because of lack of work coverage, he may purchase the coverage by payment of a monthly premium.

8.6.2.B Medicare Part B – Supplementary Medical Insurance

There is no work coverage requirement for Part B. Any citizen or legally admitted noncitizen who has resided in this country for five years and who is age 65 or over is eligible even though he may not be eligible for Part A.

Individuals enrolled in Part B pay a monthly premium. If the person is receiving RSDI or Railroad Retirement Benefits, the premium is deducted from his benefit. Otherwise, he must pay

the premium from his income. See Section 23.12 for Medicaid coverage groups for Medicare premium payments.

8.6.2.C Medicare Part D – Medicare Prescription Drug Benefit

An individual who is already enrolled in Medicare Part A or Part B may receive the Medicare Prescription Drug Benefit.

The Part D Prescription Drug Benefit is not administered by the SSA. The benefit is obtained by enrolling in a Prescription Drug Plan (PDP). Enrollees may pay a monthly premium, unless financially qualified for extra help, also known as the Low-Income Subsidy (LIS). The extra help pays all or part of the drug benefit premium, co-pays, and deductibles that may be required. Workers must assist individuals who request LIS complete the LIS application. The application must be submitted on an original SSA form, the SSA-1020-OCR-SM, or submitted on the internet at www.ssa.gov/prescriptionhelp/.

Medicaid clients enrolled in Medicare automatically qualify for the extra help and will be automatically enrolled in a PDP. With a few exceptions, Medicaid will not pay for prescription drugs for individuals age 65 or over who are eligible for and do not enroll in a PDP. This also applies to Medicare-enrolled individuals under age 65 who are identified by the Department of Human Services (DOHS).

Additional information about the Prescription Drug Benefit and extra help is available at www.ssa.gov and www.medicare.gov.

8.6.2.D Automatic Enrollment of Individuals in Medicare

In the following circumstances, an individual is automatically enrolled in Medicare Part A. He is also automatically enrolled in Part B unless he specifically declines enrollment.

- When the individual is receiving RSDI, he is automatically enrolled by the SSA when he becomes eligible.
- When the individual is receiving Railroad Retirement Benefits, he is automatically enrolled by that Board when he becomes eligible.

Individuals who are automatically enrolled by the SSA are not referred for enrollment. However, at the time of application and redetermination, the Worker must identify each client who will be automatically enrolled before the next redetermination. The client must be asked to notify the

Worker when he receives his Medicare card. The Worker enters the claim number in the eligibility system.

8.6.2.E Who Must Be Referred for Medicare Enrollment

All Medicaid applicants and clients, age 65 or over, who are not enrolled, and all others who appear to meet the criteria in item 4 above, must be referred for enrollment. Failure to enroll for those eligible for Medicare Buy-In, and who do not meet an exemption described in Section 8.2.2., results in denial of the Medicaid application, removal from the Medicaid AG, or closure of the Medicaid AG.

8.6.2.F Use of MOBIUS Report WRCM260A – MA Turning 64 Yrs. and 9 Months and Reports from BMS

The Worker must use the MA Turning 64 Yrs. and 9 Months report in MOBIUS each month to ensure that individuals who are near the age for Medicare eligibility begin the enrollment process with the SSA. These individuals may enroll in Medicare Part D, the Prescription Drug Benefit, at this time also so prescription drug benefits are not delayed.

The eligibility system provides a letter to the client when his name appears on the report.

The letter informs the client to enroll in Medicare and inform him that his Medicaid will stop if he fails to comply and is not exempt from the requirement.

8.6.2.G Procedure for Referrals to the SSA

The Worker refers the client to SSA for any of the benefits listed above using the HS-3 or the verification checklist.

In addition, the Worker must instruct the client to phone or visit his local SSA office to file an enrollment application in accordance with local SSA procedures.

8.6.2.H Follow-Up When a WV WORKS Client Becomes Eligible for SSI

When a WV WORKS client becomes eligible for SSI, the SSA is required to count his share of the WV WORKS benefit as income.

The Worker must notify the local SSA Office when the individual(s) no longer receives WV WORKS. See Section 10.5.4 for cash assistance information requested by the SSA.

8.6.3 VETERANS AFFAIRS (VA) BENEFITS

VA Benefits include Pension Benefits, Compensation Benefits, and Aid and Attendance Benefits.

8.6.3.A Pension Benefits

8.6.3.A.1 Requirements for Coverage

Following are the coverage requirements for Pension benefits:

- The veteran must have at least 90 days of active duty service, with at least one day during a wartime period.

  The dates for such services are:

  - World War I (April 6, 1917 – November 11, 1918)
  - World War II (December 7, 1941 – December 31, 1946)
  - Korean Conflict (June 27, 1950 – January 31, 1955)
  - Vietnam Era (February 28, 1961 – May 7, 1975, for veterans who served in the Republic of Vietnam during that period; otherwise, August 5, 1964 – May 7, 1975)
  - Gulf War (August 2, 1990 – through a date to be set by law or Presidential Proclamation)

- In addition to meeting minimum service requirements, the veteran must be:
  - Age 65 or older;
  - Totally and permanently disabled;
  - A patient in a nursing home receiving skilled nursing care;

- Receiving Social Security Disability Insurance; or
- Receiving SSI.

8.6.3.A.2 Who May Receive Benefits

The veteran, his wife, his dependent children who are unmarried and under age 18, or under 23 if in school, his dependent parents, and his unmarried disabled children of any age.

If the veteran who was eligible for VA Pension Benefits is deceased, his un-remarried widow and his dependent children, his dependent parents, and unmarried disabled children are eligible.

8.6.3.B Compensation Benefits

8.6.3.B.1 Requirements for Coverage

The applicant must be a veteran who is disabled by injury or disease incurred in or aggravated by active service in the line of duty. The veteran must have had wartime or peacetime service and separated or discharged under conditions other than dishonorable.

8.6.3.B.2 Who May Receive Benefits

The following individuals may receive Compensation benefits:

- The veteran.
- The veteran's spouse, dependent children who are unmarried and under 18, or under 22 if in school, his dependent parents, and disabled children, if the veteran's benefit is based on 50% or more disability.
- The veteran’s surviving spouse, dependent children, his dependent parents, and disabled children, if the veteran died as a result of a service-connected cause, or if he was receiving benefits based on at least 10% disability.

8.6.3.C Aid and Attendance Benefits

8.6.3.C.1 Requirements for Coverage

Following are the coverage requirements for Aid and Attendance benefits:

- The veteran must be eligible to receive either of the other two benefits described above;
- The veteran must be in a nursing home; or
- The veteran is in his home and in need of in-home care; or
- The veteran's eyesight is limited to a corrected 5/200 visual acuity or less in both eyes; or concentric contraction of the visual field to five degrees or less.

8.6.3.C.2 Who May Receive Benefits

The following individuals may receive Aid and Attendance benefits:

- The veteran who is in a nursing home or in need of in-home care, and also receives either Compensation or Pension Benefits.
- The widow of a deceased veteran who is in a nursing home or needs in-home care.
- The dependent parent(s) of the disabled or deceased veteran who is in need of nursing home or in-home care.

This special allowance is payable monthly in addition to Compensation Benefits paid to the veteran's spouse or dependents.

Some veterans are eligible to receive education and housing benefits.

8.6.3.D Who Must Be Referred

Clients who appear to meet any of the criteria listed above.

8.6.3.E Procedure for Filing a Claim

Applications for Veterans Benefits can be secured by the applicant contacting the West Virginia Department of Veterans Assistance, the Red Cross, the Veterans of Foreign Wars of the U.S. (VFW), the American Legion, or the U.S. Department of Veterans Affairs (VA). Individuals can also receive assistance in filling out the application from these organizations.

If the veteran lives in West Virginia, his completed application is sent to the Philadelphia VA Regional Office. The address is:

Department of Veterans Affairs
Claims Intake Center
Attention: Philadelphia Pension Center
P.O. Box 5206
Janesville, WI 53547-5206

If the veteran lives elsewhere in the state, his completed application is sent to the VA benefit office in Huntington to be processed. The address is:

Huntington Regional Benefit Office
640 Fourth Avenue
Huntington, WV 25701
1-800-827-1000

All applications must be accompanied by a medical report describing the nature of the disability. If the VA determines that additional medical information is needed, they arrange for examination at the nearest VA hospital or medical clinic.

8.6.4 UNITED MINE WORKERS OF AMERICA (UMWA) BENEFITS

8.6.4.A Requirements for Coverage

The miner must be at least 55 years old at the time of application, and he must have worked in the mining industry prior to January 1, 2012 for at least 20 years.

Benefits are also available to the following individuals:

- The wife of a retired miner and dependent unmarried children up to age 22.
- Parents of the deceased miner or of his spouse who have been dependent upon and living with the miner for at least one year.
- Spouses of deceased miners.

UMWA miners and retired miners and their families may receive medical insurance through the UMWA.

8.6.4.B Who Must Be Referred

Clients who appear to meet the above criteria.

8.6.4.C Procedures for Filing a Claim

Applicants may obtain the necessary application form and information from any UMWA local or district office or by writing to:

UMWA Health and Retirement Funds
2121 K Street, NW
Washington, D.C. 20037
Phone: 1-800-291-1425

8.6.4.D Referral Method

Potentially eligible individuals should be referred to the UMWA Local Union or to one of the Health Funds field offices listed on the UMWA website.

8.6.5 WORKERS' COMPENSATION BENEFITS

The West Virginia Worker's Compensation Fund oversees two programs: Occupational Pneumoconiosis and Compensation for Injury or Occupational Disease.

8.6.5.A Occupational Pneumoconiosis (State Black Lung Benefits)

8.6.5.A.1 Requirements for Coverage

In order to receive Occupational Pneumoconiosis benefits, the individual must meet the following requirements:

- The claimant must have a medically determined pulmonary disorder as a result of exposure to dust at this place of employment.
- Generally, the individual must have been exposed to dust for a period of two continuous years and filed a claim within three years of his last exposure. However, regulations provide for exceptions to these time periods.
- The individual must be either totally or partially disabled as a result of a pulmonary disorder, except that if he has worked in an industry in which he is exposed to dust for 20 years or more, he need not have any degree of disability.

It should be noted that these benefits do not apply only to individuals who have worked in the mining industry, but that they also apply to employees in an industry in which he may be exposed to dust (e.g., glass factories, textile mills).

Benefits paid to individuals who qualify as a result of working in the mining industry are commonly referred to as "State Black Lung Benefits."

8.6.5.A.2 Persons Who May Receive Benefits

The following individuals may receive Occupational Pneumoconiosis benefits:

- Persons who are disabled from occupational pneumoconiosis.
- The spouse of the person described in item 1 above.
- Dependent children under age 18, if the primary wage earner died of occupational pneumoconiosis.
- Dependent children between the ages of 18 – 22, if full-time students, or over the age of 18, if they are disabled and the father died of pneumoconiosis.
- In certain cases, a dependent parent.

8.6.5.B Compensation for Injury or Occupational Disease

8.6.5.B.1 Requirements for Coverage

In order to receive benefits, the individual must have been injured on the job during the last two years while working for an employer who has paid into Worker's Compensation Fund.

8.6.5.B.2 Persons Who May Receive Benefits

The following individuals may receive compensation for injury or occupational disease benefits:

- A worker injured on the job while working for an employer who has paid into the Worker's Compensation Fund.
- Surviving spouses of a worker who died as a result of a work-related injury.
- Dependent children under 18, if one of their parents died from a work-related injury.
- Dependent children ages 18 – 22, if they are full-time students, or over 18, if they are disabled and the parents died from a work-related injury.
- In certain cases, a dependent father or mother.

8.6.5.C Who Must Be Referred for Worker's Compensation Benefits

Clients who appear to meet the above criteria must be referred for Worker's Compensation benefits. Individuals who are referred to apply for State Black Lung benefits should also be referred to the SSA to apply for Federal Black Lung benefits.

8.6.5.D Procedures for Filing a Claim

8.6.5.D.1 Occupational Pneumoconiosis (State Black Lung Benefits)

Workers' Compensation may be contacted at 1-888-4WV-COMP or locally in Charleston at (304) 926-3400. Information is available on their website.

8.6.5.D.2 Compensation for an Injury or Occupational Disease Application

Compensation for an Injury or Occupational Disease Application for benefits may be obtained at the following places:

- Doctors' offices
- Hospital
- Employers

The claim must be filed within two years from the date of the injury.

8.6.6 UNEMPLOYMENT COMPENSATION INSURANCE (UCI)

UCI benefits are administered through WorkForce West Virginia. The purpose of these benefits is to maintain income to families during temporary periods of unemployment.

8.6.6.A Requirements for Coverage

In order to receive UCI benefits, the individual must meet the following requirements:

- Must be unemployed or under-employed.
- Must be able and willing to work.
- Must have worked in employment covered by the Unemployment Compensation regulations.
- Must have earned at least $2,200 in his base period. The base period is the first four out of the last five completed calendar quarters preceding the date of the claim.

8.6.6.B Who Must Be Referred

All parents/caretaker relatives, Aid to Families with Dependent Children (AFDC)-Related Medicaid and WV WORKS unemployed parents, and any other persons who appear to meet the above criteria must be referred.

8.6.6.C Procedures for Filing a Claim

All claims for UCI Benefits must be filed at the local WorkForce West Virginia Office.

8.6.7 RSDI BENEFITS

Railroad Retirement, Survivor, and Disability Insurance (RSDI) Benefits may be available to a railroad worker, his surviving widow, and dependent children. These benefits are administered through the Railroad Retirement Board.

8.6.7.A Requirements for Coverage

There are five types of benefits available through the Retirement Board.

8.6.7.A.1 Railroad Retirement Benefits

Retirement Benefits are available to railroad workers who are at least age 65 and have at least 10 years of railroad service.

A railroad worker may retire with reduced benefits at age 60, depending on his length of service.

8.6.7.A.2 Survivor Benefits

The following individuals may be eligible to receive survivor benefits.

- A widow who is caring for a child under age 18 or disabled
- A widow when she reaches age 60
- A widow age 50 who is permanently disabled and unable to work in regular employment
- An unmarried child under the age of 18 or under age 22 if a full-time student
- An unmarried child over age 18 if he became permanently disabled before age 22 and was dependent on the railroad worker

➢ Sickness Benefits

A railroad worker who is off work due to illness may be eligible to receive Sickness Benefits. A railroad worker may receive up to 60% of his salary.

➢ Unemployment Benefits

If a railroad worker is laid off, he may be eligible to receive unemployment benefits from the Railroad Retirement Board. In order to be eligible for these benefits, the railroad worker must meet the eligibility criteria similar to that for receiving UCI Benefits. A railroad worker is not eligible to receive both benefits. He can receive only the benefits from the Railroad Retirement Board.

8.6.7.A.3 Disability Benefits

Disabled railroad workers who have at least 10 years of service may qualify for benefits.

8.6.7.B Who Must Be Referred

Clients who appear to meet the above criteria.

8.6.7.C Procedure for Filing a Claim

The office shown below provides service for all counties in West Virginia except for the 12 listed below:

The District 153 Railroad Retirement Board
640 Fourth Avenue, Room 112
Huntington, WV 25701
Phone: 304-529-5561

OR

P. O. Box 2153
Huntington, WV 25721-2153

8.6.7.C.1 Filing a Claim: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, and Morgan Counties

Altoona, PA District Office
1514 – 11th Avenue
Altoona, PA 16603
Phone: 814-946-3601

OR

P. O. Box 990
Altoona, PA 16603-0990

8.6.7.C.2 Filing a Claim: Brooke, Hancock, Marshall, Ohio, and Wetzel Counties

Pittsburgh, PA District Office

Moorhead Federal Building, Room 1534
1000 Liberty Avenue
Pittsburgh, PA 15222
Phone: 412-395-4634

8.6.8 GOVERNMENT SURVIVOR BENEFITS FOR ILLEGITIMATE CHILDREN

8.6.8.A Requirements for Coverage

Illegitimate children of federal government workers are eligible for benefits after the government worker dies, regardless of whether the child lived with the government worker or not, if they meet the following criteria:

- Be the child of a federal government worker who died on or after February 24, 1982.
- Have proof that he was actually the child of this government worker, such as a birth certificate, court order of support, or some other kind of proof.
- Must be under age 18.

If the child is eligible, he will receive monthly benefits.

8.6.8.B Who Must Be Referred

Clients who appear to meet the above criteria must be referred.

8.6.8.C Referral Method

The client must contact:

Office of Personnel Management Federal Building
1000 Liberty Avenue
Pittsburgh, PA 15222
Phone: (412) 722-2758

Information may be obtained online at www.opm.gov.

8.6.9 DISABILITY AND RETIREMENT BENEFITS

Any person who has been employed may qualify for disability, retirement, or pension benefits.

The surviving spouse or dependents may also qualify for benefits.

8.6.10 INCOME PROTECTION INSURANCE

Clients may have insurance that provides a source of income or direct payments during periods of illness or recovery.

8.6.11 CHILD SUPPORT

The Bureau for Child Support Enforcement (BCSE) provides a structured method for development of financial and medical support from absent parents. Eligibility requirements and procedures are found in Chapter 18 and Chapter 23.

Chapter 9

Client Notification

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Change History Log

Section	Date of Change	Change Number	Sub-Section(s) Changed	Description of Change
9.1	4/1/20	784	9.1	Changed inROADS to WV Path.
9.2				
9.3	7/1/18	761	9.3.3.A	Removed obsolete SNAP E&T policy.
	6/1/24	851	9.3.4	Updated Waiver of 13-Days Advance Notice form to DFA-NL-5.
			9.3.5.C	Removed the word MAGI.
	4/1/25	862	9.3.1.B	Added policy stating when it is established a client has been approved for Medicaid benefits in another state, territory, or commonwealth, then Advanced Noticing is not required.
	1/1/26	872	9.3.4	NEW/Main Section that explains the Notice of Match Results – titled “Notice of Match Results for SNAP.”
9.4				
9.5	2/1/24	846	9.5.2	Updated and removed language to comply with federal

Section	Date of Change	Change Number	Sub-Section(s) Changed	Description of Change
				regulations regarding the 1095-B tax forms.
App A	9/1/23 1/1/25 1/1/26	840 859 872		Updated spelling. Update the address of Legal Aid in Charleston. Update the address of Legal Aid in Logan.
App B				
App C	7/1/22	824		Update form DFA-FH-1.

9.1 INTRODUCTION

The applicant must be notified in writing of the action taken on his application, and the client must be notified in writing, and usually in advance, of any action resulting in a change in benefits. Adverse actions, other than those specified in Section 9.3, require an advance notice period before any action is effective.

For Medicaid, the client may choose to receive notifications by regular post mail or electronically. If the client opts to receive his notifications electronically, he must provide his email address through WV PATH or the Federally Facilitated Marketplace (FFM, the Marketplace). The client will then receive a confirmation email alerting him to access the notification in his account within one business day. In the event a notification is undeliverable electronically, the notification must be sent by post mail within three business days. The client may change the delivery route of his notifications at any time.

Form letters are available for most situations that require a notice. Printed copies of these forms are commonly referred to as “shelf documents” and are readily available in each office. These Worker-completed forms provide spaces for the required information. These letters must be prepared in duplicate, with one copy filed in the case record. Most client notification is accomplished with eligibility system letters. The eligibility system provides both system generated and Worker-requested letters. When the eligibility system automatically sends appropriate notice to the client, no additional notification is required. A history of notification letters sent to the client is stored in the eligibility system. No additional copies are required for the case record.

The instructions in this chapter apply to notification letters completed by the Worker. Information specific to long-term care assistance groups (AGs) is found in Chapter 24.

There are instances in which more than one action takes place simultaneously, such as approval for Medicaid and denial of Supplemental Nutrition Assistance Program (SNAP) benefits. One notification letter is sufficient in these situations provided:

- The details of all actions are contained in the letter;
- The one form letter used provides the client with all rights due him for all addressed issues; and
- Notice requirements for each benefit are met.

In addition to the client notification letter, the Worker must provide the client with calculations showing how eligibility and/or the amount of the benefit were determined. The Worker must also provide the client the opportunity to request a Pre-Hearing Conference and/or a Fair Hearing.

Appendix B contains a listing of Worker-completed notification letters and the corresponding eligibility system notification letters, when available.

9.2 NOTIFICATION OF ACTION TAKEN ON AN APPLICATION

These forms are used for notifying an applicant of the status of his application:

- DFA-6, Notice of Information Needed
- DFA-6A, Spenddown Explanation
- DFA-NL-6, Notice of Withdrawal of Application
- DFA-NL-A, Notice of Decision – Application
- DFA-20, Application Not Acted On Letter
- DFA-FS-19, Notification of Denial of Expedited Service (SNAP Only)

The final disposition of the application is reported to the client only on the DFA-NL-A or the DFA-NL-6.

When the DFA-NL-A is used, it must always be accompanied by the DFA-FH-1 Fair Hearing Request Form.

9.2.1 DFA-6, NOTICE OF INFORMATION NEEDED

The DFA-6 may be used during any phase of the eligibility determination process. At the time of application, it is given or mailed to the applicant to notify him of information or verification he must supply to establish eligibility. When the DFA-6 is mailed at the time of application, the client must receive the DFA-6 within five working days of the date of application.

If the client fails to adhere to the requirements detailed on the DFA-6, the application is denied or the deduction disallowed, as appropriate. The client must be notified of the subsequent denial by form DFA-NL-A.

This form also notifies the client that his application will be denied, or a deduction disallowed, if he fails to provide the requested information by the date specified on the form. The Worker determines the date to enter to complete the sentence, "If this information is not made available to this office by_____..." as follows.

9.2.1.A Supplemental Nutrition Assistance Program (SNAP)

The date entered in the DFA-6 must be 10 days from the date of issuance.

If information involving an eligibility factor is not provided by the date indicated, and the client has not contacted the Worker to explain the delay, the application is denied using a DFA-NL-A. If eligibility is established, but the client does not provide proof of entitlement to a deduction, the deduction is not allowed, but the assistance group (AG) is approved. The DFA-NL-A is used for notification of approval.

Federal regulations require that the DFA-6 be given to the client no later than 30 days after the date of application. He must also be allowed 10 days to respond to the DFA-6. The Worker must issue benefits retroactive to the date of application if the client supplies the needed information within the 30-day time limit.

The section following the Worker's signature must be completed for SNAP AGs only.

The Worker enters the date that is 60 days from the date of application. When the AG is denied for failure to provide information required to determine eligibility and subsequently provides the requested information within 60 days of the original application, a new DFA-2, Application for Benefits, is not required. If the information is not provided by the date requested, a DFA-NL-A must be sent for denial of eligibility.

9.2.1.B WV WORKS

The Worker and the applicant must agree upon the date entered in the DFA-6. If the form is mailed to the client, the Worker must use his judgment about a reasonable amount of time required for the client to provide the information. The date entered must be at least 10 days from the date of issuance and no later than 30 days from the date of application.

If the information is not provided by the date indicated, and the client has not contacted the Worker, the application is denied. The client must be notified by a DFA-NL-A. If eligibility is established, but the client does not provide proof of entitlement to a deduction, the deduction is not allowed. The AG is approved, and the client is notified by a DFA-NL-A.

9.2.1.C Medicaid and WVCHIP

The date entered in the DFA-6 must be at least 10 days from the date of issuance or a time agreed upon with the applicant. See Due Date of Additional Information in Section 1.6.4.

9.2.1.C.1 Evaluation for Non-Modified Adjusted Gross Income (MAGI) Coverage

Information regarding potential eligibility for non-MAGI Medicaid coverage groups, and the benefits and services afforded to the applicant in the non-MAGI coverage groups, will be provided to the applicant in the MAGI notice. A description of additional information needed to determine non-MAGI eligibility and how to apply will be provided to the applicant. The information should be sufficient to enable the applicant to make an informed choice.

9.2.2 DFA-6A, SPENDDOWN EXPLANATION

The date entered in the DFA-6 must be 30 days from the date of application when it is determined that the client will be required to meet a spenddown. The DFA-6A, Spenddown Explanation, must be attached to the DFA-6. In addition, the DFA-6 must indicate that evidence of medical expenses must be provided by the deadline date shown on the form, and the amount required to meet the spenddown must be specified. This is in addition to any other verification that may be needed.

If the AG did not appear to be subject to a spenddown when the DFA-6 was issued, but verification of or a change in income results in a spenddown prior to approval, a new DFA-6 is issued to obtain medical bills to establish eligibility. However, the time limit for providing medical expenses remains 30 days from the date of application.

9.2.3 DFA-NL-6, NOTICE OF WITHDRAWAL OF APPLICATION

If the applicant withdraws his application, the Worker must give or mail him a DFA-NL-6.

9.2.4 DFA-NL-A, NOTIFICATION LETTER: ACTION TAKEN ON YOUR APPLICATION

The DFA-NL-A is used for approvals and denials for all programs. The form is self-explanatory but must provide the client with a full understanding of the reason for the action taken.

NOTE: The Pre-Hearing Conference and/or a Fair Hearing Request Form, DFA-FH-1, must always be included with the DFA-NL-A and the appropriate computation forms.

The Worker must use terms understandable to the client and avoid the use of agency jargon. Examples of proper and improper completion of sections of the form are shown in the table below.

Improper Completion of the Form	Proper Completion of the Form
The action taken on your application is as follows: your application has been denied.	The action taken on your application is as follows: Your application for SNAP benefits has been denied.
The reason for this action is as follows: failure to cooperate.	The reason for this action is as follows: You did not verify the amount of your earnings by 2/10/2016. Income must be verified before SNAP benefits can be approved. The penalty for not doing this is denial of the application.
The Department's policy requiring this action is found in: Chapter 1 of the Manual.	The DOHS's policy requiring this action is found in <insert section(s) reference> of the Income Maintenance Manual (IMM).

In the space provided, the Worker must indicate the name, address, and telephone number of local agencies or organizations that provide legal services without charge. Use Appendix A to identify nearby providers of legal services.

The information that must be contained on the DFA-NL-A is found below, by program.

9.2.4.A Approvals

9.2.4.A.1 SNAP

The notice must include:

- The month of approval
- The amount of the benefit, pro-rated and ongoing
- The length of the certification period
- The reason for the approval
- The Manual section on which the decision is based, and any other action taken

- The amount of the benefits noted with an explanation if retroactive benefits are being issued

9.2.4.A.2 WV WORKS

The notice must include:

- The month of approval
- The prorated and ongoing amounts of the benefit
- The reason for the approval
- The Manual section on which the decision is based, and any other action taken

9.2.4.A.3 Medicaid and WVCHIP

The notice must include eligibility information:

- The date that the medical coverage begins and ends
- The reason for the approval
- The Manual section on which the decision is based
- Any other action taken

The notice must include information on the level of benefits and services approved including, if applicable:

- Any premiums
- Enrollment fees
- Cost sharing
- The right to appeal the level of benefits and services approved

The notice must include the:

- Changes in circumstances that must be reported
- Procedures for reporting any changes that may affect the client's eligibility

For the Pregnant Women coverage group only, the notice must include:

- The fact that the client remains eligible for two months after the month in which the pregnancy ends.

9.2.4.B Denials

The Worker completes the DFA-NL-A by indicating:

- The program for which benefits are being denied
- The reason for denial
- The name of the person whose income, assets, or other circumstances prevent approval
- The Manual section on which the denial is based.

If the denial is due to excessive assets, the notification letter must specify:

- The asset limit
- The total value counted for all the client's assets

For Worker-completed letters only, the letter must contain the following statement: "You may request a detailed accounting of the asset calculations used by the Department. If you so request, this will be mailed to you within five working days of receipt of your request. You may request this in writing, by phone, or in person." The eligibility system provides a detailed asset calculation with all notices of decision.

9.2.4.B.1 SNAP

When the applicant has a Supplemental Security Income (SSI) application pending with Social Security Administration (SSA), the SNAP denial notice must explain the possibility of Categorical SNAP Eligibility if the client’s SSI application is approved. He must be advised to contact the Department of Human Services (DOHS) upon SSI approval.

9.2.4.B.2 WV WORKS

If the AG is denied for WV WORKS and a child in the denied AG has an absent parent, the following statement must be shown on the denial letter: "You may still receive help in locating and obtaining support from the absent parent(s) of your child(ren). Please call the telephone number shown above and ask to speak to a Bureau of Child Support Enforcement (BCSE) Worker. You may also write or visit your local DOHS office for help."

9.2.5 DFA-20, APPLICATION NOT ACTED ON LETTER

If the application is not acted on within the required time limit, the Worker must send a DFA-20 to the applicant, informing him of the required information that DOHS has not received. The DFA-20 is sent at the time of the expiration of the maximum allowable time for acting on the application. When manually completed, a copy of the DFA-20 must be filed in the case record.

9.2.6 DFA-FS-19, NOTIFICATION OF DENIAL OF EXPEDITED SERVICE (SNAP Only)

The DFA-FS-19 must be used for each SNAP applicant who requests Expedited Service but does not qualify for it. The DFA-FS-19 is a Worker-requested notice in the eligibility system. When possible, the DFA-FS-19 must be given to the client at the intake interview. The case record must indicate that a DFA-FS-19 was given. A recording in case comments is sufficient for those AGs approved for Expedited Service and those AGs not requesting Expedited Service.

9.3 NOTICE OF ACTION RESULTING IN A CHANGE IN BENEFITS

Three forms are central to client notification of a change in benefits, whether this change occurs at redetermination, or as a result of a case maintenance activity.

- The DFA-NL-B, Notification Letter, Action Taken on the Benefits You Receive from DOHS is used to notify the client of an increase in benefits, of action taken resulting in no benefit change, and, in very few instances, of a decrease or case closure.
- The DFA-NL-C, Notification Letter: Pending Change In The Benefits You Receive, is used to notify the client of case closure or a decrease in benefits when advance notice is required. Advance Notice is required for most adverse actions, as defined below.
- DFA-FH-1, Pre-Hearing Conference and/or Fair Hearing Request Form, must always accompany the DFA-NL-B, DFA-NL-C, and DFA-WVW-NL-1.

In addition, these notices are used for client notification in certain circumstances:

- DFA-NL-5, Waiver of 13-Days Advance Notice,
- DFA-6, Notice of Information Needed and DFA-6A, Spenddown Explanation
- DFA-WVW-NL-1, Notice of Pending Reduction of Benefits (WV WORKS only)
- DFA-10, Appointment Letter

The use of each of these forms is described below.

NOTE: Client notification must be sent even when the only client in the AG dies.

9.3.1 ADVANCE NOTICE REQUIREMENTS

A client must receive advance notice in all situations involving adverse actions except those described in the Adverse Actions Not Requiring Advance Notice section below.

The advance notice requirement is that notification be mailed to the client at least 13 days prior to the first day of the month in which the benefits are affected.

NOTE: The date on the notice must be the date it is mailed.

9.3.1.A Adverse Actions Requiring Advance Notice

Adverse actions are defined by program as follows. Use the DFA-NL-C in these situations.

	Adverse Actions	Notes
SNAP	AG closure Decrease in SNAP benefit amount Shortened certification period	The following are not adverse actions, but do require client notification: • When the amount does not increase following a Supplemental Security Income (SSI) check reduction for repayment of an error caused by client's intentional misrepresentation. • When the benefit amount does not increase following a reduction, suspension, or termination of a federal, State, or local means-tested welfare or public assistance program due to the client's failure to comply with the program's requirements. This includes a reduction in WV WORKS benefits due to a sanction.
WV WORKS	AG closure, including closure due to imposition of the third or subsequent sanction Reduction in the benefit amount including reductions due to imposition of the first or second sanction. Removal of a client from the AG, when the benefit amount decreases	A special notice letter, DFA-WVW-NL-1, is required to impose a sanction based on failure to comply with the Personal Responsibility Contract (PRC) or Self-Sufficiency Plan (SSP). See Section 9.3.6 below.
Medicaid and WVCHIP	AG closure Removal of a client from the AG	

9.3.1.B Adverse Actions Not Requiring Advance Notice

The following adverse actions do not require advance notice; use the DFA-NL-B in these situations.

- When adverse action occurs as a result of a mass change initiated, such as:
  - The annual updates of SNAP allotments or deductions;
  - The annual Retirement, Survivors, and Disability Insurance (RSDI)/SSI updates;
  - A change in the WV WORKS benefit levels; or
  - A change in the Medically Needy Income Levels (MNIL).
- When the client has signed a DFA-NL-5, Waiver of 13-Day Advance Notice, to waive his right to a 13-day advance notice. See Section 9.3.
- For SNAP only: when the benefit is terminated or reduced as a result of a redetermination.
- For Medicaid and WVCHIP only:
  - When it is established the client has been accepted for Medicaid services in another state, territory, or commonwealth.
  - When the Department has information confirming the death of the client.

9.3.1.C Beginning and Ending of the Advance Notice Period

The 13-day advance notice period begins with the date shown on the notification letter. It ends after the 13th calendar day has elapsed. If the 13-day notice period ends on a weekend or holiday, the action is taken on the first subsequent workday.

> **Advance Notice Period Example:** A DFA-NL-C is dated and mailed on October 18. The 13-day advance notice period begins October 18. The 13-day advance notice period ends at the close of the business day on October 31. The action is effective no earlier than November 1.

9.3.1.D Date Adverse Action May Be Taken

9.3.1.D.1 Advance Notice Period Expires Before the First of the Following Month

Usually the Worker will take the action in the eligibility system before the 13-day advance notice begins, in order to be effective, the first day of the following month.

> **Advance Notice Expires Before the First of the Following Month Example:** Ms. Dahlia reports a change that requires advance notice. The Worker makes the change in the eligibility system on October 9. A DFA-NL-C is dated and mailed by the eligibility system on October 10. The 13-day advance notice period starts on October 10 and ends October 22. Since the advance notice period ends before November 1, the change is effective November 1.

9.3.1.D.2 Advance Notice Period Expires the First of the Following Month or Later

If the 13-day advance notice period does not expire until the first day of the following month or later, the change is not effective until the month following the end of the 13-day advance notice period.

> **Advance Notice Expires the First of the Following Month or Later Example:** A DFA-NL-C is dated and mailed on December 27. The 13-day advance notice period expires January 8. The change is effective February 1. The client is eligible to receive January benefits at the previous level.

9.3.1.D.3 Fair Hearing Requested after Receipt of DFA-NL-C

➢ *Requesting within Advance Notice Period*

When the client requests a Pre-Hearing Conference or a Fair Hearing before the date of proposed closure or reduction, benefits are restored or reinstated immediately, whether or not the client requests reinstatement. If the client specifically requests benefits not be reinstated—verbally, by checking the appropriate section of the DFA-FH-1, or in some other written manner—no reinstatement action will be taken.

No change is made in AG status or benefit levels related to the current issue until a final decision is made as a result of a Pre-Hearing Conference or Fair Hearing.

Other changes may occur during the Hearing process. If this happens, the client must receive proper notification of these other changes. If the client does not request a Pre-Hearing Conference or a Fair Hearing on these subsequent changes, the changes are made, even though the first change is in Pre-Hearing Conference or Hearing status.

If the client requests a Pre-Hearing Conference or a Fair Hearing on the subsequent changes, the Worker must take action depending on whether the client requests a Pre-Hearing Conference or a Fair Hearing only.

▪ *Pre-Hearing Conference Is Requested*

The Worker must:

- Hold a Pre-Hearing Conference; and
- If the issue is not resolved, contact the Hearings Officer to see if all issues can be dealt with in one Hearing; and
- Continue benefits at the current level until the subsequent changes are resolved.

The Pre-Hearing Conference decision will be final unless the client continues with a Fair Hearing.

▪ *Fair Hearing Only Is Requested*

The Worker must:

- Contact the Hearings Officer to see if all issues can be dealt with in one Hearing, and
- Continue benefits at the current level until the subsequent changes are dealt with in a Hearing.

If the Department is upheld in the Hearing, the previously proposed action is taken without further notice to the client, and benefits in excess of the amount of entitlement, which were received after the month in which the DFA-NL-C was received, are subject to repayment

SNAP ONLY EXCEPTION: If the client did not complete a redetermination, benefits are not reinstated or continued. Benefits will be continued or reinstated only after the client completes a redetermination. If the SNAP certification period ends prior to the decision of the Hearings Officer, or prior to the Pre-Hearing Conference decision, the client is not entitled to benefits at the previous level or continued benefits.

requirements. For this reason, the client may return such benefits, or request that his benefits be stopped or reduced, while awaiting the outcome of the Pre-Hearing Conference or Fair Hearing. When the client makes such a request, the Worker takes the adverse action and sends the client a DFA-NL-B, confirming his request.

- ***Requested after Advance Notice Period, But within 90 Days of the Effective Date of the Action***

Benefits are not reinstated or restored pending the Fair Hearing or Pre-Hearing Conference decision after expiration of the 13-day advance notice period.

9.3.2 DFA-NL-B, NOTIFICATION LETTER: ACTION TAKEN ON THE BENEFITS YOU RECEIVE FROM DOHS

The DFA-NL-B is used to notify a client of an increase in benefits, changes not affecting the benefit level, or an adverse action when no advance notice is required.

NOTE: The Pre-Hearing Conference and/or Fair Hearing request form, DFA-FH-1 must always be included with the DFA-NL-B and the appropriate computation forms.

9.3.2.A An Increase in Benefits

The client must be notified in writing any time there is an increase in benefits. The client must receive the notification prior to or at the same time he receives the increase.

In the space provided in the DFA-NL-B, the Worker must indicate the name, address, and telephone number of local agencies or organizations that provide legal services without charge. See Appendix A for a listing of Legal Aid offices.

An increase in benefits is defined below for each program and the following information must be contained on the DFA-NL-B when an increase in benefits occurs.

9.3.2.A.1 SNAP

An increase in benefit amount requires that the notice include:

- The present benefit amount;
- The increased benefit amount (i.e., "Your SNAP benefit amount is being increased from $100 to $120.");
- The date that the increase is effective;
- The reason for the increase;
- The length of the certification period;
- The Income Maintenance Manual (IMM) section on which the change is based; and
- Any other action taken.

9.3.2.A.2 WV WORKS

An increase in the benefit amount or the addition of another person to the AG, when the benefit amount increases, requires that the notice include:

- The present benefit amount;
- The increased benefit amount (i.e., "Your WV WORKS benefit is being increased from $262 to $301.");
- The date that the increase is effective;
- The reason for the increase, the IMM section on which the change is based; and,
- Any other action taken.

9.3.2.A.3 Medicaid and WVCHIP

The addition of a client to the Medicaid AG requires that the notice include:

- The name of the client being added;
- The date that the change is effective;
- The reason for the change;
- The IMM section on which the change is based; and
- Any other action taken.

9.3.2.B Changes Not Affecting the Benefit Level

The client must be notified of all changes made, even when the benefit level is not affected, such as a transfer to another county or a change in payee. When the DFA-NL-B is used for this purpose, the following information must be included:

- Specific information about what the change is;
- The date the change is effective;
- The reason for the change;
- The IMM section on which the change is based, if applicable; and
- Any other action taken must be included on the form.

> **Change of Address Example:** "You have reported that you moved to Kanawha County. Your case has been transferred to the Kanawha County office effective August 1, 2016, which is located at: 4190 W. Washington Street, Charleston, West Virginia. Your new Worker is: Angelica Smith."

9.3.2.B.1 SNAP

The following are not adverse actions, but do require client notification using the DFA-NL-B:

- When the benefit amount does not increase following an SSI check reduction for repayment of an error caused by the client's misrepresentation.
- When the benefit amount does not increase following a reduction, suspension, or termination of a federal, State, or local means-tested welfare or public assistance program due to the client's failure to comply with the program's requirements. This includes WV WORKS sanctions.

When used to notify the client of the actions above, the DFA-NL-B must:

- Specify that SNAP benefits would normally increase following a reduction in income, but since the client caused these reductions by his own actions, benefits will not increase; and
- Indicate which agency made the determination of the client's failure to comply.

9.3.2.C Adverse Actions Not Requiring Advance Notice

For the adverse actions listed in 9.3.1.B that do not require advance notice, use DFA-NL-B.

The following items indicate the information that must be contained on the DFA-NL-B when it is used as a notice of adverse action.

NOTE: When a DFA-NL-B is used to notify the client of an adverse action, and the client requests a Hearing or Pre-Hearing Conference, benefits are not continued or reinstated pending a decision. In the space provided, the Worker must indicate the name, address, and telephone number of local agencies or organizations that provide legal services without charge. See Appendix A.

NOTE: If the closure is due to excessive assets, the notification letter must specify the asset limit and the total value counted for all the client's assets.

For Worker-completed letters only, the letter must contain the following statement: "You may request a detailed accounting of the asset calculations used by the DOHS. If you so request, this will be mailed to you within five working days of receipt of your request. You may request this in writing, by phone, or in person." The eligibility system provides a detailed asset calculation with all notices of decision.

9.3.2.C.1 SNAP

The notice must include:

- The fact that the SNAP AG is closed, or the benefit amount has decreased;
- The date the action becomes effective;
- The reason for the action;
- The IMM section on which the decision is based; and

- Any other action taken.

NOTE: If the SNAP benefits decrease only because of an increase in the WV WORKS payment, the Worker must complete two separate notices, to be mailed on the same day.

1. The DFA-NL-B is used to notify the client of the increase in the WV WORKS benefit amount.
2. The DFA-NL-C is used to notify the client of the decrease in SNAP benefits.

The DFA-FH-1 is attached to the DFA-NL-B and the DFA-NL-C. Appropriate computation forms must also be attached.

9.3.2.C.2 WV WORKS

The notice must include:

- That the benefit is being stopped or reduced;
- The date the action is effective;
- The reason for the action;
- The IMM section on which the decision is based; and
- Any other action taken.

9.3.2.C.3 Medicaid and WVCHIP

The notice must include:

- The specific action being taken;
- The date that the action is effective;
- The reason for the action;
- The IMM section on which the decision is based; and
- Any other action taken.

The following must be included as appropriate:

- For Closures: The fact that the Medicaid AG is being closed.
- For Removal of a Client from the Medicaid AG: The name of the client being removed.

- For a Change to a Spenddown AG: The fact that the eligibility status has changed, reason for and the effective date of the change, beginning and ending dates of the new Period of Certification (POC).

9.3.3 DFA-NL-C, NOTIFICATION LETTER: PENDING CHANGE IN THE BENEFITS YOU RECEIVED

A DFA-NL-C, Notification Letter: Pending Change In The Benefits You Receive, is used to notify a client of an adverse action in situations requiring a 13-day advance notice period except as described above.

NOTE: The Pre-Hearing Conference and/or a Fair Hearing Request Form, DFA-FH-1, must always be included with the DFA-NL-C and the appropriate computation forms.

Instructions for completion of the DFA-NL-B in the Adverse Actions Not Requiring Advance Notice section 9.3.2.C above also apply to the DFA-NL-C.

9.3.3.A SNAP

If the SNAP benefit amount is reduced or terminated within the certification period because a member is disqualified, the reason for the disqualification, the eligibility, and benefit level of the remaining AG members and the action the AG must take to end the disqualification, if applicable, must be shown on the form.

9.3.4 NOTICE OF MATCH RESULTS FOR SNAP

When the agency receives a Notice of Match Results from the Income Eligibility Verification System that conflicts with case information, and the agency cannot resolve it internally, the client is required to provide the independent verification to clarify or confirm the information.

The Notice of Match Results (NCHZ) will be utilized when the agency receives information from a third-party source (see 10.4.2.B.3 third-party sources). The data may include wages, death, new hire, Internal Revenue Service (IRS), prisoner, and Federal Public Assistance Reporting Information System (PARIS).

The NCHZ will be sent to the household explaining:

- The data match that triggered the review
- What information is missing or inconsistent
- What type of independent verification is needed
- The deadline to respond

If the client does not provide the requested verification, fails to respond to the notice, or refuses to cooperate, the eligibility worker may take action to remove the household member from the SNAP assistance group or close the SNAP case.

NOTE: The Notice of Match Results will not replace the DFA-6. The current verification checklist (DFA-6) does not contain specific data match hit findings, nor does it inform the individual of the opportunity to contest such findings in order to clarify the circumstances. Therefore, independent verification will be required from the client.

If verification is sufficient and resolves the conflict:

- The case continues, or
- Is adjusted as needed.

If the verification is not received, or is insufficient, the agency may:

- Close the case, or
- Is to adjust benefits based on the best available information.

9.3.5 DFA-NL-5, WAIVER OF 13 DAYS' ADVANCE NOTICE

Form DFA-NL-5 is used when the information that results in an adverse action is undisputed by the client, he agrees with the action to be taken on his case and understands that he is entitled to receive benefits if the 13-day advance notice requirement is not waived. The waiver allows DOHS to make the change without application of the 13-day advance notice requirement.

If the proposed adverse action normally requires a DFA-NL-C, but the client signs a DFA-NL-5, the Worker sends a DFA-NL-B instead of a DFA-NL-C.

The DFA-NL-5 must be completed in a face-to-face interview. It is completed in duplicate and must be signed by an adult AG member. The original is given to the client, and the copy is filed in the case record.

EXCEPTION: The DFA-NL-5 can be mailed to a client who moves to another state and is unable to comply with the face-to-face interview requirement. Supervisory approval is required and the Worker must completely fill out the form before it is mailed. A written explanation of the effect of signing the form must accompany the form.

Under no circumstances are blank DFA-NL-5s to be signed and used at a later date. It is always the client's option to sign or not to sign the form.

> **Change of SNAP AG Example:** Fern moves from SNAP AG 1 to SNAP AG 2 on June 20 and reports this the same day. His removal from AG 1 is an adverse action requiring 13 days' notice. He cannot be included in AG 2 for July because he will still be included in AG 1. However, AG 1 signs a DFA-NL-5 to waive the right to advance notice. He can be removed from AG 1 and included in AG 2 effective July.

9.3.6 DFA-6, NOTICE OF INFORMATION NEEDED; DFA-6A, SPENDDOWN EXPLANATION

If, at redetermination, or the time of any other change in client circumstances, it becomes clear that additional information or verification is needed, the DFA-6 is used to notify the client in writing of the needed information and the date by which the information must be received.

The DFA-6A is used in addition to the DFA-6 when it is necessary to explain the spenddown process to the client.

9.3.6.A Case Maintenance for All Programs

The date entered in the DFA-6 must be at least 10 days from the date the DFA-6 is completed. If the client fails, without good cause, to provide the information by the established date, a DFA-NL-C must be sent to notify the client of the failure and the resulting case action.

9.3.6.B Supplemental Nutrition Assistance Program (SNAP) Redeterminations

The date entered in the DFA-6 must be at least 10 days from the date of the DFA-6. If the information is not available by the date indicated, and the client has not contacted the Worker,

the assistance group (AG) is closed or the deduction disallowed. The client must be notified of the denial or disallowance of a deduction by form DFA-NL-B, Notification Letter: Action Taken On The Benefits You Receive From The DOHS. Benefits must not be continued beyond the certification period, unless a redetermination is completed, and the client remains eligible. See Section 1.4.

9.3.6.C Medicaid and WVCHIP Redeterminations

All data sources, electronic or otherwise, must be checked before verification is requested for Medicaid.

9.3.7 DFA-WVW-NL-1, NOTICE OF PENDING REDUCTION OF BENEFITS

The DFA-WVW-NL-1 is used only for WV WORKS and only when the imposition of a sanction for failure to adhere to the terms of the PRC/SSP is involved.

The DFA-WVW-NL-1 must always be used with the Pre-Hearing Conference and/or a Fair Hearing request form, DFA-FH-1, and the appropriate computation forms.

Instructions for completion of the DFA-NL-B (see Section 9.3.2 above) also apply to completion of the DFA-WVW-NL-1. In addition, there is space on the form for the Worker to schedule a good cause interview. The interview must be scheduled for a date that allows the client to attend the interview and to comply with the PRC/SSP requirements before the advance notice period expires. The good cause interview must be scheduled no less than seven calendar days beginning with the date the letter is requested in the eligibility system or with the date a manual letter is sent. If the letter is hand delivered, case comments must be made indicating the date the letter was given to the client. If the good cause interview is scheduled for a date prior to the seven days, the client and the Worker must agree on the date.

All other policies and procedures that normally apply to the DFA-NL-C apply to the use of the DFA-WVW-NL-1. See Section 9.3.3 above.

9.3.8 DFA-FH-1, THE PRE-HEARING CONFERENCE AND / OR FAIR HEARING REQUEST FORM

The DFA-FH-1 is used to request a Pre-Hearing Conference and/or Fair Hearing and must be used when a DFA-NL-A, DFA-NL-B, DFA-NL-C, or DFA-WVW-NL-1 is issued.

If more than one notification letter is sent at the same time, the DFA-FH-1 must be sent with each notification letter.

> **WV WORKS Increase Affects SNAP Example:** Mr. Beech experiences a change that increases his WV WORKS benefit amount. His SNAP benefits decrease, solely due to the increase in the WV WORKS benefit. The system prepares a DFA-NL-B to address the increase in WV WORKS and prepares a DFA-NL-C to address the decrease in SNAP and attaches form DFA-FH-1 to both.

9.3.9 DFA-10, APPOINTMENT LETTER

The DFA-10 is used to notify the client of the time and place of an appointment. These appointments are usually scheduled for redeterminations. However, the form can be used to notify the client of an appointment when a face-to-face contact is indicated for a case maintenance activity.

If the client fails to keep the appointment, the Worker must send a DFA-NL-C prior to AG closure, except for closures resulting from failure to complete a SNAP redetermination. A DFA-NL-B is used in this situation.

For SNAP AGs, the DFA-10 serves as the first notification of the end of the certification period. When Worker-completed, the original DFA-10 is mailed or given to the client, and a copy is filed in the case record.

9.4 COMPUTATION FORMS

The Department of Human Services (DOHS) is required to provide the client with the calculations used to determine eligibility and benefit level. The following forms must be used. If a computation form is not available, the Worker must prepare a letter explaining the computation. When manually-prepared, the original is sent with the notification letter, and a copy is retained in the case record.

Each of the following forms is self-explanatory. They guide the Worker through the various steps of the income calculations.

9.4.1 DFA-NL-SNAP-1, SNAP COMPUTATIONS

This form must be sent with each DFA-NL-A sent for approval of SNAP benefits and to each applicant denied for income reasons.

In addition, it must be sent with each DFA-NL-C and each DFA-NL-B sent for notification of an increase, decrease, or closure of SNAP benefits, when recalculations of income eligibility or benefit level are required.

9.4.2 DFA-WVW-1, WV WORKS COMPUTATIONS

This form must be sent with each DFA-NL-A sent to the client for approval of WV WORKS benefits and to each applicant denied for income reasons.

In addition, it must be sent with each DFA-NL-A and DFA-NL-C sent for notification of ineligibility due to income reasons.

9.4.3 DFA-NL-MN-1, AFDC-RELATED MEDICAID COMPUTATIONS

This form must be sent with each DFA-NL-A sent for approval of AFDC-related Medicaid benefits.

In addition, it must be sent with each DFA-NL-C and DFA-NL-B sent for changes in the spenddown amount.

9.4.4 IM-SSIR-1, SSI-RELATED MEDICAID COMPUTATIONS AND DEEMING FORMS: IMM-SSIR-1A, IM-SSIR-1B, IM-SSIR-1C

This form must be sent with each DFA-NL-A sent for approval of SSI-related Medicaid benefits.

In addition, it must be sent with each DFA-NL-C and DFA-NL-B sent for changes in the spenddown amount.

There are three forms used to calculate the amount of income deemed to an SSI-related Medicaid client, as follows:

- IM-SSIR-1A Deeming to Spouse
- IM-SSIR-1B Deeming to Child
- IM-SSIR-1C Deeming to Spouse and Child

9.4.5 WV WORKS REPAYMENT COMPUTATIONS

Computation of the WV WORKS overpayment amount must be provided to the client upon request. The form must be mailed to the client or the client's representative within five working days of the receipt of the request. If time permits, the form may be prepared and given to the client during an office interview.

9.4.6 IM-NL-QMB-1, QUALIFIED MEDICARE BENEFICIARIES (QMB) SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB) AND QUALIFIED INDIVIDUALS (QI-1)

This form must be sent with each notification of approval, denial, or ineligibility based on income for QMB, SLIMB, or QI-1 applicants or clients.

9.4.7 IM-NL-AC-1, ASSET COMPUTATIONS

Asset computations must be provided to the client upon request. The form must be mailed to the client or the client's representative within five working days of receipt of the request. If time permits, the form may be prepared and given to the client during an office interview.

The Worker must designate the program(s) for which the form is being completed and the appropriate asset limit. If two or more programs' assets are being shown on the same form, and an asset is excluded for one program but not others, the Worker must show for which program(s) the asset was counted under "Additional Information." This same section is also used for any special considerations given to an asset, such as "jointly-owned but fully available" or "cash-in value only counted."

In the column headed, "Value (How Obtained)," the Worker must indicate the source of information used to determine the value, such as NADA Book for vehicle values, Client's Statement, Bank Statement of (date) and/or Vehicle Estimate.

9.5 1095-B VERIFICATION OF MINIMUM ESSENTIAL COVERAGE

9.5.1 WHO MUST FILE FORM 1095-B

Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP) provide health benefits coverage designated as Minimum Essential Coverage (MEC) under Section 5000(f) of Subtitle D of the Internal Revenue Code (IRC). The Affordable Care Act added Section 6055 to the IRC, which requires that every provider of MEC will report coverage information by filing an information return with the Internal Revenue Service (IRS) and by furnishing a statement to covered clients upon request.

Medicaid and WVCHIP are required to file an annual 1095-B statement to clients enrolled in MEC, and to send an electronic copy of the same information to the IRS. The IRS requires a report on Form 1095-B for every client covered by MEC and for every month of coverage. Even if the client had only one day of coverage, it is reported as a month of coverage.

The information furnished and reported is used by individuals and the IRS to verify the months in which clients were covered by MEC and, therefore, have satisfied the individual shared responsibility requirement of Section 5000A of the IRC.

9.5.2 FURNISHING FORM 1095-B

The eligibility system will electronically send the 1095-B forms, along with form 1094-B, *Transmittal of Health Coverage Information Returns*, to the IRS. The forms must be submitted to the IRS on or before March 31 of the year following the calendar year in which MEC is provided.

The 1095-B forms must be made available in the eligibility system on or before January 31 of the year following the calendar year in which MEC is provided.

Upon request of the client, a worker may generate a 1095-B form out of the eligibility system. The requested document must be sent to the client within 30 days of the date of the request.

9.5.3 CORRECTIONS AND REPLACEMENTS TO FORM 1095-B

When the Medicaid or WVCHIP client identifies an error on his 1095-B form, he must have a corrected 1095-B form manually generated.

When requested, the Worker must reprint a damaged or lost 1095-B form for the client.

9.5.4 ADDITIONAL WORKER RESPONSIBILITIES

The Worker should be able to answer basic questions regarding the 1095-B, *Verification of Minimal Essential Coverage*, form. The Worker should not provide tax advice, such as whether a tax return is required, how to fill out IRS forms, or what to claim on a tax return. The Worker should direct clients to the IRS website for answers to tax-related questions.

9.6 CONSOLIDATED WORK NOTICE-SNAP WORK REQUIREMENTS

The Consolidated Work Notice (CWN) is the SNAP work requirement notification for the state of West Virginia. The CWN explains the requirements for SNAP members who must comply with either/both the **SNAP Basic Work Rules** or the **Able-Bodied Adults without Dependents (ABAWD) Time Limit Rules**. In addition, the CWN provides the AG with their right to a fair hearing, information on non-discrimination and how to contact the state ADA Coordinator if additional assistance is needed.

Individuals who are working enough hours or those who are exempt are not required to comply with work requirements. These individuals are not documented on the CWN. Demographic information entered into the eligibility system determines who must comply with work requirements.

The following information is detailed on the CWN:

SNAP Basic Work Rules

- An explanation of the different SNAP work requirements
- What qualifies as an exempt individual
- When and how each individual must register with job service through Workforce WV
- What happens if the work requirement is not followed
- What to do if the individual has a good cause situation
- Penalty periods for not complying with work requirements

ABAWD Time Limit Rules

- Why an individual is considered ABAWD
- How to meet the ABAWD work requirement
- Reporting when the individual is no longer meeting the requirement
- Who is exempt from ABAWD
- Penalty after receiving 3 months without meeting the requirement
- What to do if the individual has a good cause situation

The CWN is sent to the SNAP AG after application certification, redetermination, when an individual who was previously exempt is now subject to either work requirement, or when a new individual is added to the SNAP AG and must comply with either work requirement. The CWN is available through the eligibility system and the PATH public portal.

APPENDIX A: LEGAL AID OF WEST VIRGINIA REGIONAL DIRECTORY

Office	Counties Served	Address	Phone	Fax
Statewide Intake	**All**	**Call or visit Legal Aid of West Virginia's website to apply for services**	**1 (866) 255-4370**	**(304) 414-0418**
Beckley	Fayette Raleigh Nicholas	115 B South Kanawha Street Beckley, WV 25801	1 (800) 319-4187 (304) 255-0561	(304) 255-0562
Charleston	Boone Braxton Clay Kanawha Lincoln Putnam Webster	123 Washington Street, West Suite 101 Charleston, WV 25302	1 (800) 642-8279 (304) 343-4481	(304) 345-5934
Clarksburg	Doddridge Gilmer Harrison Lewis Taylor	110 South Third Street Clarksburg, WV 26301	1 (866) 401-6439 (304) 623-6649	(304) 623-6215
Elkins	Barbour Grant Pendleton Randolph Tucker Upshur	224 Third Street. PO Box 229 Elkins, WV 26241	1 (866) 400-0196 (304) 635-7600	(304) 630-2058
Huntington	Cabell Mason Wayne	418 8th Street, Second Floor Huntington, WV 25701	1 (866) 313-6129 (304) 697-2070	(304) 697-2071
Lewisburg	Greenbrier Monroe Pocahontas Summers	125 Green Lane P. O. Box 689 Lewisburg, WV 24901	1 (866) 401-9391 (304) 645-3131	(304) 647-3581
Logan	Logan Mingo	229 Stratton Street, Suite 101 Logan, WV 25601	1 (800) 319-4203 (304) 752-4178	(304) 752-4185
Martinsburg	Berkeley	301 W. Burke St. Suite B	1 (866) 401-8871	(304) 264-8945

Office	Counties Served	Address	Phone	Fax
	Hampshire Hardy	P. O. Box 6040 Martinsburg, WV 25401	(304) 263-8871	
Morgantown	Marion Monongalia Preston	165 Scott Avenue, Suite 209 Morgantown, WV 26508	1(800) 453-1939 (304) 296-0001	(304) 296-0276
Parkersburg	Calhoun Jackson Pleasants Ritchie Roane Wirt Wood	327 Ninth Street Parkersburg, WV 26101	1 (800) 675-7970 (304) 485-7522	(304) 428-6741
Princeton	McDowell Mercer Wyoming	1519 North Walker Street Princeton, WV 24740	1 (800) 319-4202 (304) 487-1463	(304) 431-3016
Wheeling	Brooke Hancock Marshall Ohio Tyler Wetzel	The Mull Center, Suite 716 1025 Main Street Wheeling, WV 26003	1 (866) 401-5460 (304) 232-1260	(304) 232-7879

ATLAS Hotline
1-866-255-4370
Call to apply for services 10:00 a.m. – 3:00 p.m.
Monday – Friday

For more information, visit the website at WV Legal Aid.

APPENDIX B: ELIGIBILITY SYSTEM NOTIFICATION FORMS

DOHS Official Form Code		DOHS Official Form Name	Chapter Reference	System Generated Notice Code	Worker Generated Notice Code	Eligibility System Form Name
DFA		1095-B MEC Form	6.5	E095	ED9C	Verification of Minimal Essential Coverage
DFA	NL-5	Waiver of Advance Notice	6.3,C,2		NMRM	Waiver of Advance Notice
DFA	NL-6	Notice of Withdrawal of Application	6.2,B	CRD2		Withdrawn RFA
ES	NL-A		6.2,C	EDA1, EDA4	NNAP	WV WORKS/SNAP Approval
				EDA7, EDA9	NNAP	Medicaid Approval
				EDA8	NNAP	CHIP Approval
				EDAA	NNAP	LIEAP Approval
				EDAB	NNAP	EA Approval
				EDAE, EDAF	NNAP	MAGI Approval
				EDAC	NNAP	NEMT Approval
				EDAM	NNAP	DCA Approval
				EDAP	NNAP	Expedited FS Approval
				EDO6	NNAP	SCA Approval
				EDD1, EDD3	NNDN	Denial WV WORKS/ SNAP/MA – MAGI Denial
				EDDA	NNDN	Deny LIEAP
				EDDB	NNDN	Deny EA
				EDDC	NNDN	Deny NEMT

DOHS Official Form Code		DOHS Official Form Name	Chapter Reference	System Generated Notice Code	Worker Generated Notice Code	Eligibility System Form Name
				EDD5	NNDN	Deny DCA
				EDD6	NNDS	Deny Spenddown
				EDO7	NDSC	Deny SCA
				CRD1	NNDN	Denied RFA
				CNAE		Potential Auto Enrollment Form

APPENDIX C: PUBLIC FORMS

Form Number	Form Title
DFA-FH-1	Pre-Hearing Conference and/or Fair Hearing Request

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES (WV DOHS)
PRE-HEARING CONFERENCE AND/OR FAIR HEARING REQUEST FORM

If you disagree with the decision made on your application or the proposed changes in your benefits, you may ask for a Pre-Hearing Conference, a Fair Hearing or both, either orally or in writing. You have the right to be assisted and/or represented by a person of your choice at the Pre-Hearing Conference/Fair Hearing. This person may be a friend, relative, attorney or any other person.

A Pre-Hearing Conference is an informal meeting with you and any person(s) you choose to have with you, your West Virginia Department of Human Services (DOHS) Case Worker and the Supervisor. This meeting is to explain anything you have questions about and for you to explain your situation. This Conference may resolve the problem and eliminate the need for a Fair Hearing. If not, you may proceed with a Fair Hearing.

A Fair Hearing is a meeting with you and anyone you choose to have with you, a State Hearings Officer, the DOHS representative and any witnesses you or the DOHS believes can provide appropriate evidence. The Fair Hearing process is designed to make sure the DOHS took the correct action on the issue(s) involved.

If you ask for a Pre-Hearing Conference and/or a Fair Hearing, due to a decrease or closure of your benefits before the date of the proposed closure or reduction, your benefits will not be reduced or stopped, pending a final decision. Otherwise, the change will be made, and you may ask for a Fair Hearing or Pre-Hearing Conference within 90 days of the effective date of the actions. **NOTE:** If your benefits are being reduced or stopped due to a SNAP Review, a mass change (such as the annual Social Security increase) or because you signed a form giving up your right to receive advance notice of this change, your benefits will not be continued (even if you request it), but a hearing will be held.

The DOHS Case Worker will help you make arrangements for transportation to a hearing if you cannot provide your own transportation and you so request. Your hearing may also be conducted by phone. Also, the Case Worker will help you prepare for the Fair Hearing, if you so request. To request assistance, call DOHS Client Services: 1-800-642-8589.

If you wish to have a Pre-Hearing Conference and/or Fair Hearing, complete the section below and return your local DOHS Office. The address is on the top of the enclosed notice or can be provided to you by DOHS Client Services. You may review the materials in your case record during normal business hours (Monday-Friday, 8:30 a.m.-5:00 p.m.). If you request, we will send you a copy of the applicable Family Assistance Manual section or you may view and print the manual sections yourself on the internet at https://DoHS.wv.gov/bcf/Pages/default.aspx.

☐ I would like to have a Pre-Hearing Conference with my Worker and/or the Supervisor. (You may have a Conference before the Fair Hearing and then proceed with the Fair Hearing if you are not satisfied.)

☐ I want a Fair Hearing before a State Hearings Officer. (You may have a Fair Hearing without a Pre-Hearing Conference.)

☐ I wish to have my Fair Hearing by phone.

☐ Please send me the Family Assistance Manual section on which the decision was based.

☐ I do NOT wish to continue receiving benefits while pending a Pre-Hearing Conference or a Fair Hearing decision. If the DOHS's decision is not upheld at the Pre-Hearing Conference or Fair Hearing, DOHS will pay you any benefits you missed during the Pre-Hearing Conference/Fair Hearing process.

Signature: _____ Date: _____

Printed Name: _____ SSN: _____

Address: _____ Phone: _____

Reason for Hearing/Pre-Hearing Request: _____

DFA-FH-1 (Rev. 6/22)

Chapter 10

The Case Maintenance Process

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
10.1				
10.2	4/1/18 12/1/19 6/1/21 5/1/22 6/1/22 4/1/25	755 779 805 821 822 862	10.2.1.B.2 10.2.1.B.1 10.2.1.A 10.2.1.B.2 10.2.1.A	Reflect the December 2017 change in the way Medical ID cards are issued. Clarifying that when mail is returned from USPS, SNAP can only close if all other programs close. Removed language about SNAP E&T Clarifying process for returned mail for Medicaid members Changed Domestic Violence to sexual harassment & domestic violence, sexual assault, and stalking.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			10.2.1.B.3	Added reference to 9.3.1.B for when advance notice requirements are waived.
			10.2.1.B.4	Added reference to 9.3.1.B for when advance notice requirements are waived.
10.3	4/1/20	784	10.3.1	Removed Customer Service
	9/1/21	808	10.3.3	Replaced grant to benefit
			10.3.3.A	Replaced 305 days with 209 days
			10.3.3.B	Removed Dormant; replaced 305 day with 274
			10.3.3.C	Deleted 10.3.3.B added Immediate Expungement when deceased
	3/1/22	818	10.3.2.B	Changed expungement to 365 days
	7/1/22	824	10.3.2.B	Changed form name to IG-IFM
	7/1/22	824	10.3.3-E	Clarify WV WORKS expungement
	5/1/24	850	10.3.3	Added expungement information for Summer EBT.
10.4	2/1/18	751	10.4.2.B.4	This change is to clarify the due date on verification checklists for unclear information.
	6/16/18	759	10.4.2.A	Update reporting requirements to include new individuals who are approved with an income that already exceeds 130% FPL.
	3/1/19	769	10.4.5.C	Paragraph added concerning restoration of benefits
	5/1/19	771	10.4.2.B.3	Deleted example to match federal instructions
	6/1/19	772	10.4.2.A	AG in receipt of substantial lottery or gaming winnings
	6/1/19	772	10.4.2.B.1	Change INS to USCIS
	6/1/19	772	10.4.2.B.3	AG in receipt of substantial lottery or gaming winnings
	12/1/19	779	10.4.2.B.3	Updated example to show when to take action on SNAP when mail is returned by USPS.
	4/1/20	784	10.4.2.B.1	OIG Findings
	9/1/20	792	10.4.2.B.1	Verification from Lottery & Gaming
			10.4.2.B.3	Removed third party reporting
	4/1/21	803	10.4.2	Added Note
	5/1/21	804	10.4.2	Clarify when Medicaid verification
	6/1/21	805	10.4.2.D	Added section to clarify that a SNAP AG is not eligible to receive a deduction if the deduction is not reported to the agency
			10.4.5.A	Restoring benefits due to DOHS error
	9/1/21	808	10.5.5.F	Removed 365-day expungement process to 274 day
		809	10.4.3.A.1	Updated reporting threshold for SNAP
	10/1/21		10.4.5.A	Updated note regarding reporting threshold for SNAP
			10.4.4.H	Changed form to IG-IFM-BENPAY-1
	7/1/22	824	10.4.5.F	Added SNAP to AG
	12/1/23	844	10.4.2	Clarification from FNS regarding loss of employment

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				and ABAWD policy.
	6/1/24	851	10.4.2	Note added that the table in 10.4.2 is not to be used for PRC-2's.
			10.4.2.D	Clarification added regarding verifications needed for PRC-2's.
			10.4.3.A.2	Example 2 updated.
	2/1/25	860	10.4.2	Removed the note below the chart
	7/1/25	866	10.4.2.D	Explains to the eligibility worker how to process the PRC-2 and what is considered an incomplete PRC-2.
	1/1/26	872	10.4.2.B.3	Expanded the list of third-party sources and added Notice of Match Results information.
			10.4.2.D	PRC-2 process is now specific to the 24-month certification population only (AD).
			10.4.4.G	Directs workers to refer retailer trafficking complaints, including attempts to bypass the soda restriction policy, to the WV OIG.
10.5	10/23/17	746	10.5.5.B.4	Added policy regarding choosing the payee for the WV WORKS benefit for not cooperating with drug testing.
	6/1/19	772	10.5.5.B.4	Moving section to 18.7.18.E
	9/1/21	808	10.5.7.D	Regarding a WV Works case
	3/1/22	818	10.5.7.D	Changed expungement to 365 days
	6/1/22	822	10.5.7.B	removed reference to check
	7/1/22	824	10.5.7.D	replaced issuance to last use
	7/1/22	824	10.5.7.G	Changed form to IG-IFM-BENPAY-1
	9/1/24	854	10.5.5.B.4	Corrected reference error from previous change to 18.7.18.E
10.6	4/1/18	755	10.6.6.C, 10.6.6.C.1	Reflect the December 2017 change in the way Medical ID cards are issued.
	5/1/20	786	10.6	Coronavirus (COVID-19) National Emergency
	1/1/21	799	10.6	R+6emoved WVCHIP
	4/1/22	819	10.6.4.E	Change postpartum period
	5/1/22	821	10.6.4.B	Added reference to Chapter 10.2.1.B.2
	1/1/23	830	10.6.4.E	Remove West Virginia from WV Foster Care
	2/10/23	833	10.6	Court Order Carr vs. Becerra, (See DW-17)
	4/1/23	835	10.6	Changed the Note to reflect the client must receive the same level of care until March 31, 2023, and have a full redetermination before closure. Also provided additional requirements prior to closure.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	12/19/23 3/1/24 11/1/24	845 848 856	 10.6 10.6	Updated third bullet to be in compliance on continuous eligibility. Added the exception to the children under age 19 continuous eligibility requirement for Medically Needy Spenddown coverage groups; clarified when WV Medicaid benefits can be closed during COVID-19 Unwinding period; corrected wording Removed note regarding guidance for COVID-19 Pandemic guidance.
10.7	10/1/20	794	10.7.1	Removed to determine ineligibility
10.8	4/1/22	819	10.8.4	Change postpartum period
10.9	4/1/22	819	10.9.2 10.9.4 1.9.5	Change postpartum period Change postpartum period Change postpartum period
10.10				
10.11	5/1/19	771	10.11.3	Removed AG closures
10.12				
10.13				
10.14	1/1/18 3/1/24 10/1/24 12/1/24	749 848 857 858	10.14.3 10.14.1 10.14.1 10.14.1	Adding Section to cover special procedure involving SSI recipients who own ABLE accounts. SSI benefits will be placed on hold by SSA if ABLE account reached $100,000 balance, however Medicaid eligibility will continue. Added clarification that a child under age 19 receiving SSI is eligible for 12 months continuous eligibility Added language to include Medicare Premium Assistance. Updated language to Bureau for Medical Services.
10.15				
10.16				
10.17				
10.18	1/1/23	830	10.18.1	Remove West Virginia from WV Foster Care.
10.19	10/1/20	794	10.19	Replaced word illegal
10.20				
10.21				
App A	3/1/19	769		Update COLA

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	3/1/20	783		Update COLA
	3/1/22	817		Update COLA
	3/1/23	832		Update COLA
	3/1/24	848		Update COLA
	3/1/25	861		Update COLA
	10/1/25	869	A.2	Reports and Worker Action – Added WRMC183U Report and definition.
	3/1/26	874		Update COLA
App B	3/1/19	769		Update COLA
	3/1/20	783		Update COLA
	3/1/24	848		Update COLA
	3/1/25	861		Update COLA
	3/1/26	874		Update COLA
App C				

10.1 INTRODUCTION

Case maintenance is used to describe all activities that are required between assistance group (AG) approval and the first redetermination, and between subsequent redeterminations, to ensure only eligible clients receive benefits and the benefit amounts are correct.

The process requires clients to report specific changes in circumstances to the Department of Human Services (DOHS). 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 eligibility 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 9.

10.2 COMMON INFORMATION

10.2.1 GENERAL SOURCES OF INFORMATION

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

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

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 individual is the client's Authorized Representative(s) or Authorized Cardholder(s).*

- Complaints about the client.

- Individuals in the community and other Department of Human Services (DOHS) employees may report information to the DOHS that 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 is true and would have a bearing on eligibility or the benefit level, the Worker must contact the client to confirm the information, keeping in mind the assistance group's (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. 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 Investigations and Fraud Management (IFM). See Chapter 11.

> **Reporting Example 1:** A woman calls to report her neighbor's oldest son moved out of the home and the neighbor 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 130% Federal Poverty Level (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 the DOHS.
- Data system matches and case maintenance functions. Each program has specific reports and other case maintenance functions. See program-specific information.

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

10.2.1.A County Transfers

When a client moves to another county, eligibility system action is taken immediately to change the address and transfer the case. The eligibility system notifies the local office in the client's new location 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 sexual harassment and domestic violence, sexual assault, and stalking situation.

When county DOHS office receives a transferred case, the Worker/Supervisor must evaluate Able-Bodied Adults Without Dependents (ABAWD) exemptions and the number of countable months received.

The Worker forwards the case record and any separate file that contains information about a sexual harassment and domestic violence, sexual assault, and stalking 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 Office of Children and Adult Services or Bureau for Child Support Enforcement (BCSE), the Worker must notify the other units of the transfer electronically or by DHS-1.

The Worker must also ensure the transfer of the electronic file from the document imaging system to the new county.

10.2.1.B 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 eligibility 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 that follow. The closures described below are related to general requirements, common to all programs.

10.2.1.B.1 Automatic Closures

AGs are automatically closed by the eligibility system under the following circumstances:

- An AG redetermination is not completed by the adverse action date in the month the AG is due for redetermination
- Phase II of Transitional Medicaid (TM) ends
- Extended Medicaid coverage ends
- Medically Needy spenddown AG is at the end of the period of consideration (POC)

10.2.1.B.2 Closure Due to Loss of Contact

Loss of contact occurs when the client moves and does not notify the DOHS. The Worker may become aware of this when a Medical ID card, or other correspondence is returned. The Federal Data Hub (FDH) may also indicate a client's updated address.

The Worker must first check the address in the eligibility system. 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 Supplemental Security Income (SSI) Medicaid recipients, the Worker must check State On-Line Query (SOLQ).

If the address is correct and/or the United States Postal Service (USPS) indicated a new address on the returned correspondence, the Worker sends a 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 advance notice. If the USPS indicates no new address on the returned correspondence, the AG is closed, after advance notice.

For SNAP AGs, see the specific reporting requirements in Section 10.4.2. SNAP AGs are not required to report a change of address, and information from the USPS is not considered verified upon receipt. The Worker must only act on this information if it closes all other programs.

Medicaid Only:
Mail returned with an in-state forwarding address is not an indication of a change affecting eligibility. The USPS in-state forwarding address is acceptable to update the client's record while sending a DFA-6 to the current address. The client's coverage is not terminated if the DFA-6 is not returned.

Mail returned with an out-of-state address must be confirmed by sending a DFA-6 to the client's current address to verify state residency. If the client fails to respond, or the information provided does not establish the client's state residency status, the worker must terminate coverage with advance notice and fair hearing rights.

Mail returned with no forwarding address must be confirmed by sending a DFA-6 to the client's current address in the eligibility system. If the client fails to respond, the worker must terminate coverage with advance notice and fair hearing rights. If the client later provides or notifies the worker of the updated address, the coverage must be reinstated with the originally scheduled renewal dates.

10.2.1.B.3 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 Medicaid and WVCHIP only: See Section 9.3.1.B for when advance notice requirements are waived.

10.2.1.B.4 Closure at Client's Request

The Worker must close the AG when the client requests 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.

For Medicaid and WVCHIP only: See Section 9.3.1.B for when advance notice requirements are waived.

10.2.1.B.5 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.

10.2.2 WV WORKS AND MEDICAID PROCEDURES FOR ADDING NEWBORN CHILDREN

Each Community Services Manager (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 the eligibility system within five workdays 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.

The eligibility system issues alert for expected births from pregnant women receiving WV WORKS and/or Medicaid. See Sections 10.8.4 and 10.5.4.

This process is required only for WV WORKS and Medicaid AGs. See Section 10.4.2 for instances in which you must add a newborn child(ren) to a SNAP AG.

10.2.3 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 1.2.1.D and Chapter 1, Appendices E, F and G.

10.3 COMMON ELECTRONIC BENEFITS TRANSFER (EBT) INFORMATION

10.3.1 CHANGE IN EBT AUTHORIZED CARDHOLDER

When the client wishes to change an authorized cardholder for Electronic Benefits Transfer (EBT), the Worker must delete the current cardholder in the eligibility system and enter the new cardholder's information, including the benefit(s) to which the cardholder has access. The client may terminate cardholder access immediately by calling the EBT Helpline. Only EBT Helpline Customer Service Representatives can deactivate a card.

When the client calls the EBT Helpline first to stop cardholder access, he must still notify the DOHS Customer Service Center or the local office Worker of the cardholder change.

10.3.2 EBT CARDS RECEIVED IN THE LOCAL OFFICE

The local office may receive an EBT card from any number of sources, including the client, the United States Postal Service (USPS), or other individuals. Regardless of the manner in which the card is received, it must be handled as a negotiable and secured by the Financial Clerk. The local office must not retain an EBT card for a client to claim unless he receives his mail at the office. When a replacement card is required, the Worker can request it through the eligibility system, or the client can request it by using the EBT Helpline. The following procedures are used for EBT cards received in the local office.

10.3.2.A Client Receives Mail in the Local Office

When a client receives his EBT card by mail in the local office, it must be secured by the Financial Clerk and entered on the negotiable log. The client must sign for the card when claimed. If not claimed within five calendar days, the Financial Clerk notifies the Worker. If not claimed in 30 calendar days, the Financial Clerk must contact the Office of EBT (WV EBT) by email with the card name, number, and an explanation of how it was received in order to have the card deactivated. The card is then destroyed, the action is noted on the negotiable log, and the Worker is notified.

10.3.2.B Client Returns EBT Card

EBT cards are not accepted by the Worker. When the client mails his EBT card to the local office with or without a request to return benefits, or intentionally/unintentionally leaves his card at the local office, the Financial Clerk must secure the card and contact WV EBT by email with the card name, number, and an explanation of how it was received in order to have the card deactivated. The card is then destroyed, the action is noted on the negotiable log, and the Worker is notified. This includes cards found in the office lobby or a store parking lot and returned by another person.

If the client wishes to return benefits from the EBT account, he must complete and sign the IG-IFM-BENPAY-1 indicating the amount to be returned. When the client is unable or unavailable to sign the IG-IFM-BENPAY-1, the Worker must write “Signature Not Available” and record the reason. Benefits are removed from the account by a Supervisor or Investigations and Fraud Management (IFM) Repayment Investigator (RI). Unless the request to return benefits is mailed to the local office along with the card, the client may retain the card. In this instance, the card is destroyed using the above procedures.

10.3.3 BENEFIT LEVEL EXPUNGEMENT

“Benefit” refers to the procedural process of depositing any Supplemental Nutrition Assistance Program (SNAP) or cash benefits into an EBT cardholder’s account.

“Expungement” is the removal of benefits from an EBT account.

The “aging process” is based on a first-in, first-out basis, oldest to newest, which means that each grant month deposit has a separate aging cycle.

The issuance date will be the parameter that determines the aging of a benefit month.

Once a benefit month account has reached 122 days after issuance for Summer EBT, 274 days after issuance for SNAP and 365 days from the date of last use for WV WORKS, the benefit is expunged.

The Worker must check the EBT account and card status when speaking with a client regarding the receipt and/or access to both SNAP and cash benefits. Although an account has an expungement, there may be remaining benefit month amounts in the account.

Expungement occurs based upon the date of issuance and the time a monthly benefit was issued to the household. Once benefits have been expunged, the benefit aging and benefit expungement process will continue for remaining benefit months on an account based on the date(s) the remaining months were issued.

Immediate expungement will for SNAP occur when it has been determined all members of the Assistant Group are deceased and the worker has obtained independent verification of the death(s).

10.3.3.A Notification of SNAP Expungement - 229 Days from the Date of Issuance

An alert will be sent to the worker and a notice to the SNAP AG advising they have not used benefits from the account that were issued 229 days prior to the date of the notice. The notice advises if the client does not take action within 13 days and a claim is present, the remaining amount from the benefit will be applied to the claim.

An alert will be sent to IFM. This will give them an opportunity to act on an open claim for the case.

10.3.3.B Notification of WV WORKS Expungement – 335 Days from the Date of Issuance

An alert will be sent to the worker and a notice to the WV WORKS AG advising they have not used benefits from the account for 335 days. The notice advises if the client does not take action within 13 days and a claim is present, the remaining amount from the benefit will be applied to the claim. An alert will be sent to IFM. This will give them an opportunity to act on an open claim for the case.

10.3.3.C SNAP Expungement – 274 Days from the Date of Issuance

An alert will be sent to the worker and a notice will be sent to the client advising the SNAP benefits have been expunged and are no longer available. The notice will also advise they may have other benefit months remaining. The clients are also encouraged to use all monthly SNAP allotments within 274 days of receipt.

274 Days of Non-Use Benefit Example: An account reaches 274 days of non-use from the date of issuance and the account balance is comprised of two benefits as follows:

- Benefit A has been available for 274 days.
- Benefit B has been available for 229 days.

Benefit A will be expunged immediately, and Benefit B will be expunged 45 days later. The benefit expungement process will continue as the benefit month reaches 274 days from the date of issuance. Aging will continue to move the account toward expungement even on a manually re-opened and active account, until the benefit month reaches 274 days from the date of issuance.

Benefit	Date of Issuance	Days After Issuance	Balance Before Expungement	Amount Expunged	Balance After Expungement
A	July	274	$200	- $200	$0
B	August	229	$100	$0	$100

The benefit(s) are based on age and drawdown priority which is affected by the date the benefit was issued.

After an expungement, all other non-zero benefits on the account will remain unaffected and will continue to age until they reach 274 days from the date they were issued and then they will be expunged as well.

10.3.3.D WV WORKS Expungement - 365 Days from the Date of Issuance

An alert will be sent to the worker and a notice will be sent to the client advising the WV WORKS benefits have been expunged and are no longer available. The notice will also advise they may have other benefit months remaining. The clients are also encouraged to use all monthly cash benefits within 365 days of last use.

On a daily basis, for every account identified in the control file, all benefits associated with that account are reviewed individually. Individual benefits that have been available for 365 days from the date of last use are expunged.

10.3.3.E Expungement Immediately when the SNAP Assistance Group has Deceased

Immediate expungement will occur for SNAP when it has been determined all members of the Assistant Group are deceased and the worker has obtained independent verification of the death(s).

10.4 SNAP

Case maintenance and corrective procedures specific to the Supplemental Nutrition Assistance Program (SNAP) are outlined in this section.

10.4.1 SOURCES OF INFORMATION

In addition to the sources listed in Section 10.2.1, the following are specific to SNAP.

10.4.1.A Report Form, DFA-SNAP-2

The DFA-SNAP-2 is mailed with system-generated notification letters and provides the client with a means to report changes. Another DFA-SNAP-2 must be sent to clients who submit a completed DFA-SNAP-2.

When the Worker receives a DFA-SNAP-2, he makes appropriate changes in the eligibility system. When the information is unclear or follow up is needed, the Worker contacts the client before taking action.

10.4.1.B Data Exchange, Reports, and Alerts

See Chapter 6 for IEVS information. All SNAP benefit reports are found in MOBIUS or the eligibility system.

10.4.2 CLIENT REPORTING REQUIREMENTS

All SNAP assistance groups (AGs) must report changes related to eligibility and benefit amount at application and redetermination. SNAP AGs are subject to limited reporting requirements, and the reporting requirements in this section apply to recipient AGs only.

The reporting requirements for SNAP clients are only for SNAP benefits and do not affect the reporting requirements of any other program of assistance that the AG also receives.

Regardless of the SNAP reporting requirement, all changes reported directly by an AG member, the AG's authorized representative and/or authorized Electronic Benefits Transfer (EBT) cardholder, or from a source that is listed as verified upon receipt below must be acted on, even if the AG is not required to report the information.

The AG is not required to report any periodic cost-of-living increases in federal benefits, such as the yearly increase in Retirement, Survivors, and Disability Insurance (RSDI), Supplemental Security Income (SSI), Black Lung, or Veterans Affairs (VA) benefits. This exception only applies to mass changes, not to an individual change affecting the level of a client's benefits. See "Other Types of Changes" below.

When reported information results in a change in benefits and additional or clarifying information is needed, the Worker must first request the information by using the DFA-6 or verification checklist. If the client does not provide the information within the time frame specified by the Worker, the appropriate action is taken after advance notice. Each reported change is evaluated independently for the appropriate action to be taken. When a reported change results in the change of the certification period, the client must receive advance notice of the change.

The table below provides some common examples of reported changes, the impact on the benefit, and the result if requested clarifying information is not returned.

NOTE: Shelter deductions must be verified at application, redetermination, and after a reported change. If the reported change is not verified, no shelter deduction is allowed. The table below is not a comprehensive list of examples. This table does NOT apply to processing of the interim contact report (PRC2) form.

Reported Change	Impact on Benefit (Increase or Decrease)	When Requested Information Is Not Returned
Add AG member	**Increase**	**Benefits remain the same**
Remove AG Member	Decrease	Not applicable; no verification required

Reported Change	Impact on Benefit (Increase or Decrease)	When Requested Information Is Not Returned
Increased Deduction	**Increase**	**Benefits remain the same**
Decreased Deduction	Decrease	Not applicable; no verification required
Increase in Same Source of Income	Decrease	Not applicable; no verification required
Decrease in Same Source of Income	**Increase**	**Benefits remain the same**
New Source of Income	Increase/Decrease	Benefits close
Change in Shelter Expense	Increase/Decrease	Benefits are determined without a shelter deduction

When Requested Information Is Not Returned Example: A client receives Adult Medicaid and SNAP. He reports a decrease in his income. The case is pended for verification (for Medicaid because the reported income was found to be discrepant with the FDH and could not be verified electronically). The client does not return the requested information. Adult Medicaid is closed, and SNAP benefits remain the same.

Reporting Example 1: A client who received a deduction for medical expenses at his last redetermination calls to report that these expenses have recently decreased. No verification is required for a decreased deduction, so the worker accepts the client's statement.

Reporting Example 2: Mr. Oak, who already receives SNAP benefits, submits an application for Modified Adjusted Gross Income (MAGI) Medicaid. He reports on this application that he still works for Greyson's Market, but his pay has increased. The FDH verifies the new income amount for MAGI purposes, but FDH information cannot be used for SNAP purposes. However, because the reported income change is an increase, the worker accepts the Mr. Oak's statement for SNAP and confirms the reduction in SNAP benefits.

Reporting Example 3: Same situation as above, except that Mr. Oak reports new employment at Advantage Auto. Again, the worker follows Medicaid verification policies and is able to use Mr. Oak's self-attestation for Medicaid. For SNAP, a new source of income requires verification, so the worker pends the case. If Mr. Oak does not return the necessary information, SNAP benefits will close.

10.4.2.A Limited Reporting

When approved with a gross non-excluded income at or below 130% of the Federal Poverty Level (FPL), an AG must report when the total gross non-excluded earned and unearned income of the Income Group (IG) exceeds 130% of the FPL for the number of individuals in the original AG.

When approved with a gross non-excluded income above 130% of the FPL, an AG must report when the total gross non-excluded earned and unearned income of the IG exceeds 200% of the FPL for the number of individuals in the original AG.

If an AG approved with income at or below 130% of the FPL reports non-excluded income in excess of 130% of the FPL, the AG's eligibility must be reevaluated. If the AG remains eligible for SNAP, the AG is then required to report when the total gross non-excluded earned and unearned income of the Income Group exceeds 200% of the FPL for the number of individuals in the original AG.

If an AG approved with income above 130% of the FPL reports non-excluded income at or below 130% of the FPL, the AG's eligibility must be reevaluated. If the AG remains eligible for SNAP, the AG is then required to report when the total gross non-excluded earned and unearned income of the Income Group exceeds 130% of the FPL for the number of individuals in the original AG.

If the household contains one or more Able-Bodied Adults Without Dependents (ABAWDs) who are exempt from the ABAWD work requirements, the household must report when an ABAWD loses his exemption or when that person's work hours are reduced to less than 20 hours a week, averaged monthly. These changes must be reported no later than the 10th calendar day of the month following the month in which the change occurs.

An individual in a sole AG or who purchases and prepares with others is required to report if they receive substantial lottery or gaming winnings greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled individual during any one game. This information should always be acted upon by the agency including application, recertification or during the certification period.

No other changes are made unless the information is reported by an AG member, comes from a source that is verified upon receipt, or is received from a source that is considered reported.

> **Limited Reporting Example 1:** A two-person AG is certified in April with an income below 130% of the FPL. On May 20, one of the AG members begins working full time. When the AG calculates the income received in May, it is still below 130% of the FPL. In the middle of June, the client receives a raise. He

receives one paycheck in June with his new rate of pay. When the AG calculates the income received in June, it is still below 130% of the FPL. No changes are required to be reported at this point. When the AG calculates its income in July, it exceeds 130% of the FPL. The AG is required to report this by August 10.

Limited Reporting Example 2: An AG consists of a mother and two children, who were initially approved with an income below 130% of the FPL. In the third month, the children's father moves into the residence. At the end of each month, the AG must consider all income sources. The father's income, when combined with the AG's, exceeds 130% of the FPL for the original three-person AG. The AG must report this by the 10th day of the fourth month. The mother calls to report that the household's combined income exceeds 130% of the FPL. The Worker determines the cause of the income change and must add the children's father because he is required to be included in the AG. See Section 3.2.

Limited Reporting Example 3: A family of four receives SNAP based on a gross income above 130% of the FPL, but below 200% of the FPL. The AG is not required to report an income change unless the total gross income exceeds 200% of the FPL. The mother, who was self-employed, calls to report that she has discontinued her business due to lack of sales. The Worker updates the income and increases the family's SNAP. The gross income of the AG is now below 130% of the FPL, so the AG is required to report if the total gross income of the AG exceeds 130% of the FPL. A few months later, the mother is hired by a local newspaper. After her first paycheck, the AG calculates the income received for the month and determines that it exceeds 130% of the FPL. The AG is required to report this by the 10th of the following month.

10.4.2.B Required Changes for SNAP AGs

10.4.2.B.1 Sources of Information Verified upon Receipt

Action must be taken for all AGs when information is received from a source that is considered verified upon receipt. Verified upon receipt sources are not subject to independent verification and the provider is the primary source of the information. The only sources considered verified upon receipt are:

- Beneficiary Earnings and Data Exchange (BENDEX) and State Data Exchange (SDX) from the Social Security Administration (SSA)
- Cost-of-living adjustment (COLA) Mass Change and reports in Appendix B
- Systematic Alien Verification for Entitlement (SAVE) from United State Citizenship and Immigration Services (USCIS) and 40 Qualifying Quarters information from SSA
- Unemployment Compensation (UC) and work registration data from WorkForce West Virginia
- Investigations and Fraud Management (IFM) findings of an investigation
- VA match with OIG findings
- Notification of application for benefits in another state
- Report from Social Service Worker
- Child Welfare Information System Provider and Client Detail Data Exchanges
- Housing and Urban Development (HUD)
- State On-Line Query (SOLQ)
- Notification of ABAWD cooperation/non-cooperation from a SNAP Employment and Training (E&T) Worker
- Information received from the WV Lottery Commission for SNAP Substantial Lottery and Gaming policy

NOTE: See Chapter 6 for additional information about data exchange sources.

10.4.2.B.2 Sources That Are Considered Reported

The following are considered reported changes for SNAP and require follow up and/or action for all AGs.

- Communication from an AG member or the AG's documented authorized representative and/or authorized EBT cardholder, such as an office visit, telephone call, or written statement to report a change for any program of assistance in the eligibility system.

Sources That Are Considered Reported Example 1: An AG member calls to report that HUD has decreased his rental obligation for the same residence. Although the AG is not required to report this information, the change is made because it was reported by an AG member.

NOTE: This does not include SSI/RSDI payees, unless they are also the authorized representative or EBT cardholder.

- Changes reported during an application for burial assistance or an application or redetermination for any program of assistance that is entered in the eligibility system and includes an AG member.

Sources That Are Considered Reported Example 2: A child is included in a SNAP AG with his mother. The next month the grandparents apply for SNAP, including the child of whom they now have physical custody. Although the child's previous AG was not required to report this change, the child is removed from the AG so that he may be included with the grandparents.

Sources That Are Considered Reported Example 3: A man applies for SNAP in April and reports that he moved in with his sister in March. He pays her $200 rent and is approved as a separate AG. The sister was previously approved for SNAP in January. The $200 does not put her over the gross income limit at which she is required to report, and the change occurred during the certification period. No change is made to the sister's benefits except to note the income and living arrangements in case comments.

NOTE: This does not include information reported solely to verify eligibility for a TANF supportive service.

- Information received on behalf of a client that results in changes made in the eligibility system for another program of assistance.

Hospital Reporting Example: A call is received from the hospital, informing the agency of the birth of a baby, for Medicaid purposes. If the baby is added to the Medicaid AG, he is also added to the SNAP AG.

- Returned mail received with a United States Postal Service (USPS) sticker indicating the client has moved out of West Virginia. If all other benefits in the case close, SNAP is also closed. If all benefits do not close, SNAP remains open and this must be addressed at next redetermination. If the case is SNAP only, benefits continue and is addressed at the next redetermination.
- Information received from any source that the client was required to report.

> **Information Requiring Reporting Example:** A report is received from Quality Control (QC) that the income of a SNAP AG exceeds the gross limit. The information is acted on because the client is required to report it.

10.4.2.B.3 Information Reported from Third-Party Sources

During the certification period, the agency may receive information about changes in a household's circumstance from a third party. The Worker must pursue clarification of the information and require verification, if needed.

Third-Party sources include but are not limited to:

- New Hire Alerts
- Bureau for Child Support Enforcement (BCSE)
- QC
- Wage
- Death
- Prisoner
- Internal Revenue Service (IRS)
- Federal Public Assistance Reporting Information System (PARIS)

The worker must follow up on all unclear information during the certification period when it is reported on the contact form or meets the following criteria:

- The information presents significantly conflicting information from that used by the DOHS at last certification; or
- The information would have to be reported under the household's reporting requirements and the information is fewer than 60 days old from the current month.

If the household does not meet this criterion, then the information should not be acted upon until next SNAP application, redetermination, or contact form.

> **Client Moved Example:** A landlord reports a client has moved out of state. The client is not required to report this information. The Worker must make case comments and evaluate this information at the next redetermination.

10.4.2.B.4 Unclear Information

Unclear information is any information received from any source with which the Worker cannot readily determine the effect of the reported information on the household's benefit. The Worker must pursue clarification and required verification of unclear information related to these reported changes. Additional information requested from the applicant is due 10 calendar days from the date of the DFA-6 or verification checklist.

> **Unclear Information Example 1:** An AG member reports her boyfriend has moved into the home and she wishes to add him to her SNAP case. She does not offer any additional information. Because it is unclear how his addition to the case will affect the benefits, the Worker must ask if he has earned or unearned income. If this information is not known, a DFA-6 will need to be issued and proper procedure followed.
>
> **Unclear Information Example 2:** An AG member reports her boyfriend has moved out of the home. She does not offer any additional information. The case information indicates he is paying the rent. The Worker must pursue clarification regarding who is now paying the rent and continue to make the appropriate changes to remove him from the case.
>
> **Unclear Information Example 3:** A woman reports her boyfriend moved in, but they are going to purchase and prepare meals separately. The Worker notices the boyfriend has the same last name as the newborn that was added to the case last month. The Worker must pursue clarification regarding the relationship between the boyfriend and the child, as this could affect benefit amount.
>
> **Unclear Information Example 4:** An AG member reports they have moved. They offer no other information. The Worker must pursue clarification regarding how the shelter and utility costs have changed and make the appropriate changes to the case. In this example, it is not appropriate to ask about income and other household members if this information is not provided.

10.4.2.C Timely Reporting and Follow Up

To determine if a claim for benefit repayment must be established or a lost benefit restored, a decision must be made as to whether or not a change was reported in a timely manner.

NOTE: Regardless of SNAP reporting requirements, when a client fails to report household expenses that would normally result in a deduction, the AG loses their entitlement to that deduction. They have a right to the expense once it is reported and verified, if necessary. Retroactive benefits are not issued.

When the client does not report in a timely manner and the change could have been made earlier, a claim for benefit repayment may be established. See Chapter 11.

If the client fails to report a change that would have increased benefits within the AG's appropriate time limit, benefits are not restored. See Limited Reporting above.

10.4.2.D How to Process an Interim Contact Report (PRC-2)

Changes Reported

If an AG reports income changes, verification of those changes must be submitted for the PRC-2 to be considered complete. If a change is reported that requires verification, it must be requested using a DFA-6. Failure to provide requested verification results in AG closure or loss of a deduction after advance notice.

The eligibility system automatically mails an Interim Contact Report form (PRC-2) to the AGs for the mid-month of eligibility. When a change in income is reported on the PRC-2, verification must be requested and received for the PRC-2 to be considered complete, regardless of whether that change would result in an increase, a decrease, or closure of the benefit. An application form can be used in substitution of a (PRC-2) during the report month, but an interview must be completed, and a new certification period will be established.

All SNAP AGs certified for 24 months must have a PRC-2 completed in the mid-month of eligibility (the twelfth month). SNAP must not continue into the 13th month of certification if a (PRC-2) is not submitted. If the PRC-2 is returned late in the 13th month, the worker can process the interim contact form and benefits will be prorated.

NOTE: The Chart in IMM Chapter 10.4.2 must not be referred to when changes in income are reported on a PRC-2.

NOTE: The AG always has the right to file a new application form. The agency must allow either the PRC-2 or a new SNAP application to be submitted to continue eligibility.

Incomplete PRC-2

- If the AG does not select either “I have read this form and I made no changes,” or “I have read this form and I have reported changes.”
  - The AG must be contacted by phone and asked about their intended selection. If the AG cannot be reached by phone a DFA-6 must be sent to the AG.
- If the AG selects “I have reported changes,” but fails to provide necessary verifications.
  - SNAP must be pended and the agency must send the DFA-6 to the AG.
- If the PRC-2 is not signed, or if the PRC-2 is submitted with a non-acceptable signature.
  - All SNAP forms require a signature; the form must be sent back to the AG for a signature.

THE AG Completes the Process by the end of the 13th month:

Reinstate SNAP when the AG provides a complete PRC-2 by the last day of the following month in which it was due. Reinstate benefits, effective the date the completed PRC-2 is received, for the remaining months of the certification period. Do not extend the certification period. A new application/interview is not required. Prorate benefits from the date the PRC-2 is returned complete. If the PRC-2 is not returned, a new application for SNAP must be completed.

10.4.2.E SNAP AGs Eligible for Reinstatement of Benefits

A SNAP AG can be reinstated from the date the household provides the information and/or necessary verification without a new application when they meet the following conditions:

- The SNAP benefits must be in closed status;
- The SNAP AG has at least one full month remaining in the certification period after the last month benefits are received;
- The SNAP AG must report and verify a change in circumstances during the 30 days following the last month benefits are received; and
- The SNAP AG must be eligible for SNAP during the reinstatement month and the remaining months of the certification period.

10.4.3 EFFECTIVE DATE OF THE CHANGE

10.4.3.A Increase in Benefits

10.4.3.A.1 Addition of an AG Member or a Decrease in Income of $125 or More

The change must be effective no later than the month following the month in which the change is reported. When the change is reported after the system deadline, supplemental benefits must be issued and received by the 10th of the following month.

The supplemental benefits are issued based upon the date the information is reported, regardless of whether or not the report is timely. Supplemental benefits issued in this situation are not considered restored benefits and, therefore, not used to offset a repayment as described in Restoring Lost Benefits below.

10.4.3.A.2 All Other Changes

For all other changes that result in an increase in benefits, except those described in Increase in Benefits above, changes are made as follows.

- If the next issuance date is more than 10 days after the date the change is reported, the change is effective the month following the report month.
- If the next issuance date is within 10 days of the date the change is reported, the change is effective two months after the report month.

  The ten-day period includes the date of the report and takes the staggered benefit issuance date into consideration.

  > **All Other Changes Example 1:** An AG reports that an additional person has moved into the household and needs to be added to the SNAP benefits. The individual has no income and is eligible for benefits. Benefits will increase, and the change is effective for June.
  >
  > **All Other Changes Example 2:** An AG reports an income decrease of $75 on May 28. The AG's next issuance is due on June 7. The change increases the benefit and is effective for June.

> **All Other Changes Example 3:** An AG reports an income decrease of $30 on May 28. The AG's next issuance is due on June 4. Benefits will increase and the change is effective for July.
>
> **All Other Changes Example 4:** Same as above, but the change was reported on May 24. The next issuance date is more than 10 days after the date the change was reported, so the change will be effective for June.

10.4.3.B Decrease in Benefits

When the reported change results in a decrease in benefits, the change is effective the following month, if there is time to issue advance notice. If not, the change is effective two months after it occurs. No claim is established unless the client failed to report in a timely manner, and this is the only reason the change could not be made within 13 days for the advance notice period. See Chapter 11 for benefit repayment.

10.4.4 OTHER TYPES OF CHANGES

10.4.4.A Changes in Case Name

The case may be changed from one valid payee to another valid payee at the request of the individuals involved or when a change in circumstances requires it. This includes, but is not limited to, marriage, divorce, or when the payee leaves the home.

There are three types of primary EBT cardholders:

- Primary person (PP)
- Legal guardian (LG)
- Protective/Substitute payee

When the Worker changes the primary cardholder, the existing EBT card is deactivated. This includes a change from one type of primary cardholder to another. The EBT benefits cannot be accessed until the new card is received. This occurs even when the Worker changes the primary cardholder back to the original cardholder on the same day.

Any changes to spelling, middle initial, or last name do not deactivate the existing EBT card. If the payee requests a new card to reflect the name change, it is requested in the eligibility system the same day the change is entered or through the EBT Helpline the next day.

In addition, if the client reports non-receipt of the newly issued card and the Worker issues another, the newly issued card is deactivated and cannot be used if or when the client receives it.

Any time a new card is requested, the original card is deactivated. All EBT cards are mailed the next business day, excluding federal holidays, and should be received five to seven days from the date requested.

Workers must inform all clients at the time of a change in payee that the current card will be deactivated, and they must plan for this benefit inaccessibility if there is not an authorized cardholder who can access benefits during this time. The Worker may delay the entry of the change to give the client time to access enough benefits to provide for the AG until the new card is received.

For EBT, changes in the payee, address, and authorized cardholder are sent to the EBT vendor overnight and are not restricted to eligibility system deadlines. Although the demographic change is sent and updated by EBT, a new card is only issued when there is a change in the primary cardholder, or the Worker specifically requests a card in the eligibility system.

10.4.4.B Change in Categorical Eligibility

When the client becomes categorically eligible, the Worker must make eligibility system changes and determine if supplemental benefits are required. See Chapters 1 and 4.

10.4.4.C Change in Work Requirement Status

When a change is reported that results in a change in an individual's SNAP work requirements, the Worker must ensure the status of each client is correct in the eligibility system. See Chapter 14.

10.4.4.D Cost-of-Living Adjustments (COLAs) in Federal Benefits

Recipients of federal benefits, such as RSDI, SSI, Black Lung, or VA Benefits, may receive periodic COLAs. RSDI/SSI increases are handled in accordance with instructions in Appendix A of this chapter. All other federal benefit COLAs are treated as any other change, except that the client is not required to report the change.

10.4.4.E Change of Address

A change of address is made in the eligibility system as soon as the client reports it. Any other changes the client reports in addition to the address change are also acted on at the same time when notice requirements permit.

A change of address after the system deadline does not affect receipt of SNAP benefits in an EBT account. When the client requests a replacement EBT card and his address has changed, the address change must be made in the eligibility system before the new card is issued to ensure the card is sent to the correct address.

10.4.4.F Closure of Other Benefits

When a WV WORKS or Medicaid AG also certified for SNAP benefits is closed, and there is enough information to continue SNAP benefits, the SNAP benefits must continue with no interruption in benefits. When notification of the closure is sent, it must also state that the AG continues to be eligible for SNAP.

When there is not enough information to continue SNAP benefits, a DFA-6 or verification checklist is sent to request the additional information needed. If the AG does not respond, notice for closure of the SNAP AG is sent.

10.4.4.G Complaints Regarding Trafficking of SNAP Benefits

The Worker must refer complaints concerning a store trafficking SNAP benefits, such as a retailer buying EBT benefits for cash or selling ineligible items, or intentionally bypassing restrictions related to the SNAP soda restriction waiver, to the WV Office of Inspector General.

The Workers must refer complaints concerning a client who is trafficking SNAP benefits, including attempts to misuse benefits to obtain restricted soda products under the SNAP soda restriction waiver, to IFM. See Section 11.2.

10.4.4.H Returned SNAP Benefits

When the client wishes to return SNAP benefits that are in the EBT account, the client is referred to the Repayment Investigator (RI) when such staff is available in the local office. The RI completes a claim and removes the benefits from the EBT account using the administrative terminal and credits the benefits as a repayment on the claim. The client must sign form IG-IFM-BENPAY-1. The RI completes the bottom of the form to indicate the benefits were removed.

If IFM staff is not available in the local office, a Supervisor in the local office completes the IG-IFM-BENPAY-1 and removes the benefits from the EBT account using the administrative terminal. The Supervisor completes a referral through the eligibility system to IFM for the claim and forwards the original IG-IFM-BENPAY-1 to the RI.

When the client is unable or unavailable to sign the IG-IFM-BENPAY-1, the Worker must write “Signature Not Available” and record the reason.

10.4.5 CORRECTIVE PROCEDURES

10.4.5.A Restoring Lost Benefits

The agency must restore benefits that were lost due to one or more of the following:

- Errors made by the DOHS, including when DOHS expunged benefits immediately upon notification of the death of the Assistance Group, then discovered the Assistance Group is not deceased and the benefits were expunged in error.
- Action taken due to failure of the client to act responsibly when good cause is established later;
- Through no fault of the DOHS or client, a sudden change in the client’s circumstances that occurred and was reported in the last 10 days of the month requires action to correct the allotment for the following month. See “Increase in Benefits” above; or

- An Intentional Program Violation (IPV) disqualification penalty was established against an AG and was subsequently reversed.

NOTE: Restored benefits are used to offset existing claims prior to issuing any remainder to the client.

NOTE: When supplemental benefits must be issued due to deadline constraints for increasing benefits, the supplemental benefits are not considered restored benefits, even when the change was not reported timely. See Addition of an AG Member or a Decrease in Income of $125 or more above.

> **Corrective Procedures Example:** A SNAP AG has a decrease in monthly income of $125 beginning in June. The change is not reported until August, but it is after the system deadline date to increase benefits for September. The change is made in the eligibility system effective October and supplemental benefits are issued for the difference due for September. Benefits are not restored for June through August. The client is notified of restored benefits.

10.4.5.B When Lost Benefits Are Not Restored?

Lost benefits are not restored when:

- The client fails to take required actions without good cause
- Benefits are lost due to the client's failure to provide correct and timely information
- The client requests restoration of lost benefits, but fails to provide documentation to verify the loss

NOTE: Lost benefits are not restored for the month in which the change occurred under any circumstances. Benefits are not restored under any circumstances for periods of time in excess of those described in Time Limits for Restoring Benefits below.

10.4.5.C Time Limits for Restoring Benefits

Benefits are not restored for more than 12 months prior to the earliest of the events:

- The date the Worker received a request from the AG for restoration of benefits;
- The date the Worker is notified or otherwise discovers that a loss has occurred; or
- The date any judicial action determined that benefits were wrongfully withheld as follows:
    - If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, benefits are restored for a period of not more than 12 months from the date court action is initiated.
    - If the judicial action is a review of the DOHS's action, benefits are restored for the period of not more than 12 months from the date the DOHS received a request for restoration. When no request for restoration was received, benefits are restored for not more than a period of 12 months from the date the Fair Hearing was requested by the client.

AGs eligible for restoration of benefits due to uncapped shelter deductions and/or excess medical deductions because of the presence of an SSI recipient are not subject to the time limits listed above. Benefits may be restored the month following the first month SSI benefits are paid or the original date of application for SNAP benefits, whichever is later.

When the restoration of benefits is due to the decision of a fair hearing, legal ruling, or appeal, benefits must be restored within 10 days of the Department receiving the decision.

Benefits restored due to a reversal of an Administrative Disqualification Hearing (ADH) are restored for a period not to exceed 12 months prior to the date of notification, which is determined as follows:

- If a member of the AG participated in the ADH and contested the DOHS's position, the date of notification is the date the ADH was held.
- When the DOHS's position was not contested at the ADH, the date of notification is the date the court decision is received.

> **Restoring Benefits Example 1:** The client tells the Worker on July 14, 2014, that he believes his benefit amount is incorrect due to failure of the Worker to allow the client a deduction for reported medical expenses. On August 10, the Worker discovers that an error was made in the birth date of one of the AG members when the case was approved, and a medical deduction should have been allowed since February 2013. The Worker takes action to update the eligibility system effective August 2014. Benefits are restored for July 2013

through July 2014. Because the request for restored benefits was made in July, benefits can be restored for up to 12 months from June.

Restoring Benefits Example 2: On May 1, 2014, an ADH was held. The individual accused of an IPV was present and denied charges made by the DOHS. The client was found guilty of having committed an IPV and was removed from the AG effective June 2014. On September 24, 2014, the disqualification was overturned by a court decision. The DOHS received the court's decision on October 15, 2014. Benefits can be restored up to 12 months prior to May 2014, the date of the ADH. Benefits are restored to the date of the ADH because none were lost prior to that time. Because benefits were not actually lost until June 2014, when the client was removed, benefits are restored for June, July, August, September, and October.

Restoring Benefits Example 3: On July 2, 2013, an ADH was held. No one from the SNAP AG was present to defend the accused member. The client was found guilty and removed from the benefit group effective August 2013. On October 1, 2014, the DOHS is notified of the reversal of the disqualification. Benefits are restored for up to 12 months prior to October 2014, so benefits are restored for October 2013 (12 months prior to October 2014) through September 2014 and also for October 2014 (the month the court decision was made).

10.4.5.D Corrective Actions to Restore Benefits

When the Worker determines the AG is entitled to the restored benefits, he must:

- Take eligibility system action to adjust the benefit amount to the correct amount.
- Identify the month(s) in which benefits have been lost.
- Determine the amount of benefits to restore.
- Offset lost benefits by the amount of any existing claim against the AG.
- Restore benefits within 30 days of the discovery.

NOTE: Initial allotments must not be used to offset a claim. See Chapter 1.

EXCEPTION: When benefits are restored due to reversal of an IPV disqualification penalty, benefits must be restored within 45 days of the date of notification.

10.4.5.E How Benefits Are Restored

Lost benefits are restored by issuing a one-time allotment to cover the amount of lost benefits. However, the client may request that lost benefits be restored in monthly installments. The Worker determines if the request is reasonable.

When benefits must be restored to an AG and the composition has changed, benefits are issued to the AG containing a majority of the individuals who were in the AG at the time the loss occurred.

If the AG containing the majority cannot be located or otherwise determined, benefits are restored to the AG containing the person who was designated as the head of household at the time the loss occurred.

If this person cannot be located, benefits are not restored.

10.4.5.F Benefits Returned to the State Office

Benefits deposited into an EBT account are not returned unless the client chooses to do so. When a SNAP AG is closed, EBT benefits remain in the account until the AG uses the benefits or until the benefits are expunged.

See Section 10.3.3.B Expungement –274 Days of Non-Use from the date of issuance above for expunged benefits.

See 10.3.3.C for the Immediate expungement of benefits when it has been determined all members of the SNAP Assistant Group are deceased and independent verification of the death(s) have been obtained by the worker.

10.5 WV WORKS

10.5.1 SOURCES OF INFORMATION

In addition to the sources in Section 10.2.1, case maintenance action may also originate from the following sources:

- Office of Children and Adult Services: This includes, but is not limited to, Child Care, Child Protective Services (CPS), and Foster Care.
- Bureau for Child Support Enforcement (BCSE): This may include the return of the absent parent or the receipt of child support in excess of the WV WORKS benefit. BCSE has its own case management system. Workers can inquire into this system to determine the child support and assistance group (AG) is receiving each month. Information is used to determine unearned income and whether or not the AG is eligible for the Child Support Incentive or Pass-Through Payment.
- SNAP Employment and Training (E&T) and WorkForce West Virginia: This may include a change in work registration status, or a report of new income or a change in income.
- DFA-SNAP-2: Although this form is used by the client to report changes in his SNAP benefits, the information may affect the WV WORKS benefit.
- Eligibility System Alerts: These alerts notify the Worker that changes have occurred or are expected to occur, and the information must be reviewed, and appropriate action taken. All actions must be recorded in case comments. The following information affects WV WORKS eligibility:
    - Social Security information
    - Household composition
    - Income
    - Miscellaneous WV WORKS program information
- Data Exchange: This system provides information about Social Security, Medicare, and unemployment. The Worker uses a PIN or Social Security Number to check this information when a system alert is received. More detailed information regarding what the Worker finds in the Data Exchange may be found by checking the State On-line Query (SOLQ) system.
- SOLQ: This system includes verified information for Social Security programs such as Retirement, Survivors, and Disability Insurance (RSDI) and Supplemental Security Income (SSI), Medicare, and Alien Status. The information includes individuals known to

the eligibility system within the last five years. Inquiries in the system are monitored and restricted to the primary Case Worker and his immediate Supervisor.

- MOBIUS and Eligibility System Reports: All reports regarding the WV WORKS Program are accessed through the eligibility system.
- Unemployment Compensation Benefit System (ESABPS): This system is accessed from the eligibility system and shows dates and amounts of Unemployment Compensation (UC) benefits received by individuals.

10.5.2 CLIENT REPORTING REQUIREMENTS

10.5.2.A What Must Be Reported

The client must report all changes in income, assets, household composition, and other circumstances.

When the client receives his WV WORKS benefit by direct deposit, he must report changes in bank account information to the Auditor's Office.

Refer to each program section in this chapter for action needed on reported changes when verification is not received.

10.5.2.B Timely Reporting

For WV WORKS cases, a client must report all changes in circumstances within 10 days. New earned income must be reported within 10 days of the date new employment begins to avoid certain penalties. The earned income disregard and dependent care deduction are not applied to any month's income received during the time the employment is unreported and any month's income for which earnings were not reported.

When a dependent child included in a WV WORKS payment will be absent from the home for a period of 30 consecutive calendar days or more, the parent or other caretaker must notify the Department of Human Services (DOHS) by the end of the fifth calendar day after the date it becomes clear to the parent/caretaker that the child will be absent for at least 30 days.

10.5.3 EFFECTIVE DATE OF THE CHANGE

The agency must act on reported changes to ensure the changes are effective in the next month's benefit, when advance notice requirements permit. Benefits must be restored to the client or repaid to the agency when changes cannot be made in a timely manner. See Chapter 11.

10.5.4 OTHER TYPES OF CHANGES

10.5.4.A Change in Income

When the WV WORKS client reports income from the same source is decreasing, the Worker will pend the case without making the change. Appropriate comments must be made. If the client does not verify the decrease in income, the WV WORKS benefit will stay the same.

When the WV WORKS client reports income from the same source is increasing and the increase will close WV WORKS, the change must be verified to determine eligibility for post-employment options.

When the WV WORKS client reports income from the same source is increasing and the increase will not close WV WORKS, the change is made based on the client's statement.

When the WV WORKS client reports income from a new source, the change must be verified.

10.5.4.B Change in Case Name

The case name may be changed from one payee to another valid payee at the request of the parents/caretaker relatives involved or when a change in circumstances requires it. In the case of a minor parent, the payee will be the major parent or other responsible adult.

The individual now being designated as payee must complete and sign a new DFA-2 unless his signature is on the most recent DFA-2. However, if the case is in a protective payment status, a substitute payee is not required to sign the DFA-2.

Workers must inform all clients at the time of a change of primary person that the Electronic Benefits Transfer (EBT) card will be deactivated and that funds will be inaccessible during this time. This includes a change from one type of primary cardholder to another. The Worker may delay the entry of the change to give the client time to access enough benefits to provide for the AG until the new EBT card is received.

Once the EBT card is received, the cardholder must call the EBT helpline to create a PIN and activate the card. The EBT benefits cannot be accessed until the new card is received and activated. This occurs even if the primary person is changed back to the original primary person on the same day.

Any changes in spelling, middle initial, or last name do not deactivate the existing EBT card. If the payee requests a new card to reflect the name change, the Worker makes the request the same date the change is entered in the eligibility system or by contacting the EBT Helpline.

In addition, if the client reports non-receipt of the newly issued card and the Worker issues another, the newly issued card is deactivated and cannot be used if or when the client receives it. EBT cards are mailed from the vendor only on weekdays, federal holidays not included.

Changes in the payee, address, and authorized cardholder can be made immediately because files are sent to the EBT vendor overnight and changes are not restricted to the eligibility system deadline.

10.5.4.C Change of Address

A change of address is made in the eligibility system as soon as the client reports it. Any other changes the client reports, in addition to the address change, are also acted on at the same time.

A change of address after deadline does not affect receipt of WV WORKS benefits in an EBT account. When the client requests a replacement EBT card and his address has changed, the address change must be made before the new card is issued to ensure the card is sent to the correct address.

10.5.4.D Change in the AG

10.5.4.D.1 Additions

Additions to the AG are effective the month the change occurs, provided the individual is otherwise eligible.

An individual who is added to an existing AG is treated as an applicant. Benefits for the individual are prorated from the date that all eligibility requirements are met, including completion of the Drug Use Questionnaire, signing the Personal Responsibility Contract (PRC), signing the Self-Sufficiency Plan (SSP), and attending orientation. Eligibility cannot begin earlier than the date the individual entered the home.

If a non-recipient work-eligible individual enters the household, he must complete orientation and a PRC/SSP as a condition of eligibility. Although he is not included in the AG, if he fails to cooperate in completing these activities, the AG will be ineligible for WV WORKS.

10.5.4.D.2 Deletions

Deletions from the AG are effective the month after the change occurs and the advance notice period expires. Repayment is sought for any overpayment that occurs. When a parent leaves the household, referral procedures to BCSE apply.

10.5.4.E 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. The Worker must include the following statement in the notification:

> "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."

10.5.4.F Continued Benefits after Case Closure

10.5.4.F.1 Continuation of SNAP after WV WORKS Closure

If a WV WORKS AG also certified for SNAP is closed and there is sufficient information, SNAP must continue uninterrupted.

A new DFA-2 is not required.

The closure notice sent to the client must state that the AG continues to be eligible for SNAP. If the benefit increases or decreases, appropriate notification must be sent. See Chapter 9.

10.5.4.F.2 Continuation of Medicaid Eligibility after WV WORKS Closure

Medicaid eligibility does not end automatically when WV WORKS eligibility ends. However, the circumstances that led to ineligibility for WV WORKS may have some bearing on Medicaid eligibility, so the Worker must evaluate continuing Medicaid eligibility based on the new circumstances.

10.5.4.F.3 Ineligibility for SNAP

When the WV WORKS client is ineligible for SNAP for any reason, such as excess income, the SNAP AG is closed and the WV WORKS AG, if eligible, remains open.

10.5.4.G Change in the PRC and SSP

The Worker is responsible for ensuring, on an ongoing basis, that the participation status of each client is consistent with the terms of his PRC and SSP. Any changes in household circumstances must be evaluated and the PRC and SSP are changed as appropriate.

10.5.5 SPECIAL PROCEDURES

10.5.5.A Child Care

When a WV WORKS client requests, or the Worker otherwise recognizes the need, a referral for assistance with childcare expenses is made to Office of Children and Adult Services. The referral is made using a DHS-1 that shows the client's name, case number, address, telephone number, and the reason childcare is needed. The Child Care Worker is responsible for determining eligibility for such assistance and for notifying the client of his status.

10.5.5.B Protective Payments

Protective payments are payments that are made to a substitute payee or by vendor payment. The client may request a Fair Hearing any time he is placed on protective payments or he questions the substitute payee selected.

There are two situations that require that the client be placed on protective payments, money mismanagement and protective payments at the client's request. These situations, along with how to choose the substitute payee, are described below.

10.5.5.B.1 Money Mismanagement

A Social Worker, providing protective services to the family, may request the case be placed in protective payment status.

When the Social Worker determines that protective payments are necessary due to money mismanagement, he sends a DHS-1 to the Worker requesting the case be placed on protective payments and indicates the substitute payee and the date protective payments are to begin. The name of the substitute payee is provided by the Social Worker.

When the case is placed on protective payments, the bills paid are those chosen by the client or with his participation and consent, to the extent possible.

Any cash benefits that are not directly deposited into a bank account will be deposited into an EBT account. The person named as the protective payee will receive the EBT card and is able to spend the AG's benefits.

Even though other cash benefits and SNAP benefits go into the EBT account, the WV WORKS, child support incentive (CSI), or the Pass-Through benefit may be directly deposited into the local office account so that the check may be written by the Financial Clerk to pay the family's expenses. The client must complete the appropriate direct deposit form and designate the account of the local office. Because only the monthly WV WORKS, CSI, or Pass-Through benefit is direct deposited, other cash benefits—such as Diversionary Cash Assistance (DCA) and initial or supplemental benefits—go into the EBT account.

If the direct deposit method is used for the WV WORKS benefit, the Financial Clerk does not have to be designated as the payee in the eligibility system.

In order for the client to access his other benefits, he must be the payee, unless another individual protective payee is chosen for the EBT benefits.

10.5.5.B.2 Protective Payments at the Client's Request

When the client requests a substitute payee in writing, the Worker must honor his request. The Worker takes the action as soon as possible after the request. The protective payments are discontinued as soon as possible after the client makes a request in writing.

10.5.5.B.3 Choosing a Substitute Payee

When a substitute payee is used, the selection of a substitute payee is made by the client, or with his participation and consent, to the extent possible. When it is in the best interest of the client for a staff member of a private agency or any other appropriate organization to serve as a substitute payee, the selection is made, preferably, from the staff of an agency or that part of the agency providing protective services.

The substitute payee cannot be an immediate member of the client's family. Immediate family members include spouse, parents, grandparents, children, uncles and aunts, and siblings. In addition, the substitute payee cannot be living in the same home with the client.

No employee of the DOHS can be a substitute payee, except when it is in the best interest of the client for a staff member of the DOHS to serve as such. The substitute payee is selected by Office of Children and Adult Services Protective Service staff.

Landlords, grocers, or other vendors of goods, services, or items who deal directly with the client may not be a substitute payee.

The substitute payee must agree to accept the responsibility and must be at least age 18.

A review of the way in which a substitute payee's responsibilities are carried out is conducted as frequently as indicated by the client's circumstances, and at least once every 12 months.

10.5.5.B.4 Choosing the Payee for a Positive Drug Test

See 18.7.18.E

10.5.5.C When a WV WORKS Client Becomes Eligible for SSI

When a WV WORKS client is determined eligible for SSI, the Social Security Administration (SSA) is required to count his portion of the WV WORKS payment as income. When determining the amount of SSI to which the individual is entitled, the SSA must have this information before the SSI claim can be processed.

Although children are not removed from the WV WORKS benefit, the child's portion must be determined and provided to SSA.

The following method is used to determine the individual's portion of the benefit:

Step 1: Determine the amount of the benefit with the individual included in the AG. This includes all applicable incentives, reductions, or sanctions.

Step 2: Determine the amount of the benefit with the individual not included in the AG. This includes the same applicable incentives or sanctions that were applied in Step 1, even if not including the individual in the payment could eliminate the incentive or sanction.

Step 3: Subtract the amount in Step 2 from the amount in Step 1. The remainder is the individual's portion of the benefit.

This amount must be determined for each month for which SSA requests the information.

10.5.6 COLA ADJUSTMENTS IN FEDERAL BENEFITS

Recipients of federal benefits, such as RSDI, SSI, Black Lung, or VA Benefits, may receive periodic cost-of-living adjustments (COLA). RSDI/SSI increases are handled in accordance with instructions in Appendix A of this chapter. All other federal benefit cost-of-living adjustments are treated as any other change.

10.5.7 CORRECTIVE PROCEDURES

10.5.7.A Correcting the Benefit Amount

Prior to issuing a corrective payment, the Worker must determine if the AG owes an overpayment. If so, the corrective payment must be offset by the amount of the overpayment. See Section 11.3.

DCA payments must not be used to offset an overpayment.

10.5.7.A.1 Underpayments

A corrective payment is made to the client when he did not receive a benefit for which he was eligible, or the amount he received was less than that to which he was entitled.

The amount of the corrective payment is the difference between the benefit the client received and the amount he was entitled to receive over the period involved.

For current clients, or persons who would have been eligible had the error causing the underpayment not occurred, the corrective payment is made when it is discovered. It does not matter when the error occurred or who was at fault. For inactive clients, the corrective payment is made when it is discovered, no matter who was at fault.

NOTE: A corrective payment for an addition to the AG is made only for the time the new AG member was eligible to be included, but was not.

Corrective payments are made to active and inactive recipients in the eligibility system.

When a corrective payment is used to offset an overpayment, due to fraud or an intentional client error, the amount offset is counted as SNAP income, if the corrective payment would

normally have been counted. See Chapter 4 to determine when corrective payments are counted as SNAP income.

10.5.7.A.2 Retroactive Payments

A retroactive payment is made when, at any time during the appeal process, it is found that, due to a DOHS error, the client did not receive a payment for which he was eligible, or that the payment he received was less than that to which he was entitled. The appeal process begins when the client requests a formal appeal. The retroactive payment covers the period over which the error occurred and is computed in the same manner as a corrective payment. Payment is made using the eligibility system.

Retroactive payments are also made when eligibility is determined in a month(s) following the month of application and the client is eligible for benefits in the prior month(s).

Any WV WORKS cash benefit that is not directly deposited into a bank account is deposited into an EBT account.

10.5.7.B Correcting the Address

When a WV WORKS support service payment is returned to Accounts Receivable, Office of Accounting, the return is entered into the eligibility system and the Worker must determine the correct disposition of the payment and enter the appropriate information in the eligibility system. The new address must be entered into the eligibility system as soon as possible.

EBT cards that are sent to an incorrect address are returned to the EBT card vendor and destroyed. When the client reports non-receipt of a card, the Worker must correct the address and indicate that a new card is required. A new card is then issued to the correct address. The Worker can check EBT card issuance on the administrative terminal.

10.5.7.C Correcting the Payee

If the new payee wishes to use direct deposit, he must enroll for himself. Otherwise, he will receive an EBT card in his name to access benefits in the EBT account. See Section 10.5.4.B above for correcting the case name for EBT benefits.

10.5.7.D Canceling the Benefit

When the benefit issued by direct deposit is returned, the Worker receives an alert in the eligibility system and must attempt contact with the client.

When cancellation is requested, the Worker must take action in the eligibility system to close the AG. If the benefit issued by direct deposit is returned and canceled, it is not counted toward the 60-month time limit.

When a WV WORKS AG is closed, EBT benefits remain in the account until the AG uses the benefits or until the benefit has reached 365 days from the date of last use and then it will be expunged. See below for benefits voluntarily returned from an EBT account.

10.5.7.E Delaying the Benefit

The benefit, either direct deposit or EBT, cannot be held under any circumstances.

10.5.7.F Reissuing a Returned Direct Deposit

The Accounts Receivable Office receives a list of direct deposits that cannot be completed, updates benefit issuance history in the eligibility system, and cancels the benefit. The Worker receives an alert in the eligibility system, and after contact with the client, must use the appropriate system procedure to issue the benefit by EBT.

Under no circumstances is a direct deposit reissued by an additional direct deposit. When WV WORKS cannot be direct deposited for any reason, the WV WORKS benefits will then be available on the EBT card.

A WV WORKS Benefit must not be held for any reason.

The Worker may delay the entry of a change of payee to give the client time to access enough benefits to provide for the AG until the new EBT card is received. See Section 10.5.7.C above.

10.5.7.G Returned EBT Benefits

A client may not return benefits unless he was ineligible for the cash benefits received in the EBT account and wishes to return them. The client is referred to the Repayment Investigator (RI), when such staff is available in the local office. The RI completes a claim and removes the benefits from the EBT account, using the administrative terminal, and credits the benefits as a repayment on the claim. The client must sign form IG-IFM-BENPAY-1. The RI completes the bottom of the form to indicate the benefits were removed.

If the RI staff is not available in the local office, a Supervisor in the local office completes the IG-IFM-BENPAY-1 and removes the benefits from the EBT account using the administrative terminal. The Supervisor completes a referral through the eligibility system to Investigations and Fraud Management (IFM) for the claim and forwards the original IG-IFM-BENPAY-1 to the RI.

10.6 MEDICAID

Individuals who receive Medicaid experience the same kinds of changes between application and the first redetermination, and between subsequent redeterminations, as individuals who receive the Supplemental Nutrition Assistance Program (SNAP) benefits and WV WORKS. The differences are as follows:

- For Medicaid, there is no benefit level determined. Therefore, the individual is either eligible or ineligible. Every reported change result in a redetermination of eligibility.
- For most Medicaid coverage groups, eligibility of assistance group (AG) members is determined on an individual basis. Therefore, the same change may impact each AG member differently.
- Regardless of any changes, except those specified in Section 10.7 for Children Under Age 19, a child under the age of 19 determined eligible for a Medicaid coverage group must have 12 months of continuous coverage.
    - Exception: A child under age 19 receiving AFDC-Related or SSI-Related Spenddown is not eligible for continuous coverage.

See Chapter 24 for case maintenance requirements for nursing care services and the Children with Disabilities Community Services Program (CDCSP), Intermediate Care Facility/Developmental Disabilities (ICF/DD) Program, Aged and Disabled Waiver (ADW), Traumatic Brain Injury Waiver (TBIW), and Intellectual/Developmental Disabilities (I/DD) Waiver.

Specific items related to case maintenance are addressed here.

10.6.1 SOURCES OF INFORMATION

In addition to the sources listed in Section 10.2.1, the FDH is used for Medicaid coverage groups.

10.6.2 CLIENT REPORTING REQUIREMENTS

Clients must report all changes in circumstances such as, but not limited to, income, assets, household composition, and change of address.

The client must report changes as soon as possible after he becomes aware of them. This allows the Worker to update the case and allows for advance notice, if the reported information results in an adverse action.

When a client reports a change during the Medicaid certification period that affects eligibility, the Worker must only request the information on the change reported.

For Modified Adjusted Gross Income (MAGI) coverage groups only, when the Worker receives the information, he evaluates the client for rolling redetermination. If the Worker has enough information available to renew eligibility with respect to all the eligibility criteria, he must begin a new 12-month certification period for the client.

> **Client Reporting Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to redetermine Medicaid. The Medicaid certification period is renewed from June 1, 2014, through May 31, 2015. When the Medicaid redetermination is completed and the client(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

10.6.3 AGENCY TIME LIMITS

The Worker must take action on reported changes as soon as possible. When the Worker is aware of anticipated changes that may affect eligibility, the Worker creates an alert in the eligibility system to take action at the appropriate time. See Section 10.7 for Children Under Age 19 Medicaid groups.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply. See Corrective Procedures below.

10.6.4 TYPES OF CHANGES

10.6.4.A Change in Case Name

The case name may be changed at the request of the individuals involved or when a change in circumstances requires it.

In such cases, the new payee must complete and sign a new application unless his signature is on the most recent application.

If the client's name changes, no new application is necessary.

For Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLIMB), or Qualified Individuals (QI-1), a new application must be signed by the spouse, if he becomes eligible, even though he will be added to the existing case.

10.6.4.B Change of Address

The Worker makes a change of address in the eligibility system as soon as the client reports it. Any other changes that the client reports, in addition to the address change, are also acted on at the same time when notice requirements permit.

Also see 10.2.1.B.2 Closure Due to Loss of Contact.

10.6.4.C Change in the AG, NG, or IG

When there is an addition to, or a deletion from, the AG, needs group (NG), and/or income group (IG), individual eligibility for each member must be reevaluated. See Chapters 3 and 4. This change(s) may require eligibility system action.

When a family reports that a child is born or a child moves into the home and there is an existing Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) AG, the Worker must evaluate the child’s eligibility for all coverage groups and WVCHIP without requiring an application. The Worker may obtain information to evaluate the child’s eligibility from the FDH, existing case information, or a phone contact. After these methods are exhausted, the Worker may request information using a verification checklist or DFA-6.

For special requirements relating to Continuously Eligible Newborn (CEN) children, see Section 10.10.

10.6.4.D Cost-of-Living Adjustments (COLAs) in Federal Benefits

Recipients of federal benefits, such as Retirement, Survivors, and Disability Insurance (RSDI), Supplemental Security Income (SSI), Black Lung, or Veterans Affairs Benefits, may receive

NOTE: For QMB, SLIMB, and QI-1, the RSDI COLAs are disregarded in determining income eligibility for January and any subsequent months prior to the effective month of the state's Federal Poverty Level (FPL) updates for the year.

periodic cost-of-living adjustments (COLAs). RSDI/SSI increases are handled in accordance with instructions in Appendix A of this chapter. All other federal benefit cost-of-living increases are treated as any other change, except that the client is not required to report the change.

10.6.4.E Possible Switching to Pregnant Women Coverage and Eligibility for Postpartum

Certain current open cases who report a pregnancy will be switched to Pregnant Women coverage and must receive 12-month postpartum coverage. See section 23.10.3.A.1. The AG must be evaluated for all other Medicaid coverage groups prior to closure.

The following Medicaid categories will be switched to the Pregnant Women group AND receive 12-month postpartum:

- Adult Group *Dually coded – Coded in the Adult Group and Pregnant Women See section 10.8.4.
- Parents/Caretaker Relatives
- Children Under age 19
- Former Foster Care
- Transitional (Phase I and Phase II)
- Extended Medicaid
- SSI-Related/Non-Cash Assistance
- AFDC-Related
- SSI-Related
- Medicaid Work Incentive Program (M-WIN)
- Breast or Cervical Cancer

The following Medicaid categories WILL NOT be switched to Pregnant Women coverage AND receive 12-month postpartum:

- Supplemental Security Income Recipients (SSI)
- Disabled Adult Children
- Blind Disabled Substantial Gainful Activity
- Essential Spouses of SSI Recipients
- Pass-Throughs
- Pickle Amendment Coverage
- Disabled Widows and Widowers
- Nursing Facility
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDD)
- Aged and Disabled Waiver (ADW)
- Intellectual and Developmental Disabilities Waiver (I/DD)
- Traumatic Brain Injury Waiver (TBI)
- Children with Disabilities Community Services Program (CDCSP)

The following Medicaid categories WILL NOT be switched to Pregnant Women coverage AND NOT receive 12-month postpartum:

- Qualified Medicare Beneficiaries (QMB)
- Specified Low-Income Medicare Beneficiaries (SLMB)
- Qualified Individual (QI-1)
- Qualified Disabled Working Individuals (QDWI)
- Emergency Medicaid
- Continuously Eligible Newborns (CEN)

10.6.5 IMPACTS OF CHANGES REPORTED

10.6.5.A AG Closures

When the client's circumstances change to the point that he becomes ineligible, the AG is closed. The eligibility system automatically closes a Medicaid AG when:

- Phase II of Transitional Medicaid (TM) coverage expiries
- Extended Medicaid coverage ends
- Medically Needy spenddown AG is at the end of the period of consideration (POC)

10.6.5.B Consideration of Eligibility under Other Coverage Groups

In no instance is Medicaid under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. A child is also evaluated for WVCHIP eligibility when Medicaid under one coverage group ends. This evaluation is done before the client is notified that his Medicaid eligibility will end. Eligibility is evaluated based on case record information. The client may be required to visit the office only for completion of a Social Summary for an MRT referral. The AG does not remain active while the MRT decision is pending.

See Section 2.14 for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

EXCEPTION:

- *Changes in income do not affect the eligibility of pregnant women.*
- *Also, regardless of any changes, except those specified in Section 10.7, a child determined eligible for Medicaid must have 12 months of continuous Children Under Age 19 coverage.*

10.6.5.C 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.

10.6.6 CORRECTIVE PROCEDURES

10.6.6.A Reimbursement for Out-of-Pocket Expenses

A client is eligible to receive direct reimbursement for out-of-pocket medical expenses that would otherwise have been paid by Medicaid in these situations:

- The client's coverage is interrupted due to agency delay or error unless the delay is due to factors beyond the control of the DOHS
- An application is denied in error
- A nursing home contribution is overpaid due to Worker error or failure to act promptly

When determining if the client is eligible to receive direct reimbursement for out-of-pocket medical expenses, the Department of Human Services (DOHS) must act on each application or case action within a reasonable period of time unless the delay is due to factors beyond the control of the DOHS. A reasonable period of time must be interpreted on a case-by-case basis.

Reimbursement for out-of-pocket medical expenses, including purchases of prescription drugs, is limited to those services covered by Medicaid. The client is reimbursed for the entire sum of his out-of-pocket expenses for those covered services, even if that expenditure exceeds the Medicaid fee schedule in effect at the time the expenditure was incurred.

The Community Services Manager (CSM) is responsible for determining if the client is eligible to receive reimbursement for out-of-pocket medical expenses. If it is determined that the client is eligible to receive reimbursement, the CSM must submit a memorandum to the Bureau for Medical Services (BMS) Policy Unit requesting reimbursement, along with the original invoices for the medical expenses for which reimbursement is requested. The memorandum must contain the amount of the reimbursement that is due the client and the accompanying bills must be marked or highlighted to indicate if they are used for reimbursement.

When the request for reimbursement is denied, the BMS Policy Unit notifies the CSM electronically of the decision. The local office notifies the client in writing of the denial.

10.6.6.B Delaying the Medicaid Benefit Issuance

The Medicaid benefit issuance is not delayed under any circumstances.

10.6.6.C Procedures for Medical ID Cards That Are Returned and Incorrect

10.6.6.C.1 Returned Medical ID Cards

Upon receipt of these cards, the State Office mails them to the appropriate local office.

When the address is incorrect, the Worker remails the card or gives it to the client when he learns the correct address. The Worker must enter the correct address in the eligibility system before benefit issuance deadline.

10.6.6.C.2 Card Not System-Issued

When Medicaid eligibility is established in the eligibility system, but a card is not system-issued, the Worker must complete a verification letter for the correct period of eligibility, and mail or give the letter to the client. Under no circumstances should a verification letter be issued unless eligibility dates are established in the eligibility system.

10.6.6.D Incorrect Eligibility Dates

When an incorrect eligibility period(s) is reflected in the eligibility system, the Worker must follow the appropriate system procedure to correct the date(s).

When a client who has a spenddown submits bills, meets the spenddown, and later sends in additional bills that would have met the spenddown at an earlier date, the Worker must follow the appropriate system procedure to correct the eligibility date and ensure the client receives coverage according to the verification letter for the new eligibility period.

10.7 CHILDREN UNDER AGE 19

Children under age 19 should not be closed unless one of the changes specified below affect the 12-month Continuous Medicaid Eligibility (CME) period for Children Under Age 19 coverage.

10.7.1 AG CLOSURES

A child may be determined ineligible prior to the expiration of the 12-month CME period only if the child's payee requests closure or the child:

- Moves out of state
- Dies
- Was approved for Medicaid in error
- Was approved for Medicaid because of client misrepresentation
- Reaches age 19
    - The child is eligible until the end of the month in which he reaches the age limit. A child who reaches age 19 on the first day of the month remains eligible until the end of that month.
    - If a child is receiving inpatient services on the date, he would lose eligibility due to attainment of the maximum age, eligibility must continue until the end of that inpatient stay.
- Does not have verification of citizenship and/or identity after match with the FDH (refer to Section 6.3)
- Is approved for Supplemental Security Income (SSI) and is eligible for SSI Medicaid
- Is institutionalized

10.7.2 CHANGE IN INCOME

A change in income does not affect eligibility once the 12-month CME period is established. In addition, a reduction in the number of people included in the needs group (NG) of the child does not affect eligibility once the 12-month CME period has been established.

> **Change in Income Example:** Jasmine, age 15, is approved for Medicaid in May 2015. In July, her mother changes jobs and the income of the family now exceeds the eligibility threshold. Jasmine's Medicaid eligibility continues through April 2016, even though income is excessive.

10.7.3 OTHER CHANGES

A change that is not specified above does not affect a child's 12-month CME period once it is established.

See Section 10.2.2 for special instructions about the addition of newborn children to Medicaid cases.

NOTE: When a child leaves one home and moves to another in West Virginia and none of the criteria above for closure is met, the child retains his eligibility through the end of his current CME period. If the current payee for the child agrees, another individual may receive Medicaid for the child, so long as the child remains eligible through the end of the current CME period. Any eligibility changes are made at redetermination. A new application is not required.

10.8 ADULT GROUP

NOTE: When a change is reported during the certification period that affects eligibility, the Department of Human Services (DOHS) must only request the information on the change reported. When the information is received, the assistance group (AG) is evaluated for rolling redetermination. See Section 1.8.6.B. The AG may be assigned a new certification period, if eligible, even though the AG is not due for a scheduled redetermination. Case comments must be made in the eligibility system to document any actions taken.

10.8.1 CHANGE IN INCOME

When a change in income is reported, eligibility for the AG must be re-evaluated. Changes include the onset or termination of income, as well as income increases and decreases. The reported change(s) may not result in any eligibility change, or they may result in AG closure. Advance notice is required for any adverse action, and the AG must be evaluated for all other Medicaid coverage groups and West Virginia Children's Health Insurance Program (WVCHIP) prior to closure.

10.8.2 ADDITIONS TO OR REMOVALS FROM THE MODIFIED ADJUSTED GROSS INCOME (MAGI)

An individual(s) is removed from the AG the month following the month of the reported change and after the advance notice period expires. Eligibility for the remaining household members is re-evaluated based on the removal of the household member.

Individuals are added to the household effective the month they meet all eligibility requirements to be included. No application form is required.

10.8.3 AG CLOSURES

The AG must be closed when the individual(s):

- Turns age 65;

- Begins receiving Medicare Part A or B; or
- Are parents or other caretaker relatives living with a dependent child under the age of 19 and the child no longer receives minimum essential coverage.

The AG is closed the month following the month of the change and after advance notice for the adverse action. The AG must be evaluated for all other Medicaid coverage groups prior to closure.

10.8.4 OTHER CHANGES: PREGNANCY

When a woman reports a pregnancy, coverage is opened in the Pregnant Women Group beginning the following month if otherwise eligible. Adult Group coverage will also remain open in the eligibility system.

NOTE: Backdating for Pregnant Women Group coverage does not apply when Adult Group coverage already exists.

The client receives the same benefits and protections while receiving Adult Group coverage as if receiving Pregnant Women Group coverage only, including:

- Co-pay exclusions
- 12-month post-partum coverage

Coverage will not be impacted by changes in income or household composition.

If a change reported during the pregnancy makes the client ineligible for the Adult Group, the Adult Group coverage ends, and the client continues to receive coverage under the Pregnant Women Group through the 12-month post-partum period.

Redetermination for the Adult Group occurs on the regularly scheduled review date. If at that time the client is still in the postpartum period, the Adult Group coverage closes, and the client continues in the Pregnant Women Group throughout the post-partum period.

10.9 PREGNANT WOMEN

10.9.1 CHANGE IN THE AG

The newborn is added to his mother's case with his own assistance group (AG).

The pregnant woman is removed from the AG at the end of 12-month postpartum period. See Chapter 23.

10.9.2 CHANGE IN CIRCUMSTANCES

Once eligibility is established, the pregnant woman's Medicaid eligibility continues, without regard to any change in family circumstances, through the end of the month in which the 12-month post-partum period ends. See Chapter 23.

10.9.3 AG CLOSURES

A pregnant woman may be determined ineligible prior to the expiration of the eligibility period only if the pregnant woman:

- Moves out of state
- Dies
- Was approved for Medicaid due to agency error
- Was approved for Medicaid because of client misrepresentation
- Does not have verification of citizenship and/or identity after match with the FDH (refer to Chapter 6.3)
- Is approved for Supplemental Security Income (SSI) and is eligible for SSI Medicaid
- Requests closure

10.9.4 EXTENDED POSTPARTUM

An individual who becomes pregnant during the postpartum period is entitled to an extended 12-month postpartum period following the end of the subsequent pregnancy.

> **Example**: Daisy is enrolled in Medicaid while pregnant. Her pregnancy ends in May 2022, and a 12-month postpartum coverage period begins. Seven months later, Daisy becomes pregnant again in December 2022, while she is still eligible for and enrolled in coverage. Daisy's subsequent pregnancy ends in September 2023. A new 12-month extended postpartum period will begin, and Daisy will remain continuously eligible through September 2024. Then Department will conduct a redetermination of eligibility and determine if Daisy remains eligible for Medicaid under the same or another eligibility group.

10.9.5 RETROSPECTIVELY ELIGIBLE

A woman who is found retroactively eligible for Medicaid is also eligible for 12-month postpartum.

> **Example**: Lily applies on June 15, 2022 and is found eligible for Medicaid. She had given birth on May 15, 2022, which is within the 3-month period prior to the month of the application. The Department determines Lily would have been eligible for Medicaid had she applied in May, and thus is covered retroactively to May. Lily is entitled to extended postpartum coverage from the time of enrollment through the end of the month in which Lily's12-month postpartum period ends May 31, 2023.

10.10 CONTINUOUSLY ELIGIBLE NEWBORN (CEN) CHILDREN

A Continuously Eligible Newborn (CEN) child (birth – 12 months) is eligible for Medicaid until he reaches age one, when all of the conditions in Chapter 23 are met.

The CEN must be added to his mother's Medicaid case within five workdays of the date the birth is reported.

10.10.1 AG CLOSURES

A child may be determined ineligible prior to the expiration of the 12-month Continuous Medicaid Eligibility (CME) period only if the child's payee requests closure or if the child:

- Moves out of state
- Dies
- Is approved for Supplemental Security Income (SSI) and is eligible for SSI Medicaid
- Is institutionalized

10.11 PARENT/CARETAKER RELATIVES

NOTE: When a change is reported during the certification period that affects eligibility, the Department of Human Services (DOHS) must only request the information on the change reported. When the information is received, the assistance group (AG) is evaluated for rolling redetermination. See Section 1.11.5.B. The AG may be assigned a new certification period, if eligible, even though the AG is not due for a scheduled redetermination. Case comments must be made in the eligibility system to document any actions taken.

10.11.1 CHANGE IN INCOME

When a change in income is reported, eligibility for the AG must be re-evaluated. Changes include the onset or termination of income, as well as income increases and decreases. The reported change(s) may not result in any coverage change or may result in AG closure or the AG's eligibility for Transitional or Extended Medicaid. See Section 23.10.9 and 23.10.8.A for Transitional and Extended Medicaid. Advance notice is required for any adverse action and the AG must be evaluated for all other Medicaid coverage groups and West Virginia Children's Health Insurance Program (WVCHIP) prior to closure. See Section 10.7 for closures when a child in the family receives Medicaid and is eligible for Continuous Medicaid Eligibility (CME).

10.11.2 ADDITIONS TO OR REMOVALS FROM THE MODIFIED ADJUSTED GROSS INCOME (MAGI) HOUSEHOLD

An individual(s) is removed from the AG the month following the month of the reported change and after the advance notice period expires. Eligibility for the remaining household members is re-evaluated based on the removal of the household member.

Individuals are added to the household effective the month they meet all eligibility requirements to be included. No application form is required.

10.11.3 OTHER CHANGES: PREGNANCY

When a woman reports a pregnancy, coverage is opened in the Pregnant Women Group beginning the following month if otherwise eligible. Parent/Caretaker Group coverage will close in the eligibility system after advance notice.

10.12 DEEMED PARENT/CARETAKER RELATIVES

10.12.1 EXTENDED MEDICAID

See Chapter 23 and Section 10.11.

NOTE: When a child loses eligibility and his family is receiving Extended Medicaid, he is included in the Extended Medicaid assistance group (AG), if otherwise eligible.

10.12.2 ADOPTION ASSISTANCE

The Office of Children and Adult Services is responsible for these cases.

10.12.3 FOSTER CARE

The Office of Children and Adult Services is responsible for these cases.

10.13 TRANSITIONAL MEDICAID (TM)

See Chapter 23, Appendix A and Section 10.11 Parents/Caretaker Relatives.

NOTE: When a child loses eligibility and his family is receiving Transitional Medicaid (TM), he is included in the TM assistance group (AG), if otherwise eligible.

10.14 SSI RECIPIENTS AND DEEMED SSI RECIPIENTS

10.14.1 AG CLOSURE

The Worker closes the Supplemental Security Insurance (SSI) Medicaid assistance group (AG) after advance notice when:

- The Worker receives a system alert and determines the individual is no longer eligible for SSI Medicaid.
- The Worker receives information from the Bureau for Medical Services (BMS) Buy-in Unit.
- The Worker receives information the client moved to another state.
    - If the Worker receives information the client moved to another state and he has not received an alert, the Worker must notify the Social Security Administration (SSA) of the new address and indicate the Medicaid AG is being closed because the individual moved to another state.
- The Worker obtains information the client receives Medicaid in another state.
- The client reports, prior to Worker's receipt of system alert, he no longer receives an SSI payment because SSA determined he is no longer eligible. This does not include a temporary suspension of SSI payments to recover an overpayment.
- Information from Social Security's State On-line Query (SOLQ) shows the individual's SSI payment was terminated.
- The individual is eligible to enroll in Medicare and fails to do so.

When the closure of SSI Medicaid is for a reason other than a move to another state or death, the Worker must evaluate the individual for all other Medicaid coverage groups, including Deemed SSI Medicaid coverage and Medicare Premium Assistance.

Note: A child under age 19 is eligible for 12 months continuous eligibility per IMM 10.6.

10.14.2 SPECIAL PROCEDURE: CONTINUED MEDICAID

When an individual no longer receives SSI because SSA determines he is no longer disabled, SSI Medicaid must be continued for 60 days from the date of the SSA notification that SSI will be stopped. It is continued after the 60-day period when:

- The individual is not eligible under any other full-coverage Medicaid group without a spenddown; and
- The individual has requested an appeal of the decision in a timely manner, as determined by SSA.

The SSI Medicaid continues until a decision is made after the SSA hearing, regardless of whether or not the individual continues to receive an SSI payment. A decision after the hearing occurs when the SSI Medicaid client has no right to further administrative appeal. See Chapter 7 for verification of appeal status.

> **Special Procedure Example:** When a recipient fails to appeal an adverse SSA Administrative Law Judge (ALJ) decision to the Appeals Council and the Appeals Council decides not to review the case, the ALJ decision is final for purposes of continued Medicaid, if the 60-day deadline for requesting an appeal has expired. If, however, a timely request is made for a review, the final decision is the Appeals Council's decision to either deny a review or make a decision on the appeal.

10.14.3 Special Procedure: ABLE Accounts

If the ABLE account balance reaches $100,000 and the beneficiary is receiving SSI benefits, any monthly SSI benefits will be placed in suspension. If the assets in the ABLE account balance drops back below $100,000, the SSI benefit suspension ceases and monthly SSI payments resume.

A beneficiary will not lose eligibility for Medicaid based on assets held in the ABLE account, even during the time the SSI benefits are suspended.

10.15 QMB, SLIMB, AND QI-1

10.15.1 QUALIFIED MEDICARE BENEFICIARIES (QMB)

When a client is dually eligible for Qualified Medicare Beneficiary (QMB) coverage and a full Medicaid coverage group, both benefits are issued under the full Medicaid coverage group case number. Continuing eligibility for both benefits must be determined separately when a change is reported.

- If the client remains eligible for both benefits, the full Medicaid coverage group assistance group (AG) is updated in the eligibility system to reflect the current case information.
- If the change results in a spenddown in the full-coverage Medicaid AG and the client remains eligible for QMB, the QMB coverage must continue uninterrupted.
- If the client is ineligible for QMB, the coverage is discontinued after advance notice.

10.15.2 SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB)

When a client is dually eligible for Specified Low-Income Beneficiaries (SLIMB) coverage and a full Medicaid coverage group, both benefits are issued under the full Medicaid coverage group case number. Continuing eligibility for both benefits must be determined separately based on the changed case circumstances.

- If the client remains eligible for both benefits, the full Medicaid coverage group case is updated in the eligibility system to reflect the current case information.
- If the change results in a spenddown in the full Medicaid case and the client remains eligible for SLIMB, the SLIMB benefit must continue uninterrupted.
- If the client is ineligible for SLIMB, the benefit is discontinued after advance notice.

10.15.3 QUALIFIED INDIVIDUALS (QI-1)

When a client is eligible for QI-1, he must not be eligible for a full-coverage Medicaid group. When a QI-1 client has an increase in income, there is no provision that his benefits must

continue uninterrupted. If the increase in income results in his being ineligible for this Medicaid coverage group, the benefit is discontinued after advance notice.

10.16 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

There are no case maintenance requirements for Qualified Disabled Working Individuals (QDWI).

10.17 AFDC-RELATED, SSI-RELATED, AND SSI-RELATED NON-CASH ASSISTANCE MEDICAID

10.17.1 CHANGE IN INCOME AND DEDUCTIONS

Case maintenance action is required to update the eligibility system when a Medicaid assistance group (AG) has a change of income.

The Worker must take the following actions:

- If the AG did not previously have a spenddown and continues not to have one, no other action is necessary.
- If the AG previously did not have a spenddown and now has one, the case is closed after advance notice.

  The following procedures are used in this situation:

  - The AG is closed and reopened with a new period of consideration (POC). The new POC must not cover any period of time in which the case was in a period of eligibility (POE).
  - The client must be notified about his spenddown and the procedures that now apply.

10.17.2 CHANGE IN THE POC

When the client requests coverage for backdated months after initial eligibility has been established, the Worker must evaluate eligibility for any months for which coverage is requested. Information necessary to determine eligibility is requested from the client, including medical bills to meet spenddown, if applicable.

The client must not receive coverage for more than a six-month POC.

> **Change in the POC Example:** Ms. Pine provided medical bills to meet her spenddown and was approved for Medicaid with a six-month POC of November 2010 through April 2011. In December, Ms. Pine discovers medical expenses she owes for services incurred in October that will meet her spenddown and requests her Medicaid coverage be backdated to October. If eligibility is

established for October, the six-month POC changes to October 2010 through March 2011.

10.17.3 MEDICAL REVIEW TEAM (MRT) REQUIREMENTS

An incapacitated, disabled, or blind person may require a Medical Review Team (MRT) reevaluation. See Chapter 13.

10.17.4 CLOSURES

When the client fails to meet any eligibility requirement, the AG is closed.

NOTE: An AG that meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individual is an AG member.

- A member(s) of the income group (IG) experiences an increase in income;
- An individual(s) with income is added to the IG; or
- An individual(s) is removed from the needs group (NG).

10.18 FORMER FOSTER CARE

When a change is reported during the certification period that affects eligibility, the Department of Human Services (DOHS) must only request the information on the change reported. When the information is received, the assistance group (AG) is evaluated for rolling redetermination. See Section 1.21.6.B. The AG may be assigned a new certification period, if eligible, even though the AG is not due for a scheduled redetermination. Case comments must be made in the eligibility system to document any actions taken.

10.18.1 CHANGE IN INCOME

There is no income requirement for the Former West Virginia (WV) Foster Child coverage group. A reported increase in income will not result in the closure of the Former Foster Child coverage group.

10.18.2 ADDITIONS TO OR REMOVAL FROM THE MODIFIED ADJUSTED GROSS INCOME (MAGI) HOUSEHOLD

An individual(s) is removed from the household the month following the month of the reported change and after the advance notice period expires. Eligibility for the remaining household members is re-evaluated based on the removal of the household member.

10.18.3 AG CLOSURES

A data exchange is conducted with the child welfare information system to verify whether the child aged out of the West Virginia foster care system. When verification is returned from the child welfare information system indicating the individual did not age out of foster care, the case is closed the month following the month of the change and after advance notice for the adverse action. The AG must be evaluated for all other Medicaid coverage groups prior to closure.

10.19 NON-QUALIFIED NONCITIZENS

The Worker's case maintenance requirements for non-qualified noncitizens emergency Medicaid is usually limited and includes checking to determine if the emergency has ended. When the emergency is ongoing, usual case maintenance and redetermination policies of the coverage group for which the recipient is approved apply. If a Medical Review Team (MRT) decision was part of the client's eligibility determination, MRT redetermination requirements apply.

10.20 BREAST AND CERVICAL CANCER (BCC)

Notify the Breast and Cervical Cancer Screening Program (BCCSP) by fax or mail of any change in the BCC client's name or demographic information, or death of the client.

10.21 AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The Bureau for Medical Services (BMS) is notified when the client becomes eligible for full Medicaid coverage.

APPENDIX A: RSDI/SSI INCREASES 2026

In January 2026, Supplemental Security Income (SSI) and Retirement, Survivors, and Disability Insurance (RSDI) recipients received a cost-of-living adjustment (COLA) of 2.8%. The new monthly maximum federal SSI payment levels for 2026 are:

Single – $994 Couple – $1,491

In 2026, the standard Part B premium amount will be $202.90.

A.1 THE RSDI/SSI COLA UPDATE PROCESS

The annual COLA Mass Change occurred on January 24, 2026, for most assistance groups (AGs) in the eligibility system that have RSDI and/or SSI entered or Medicare enrollment. Reports that identify individuals affected by the COLA update become available on MOBIUS January 26, 2026. Manual updates must be completed by the February deadline, effective March 2026. Advance notice requirements apply.

For the automatic update to occur, the Social Security Number (SSN) in the eligibility system must match the SSN in the Social Security Administration (SSA) file. In addition, the individual's RSDI and/or SSI income must have been entered in the eligibility system. The automatic update is effective March 2026.

The automatic update does not occur if the income was entered, but end-dated prior to March 2026. It also does not occur if the begin date for RSDI and/or SSI income is later than February 2026.

NOTE: The automatic update does not occur if the case is due for review. If the AG is due for a Periodic Review (PR), the automatic update of income and Medicare information does occur, but eligibility is not run. This prevents closure before the client has an opportunity to complete the PR. Eligibility must be run to apply the updated income.

Two messages on the WRMC192A – Mass Change Exception Listing identify cases skipped when an AG is due for a review by PR and include:

- PR Due (Review date for case)
- PR Due (No review date for case)

For Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), and Qualified Individuals (QI) AGs, functionality prevents the inappropriate closure and

denial of these AGs due to the COLA increase. The eligibility system uses the begin MM/YY to determine whether to enter a COLA disregard amount for Social Security income using a calculation based on the percentage of the COLA increase, unless a COLA Disregard Amount other than zero is entered manually. For procedures regarding Pickle Amendment Coverage (PAC) AGs, see below.

Any AG that becomes ineligible for a benefit because of the update will not receive that benefit after February 2026. The appropriate notice is mailed. Workers must evaluate Medicaid AGs that fail for all other coverage groups. These AGs appear on WRMC182A – Assistance Groups Affected by Mass Change, which is described in A.2.

If the current benefit is not confirmed, and there is no previously confirmed passing benefit for the AG, the individual's information is not updated, and the case is skipped by Mass Change. These AGs are shown on WRMC182U – Mass Changes Pending AG Listing.

When the Social Security Administration (SSA) file indicates the customer is receiving RSDI or SSI and the amount is zero, the information in eligibility system is not updated. This amount may not be accurate by the time of the COLA Mass Change and an error message displays this information on the COLA Match Report. The actual SSA benefit amount can be determined on State On-Line Query (SOLQ).

The WRMC 206A COLA Match Report – Match Result contains the same information as the WRMC202A RSDI/SSI/Medicare COLA Match Report – Last Name. On the 206A, the individuals within a Worker's caseload are sorted by match result message. On the 202A, the individuals within a Worker's caseload are sorted by last name. By using the 206A, Workers can identify particular match results that require immediate attention.

Mass Change report, WRMC216A – Post Mass Change Participation Status Report, identifies individuals whose participation status changed as a result of the Mass Change. Workers must determine if the change is valid.

A.2 REPORTS AND WORKER ACTION

Reports identifying individuals who have been affected by the COLA update became available on MOBIUS on January 26, 2026. Manual updates must be completed by the February deadline, effective March 2026.

Report WRMC 202A: RSDI/SSI/Medicare COLA Match Report – Last Name and Report WRMC 206A: RSDI/SSI/Medicare COLA Match – Match Result

These reports list all individuals who have RSDI and/or SSI income and Medicare. The reports describe the result of the match between these individuals in eligibility system and those on the COLA tape from the Social Security Administration (SSA). Individuals, rather than cases, appear on the reports. Individuals are listed in alphabetical order by caseload. Report WRMC206A is sorted by match result. For each individual, the Worker sees the following: Case Number, SSN, Name of Individual, SSA Amount, Medicare Part B Amount, and Match Result. Some of these columns are self-explanatory, but columns that require explanation are listed below.

SSA Amount

This column is divided into two additional columns. The first column is the income received from SSA as found in eligibility system (amount prior to the COLA increase). The second column is the income from SSA as found on the tape sent by the SSA (amount after the COLA increase). It may be either RSDI or SSI. If an individual is receiving both RSDI and SSI, there is a separate entry for each type of unearned income.

Part B Amount

This is the Medicare Part B premium. This column is divided into two additional columns. The first column is the Medicare premium found in eligibility system (the amount prior to the premium increase). The second column is the Medicare premium found on the tape sent by the SSA (amount after premium increase).

Match Result

This is the result of the match between the information in eligibility system prior to the COLA updates and the information on the COLA update tape sent by the SSA.

The Worker may see multiple entries on this printout for the same individual. The Worker must carefully review each entry for the individual. A variety of situations result in multiple entries.

Match Result Example 1: If the customer receives both RSDI and SSI, and each benefit was updated successfully, the Worker sees the individual name on the printout twice with the match result Record Successfully Updated. This message appears once with the match result for the RSDI update and again with the match result for the SSI update. There are no indicators to identify which entry is for RSDI and which is for SSI.

Match Result Example 2: If the SSA file indicates the RSDI and/or the SSI amount is zero, the match result indicates that the case was not updated. The match result displayed is either Record Not Updated – $0 RSDI Amount or Record Not Updated – $0 SSI Amount. This is because the amounts of these benefits are rarely this amount by the time of the COLA Mass Change. Use SOLQ to determine the current amount of the RSDI and/or SSI.

Match Result Example 3: If the customer receives more than one type of RSDI, the Social Security Administration combines all amounts. The RSDI amount appearing on the COLA tape and the Match Report is the total of all combined updated amounts for that individual. However, the eligibility system identifies each specific type of RSDI separately. Because the amount on the COLA tape is a combined amount and the amount in the eligibility system is specific to each type of RSDI received, it is not possible for an automatic update to occur on these cases. The Worker must manually update each RSDI amount. The Match Result for this situation is Multiple Records for a Type.

If the individual receives SSI, in addition to multiple types of RSDI, the SSI amount is automatically updated even though the RSDI amounts are not.

Match Result Example 4: If the RSDI is garnished, the amount is not updated. The match result is RSDI Not Updated Due to Garnishment. A Mass Change report provides the new RSDI gross amount and the amount of the garnishment.

Match Result Example 5: If the automatic update resulted in an update of Medicare information, the Worker sees two entries for an individual. The match result for the premium update is Record Successfully Updated. A separate match result appears for updated information. Only the Medicare Part B premium information is updated by the COLA Mass Change.

Match Result Example 6: If there is a Medicare premium amount other than zero and no Medicare amount on the COLA tape, one entry for the individual is on the Match Report. The match result is Person is Not Part B Entitled. To prevent possible disruption of Buy-In, the Medicare information is not updated. Workers must determine if a change in the Medicare information is needed.

Match Result Example 7: If there is a Medicare premium amount of zero and the COLA tape shows the individual is eligible for Medicare, the match result for

the first entry is Person is Part B Entitled. The match result for the second entry is Record Successfully Updated.

Match Result Example 8: If the Medicare Payer is 510 and Self on the COLA tape, to prevent disruption of the Buy-In process, the payer is not updated. The match result displayed is COLA Record Has Payer As Self. Otherwise, the payer is updated and the match result for the payer update is Updated Part B Payer.

Match Result Example 9: When the RSDI/SSI/Medicare premium amount(s) in the eligibility system reflects the same amount as listed on the COLA tape, and the begin date in the eligibility system is prior to March 2026, the match result is Record Successfully Updated. When this occurs, the same amount(s) listed in both the SSA and the eligibility system columns is seen, and no action is necessary.

Match Result Example 10: The match result NO COLA Found for RSDI and No COLA Found For SSI indicates no benefit information was found for this individual's SSN on the SSA's tape, even though RSDI and/or SSI was entered by the Worker. If the client's SSN is correct, DXSA must be checked to see if SSA benefits received are based on another person's SSN.

Match Result Example 11: Other entries in the match results column may require explanation. A guide of commonly found match result notations is found in A.3 below.

Report WRMC 192A – Mass Change Exception Listing

This report lists the AGs with RSDI and/or SSI that were skipped in the eligibility run of Mass Change. The column titled Exception Description contains information about why the update did not occur. AGs with manual overrides and pending cases appear on the report and require evaluation. Those that did not update due to pending status do not appear on the COLA Match Report and require independent verification of income.

Report WRMC182A – AGs Affected by Mass Change

This report contains detailed information about AGs on which a mass change COLA update occurred and on which ED/BC was successfully run. This printout contains information by case, rather than by individual. Most of the columns are self-explanatory. The column titled Action Indicator includes one of the following: INC (Increase), DEC (Decrease), and CLO (Closure). If the column is blank, no change in benefits occurred.

NOTE: A special report is provided to notify the Long-Term Care Unit of changes in nursing home contributions due to the COLA Mass Change.

Report WRMC 183U – Mass Changes Pending/Unconfirmed AG Listing

This report lists all SNAP AGs that are in Pending/Unconfirmed status that require manual confirmation. Take appropriate action to determine if eligibility should be run on these cases so that COLA changes apply.

Report WRMC 212A – Individuals Changed from State Payer to Self

This report was discontinued. If the eligibility system indicates the State is paying the premium, the message, COLA Record has Payer as Self, is displayed on the COLA Match Report.

Report WRMC 203A – RSDI Garnishment Report

This report lists the individuals who have garnishments applied to RSDI and, as a result, the RSDI has not been updated. It lists the gross RSDI and the amount of the garnishment.

Report WRMC 205A – Income on COLA File with No Corresponding

This report lists the individuals who have either RSDI or SSI on the COLA file and have no current corresponding screen for that type of income.

WRMC 216A – Post Mass Change Participation Status Report

This report identifies individuals whose participation status changed as a result of the mass change. The report is sorted by case Worker and lists the case number, PIN, caseload, name, current participation status after the mass change, and the category. Workers must determine if the change is valid. An example of a valid change is an Able-Bodied Adults Without Dependents (ABAWD) with a new 36-month tracking period.

PAC AGs

Although the automated determination of the COLA Disregard Amount for RSDI will prevent the inappropriate closure of QMB, SLIMB, and QI-1 AGs, it will not prevent the inappropriate closure of Pickle (MP W) AGs. The system will replace the current COLA disregard amount for Pickle AGs with an amount based on the current RSDI COLA percentage increase. These AGs appear on the WRMC182A – Assistance Groups Affected by Mass Change report with the notation CLO to indicate AG closure. These failed AGs require manual correction by the Worker. As an added check, designated Supervisors will receive an email message listing all affected Pickle AGs at a later date. Worker action required for affected Pickle AGs is:

- Display the RSDI amount for the affected individual in the eligibility system using a future date.
- Note the current COLA disregard amount.
- Review historical data to should display the previous COLA disregard amount in the system.
- Add the two COLA disregard amounts together and enter the total on the current screen for RSDI as the COLA disregard amount.
- Run eligibility. Check the benefits for correctness, then confirm.
- Suppress any inappropriate notices.

A.3 COMMONLY FOUND MATCH RESULTS

The chart below shows the commonly found results of the match between the eligibility system information prior to the COLA updates and the information from the SSA COLA update file.

Match Result	Definition
RECORD NOT UPDATED – $0 RSDI AMOUNT	This individual exists in the eligibility system with an RSDI amount that is greater than zero, but the same individual exists in the COLA file with a zero RSDI amount. Check SOLQ.
RECORD NOT UPDATED – $0 SSI AMOUNT	This individual exists in the eligibility system with an SSI amount that is greater than zero, but the same individual exists on the COLA file with a zero SSI amount. Check SOLQ.
FUTURE BEGIN DATE – NO UPDATE	This individual's income in the eligibility system has a begin date for RSDI or SSI of later than February. No update occurs in this situation.
MANUAL OVERRIDE	An AG containing an override is open and ongoing. Mass Change will not run on this case. *NOTE: If an AG was overridden to fail for the ongoing month, the case will still run in a mass change.*
MULTIPLE RECORDS FOR A TYPE	This individual is receiving multiple types of RSDI according to the eligibility system, and the COLA file only shows one amount. No update occurs with this match result. Check SOLQ.
NO COLA FOR RSDI	This individual exists in the eligibility system but was not found on the COLA file. Check SOLQ.
PENDING CASE	This case is pending in the eligibility system, and therefore no update occurs.
CASE HAS PENDING AG	There is an unconfirmed AG with no previously open confirmed AG. The case is skipped. No updates occur.
PERSON IS NOT PART B ENTITLED	This individual has a Medicare, Part B, premium amount greater than zero, and the COLA file shows that the individual has a zero amount. No update occurs.
UPDATED PART B PAYER	The Payer in the eligibility system differed from the Payer found on the COLA tape. The Payer on the COLA file is not Self. An update occurs with this match.
COLA RECORD HAS PAYER AS SELF	The Payer on the Medicare screen in the eligibility system was 510 (Buy In). The Payer found on the COLA tape was Self. An update does not occur with this match.

Match Result	Definition
RECORD SUCCESSFULLY UPDATED	The eligibility system amount listed was updated with the SSA amount listed.
RSDI NOT DATED DUE TO GARNISHMENT	The COLA tape indicates a garnishment is applied to the RSDI. An update does not occur. Check SOLQ.

APPENDIX B: SPECIAL PROCEDURES FOR RSDI/SSI COLA INCREASES

Recipients of federal benefits, such as Retirement, Survivors, and Disability Insurance (RSDI), Supplemental Security Income (SSI), Black Lung, or Veterans Affairs Benefits, may receive periodic cost-of-living (COLA) increases. RSDI and SSI increases are handled in accordance with instructions in Appendix A of this chapter. All other federal benefit cost-of-living increases are treated as any other change, except that the client is not required to report the change nor is repayment required when the client fails to do so.

NOTE: State On-Line Query (SOLQ) may display the updated SSI and RSDI amounts based on the COLA at the end of the current year. See Section 6.3. The Worker must determine the correct income to use for any benefits with eligibility beginning prior to January. This applies to all programs, including the Low-Income Energy Assistance Program (LIEAP).

The following provides procedures for use of RSDI and SSI COLA information for applicants and clients.

B.1 APPLICANTS

For applications with eligibility beginning in November or December, the Worker must use the current year's amount and allow the eligibility system Mass Change to update the income. The Worker must not enter an anticipated income amount for January's benefits.

> **Applicant Example 1:** An application for SNAP benefits is made on December 15, 2025. The client reports his SSI is $967 for December and $994 for January. The Worker enters $967 as the client's income and does not code the eligibility system to anticipate the $994 for January's benefits. He records this in case comments. The SSI is updated when the eligibility system mass change occurs.

For applications with eligibility beginning in January, the Worker must use the new amount of SSI and/or RSDI that is effective in January and not wait for the eligibility system COLA mass change to update the income.

> **Applicant Example 2:** An application for Medicaid is made on January 5, 2026. The client reports his RSDI is currently $1,250. The Worker must use this amount in determining his eligibility for Medicaid.

B.2 CLIENTS

The Worker must not act on reported income changes due solely to an SSI and/or RSDI COLA. These changes are made during the eligibility system Mass Change or shown on one of the COLA Exception Reports.

> **COLA Mass Change Example 1:** A WV WORKS client reports in January, prior to the eligibility system COLA Mass Change, that his RSDI amount has increased. The Worker notes this in case comments but does not change the income. The income is updated when the eligibility system COLA Mass Change occurs.

For redeterminations completed prior to the eligibility system Mass Change, the Worker must use the previous amount, even if the redetermination is completed in January. For redeterminations completed in the month before the eligibility system COLA Mass Change, use the new amount.

> **COLA Mass Change Example 2:** A SNAP client completes a redetermination in January. The eligibility system COLA Mass Change is scheduled to occur in January, effective March. He reports that his SSI increased in January. The Worker notes this in case comments, but completes the redetermination using the previous year's amount of SSI income. The SSI income is updated during the eligibility system COLA mass change.

B.3 CHANGES NOT RELATED TO COLA

Changes in RSDI and SSI for applicants and recipients that are not related to the COLA must be acted on according to the program of assistance. The eligibility system mass change will not automatically update these AGs. See the program-specific sections in this chapter and Section 6.3 for data exchange.

> **Changes Not Related to COLA Example 1:** A client reports on December 2 that his SSI is ending that month and he will not receive any SSI income in January. The Worker takes action to update his January benefits based on this change.
>
> **Changes Not Related to COLA Example 2:** A client reports on January 9 that her SSI is being reduced effective February due to an error made by Social Security Administration (SSA) not related to the COLA. The Worker takes action to update her February benefits based on this change.

APPENDIX C: PUBLIC FORMS

Form Number	Form Title
DFA-SNAP-2	Reporting Changes

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN

RESOURCES

Supplemental Nutrition Assistance Program (SNAP)

CHANGE REPORTING FORM

If you wish to report changes for your SNAP benefits, you may use this form to do so. This will help make sure you get the correct benefits you are eligible to receive. If you receive SNAP benefits, you are not required to report changes except when the gross earned and unearned income of everyone who lives in your home exceeds the gross income limit for your assistance group's size. In addition, if your household contains an Able-Bodied Adults Without Dependents (ABAWD), you may need to report additional changes. The gross income limit for your assistance group and the additional reporting requirements for ABAWD can be found on any recent notification letter or may be obtained by contacting the Customer Service Reporting Center. However, any changes that you choose to report will be acted on for all programs if required. If you are unsure of the reporting requirements for the benefits you receive, please contact the Customer Service Reporting Center at 1-877-716-1212 before reporting information.

If you intentionally give FALSE INFORMATION or WITHHOLD INFORMATION, you will have to pay back your SNAP Benefits and may be disqualified from SNAP for 12 months, 24 months or permanently. In addition, you may be found guilty of FRAUD. Punishment upon conviction may be a fine up to $250,000 or a jail sentence of up to 20 years.

Name (Please print):_____ Case Number: _____

SIGNATURE:_____ DATE:_____

1. Please check one of the following boxes:

   ☐ The changes I am reporting are only for this month.

   ☐ The changes I am reporting will be continuing.

2. If the address where you live has changed, please write your NEW address below.

Street Address: _____ Apt. #: _____

City, State:_____ Zip:_____ Phone:_____

Directions to your home: _____

_____

If the address where you get your mail is different, please write your new mailing address below.

Post Office Box #:_____ or Street Address:_____ Apt. #: _____

City, State: _____ Zip: _____

3. Please enter the amount paid each month for the items below or zero (0) if you no longer pay this expense. If you now pay a shelter or utility expense that is not listed, please write it in the section listed as other. If any agency or individual not living in your home now pays all or part of these expenses, please list the amount that they pay and whether it is paid to you or directly to the company that bills you. PLEASE CIRCLE YOUR PRIMARY SOURCE OF HEATING OR COOLING.

Type of Expense	Amount Owed Each Month	Paid By (Self, HUD, etc.)
Rent/Mortgage Payment, Lot Rent, Property Tax, Homeowner's Ins., Etc.	$	
Electric	$	
Gas	$	
Propane	$	
Fuel Oil	$	
Sewer/Water	$	
Other	$	

4. Has anyone moved into or out of your household? ☐ Yes ☐ No If yes, complete the chart below.

Name	Date of Birth	Relationship to You	Date Moved In	Date Moved Out

5. Has there been a change in the income of anyone in the home? Yes ☐ No ☐

If yes, please list all changes and new sources of earned and/or unearned income received in your household.

Name	Source of Income	Gross Amount

6. Does anyone in your household have any new assets and/or a change in value for any of the following assets? ☐ Yes ☐ No

If so, list who and the current amount. Please also list accounts on which the name of any household member is listed, even if the other person does not live with you.

	Name	Amount
Checking Accounts		
Savings Accounts		
Stocks and Bonds		
Burial Funds		
Other Assets		

7. Does anyone in your household now pay or have a change in the amount they pay for court-ordered child support, other expenses, or medical insurance for a child? ☐ Yes ☐ No

If yes, provide the following for each of the last 3 months:

Name	Month	Court-Ordered Amount	Payment Actually Made

Chapter 11

Benefit Repayment

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
11.1				
11.2	6/1/20 9/1/21	787 808	11.2.2 11.2.6.A.2	Reference to Basis of Issuance Chart Removed references to inactive & dormant accounts
11.3	9/1/21 1/1/21 3/1/22 7/1/22 6/1/25	808 814 818 824 864	11.3.6.B.3 11.3 11.3.6.B.3 11.3.6.B.3 11.3.8.G	Removed references to inactive & dormant accounts Added payments to cash assistance claim procedures Changed expungement to 365 days Clarify WV WORKS expungement To clarify how TANF months may be removed from the lifetime limit after repayments.
11.4				
11.5				
11.6				
App A				
App B				

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
App C				

11.1 INTRODUCTION

The Department of Human Services (DOHS) is responsible for accurately determining the client's eligibility for the Supplemental Nutrition Assistance Program (SNAP), the former Aid to Families with Dependent Children/Unemployed Parent (AFDC/U) program, WV WORKS, Child Support Incentive (CSI), Temporary Assistance for Needy Families (TANF) program, WV WORKS School Clothing Allowance (SCA), West Virginia School Clothing Allowance (WVSCA), and Medicaid. When it is discovered that excess benefits have been issued, corrective action must be taken.

Investigations and Fraud Management (IFM) consists of three units whose primary functions are to assist with program integrity and to recover overissued benefits resulting from Departmental error, client error, or client misrepresentation.

The material that follows, when used in conjunction with the eligibility system user guide provides detailed instructions for repayment and corrective procedures for all programs.

For corrective action related to underpayments, See Chapter 10.

11.2 SNAP CLAIMS AND REPAYMENT PROCEDURES

When an assistance group (AG) has been issued more Supplemental Nutrition Assistance Program (SNAP) benefits than it was entitled to receive, corrective action is taken by establishing either an Unintentional Program Violation (UPV) or Intentional Program Violation (IPV) claim. The claim is the difference between the SNAP entitlement of the AG and the SNAP allotment the AG was entitled to receive. The procedures and policy by which SNAP claims are referred, established, collected, and maintained follow.

NOTE: Referrals are made for all overissuances, regardless of the dollar amount. Claims are not written for under $125 unless there is a liable debtor receiving SNAP at the time the claim is written, the error is discovered as the result of a Quality Control (QC) review, or it is an IPV claim. In these three situations, claims under $125 are written and collected. IPV claims must be established regardless of the total amount or participation status of the liable debtor(s). See Section 11.2.5 for definition of who is a liable debtor.

11.2.1 REFERRAL PROCESS

The establishment, notification, and collection of SNAP claims is the responsibility of the Investigations and Fraud Management (IFM) Claims and Collections Unit (CCU). The collection staff members are known as Repayment Investigators (RI). Upon discovery of a potential SNAP claim, the Worker refers the case to the RI through the eligibility system. In determining if a referral is appropriate, the Worker must consider the client's reporting requirements, the Worker's timely action, and the advance notice period.

NOTE: Claims are not established for excess benefits received solely due to the 13-day advance notice period.

NOTE: If either of the following conditions exist, see the fraud referral process in Section 11.6:

- *The amount of SNAP overissuance due to client misrepresentation is greater than $500*
- *The SNAP overissuance, in combination with other overissued benefits of other programs due to client misrepresentation, is greater than $500.*

11.2.2 PROCEDURES FOR ESTABLISHING SNAP CLAIMS

The following are procedures the IFM investigative staff must perform to establish a claim against the AG:

- Accept all referrals regarding potential SNAP overissuances
- Review the case record and data system information
- Obtain third-party verifications to support allegations
- Identify the month(s) for which the claim is to be established
- Classify the claim as UPV or potential IPV
- To determine the amount of overissuance use the calculation and instructions found in IMM 4.4.3.C
- Establish an IPV by obtaining the client's waiver of, or presenting evidence at, an Administrative Disqualification Hearing (ADH) or IPV, or through court action
- Notify the AG of the overissuance
- Initiate and monitor collection activity on the claim
- Complete the appropriate screen in the eligibility system, which issues notification of disqualification
- Notify the Worker to initiate the disqualification

11.2.3 IDENTIFYING THE MONTH(S) FOR WHICH CLAIMS ARE ESTABLISHED

The number of month(s) for which claims are established depend on whether it is an IPV or UPV.

11.2.3.A UPV Claims

There are two types of UPVs—client errors and agency errors.

A UPV claim may be established when:

- An error by the Department of Human Services (DOHS) resulted in the overissuance
- An unintentional error made by the client resulted in the overissuance

- The client's benefits are continued pending a Fair Hearing decision and the subsequent decision upholds the DOHS's action
- It is determined by court action or ADH the client did not commit an IPV; the claim is pursued as a UPV
- The AG received SNAP solely because of Categorical Eligibility, and it is subsequently determined ineligible for WV WORKS and/or Supplemental Security Income (SSI) at the time it received it

EXCEPTION: If the client misrepresented circumstances in order to receive cash assistance or SSI, the SNAP claim may be an IPV.

- The DOHS issued duplicate benefits and the overissued amount was not returned
- The DOHS continued issuance beyond the certification period without completing a redetermination

A client error UPV is only established retroactively for the six-year period preceding the month of discovery. An agency error is only established retroactively for the one-year period preceding the date of the discovery.

The RI determines the month in which the overissuance initially occurred as follows.

NOTE: Failure to Take Prompt Action and Computation Error below are used when the overissuance is not contested in a Fair Hearing. If a Fair Hearing is held, the Hearings Officer's decision is final.

11.2.3.A.1 Agency Errors

➢ *Failure To Take Prompt Action*

The first month of overissuance is the month the change would have been effective had the agency acted promptly.

➢ *Computation Error*

The first month of overissuance is the month the incorrect allotment was effective.

11.2.3.A.2 Client Errors

When the client fails to provide accurate or complete information, the first month of the overissuance is the month the incorrect, incomplete, or unreported information would have affected the benefit level considering notice and reporting requirements.

NOTE: When determining the amount of overissuance for any claim type, due to the failure of the household to report earned income in a timely manner, the amount of benefits the client should have received is computed without applying the earned income disregard to any portion of the earnings the client did not report. This applies to IPV claims for benefits issued for October 1987 and later, and to UPV claims established on or after November 1, 1996.

NOTE: Depending on whether or not an AG has earned income or at least one WV WORKS participant, reporting requirements may be different. See Section 10.4.2 for the appropriate AG reporting requirements.

11.2.3.B IPV Claims

IPVs include making false or misleading statements, misrepresenting facts, concealing or withholding information, and committing any act that violates the Food Stamp Act of 1977, SNAP regulations, or any State statute related to the use, presentation, transfer, acquisition, receipt, or possession of SNAP benefits.

The client(s) who is found to have committed an IPV is ineligible to participate in the program for a specified time, depending on the number of offenses committed.

An IPV can only be established in the following ways:

- The client signs an IG-BR-44, Waiver of Rights to an ADH

  NOTE: Form IG-BR-44 is used only by IFM Workers and Hearings Officers. When the client waives his right to an ADH, the disqualification cannot be changed by a subsequent Fair Hearing.

- By an ADH decision

- By Diversionary Consent Agreement
- By court decision

Once an IPV is established, a disqualification penalty is imposed on the AG member(s) who committed the IPV. See Section 3.2.1 for penalties.

NOTE: Prior to May 1, 1983, IPVs were referred to as fraud. When determining the appropriate penalty, all disqualifications prior to May 1, 1986, are considered as one previous disqualification.

If a court fails to impose a disqualification period, the Department imposes the appropriate penalty as indicated in Section 3.2.1. If the court imposes a sanction that differs from those in Section 3.2.1, the court-ordered sanction is applied.

If an overissuance is discovered more than six years after it occurs, no claim is established.

When the client commits an IPV, the first month of the claim is the first month in which the benefit would have been effective considering the reporting and notice requirements.

NOTE: Overlapping claim periods run concurrently. Regardless of participation status, a penalty must be imposed within 45 days of the ADH decision, the signing of the waiver, Diversionary Consent Agreement, or the issuance of the court order.

After the first month is determined, the IFM Worker identifies the subsequent months in which overissuances resulted from the same IPV act.

IPV claims must be established for trafficking-related offenses. Claims arising from trafficking-related offenses are the value of the trafficking benefits as determined by the individual's admission, adjudication, or documentation that forms the basis of the trafficking determination.

11.2.4 FACTORS AFFECTING THE AMOUNT OF THE CLAIM

There are no special factors affecting the amount of the SNAP claim.

11.2.5 COLLECTING THE CLAIM

Collection action is initiated against the AG that received the overissuance. When the AG composition changes, collection is pursued against any and all AGs that include a liable debtor.

The following persons are equally liable for the total amount of the overpayment and are liable debtors:

- Adult or emancipated minors in the AG
- Disqualified individuals who would otherwise be required to be included
- An unreported adult who would have been required to be in the AG had he been reported
- Sponsors of noncitizen AGs when the sponsor is responsible for the overpayment
- An authorized representative of an AG if he is responsible for the overpayment

For AGs containing a liable debtor that are certified at the time the claim is established, collection activity may begin by recoupment, after the notice period expires. Recoupment by benefit allotment reduction is mandatory for all claims when a liable debtor is certified for SNAP. The eligibility system automatically begins recoupment and posts these payments to the claim.

NOTE: When the reduction causes the benefit to be reduced to zero, the AG must remain active if otherwise eligible. The AG is subject to all program requirements, including redetermination. This ensures that the benefit reduction is credited in the eligibility system.

11.2.5.A Collection Priority

Collections may be made on only one SNAP claim at a time. Claims are collected in the following priority order:

- IPV
- UPV, Client
- UPV, Agency

Based on this priority list, payments are credited to the oldest claim first, until it is paid. Then, payments are credited to the next oldest claim.

EXCEPTION: Payments received due to a court order are credited to the specific claim, regardless of the priority order or age of the claim. Also, payments received from the Treasury Offset Program (TOP) are credited to the targeted claim.

11.2.5.B Claim Notification

11.2.5.B.1 UPV Claims

The AG is notified of the SNAP claim by computer-generated notification/demand payment letters from the eligibility system. Enclosed with the letter is a repayment agreement, form ES-REPAY-1, and a postage-paid envelope.

11.2.5.B.2 IPV Claims

In the case of a potential IPV, the AG is notified of the claim by one of the following:

- An appointment letter scheduling a face-to-face interview
- A letter explaining the claim, cause, and amount, which includes a Waiver of Rights to an ADH
- A request that the client return the signed Waiver of Rights

➢ *Repayment Interview*

A Repayment Interview is conducted in conjunction with the interview to discuss the signing of the Waiver of Rights to an ADH. During the interview, the client is asked to sign form ES-REPAY-1, Repayment Agreement, after the options on the agreement are explained. After the ES-REPAY-1 is thoroughly explained, the IFM Worker advises the client to leave the signed form at the front desk at the local office or return it by mail.

➢ *Computer-Generated Letter*

When an IPV claim is established through an ADH or court decision, the AG is sent a computer-generated letter notifying it of the claim amount. Form ES-REPAY-1 and a postage-paid envelope are enclosed.

11.2.5.C Collection Procedures

11.2.5.C.1 Offsetting Lost Benefits

A claim, whether UPV or IPV, must be collected by offsetting when lost benefits are owed to the AG, but have not yet been restored.

The Worker determines the amount of corrective benefit due the household and initiates issuance in the eligibility system.

The auxiliary code used by the Worker causes the eligibility system to search for outstanding SNAP claims and offset the claim, if appropriate.

11.2.5.C.2 Treasury Offset Program (TOP)

All IPV and client UPV claims are subject to collection through the TOP. Claims that have a payment balance of at least $25 are delinquent and are subject to referral for collection of the claim by offset of the client's federal income tax refund and any federal benefits/payments. Agency-caused UPV claims, established on or after November 1, 1996, are eligible for TOP collection under the condition described above.

Outstanding claims may be combined to reach the $25 threshold when evaluating for TOP targeting.

11.2.6 DETERMINING THE REPAYMENT AMOUNT

The minimum amount of repayment is determined as follows.

11.2.6.A UPV Client and Agency Errors

11.2.6.A.1 Current Recipients

The current benefit entitlement is reduced by 10% or $10, whichever is greater.

11.2.6.A.2 Former Recipients

Form ES-REPAY-1 offers the liable debtor the following options for repayment.

- ***Lump-Sum Payment***

One payment is made to pay the claim in its entirety.

- ***Installment Payments***

When the AG is financially unable to pay the claim in one lump sum, regular monthly installment payments are accepted.

The minimum amount of the monthly payment is $50. If the IFM Worker determines that the AG cannot afford the minimum payment, the payment amount is negotiated on a case-by-case basis.

Lump sum or installment payments may be made by money order, cashier's check, and certified check. Personal checks are accepted until one is returned for insufficient funds. Payments in cash, SNAP benefits, or Electronic Benefits Transfer (EBT) benefits are acceptable; checks and money orders are made payable to the West Virginia Department of Human Services and are mailed or brought to the local office. If a client wishes to pay with cash, he should be

discouraged from sending payments through the mail. If he does so, however, it is accepted. All such payments are forwarded to the Financial Clerk.

The Financial Clerk is responsible for collecting all repayments in cash. If payments are received by mail, they are forwarded to the Financial Clerk, who is responsible for the record-keeping and forwarding the payment to the State Office. Upon notification from the Financial Clerk by the DF-25 form, the Repayment Officer posts the payments to the eligibility system.

With the implementation of EBT, benefits in an EBT account may be used to repay a SNAP claim. When the client wishes to repay in this manner, he is referred to a Supervisor or RI who accomplishes the repayment by use of the EBT administrative function.

➢ *Use of EBT SNAP Account Benefits*

- When there has been an unused benefit in a SNAP EBT account 229 days from the date the benefit was issued, a notice is generated to the client, advising if they do not take action within 13 days and a claim is present, the benefit from this benefit month will be applied to the claim. An alert will be sent to the Worker; however, no action is required by the worker. An alert will also be sent to IFM. This will give them an opportunity to act on an open claim for a case.
- Expungement – When there has been an unused benefit in a SNAP EBT account for a period of 274 days from the date the benefit was issued, a notice is generated to the client, advising the benefits have been expunged and are no longer available. The notice will also advise they may have other benefit months remaining. The client is also encouraged to make monthly transactions on remaining benefits.

  There will be an immediate expungement when it has been determined the SNAP Assistant Group is deceased and when the worker has obtained independent verification of the death(s).

  An alert will be sent to the Worker; however, no action is required by the Worker at that time. IPV Errors

11.2.6.A.3 Current Recipients

The current benefit entitlement, after the disqualified member(s) has been removed from the AG, is reduced by 20% of the entitlement or $20, whichever is greater. The reduction is based on the entitlement amount prior to the removal of the disqualified member.

11.2.6.A.4 Former Recipients

Form ES-REPAY-1 offers the client the following options to repay when no liable debtor is certified for SNAP.

- One payment is made to pay the claim in its entirety.
- When the AG is financially unable to pay the claim in one lump sum, regular monthly installment payments are accepted. The minimum amount of the monthly payment is $50. If the IFM Worker determines that the AG cannot afford the minimum payment, the payment amount is negotiated on a case-by-case basis.

11.2.7 RIGHT TO A FAIR HEARING

The client has 90 days from the date of the initial notification/demand payment letter in which to request a Fair Hearing. The Hearings Officer only rules on the type and amount of the claim.

If the client requests a Fair Hearing within 30 days, the Worker stops collection until the Fair Hearing is completed. If a Fair Hearing is requested between 30 and 90 days, collection action proceeds during the Fair Hearing process. Any adjustments in the amount of the claim, required by the Fair Hearing decision, are made after the decision.

11.2.8 REFERRAL MANAGEMENT AND MAINTENANCE OF THE SNAP CLAIM

11.2.8.A Time Limits to Establish Claims

Claims should be established by the end of the quarter following the quarter of receipt of the referral. However, there are no time limits pertaining to the length of time between discovery of a claim and establishment of the claim.

11.2.8.B Status of Claims

All claims remain in open status as long as the debt has been submitted to TOP and remain eligible for TOP targeting. When the claim is no longer eligible for TOP targeting, the claim is changed to terminated status.

NOTE: When all liable debtors are deceased, the claim is terminated. When all liable debtors have declared bankruptcy for a dischargeable debt, the claim is changed to bankrupt status. When it is determined that a claim was not properly established due to a Fair Hearing decision, improper notice, or incorrect determination by Investigations and Fraud Management (IFM) staff, the claim status is changed to invalid. When the claim status is changed to invalid due to improper notice, a new claim may be established after proper notice procedures are followed.

11.2.8.C Notification of Delinquent Payments

A delinquent notice letter is sent to a client with an open status claim when 60 days elapses since the last payment.

11.2.8.D Receipts

Clients who make cash payments, or for whom a TOP payment is collected, receive a receipt at the end of the month in which the payment is posted.

11.2.8.E Action Required When a Client Moves

11.2.8.E.1 Clients Moving Out of West Virginia

If another state contacts a county office inquiring about a claim of a former recipient, the Worker forwards the inquiry to the appropriate Repayment Investigator.

11.2.8.E.2 Clients Moving from Another State to West Virginia

When a SNAP application is made in West Virginia by an individual moving from another state, and the applicant indicates he received SNAP in the other state, the Worker must determine if repayment is owed in the other state.

If the client states that he owes a repayment to the other state, the Worker notifies the RI immediately, but continues to process the application.

11.2.8.F Repayment of an Overpaid Claim

The DOHS may not, under any circumstances, retain more than the total amount of all outstanding claims. When this occurs as a result of collection from more than one AG, benefits must be restored.

RIs and Financial Clerks are responsible for cash refunds when a claim has been overpaid. If benefits must be restored, IFM notifies the Worker.

The refund must be made by the method of payment that caused the claim to be over (e.g., recouped benefits, cash, or any combination of these methods paid to the Financial Clerk). When a cash refund is appropriate, IFM will notify the Financial Clerk.

EXCEPTION: All refunds due to TOP offsets must be referred to the IFM state office to the attention of the TOP Coordinator or Director.

NOTE: EBT benefits removed from an account in error are reissued as a supplemental issuance in the eligibility system using the appropriate coding procedures.

11.2.8.G Effect of Bankruptcy

The DOHS, acting on behalf of the United States Department of Agriculture (USDA), may act as a creditor for a bankrupt AG against which the DOHS has established a claim. When the county receives a "Notice to Creditor" document from the Bankruptcy Court, it must immediately forward it to the RI. The RI changes the eligibility system claim status to "B" for agency and client error claims and forwards the document to the IFM State Office. Further collection action is suspended.

EXCEPTION: When a claim is a type "F" IPV, the RI determines if the claim is an administrative IPV or court adjudicated. Administrative IPVs are changed to claim status "B" and further collection activity is suspended. Court-adjudicated claims that declare Chapter 7 bankruptcy are not dischargeable and remain in "O" status. Court-adjudicated claims that declare Chapter 13 bankruptcy are dischargeable and the RI changes the status to "B." If there is more than one liable debtor, all liable debtors must declare bankruptcy for the claim to be changed to "B" status. If not, the status must remain open.

11.2.8.H Effect of Expunged EBT SNAP Accounts

When benefits are expunged from an EBT SNAP account, the following occurs:

- If a claim exists, as indicated in the eligibility system, the RI receives an alert that the EBT SNAP account is being expunged.
- The RI reduces the amount of the claim(s) by the amount of the expunged benefits.

11.3 CASH ASSISTANCE CLAIMS AND REPAYMENT PROCEDURES

Repayment is pursued for cash assistance overpayments made under the former Aid to Families with Dependent Children/Unemployed Parent (AFDC/U) Program, WV WORKS, Child Support Incentive (CSI), Temporary Assistance for Needy Families (TANF) Program, WV WORKS Support Service Payments, WV WORKS School Clothing Allowance, and the West Virginia School Clothing Allowance.

EXCEPTION: Diversionary Cash Assistance and Emergency Assistance (EA) overpayments are not subject to repayment, unless fraud is established.

The establishment, notification, and collection of cash assistance claims are the responsibility of the Claims and Collections Unit (CCU) and Investigations and Fraud Management (IFM).

When an assistance group (AG) has received more cash assistance than it was entitled to receive, corrective action is taken by establishing a claim for the overpayment. The claim is the difference between the amount of benefits received and the amount of benefits to which the AG was entitled. The policy by which cash assistance claims are referred, established, collected, and maintained follows.

NOTE: Referrals must be made for all overpayments, regardless of the dollar amount. However, IFM does not write claims for under $100 unless there is a liable debtor approved for cash assistance at the time the claim is processed. Claims under $100 are written and collected by check reduction. See Section 11.3.6 below.

Once the claim is established, there are no hardship provisions or exceptions that delay, suspend, or terminate efforts to collect the claim.

11.3.1 REFERRAL PROCESS

Upon discovery of a potential cash assistance claim, the Worker refers the case to the Repayment Investigator (RI) in the eligibility system.

NOTE: If either of the following conditions exist, see the fraud referral process in Section 11.6:

- *The amount of cash assistance due to client misrepresentation is greater than $500.*
- *The cash assistance overpayment, in combination with other overissued benefits of other programs due to client misrepresentation, is greater than $500.*

11.3.2 PROCEDURES FOR ESTABLISHING CASH ASSISTANCE CLAIMS

The following actions are taken by the IFM Worker in establishing a claim against the AG. The IFM Worker:

- Accept all referrals related to potential cash assistance overpayments
- Review the case record
- Obtain third-party verifications to support the allegations
- Identify the month(s) for which the claim is established
- Classify the claim as agency or client error
- Use policy that was in effect at the time of the error to determine the amount of the overpayment
- Notify the AG of the overpayment
- Initiate and monitor collection activity on the claim

11.3.3 IDENTIFYING THE MONTH(S) FOR WHICH CLAIMS ARE ESTABLISHED

When a client fails to report changes timely according to Section 10.5.2, and the change would have decreased benefits, a claim is established.

NOTE: Claims are NOT established for excess benefits received solely because of the 13-day advance notice period.

Failure to Take Prompt Action and Computation Error below are used when the overpayment is not contested in a Fair Hearing. If a Fair Hearing is held, the Hearing Officer's decision is final.

11.3.3.A Agency Errors

11.3.3.A.1 Failure to Take Prompt Action

The first month of overpayment is the month the change would have been effective had the agency acted properly.

11.3.3.A.2 Computation Error

The first month of overpayment is the month the incorrect payment was effective.

11.3.3.B Client Errors

When the client fails to provide accurate or complete information, the first month of the overpayment is the month the incorrect, incomplete, or unreported information would have affected the benefit level, considering reporting and noticing requirements.

11.3.3.C Fraud Claims

Any claim established as a result of an investigation conducted by the Criminal Investigation Unit and subsequent court order is classified as a fraud claim.

NOTE: When determining the amount of overpayment due to the failure of the household to report earned income in a timely manner, the amount of benefits the client should have received is computed without applying the earned income disregard and deductions to any portion of the earned income the client did not report.

11.3.4 FACTORS AFFECTING THE AMOUNT OF THE CLAIM

The RI must consider the following when determining the amount of the claim.

11.3.4.A Redirected Child Support

11.3.4.A.1 Recoupment of Total WV WORKS Payment

When child support is redirected to the Bureau of Child Support Enforcement (BCSE), the total amount is considered in determining the amount of the claim. The IFM Worker must request payment information from BCSE for each month for which repayment is sought. On a month-by-month basis, the amount applied by BCSE to the month for which repayment is due is subtracted from the amount the client would otherwise have to repay. If BCSE refunds the support to the client, the full check amount is subject to repayment.

> **BCSE Total Recoupment Example 1:** In July, the Worker discovers that the client was ineligible for the cash assistance payment he received in June. The June cash assistance payment was $275. The IFM Worker sends a DHS-1 to BCSE to request the amount of support credited to this case for June. The BCSE Worker responds with $100. Therefore, the client must repay the difference between $275 and $100, which is $175.
>
> **BCSE Total Recoupment Example 2:** In July, August, and October, a cash assistance client was ineligible, but received the following cash assistance amounts: July – $206; August – $275; October – $275. The IFM Worker sends a DHS-1 to BCSE to determine the amount of child support applied to his case for these months and receives the following information: July – $280; August – $270; October – $270. Therefore, there is no repayment required for July. The client owes the Department $5 for August and $5 for October. The total repayment amount for this client is $10.

11.3.4.A.2 Recoupment of Partial WV WORKS Payment

If part, but not all, of the WV WORKS benefit is to be repaid, the amount paid to BCSE is compared to the repayment amount and to the amount for which the client was eligible. If the

BCSE amount is less than the benefit amount but more than the amount he was eligible for, the difference between the BCSE amount and the amount he was eligible for is used to offset the repayment amount. If the BCSE amount is less than the amount the client was eligible for, the BCSE amount does not affect the repayment amount.

> **BCSE Partial Recoupment Example 1:** In November, a cash assistance client received a WV WORKS benefit for $360 but was only eligible to receive $100. The BCSE amount for November was $210. Because the State was reimbursed the redirected child support, the repayment is the difference between the check received and the amount of child support. The amount the client is eligible for is subtracted from the child support to determine the offsetting amount: $210 - $100 = $110. The amount of overpayment, $260, is then offset by the redirected child support, $110, leaving $150 as the repayment amount.
>
> **BCSE Partial Recoupment Example 2:** In December, a client received a WV WORKS benefit of $312, but was only eligible to receive $200. The BCSE amount paid for December was $100. Because the redirected child support is less than the amount the client was eligible for, the BCSE amount does not offset any of the repayment amount of $112.

11.3.4.B Determining the First Month of Ineligibility

In situations involving ineligibility, the first month is determined as follows:

- Any month that countable income exceeds the payment level is an ineligible month, even if the case closure is for a reason other than increased income, except when the case becomes ineligible due to excessive, redirected child/spousal support. See below.

  > **First Month of Ineligibility Example:** A cash assistance client reports on August 19 that he started to work full time and that his only dependent child left the home. Because of advance notice, the first month of ineligibility is October.

- In all other cases, including cases that become ineligible due to excessive, redirected child/spousal support, the first month of ineligibility is the month following the month in which the change occurs.

11.3.4.C Corrective Payments Due the AG

NOTE: Initial payments and Diversionary Cash Assistance payments are not subject to recoupment or offsetting.

If the AG has both an overpayment and an underpayment, the amount of the underpayment is treated as a payment toward the overpayment.

11.3.5 COLLECTING THE CLAIM

The following persons are equally liable for the total amount of overpayment and are liable debtors:

- Adult or emancipated minors in the AG
- Disqualified individuals who would otherwise be required to be included
- Caretaker relatives who signed the application/redetermination at the time of overpayment
- An unreported adult who would have been required to be in the AG had he been reported
- Sponsors of noncitizen AGs when the sponsor is responsible for the overpayment

When the AG composition changes, collection is pursued against any and all AGs that include a liable debtor.

NOTE: The DOHS may not under any circumstance retain more than the total amount of all outstanding claims. When this occurs regardless of the reason, benefits must be restored.

For AGs containing a liable debtor, collection activity may begin immediately. Repayment is initiated at the time the notification letter is generated by the eligibility system. Repayment by benefit reduction is mandatory when a liable debtor receives cash assistance. The eligibility system automatically begins recoupment and posts these payments to the claim.

NOTE: When the benefit reduction causes the check to be reduced to zero, cash assistance benefits must remain at $1, if otherwise eligible.

11.3.5.A Collection Priority

Collections can be made on only one claim at a time. Claims are collected according to the following priority order:

- Fraud
- Client error
- Agency error

Based on this priority order, payments are credited to the oldest claim first, until it is paid.

EXCEPTION: Payments received due to a court order are credited to the specific claim, regardless of the priority order or age of the claim.

Payments are then credited to the next claim in priority order.

11.3.5.B Claim Notification

11.3.5.B.1 Client and Agency Claims

The AG is notified of the cash assistance claim by computer-generated notification/demand payment letters from the eligibility system. Enclosed with the letter is a repayment agreement, form ES-REPAY-1, and a postage-paid envelope.

11.3.5.B.2 Fraud Claims

Fraud claims may only be established by court order. Upon receipt of the court order, the claim is entered into the eligibility system and notice that the claim has been established is produced. Enclosed with the letter is a repayment agreement, form ES-REPAY-1, and a postage-paid envelope.

11.3.5.C Collection Procedures

A claim must be collected by offsetting when lost benefits due the AG have not been restored. The Worker determines the amount of corrective benefits due the household and initiates the auxiliary issuance in the eligibility system. The auxiliary code used by the Worker causes the eligibility system to search for outstanding cash assistance claims and offset the claim, if appropriate.

11.3.6 DETERMINING THE REPAYMENT AMOUNT

11.3.6.A Active Recipients

The monthly repayment amount is 10% of the AG's total gross, non-excluded earned and unearned income, including the actual WV WORKS benefit amount, which may include reductions and incentives described in Section 4.5 or sanctions described in Section 14.8 and the Child Support Incentive (CSI). The amount is determined as follows:

- If the AG has no income other than the WV WORKS benefit, the repayment amount is determined by multiplying the benefit amount, after application of any reductions, incentives, or sanctions by 10% and dropping the cents.
- If the AG has income other than the WV WORKS benefit, the repayment amount is determined as follows:

  Step 1: Add together:

  - The non-excluded gross earned income of the income group, with no deductions applied
  - All non-excluded unearned income of the income group
  - The actual WV WORKS check amount, including the CSI

  Step 2: Determine 10% of the amount in Step 1 and drop the cents.

This is the monthly repayment amount. When the amount determined in Step 2 is less than the WV WORKS benefit amount, the monthly recoupment amount is equal to the amount calculated in Step 2. When the amount determined in Step 2 is greater than or equal to the WV WORKS benefit amount from Step 1, the monthly recoupment amount is equal to the WV WORKS benefit amount, less $1.

The client may voluntarily repay at a higher rate, but the DOHS may not require repayment at a higher or lower rate than that specified above.

> **Determining the Repayment Amount Example 1:** A six-person AG has been overpaid $300. It has $100 unearned income and receive a $313 WV WORKS benefit. The total income for the AG is $413. Ten percent of $413 is $41.30, which after dropping the cents is $41. This is the required monthly repayment.
>
> **Determining the Repayment Amount Example 2:** A family of three receives a $12 WV WORKS benefit. They have $241 per month unearned income. The monthly repayment amount is 10% of the gross income ($241 + 12) or $25. The check is less than the repayment amount. The check is reduced to $1 and $11 is recouped. The client must be encouraged to supplement this amount from his other income.

11.3.6.B Former Recipients

Liable debtors are responsible for payment of all claims regardless of case status. Form ES-REPAY-1 offers the client the following options to repay when there is no liable debtor.

11.3.6.B.1 Lump-Sum Payment

One payment is made to pay the claim in its entirety.

11.3.6.B.2 Installment Payments

When the AG is financially unable to pay the claim in one lump sum, regular monthly installment payments are accepted. The minimum amount of the monthly payment is $50. If the IFM Worker determines that the AG cannot afford the minimum payment, the payment amount is negotiated on a case-by-case basis.

11.3.6.B.3 Use of EBT Cash Account Benefits

- When there has been an unused cash benefit in an EBT cash account for a period of 229 days from the date the benefit was issued, a notice is generated to the client,

advising if they do not take action within 13 days and a claim is present, the benefit from this benefit month will be applied to the claim. An alert will be sent to the Worker; however, no action is required by the Worker.

An alert will also be sent to IFM. This will give them an opportunity to act on an open claim for the case.

- Expungement – When there has been an unused cash benefit in an EBT cash account for a period of 365 days from the date the benefit was last use, a notice is generated to the client, advising the benefits have been expunged and are no longer available. The notice will also advise they may have other benefit months remaining. The client is also encouraged to make monthly transactions on remaining benefits.

  An alert will be sent to the Worker; however, no action is required by the Worker at that time.

11.3.7 RIGHT TO A FAIR HEARING

The client has 90 days from the date of the initial notification/demand payment letter in which to request a Fair Hearing. The Hearings Officer only rules on the type and amount of the claim. If the client requests a Fair Hearing within 30 days of the initial notification/demand payment letter, the Worker stops collection until the Fair Hearing is completed. Any adjustments in the amount of the claim, required by the Fair Hearing decision, are made after the decision.

11.3.8 MAINTENANCE OF THE CASH ASSISTANCE CLAIM

11.3.8.A Notification of Delinquent Payments

A delinquent notice letter is sent to a client with an open status claim when 60 days elapses since the last payment.

11.3.8.B Receipts

Clients who make cash payments receive a receipt at the end of the month in which the payment is posted.

11.3.8.C Action Required When a Client Moves

There is no special action required when a client moves to or from West Virginia. Claims from other states will not be pursued for collection.

Claims established in West Virginia may be collected in another state, depending upon that state's policy.

11.3.8.D Repayment of an Overpaid Claim

RIs and Financial Clerks are responsible for cash refunds when a claim has been overpaid. If benefits must be restored, IFM notifies the Worker.

11.3.8.E Effect of Bankruptcy

The DOHS may act as a creditor for a bankrupt AG against which the DOHS has established a claim. When the RI receives documentation, he changes the claim status to "B" for agency and client error claims and forwards the document to the IFM State Office. Further collection action is suspended.

NOTE: Court adjudicated claims that declare Chapter 7 bankruptcy are not dischargeable and remain in "O" status. Court adjudicated claims that declare Chapter 13 bankruptcy are dischargeable and change to "B" status. If there is more than one liable debtor, all liable debtors must declare bankruptcy for the claim to be changed to "B" status. If not, the status must remain open.

11.3.8.F Effect of Expunged EBT Cash Accounts

When benefits are expunged from a cash EBT account, the following occurs:

- If a claim exists, as indicated in the eligibility system, the RI receives an alert that the EBT cash account is being expunged.

- The RI reduces the amount of the claim(s) by the amount of the expunged benefits.

NOTE: All funds deposited into a cash EBT account, including WV WORKS, CSI, and Diversionary Cash Assistance, are used to reduce cash claims when removed from an EBT account and a claim exists.

11.3.8.G Months Removed from the Lifetime Limit

Once a participant has repaid a month of TANF benefits that was received ineligibly, it is the Family Support Specialist's responsibility to inquire about any months which should be removed from the TANF lifetime limit. SSI parents may not choose to repay any month to reduce their lifetime limit to below 60 months to receive child only WV WORKS; benefits must have been received ineligibly. See also IMM 18.2.1.

11.4 MEDICAID CLAIMS AND REPAYMENT PROCEDURES

This section describes the procedures for establishing claims and collecting repayments for Medicaid services.

11.4.1 REPAYMENT OF CORRECTLY PAID BENEFITS – ESTATE RECOVERY

Under certain circumstances, the Department of Human Services (DOHS) must be reimbursed for Medicaid expenditures made on behalf of an eligible client. Repayment of correctly paid benefits is required only for those who received nursing facility services, Home and Community-Based (HCB) Waiver, Traumatic Brain Injury (TBI) Waiver, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and related hospital and prescription drug services. The Bureau for Medical Services (BMS) is responsible for implementing this law. Any inquiries are referred to the BMS' Estate Recovery contract agency at (304) 342-1604 or 1 (877) 598-5220.

11.4.2 REPAYMENT OF BENEFITS FOR WHICH CLIENT WAS INELIGIBLE

When it is determined that the client was ineligible for Medicaid and that the DOHS paid for medical services, the action depends upon whether or not the claim is due to intentional misrepresentation.

11.4.2.A Intentional Misrepresentation

When intentional misrepresentation is suspected and the amount of the medical payment is $500 or more, the case is referred to Investigations and Fraud Management (IFM) for investigation, using the IFM-1. Prior to the IFM referral, the Worker must determine that payment for medical services was made by the Department. The Worker must request such information from BMS in writing. The Medical Processing Unit produces a printout of the paid Medicaid expenses. This printout must be attached to the IFM-1.

The Worker takes no further action on the claim. If the IFM Investigator notifies the Worker that prosecution is not being pursued, the instructions in item B below are used.

11.4.2.B Unintentional Misrepresentation or Worker Error

Unless intentional misrepresentation is established, repayment from the client is not pursued. BMS may pursue repayment from the provider of the medical services, but not from the client.

11.4.3 PROVIDER FRAUD

If fraud on the part of any provider of Medicaid services is suspected, the Worker must submit a memorandum to the Medicaid Fraud Unit or complete the online reporting form.

The memorandum must contain the following information:

- Provider name and address
- Reason fraud is suspected
- Detailed explanation of the information accumulated that leads to the suspicion of fraud
- Names and addresses of clients who might have knowledge that would help in a fraud investigation

11.5 REFERRALS TO THE FRONT-END FRAUD UNIT (FEFU)

The Front-End Fraud Unit (FEFU) is operational only in select counties. The FEFU currently operates in Boone, Cabell, Kanawha, McDowell, Mercer, Putnam, Ritchie and Wood counties. FEFU verifies questionable information to assist in reducing errors and the potential for fraud. Staff of the FEFU are known as Front-End Verification Specialists (FEVS).

Programs of assistance (PA) are investigated by the FEFU in the following priority order:

- Non-PA Supplemental Nutrition Assistance Program (SNAP)
- PA SNAP
- Medicaid
- Cash assistance

Priority for referrals is as follows:

- Applications
- Reapplications
- Redeterminations
- Active cases

NOTE: FEFU does not investigate inactive cases.

11.5.1 REFERRAL CRITERIA

Below are some of the most frequent eligibility elements subject to error-prone findings. This is a guide for referral to FEFU, but referrals are not limited to these items only.

11.5.1.A Identification

- The client presents an identification document that appears to have been altered and/or does not appear to be authentic.

11.5.1.B Residency

- The client presents verification of residency (e.g., rent receipt, mortgage payment, utility bill) that appears to have been altered and/or written by applicant.

11.5.1.C Household Composition

- The client reports that a person with income has recently left the household; or
- The client reports that a person who was previously employed and not previously included in the SNAP assistance group (AG) is presently in the home and is not employed; or
- The client reports a large increase in the household size, or provides inconsistent information about Social Security numbers, dates of birth, or relationships; or
- Unreported individual(s) with income are suspected to be living in the home.

11.5.1.D Assets

- The client reports savings accounts for children but no savings accounts for adults; or
- Unreported bank holdings, such as certificates of deposit (CD), stocks, bonds, or checking accounts, are identified; or
- Unreported holdings of real property are identified; or
- Households with wage earners in which no vehicles are reported.

11.5.1.E Earned Income

- Households in which the principal wage earner has a long history of unemployment but reports receipt of Unemployment Compensation Insurance (UCI) benefits. Subsequently, the termination of UCI is reported, but the wage earner continues to be unemployed.
- Households where paid expenses are consistently higher than reported income; or

- The client presents an employment verification document that is not signed, does not appear to be authentic, or appears to have been altered or changed; or
- Reported earnings do not appear to be consistent with earnings reflected on wage-match reports; or
- Household in which a member has a history of employment that does not appear on wage match reports, such as domestic work or babysitting, but is reportedly no longer employed.

11.5.1.F Unearned Income

- Household where the wage earner loses a job and UCI is not reported, or a wage earner has been injured on the job and is not reporting Workers' Compensation; or
- Households reporting enrollment in institutions of higher learning but not reporting scholarships or loans.

11.5.1.G Living with a Specified Relative

- The client presents documentation to establish relationship to the child(ren) that appears to be altered and/or does not appear to be authentic. Examples of documentation include: birth certificates, marriage licenses, divorce records, adoption papers, statements of persons in a position to know about the relationship, etc.

11.5.2 REFERRAL PROCESS

The Worker makes a referral using the eligibility system. To accomplish the referral, the Worker:

- Prints the appropriate screen from the eligibility system
- Summarizes questionable eligibility issues
- Signs and dates the bottom, and forwards to the FEVS

11.5.2.A Investigative Priorities

Applications and redeterminations have priority.

Investigative findings on applications/reapplications are reported within 10 working days of receipt.

Investigative findings for all other referrals are reported to the Worker preferably within 30 working days.

11.5.2.B Referral Disposition

The FEVS reports his investigative findings by completing Section A of the FEFU-1 and forwarding it to the Worker. A copy of the eligibility system referral is attached to the FEFU-1. The Worker must take appropriate case action based on the investigative findings.

The Worker notifies the FEVS of action taken by completing Section B of the FEFU-1 and returning it within 10 days of receipt. See Appendix A for an example of a completed FEFU-1.

If an overpayment appears likely, the FEVS makes the appropriate referral to the Claims and Collections Unit (CCU) or the Criminal Investigations Unit (CIU).

11.6 REFERRALS TO THE CRIMINAL INVESTIGATIONS UNIT (CIU)

NOTE: Workers must never accuse the client or insinuate to him that he is guilty of fraud or any criminal activity, and must never imply a threat of criminal action to obtain repayment.

NOTE: When an agency employee believes that an overpayment of benefits is $500 or greater due to an alleged fraudulent act (e.g., intentional false statement or deliberate client misrepresentation), the case is referred to the Criminal Investigations Unit (CIU) for evaluation, investigation, and referral for prosecution if warranted. Employees in this unit are known as Criminal Investigators (CIs). The overpayment can be in one program of assistance or programs may be combined to reach the $500 threshold.

11.6.1 DEFINITION OF WELFARE FRAUD

The principle statute dealing with obtaining welfare assistance through misrepresentation is Section 4, Article 5, Chapter 9, of the Code of West Virginia, 1936 as amended:

“Any person who obtains or attempts to obtain, or aids or abets an applicant or recipient in obtaining or attempting to obtain, by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device:

- Any class of welfare assistance to which the applicant or recipient is not entitled; or
- Any class of welfare assistance in excess of that to which the applicant or recipient is justly entitled shall upon conviction be punished as follows:
    - If the aggregate value of all funds or other benefits obtained or attempted to be obtained shall be less than five hundred dollars, the person so convicted shall be guilty of a misdemeanor and shall be fined not more than one thousand dollars or confined to jail not exceeding one year; or
    - If the aggregate value of all funds or other benefits obtained or attempted to be obtained shall exceed five hundred dollars, the person so convicted shall be guilty of a felony and shall be fined not more than five thousand dollars or confined in the penitentiary not less than one year nor more than five years.”

The important elements constituting an offense under this statute are that any false representation was willfully made or that any other device to obtain assistance was a misrepresentation.

A willfully false statement is one that is deliberately given, with the intent that it be accepted as true, and with the knowledge that it is false. It is an essential element in a misrepresentation charge that the client knew his statement was false.

The misrepresentation must be of an existing fact and cannot be said to be willfully false if it is merely an expression of opinion.

Likewise, it is not essential that an affirmative representation be made. Misrepresentation may also be the suppression of what is true, as well as in the representation of what is false.

11.6.2 REFERRAL CRITERIA

The following guidelines assist the Worker in determining whether or not a referral is made to the CIU.

No referral is made in the following situations:

- The misrepresentation period ended more than two years ago.

  > **Referral Example:** A case was last certified in December 1994. An overpayment occurred due to a false statement but was not discovered until November 1998. The case is not referred for fraud investigation but is referred for repayment as detailed in Sections 11.2 and 11.3.

- Pertinent sections of the application form (e.g., income, assets, potential resources, employment) were not properly completed by the Worker.
- The Rights and Responsibilities form was not signed.
- The application form was not signed.
- Correct information affecting eligibility was reported, but the agency did not take appropriate action.
- The total amount is less than $500. Repayment procedures should be followed instead. See Sections 11.2 and 11.3.
- The Worker believes the client is not mentally capable of understanding his responsibilities to report changes.
- The client is seriously ill, blind, or is suffering from a terminal illness.

- The client is over age 70.

EXCEPTION: In certain cases, misrepresentation may be so blatant and repetitive that referral may be indicated even though the amount is under $500. If there are any questions concerning a referral, the Worker may discuss the case with the CI assigned to his county.

11.6.3 REFERRAL PROCESS

When it is determined that an overpayment meets the requirements for referral to the CIU, the Worker completes Form IFM-1 and forwards it to the Director, Investigations and Fraud Management, Building 6, using interdepartmental mail. The form requires the Worker to indicate the case name, RFA or case number, county of overissuance/overpayment, program(s) or assistance involved, and a summary of the questionable eligibility factors. See Appendix B of this chapter. The forms are available in the county offices.

A Desk Guide to assist Workers in determining when and where to refer cases is found in Appendix C of this chapter.

NOTE: A referral to the CIU for possible criminal action has no bearing on current eligibility. The Worker must adhere to the eligibility requirements, require the client to verify all questionable information, and take the appropriate action.

11.6.4 DISPOSITION

Upon completion of the investigation, the CIU notifies the Worker of the disposition of the referral.

APPENDIX A: FRONT-END FRAUD UNIT

FRONT-END FRAUD UNIT
INVESTIGATIVE FINDINGS

SECTION A: Completed by Front-End Verification Specialist

CASE NAME: Kiddy Smith

RFA NUMBER: 2588888888

COUNTY: Kanawha (20)

Summary of Investigative Findings:

Allegation: Absent parent, John Smith, is believed to be residing in the home.

Investigation Determined: Absent parent, John Smith, has been residing in the home of Kiddy Smith since last review, 06/20/2015. John Smith is employed at Wal-Mart at South Ridge and is paid weekly.

His last thirty (30) days of pay were as follows:
$350.25 on 08/1/17
$315.25 on 08/7/17
$250.15 on 08/14/17
$375.25 on 08/28/17

Verifications:
*Two (2) sworn affidavits regarding household composition
*Landlord verificaiton
*Postal verification
*DMV verification
*Employer verification

Please take appropriate action on the case.

FEFU will make any necessary referrals regarding overpayments if applicable.

IFM-FEFU-1 (04/13)

Front-End Verification Specialist Jane Doe	**Date** **09/01/2017**

SECTION B: Completed by OFS Staff			**SECTION C: Completed by FEVS**		
ACTION TAKEN ON CASE					
	SNAP	Cash Asst.		Food Stamp	Cash Asst.
Approved	☐	☐	Amount of Monthly Allotment or Entitlement-Initial Information	$____	$____
Approved-Benefit Reduction	☐	☐			
Denied	☐	☐	Corrected Monthly Allotment or Entitlement	$____	$____
Voluntary Withdrawal	☐	☐			
Closure	☐	☐	Actual One-Month Savings (Line 1 minus Line 2)	$____	$____
No Change	☐	☐			
Signature of OFS Worker	Date		Estimated Savings FS = 6 mos.; AFDC = 12 mos.	$____	$____
_____	_____		FEVS Signature	Date	
			_____	_____	
			Checklist of Completion ☐ IFM-1 ☐ BVRF # ☐ DHS-1 # To Whom _____ Date _____		

IFM-FEFU-1 (04/13)

APPENDIX B: FRAUD REFERRAL FROM IFM-1

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
FRAUD REFERRAL FORM
IFM-1

Case Name: _____ Case Number: _____ County Number: _____

Date of Birth: _____ Soc. Sec. Number: _____ Date of Last Application Review: _____

Programs Overpaid: ☐ Cash Assistance ☐ Food Stamps ☐ Medicaid ☐ Other: _____

Estimated Fraud Period: FROM: _____ (MM/YY) TO: _____ (MM/YY)

UNREPORTED INFORMATION: (Fill in known details in Summary section)

- ☐ **Household Composition** (Someone in / out of the home? If so, Who?)
- ☐ **Income** (Someone with unreported earned / unearned income? Who? From where?
- ☐ **Assets** (Someone with unreported Bank Accounts? CDs? Autos? Who has it? Where is it?
- ☐ **Residence** (Someone living out of State? Who? Where? Incorrect shelter / utility costs?

SUMMARY OF QUESTIONABLE ELIGIBILITY FACTORS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOURCE OF INFORMATION: (Person making the original complaint / informing DHHR)

Name: _____ Telephone: _____ Address: _____

* Is this person willing to be known and go to court if necessary? ☐ Yes ☐ No ☐ Unknown
* Has the Worker validated the complaint? ☐ Yes ☐ No

Worker Signature: _____ Date: _____

FOR IFM USE ONLY

AG Error ☐ Yes ☐ No

Suspect Over Age 69	☐ Yes ☐ No	Total Over-Issuance Less Than $1,000	☐ Yes ☐ No
Agency Error	☐ Yes ☐ No	Lack of False Statement in Record	☐ Yes ☐ No
Vehicle Case	☐ Yes ☐ No	CAF and/or R & R Incomplete	☐ Yes ☐ No
Terminally Ill or Dead	☐ Yes ☐ No	Fraud Ended More Than Two Years Ago	☐ Yes ☐ No

IFM-1 (Revised 03/04)

APPENDIX C: INVESTIGATIONS AND FRAUD MANAGEMENT (IFM) REFERRALS

When and Where to Make a Referral – Make Referral to Only One Unit		
FRONT-END FRAUD (FEFU) REFERRALS Referrals to FEFU are only made for applicants and recipients. **REFERRAL PROCESS:** • Print ACCH Screen(s) in the eligibility system • Describe questionable eligibility factors • Forward to FEFU Worker in your county **EXAMPLES OF APPROPRIATE REFERRALS:** • You receive a complaint that an unreported household member resides in the house and is working. • Client reports newborn child to be added to case. You suspect that the ABSENT PARENT is in the home and working. • Client applies for assistance claiming ZERO income, no work history, and NO Assets. He/she has excessive expenses and recently paid rent receipts and is seen driving away in a new model vehicle. Refer to FEFU and they will have a response within 10 working days since this is an application.	**REPAYMENT INVESTIGATOR (RI) REFERRALS** Referrals to RIs are to be made for Cash Assistance and SNAP cases due to Agency, Unintentional Program Violation (UPV) and Intentional Program Violation (IPV) errors of less than $500. **REFERRAL PROCESS:** • Complete BVRP Screen in the eligibility system **EXAMPLES OF APPROPRIATE REFERRALS:** • Client begins works on January 20 but does not report income until March 1. • Client reports her children is out of the home in February, however, the Worker does not take action until May. This is an agency error referred to the RI for repayment.	**CRIMINAL INVESTIGATOR (CI) REFERRALS** Referrals to CIs are made when a client INTENTIONALLY withheld information affecting eligibility for Cash Assistance, SNAP, Medicaid, Emergency Assistance, Child Care, and/or LIEAP, and the total overpayment exceeds $500. **REFERRAL PROCESS**: • Complete IFM-1. Include all information regarding the unreported information • Mail completed IFM-1 to Investigations and Fraud Management (IFM) headquarters in Charleston **EXAMPLES OF APPROPRIATE REFERRALS:** • Client admits spouse is and has been in household. Take corrective action and complete IFM-1. • It is discovered the client has been employed for months and not reporting it to the Agency. Take corrective action and complete IFM-1 to Investigator. **DO NOT REFER** – if the client is over 70 years old, the fraud occurred 2 or more years ago, or the client is terminally ill or not capable of understanding policy. Administrative Claims must still be established and are referred to the RI.
DO NOT DISCUSS FRAUD OR REPAYMENT WITH THE CLIENT OR THREATEN WITH CRIMINAL PROSECUTION.		

Chapter 12

Benefit Replacement

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
12.1				
12.2	4/1/20 4/1/25	784 862	12.2.1.B&2 12.2.1.A.1 12.2.1.A.2 12.2.1.D	Removed Customer Service Clarifying household misfortune, disaster and perishable food. Clarifying replacements are issued per incident. Adding a banner that the program to replace Stolen SNAP Benefits ended December 20th, 2024.
12.3	1/1/20 4/1/20 6/1/22 6/1/25	780 784 822 864	12.3.11 12.3.9.B 12.3.7 12.3.10	WV WORKS EBT transaction disputes Removed Customer Service Alternate issuance of supportive services will no longer be available. Once DFS confirms the theft is from card skimming/cloning/phishing, they will advise the worker of the amount that can be replaced via an email.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
12.4	4/1/18	755	12.4	Reflect the December 2017 change in the way Medical ID cards are issued.
App A	5/1/22	821	A.1	Corrected reference 21.2.2 to 12.2.2

12.1 INTRODUCTION

This chapter contains policies and procedures related to replacement of benefits by program. It also contains information regarding the replacement of electronic benefit transfer (EBT) cards and personal identification numbers (PIN).

When the client reports non-receipt, partial receipt, loss, theft, or damage of the benefit, the Worker must determine if the benefit will be replaced.

12.2 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

The following section covers the replacement of destroyed food that was purchased with SNAP benefits. When the assistance group (AG) is eligible to receive a replacement allotment, the allotment must be received as follows:

- Within 10 days after the client reports, or
- Within two working days after the client returns the DFA-SNAP-36, whichever is later.

12.2.1 SNAP BENEFIT REPLACEMENT

12.2.1.A Destroyed Food

12.2.1.A.1 Replacement Procedures

In cases when food purchased with SNAP is destroyed in a household misfortune or disaster, the AG will be eligible for replacement of the actual value of the loss, not to exceed one month's allotment, if:

- The loss is reported within 10 days of the incident; and
- The AG's misfortune or disaster is verified; and
- The DFA-SNAP-36 is completed and signed within 10 days of the report of the loss.

A household misfortune such as, but not limited to, loss of power more than 4 hours, termination of service or equipment malfunction (refrigerator or freezer) may affect an individual household. In these cases, replace perishable food only. Examples of perishable foods are meat, fish, dairy, fruits vegetables, frozen foods, etc. A disaster, such as, but not limited to, fire, flood, tornado and hurricanes may affect either an individual household or more than one household. In these cases, replace the last full monthly allotment issued.

NOTE: The loss of power due to the termination of service to an individual household is considered a household misfortune.

During a mass power outage, verification of the outage is self-attested.

The Worker replaces the value of the food using the appropriate eligibility system procedure. The replacement benefit must be received within two days of the receipt of the completed and signed DFA-SNAP-36. The original DFA-SNAP-36 is retained in the case record. It is not necessary to send a copy to the Division of Family Assistance Policy Unit.

12.2.1.A.2 Limits on Replacement

There is no limit on the number of times the value of food lost in a misfortune or disaster may be replaced, but replacements are issued only once per incident.

The Department of Human Services (DOHS) may deny or delay replacement issuances in cases where available documentation indicates that the household's request for replacement appears to be fraudulent.

12.2.1.A.3 Offsetting Claims

Replacements of destroyed food must not be used to offset claims.

12.2.1.B Lost, Stolen, Damaged, or Destroyed EBT Cards

The client may request a new card by contacting the EBT Automated Response Unit (ARU), DOHS Customer Service Center, or the local office. All replacement cards are sent in an active status, unless never previously activated. The following details the processes used when each is contacted.

If the EBT card is stolen prior to receipt by the client and benefits are fraudulently accessed, see the Exception in 12.2.2. The DFA Economic Services Policy Unit must be consulted in this situation.

12.2.1.B.1 EBT Automated Response Unit (ARU)/Helpline

When the client requests a new card through the EBT ARU, the old card is deactivated, and, if the current address is in the EBT Administrative System, a new card is mailed to the client. When the client's current address is not in the EBT Administrative System, the card is

deactivated, but a replacement card is not mailed. The client is instructed by the EBT ARU to contact his Worker to change his address. The client must contact the EBT ARU the day following the address change to request a new card.

12.2.1.B.2 DOHS Customer Service Center

When the client requests a new card through the DOHS Customer Service Center, the old card is deactivated in the EBT Administrative System and, if the current address is in the EBT Administrative System, a new card is mailed to the client.

When an address change is required, the Worker must complete an address change and request a replacement card in the eligibility system the next business day.

NOTE: Deactivation of the card in the EBT Administrative System must take place immediately to prevent unauthorized use. Deactivation of the EBT card is effective immediately.

12.2.1.B.3 Local Office

When a client reports a lost, stolen, or damaged card to the local office, he is referred to the EBT ARU. When a client reports an address change and requests a replacement EBT card, the address change is completed in the eligibility system and the client is referred to the EBT ARU to immediately deactivate the card. The client must contact the EBT ARU the following day to request a new card.

NOTE: Address changes in the eligibility system are received by the EBT vendor the following day. If a client's card has already been deactivated or is not in danger of unauthorized use (e.g., damaged), the Worker may request a new card in the eligibility system after the address change is made.

If the client requests a replacement card at application or redetermination, the Worker must request a new card in the eligibility system. This method is only used if the client's old card is not in danger of unauthorized use.

12.2.1.C EBT Personal Identification Number (PIN) Changes

The payee or authorized cardholder may request a PIN change at any time. Replacement cards are issued with the same PIN, unless the individual requests a new one. A PIN-only change request must be made to the EBT ARU.

12.2.1.D SNAP BENEFIT REPLACEMENT DUE TO CARD SKIMMING/CLONING/ PHISHING

The program to replace Stolen SNAP Benefits ended on December 20, 2024, and any benefits stolen after that date cannot be replaced.

12.2.1.D.1 Replacement Procedures

In cases when SNAP benefits are stolen due to card skimming/cloning/phishing, the AG will be eligible for replacement of the actual value of loss, not to exceed the lesser amount of either the full amount of stolen benefits or the amount equal to two months of the household's monthly allotment immediately prior to the date when the benefits were stolen, if:

- The theft is reported within 30 days of the incident; and
- The AG's theft was verified by OIG; and
- The DFA-36B is completed, and a signature is obtained by the affected household.

Theft is considered stolen SNAP benefits via card skimming, card cloning and phishing.

Note: The loss of SNAP benefits due to giving someone your PIN number will not be considered a theft.

The client will complete a DFA-36B with a signature to start the claim process for benefit theft. This form will be sent to OIG for investigation. Once OIG investigates and confirms the theft was from card skimming/cloning/phishing, they will advise the worker of the amount they can replace via an email. The worker will then replace the lesser of the two instances listed above

using the appropriate eligibility system procedures. The DFA-36B is retained in the case record along with the email from OIG containing the approval/denial. If the claim is found by OIG to be invalid, the worker will check the appropriate denial reason on the system generated notice (NCSB) and mail it to the client. The worker will retain the (NCSB) in the case record.

12.2.1.D.2 Policy Limits on Replacements

Limits replacements to the lesser of the amount of benefits stolen from the household or the amount equal to two months of the household's monthly allotment immediately prior to the date when the benefits were stolen. A household may only receive two instances of replacement benefits in each Federal Fiscal Year (FFY), even if an occurrence of theft crosses two FFY's.

12.2.1.D.3 Required Periods of Benefit Replacement

Workers must make available retroactive replacement of stolen benefits starting October 1, 2022, with authority for replacing benefits sunsetting on September 30, 2024.

12.2.2 WHEN SNAP BENEFITS ARE NOT REPLACED

Replacement issuances are not provided in the following circumstances:

When the issuance would normally be replaced, but the AG has not signed the DFA-SNAP-36 within 10 days of the date the client reports the loss.

When the client does not report the benefit loss within the period of intended use or within 10 days of the specific incident.

When benefits are issued into an EBT account.

EXCEPTION: When the EBT card is stolen before receipt by the client and benefits are fraudulently accessed, this situation must be reported to the DFA Economic Services Policy Unit for specific replacement procedures.

12.3 WV WORKS PROGRAM

All initial, monthly and supplemental WV WORKS cash assistance benefits are issued by direct deposit or electronic benefits transfer (EBT).

The information contained in Sections 12.3.1 – 12.3.5 below describes the circumstances under which a Support Service Payment, BA-67 or EBT card is replaced and the procedures for replacement.

12.3.1 WHEN THE SUPPORT SERVICE PAYMENT IS REPLACED

Support Service Payments to a vendor may be replaced when one of the following conditions is met:

- The check is not received by the vendor and has not been returned to the DOHS.
- The check is received by the vendor, but is stolen, lost, or accidentally destroyed before being cashed.

When a replacement check is issued and the vendor subsequently finds and cashes the original check, he must reimburse the amount of the replacement check.

12.3.2 WHEN THE SUPPORT SERVICE PAYMENT IS NOT REPLACED

The Support Service Payment is not replaced when it is received by EBT

Unless one of the criteria in Section 12.3.1 above is met, the check is not replaced.

If the vendor cashes the check and the money is stolen, lost, or destroyed, the money must not be replaced.

When a replacement check is issued and the vendor subsequently finds and cashes the original check, he must reimburse the amount of the replacement check.

See Section 12.3.8 below for direct deposits.

12.3.3 PROCEDURES FOR REMAILING SUPPORT SERVICE CHECK

The following steps are followed for remailing a Support Service check to a vendor:

- Determine that the check was issued by inquiring in the case management system. The benefit must be in a disposition of issued and history updated with the check number.
- Determine, either by inquiring benefit issuance history or telephone call, that the check has been returned to Client Accounts.
- If returned, determine the address to which the check should be mailed. The local office Worker must request a new benefit in the eligibility system.

12.3.4 SUPPORT SERVICE CHECK REPLACEMENT PROCEDURES

The following steps are used for Support Service replacement checks to a vendor. Support Service replacement checks are not issued by the Worker.

- Determine that the check was issued by inquiring benefit issuance history in the case management system. The benefits must be in a disposition of issued and history updated with the check number.
- If the Support Service check is not received within 10 workdays, excluding Sundays and holidays, after the expected check receipt date, the Worker prepares an original and four copies of the Lost Check Affidavit form (DF-36). When completing the name and address on the DF-36, the information must match the original information in the case management system on the check.
- Have the vendor read or read to him the DF-36 and explain that he must return the original check if later received or found.
- The vendor signs the DF-36. The vendor's name must be exactly as shown in the case management system. Two witnesses are required if the vendor signs with an X. Signatures on all copies must be original. The Worker must complete the state, county, and date sections of the DF-36.
- The Worker sends the original and two copies of the DF-36 to:

  Client Accounts
  1 Davis Square, Suite 402
  Charleston, WV 25301

  File a copy of the memorandum and DF-36 in the case record.

- The Worker requests stop payment of the check through the eligibility system.
- When Client Accounts determines the check has not been cashed, they will request stop payment of the check and Client Accounts will issue a replacement.

12.3.5 WHEN THE ORIGINAL SUPPORT SERVICE CHECK IS LOCATED

If the vendor later receives or finds the original check, he must return it to the local office and endorse it to the DOHS. The Financial Clerk or designee accepts the check and issues a receipt.

12.3.6 TIME LIMITS ON REPLACEMENTS

There is no specific timeframe in which a vendor must request a replacement. There is no limit on the number of times a client may have a check replaced.

12.3.7 DIRECT DEPOSIT REPLACEMENT PROCEDURES

The State Auditor's Office makes every attempt to resolve problems with unsuccessful direct deposit transactions. When a client reports that a direct deposit is not received in his account by the last State workday of the month, he must be referred to the Auditor's Office immediately so that the deposit can be traced, and the problem resolved as soon as possible.

However, when a direct deposit return is not indicated in the eligibility system, but is not credited in the client's specified account within five State workdays of the usual direct deposit date, the following procedure is used:

- The client must obtain documentation from his financial institution that the deposit has not been credited to his account. The documentation must be in writing and contain his account number. In addition, the client must sign the Non-Receipt of Direct Deposit Affidavit. An original and two copies are sent to Accounts Receivable and a copy is placed in the case record. The benefit is replaced using appropriate eligibility system procedures.
- The benefit is replaced by EBT. Under no circumstances is the benefit replaced by an additional direct deposit. If the deposit is not returned from the Auditor's Office, the

Office of Accounting refers the case to Investigations and Fraud Management (IFM). The IFM referral is only for the purpose of seeking repayment.

12.3.8 LOST, STOLEN, DAMAGED, OR DESTROYED EBT CARDS

The client may request a new card by contacting the EBT Automated Response Unit (ARU), DOHS Customer Service Center, or the local office. All replacement cards are sent in active status, unless never previously activated. The following details the processes used when each is contacted. EBT Automated Response Unit (ARU)

When the client requests a new card through the EBT ARU, the old card is deactivated, and, if the current address is in the EBT Administrative System, a new card is mailed to the client. When the client's current address is not in the EBT Administrative System, the card is deactivated, but a replacement card is not mailed. The client is instructed by the EBT ARU to contact his Worker to change his address. The client must contact the EBT ARU the day following the address change to request a new card.

12.3.8.A DOHS Customer Service Center

When the client requests a new card through the DOHS Customer Service Center, the old card is deactivated in the EBT Administrative System and, if the current address is in the EBT Administrative System, a new card is mailed to the client.

When an address change is required, the Worker must complete an address change and request a replacement card in the eligibility system the next business day.

12.3.8.B Local Office

When a client reports a lost, stolen, or damaged card to the local office, he is referred to the EBT ARU. When a client reports an address change and requests a replacement EBT card, the address change is completed in the eligibility system and the client is referred to the EBT ARU to immediately deactivate the card. The client must contact the EBT ARU the following day to request a new card.

If the client requests a replacement card at application or redetermination, the Worker must request a new card in the eligibility system. This method is only used if the client's old card is not in danger of unauthorized use.

NOTE: Address changes in the eligibility system are received by the EBT vendor the following day. If a client's card has been already been deactivated or is not in danger of unauthorized use (e.g., damaged), the Worker may request a new card in the eligibility system after the address change is made.

12.3.9 EBT PERSONAL IDENTIFICATION NUMBER (PIN) CHANGES

The payee or authorized cardholder may request a PIN change at any time. Replacement cards are issued with the same PIN, unless the individual requests a new one. A PIN-only change request must be made to the EBT ARU.

12.3.10 WV WORKS REPLACEMENT DUE TO CYBER FRAUD/SKIMMING/CLONING/ PHISHING

When a WV WORKS participant reports unauthorized transactions on their EBT card that resulted in stolen benefits due to cyber fraud, the steps below must be taken. Cyber fraud includes, but is not limited to, account access by a fraudulent bot or EBT card data compromised through skimming/cloning/phishing. The theft must be reported within 30 days of the incident.

- Direct the participant to:
    - Immediately notify the Office of EBT Banking Services at 304-558-4126;
    - File a police report;
    - Immediately replace the card that was used fraudulently, by calling 1-866-545-6502, which will deactivate the card number that was used for the stolen benefit transactions;

- Complete a DFA-36B.

- Place a block on out-of-state transactions on their EBT card.
    - To block Out-of-State Transactions: Go to ebtEDGE.com or use the FIS ebtEDGE mobile app to block out-of-state transactions. This can be unblocked at any time when needed.

- Once the DFA-36B is completed and signed, the form must be sent to the Division for Family Support (DFS) unit with a printout of the questionable EBT transaction. Once DFS investigates and confirms the theft was from card skimming/ cloning/phishing, they will advise the worker of the amount that can be replaced via an email. The DFA-36B is retained in the case record along with the email from DFS containing the approval/denial.

- The Case Manager will replace the stolen WV WORKS benefit amount only on the EBT card by using the auxiliary reason, replace stolen benefits due to skimming/cloning/phishing.

- If the claim is found by DFS to be invalid, the worker will complete a system generated notice (NCSB) by checking the appropriate denial reason and mailing it to the client. The worker will retain the NCSB in the case record.

- Replacements will be limited to the lesser amount of the benefits stolen from the household or the amount equal to two months of the households monthly allotment.

- The household may only receive two instances of replacement benefits in each Federal Fiscal Year (FFY), even if an occurrence of theft crosses two FFY's.

12.3.11 WHEN THE BA-67 IS REPLACED

The BA-67 is replaced when one of the following conditions is met:

- The BA-67 is not received by the client and has not been returned to the DOHS.
- The BA-67 is received by the client, but is stolen, lost, or accidentally destroyed before being redeemed.

When a replacement BA-67 is issued and the client subsequently finds and redeems the original BA-67, he must reimburse the amount of the replacement BA-67. Until the amount is repaid in full, the client is ineligible for any future replacements.

12.3.12 WHEN THE BA-67 IS NOT REPLACED

Unless one of the criteria in Section 12.3.11 above is met, the BA-67 is not replaced.

12.3.13 BA-67 REPLACEMENT PROCEDURES

12.3.13.A If the BA-67 Is Not Received

If the BA-67 is not received within 10 workdays, excluding Sundays and holidays, after the expected receipt date, the Worker prepares an original and two copies of the Lost Check Affidavit form (DF-36). When completing the name and address on the DF-36, the information must match the original information on the BA-67.

- Have the client read or read to him the DF-36 and explain that he must return the original BA-67 if later received or found.
- The client signs the DF-36 in the presence of the Worker. The client's name must be exactly as shown on the BA-67. Two witnesses are required if the client signs with an X. Signatures on all copies must be original. The Worker must complete the state, county, and date sections of the DF-36.
- The Worker or Supervisor logs into the BA-67 system to request a cancel. The request is automatically electronically sent to the Financial Clerk to cancel the voucher.
- One copy of the DF-36 is kept in the Work Programs portion of the case record, one copy is given to the Financial Clerk, and one copy is given to the customer.

12.3.13.B If the BA-67 Has Been Canceled

If the BA-67 has been canceled, and then the Worker receives a request for payment from the canceled BA-67, the Worker must request a new BA-67 as a replacement. The replacement BA-67 voucher is used to issue a payment to the vendor and never leaves the county office.

- The Worker must create a new BA-67 in the case management system with details matching the canceled voucher, including the vendor name and maximum amount.

- The new BA-67 description must specify that it is a replacement of the canceled voucher and include the canceled BA-67 number.
- The new BA-67 must be printed and attached to the canceled BA-67 along with the receipt sent by the vendor.
- The Worker and Supervisor will then follow the standard process of editing the BA-67 amount and approving the payment in the eligibility system.

12.4 MEDICAID

The client must be an eligible Medicaid recipient to receive services. A replacement card or other approved verification may be necessary to avoid a medical emergency.

The Medical ID card must be replaced any time a client reports he has not received the card or received the card and it is lost, stolen, or destroyed, and he requests a replacement.

When the client reports non-receipt of the Medical ID card, the Worker must check the eligibility system to determine if a card was issued and/or if an incorrect entry is found, the Worker must correct the information and reissue the benefit.

If the client's address is incorrect and the card has not been returned to Accounts Receivable or the local office, the Worker must correct the address in the eligibility system and issue a replacement card or verification letter for the correct period of eligibility.

APPENDIX A: SNAP AND WV WORKS CHECK AND EBT CARD/PIN REPLACEMENT DESK GUIDE

A.1 SNAP REPLACEMENT DESK GUIDE

Replacing SNAP	Can SNAP Be Replaced?	Report Within 10 Days	DFA-SNAP-36	Replacement Limit	Eligibility System Auxiliary Reason Codes
Partial Allotment not deposited to EBT – total amount issued not credited to account	NO – Must be resolved by EBT vendor after eligibility system issues	N/A	N/A	N/A	N/A
Food purchased with SNAP benefits destroyed in disaster or misfortune	YES – Cannot exceed 1 month's allotment	YES	YES – retain in case record	NO	902
Benefits stolen due to theft from card skimming/cloning/phishing	Yes – See Replacement Limit Instructions	No – Reported within 30 days of incident	No - Requires a DFA-36B	Yes – Limits the replacement to the lessor of the amount of benefits stolen from the household or the amount equal to two months of the household's monthly allotment immediately prior to the date when the benefits were stolen.	985
1. EBT benefits used by unauthorized person 2. EBT benefits stolen before receipt. See 12.2.2 EXCEPTION	1. NO 2. YES – Upon approval by DFA Economic Services Policy Unit.	1. N/A 2. YES	1. N/A 2. N/A	1. N/A 2. N/A	1. N/A 2. 902 with recording of Exception in the eligibility system

EBT benefit*	N/A	N/A	N/A	N/A	N/A

* For replacement of the EBT card, see the EBT Card Replacement Desk Guide.

A.2 WV WORKS REPLACEMENT DESK GUIDE

Replacing WV WORKS Benefits	Is Benefit Replaced?	Time Limits	DF-36	Replacement Limits	Eligibility System Auxiliary Reason Codes
Check never received	YES	NO replacement until five mailing days elapse	Original and four copies: one copy to case record; original and two copies to Check Control; one copy with cover memo to IFM	NO – if multiple replacements requested, consider alternate address, direct deposit or protective payments	916
EBT account not credited with amount	NO – Must be resolved with EBT vendor after eligibility system issues	N/A	N/A	N/A	N/A
1. Check received, then stolen, lost or destroyed before being cashed 2. EBT benefits used by unauthorized person 3. WV WORKS stolen due to cyber fraud, skimming, cloning, phishing.	1. YES 2. NO 3. YES	1. NO replacement until five mailing days elapse 2. N/A 3. 30 Days	1. Original and four copies: one copy to case record; original and two copies to Check Control; one copy with cover memo to IFM 2. N/A 3. DFA-36B is completed and sent to OIG and copy is retained in case record.	1. NO – if multiple replacements requested, consider alternate address, direct deposit or protective payments 2. N/A 3. Two replacements in each Federal Fiscal Year.	1. 916 2. N/A 3. 985
1. Check cashed, then cash stolen,	1. NO	1. NO	1. N/A	1. N/A	1. N/A

Replacing WV WORKS Benefits	Is Benefit Replaced?	Time Limits	DF-36	Replacement Limits	Eligibility System Auxiliary Reason Codes
lost or accidentally destroyed 2. EBT benefits used by unauthorized person	2. NO	2. N/A	2. N/A	2. N/A	2. N/A

** If client's check has been replaced and it is later determined that he signed and cashed the original check, he is ineligible for any further replacements until he has repaid the amount.*

*** Benefits received by direct deposit are never replaced by another direct deposit.*

**** For EBT card replacements, see the EBT Card Replacement Desk Guide.*

A.3 EBT CARD/PIN REPLACEMENT GUIDE

Reason New Card/PIN Requested	Is Card Replaced? *	How Replaced?	Forms to Sign	Replacement Limits	Other Act Required
Card mailed but never received	YES New Card Issued. If new card issued, old one is deactivated. Cards returned to the card vendor are destroyed and deactivated by the EBT Vendor.	Client calls: Vendor's toll-free ARU Customer Service Center Local Office using the eligibility system	NONE	NONE	Ensure address is corrected in the eligibility system and transmitted to the vendor. Address change must be transmitted before new card is issued.
Card lost, destroyed, damaged, or stolen	YES New card issued and previously issued card deactivated.	Client calls: Vendor's toll-free ARU	NONE	NONE	NONE Ensure address is corrected in the eligibility

Reason New Card/PIN Requested	Is Card Replaced? *	How Replaced?	Forms to Sign	Replacement Limits	Other Act Required
		Customer Service Center Local Office using the eligibility system			system and transmitted to the vendor. Address change must be transmitted before new card is issued.
Change of payee or authorized cardholder (AC)	YES Card issued to new payee or AC and previous payee and/or AC cards deactivate.	A change in payee or AC in the eligibility system automatically sends new EBT cards to the new payee and/or new AC and deactivates previous cards. A PAYEE OR AC's EBT Card can be deactivated at any time by calling: Vendor's toll-free ARU Customer Service Center	NONE	NONE	Change payee or AC in the eligibility system.
PIN not received, lost, forgotten, compromised or new PIN request	YES	Vendor's toll-free ARU	NONE	NONE	NONE
	** A New PIN can only be requested through the local office or DOHS Customer Service Center. Both a new card and PIN are requested in the eligibility system.				
EBT card replacement is only for account access. It is not a replacement of the SNAP or cash assistance benefit.					

Chapter 13

Determining Disability, Incapacity, and Blindness

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
13.1				
13.2				
13.3				
13.4				
13.5				
13.6				
13.7	12/1/24	858	13.7.1.A.2	Updated language to Bureau for Medical Services.
13.8				
13.9				
13.10				
13.11				
13.12				
13.13				
13.14				
13.15	10/1/20 9/1/23 8/1/25	794 840 867	13.15.2 13.15.3 13.15.3	Replaced illegal alien Removed worker evaluation for homelessness to determine fitness for employment. Updated the process for applying the unfit for work exemption when a disability status or doctor statement does not exist.
App A				
App B				
App C				

13.1 INTRODUCTION

Several of the Division of Family Assistance (DFA) programs require that a medically determined physical and/or mental impairment exist for the client and/or family to receive benefits. This chapter deals with how disability is established for these programs. The nature, degree, and duration of the impairment required for eligibility purposes vary from program to program. Some decisions are made by the Medical Review in the Bureau for Medical Services (BMS).

13.1.1 MRT DECISIONS

The following incapacity/disability decisions are made by MRT:

- Supplemental Security Income (SSI)-Related Medicaid – when eligibility of the individual is based on disability or blindness and neither has been determined by Social Security.
- WV WORKS – when a temporary exemption from the work requirement, based on incapacity or temporary incapacity, is alleged and the Worker and Supervisor are unable to make the determination.
- WV WORKS – when an assistance group (AG) is being considered for an extension of the 60-month lifetime limit based on disability, and disability was not established prior to the 55th month, a referral to MRT is mandatory. See Section 18.2.
- Medicaid Work Incentive (M-WIN) – when eligibility of the individual is based on disability or blindness and neither has been determined by Social Security.

13.1.2 OTHER DISABILITY DECISIONS

Other Medicaid coverage groups require a medical determination of disability or blindness, but the responsibility for the determination rests elsewhere. The Worker, therefore, is not usually involved in the process, but must be notified of the disability decision prior to case approval and recertification. These coverage groups are:

- SSI Recipients: The disability decision is made by the Social Security Administration (SSA).
- Deemed SSI Recipients, except essential spouses of SSI Recipients: The disability decision is made by the SSA.

- Qualified Disabled Working Individuals (QDWI): The disability decision is made by the SSA.
- Aged and Disabled Waiver (ADW), Traumatic Brain Injury (TBI), and Intellectual/Developmental Disabilities (I/DD) Waiver: The disability decision is made by the BMS contract agency. The Worker is notified of the decision by the BMS contract agency.
- Children with Disabilities Community Service Program (CDCSP): The disability decision is made by the BMS contract agency. The Worker is notified of the decision by the BMS contract agency.
- Acquired Immune Deficiency Syndrome (AIDS) Drug Assistance Program (ADAP): A medical diagnosis of human immunodeficiency virus (HIV) positive is the only disability requirement. The Worker obtains the medical statement from the client and forwards it to the BMS with the application.

13.2 CLIENT HAS BEEN FOUND NOT DISABLED BY SSA

The blind or disabled individual who is determined not disabled by the SSA must not, normally be found disabled for Medicaid purposes.

However, in the following situations, the client who has been found not disabled by the SSA may be eligible for Medicaid when:

- There has been a deterioration in the client's condition subsequent to the SSA's determination of ineligibility; or
- The client has appealed the SSA decision and DOHS's determination of disability or blindness is made prior to completion of the SSA appeal process. If the SSA's decision is upheld, Medicaid must be stopped.
- An individual may be eligible for Medicaid while his claim for RSDI and/or SSI is being processed, providing that an MRT determination of disability or blindness is made prior to SSA's determination that the client is not disabled.

NOTE: When a Medicaid application is denied or the benefit is stopped because the SSA found the client not disabled, consideration must be given to his eligibility for all other coverage groups.

13.3 DEFINITIONS OF DISABILITY AND BLINDNESS

13.3.1 DEFINITION OF DISABILITY

The definitions of disability for WV WORKS and Medicaid purposes are the same as the definitions used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or Retirement, Survivors, and Disability Insurance (RSDI) based on disability, which are as follows.

13.3.1.A Individuals Age 18 or Over

An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment that has lasted, or is expected to last, for a continuous period of at least 12 months, or is expected to result in death.

13.3.1.B Individuals Under Age 18

The child who is under age 18 is considered to be disabled if he has a medically determinable physical or mental impairment (or combination of impairments), the impairment(s) results in marked and severe functional limitations, and the impairment(s) has lasted (or is expected to last) for at least one year or to result in death.

An individual under age 18 is not considered a child if he:

- Is legally married;
- Is divorced; or
- Is over age 16 and has been emancipated by a court of law.

13.3.2 DEFINITION OF BLINDNESS

To meet the definition of blindness, the individual must have:

- Central visual acuity that cannot be corrected to better than 20/200 in the better eye; or
- A limitation of the field of vision in the better eye so that the widest diameter of the visual field subtends an angle of 20 degrees or less.

13.3.3 CONSIDERATION OF MEDICAL AND SOCIAL FACTORS IN DETERMINING DISABILITY

In determining whether or not an individual is disabled, medical and social factors and the relationship between the two must be considered.

If the medical information indicates that the individual has an impairment that has lasted or can be expected to last the required length of time, social factors must be examined to determine the effect of the impairment on the individual.

When a case is referred to the Medical Review Team (MRT) for a disability decision, the Worker must complete form DFA-RT-1, Social Summary Outline that identifies the social information used by the Worker in making a presumptive decision and by MRT in making the final disability decision.

The DFA-RT-1 must be completed and sent to the MRT.

13.4 PROCESS FOR DETERMINING DISABILITY, INCAPACITY AND BLINDNESS

13.4.1 GENERAL REQUIREMENTS

The following steps are necessary in the process of determining incapacity, disability, and blindness. These steps do not apply to the determination of disability for Supplemental Nutrition Assistance Program (SNAP); see Section 13.15.

- Accept the application
- Prepare the Social Summary Outline
- Obtain initial medical reports
- Evaluate for presumptive approval and/or referral to the Medical Review Team (MRT)
- Obtain additional medical reports when indicated
- Reevaluate for presumptive approval
- Re-refer to the MRT
- Receive MRT decision
- Notify the client of disposition
- Notify the Federally Facilitated Marketplace (FFM) electronically when appropriate

NOTE: Determining whether the client will meet the spenddown should not delay the determination of disability, incapacity, or blindness for Supplemental Security Income (SSI)-Related Medicaid applicants. The establishment of disability, incapacity or blindness and meeting a spenddown requirement are both eligibility factors and both must be pursued simultaneously. If the application is denied in the eligibility system for a reason other than failure to meet a spenddown prior to a MRT decision, the Worker must notify MRT of the denial. MRT will stop consideration of the case and return all information to the Worker. If the Worker determines that the client is ineligible for any other reason prior to the MRT decision, the application is denied, and the Worker must notify MRT to stop consideration of the application. This does not apply when the only reason for denial is failure to meet a spenddown.

13.4.2 SSI-RELATED DISABILITY PROCESSING REQUIREMENTS

13.4.2.A Target Time Periods

Target time periods have been established to assure that SSI-Related disability cases are processed within the 90-day processing time limit, except when the delay is beyond the Department of Human Services' (DOHS) control.

Required Action	Time Limit
Request medical records and reports	By the 7th calendar day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request (and each 30 days thereafter)
Submission to the MRT	By the 7th day after medical records/reports received
Receipt of file and logged	By the 2nd day after receipt by the MRT
Initial review by the MRT staff	By the 7th day after receipt
Physician review (initial)	By the 14th day after receipt
Additional medical information requested (if required) by physician	By the 7th day after initial physician review
Physician's final review	By the 7th day after receipt of additional medical information
Final decision (completion of ES-RT-3 and/or DFA-RT-3M form[s])	By the 7th day after final physician's review
File returned to county office	By the 3rd after final physician's review
Notice to the client	By the 7th day after receipt of final decision at county office

NOTE: The 90-day processing time limit concludes with the mailing of the client notification, not eligibility system action.

13.4.2.B DFA-20

Disability cases that have been pending longer than 90 days must receive a DFA-20 by the 100th day stating the reason for the delay.

A copy of the DFA-20 must be filed in the case record if not issued out of the eligibility system.

13.4.2.C Holcomb Log Sheet

As a result of Holcomb v. Lewis, the processing of SSI-Related disability applications was tracked using the Holcomb Log Sheet.

Effective October 1, 1995, the Holcomb Log Sheet is no longer required by the court order. Its use is optional.

13.4.3 INCAPACITY FOR WV WORKS

For WV WORKS purposes, a determination of incapacity must be made to determine if an individual may have good cause for failure to participate in countable activities.

The decision is made by the Worker and/or Supervisor, at the discretion of the Community Services Manager or the MRT, depending on the length of the expected incapacity. The Worker must provide the applicant with Form DFA-DIMA-1 to be completed by his medical provider. If the incapacity is obvious and not expected to continue for an extended period, no medical verification is required, but the Worker must record his findings and justify his decision. For any period of disability or incapacity that is expected to continue for more than a six-month period, the case must be submitted to the MRT for evaluation.

If the incapacity is not obvious, verification must be provided from a physician, licensed or certified psychologist, surgeon, doctor of osteopathy, or other medically qualified individual. The verification must include an estimate of the duration of the incapacity. The medical practitioner is not required to state that the individual must be excused from participation. The Worker and/or Supervisor make this decision, based on medical records submitted and any necessary follow-up contact, but the period must not last longer than six months.

The medical condition must be reevaluated according to the statement of the medical practitioner or as determined by the MRT. However, each individual who has good cause for

failure to participate in countable activities must have documentation of a medical reevaluation at least once quarterly. During the time that the client is unable to participate in work activities, he must be referred to other potential resources, such as the Social Security Administration (SSA), Legal Aid, and Division of Rehabilitation Services (DRS). Such referrals and follow-up must be added to the client's Self-Sufficiency Plan (SSP) as appropriate.

13.5 DETERMINATION OF DISABILITY OR BLINDNESS WITHOUT MEDICAL REPORTS OR SOCIAL SUMMARY

13.5.1 DISABILITY ESTABLISHED BY SSA

It is not necessary to obtain medical reports, complete the social summary, or refer the case to the Medical Review Team (MRT) when the disabled individual receives Retirement, Survivors, and Disability Insurance (RSDI) benefits based on his own disability. This includes benefits for the disabled wage earner; benefits for the adult disabled child of a retired, deceased, or disabled wage earner; and benefits for the disabled spouse of the retired, deceased, or disabled wage earner.

See Section 13.6.2 for disabled individuals who previously received Supplemental Security Income (SSI).

13.5.2 DISABILITY ESTABLISHED BY RAILROAD RETIREMENT BOARD

It is not necessary to obtain medical reports, complete the social summary, or refer the case to the MRT when disability has been established by the Railroad Retirement Board.

To meet the Medicaid definition of disability, the client's Railroad Retirement annuity must be based on his own total and permanent disability. The individual who is receiving a Railroad Retirement annuity based on occupational disability does not meet the disability requirements for Medicaid.

13.5.3 BLINDNESS

It is not necessary to obtain medical reports, complete the social summary, or refer the case to the MRT when both eyes are missing.

13.5.4 DISABILITY ESTABLISHED BY RECEIPT OF RSDI – CLIENT CLAIMS BLINDNESS

When an individual receives RSDI based on his disability but has earned income and would benefit from the more generous treatment of earned income available to blind persons, the Worker must pursue establishment of his blindness. The application must first be approved based on disability. The Worker proceeds with the usual processes involved in establishing blindness.

13.6 PRESUMPTIVE MEDICAL APPROVAL

13.6.1 INTRODUCTION

The process of making a disability, incapacity or blindness decision at the local level is referred to as the presumptive medical eligibility process.

In some situations, the decision may be made prior to obtaining any medical reports.

However, in all other situations, the presumptive medical decision is made only when medical information and the social summary are available. The presumptive decision is always one of presumptive approval, not presumptive medical denial.

When the case is referred to the Medical Review Team (MRT) for a final decision, the presumptive medical eligibility decision is made by the Worker, with approval of his Supervisor.

The guidelines for presumptive medical decisions based on medical and social information are found below. The definitions of incapacity, blindness, and disability follow.

In making a presumptive medical decision of incapacity or disability, the Worker uses the guidelines appropriate for the coverage group to determine if the medical/psychological impairment of the applicant is likely to last the required length of time. He then uses the social summary information to determine if the impairment:

- Prevents the incapacitated parent, age 18 and over, from working; or,
- Prevents the applicant under age 18 from functioning independently and effectively in an age-appropriate manner; or,
- Prevents the incapacitated parent from caring for himself or performing household duties and, therefore, requires the presence of the spouse in the home.

13.6.2 WHEN THE APPLICANT HAS RECEIVED SSI BASED ON DISABILITY OR BLINDNESS

When an individual whose SSI payment has terminated applies for Medicaid, and it is necessary to establish incapacity, disability, or blindness, the procedure is as follows:

- If it is verified that the SSI payment was terminated for some reason other than the lack of disability or blindness, medical eligibility is presumed prior to obtaining medical reports.
- The Worker then follows the usual procedures to obtain medical reports, complete the DFA-RT-1, Social Summary Outline and submits the case to the MRT for a final decision, etc. See Section 13.3 for instructions regarding completion of the DFA-RT-1.

13.6.3 GUIDELINES FOR PRESUMPTIVE MEDICAL DECISION OF BLINDNESS

To meet the definition of blindness, the client must have central visual acuity of 20/200 or less in the better eye with correcting glasses.

13.6.4 GUIDELINES FOR PRESUMPTIVE MEDICAL DECISION OF DISABILITY FOR SSI-RELATED MEDICAID AND M-WIN, AGE 18 OR OVER

13.6.4.A Definition of Disability

An individual, who is age 18 or over, is considered disabled if he is unable to engage in substantial gainful employment by reason of any medically determined physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.

13.6.4.B Role of the Worker in the Presumptive Medical Approval Process

Prior to referral to the MRT, the Worker must review the medical information to determine if the client's conditions meet any of the criteria for presumptive approval listed in Appendix A. If a client’s medical information does not meet the criteria for presumptive approval, but the Worker or Supervisor feels the client’s condition(s) is severe enough to warrant an immediate evaluation, he should submit the case to the MRT as soon as possible.

13.6.5 GUIDELINES FOR PRESUMPTIVE MEDICAL DECISION OF DISABILITY FOR SSI-RELATED MEDICAID AND M-WIN, UNDER AGE 18

13.6.5.A Definition of Disability

A child who is under age 18 is considered disabled if he has a physical or mental impairment that can be expected to last or has lasted for at least 12 months and is of comparable severity to that which qualifies an individual age 18 or over.

Comparable severity exists, provided the child is not engaged in substantial gainful activity, when the child's physical or mental impairment(s) so limits his ability to function independently, appropriately and effectively in an age-appropriate manner that the impairment(s) and the limitation(s) resulting from it are comparable to those that would disable an adult.

13.6.5.B Role of the Worker in the Presumptive Medical Approval Process

Prior to referral to the MRT, the Worker must review the medical information to determine if the client's condition meets any of the criteria for presumptive approval listed in Appendix B. If a client’s medical information does not meet the criteria for presumptive approval, but the Worker or Supervisor feels the client’s condition(s) is severe enough to warrant an immediate evaluation, he should submit the case to the MRT as soon as possible.

13.7 OBTAINING MEDICAL REPORTS

This section outlines procedural instructions for obtaining medical reports.

13.7.1 INITIAL MEDICAL REPORTS

13.7.1.A General Information About Providers

The instructions that follow apply to all requests for which the provider of the service bills the Department of Human Services (DOHS).

13.7.1.A.1 Providers Certified by DOHS

Requests for medical procedures and information must be made only to medical providers who have been certified for participation in DOHS's Medicaid program.

13.7.1.A.2 Out-of-State Providers Certified by DOHS

Only providers certified by the Bureau for Medical Services (BMS) are to be used to obtain initial medical reports. When necessary, the Worker must contact BMS to verify certification.

13.7.1.A.3 General Information for Completion of Medical Request Forms

The following forms are for requesting information when the provider will be billing the Department. Each contains instructions to the provider to attach the form to his billing.

- DFA-RT-5: General Medical Examination Report, Adults

NOTE: Even when the examining physician suggests an exam or report, the case must be submitted to the Medical Review Team (MRT) for authorization by an additional medical request. Diagnostic testing must also be requested by the MRT prior to authorization.

- DFA-RT-5a: General Medical Examination Report, Children
- DFA-RT-6: Medical Information/Diagnostic Request Letter

Used to request a general physical examination, eye examination, or an outpatient psychological exam. It must be used with DFA-RT-5 and DFA-RT-5a when a general physical examination is needed.

- DFA-RT-7: Specialist Consultation

  Used to obtain a consultation by a specialist at the request of the examining physician and/or the MRT.

NOTE: When the MRT requests an evaluation or consultation by any specialist including, but not limited to, a psychiatrist, cardiologist, orthopedist, etc., the DFA-RT-7 must be attached to the physician's billing form in order for payment to occur.

- DFA-RT-8: Request from Physician's Record

  Used to request a copy of medical information from a physician's records. This must be attached to the DFA-RT-8a in order for payment to occur.

- DFA-RT-8a: Physician's Summary

  Used to obtain the physician's recommendation to the MRT. When this form is used it must have the DFA-RT-8 attached.

- DFA-RT-9: Report from Hospital Records

  Used to request a copy of medical information from hospital records. Requests for special test results must be stated on the form.

- DFA-RT-10: Inpatient Diagnostic Services

  Used to request hospitalization for specific procedures. Prior approval from the MRT is required.

- DFA-RT-11: Physician's Hospital Services

  Used to request hospitalization for specific procedures. Prior approval from the MRT is required.

- DFA-RT-15: Request from Psychiatrist's Record

  Used to obtain medical information from a psychiatrist/psychologist. This must be included with the DFA-RT-15a and attached to the physician's billing form in order for payment to occur.

- DFA-RT-15a: Psychiatrist's Summary

Used to obtain the Psychiatrist's/Psychologist's recommendation to the MRT. When this form is used it must have the DFA-RT-15 attached.

13.7.1.A.4 General Instructions for Completion

Forms are to be completed as follows:

- Each form is prepared in duplicate. One copy is filed in the case record.
- The date, name, and address of the medical provider to whom the authorization is issued must be entered.
- The Worker must also include the address of the county office.
- Refer below for the number to enter as the case number.

13.7.1.A.5 Numbers Used on Medical Request Forms

The forms used for requesting medical examinations and reports are self-explanatory. For auditing and federal reimbursement reasons, the Medicaid Identification (MAID) number or the Pending Medicaid Number must be used for any medical information requested. The following explains the numbers and when each is used.

➢ *Pending Medicaid Number*

The number is 80 followed by seven zeros and the county number. For example, the Pending Medicaid Number for Kanawha County is 80-0000000.20. This number is used for an individual who is not a Medicaid recipient at the time the information is requested. This includes individuals who previously received Medicaid but are not current recipients.

➢ *MAID Number*

This is the number assigned by the eligibility system for Medicaid billing. This number is used when medical information is requested for a current Medicaid recipient only.

The local office must keep a log of all requests issued. The log must contain the following information:

- MAID number or Pending Medicaid Number and the county number;

- Case name;
- Client's name;
- Date of the request; and,
- Name of the provider to whom the request was sent.

13.7.1.B Obtaining Initial Medical Reports

The following forms and instructions are used by the Worker to obtain initial medical reports.

NOTE: Medical reports must be requested within seven days after the date of application. In addition, follow-ups must be done every 30 days, when the medical reports are not received.

13.7.1.B.1 DFA-PHI-1: Authorization for Information

When the instructions in the following sections specify that form DFA-PHI-1 is included with a request for medical information, the date entered on the form must be no earlier than one month prior to the date it is mailed. The name of the provider must be placed on the form prior to the client's signature.

13.7.1.B.2 Physician's or Psychiatrist's/Psychologist's Summaries

Form DFA-RT-8 and DFA-RT-8a are sent to request information from physicians and forms DFA-RT-15 and DFA-RT-15a are sent to request information from psychiatrists/psychologists. If the physician or mental health professional fails to complete the form, a second one must be sent. The date the second one is sent must be noted on the DFA-RT-2.

The Worker must indicate which sections of the form must be completed by the physician or psychiatrist/psychologist.

13.7.1.B.3 Initial Medical Report – Blindness

When an application is made for Medicaid due to incapacity or disability based on blindness, the Worker:

- Determines the ophthalmologist (MD/DO) of the client's choice who is an approved Medicaid provider;
- Makes an appointment with the ophthalmologist and notifies the client in writing of the date and time;
- Completes form DFA-RT-6 in duplicate with "Eye Examination and Report on the Enclosed Form" checked. The original is sent to the ophthalmologist, and a copy is filed in the case record; and,
- If the appointment is with an ophthalmologist, form DFA-B-13 is enclosed with the DFA-RT-6. The DFA-B-13a is a report form for the ophthalmologist.

13.7.1.B.4 Initial Medical Report, Incapacity and Disability

Sources of initial medical reports are listed in order of priority. The exception is, under some circumstances, when incapacity or disability is being established, medical reports are first requested from the Social Security Administration (SSA). See Section 13.7. If the SSA reports are not available, the Worker then obtains the reports as found below.

➢ *Medical Information Available in the Case Record*

The Worker should first consult the case record and review available medical information.

➢ *Medical Reports from Children with Special Health Care Needs Program (CSHCN) and the PAS-2005, Patient Medical Evaluation*

In the following situations, the only initial medical reports needed are those available in the case record:

- The applicant is currently receiving services from the CSHCN. In this case, copies of these medical reports are submitted to the MRT.
- The applicant is residing in, or planning to enter, a nursing home.

In both of the above situations, no other medical information is needed unless requested by the MRT.

➢ *Other Medical Information*

The case record is examined to determine if there are any past medical and/or psychological reports. If so, information that relates to the applicant's current impairment is submitted to the MRT along with current medical report(s).

➢ *Medical/Psychological Reports from the Division of Rehabilitation Services (DRS)*

When the applicant is referred to DOHS by the DRS, or reports that he is receiving DRS services, copies of the DRS medical reports must be obtained.

Under terms of the agreement between the DRS and DOHS, the DRS is expected to provide all available medical information when the DRS refers the client to DOHS.

Copies of medical reports are to be attached to the HS-3 used for the referral.

If medical reports are not attached to the HS-3, or if the client is not referred by the DRS, but reports that he is receiving services from them, the Worker must ask the DRS to forward available medical reports. The medical reports from the DRS will usually eliminate the need for any other initial medical information and may include copies of specialist's consultations, psychological evaluations, etc.

➢ *Reports from Hospitals and Physicians*

If the applicant has recently received medical treatment, or is currently receiving medical care, it may be possible to obtain copies of medical reports from the hospital or physician.

All requests are sent with form DFA-PHI-1, Authorization for Information, signed by the applicant. If the application is made for a child, the person who made the application signs the child's name and his own and indicates his relationship to the child.

➢ *Mental Hospitals*

If the client has recently been discharged from a mental hospital, the Worker must request a report about the individual's condition at the time of release.

If the client was in a West Virginia mental hospital, the Worker sends a memorandum to the Human Services Mental Health Coordinator in the county in which the hospital is located.

➢ *Veterans Affairs (VA) Hospitals and Clinics*

If the client has been in a VA hospital and/or is currently receiving, or has recently received, medical services from a VA clinic, the Worker sends the request for a copy of medical reports to the appropriate facility.

The letter is addressed as follows:

- For VA hospitals and outpatient clinics located in a VA hospital, write to Chief, Medical Information Services.
- For VA clinics located outside of a VA hospital, write to Chief, Medical Administration Services.

➢ *Private Hospitals, In-State and Border Facilities*

Form DFA-RT-9 is used to request reports from private hospitals. Special instructions for completion of the forms are as follows:

- The county office determines person to whom the form is addressed.
- There are spaces on the form to enter the applicant's hospital ID number, the dates the applicant was in the hospital, and the name of his physician. Entries are made as follows:
    - If the applicant cannot provide all the required information, the Worker completes as much of the information as possible.
    - None of the spaces are left blank. If the information is not known, "unknown" is entered in the indicated space.

➢ *Private Hospitals, Out-of-State Facilities*

The procedures are as follows:

- The Worker contacts BMS to determine if the facility is certified.
- If so, a DFA-RT-9 is prepared.

➢ *Physicians and Psychiatrists/Psychologists*

Form Letter DFA-RT-8 is used to request copies of medical records from a physician, and the DFA-RT-15 to request medical records from a psychiatrist/psychologist.

13.7.1.B.5 DFA-RT-5 and DFA-RT-5a

General physical examinations are arranged only when it is not possible to obtain the required medical information from any other source.

The general physical examination is made by a physician who is a general practitioner (family practice). The term "physician" refers to a medical practitioner who is either a medical doctor (MD) or a doctor of osteopathy (DO). The physician must have been approved for participation in the Bureau for Medical Services' (BMS) Medicaid Program.

Form DFA-RT-5 is the report form for adults; form DFA-RT-5a is used for children.

➢ *Procedures for Arranging for the General Physical Examination*

The procedures for arranging for the general physical examination are as follows. At intake, or when the Worker becomes aware that a general physical examination is needed, he:

- Completes the appropriate sections of the DFA-RT-5 or DFA-RT-5a; and
- Determines the client's physician of choice; and
- Determines if the individual wishes to make his own appointment or if his physician does not schedule appointments.
    - If the client prefers to have the Worker make the appointment, the Worker forwards the DFA-RT-5 or DFA-RT-5a with a completed DFA-RT-6 to the physician and notifies the client of the appointment time.
    - If the client prefers to make his own appointments, or the physician does not schedule appointments, the DFA-RT-5 or DFA-RT-5a and a completed DFA-RT-6 are given or mailed to the client. The DFA-RT-6 must be completed in duplicate with "General physical examination and report on enclosed form" checked.

13.7.1.B.6 Known Source of Medical Information Does Not Respond to Request

If a request for medical information has been issued and the physician and/or medical facility failed to respond in the allotted time frame, the Worker is to secure a general physical. The Worker does not deny a case due to failure of the physician and/or medical facility to provide the requested information.

13.7.2 EXCHANGE OF MEDICAL INFORMATION WITH THE SSA

DOHS and the SSA have an agreement to exchange information. The procedures are outlined below.

13.7.2.A Providing Medical Information to the SSA

Copies of medical information are provided to the SSA upon receipt of a written request. The client's signature is not required to be on the form.

If the individual is referred to the SSA for Supplemental Security Income (SSI) and/or Retirement, Survivors, and Disability Insurance (RSDI) based on disability, copies of medical/psychological information must be attached to the HS-3, provided that the HS-3 is mailed to the SSA Office. If the HS-3 is given to the client to take to the SSA Office, the medical reports will not be sent, unless a written request from the SSA is received.

13.7.2.B Requesting Medical Reports from the SSA

Upon receipt of a properly completed request, the SSA provides the Worker with copies of medical reports used to evaluate an individual's disability for purposes of SSI and/or RSDI, when such reports are available to the SSA District Office. The availability of the medical reports depends on the location of the individual's SSA claims file at the time the request from the Department is received.

13.7.3 ADDITIONAL MEDICAL REPORTS

Additional medical reports may be requested by: the MRT, the client, or the Hearings Officer. See Section 13.7 and Common Chapters Manual Chapter 700.

The Worker is responsible for obtaining the requested medical reports. The procedures for obtaining additional medical reports are the same as for obtaining initial reports.

NOTE: Additional medical reports must be requested within seven days after the receipt of the MRT's request.

When the additional medical reports are received, the Worker evaluates them for presumptive approval. See Section 13.6.

NOTE: The additional medical reports must be re-submitted to the MRT within seven days after receipt.

13.7.4 FAILURE TO KEEP MEDICAL APPOINTMENTS

Penalties for failure to keep medical appointments vary, depending on the point at which the non-compliance occurs. If the client has good cause for not keeping the appointment, another one is made.

Only cases involving the client's deliberate failure to provide necessary information are subject to adverse action. The client must be informed of the possible consequence at the time of appointment notification. The Worker must determine whether or not the client has good cause for failing to keep a medical appointment.

13.7.4.A Initial Medical Examination

If the DFA-RT-5, 5a, or DFA-B-13 is the only available medical information, and the applicant fails, without good cause, to keep the appointment, another appointment is not made. The application is denied using the appropriate reason code.

If the applicant who is making his own appointment fails to do so, without good cause, within two working days from the date he receives the DFA-RT-6, the application is denied.

If the physician does not schedule appointments, the application is denied if the client fails, without good cause, to go to the physician's office within one week from the date he received the DFA-RT-6.

13.7.4.B Appointments for Medical Examinations Requested by the MRT

If the MRT requests an additional medical examination, and the client fails to keep the appointment, without good cause, the application is denied, or the case is closed if it was a presumptive approval.

If the client has good cause, the Worker schedules another appointment.

When the Worker denies the application or stops the benefit, he must notify the MRT of the action. The Worker must record the action taken in the case record.

In addition, if the individual qualifies for Medicaid under a different coverage group that does not require a disability determination, his eligibility for that coverage group is not affected by his failure to keep a medical appointment.

NOTE: Failure of one person to keep medical appointments does not affect the eligibility of any other assistance group (AG) member, for example, completion of an SSI-Related Medicaid application for two people.

13.8 REFERRAL TO THE MEDICAL REVIEW TEAM (MRT)

13.8.1 THE MEDICAL REVIEW TEAM (MRT)

13.8.1.A MRT Composition

The MRT is located at the State Office in the Bureau for Medical Services (BMS), and is comprised of the following members:

- Licensed General Practitioners;
- Licensed Psychiatrist; and,
- MRT Coordinator.

13.8.1.B MRT Responsibilities

The MRT has the following responsibilities:

- Evaluate available medical and social information and determine if the individual is medically incapacitated, disabled, or blind. To determine disability, the MRT uses the Sequential Evaluation Process established by the Social Security Administration (SSA) for Supplemental Security Income (SSI) disability determinations.
- Evaluate WV WORKS recipients who maintain they are physically/mentally unable to participate in work activities, when the decision cannot be made by the Worker and/or Supervisor.
- Evaluate applicants for Medicaid Work Incentive (M-WIN) to determine disability or blindness.
- When the client has physical and mental disabilities/incapacities, notify the Worker of the MRT's decision using forms ES-RT-3 and/or DFA-RT-3M.

13.8.2 THE MRT REFERRAL AND THE FFM

During the MRT process, the Worker refers the client to contact the Federally Facilitated Marketplace (FFM) for consideration of medical coverage.

13.8.2.A Content and Organization of Material Submitted

The following items are required to submit a case to the MRT, and they must be arranged in the following order:

- DFA-RT-2;
- DFA-RT-1; and,
- Medical reports arranged in order from most recent to oldest. (For cases previously referred to the MRT, the old packet of material must be included with the new information, if available.)

13.8.2.B Cases Submitted to the MRT for Reevaluation

When a case is submitted for reevaluation of disability, incapacity, blindness, WV WORKS work requirement good cause, or M-WIN Medically Improved, the following materials must be included:

- DFA-RT-2;
    - If the MRT requested the reevaluation, the Worker must check the appropriate column and note the month the reevaluation is due in the comments section.
    - If the Worker is requesting reevaluation, the comment must explain the reason for the request.
- A current DFA-RT-1, Social Summary Outline, if the previous ES-RT-3 and/or DFA-RT-3M indicated one is needed. See Section 13.3 for instructions regarding completion of the DFA-RT-1;
- The latest ES-RT-3, and/or DFA-RT-3M;
- All material on which the original decision was based;

- The new information requested by the MRT for reevaluation purposes; and,
- Hearing summary if the MRT decision was reversed by the Hearings Officer on the issue of incapacity, disability, or blindness.

13.8.2.C Division of Rehabilitation Services (DRS) Referrals

When an individual is active with the DRS, the Worker requests medical reports from the DRS. These reports should be included in the material when sent to the MRT for evaluation.

13.8.2.D Fair Hearings

When a Hearings Officer reverses a decision of the MRT, it is the responsibility of the Hearing Officer to decide when the case is to be reevaluated and the information that will be needed. The Worker is to advise the MRT using form DFA-RT-2. A copy of the Hearing summary must be included in the material submitted to the MRT for the next reevaluation.

13.8.2.E Notifying the MRT of Eligibility Related Information

After a case is submitted to the MRT, the Worker must notify the MRT immediately if the client is found ineligible for any other reason other than failure to meet a spenddown or if the SSA makes a disability, blindness determination. The MRT must also be notified when a client moves to another county. If the pending MRT case is approved at the Marketplace, the Worker is notified. See Section 23.8.2.

13.8.3 Processes for Pending MRT Referrals

13.8.3.A Responsibilities of the Sending Local Office

The local office that sends the case must do the following:

- Send a message to the receiving local office about the case transfer and informing them there is a pending MRT referral;
- Make case comments in the eligibility system regarding the current case status, medical records that were requested, whether or not the information has been submitted to the MRT, and the final disposition of case and review date, if applicable;
- Complete the appropriate screens in the eligibility system;
- Forward all information regarding the MRT referral to the receiving local office (e.g., Social Summary, general physical, medical records, etc.);
- Forward any additional medical information received after the case is transferred to the receiving local office as it is received; and,
- Send a message to the MRT to notify them of the name of the local office to which the case was transferred for any case already submitted to the MRT.

13.8.3.B Responsibilities of the Receiving Local Office

The receiving local office must do the following:

- Review transferred cases to determine if a pending MRT referral exists;
- Schedule a general physical examination with a medical doctor (MD) or a doctor of osteopathic medicine (DO) if needed, for any person who has not already had an examination. The examination should be scheduled in the county in which the person now resides, if possible;
- Complete the MRT referral process. If additional information is required, contact the appropriate individual in the sending office; and,
- Make appropriate case comments and ensure that appropriate MRT screens are completed.

13.8.3.C Procedures Related to Hospital Workers

When the local office initiates an MRT referral, and the client is subsequently admitted to a hospital served by a Hospital Worker before the process is complete, the local office transfers all medical information, the social summary, etc. to the Hospital Worker, if the Hospital Worker

requests that information. The Hospital Worker is responsible for completing the MRT referral process.

When the Hospital Worker initiates the MRT referral process, he is responsible for working with the MRT until the process is completed. When the MRT process is complete, the Hospital Worker transfers all medical information to the appropriate local office.

13.9 APPLICATION PROCESS WHEN SSA DETERMINATION OF DISABILITY IS INVOLVED

At application, if the client is otherwise eligible, the Worker determines if the client has applied for Supplemental Security Income (SSI) and/or Retirement, Survivors, and Disability Insurance (RSDI) based on his disability. Procedures then depend on the status of a current application for SSI/RSDI or the results of a former application as follows.

13.9.1 APPLICANT IS CURRENTLY RECEIVING RSDI, BASED ON HIS OWN DISABILITY

In this situation, it is not necessary to obtain medical reports or to refer the case to the Medical Review Team (MRT). Disability is established.

13.9.2 SSA DECISION PENDING

When the applicant has applied for RSDI and/or SSI based on his disability and has not yet been notified of the result, or his application for RSDI and/or SSI has been denied due to lack of disability and he has appealed the decision, the Worker:

- Follows up to determine the results of the application and/or appeal.
- Processes the Medicaid application.
- Approves the application if an MRT decision that the client is disabled or blind is made prior to the final SSA decision becoming known to DOHS.
- If the SSA's decision on the individual's disability becomes known to the Worker before the Medicaid application is approved, the Worker takes one of the following actions:
    - If the individual is found eligible for SSI, an SSI Medicaid case is opened for him.
    - If the individual is found eligible for RSDI based on his disability and is not found eligible for SSI, the Worker approves the application based on disability or adds him to the assistance group (AG).
- If the final SSA decision is that the client does not meet the definition of disability for SSI or RSDI, except for disabled widow's benefits, the application is denied, or the individual is excluded from the AG. The application continues to be processed only if the disabled widow's benefits have been denied by the SSA.

- If the medical reports and social summary are with the MRT at the same time the above action is taken, the Worker notifies the MRT using form DFA-RT-2. If the case was referred for a blindness decision, the DFA-RT-2 must indicate whether or not a decision about blindness is still needed.

13.9.3 PROCEDURE WHEN DISABILITY IS DISALLOWED BY THE SSA PRIOR TO MEDICAID APPLICATION

When the Worker learns that the applicant has previously applied for SSI and/or RSDI and that his claim was denied by the SSA on the basis that the client was not disabled, the procedures are as follows:

- If the client states that there has been no deterioration in his condition since the SSA decision, and social information supports his statement, the application cannot be approved based on disability.
- If the client's statement and/or social information indicates that there has been a deterioration in his condition, the Worker:
    - Begins the process of obtaining medical reports, completing the Social Summary Outline (DFA-RT-1) and the DFA-RT-2, and sending the packet to the MRT. The hand-written form is acceptable only when an electronic version is unavailable. The DFA-RT-1 must include a clear explanation of the reason the client and/or the Worker believe that there has been a deterioration in his physical and/or mental condition.
    - Refers the client to the SSA for reevaluation or reconsideration of his eligibility for SSI or RSDI. See Chapter 8, Resource Development.
    - Approves the application if a referral to the SSA for reevaluation is not required, and the client is found to be disabled or blind by the MRT.
    - Follows the procedures used when a claim is pending a final SSA decision, if a referral is made to the SSA for reevaluation.

13.10 ACTION FOLLOWING THE RECEIPT OF THE FINAL MRT DECISION

Upon receipt of the notification of the MRT's final decision, the Worker records receipt of the form and the decision in the eligibility system. Additional action depends on the content of the information on the notification form.

13.10.1 SSI-Related Medicaid and Medicaid Work Incentive (M-WIN)

13.10.1.A Client Is Blind or Disabled

If the applicant was found to be disabled or blind and the case was not presumptively approved, then the application is approved, or the individual is added to the assistance group (AG), whichever is appropriate.

If the case was presumptively approved, or the individual was already added, a recording of the final decision must be made in the eligibility system.

13.10.1.B Client Is Not Blind or Disabled

If the applicant is found not to be disabled or blind, the application is denied, the case is closed, or the individual is excluded from the AG after advance notice.

A copy of the ES-RT-3 and/or DFA-RT-3M must be attached to the notification letter sent to the client.

13.10.2 WV WORKS

13.10.2.A Parent Is Incapacitated

If the ES-RT-3 and/or DFA-RT-3M indicates the parent is incapacitated, and the case was not presumptively approved, the application is approved.

If the case was presumptively approved, a recording of the final decision is made in the eligibility system.

13.10.2.B Parent Is Not Incapacitated

If the ES-RT-3 and/or DFA-RT-3M indicates the parent is not incapacitated, eligibility for other Medicaid is evaluated.

A copy of the ES-RT-3 and/or DFA-RT-3M is attached to the client notification letter.

13.10.2.C WV WORKS Good Cause for Not Participating in Work Activities

13.10.2.C.1 Individual Is Incapacitated

If the ES-RT-3 and/or DFA-RT-3M indicates the individual is incapacitated, the individual is temporarily given good cause for not participating in work activities for the period of time

NOTE: Even though the MRT was involved in the determination of incapacity, the Worker and/or Supervisor may make the determination at the subsequent reevaluation(s). However, once a decision is made by the MRT, it cannot be overridden by the Worker and/or Supervisor until the MRT good cause period expires or additional medical information is received. When the Worker and/or Supervisor make the decision upon reevaluation, the MRT must be notified by memorandum.

determined by the MRT, not to exceed 12 months. A reevaluation must be completed at the end of the good cause period or by the end of the 12th month, whichever is earlier.

13.10.2.C.2 Individual Is Not Incapacitated

If the ES-RT-3 and/or DFA-RT-3M indicates the individual is not incapacitated, the individual is not given good cause for not participating in work activities. The client must be contacted immediately to begin participation.

A copy of the ES-RT-3 and/or DFA-RT-3M is attached to the client notification letter.

13.10.3 ACTION WHEN THE MRT DECISION CONFLICTS WITH THE SSA DECISION

When the MRT disability or blindness decision conflicts with the decision made by the SSA, follow the procedures outlined in Section 13.10 for SSI-Related Medicaid and M-WIN.

13.10.4 ACTION WHEN THE WORKER AND SUPERVISOR DISAGREE WITH THE MRT'S DECISION TO DENY

If the Worker and Supervisor disagree with the MRT's decision to deny incapacity, disability, or blindness, the case is submitted to the MRT for reconsideration. An explanation of why the Worker and Supervisor disagree with the denial is entered on the DFA-RT-2.

13.11 CLIENT'S RIGHTS IN THE DETERMINATION PROCESS

13.11.1 CLIENT'S RIGHT TO AN ADDITIONAL MEDICAL REPORT

If the client requests a second medical examination, either during the application, reevaluation or Hearing process, such examination must be provided and paid for by the Department of Human Services (DOHS).

If the client does not secure the additional medical report within 90 days, the application is processed using the medical reports that were originally obtained.

In the following instances an individual in an active assistance group (AG) is entitled to an additional medical report at the Department's expense after the Medical Review Team (MRT) makes a negative decision about continuing medical eligibility:

- If only one medical report was used in making the MRT decision; or
- If a new medical report, in addition to previous reports, is used in making the negative decision, and it is the new one that causes ineligibility.

The Worker must notify the client of the availability of this service and the impending case closure or removal of the client from the case. An DFA-NL-C or appropriate letter from the eligibility system is used for client notification.

13.11.2 PROCEDURE AFTER THE CLIENT'S DECISION TO REQUEST AN ADDITIONAL MEDICAL REPORT

The Worker's action after the client makes a decision to request an additional medical report at DOHS's expense depends upon the client's request. The possibilities are as follows:

- If the client does not request the additional medical report or does not make a timely (13 days) response to the notification, the Worker closes the AG or removes the client from the AG.
- If the client requests the additional medical report and responds within the time limit of the DFA-NL-C or the eligibility system notice, the Worker does not take any action until notified by the MRT that a second decision has been made. If action is required, follow these procedures:

- If the original MRT decision is upheld, the Worker takes the action indicated on the original DFA-NL-C or the eligibility systems notice. No additional 13-day notice period is required.
- If the original MRT decision is reversed, the Worker takes the action indicated on the new ES-RT-3 and or DFA-RT-3M.

13.11.3 CLIENT'S RIGHT TO AN MRT RECONSIDERATION

Following a negative decision by the MRT, the client may request a reconsideration on the medical evidence originally presented. This reconsideration may also include any additional medical reports the client may provide.

The Worker holds the application pending, leaves the active AG open or leaves the individual in the AG, whichever is appropriate, until notified by the MRT.

The Worker's action following the final MRT decision is as follows:

- If the original MRT decision is upheld, the Worker denies the application, closes the AG, or removes the individual from the AG.
- If the original MRT decision is reversed, the Worker approves the application, leaves the AG active, or leaves the individual in the AG. A recording in the eligibility system is required.

13.11.4 CLIENT'S RIGHTS IN THE FAIR HEARING PROCESS

In addition to all other reconsiderations, the client has the right to request a Fair Hearing. See Chapter 700 in Common Chapters.

This step is usually taken after the second medical report paid for by DOHS, and the reconsideration by the MRT, but the client may choose to bypass either or both of these steps and go directly to a Fair Hearing.

The Hearings Officer may, at any point after the client requests a Hearing, request a second medical report, additional medical reports, or a reconsideration by the MRT. The Worker is responsible for arranging any such reports.

13.12 PROCEDURES WHEN SSA FINAL DISABILITY DECISION IS MADE AFTER MEDICAID APPROVAL

When the SSA's disability decision becomes known after the Medicaid application is approved, the procedure is as follows.

13.12.1 CLAIM DISALLOWED

If Medicaid eligibility cannot be based on disability, the Worker needs to reevaluate the client for other Medicaid coverage groups.

NOTE: If the client appeals the SSA decision, the reevaluation on the Medicaid case is delayed until the results of the appeal are known.

13.12.2 CLAIM APPROVED

When the client's claim for Supplemental Security Income (SSI) and/or Retirement, Survivors, and Disability Insurance (RSDI) based on his disability is approved after the Medicaid application is approved, the procedure is as follows:

- If the Medicaid recipient becomes eligible for SSI, an SSI Medicaid case is opened for him.
- If the Medicaid application was approved on a presumptive basis and the medical reports and social summary are with the Medical Review Team (MRT), the MRT must be informed that the client has been approved for SSI.
- If the Medicaid recipient becomes eligible for RSDI, but not for SSI, the application was approved presumptively, and a final decision of the MRT has not been received, the MRT must be notified.

13.13 REEVALUATION OF DISABILITY, INCAPACITY OR BLINDNESS

At the time of the initial approval of blindness, incapacity, or disability, the Medical Review Team (MRT) determines whether or not the client's circumstances require a reevaluation of his medical condition. If a reevaluation is required, the Worker is responsible for providing the medical or social information needed by the MRT. The MRT reevaluation decision is noted on the ES-RT-3 and/or the DFA-RT-3M.

If the client continues to receive Medicaid in a category that requires a disability determination, and continues to cooperate with the scheduled MRT reevaluation process, then the most recent MRT determination that the client is disabled, incapacitated, or blind is considered as established and continues until the MRT determines otherwise, and issues a decision.

The client should no longer be coded as disabled by MRT in the eligibility system when the client begins receiving Medicaid in a category that does not require a disability determination.

13.14 REAPPLICATIONS

If the client reapplies for Medicaid within 90 days of the Medical Review Team's (MRT) decision, the application is denied by the Worker on the basis that the client is not disabled, blind, or incapacitated. This action is taken only when the applicant does not request a new medical examination, does not present any new or different information, and the Worker has no reason to question the original decision.

See Chapter 1. These applicants are treated as new applications and the Worker follows the steps outlined in Section 13.4.

13.15 ESTABLISHING DISABILITY AND FITNESS FOR EMPLOYMENT FOR THE SNAP PROGRAM

13.15.1 INTRODUCTION

Disabled means the individual is unfit to engage in full-time employment due to a physical and/or mental disability.

There are several different SNAP policies that require a determination of physical and/or mental disability. The policies that require a disability determination are listed below, followed by a citation.

- Medical deduction provision in Section 4.4.
- Asset policy in Section 5.4.
- 24-month certification policy for elderly and/or disabled adults in Section 1.4.
- Elderly or Disabled provision for removal of the shelter/utility cap in Section 4.4.
- Elderly or Disabled provision for use of net income test in Section 4.4.
- Group Living Facility (GLF) policy in Section 3.2.
- Elderly and disabled separate assistance group (AG) provision. See Section 3.2 for establishing disability.

13.15.2 ESTABLISHING A CLIENT AS DISABLED

Disabled means the individual is receiving one of the following:

- Supplemental Security Income (SSI)
- Social Security Disability benefits
- Federally or State-administered supplemental benefits under section 1616(a) of the Social Security Act based on disability or blindness criteria under Title XVI of the Social Security Act
- Federally or State-administered supplemental benefits under section 212(a) of Pub. L. 93-66
- Disability retirement benefits from a government agency based upon a permanent

disability

- VA disability benefits rated by the VA as total or paid as total
- VA aid and attendance or housebound benefits, either as a veteran or as a surviving spouse
- Surviving spouse or surviving child benefits of a veteran when the individual has a disability considered permanent
- Annuity payment under Railroad Retirement Act of 1974 and is eligible for Medicare through Railroad Retirement and is determined disabled
- Interim assistance benefits pending receipt of SSI
- Disability related medical assistance under Title XIX (Medicaid based upon disability)
    - Eligible Medicaid categories: SSI, Disabled Adult Children, Substantial Gainful Activity, Essential Spouses, Pass-Throughs, Pickle Amendment Coverage, Disabled Widows and Widowers, Drug Addicts and Alcoholics, SSI-Related, Medicaid Work Incentive Network (M-WIN), Nursing Home, Aged and Disabled Waiver,
    - Intellectual/Developmental Disabilities, Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID), Traumatic Brain Injury (TBI), Children with Disabilities Community Service Program (CDCSP), Non-citizen Emergency Medicaid,
- State general assistance benefits based on disability or blindness

NOTE: For individuals who may qualify due to receiving disability retirement benefits from a government agency or receiving surviving spouse or surviving child benefits of a veteran when the individual has a disability considered permanent, the list of conditions considered permanent are established by the Social Security Administration's most current Listing of Impairments – Adult Listings (Part A)

13.15.3 ESTABLISHING A CLIENT AS UNFIT FOR EMPLOYMENT

This policy applies only to student policy, SNAP work requirements, and Able-Bodied Adults Without Dependents (ABAWD) policy.

- A client who meets the definition of disability is considered to be unfit for employment. No other verification is needed.

- A client who does not meet the definition of disability should be evaluated for fitness for employment. If it is clearly obvious to the worker that the client is unfit for employment, the worker must seek supervisory approval prior to providing the unfit exemption. The supervisor or senior worker must provide the approval. If approved by a supervisor or senior worker, no further verification is needed, but thorough case comments from the supervisor or senior worker must be entered explaining why the client is obviously unfit for employment.

- A client who does not meet the definition of disability and is not obviously unfit for employment will be requested to provide written verification from a licensed medical professional that the client is unfit for employment.

> **Unfit for Employment Example 1:** During the interview with the client, the worker notices that the client has few or no teeth and a lack of access to regular personal hygiene, which would prevent the individual from being able to find employment. The worker could exempt the client due to being unfit for employment, if the supervisor or senior worker agrees an unfit designation is necessary.
>
> **Unfit for Employment Example 2:** During the interview with the client, the worker notices that the client's thoughts and attention seem to be very scattered and the individual is unable to focus or complete basic fundamental tasks or answer questions. The worker could exempt the client due to being unfit for employment, if the supervisor or senior worker agrees an unfit designation is necessary.
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APPENDIX A: PRESUMPTIVE MEDICAL APPROVAL – SSI-RELATED MEDICAID AND M-WIN, AGE 18 OR OLDER

When the individual's medical condition or diagnosis is not listed in this Appendix, refer to Section 13.6 regarding the presumptive approval process.

A.1 DISABILITY OF THE SKELETAL SYSTEM AND MUSCLES

The severity is determined by a physical examination, laboratory tests, and x-rays. The following are examples of disability of the skeletal system and muscles that would result in a presumptive medical approval:

- Rheumatoid arthritis with a history of joint pain, swelling of major joints, and limitation of motion of joints.
- Severe osteo or degenerative arthritis resulting in limitation of motion of both hips or both knees, or a combination of one hip or one knee. Severity results in difficulty in ambulation and may necessitate surgery (arthrodesis) of the hip and knee.
- Injuries to the spine with cord involvement, resulting in paraplegia or quadriplegia.
- Amputation of two limbs, amputation of a leg at the hip, or amputations due to vascular insufficiency or diabetes mellitus, with inability to use a prosthesis effectively.
- Non-union of a fracture of a major extremity, requiring continuing surgical management, with function not expected to be restored fully.
- Osteomyelitis of a major joint, as confirmed by x-ray, with persistent drainage, swelling, and redness that has not responded to medical treatment.
- Cerebral palsy, muscular dystrophy, or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.

A.2 DISEASES OF THE RESPIRATORY SYSTEM

These are confirmed by x-ray spirometry or pulmonary function studies, in addition to physical examination. The following are examples of diseases of the respiratory system that would result in a presumptive medical approval:

- Active pulmonary tuberculosis, verified by a positive culture and x-ray, that is expected to result in at least a 12-month disability.
- Severe chronic obstructive pulmonary disease (C.O.P.D.), or pneumoconiosis.
- Cor Pulmonale, enlargement of the right ventricle of the heart due to respiratory disease, in combination with congestive heart failure.

A.3 DISEASES OF THE HEART

Diseases of the heart will be established through physical examination, x-ray, electrocardiogram (EKG), treadmill tests, and other appropriate tests for cardiac function. The following are examples of diseases of the heart that would result in a presumptive medical approval:

- Congestive heart failure with cardiac enlargement, vascular congestion or pulmonary edema.
- Angina pectoris, confirmed by abnormal resting EKG, with chest pain relieved by nitroglycerin.
- Persistent heart block with recurrent arrhythmia as confirmed by abnormal EKGs.
- Two myocardial infarctions within a six-month period, necessitating use of nitroglycerin to relieve chest pain.

A.4 KIDNEY DISEASE

This is based on laboratory findings and a urological examination. The following are examples of kidney disease that would result in presumptive medical approval:

- Kidney disease, resulting in the need for removal of one kidney, and treatment of disease in the remaining kidney.
- Kidney disease requiring the need for a dialysis machine or renal transplant.

A.5 DISEASES OF THE BLOOD

This is confirmed by laboratory findings and physical examination. The following are diseases of the blood that would result in a presumptive medical approval:

- Acute leukemia, as established by bone marrow examination or blood smear.
- Chronic leukemia with recurrent hemorrhaging, low blood platelet count or organ enlargement.
- Human Immunodeficiency Virus (HIV) infection with T-cell CD4 count under 400.

A.6 NEUROLOGICAL DISORDERS

This must be confirmed by physical examination, preferably by a neurologist, with appropriate testing. The following are examples of neurological disorders that would result in a presumptive medical approval:

- Cerebrovascular accidents, with speech impairment or paralysis of two extremities, continuing for a period of four months after the stroke.
- Parkinson's Disease with tremor, rigidity and impairment of mobility.
- Cerebral Palsy with I.Q. of 59 or less, with speech impairment, motor deficiency in two extremities, or poor muscular coordination (ataxia).
- Multiple Sclerosis with moderate motor deficits in two extremities or poor muscular coordination (ataxia).
- Muscular Dystrophy with an incoordinate weakness or paralysis of shoulder area and limitation of arm motion.

A.7 MENTAL DISORDERS

These must be verified by psychological testing or psychiatric examination. The following are examples of mental disorders that would result in a presumptive medical approval:

- Chronic brain syndrome with a deterioration in intellectual functioning, such as marked memory defect or slow, confused or disoriented thinking.
- Chronic Schizophrenia with persistent depression, hallucinations, withdrawal from daily activities or illogical association of ideas.
- Mental deficiency with I.Q. of 59 or less, as established by psychological testing. If the I.Q. is above 59, there must be a combination of low I.Q. and another documented mental or physical impairment.

A.8 MALIGNANT DISEASES

These must be documented by physical examination, laboratory findings and post-operative notes, if available. The following are examples of malignant diseases that would result in a presumptive medical approval:

- Cancer of any organ of the body that has been diagnosed by a physician as being inoperable and not expected to respond to radiation or chemotherapy.
- Cancer that has spread from one organ of the body to another (metastasis), such as cancer of the lung that has spread to the brain.
- Recurrence of cancer after the initial successful treatment, with a medical opinion that the second treatment period will require at least 12 months.

A.9 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

This must be documented by a physical examination and laboratory findings. The following are examples of AIDS that would result in a presumptive medical approval:

- HIV Positive and diagnosed by a physician as having AIDS based on the patient's having a disease indicative of AIDS or a T-helper/inducer lymphocyte (T-cell CD4) count under 400.
- Some common indicator diseases are: pneumocystis carinii, Kaposi’s sarcoma, bacterial infections, HIV encephalopathy, and lymphoma of the brain.

APPENDIX B: PRESUMPTIVE MEDICAL APPROVAL – SSI-RELATED MEDICAID AND M-WIN, UNDER AGE 18

When the individual's medical condition or diagnosis is not listed in this Appendix, refer to Section 13.6 regarding the presumptive approval process.

B.1 MUSCULOSKELETAL SYSTEM DISORDERS

This must be confirmed by a pediatrician or orthopedist with x-rays. The following are examples of musculoskeletal system disorders that would result in a presumptive medical approval:

- Juvenile rheumatoid arthritis with joint inflammation, significant limitation of motion of two major joints or severe deformity of two major weight-bearing joints.
- Congenital deformities of the musculoskeletal system, such as dislocation of the hip, in that walking is possible only with crutches or a walker.

B.2 DISORDERS OF THE SPINE

This must be confirmed with reports from an orthopedist or pediatrician. The following are examples of disorders of the spine that would result in a presumptive medical approval:

- Fractured vertebra with spinal cord involvement, resulting in paralysis.
- Scoliosis with spinal curve measuring 60 degrees or greater, established by physical examination and x-ray.
- Chronic osteomyelitis, as confirmed by x-ray, with persistent drainage, despite treatment.

B.3 RESPIRATORY IMPAIRMENTS

This must be confirmed by physical examination, x-ray, and/or pulmonary function studies. The following are examples of respiratory impairments that would result in a presumptive medical approval:

- Bronchial asthma with recurrent intense attacks, or persistent prolonged wheezing and x-ray findings of bronchial disease.
- Cystic Fibrosis with poor response to treatment, diagnosed by specific laboratory tests.

B.4 CARDIOVASCULAR IMPAIRMENTS

This includes congenital or acquired heart disease, involving the arteries, valves, or cardiac muscles, as established by a cardiologist or pediatrician. The following are examples of cardiovascular impairments that would result in a presumptive medical approval:

- Chronic congestive heart failure with tachycardia and cardiac enlargement, or retention of pulmonary fluid and intolerance for exercise.
- Cyanotic congenital heart disease requiring surgery, with symptoms of dizziness, bloody sputum, and bluish discoloration of the skin.
- Cardiac arrhythmia, such as persistent or recurrent heart block and symptoms, such as exercise intolerance or pulmonary hypertension.
- Chronic rheumatic fever with heart enlargement and significant heart murmur.

B.5 DISORDERS OF THE DIGESTIVE SYSTEM

These may interfere with nutrition and growth of the child and are disabling, if treatment may be expected to extend to a 12-month period. The following are examples of disorders of the digestive system that would result in a presumptive medical approval:

- Chronic liver disease with destruction of the liver, or coma.
- Chronic bowel disease such as ulcerative colitis or regional enteritis.

B.6 URINARY DISORDERS

This must be evaluated by a pediatrician or urologist. The following are examples of urinary disorders that would result in a presumptive medical approval:

- Chronic renal disease resulting in the need for treatment over a 12-month period, or loss of one kidney and disease in the remaining kidney.

- Use of a dialysis machine.
- Need for renal transplant.

B.7 DISORDERS OF THE BLOOD

The following are examples of disorders of the blood that would result in a presumptive medical approval:

- Sickle cell disease with a severe, persistent anemia.
- Coagulation defects such as hemophilia, documented by laboratory tests with spontaneous bleeding or bleeding deformity.
- Acute leukemia as diagnosed by blood examination, bone marrow tests and lymph node biopsy.

B.8 GLANDULAR DISTURBANCES

These may result in growth impairments. Disability must be documented by laboratory tests and physical examination. The following are examples of glandular disturbances that would result in a presumptive medical approval:

- Thyroid disorders requiring a treatment of 12 months or longer, with impairment of growth.
- Insufficiency of the adrenal gland with episodes of circulatory collapse.
- Juvenile diabetes with poor response to insulin and difficulty with control, necessitating recent, recurrent hospitalization.
- Pituitary dwarfism with hormone deficiency documented by laboratory tests.

B.9 SEVERE CONGENITAL ABNORMALITIES IN NEWBORNS

These conditions may include severe mental and/or physical abnormalities that will necessitate total care for the life expectancy of the child.

B.10 NEUROLOGICAL DISORDERS

The following are examples of neurological disorders that would result in a presumptive medical approval:

- Major motor seizures (grand mal epilepsy) with documented recurrent seizures, despite medical treatment.
- Brain tumors that are either malignant or benign, with symptoms of motor dysfunction involving two extremities and difficulty with ambulation.
- Cerebral Palsy with motor dysfunction involving two extremities and difficulty with ambulation.
- Meningomyelocele (defect of the spinal column), resulting in motor dysfunction and urinary or fecal incontinence.
- Hydrocephalus that has not been treated or has not responded well to treatment, and that interferes with mental or physical development.

B.11 HEARING IMPAIRMENTS

The following are examples of hearing impairments that would result in a presumptive medical approval:

- Deafness with little or no response to a hearing aid and with associated speech defects.

B.12 EMOTIONAL AND MENTAL DISORDERS

This must be diagnosed by a physical examination, psychological testing, or psychiatric examination. The following are examples of emotional and mental disorders that would result in a presumptive medical approval:

- Mental retardation with an I.Q. of 59 or less as documented by psychological testing using intelligence tests for children. If the I.Q. is above 59, disability must also include another physical or mental impairment.

- Children with Down's syndrome as diagnosed by chromosome tests. These children are mentally retarded and may also have cardiac or pulmonary problems, along with growth retardation.
- Childhood psychosis, such as schizophrenia, must be documented by psychiatric reports. Symptoms include withdrawal from reality, bizarre behavior, panic or severe anxiety.

B.13 MALIGNANCIES

This must be diagnosed by physical examination, laboratory tests, x-rays, and post-operative surgical reports, if the child has had recent surgery. The following are examples of malignancies that would result in a presumptive medical approval:

- A diagnosis of cancer requiring a combination of surgery, radiation and chemotherapy that will result in disability for the child from both the carcinoma and the side effects from the treatment.
- A diagnosis of carcinoma that has spread from the primary site to another major organ of the body (metastasis).
- Cancer that has responded to treatment but has since recurred and will require a new treatment plan.

B.14 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

This must be documented by physical examination and laboratory findings. The following are examples of AIDS that would result in a presumptive medical approval:

- Human immunodeficiency virus (HIV) positive and diagnosed by a physician as having AIDS based on the patient's having a disease indicative of AIDS or a T-helper/inducer lymphocyte (T-cell CD4) count under 400.

Some common indicator diseases are: pneumocystis carinii, Kaposi’s sarcoma, bacterial infections, HIV encephalopathy, and lymphoma of the brain.

APPENDIX C: PRESUMPTIVE APPROVAL – WV WORKS

When the individual's medical condition or diagnosis is not listed in this Appendix, refer to Section 13.6 regarding the presumptive approval process.

C.1 INCAPACITIES OF THE SKELETAL SYSTEM

The severity is based on physical examination, laboratory tests, and x-rays. The following are examples of incapacities of the skeletal system that would result in a presumptive medical approval:

- Ruptured disc requiring conservative bed rest and traction, or surgery. Diagnosis should be confirmed by an orthopedist or neurosurgeon.
- Simple fracture of the arm or leg with a physician's report and x-rays.
- Amputations requiring healing time and period of adjustment, with prosthesis.

C.2 DISEASE OF THE HEART

This must be diagnosed by medical examination, x-rays, electrocardiogram (EKG), and other appropriate cardiac function studies. The following are examples of diseases of the heart that would result in a presumptive medical approval:

- Myocardial infarction as confirmed by physical examination and EKG.
- Acute rheumatic heart disease evaluated by a cardiologist or internist and necessitating a period of medical treatment prior to returning to work.

C.3 GENERAL SURGICAL PROCEDURES

This must be recommended by a surgeon through physical examination and appropriate laboratory tests. The following are examples of general surgical procedures that would result in a presumptive medical approval:

- Peptic, gastric, duodenal or jejunal ulcer requiring surgical intervention and recovery period.

- Hernia, if surgical repair is needed, as confirmed by physical examination.
- Splenectomy due to traumatic injury.
- Diverticulitis or polyps of the bowel requiring surgical intervention.
- Cholecystectomy due to gall bladder disease.
- Hysterectomy if needed in the treatment of fibrous tumors through removal of the uterus.
- Appendectomy due to inflammation of the appendix.

C.4 DISEASE OF THE ENDOCRINE SYSTEM

This requires physical examination and laboratory tests. The following are examples of diseases of the endocrine system that would result in a presumptive medical approval:

- Hyperthyroidism or goiter resulting in the need for surgery or radioactive iodine as a part of the treatment plan.
- Brittle diabetes with poor control requiring a short-term incapacity period for stabilization of insulin.

C.5 NEUROLOGICAL DISORDERS

This must be confirmed by a neurologist or neurosurgeon with electroencephalogram (EEG), if indicated, and other appropriate tests. The following are examples of neurological disorders that would result in a presumptive medical approval:

- Epileptic seizures that have not responded to medication and require a short period of time for medical control.
- Cerebral concussion with residual effects lasting 30 days or longer.
- Nerve injuries due to trauma and requiring neurosurgery.

C.6 MENTAL ILLNESS

Mental illness must always be diagnosed by a psychiatrist, and mental retardation must be established through psychological testing. The following are examples of mental illness that would result in a presumptive medical approval:

- Acute schizophrenic reaction that is expected to respond to psychotherapy and medication.
- Mental retardation with an I.Q. of 65 or less, as documented with psychological testing.

C.7 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

This must be documented by physical examination and laboratory findings. The following are examples of AIDS that would result in a presumptive medical approval:

- Human immunodeficiency virus (HIV) positive and diagnosed by a physician as having AIDS based on the patient's having a disease indicative of AIDS or a T-helper/inducer lymphocyte (T-cell CD4) count under 400.
- Some common indicator diseases are pneumocystis carinii, Kaposi’s sarcoma, bacterial infections, HIV encephalopathy, and lymphoma of the brain.

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Work Requirements
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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
14.1	7/1/18	761	14.1	Clarified that SNAP clients must be at least 16 years old to volunteer for SNAP E&T
14.2	11/1/25	870	14.2.1.B	Added sub-bullet to age exemption.
14.3				
14.4				
14.5				
14.6				
14.7				
14.8	12/1/17 7/1/18 4/1/19 9/1/20 4/1/22	747 761 777 792 819	14.8.2 14.8.1 & 14.8.2 14.8.2 14.8.2 18.8.1	Added sanction information for providing false information on the DFA-WVW-DAST-1. Added clarification Clarified that false information must be from evidence, not hearsay. Notice may be manual, or system generated Update procedures for sanctions
14.9	4/1/19 7/1/21 6/1/22	770 806 822	14.9.1.A 14.9 14.9.1.B	Clarified that age of child good cause may only be given for 12-week post-partum following a positive drug test. Removed the five-day eligibility period Changed Domestic Violence to sexual harassment & domestic violence, sexual assault, and stalking.
14.10				
14.11				

14.1 INTRODUCTION

This chapter details work requirements for Supplemental Nutrition Assistance Program (SNAP) benefits, WV WORKS and Medicaid. It designates the member(s) of the assistance group (AG) to whom the requirements apply and the penalty or sanction for failure to meet the requirements. This chapter also discusses good cause.

There are no work requirements for the Medicaid Program.

For requirements and responsibilities related to the SNAP Employment and Training Program (SNAP E&T), see Chapter 17. All SNAP clients at least 16 years old may volunteer for SNAP E&T.

14.2 GENERAL SNAP WORK REQUIREMENTS AND EXEMPTIONS

All Supplemental Nutrition Assistance Program (SNAP) clients are subject to a work requirement, unless exempt. Two separate and distinct policies described in this section define these work requirements and the exemptions from these requirements.

14.2.1 SNAP WORK REQUIREMENTS FOR NON-WV WORKS CLIENTS

The following work requirements apply to all SNAP clients who:

- Do not receive and/or are disqualified from WV WORKS; or
- Do not receive WV WORKS but do receive SNAP benefits in the same SNAP assistance group (AG) with WV WORKS clients.

The work requirements found in this section (Section 14.2.1 only) also apply to Able-Bodied Adults Without Dependents (ABAWD). These work requirements are in addition to, rather than a substitution for, the ABAWD work requirements.

NOTE: Applications which qualify for Expedited Service may require special considerations in meeting work requirements. See Section 1.4.

NOTE: When an applicant is ineligible until he meets one of the following requirements, this period of ineligibility does not count as a penalty period.

14.2.1.A Work Requirements

- Registration with WorkForce West Virginia

  Details are in Section 14.3 Failure of an individual to register within the time limits found in Section 14.3 and each 12 months thereafter, results in application of a penalty for not meeting the work requirement.

- Voluntary Quit, including Voluntary Reduction in hours

  Details are in Section 14.4. A voluntary quit or reduced hours of employment without good cause results in a period of ineligibility for non-exempt applicants and non-exempt

clients. The applicant who takes either of these actions is ineligible for the month of application and two calendar months following the month of application or until he reports a change which makes him exempt from the SNAP work requirement. This three-month period of ineligibility is not counted as one of the applicant's SNAP penalties.

Voluntarily quitting employment after becoming a client results in application of a SNAP penalty for failure to meet the work requirement. Neither an applicant nor a client may be required to return to the same or comparable employment before eligibility is reestablished. Work-requirement eligibility is reestablished at the end of the three-month period of ineligibility for applicants, or at the end of the appropriate penalty period for clients, unless they report their exempt status earlier.

- Refusal of Employment

  Details are in Section 14.5. Applicants who refuse an offer of employment are ineligible to be included in the AG until they accept employment, or until they report a change that makes them exempt from the SNAP work requirement. Refusal of employment by non-exempt clients results in a penalty for failure to meet the work requirement.

- Providing Information about Employment Status and Job Availability

  Details are in Section 14.5. Refusal to provide information about employment and job availability to WorkForce West Virginia and/or the SNAP Employment and Training program (SNAP E&T) results in ineligibility for the non-exempt individual. The applicant who fails to provide such information is ineligible until the information is provided or he reports a change that makes him exempt. A client's failure to supply this information results in a penalty for failure to provide information about employment and job availability.

14.2.1.B Exemptions from SNAP Work Requirements

NOTE: The SNAP work requirements are waived for individuals who complete a joint SNAP/Supplemental Security Income (SSI) application at the Social Security Administration (SSA) office until SSI eligibility is determined. See Section 1.4.17.

The following SNAP clients are exempt from the SNAP work requirements and are not subject to a SNAP penalty for failure to comply:

- A person under age 16.
- A person age 16 or 17 who is not the SNAP payee or primary person.

> **SNAP Work Requirement Exemption Example 1:** An AG consists of two 17-year olds, Ms. Peony and Mr. Orchid. Ms. Peony is designated as the primary person and SNAP payee. She is, therefore, subject to the work requirements, unless another exemption is met. Mr. Orchid is exempt from the work requirements.

- A person age 16 or 17 who is attending school or enrolled in an employment training program on at least a half-time basis.
- A person enrolled at least half-time in any recognized school, recognized training program, or institution of higher education. If enrolled in an institution of higher education, the student must meet one of the exceptions to the restriction on student participation listed in Section 3.2. This exemption continues through normal periods of vacation, unless the person does not intend to register for the next term, excluding summer terms.
- A person age 60 or over.
    - Individuals age 60 but not yet 65 are exempt from SNAP Work Requirements but may have to comply with ABAWD work requirements if another exemption does not exist.
- A parent, or other member of the AG who has the responsibility for the care of a child under the age of six, or of an incapacitated and/or disabled individual. The person receiving the care is not required to reside with the AG or be a member of the SNAP AG. Unborn children are not considered children under the age of six.

  Separate families included in the same AG may have one person from each family exempted. Separate families, not in the same AG, but living together, may also have one person from each family exempted.

  > **SNAP Work Requirement Exemption Example 2:** Two sisters live together and are in the same AG. They each have two children under age six. Both women may be exempt for caring for a child under age six.
  >
  > **SNAP Work Requirement Exemption Example 3:** A man and woman apply for SNAP benefits. They have one child, age five. The man receives Retirement, Survivors and Disability Insurance (RSDI) based on his disability and is, therefore, exempt from the SNAP work requirements. He is, however, able to care for the child, so the mother is not exempt from the requirements.

- Individuals receiving Unemployment Compensation Insurance (UCI) from any state. This includes persons receiving benefits under the Trade Readjustment Allotment (TRA).

  If an individual's UCI benefits are suspended, he becomes subject to the SNAP work requirements when the change is reported, unless a SNAP penalty is applied, or unless exempt for some other reason.

When a client reports the loss of UCI income, the Worker must evaluate the circumstances to determine if a penalty must be applied. A penalty is applied when the individual is exempt from SNAP work requirements due solely to the fact that the client was receiving UCI, unless another exemption is met. Good cause for failure to comply with UCI requirements include all situations described in Section 14.4 for voluntary quit.

- Individuals who are physically or mentally unfit to engage in full-time employment. See Section 13.15.
- Regular participants in a drug addiction or alcoholic treatment and rehabilitation program, either on a resident or non-resident basis. Regular participation is defined by the drug addiction or alcoholic treatment and rehabilitation program.
- Individuals who are employed or self-employed and working a minimum of 30 hours per week, or who are receiving weekly earnings equal to the federal minimum wage multiplied by 30 hours. When the client is employed or self-employed for at least 30 hours per week, no consideration is given to the amount earned.
- Individuals who receive WV WORKS and do not meet any of the other SNAP exemptions listed above, so long as they are subject to, and complying with, a WV WORKS work requirement. These individuals would be required to meet the SNAP work requirements if they did not receive WV WORKS.

When a client loses eligibility for an exemption, the Worker must determine if the client meets any other exemption criteria prior to imposing a penalty.

If the exemption is lost during the certification period and clients are not required to report the change, they become subject to SNAP work requirements at redetermination. However, if the client reports losing the exemption, he becomes subject to SNAP work requirements at the time the change is reported.

14.2.2 SNAP WORK REQUIREMENTS FOR WV WORKS CLIENTS

The following requirements apply only to SNAP clients who are also WV WORKS clients. They do not apply to non-WV WORKS clients who are included in the SNAP AG with WV WORKS clients, or to individuals who would normally be included in the WV WORKS AG, but who have been disqualified or excluded by law. These individuals must meet the work requirements in 14.2.1.A, unless exempt, disqualified, or excluded by law from the SNAP program.

14.2.2.A Work Requirements

The SNAP work requirements for WV WORKS clients are outlined in Section 18.9. As long as an individual is subject to the WV WORKS work requirement and is meeting his work requirement, he is also meeting his SNAP work requirement.

14.2.2.B Exemptions from SNAP Work Requirements

14.2.2.B.1 Individuals Exempt from WV WORKS Work Requirements

WV WORKS clients who are temporarily exempt from meeting a WV WORKS work requirement, as found in Section 14.7, are also exempt from meeting the SNAP work requirements, as long as they receive WV WORKS benefits. These individuals are not subject to either a WV WORKS sanction or SNAP penalty for not complying with the work requirements when the individual meets a WV WORKS exemption found in Section 14.7 or a WV WORKS good cause requirement found in Section 14.9.

14.2.2.B.2 Individuals Exempt from SNAP Work Requirements

WV WORKS clients who are subject to the WV WORKS work requirement, and who fail, without good cause, to meet a WV WORKS work requirement, are not subject to a SNAP penalty for not meeting the work requirement if they meet an exemption listed above in Exemptions from SNAP Work Requirements.

14.2.2.B.3 WV WORKS Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP) Requirement

An individual who fails to meet a WV WORKS PRC requirement is not subject to a SNAP penalty, unless that PRC/SSP requirement is directly related to one of the following WV WORKS work requirements found in Section 18.9:

- Employment (Unsubsidized and Subsidized)

- On-the-job Training
- Job Search and Job Readiness Assistance
- Work Experience
- Community Service Programs
- Vocational Educational Training / College
- Providing Child Care for a Community Service Participant
- Non-Core Work Activities

Other PRC/SSP requirements that may result in a WV WORKS sanction, but not a SNAP penalty, include but are not limited to enumeration, immunizations and cooperation with the Bureau for Child Support Enforcement (BCSE).

14.3 SNAP WORK REGISTRATION

14.3.1 WORK REGISTRATION

14.3.1.A Registration Requirements

All individuals must register for employment with WorkForce West Virginia, within 30 days of the date of the original approval, unless exempt according to Section 14.2. Clients must register every 12 months thereafter, regardless of the length of time that WorkForce West Virginia considers the registration valid.

The Consolidated Work Notice (CWN) is sent to the SNAP AG when an individual(s) is required to register with job service through Workforce WV. The CWN details who must register and the due date of registration. The CWN also explains why the individual(s) is required to register and how to register.

Actions which constitute a registration are defined by WorkForce West Virginia and the eligibility system must:

- Match with WorkForce West Virginia. Registration date updated.
- Match the date returned from WorkForce West Virginia is more than 12 months old. The client must register again.
- Match with WorkForce West Virginia with inactive job status and no job preference. The client must choose a job preference and become active to be considered registered.
- Match with WorkForce West Virginia with inactive job status and with job preference. The client must become active to be considered registered.
- Match with WorkForce West Virginia with active job status and no job preference. The client must choose a job preference to be considered registered.

Once the client registers with WorkForce West Virginia for Supplemental Nutrition Assistance Program (SNAP) purposes, he cannot be required to register more often than every 12 months, even when the benefit is opened and closed within the 12-month period. This is tracked through the eligibility system.

The client may register by visiting a WorkForce West Virginia office, or by registering online. The Worker must explain these requirements to the client and enter the registration date in the eligibility system.

> **Work Registration Example 1:** An assistance group (AG) is approved for SNAP benefits on April 10. Mr. Hibiscus, the father, registers with WorkForce West Virginia as required by May 10. In June, a change is reported which makes the AG ineligible and the benefit is closed effective for July. The AG reapplies in September and is determined to be eligible. Because Mr. Hibiscus registered with WorkForce West Virginia in May, he cannot be required to register again until the following May.
>
> **Work Registration Example 2:** Mr. Freesia, a non-SNAP client, registers with WorkForce West Virginia in January. He later applies for SNAP in June. Since Mr. Freesia has not registered for SNAP purposes in the last 12 months, he is required to register with WorkForce West Virginia within 30 days of his SNAP approval.

The Worker must enter the appropriate information in the eligibility system at any point during the certification period when the client is due to register with WorkForce West Virginia. The eligibility system uses this information to send the client the notice to register 30 days prior to the due date.

When the Worker discovers the client was not notified that he must re-register during the certification period and is not currently exempt, the Worker must follow the same steps as noted above to establish a new registration due date and to ensure the client is notified 30 days prior to the new registration due date.

The Worker must not delay completion of a redetermination due to WorkForce West Virginia registration requirements.

If the applicant is currently in a SNAP penalty for failure to register and has completed his minimum penalty time, he must register prior to benefit approval. A second notice to register is not required. If he continues to refuse or fails to register, his penalty continues. See Section 14.5.

Prior to approval, an individual who verbally refuses to register with WorkForce West Virginia is ineligible until he registers or meets an exemption to the work requirements.

When an individual is added to the SNAP AG, or becomes subject to the SNAP work requirements due to the reported loss of an exemption, he is required to register with WorkForce West Virginia within 30 days of the date a notice to register is issued to the client, unless he has already registered for SNAP purposes within the past 12 months. See Section 14.2, General SNAP Work Requirements and Exemptions.

> **Work Registration Example 3:** Juniper reports on August 10 that his brother Ficus moved in with him and requests that Ficus be added to the SNAP benefit. Ficus is otherwise eligible and the Worker takes action on August 12 to add him to the SNAP benefit effective September 1. The Worker sends a notice to register on August 12 to notify Ficus that he is required to register with WorkForce West Virginia by September 12 since he has not registered for SNAP purposes in the last 12 months.

A client who fails to comply by the due date established on the notice to register is subject to a SNAP penalty and the Worker must send an adverse action notice. See Section 14.5. The penalty is not imposed, and any lost benefits are restored if, before the end of the month in which the adverse notice expires, the following occurs:

- The client registers; and
- The client notifies the Department of Human Services (DOHS) that he has registered. If the Worker independently discovers before the penalty goes into effect that the client has registered before the end of the month in which the adverse notice expires, the penalty may be lifted, and benefits restored. There is no requirement on the Department, however, to attempt to independently verify if the client has registered after the date the penalty is entered into the system.

> **Work Registration Example 4:** Ms. Iris is added to an active SNAP case on August 12 and is notified she must register with WorkForce West Virginia by September 12. If Ms. Iris does not register by September 12, the Worker must send notification that she is subject to a SNAP penalty beginning October 1. If she registers by September 30 and notifies the Worker, the penalty is not imposed. Any lost benefits must be restored.
>
> **Work Registration Example 5:** Mr. Daffodil is added to an active SNAP case on August 12 and is notified he must register with WorkForce West Virginia by September 12. If Mr. Daffodil does not register by September 12, the Worker must send notification that he is subject to a SNAP penalty beginning October 1. If Mr. Daffodil registers and notifies the Worker on or after October 1, the penalty is imposed.

14.3.1.B WorkForce West Virginia

During the application and redetermination process, the eligibility system will present a registration date obtained from WorkForce West Virginia. If the client is not registered, no date will be returned.

During the certification period, the Worker may request the registration date through the eligibility system. The client is required to register with WorkForce West Virginia every 12 months for SNAP purposes.

When the client is due to re-register, he must show activity to fulfill this requirement. The date of the re-registration is the date of the last action with WorkForce West Virginia or the due date of the re-registration, whichever is later.

14.4 SNAP VOLUNTARY QUIT

14.4.1 ACTIONS WHICH ARE VOLUNTARY QUITS

Applicants who voluntarily quit employment without good cause are ineligible for three months, while a penalty is applied to an active client without good cause. See Section 14.2 and 14.5.

A voluntary quit has occurred when all of the following conditions exist without good cause:

- The individual left full-time employment of at least 30 hours per week, other than self-employment, of his own volition, or the individual voluntarily reduced his work hours to below 30 hours/week.
- The individual who left employment was not exempt from the work requirement at the time of the quit.
- The individual quit the most recent job of at least 30 hours per week within 60 days prior to the date of application, or anytime thereafter. See Section 14.4.
- Special Situations
    - An individual who is exempt from the work requirement due to employment loses this exemption immediately upon leaving employment. The client is, therefore, subject to the work requirement penalty even though he was exempt while employed, or while working 30 hours/week.
    - An individual exempt from the work requirement at the time of the quit due to receipt of, or registration for, Unemployment Compensation Insurance (UCI) benefits is exempt from the Supplemental Nutrition Assistance Program (SNAP) penalty. However, failure to comply with UCI requirements without good cause results in the penalties listed in Section 14.5.
    - An individual who meets the above conditions and is an employee of federal, state or local government is considered to have voluntarily quit a job without good cause when the individual participates in a strike against such government and is dismissed because of participation in the strike.

14.4.2 ACTIONS WHICH ARE NOT VOLUNTARY QUITS

The following are not considered Voluntary Quit actions:

- Leaving a job of less than 30 hours per week.
- Reduction in the number of hours of employment for the same employer, at the request of the employee, as long as after the reduction he is still employed 30 hours or more per week.
- Termination of self-employment.
- Resignation or termination from the employment at the demand of the employer for any reason, including lay-offs and firings. Even when the reason for firing is failure of the client to follow rules that the employer can reasonably expect to be followed, being fired is not of the client's own volition and is not, therefore, a voluntary quit. See 14.4.1.
- Leaving employment by a person who was exempt from work requirements at the time of the quit. See 14.4.1.
- For applicants: The quit did not occur within the 60-day period prior to the date of application and/or did not involve the most recent job of at least 30 hours per week.
- For clients: The quit did not involve the most recent job of at least 30 hours per week and/or the client is exempt from the work requirements at the time of the quit or at the time the voluntary quit is determined.

14.4.3 GOOD CAUSE FOR VOLUNTARY QUITS

Once a determination is made that the client voluntarily quit, the Worker determines if the individual had good cause for leaving employment. Good cause for leaving employment includes:

- Discrimination by the employer based on age, race, sex, color, disability, religious beliefs, national origin or political beliefs.
- Work demands or conditions were unreasonable, such as, but not limited to, working without being paid on schedule.
- Acceptance of employment by the individual, or enrollment by the individual at least half-time in any recognized school, training program or institution of higher learning on at least a half time basis, that requires the individual to leave employment.
- Acceptance by other assistance group (AG) members of employment or enrollment of at least half-time in any recognized school, training program or institution of higher learning in another area which requires the AG to move and, thereby, requires the individual to leave employment.

- Acceptance of a bona fide offer of employment of more than 30 hours per week which, through no fault of the individual, either does not materialize or results in employment of less than 30 hours per week.
- Leaving a job in connection with patterns of employment in which workers frequently move from one employer to another, such as construction work or migrant farm labor.

  There may be times when a SNAP AG applies for benefits between jobs, particularly in cases where work may not be available at the new job site. Even though employment at the new site has not actually begun, the quitting of the previous employment is considered to have been with good cause when it is part of the pattern of that type of employment.
- Resignations by persons under the age of 60, which are recognized by the employer as retirement.
- Leaving employment due to circumstances beyond the client's control, such as, but not limited to: illness, illness of another AG member requiring the presence of the client, a household emergency, the unavailability of transportation, or lack of adequate child care for a child who is at least age 6, but not yet age 12.
- The employment does not meet the suitability requirements.

  Employment is considered unsuitable if any of the following conditions exist:
    - The wage offered is less than the highest of:
        - The applicable federal minimum wage;
        - The applicable State minimum wage; or
        - Eighty percent (80%) of the federal minimum wage, if neither the federal nor the State minimum wage is applicable.
    - The employment in question is on a piece-rate basis and the average hourly yield the employee can reasonably expect is less than the applicable hourly wages specified above.
    - The individual, as a condition of employment, is required to join, resign from or refrain from joining any legitimate labor organization.
    - The work is at a site subject to a work stoppage as a result of a strike or lockout at the time of the offer, unless the strike has been enjoined under section 208 of the Labor-Management Relations Act (Taft-Hartley Act) or section 10 of the Railway Labor Act.
- In addition, employment is considered suitable unless the AG member can demonstrate, or the Worker otherwise becomes aware that:
    - The degree of risk to health and safety is unreasonable;

- The AG member is physically or mentally unfit to perform the employment, as established by documented medical evidence or by reliable information provided from another identifiable source;
- The employment offered is not in the client's major field of experience. This is applicable only within the first 30 days of becoming subject to the work requirements;
- The distance traveled to the employment from the AG member's residence is unreasonable, considering the expected wage and the time and cost of commuting. Employment is not considered suitable if daily commuting time exceeds two hours per day, not including the transporting of a child to and from a childcare facility. Nor is employment considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the individual to the job site;

  Clients who move to a residence which renders the distance to the place of employment unreasonable are not subject to the work requirement penalty. This includes those who move to West Virginia from another state or country and those who move within the state; or
- The working hours or nature of the employment interferes with the AG member's religious observances, convictions or beliefs.

14.4.4 ESTABLISHING GOOD CAUSE

See Section 7.3 for possible sources of verification of the reason for the quit. Verification of the reason is routinely required when the client claims good cause, except as follows.

The individual must not be penalized if the individual and the Worker are both unable to obtain the needed verification because the cause for the quit resulted from circumstances that, for good reason, cannot be verified, such as a resignation from employment due to discrimination, unreasonable demands by an employer, or because the employer cannot be located. The Worker must record all case activity.

14.4.5 WHEN TO APPLY A SNAP PENALTY FOR VOLUNTARY QUIT

Once a determination is made that the client voluntarily quit a job of at least 30 hours per week and did not have good cause for quitting, he may be subject to a SNAP penalty as described below.

14.4.5.A Applicants

When the Worker determines that an applicant has voluntarily quit a job 60 days prior to application without good cause, his period of ineligibility is the month of application and two calendar months following the month of application or until he reports a change which makes him exempt from the SNAP work requirement. This three-month period of ineligibility is not counted as a penalty for the applicant.

Eligibility for the individual is reestablished when an exemption is established or at the end of the three-month period of ineligibility.

14.4.5.B Clients

When the Worker discovers from the client that they have voluntarily quit employment, he must verify if it was with or without good cause to determine if the client is subject to a SNAP penalty. If sufficient information exists to determine that the client had good cause, the Worker records this information in case comments and on the appropriate eligibility system screen. If the Worker verifies that the client voluntarily quit without good cause and is not exempt from the work requirements, a penalty is applied.

If sufficient information is not available to determine that the client had good cause, the Worker must record the available information in case comments and explore good cause at the next redetermination, even when it appears the client does not have good cause. The client is not required to report that he quit a job and/or that he had good cause for quitting during the certification period.

> **SNAP Penalty Example 1:** Mr. Begonia client calls to report that he quit his full-time job because he has not been paid in over a month. The Worker acts on the change in income, grants the client good cause for the voluntary quit, and

records the information in case comments. No additional follow up for this voluntary quit is required at the next redetermination.

SNAP Penalty Example 2: Mr. Tansy, a SNAP client, applies for Emergency Assistance (EA) and reports that he quit his job of 30 hours a week because he had an argument with his boss. Since there is no voluntary quit provision for EA, the Worker acts on the income change, delays the good cause determination, and records this in case comments. At the next redetermination, if Mr. Tansy is not currently working at least 30 hours a week or meeting a SNAP WORK requirement exemption, the Worker discusses this voluntary quit with Mr. Tansy in order to determine if good cause existed.

14.4.5.B.1 Voluntary Quit Discovered at Redetermination

When the Worker determines at redetermination, based on information available in case comments and new information reported by the client during the normal redetermination process, that the client voluntarily quit employment without good cause during the prior certification period, he must determine if the client is subject to a SNAP penalty.

If the Worker determines at redetermination that the client did voluntarily quit without good cause at any time during the certification period and he is not currently working 30 hours a week and is not exempt from the work requirements, a penalty is applied. See Section 14.5.

The Worker must only explore the potential for voluntary quit using information previously recorded in case comments and information that the client reported in order to update the current information. Neither the Worker nor the client is required to explore the potential for voluntary quit when the job is not previously known to the Department.

Eligibility for the individual is reestablished when an exemption is established or at the end of the appropriate penalty period.

14.5 SNAP WORK REQUIREMENT PENALTIES

A Supplemental Nutrition Assistance Program (SNAP) penalty is imposed when clients do not comply with a work requirement and do not have good cause. See Section 20.2 for the effect of penalties on eligibility for Emergency Assistance (EA).

When determining the correct number of penalties, the Worker must look at the total number of penalties previously served, not just the number of penalties for each work requirement.

NOTE: If the effective begin date of a penalty occurs at the same time the client is determined to be ineligible or requests closure of his benefits, the penalty must still be applied.

The penalty must be served unless the client meets an exemption. The penalty is never applied to an entire assistance group (AG), only to the client who does not comply. When the reported exemption ends, the client is subject to the original penalty, unless he has complied or meets another exemption.

Penalties are applied sequentially, regardless of the requirement not met. In addition, penalties are applied consecutively, and one penalty must end before another one is imposed.

14.5.1 SNAP CLIENT NOT RECEIVING WV WORKS

When a SNAP client that does not receive WV Works fails to comply with the SNAP work requirements in Section 14.2, he is subject to the following penalties.

14.5.1.A Voluntary Quit and Voluntary Reduction of Hours Penalties

A client who voluntarily quits employment of at least 30 hours a week or voluntarily reduces his hours to below 30 hours a week is subject to the following penalty periods or until he reports an exemption. See Section 14.2 for exemptions. The client must not be required to return to the same or comparable employment before eligibility is established.

- First violation: The client is removed from the AG for three months or until he meets an exemption. If the client does not meet an exemption prior to the end of the penalty, he is added back into the active AG after three months. A one-person AG must reapply to establish eligibility.

- Second violation: The client is removed from the AG for six months or until he meets an exemption. If the client does not meet an exemption prior to the end of the penalty, he is added back into the active AG after six months. A one-person AG must reapply to establish eligibility.
- Third and subsequent violations: The client is removed from the AG for 12 months or until he meets an exemption. If the client does not meet an exemption prior to the end of the penalty, he is added back into the active AG after 12 months. A one-person AG must reapply to establish eligibility.

> **Voluntary Quit Penalty Example:** Mr. Dogwood is a man in a three-person AG. Mr. Dogwood failed to register with WorkForce West Virginia in December. He was placed in a first penalty beginning in January. The length of the penalty was three months, but he did not register until April, so he was not added back into the active AG until May. In July, Mr. Dogwood quit a job of at least 30 hours a week without good cause. He was placed in a voluntary quit penalty beginning in August. Since this was his second penalty, the length of the penalty is six months. If he does not meet an exemption prior to the end of the six months, he is not eligible to be added back into the active AG until February.

14.5.1.B Non-Voluntary Quit Penalties

A client who refuses or fails to register with WorkForce West Virginia, refuses employment, or refuses to provide information about employment status and job availability is subject to the following penalties for the full penalty period or until he reports a change which makes him exempt from the work requirements. See Section 14.2 for exemptions.

- First violation: The client is removed from the AG for at least three months or until he meets an exemption. If after three months, the client has not complied or met an exemption, the penalty continues until he does comply or meets an exemption for some reason other than Unemployment Compensation Insurance (UCI) related activities.
- Second violation: The client is removed from the AG six months or until he meets an exemption. If after six months, the client has not complied or met an exemption, the penalty continues until he does comply or meets an exemption for some reason other than UCI-related activities.
- Third and subsequent violations: The client is removed from the AG for 12 months or until he meets an exemption. If after the 12 months, the client has not complied or met an exemption, the penalty continues until he does comply or meets an exemption for some reason other than UCI-related activities.

Non-Voluntary Quit Penalty Example 1: In April, Mr. Zinnia, a client, fails to register with WorkForce West Virginia and refuses a job offer. He incurs the first penalty for failure to register and is disqualified for a minimum of three months beginning in May. In June, Mr. Zinnia registers with WorkForce West Virginia, but still has a month of the penalty left. Effective August 1, his first penalty ends, but his second penalty for refusing a job offer begins after expiration of the first penalty, taking into consideration advance notice requirements.

Non-Voluntary Quit Penalty Example 2: In June, Mr. Rose, a client, fails to register with WorkForce West Virginia and a penalty is imposed effective July 1. At the end of the minimum penalty period of three months, he still has not registered, so the penalty continues. In November, Mr. Rose reports he is working 35 hours a week. Since he meets an exemption, he is added back to the AG effective December. In February, he reports he was fired. He does not meet another exemption. He has still not registered with WorkForce West Virginia, so he remains subject to the original penalty. He is ineligible until he registers with WorkForce West Virginia or meets another exemption.

14.5.2 WV WORKS CLIENT

A WV WORKS client who is exempt from SNAP work requirements only because he is subject to, and complying with, a WV WORKS requirement in Section 18.9 is subject to the following penalties when he does not comply. A WV WORKS offense that involves a work requirement which results in application of a WV WORKS sanction may also result in a SNAP penalty. See Section 14.10.

- First violation: The client is removed from the AG until the client reports a change that makes him exempt according to Section 14.2.1.B for some reason other than UCI-related activities or for a maximum of three months. Following the end of the first penalty, the Worker must add the client to the active AG, if the client is otherwise eligible.
- Second violation: The client is removed from the AG until the client reports a change that makes him exempt according to Section 14.2.1.B for some reason other than UCI-related activities or for a maximum of an additional six months. Following the end of the second penalty, the Worker must add the client to the active AG, if the client is otherwise eligible.
- Third and subsequent violations: The client is removed from the AG until the client reports a change that makes him exempt according to Section 14.2.1.B for some reason other than UCI-related activities or for a maximum of an additional 12 months. Following

the end of the third penalty, the Worker must add the client to the active AG, if the client is otherwise eligible.

14.6 WV WORKS REQUIREMENTS: EFFECT OF THE WORK ASPECT ON ELIGIBILITY

The work component of WV WORKS is described in detail in Chapter 18. Failure or refusal to comply with the requirements of the work component may adversely affect the client's WV WORKS eligibility or the amount of his WV WORKS benefit. The following sections provide information about those who are temporarily exempt from the work requirement, how eligibility and benefit amounts are affected, sanctions, determining good cause and the effect of a WV WORKS sanction on other programs.

14.7 WV WORKS EXEMPTIONS

The following are exemptions from meeting the work requirement. This does not automatically exempt appropriate individuals from the 60-month, or 24-month time limits described in Sections 18.2 and 18.8. Individuals exempt from the work requirement may participate voluntarily. See Sections 1.5 and 3.21. However, no sanction is applied for failure to do so. The Case Manager must place participants who choose to participate in the appropriate work components, as well as the applicable exemption component.

- Undocumented aliens and aliens under the five-year ban

  This includes those aliens who are ineligible to receive assistance due to their immigration status and those who do not meet the necessary time requirements for living in this country;

- Parents, stepparents, or caretaker relatives receiving Supplemental Security Income (SSI)

  These individuals must be offered an opportunity to participate, if they so choose;

NOTE: WV WORKS participants who have a documented disability must be placed in the "Participant with a Documented Disability" (AD) component in the case management system, in addition to other component codes.

- Care for a disabled family member (TW)

  A participant who is providing medically necessary care for a disabled family member who resides in the home. Medical documentation must be provided to support the need for the participant to remain in the home to care for the disabled family member. See Chapter 18. Only one participant in the assistance group (AG) at a time can be temporarily exempt for this reason.

  The Case Manager must review this documentation at least once quarterly and it must be verified by a doctor's statement. This care cannot be counted as participation hours under any activity. When medical documentation is obtained that the family member is no longer disabled, the exemption ends, and the participant becomes a Work-Eligible Individual and must be assigned to a countable

NOTE: Because the time limit applies to participants in this component, the family should be encouraged to make other care arrangements. This includes an application for Medicaid Aged and Disabled Waiver (ADW), Intellectual Development Disabilities (I/DD) Waiver or Traumatic Brain Injury (TBI) Waiver services.

activity. Individuals under this exemption must be placed in TW component in the case management system;

- Minor parents who are not head of household; and
- Grandparents and other non-parent caretaker relatives

  These individuals may choose to be included in the WV WORKS AG, and if so, must complete a Personal Responsibility Contract (PRC), complete a Self-Sufficiency Plan (SSP), attend orientation, and participate in work activities.

NOTE: Refer to Section 18.4 for those Work-Eligible Individuals who are excluded from the calculation of the federal work participation rate. This is not to be confused with any WV WORKS exemption in this section or any good cause reason listed in Section 14.9.

14.8 WV WORKS SANCTIONS

When a member of the assistance group (AG) or non-recipient Work-Eligible Individual does not comply with requirements found on his Personal Responsibility Contract (PRC) or Self-Sufficiency Plan (SSP), a sanction must be imposed unless the Case Manager determines that good cause exists. Information about development of the SSP is found in Chapter 18. Information about the PRC and SSP as an eligibility requirement is found in Section 1.5.

NOTE: When the person whose actions cause a sanction to be imposed becomes a Supplemental Security Income (SSI) recipient prior to imposition of the sanction, no sanction is imposed. In addition, the offense is not counted when determining the level of subsequent sanctions. If the family has already been sanctioned when the offender becomes an SSI recipient, the sanction is lifted as soon as possible. The partial sanction already served counts when determining the level of the subsequent sanctions.

NOTE: If a disabled client chooses to participate, no sanction is imposed for failing to meet the work requirements if the Case Manager or Supervisor determines the participant failed to meet the SSP requirements due to his disability. WV WORKS participants who have a documented disability must be placed in the "Participant with a Documented Disability" AD component in the case management system, in addition to other component codes.

14.8.1 DEFINITION OF A SANCTION

Sanctions are applied in the form of termination of WV WORKS benefits. The duration of the sanction period is determined as follows:

- First Offense = Ineligibility for cash benefits for 1 month;
- Second Offense = Ineligibility for cash benefits for 6 months;
- Third and All Subsequent Offenses = Ineligibility for cash benefits for 12 months.

WV WORKS sanctions are applied to all Work-Eligible members of a WV WORKS case, not only to the member who causes the sanction.

A sanction is not imposed by having the client repay all or part of the benefit he has already received. A termination of cash assistance for at least one month is the only means by which a sanction is imposed.

Once the beginning of the sanction period has started, it cannot be stopped until the appropriate time has elapsed.

When two or more offenses, by the same or different participants, occur in the same month, it is treated as if only one offense has occurred. All offenses must be addressed in the client notification and only one sanction is imposed. If an additional offense, by the same or different participants, occurs in the same month after the Case Manager has mailed the notification of the preceding offense, an additional sanction may not be imposed.

The second and subsequent WV WORKS sanctions require supervisory approval. A Supervisor must confirm the sanction in the eligibility system. When a Supervisor is not available, a back-up Supervisor may confirm the sanction.

If good cause is granted for the first or second sanction the Supervisor must give approval for removing the sanction and must make comments in the eligibility system.

The third and subsequent WV WORKS sanctions must be approved by the Division of Family Assistance (DFA) Temporary Assistance for Needy Families (TANF) Policy Unit. The Supervisor must send an email to TANF Policy Unit members and his Regional Program Manager once the prospective sanction is placed in the eligibility system with the date and time of the scheduled case staffing, along with a detailed summary on a DFA-WVW-75 outlining the reason for the sanction including:

- Case name, case number, PIN numbers;
- Current PRC;
- Number of referrals provided to the AG for help in removing barriers;
- Number of home/work site visits in the past 12 months. If a home visit has not been completed within 60 days of the third or subsequent sanction request, the Case Manager must schedule, attempt and document a home visit before a sanction approval will be considered. A site visit must not be completed for this purpose.
- Any special or unusual circumstances in the family; and
- Worker, Supervisor and/or Community Services Manager (CSM) decision, including reason, about whether or not the family should be sanctioned.

This process is to ensure all challenges identified have been addressed.

If good cause is requested, the Supervisor must notify the Policy Unit and Program Manager by email, that they are requesting the sanction be lifted, and the Policy Unit must approve the good cause.

To be considered for future benefits, the individual will be required to re-apply for WV WORKS.

14.8.2 SUBSTANCE ABUSE SANCTION

Any applicant who refuses a Drug Use Questionnaire, DFA-WVW-DAST-1, or a drug test is ineligible for WV WORKS assistance.

Any applicant who provides false information on the Drug Use Questionnaire is ineligible for WV WORKS assistance for 12 months. He must also be referred to repayments for benefits overpaid due to the false information. The false information must be from evidence and not hearsay.

Any applicant who has a positive drug test and who fails to complete or refuses to participate in substance abuse treatment and counseling and job skills program is ineligible for WV WORKS until he is enrolled in these programs. Once he can document successful completion, he may reapply for those benefits six months after the completion and must submit to random drug testing.

Upon a second positive drug test, the individual must complete a second substance abuse treatment and counseling and job skills program. These individuals shall be ineligible for WV WORKS for twelve months or until he completes a substance abuse treatment and counseling program and a job skills program whichever is shorter.

Upon a third positive drug test, the individual is permanently ineligible for WV WORKS.

In any of the above situations the applicant is considered a non-recipient work-eligible individual and must choose a protective payee for the WV Works payment for the other members of the WV Works AG.

14.8.3 ADVANCE NOTICE

All benefit terminations due to imposition of a sanction require advance notice. See Chapter 9 the sanction is effective.

Once a period of ineligibility is imposed, i.e. after expiration of the 13-day advance notice period, the ineligibility remains in effect for the pre-determined number of months, regardless of case status.

14.8.4 CASE STAFFING

A case staffing is required before all sanctions start.

After a sanction has been imposed, the Worker must send a pending closure notice (DFA-WVW-5) or system notice, which includes an appointment for a case staffing. The case staffing notice may be sent any time after notification that the sanction has been imposed, but before start of the sanction. It is recommended that the case staffing occur as soon as possible after the notification to try to avoid the sanction.

When the sanction is scheduled to start prior to the case staffing, the sanction must be delayed until the case staffing has been attempted. The Worker must document in comments the dates the case staffing was scheduled and also document the outcome of a completed case staffing on a DFA-WVW-6 and in comments. At the Supervisor's discretion, a home visit may be made in addition to the case staffing. However, the home visit does not substitute for the case staffing.

During the case staffing, the Case Manager must discuss with the participant the reason(s) for the sanction. The Case Manager will explore with the participant why he has not complied with the PRC or SSP or otherwise participated and cooperated. During the visit, the Case Manager will explore any support services, other Department services or community resources that are available to the client to address any challenges to participation. Appropriate services and referrals will be arranged. The Case Manager must also discuss the following during the case staffing visit:

- Plans for how the children's needs will be met when the WV WORKS benefit stops.
- How rent and utilities will be paid while the WV WORKS case is ineligible.

NOTE: Under no circumstances is the Worker to suggest or indicate that the loss of WV WORKS benefits will result in removal of the children from the home.

- Determine how extra expenses, such as, but not limited to, cleaning and laundry supplies, clothing, etc. will be covered.
- Explain that if a participant is in their first sanction, Emergency Assistance is not available for one month. For the second and subsequent sanctions, Emergency Assistance is not available for the first three months of a sanction period.
- Explain that Supplemental Nutrition Assistance Program (SNAP) benefits will not increase due to the loss of WV WORKS.
- Explain that the participant must establish good cause to avoid a sanction.

The case staffing does not substitute for advance notice of any additional sanctions or for any good cause appointments.

14.8.5 BEGINNING OF THE SANCTION PERIOD

The sanction period begins the month after expiration of the advance notice period. The date the Worker enters the pending sanction in the eligibility system determines the initial month of the sanction.

Imposition of a sanction may be delayed by a Fair Hearing request. When the Department of Human Services (DOHS) is upheld, the sanction begins in the month following the Fair Hearing decision. If the Fair Hearing decision is reached after the adverse action deadline date, the sanction begins two months after the decision.

14.8.6 EXPIRATION OF THE SANCTION PERIOD

The sanction periods expire when the participant has not received WV WORKS benefits for the appropriate number of months, whether the case remains active or not.

If the participant is not notified of the imposition of the sanction prior to a requested case closure, no sanction may be imposed until the client has received proper notice. Therefore, when the participant requests case closure before being notified of the imposition of the sanction, the Worker must still notify the client of the imposition of the sanction. The notification letter must explain that the sanction will be applied upon reapplication if the client chooses to reapply during the sanction period. Refer to Chapter 9 for client notification. The letter must specify the dates of the sanction period. The client may request a Fair Hearing on the sanction issue when the notification is received or upon reapplication within 90 days of closure notification.

The client may reapply at any time, but applications made prior to the expiration of the sanction are denied.

14.8.7 DETERMINING THE NUMBER OF SANCTIONS AND WHEN THE AG OR NON-RECIPIENT WORK-ELIGIBLE INDIVIDUAL SEPARATES

The following information is used to determine the number of sanctions when the sanctioned WV WORKS case separates into two or more cases, or when one or more household members leave the case.

- Each adult and emancipated minor included in the same WV WORKS AG, and each non-recipient Work-Eligible Individual, is assigned one sanction for each time the case is sanctioned. Sanctions are not assigned to children.

  > **Assigning WV WORKS Sanctions Example 1:** Mr. and Mrs. Pine receive WV WORKS for themselves and their two children. Mr. Pine refused an offer of employment without good cause and a sanction is applied to the case. The case has one sanction; therefore, Mr. Pine is assigned one sanction and Mrs. Pine is assigned one sanction.

- When an adult or emancipated minor leaves the home, he takes his assigned sanctions with him. Those adults and emancipated minors remaining in the home retain their assigned sanctions.

  > **Assigning WV WORKS Sanctions Example 2:** Continuation of the previous example. After application of the sanction, Mr. Pine leaves the home. Mrs. Pine is the only adult remaining in the AG. She carries the sanction that was assigned to her when Mr. Pine refused a job, so the sanction continues.

- When a Work-Eligible adult or emancipated minor leaves the home of one WV WORKS case and joins another one, all members of the new AG and any non-recipient Work-Eligible Individuals are assigned the same number of sanctions. This number is determined by assigning each adult/emancipated minor the highest number of sanctions assigned to any one of the adults/emancipated minors in the new AG or any non-recipient Work-Eligible Individuals.

  > **Assigning WV WORKS Sanctions Example 3:** Continuation of previous example. When Mr. Pine leaves Mrs. Pine, he moves in with a former fiancée, Nellie. Mr. Pine is the father of two of Nellie's children. Nellie and her three children are WV WORKS clients. Nellie previously failed, without good cause, to cooperate with the Bureau for Child Support Enforcement (BCSE) in obtaining support for her third child. In addition, she failed, without good cause to continue her Community Work Experience Program (CWEP) placement. Nellie's case has been sanctioned twice. When Mr. Pine joins her AG, he is assigned two sanctions, since Nellie has the higher number of sanctions. After six months, Mr. Pine decides to return to his wife. When he leaves, Nellie continues to have two sanctions. When Mr. Pine returns to his wife, he now has two sanctions that were assigned to him from Nellie's case. Therefore, the case which includes Mr. and Mrs. Pine now has been assigned two sanctions. The next offense by Mr. or Mrs. Pine results in application of the third sanction.

Upon learning of his sanction status, Mr. Pine goes back to live with Nellie. Mr. Pine and Nellie each continue to have two assigned sanctions. Shortly after his return, Nellie fails to keep an appointment with a prospective employer. She tells the Case Manager that she wanted to stay home to be with the father of her children. The Case Manager determines that she did not have good cause and applies the third sanction. Mr. Pine immediately returns to his wife. This makes his wife and children ineligible when the third sanction was applied.

Assigning WV WORKS Sanctions Example 4: A household consists of Mr. and Mrs. Green and their two children. Mr. Green was convicted of a drug felony and is not included in the WV WORKS benefit. Mrs. Green has incurred two previous WV WORKS sanctions. Because Mr. Green was convicted of a drug felony, he is considered a non-recipient Work-Eligible-Individual. Mr. Green is immediately assigned two WV WORKS sanctions previously incurred by Mrs. Green.

Assigning WV WORKS Sanctions Example 5: Ms. Smith is a non-recipient Work-Eligible Individual because she is a parole violator. She fails to attend her assigned activity without good cause and a sanction is applied to the case. The case now has one sanction.

- Sanctions applied to a case are never assigned to dependent children.

Assigning WV WORKS Sanctions Example 6: Sam, one of Mr. and Mrs. Pine's children, runs away to live with his grandmother. She applies for WV WORKS for Sam and herself and is approved. Because Sam is a dependent child, no sanctions are assigned to the new AG even though his previous AG has three sanctions.

Assigning WV WORKS Sanctions Example 7: Mr. and Mrs. Oak had four children and are notified that a third sanction will be imposed, and the benefit amount will be reduced from $460 to $0. The WV WORKS amount counted for SNAP benefits is $460. The AG separates; Mr. and Mrs. Oak each will then have $230 of the WV WORKS benefit counted for the SNAP benefits in their separate AGs. If they reconcile before the end of the sanction period, $460 WV WORKS benefit will be counted for their SNAP benefit.

14.9 GOOD CAUSE FOR FAILURE TO PARTICIPATE FOR WV WORKS

All Work-Eligible Individuals must be placed into an allowable activity described in Chapter 18.10 – 18.18 on approval date after negotiation of the Self-Sufficiency Plan (SSP), unless a good cause reason discussed below exists. The participant must remain in that activity until either the case is closed at the end of the month or the Case Manager and participant agree to change the activity.

The Case Manager has considerable discretion in imposing a sanction or granting good cause. The Case Manager must determine whether or not the participant is meeting the requirements, attempting to comply with the best of his ability, understands the requirements, and the sanction process. The Case Manager may determine that the requirement was inappropriate based upon additional assessment. In addition, the Case Manager may determine that not applying a sanction in a particular situation provides more motivation for future participation than the imposition of a sanction.

The applicant may not claim good cause for failure to enroll in or complete a substance abuse treatment and counseling program and a job skills program following a positive drug test. Should unforeseen circumstances prevent the applicant from enrolling in a treatment and counseling program within seven business days, the Case Manager may allow additional time to enroll. Individuals who refuse to enroll in a substance abuse treatment and counseling program and a job skills program are ineligible for WV WORKS until enrolled.

The Case Manager must determine if good cause exists if a parent or a non-parent caretaker relative included in the payment, or a non-recipient Work-Eligible Individual quits or refuses employment within the 30-day period prior to the date of application or when the client fails or refuses to meet his work requirement and/or adhere to his SSP requirements. Appropriate documentation must be provided, and the circumstances must be recorded in comments, where applicable.

Some reasons for granting good cause for temporarily not meeting participation requirements, the beginning date of eligibility~~,~~ and the 24-month eligibility requirement are life events or problems such as, but not limited to:

- The death of a spouse, parent, child, or stepchild.
- In accordance with the Family and Medical Leave Act (FMLA) of 1993, an acute, life-threatening illness of a spouse, parent, or child that requires the client's immediate attention. This does not include individuals who are exempt from participation due to caring for a disabled family member as outlined in Section 14.7.
- The 12-week period following the placement of a child with the participant for adoption or foster care.

- The minimum suitability standards for the specific activity are not met. See Sections 18.10 – 18.18 for minimum requirements. If none are listed for the activity, the Case Manager must determine if the activity placed unreasonable requirements on the client. The Case Manager must schedule an appointment or home visit for individuals granted good cause for this reason to review the situation and possible SSP update.
- An appointment to update the SSP and place the individual in another component must be scheduled as soon as possible.
- The parent, an included non-parent caretaker, or a non-recipient Work-Eligible Individual quits employment or fails to participate in his assigned activity due to enrollment and full-time attendance in school, training, or an institution of higher learning. The SSP must be updated and these individuals should be placed in the Vocational Educational Training (VT), Secondary School (AB), or College (CL) components as soon as possible.
- The participant is required to appear in court or for jury duty.

Failure or refusal to comply, without good cause, results in imposition of a sanction and a notice of adverse action must be issued, which includes scheduling the good cause interview. The appointment date for the good cause interview must be scheduled at least seven calendar days after the day following the date the letter is requested in the eligibility system or the day following the date a manual letter is sent. If the letter is hand delivered, case comments must be made indicating the date the letter was given to the participant. If the appointment is scheduled for a date prior to the seven calendar days, the participant and the Case Manager must agree on the appointment date. See Section 9.3.3 and Section 9.3.6. A system generated letter or a manual letter (DFA-WVW-NL-1) is used.

NOTE: A good cause determination is not required when the participant is exempt from participation in a work activity. See Section 14.7 for these exemptions. However, documentation is required for not being able to meet the minimum five hours per week work requirement or for referrals for assessment testing, or referrals to other appropriate services. See Section 18.8.

All of these good cause determinations must be recorded in the case management system. All good cause determinations must be reviewed monthly and the Case Manager must update the case comments with the information on the status of the participant. The Case Manager must enroll the participant in the Other Work Activities (OW) component to capture time spent with the customer during these monthly reviews. Once the good cause determination has been reviewed and the Case Manager determines that the good cause reason is still appropriate or the customer may be assigned to a countable work activity, the time spent for that review is entered as completed hours for the OW component. Comments are completed, and the participant is disenrolled from the OW component.

14.9.1 Good Cause Components

When the Case Manager determines that the client has good cause for failure to participate for one of the reasons listed in Section 14.9.1.A through Section 14.9.1.E below, the participant must be placed in the appropriate good cause component.

Clients in any of the good cause components listed below are still considered in the federal participation rate calculation.

14.9.1.A Age of Child (TF)

This component is used only for a single custodial parent caring for a child under the age of one. It is a good cause period for a maximum of 12 months lifetime, and it ends when the child attains the age of 12 months. It does not apply during the pregnancy period. Any remaining months can be applied following the birth of another child. This good cause reason may be applied when an applicant has given birth to a child and the child is under 12 months of age. The Case Manager must check the number of months previously used in the TF component before using this good cause reason.

The 12-month good cause period begins the month that the child is born and extends to the end of the month preceding the child's first birthday. The parent no longer has good cause for not meeting the participation requirements beginning with the month in which the child reaches 12 months of age.

NOTE: This good cause reason is not available for a two-parent household, even if only one parent is a Work-Eligible Individual.

Any individual who has had a positive drug test as a result of the Drug Use Questionnaire, DFA-WVW-DAST-1, is given good cause for not participating in job readiness and counseling / rehabilitation during the 12-week postpartum period only.

Time in this component before October 2006 is not counted towards the lifetime limit of 12 months.

> **Age of Child Good Cause Example:** Ms. Dahlia, a WV WORKS single parent, had a baby on January 5, 2017. For this child she is eligible for the 12-month good cause exemption from meeting participation requirements. She must be placed in the TF component from January 5, 2017 through December 31, 2017. If she chooses to volunteer to participate in a work activity during this period, she is

enrolled in a work component and disenrolled from the TF component. If she fails to meet her work requirement, she cannot be sanctioned. Remaining TF months may be used when she has another child while she is a WV WORKS participant.

If Ms. Dahlia has another child(ren) while she is a WV WORKS participant after using 12 months lifetime of TF, she will temporarily have good cause for not participating in an activity only for a 12-week postpartum period in accordance with the FMLA. The need for an extended good cause period must be verified by a doctor's statement.

14.9.1.B Sexual Harassment and Domestic Violence, Sexual Assault, and Stalking

When sexual harassment and domestic violence, sexual assault, and stalking and/or the need to protect abused children makes participation impossible, dangerous, or embarrassing, in order for good cause to be granted for this reason, the participant must accept a referral to the Bureau for Children and Families (BCF) Division of Children and Adult Services or a local domestic violence agency. The participant must comply with the requirements of the domestic violence agency plan. This period is limited to six months but may be extended when extenuating circumstances exist and counseling continues at the recommendation of the domestic violence counselor. The Case Manager must maintain close contact with the domestic violence agency and monitor this plan regularly.

14.9.1.C Child Under Six / Unavailable Child Care (TD)

A single parent can prove that appropriate childcare is unavailable for his child, under age six. The client must accept available childcare unless it is an unreasonable distance from the individual's home or work site. Special needs children may require special childcare arrangements. If so, the unavailability of suitable and appropriate care must be considered for special needs children. Circumstances involving unavailable childcare must be reviewed monthly.

14.9.1.D Additional Parent (AP)

The AP component is only used when one parent is in the home caring for the children while the other parent is participating in a countable work activity for the required number of monthly hours.

14.9.1.E Physical/Mental Incapacity (TI – Physical, TM – Mental Health Issues)

An individual is experiencing a physical or mental health condition, or he is suffering from a temporary debilitating injury for which a reasonable accommodation cannot be made, the individual's condition must be reevaluated within the time limits specified by his medical practitioner or at least quarterly. Form DFA-DIMA-1 must be requested to be completed by the medical provider.

For any period of disability or incapacity that is expected to last longer than six months, the case must be submitted to the Medical Review Team (MRT) for evaluation. MRT must also approve all individuals claiming permanent and total disability. See Section 13.3.3 for instructions to determine incapacity.

A Work-Eligible female may be placed in the TI component when her doctor places her on bed rest because of a high-risk pregnancy.

The 12-week postpartum period following the birth of any additional child after having used the 12-month lifetime Age of Child (TF) period. Any time other than the usual 12-week period requires medical documentation of the expected return to work date.

The individual refuses to accept surgery which would eliminate or significantly improve his condition, even if the refusal precludes participation.

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.

14.9.1.F Disability/Incapacity – Definition Only for Temporary Good Cause

NOTE: A two-parent family with one parent disabled or incapacitated according to this section is still considered a two-parent family for minimum participation rate requirements. The family may be temporarily granted good cause for not meeting the minimum requirements. See Section 14.9. Meeting either definition does not automatically exempt the family or individual from the 60-month or 24-month time limits described in Section 18.2 and 18.8.

Disability and incapacity for a Work-Eligible Individual may be established with or without a physician's statement as follows.

14.9.1.F.1 Establishing Disability without a Physician's Statement

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

If the disability is not obvious to the Worker, disability may be established according to other criteria below. If disability cannot be established according to this item (Section 14.9.1.F.1), see Establishing Disability With A Physician's Statement below (Section 14.9.2.F.2).

- 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, Retirement, Survivors and Disability Insurance (RSDI), Supplemental Security Income (SSI), Veteran's Administration (VA) benefits, Black Lung benefits, Medicaid (incapacity, blindness, or disability), private insurance, sickness benefits, etc. However, if any of these conditions are questionable, such as a low percentage disability for VA benefits, a physician's statement may still be required.

  For SSI and RSDI purposes, being certified for these benefits (approved, but not yet receiving payment withheld to repay, etc.) is the same as receiving them.
- The individual is a veteran with a service-connected or non-service-connected disability, rated or paid as total, under Title 38 of the United States Code (USC).
- 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 USC.
- 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 USC.
- 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 USC.
- 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; or
- 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;
  - Medicaid Aged and Disabled Waiver (ADW);
  - Intellectual Developmental Disabilities (I/DD) Waiver; or
  - Traumatic Brain Injury (TBI) Waiver.

14.9.1.F.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 Section 14.9.1.F.1.

14.9.1.F.3 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; and
- Nurse Practitioners.

➢ *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.

➢ *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 C of Chapter 13 as a guideline for presumptively approving an Aid to Families with Dependent Children (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.

- Establishing Incapacity

The definition of incapacity and the procedures for making the determination found in Section 13.4 apply here.

14.10 EFFECT OF WV WORKS SANCTION ON SNAP BENEFITS

A WV WORKS sanction may result in application of a Supplemental Nutrition Assistance Program (SNAP) penalty when the WV WORKS sanction results from failure to comply with a requirement related to an activity which is listed in Sections 18.10 - 18.18.

Even though the WV WORKS benefit closes due to the sanction, SNAP benefits must not increase. See Section 4.4.4.H.2. This applies even when a SNAP penalty is also imposed. See Section 4.4.4.H.1 for the treatment of income for disqualified individuals.

WV WORKS sanctions are applied to all Work-Eligible members of a WV WORKS case, not just to the participant who causes the sanction to be imposed. However, only the participant who causes the WV WORKS sanction to be imposed may be subject to a SNAP penalty.

14.10.1 SNAP PENALTY

The appropriate SNAP penalties found in Section 14.5 are applied to a WV WORKS participant when:

- The participant is exempt from SNAP work requirements only because he is subject to and complying with a WV WORKS work requirement (i.e., if he did not receive WV WORKS, he would be subject to SNAP work requirements); and
- The participant failed to comply with a requirement related to an activity which is listed in Sections 18.10 - 18.18.
- Once the SNAP penalty begins, the full SNAP penalty period must be served, even if the WV WORKS benefit is closed. The penalty is only lifted if:
- The participant is receiving WV WORKS and becomes exempt from WV WORKS work requirements; or
- The participant meets one of the exemptions listed in Section 14.2.1.B, except for receipt of WV WORKS.

NOTE: The non-recipient Work-Eligible Individual who fails to comply with a requirement related to an activity which is listed in Sections 18.10 – 18.18 and who is subject to a WV WORKS sanction is not subject to a SNAP penalty when they are not included in the SNAP assistance group (AG).

14.10.2 SNAP PENALTY EXAMPLES

Example 1: A SNAP AG consists of: Mr. Hollyhock, his two children (ages three and four), Mr. Hollyhock's brother and sister-in-law and their newborn child. Mr. Hollyhock receives a WV WORKS benefit and must meet the WV WORKS work requirements, unless temporarily exempt. The brother and sister-in-law do not receive WV WORKS and must meet the SNAP work requirements. The brother is 17 years old and just graduated from high school. At the last redetermination, the brother was exempted from the SNAP work requirement due to high school attendance. The sister-in-law, who is on extended maternity leave from her employment, is planning to return to work in three months. In October, Mr. Hollyhock and his brother are both offered jobs at the same work site. The work is manual labor and pays minimum wage. Both Mr. Hollyhock and his brother are able to perform the work, but they believe they can find better jobs; both refuse the employment. The Worker determines that neither had good cause for the refusal and applies the following penalties:

For Mr. Hollyhock: A sanction is imposed for WV WORKS and the benefit is closed. The amount of his previous WV WORKS benefit is counted as income for SNAP purposes. A SNAP penalty is not imposed because Mr. Hollyhock is responsible for the care of a child under age six. If he received SNAP only, he would be exempt from SNAP work requirements.

For the brother: No SNAP penalty is applied for the brother's offense because he was exempt at the last redetermination and is not subject to the SNAP work requirements until the next redetermination.

Example 2: Ms. Aster receives a WV WORKS benefit for herself and her three children, ages 15, 12 and 7. She refuses without good cause to pursue child support for her last child and her WV WORKS case is sanctioned. Even though cooperation with the Bureau for Child Support Enforcement (BCSE) is a Personal Responsibility Contract (PRC) requirement, it is not a work-related requirement. Therefore, a SNAP penalty is not applied for this offense.

Example 3: Continuation of example above. After the first WV WORKS sanction has been applied, Ms. Aster fails to participate in her Community Work Experience Program (CWEP) assignment with no reason given. The Case Manager determines that she did not have good cause and applies a second WV WORKS sanction. Because this is a WV WORKS work requirement, a SNAP penalty is applied. Ms. Aster continues in her second WV WORKS sanction and her first SNAP penalty is applied.

Example 4: Ms. Carnation received SNAP for several years before starting to receive WV WORKS. One SNAP penalty was imposed and ended before the WV WORKS benefit started. After becoming a WV WORKS participant, Ms. Carnation is sanctioned for failure to have her 18-month-old child immunized without good cause. Since this is not a work-related activity, no SNAP penalty is applied, but she still has one WV WORKS sanction and one SNAP penalty. A year later, a second WV WORKS sanction is imposed due to failure without good cause to maintain her part-time job of ten hours per week. No SNAP penalty is imposed because she has a child under age six and is exempt from SNAP work requirements for that reason.

Example 5: Ms. Geranium and her three children begin receiving WV WORKS after receiving SNAP for several years; at that time, they have already had two SNAP penalties applied. The children in the home are ages 13, 15 and 17. Ms. Geranium accepts part-time employment, but continues to receive a monthly WV WORKS benefit. Three months later, she quits her job and the Case Manager determines she did not have good cause. The first WV WORKS sanction is applied, and this results in application of the third SNAP penalty because Ms. Geranium would not be exempt from SNAP work requirements if she received SNAP only.

Example 6: Mr. Tulip, a father who is a fleeing felon, is a non-recipient Work-Eligible Individual for WV WORKS. He receives a WV WORKS sanction for failure to participate in his CWEP assignment without good cause. Even though this is a WV WORKS work requirement, a SNAP penalty is not imposed because Mr. Tulip is not included in the SNAP AG. Mrs. Tulip returns to the household and is assigned the same number of WV WORKS sanctions as Mr. Tulip. Since Mrs. Tulip did not cause the WV WORKS sanction, no SNAP penalty is applied to the Mrs. Tulip.

14.11 EFFECT OF WV WORKS SANCTION ON MEDICAID

A WV WORKS sanction or ineligibility has no bearing on Medicaid eligibility, under any coverage group.

Chapter 15

Noncitizens, Refugees, and Citizenship

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
Effective June 14, 2019 INS changed to USCIS				
15.1	2/1/26	873	15.1	Revised definition of Conditional Entrant
15.2	10/1/20 2/1/26	794 873	15.2.3.K.6 15.2.3.K.6	Replace word alien Revised Coherency of Dates
15.3	7/1/21 2/1/26	806 873	806 15.3.1	Added COFA migrant to description of qualified non-citizens Added language to reflect implementation of HR-1 Added a note

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			15.3.2.A	Added language to reflect implementation of HR-1.
			15.3.2.B	Removed language regarding older statuses
			15.3.2.C	Removed language, added new definition of American Indian born in Canada
15.4	2/1/26	873	15.4.1	Added language
15.5				
15.6	10/1/20	794	15.6.1, D & E	Replaced words ineligible/illegal
15.7	5/1/20	786	15.7.6.B.2	Coronavirus (COVID-19) National Emergency
	10/1/20	794	15.7	Replaced words illegal/ineligible
	7/1/21	806	15.7.5.B.1	Added COFA migrant to list of qualified non-citizens
	5/1/23	837	15.7.6.B.2	Removed sentence naming COVID 19 testing and treatment as part of definition for emergency Medicaid. COVID-19 testing, and treatment may not be considered a medical emergency if the date of service is after May 11, 2023.
	7/1/24	852	15.7.5.B.1	Add Ukrainian Nationalists to list of Qualified Non-Citizens.
	11/1/25	870	15.7.6.B.1	Removed reference for pregnant noncitizens; how they are evaluated using Medicaid guidelines and treat an unborn child to avoid confusion.
	2/1/26	873	15.7.1.A	Removed existing language. Added language and eligibility tables
			15.7.1.B	Removed and added language
			15.7.2.A	Removed language. Added language to revise qualified status list.
			15.7.2.B	Removed language.
15.8	7/1/21	806	15.8.6.C	Changed OMRS to RRIS
			15.8.7.A B D	Changed OMRS to RRIS
			15.8.10	Changed OMRS to RRIS
	6/1/22	822	15.8	Updated information for the RCA/RMA extension from 8-months to 12-months
			15.9	
	6/1/25	864	15.8.1	Removed outdated policy, and revised policy according to new federal regulation reducing RCA/RMA period of eligibility from 12 months to 4 months.
			15.8.3.1.A.1	
			15.8.6.E	
			15.8.12	Removed this section altogether. Permanent Resident Status and Refugee Status are two different statuses.
			15.8.3.B	
			15.8.7.A	Corrected the spelling of the acronym RDA to RCA.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	2/1/26	873	15.8.4.D	Added language to describe the referral process to Social Security Administration.
			15.8.4.E	Removed section
			15.8.4.F	Changed section name
			15.8.4.G	Changed section name
			15.8.4.H	Changed section name
			15.8.4.I	Changed section name
			15.8.7.A & 15.8.7.B	Added language to identify CCWVA as a referral agency. Removed language referring to RRIS.
			15.8.9	Removed section
			15.8.10	Changed section ID and name. Added language to identify CCWVA as a referral agency. Removed language referring to RRIS.
			15.8.10.1	Added a new sub-section
			15.8.10.A	Added a new sub-section, utilizing some language from a prior section.
			15.8.10.B	Added a new sub-section
			15.8.11	Changed section ID and name
			15.8.12	Changed the ID name of the section. Added new language to elaborate on RCA policies. Removed some existing language referring to reimbursements.
			15.8.13, 15.8.13.A, 15.8.13.A.1, 15.8.13.A.2, 15.8.13.B & 15.8.14	Changed Section ID
15.9	6/1/25	864	15.9.1 15.9.2.C.1	Removed outdated policy, and revised policy according to new federal regulation reducing RCA/RMA period of eligibility from 12 months to 4 months.
	2/1/26	873	15.9.1	Added language to inform that VOT requires LPR status and 5-year bar for SNAP eligibility.

15.1 DEFINITIONS

ADMISSION NUMBER

An 11-digit number assigned to a noncitizen when he enters the United States (U.S.). This number is frequently found on the Arrival-Departure Record (Form I-94) and should not be confused with the Noncitizen Registration Number (A-Number) defined below.

ALIEN

Any person who is not a citizen or national of the U.S.; also referred to as a noncitizen.

ALIEN REGISTRATION NUMBER OR UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES NUMBER (USCIS/A-NUMBER)

A seven or eight-digit number assigned to a noncitizen at the time his Alien File is created.

ALIEN REGISTRATION RECEIPT CARD

United States Citizenship and Immigration Services (USCIS) document that certifies lawful permanent resident status, commonly called a Green Card; older versions may be green, blue/white, salmon, or pink. It carries the USCIS form number I-151 or I-551.

ALIEN STATUS VERIFICATION INDEX (ASVI)

A database designed for the use of entitlement benefit agencies in verifying noncitizen immigration status in accordance with the Immigration Reform and Control Act of 1986 (IRCA).

AMERASIAN (VIETNAM)

Children born in Vietnam to Vietnamese mothers and American fathers and are admitted to the U.S. under P.L. 100-202 as immigrants but are entitled to the same social services and assistance benefits as refugees. Spouses, children, and parents or guardians may accompany the noncitizen to the U.S.

ASYLEE

A noncitizen already in the U.S. or at a port of entry who is granted asylum in the U.S. Asylum may be granted to those persons who are unable or unwilling to return to their countries of nationality, or to seek the protection of those countries, because of persecution or a well-founded fear of persecution. This status is covered by Section 208 of the Immigration and Nationality Act of 1952 (INA).

See REFUGEEwhich explains the difference between asylum and refuge in the U.S.

CENTRAL INDEX SYSTEM (CIS)

An automated system containing information on noncitizens. The CIS, from which ASVI is extracted, is the USCIS' most complete database of information on noncitizens in the U.S.

CERTIFICATE OF CITIZENSHIP

An identity document proving U.S. citizenship.

CERTIFICATE OF NATURALIZATION

An identity document proving U.S. citizenship.

CHANGE OF NONIMMIGRANT STATUS

The action of changing a nonimmigrant's classification (e.g., from visitor to student).

CITIZEN

A person born in a country or who has become a naturalized citizen of that country.

CONDITIONAL ENTRANT

A status that is now considered obsoleted which used to refer to individuals granted conditional entry under the same criteria as a refugee.

CONDITIONAL PERMANENT RESIDENT

A conditional permanent resident receives a Permanent Resident Card valid for two years. In order to remain a permanent resident, a conditional permanent resident must file a petition to remove the condition during the 90 days before the card expires. The conditional card cannot be renewed. The conditions must be removed, or permanent resident status will be lost.

CONDITIONAL RESIDENT NONCITIZEN

A noncitizen granted conditional resident status based on marriage to a U.S. citizen or national, or a permanent resident noncitizen; conditional status is removed after two years if USCIS rules favorably on a petition by the noncitizen for retention of lawful permanent residence. (The noncitizen's children, under the age of 18, can also be granted this status.) During the pendency of any such petition not adjudicated by the end of the two years, the noncitizen can present his I-551 and an USCIS receipt for the filed petition as proof of work authorization.

CUBAN/HAITIAN ENTRANT

The status afforded to (a) Cubans who entered the U.S. illegally between April 15, 1980, and October 10, 1980, and to (b) Haitians who entered the country illegally before January 1, 1981. This status is covered by Section 520(e) of Public Law 96-422.

DOCUMENT VERIFICATION REQUEST (FORM G-845)

A form designed for use by entitlement benefit agencies to request secondary verification of noncitizen status from USCIS under the Immigration Reform and Control Act of 1986. This is used by the Systematic Alien Verification for Entitlement (SAVE) Coordinator for such requests to USCIS.

DOCUMENT NONCITIZEN

A noncitizen in the U.S. who is in possession of valid documents. See Section 15.2.3 for examples of valid documents.

ELIGIBLE LEGALIZED ALIEN (ELA)

A noncitizen who has been granted lawful temporary resident status under Section 245A or Section 210 of the Immigration Reform and Control Act (IRCA) of 1986 and who may apply for permanent resident noncitizen status.

ENGLISH AS A SECOND LANGUAGE (ESL) OR ENGLISH FOR SPEAKERS OF OTHER LANGUAGES (ESOL)

The use or study of English by speakers with different native languages.

FAMILY UNIT

Provides protection from deportation and eligibility for employment authorization to the spouses and children of noncitizens who were legalized under the IRCA.

GREEN CARD

A slang term describing the Permanent Resident Card (Form I-151 or Form I-551). Many versions of these forms are not green in color.

ILLEGAL NONCITIZEN

A foreign national who either entered the U.S. without inspection, entered with fraudulent documentation, or who, after entering legally as a nonimmigrant, violated status and remained in the U.S. without authorization. See the definition for undocumented noncitizen, which is one type of illegal noncitizen.

IMMIGRANT

A noncitizen who has been lawfully afforded the privilege of residing permanently in the U.S. with the right to eventually obtain citizenship. This status allows authorization for work and entitlement benefits. See the definitions for lawful permanent resident noncitizen and permanent resident noncitizen, which are terms used interchangeably with immigrant.

IMMIGRATION AND NATURALIZATION SERVICE (INS)

The federal agency under the Department of Homeland Security that administers immigration law.

IMMIGRATION STATUS

The legal status conferred on a noncitizen by immigration laws.

IMMIGRATION STATUS VERIFIER (ISV)

An USCIS employee who performs secondary verification duties at the local File Control Offices.

INELIGIBLE NONCITIZEN

See nonimmigrant. Exceptions are made for pregnant women and children 18 and under for Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP); see Section 15.7.5.

LAWFUL PERMANENT RESIDENT ALIEN (LPRA)

A noncitizen who has been lawfully afforded the privilege of residing permanently in the U.S. See the definitions for IMMIGRANT and PERMANENT RESIDENT NONCITIZEN, which are terms used interchangeably with this term.

LAWFULLY PRESENT

For Medicaid and WVCHIP, a noncitizen who has been legally permitted to enter the U.S. and meets the state residency requirements in Section 2.2. See Section 15.7.5 for an inclusive list of lawfully present individuals.

NATIONAL OF THE U.S.

A citizen of the U.S. or an individual who, though not a citizen of the U.S., owes permanent allegiance to the U.S.

NATIONALITY

The state or country to which a person has legal allegiance. Note that the country of birth does not necessarily correspond to the nationality.

NATURALIZATION

The legal act of becoming a citizen, other than birth. A resident noncitizen married to a U.S.-born citizen must hold permanent resident noncitizen status for three years before petitioning for naturalization. Also, others must hold permanent resident status for five years before petitioning for naturalization.

NONCITIZEN

Any person who is not a citizen or national of the U.S.; also referred to as an alien.

NONIMMIGRANT

A noncitizen who is permitted to enter the U.S. for a specific purpose and for a limited period of time. Examples include tourists, students, and business visitors.

PAROLEE

A noncitizen who appears to be inadmissible to the inspecting officer, but who is permitted to enter the U.S. under emergency conditions or because that noncitizen's entry is determined to be in the public interest. Although parolees are required to leave when the conditions supporting their parole cease to exist, they may sometimes adjust immigration status.

PASSPORT

Any travel document issued by a competent authority showing the bearer's origin, identity, and nationality, if any, which is valid for the entry of the bearer into a foreign country.

PERMANENT RESIDENT NONCITIZEN

A person who enters the country with an immigrant visa or adjusts his status after entering as a nonimmigrant, Refugee or asylee. Persons with this status are entitled to live and work in the U.S. and collect entitlement benefits, if qualified. See the definitions for immigrant and lawful permanent resident noncitizen, which are terms used interchangeably with this term.

PRIMARY VERIFICATION

A query to validate noncitizen documentation using the ASVI system.

REFUGEE

Any person who is outside his country of nationality and who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Unlike asylees, refugees apply for and receive this status prior to entry into the U.S.

REPLENISHMENT AGRICULTURAL WORKER (RAW)

Any noncitizen who is granted temporary or permanent resident status under Section 210A(c) of the Immigration and Nationality Act, as amended by IRCA, based on prior agricultural employment within the U.S. The RAW program was implemented during a fiscal year from 1990 – 1993 only upon announcement by the Secretaries of Agriculture and Labor of a shortage of agricultural workers in the U.S. for that fiscal year.

SECONDARY VERIFICATION

A request to validate noncitizen documentation, after or in lieu of primary verification, using Form G-845. Secondary verification is performed by the ISV using various automated or manual sources. This is completed by the Division of Family Assistance (DFA) Systematic Alien Verification for Entitlement (SAVE) Coordinator.

SEVERE VICTIM OF TRAFFICKING AND VIOLENCE

An individual who has been used in severe forms of trafficking in persons. For example, sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the

person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provisions, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENT (SAVE)

An automated or manual information-sharing program whereby state agencies may verify the immigration status of noncitizen applicants for entitlement benefits. This verification is completed by the SAVE Coordinator upon request from the Worker.

TEMPORARY LAWFUL RESIDENT NONCITIZEN

A noncitizen granted a one-year period of lawful resident status based on his qualifications under the legalization or Special Agricultural Worker (SAW) programs. The temporary status may be removed after one year, when USCIS rules favorably or unfavorably on granting permanent lawful resident status to the noncitizen.

UNDOCUMENTED NONCITIZEN

A noncitizen in the U.S. without proper documentation. He is in violation of U.S. immigration law. (See also the definition for illegal noncitizen for a broader explanation of unauthorized noncitizens in the U.S.).

UNITED STATES

Defined in a geographical sense as the continental U.S., Alaska, Hawaii, Puerto Rico, Guam, U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS)

The federal agency under the Department of Homeland Security that administers immigration law.

15.2 IMMIGRATION DOCUMENTS

15.2.1 INTRODUCTION

To determine eligibility for federal programs, the Worker must identify the noncitizen's immigration status based on information contained in immigration documents and then match that information to noncitizen eligibility guidelines. See Section 15.7.

Immigration documents should include the individual's name, date of birth, and a reference to the individual's noncitizen registration number (A-Number), which is assigned by the United States Citizenship and Immigration Services (USCIS).

Noncitizens age 18 years or older must have immigration documentation in their possession at all times. Noncitizens without documentation should be referred to the local USCIS office located in Pittsburgh, Pennsylvania, to request replacement documentation.

NOTE: An A-Number is the same as a United States Citizenship and Immigration Services (USCIS) number. These two terms may be used interchangeably.

15.2.2 EXAMINING USCIS DOCUMENTS

All noncitizen applicants for benefits must present original documentation of noncitizen registration. A copy of the documentation must be kept in the case record. These documents should show the A-Number of the noncitizen, except for Form I-94, which does not always include an A-Number. Some forms, as noted, have expiration dates. These dates should be checked during initial viewing of the documentation.

15.2.2.A Sources of Verification of Noncitizen Status

Immigration documentation includes, but is not limited to, the following forms.

Samples for most of these documents with background information and coding keys for documents I-94, I-551, I-151, and I-688B are found in Section 15.2.3.

Some USCIS documentation does not contain a photograph of the bearer. When such documentation is presented, the Worker should ask for an additional identification document that includes a photograph, such as a driver's license or an employee's badge.

NOTE: An asterisk (*) indicates documentation for qualified noncitizens.

I-94*

Arrival/Departure Record (expires, does not always contain A-Number)

I-134

Affidavit of Support (not valid on December 19, 1997)

I-179*

U.S. Citizen I.D. Card (last issued February 1974)

I-197*

U.S. Citizen I.D. Card (issued until April 7, 1983)

I-210

Voluntary Departure

I-221S

Order to Show Cause

I-327

Reentry Permit (expires)

I-444

Mexican Border Visitors Permit (limited to states they may visit)

I-512

Parole Authorization

I-551*

Resident Noncitizen Card (commonly known as a Green Card)

I-551*

Unexpired Temporary Stamp in Foreign Passport (or on USCIS Form 1-94)

I-571*

Refugee Travel Document (expires)

I-580

Mexican Border Crossing Card (limited to area they may travel in)

I-688

Temporary Resident Card (expires)

I-688A

Employment Authorization for Legalization Applicants (expires)

I-688B*

Employment Authorization Document (EAD) (expires)

I-766*

Employment Authorization Document

I-797

Family Unity Approval Notice

I-864*

New Affidavit of Support (effective December 19, 1997)

N-550*

Certificate of Naturalization

N-560*

Certificate of Citizenship

N-561*

Certificate of Citizenship

N-570*

Certificate of Naturalization

NO ASSIGNED NUMBER

Decision Granting Asylum

NO ASSIGNED NUMBER

Order Granting Suspension of Deportation

15.2.2.B Methods of Documenting U.S. Citizenship

The following documents may be used to verify U.S. citizenship of applicants when their noncitizen status is questionable:

- Birth certificate.
- Religious document, such as a baptismal record, recorded within three months of age and showing that the ceremony took place in the U.S. or its territories. The document must show either the date of birth or the individual's age at the time the record was made.

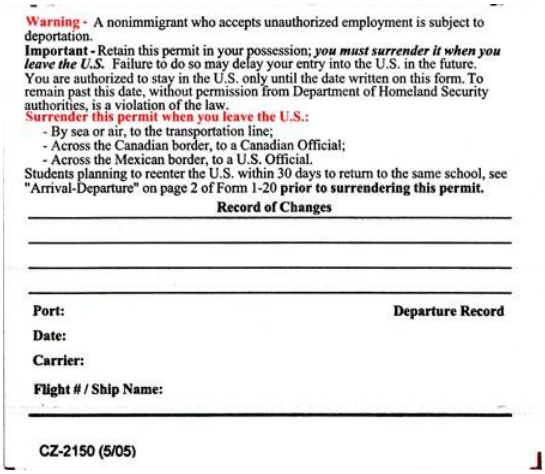
NOTE: See Section 7.4 for additional information regarding the requirements for documentary evidence of citizenship and identity for Medicaid.

- U.S. passports; limited passports that are issued for periods of less than five years are not acceptable.
- Form FS-240, Report of Birth Abroad of a Citizen of the U.S.
- Form FS-545, Certificate of Birth.
- I-197, U.S. Citizen I.D. Card.
- N-550 or N-0570, Naturalization Certificate.
- N-560 or N-561, Certificate of Citizenship.
- Northern Mariana Identification Card issued by USCIS to a collectively naturalized citizen of the United States (U.S.) who was born in the Mariana Islands before November 3, 1996.
- Current hospital record of birth in one of the 50 states, the District of Columbia, or Puerto Rico, on or after January 13, 1941; Guam, on or after April 10, 1899; the U.S. Virgin Islands, on or after January 17, 1917; American Samoa, Swains Island, or the Northern Mariana Islands, unless the person was born to foreign diplomats residing in such a jurisdiction.

15.2.3 EXAMPLES OF IMMIGRATION DOCUMENTS, SOURCES OF VERIFICATION OF NONCITIZEN STATUS

15.2.3.A I-94 Arrival/Departure Record

Issued by USCIS to certain classes of noncitizens and nonimmigrant noncitizens. The I-94 does not include an A-Number and will not contain a photograph. The expiration date is noted on the Form I-94.



Warning - A nonimmigrant who accepts unauthorized employment is subject to deportation.
Important - Retain this permit in your possession; ***you must surrender it when you leave the U.S.*** Failure to do so may delay your entry into the U.S. in the future. You are authorized to stay in the U.S. only until the date written on this form. To remain past this date, without permission from Department of Homeland Security authorities, is a violation of the law.
Surrender this permit when you leave the U.S.:
- By sea or air, to the transportation line;
- Across the Canadian border, to a Canadian Official;
- Across the Mexican border, to a U.S. Official.

Students planning to reenter the U.S. within 30 days to return to the same school, see "Arrival-Departure" on page 2 of Form 1-20 **prior to surrendering this permit.**

Record of Changes

Port: **Departure Record**
Date:
Carrier:
Flight # / Ship Name:

CZ-2150 (5/05)



Departure Number
OMB No. 1651-0111

626633123 12

ADMITTED ATL
JUN 25 2006
CBP/INS Unit
L-1
April 23, 2009

I-94
Departure Record

14. Family Name
SAMPLE

15. First (Given) Name
JANE

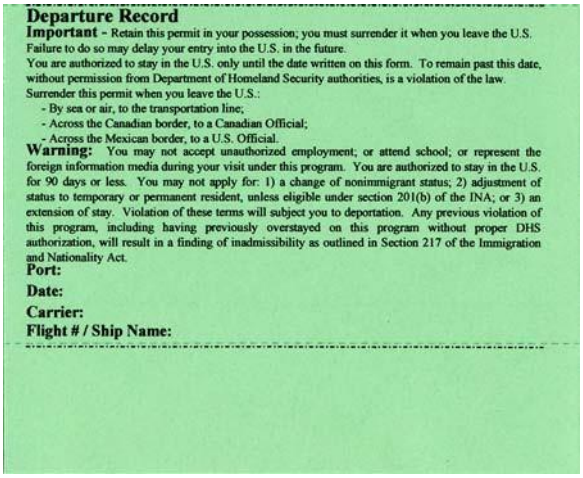
16. Birth Date (Day/Mo/Yr)
23 03 68

17. Country of Citizenship
NEW ZEALAND

See Other Side

CBP Form I-94 (10/04)
STAPLE HERE

15.2.3.B I-94 W

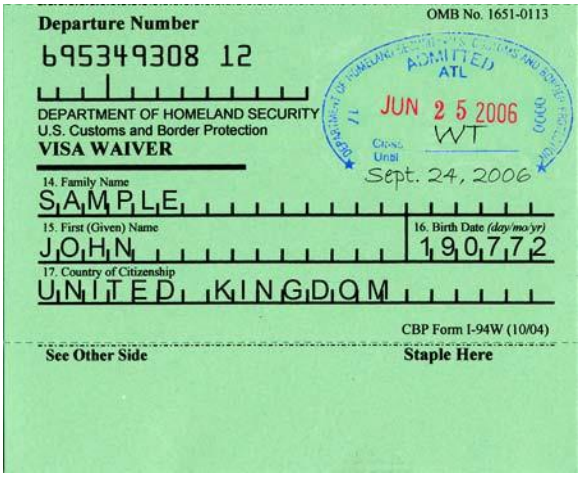


Departure Record

Important - Retain this permit in your possession; you must surrender it when you leave the U.S. Failure to do so may delay your entry into the U.S. in the future.
You are authorized to stay in the U.S. only until the date written on this form. To remain past this date, without permission from Department of Homeland Security authorities, is a violation of the law.
Surrender this permit when you leave the U.S.:
- By sea or air, to the transportation line;
- Across the Canadian border, to a Canadian Official;
- Across the Mexican border, to a U.S. Official.

Warning: You may not accept unauthorized employment; or attend school; or represent the foreign information media during your visit under this program. You are authorized to stay in the U.S. for 90 days or less. You may not apply for: 1) a change of nonimmigrant status; 2) adjustment of status to temporary or permanent resident, unless eligible under section 201(b) of the INA; or 3) an extension of stay. Violation of these terms will subject you to deportation. Any previous violation of this program, including having previously overstayed on this program without proper DHS authorization, will result in a finding of inadmissibility as outlined in Section 217 of the Immigration and Nationality Act.

Port:
Date:
Carrier:
Flight # / Ship Name:



Departure Number OMB No. 1651-0113

695349308 12

ADMITTED ATL
JUN 25 2006
WT

DEPARTMENT OF HOMELAND SECURITY
U.S. Customs and Border Protection
VISA WAIVER

Class Until Sept. 24, 2006

14. Family Name
SAMPLE

15. First (Given) Name
JOHN

16. Birth Date *(day/mo/yr)*
19072

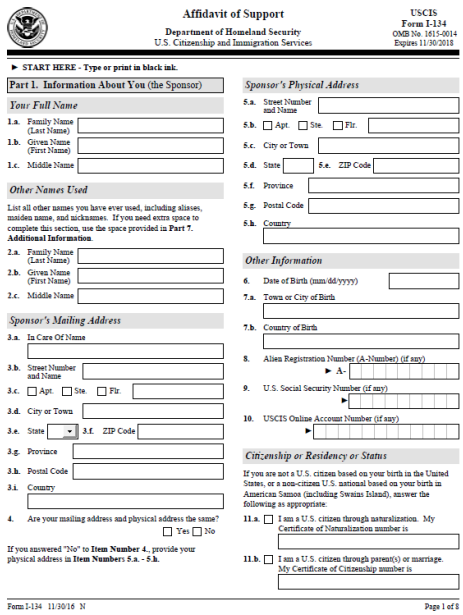
17. Country of Citizenship
UNITED KINGDOM

CBP Form I-94W (10/04)

See Other Side **Staple Here**

15.2.3.C I-134 Affidavit of Support

When a noncitizen applies for an immigrant visa, sometimes he needs a sponsor to submit an affidavit promising to financially assist the noncitizen should it be necessary. Whether a noncitizen has a sponsor is relevant for public benefit eligibility because the income of the sponsor may be “deemed” to the noncitizen when applying for certain federal programs.



Affidavit of Support

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-134
OMB No. 1615-0014
Expires 11/30/2018

► START HERE - Type or print in black ink.

Part 1. Information About You (the Sponsor)

Your Full Name

1.a. Family Name (Last Name)
1.b. Given Name (First Name)
1.c. Middle Name

Other Names Used

List all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in **Part 7. Additional Information**.

2.a. Family Name (Last Name)
2.b. Given Name (First Name)
2.c. Middle Name

Sponsor's Mailing Address

3.a. In Care Of Name
3.b. Street Number and Name
3.c. ☐ Apt. ☐ Ste. ☐ Flr.
3.d. City or Town
3.e. State 3.f. ZIP Code
3.g. Province
3.h. Postal Code
3.i. Country
4. Are your mailing address and physical address the same? ☐ Yes ☐ No

If you answered "No" to **Item Number 4.**, provide your physical address in **Item Numbers 5.a. - 5.h.**

Sponsor's Physical Address

5.a. Street Number and Name
5.b. ☐ Apt. ☐ Ste. ☐ Flr.
5.c. City or Town
5.d. State 5.e. ZIP Code
5.f. Province
5.g. Postal Code
5.h. Country

Other Information

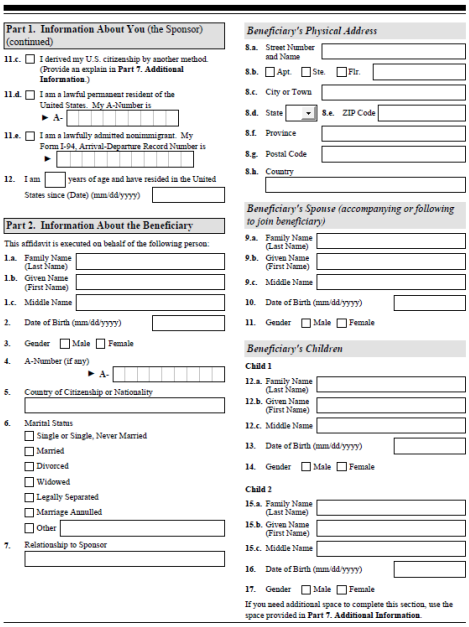
6. Date of Birth (mm/dd/yyyy)
7.a. Town or City of Birth
7.b. Country of Birth
8. Alien Registration Number (A-Number) (if any) ► A-
9. U.S. Social Security Number (if any) ►
10. USCIS Online Account Number (if any) ►

Citizenship or Residency or Status

If you are not a U.S. citizen based on your birth in the United States, or a non-citizen U.S. national based on your birth in American Samoa (including Swains Island), answer the following as appropriate:

11.a. ☐ I am a U.S. citizen through naturalization. My Certificate of Naturalization number is
11.b. ☐ I am a U.S. citizen through parent(s) or marriage. My Certificate of Citizenship number is

Form I-134 11/30/16 N — Page 1 of 8



Part 1. Information About You (the Sponsor) (continued)

11.c. ☐ I derived my U.S. citizenship by another method. (Provide an explain in **Part 7. Additional Information**.)
11.d. ☐ I am a lawful permanent resident of the United States. My A-Number is ► A-
11.e. ☐ I am a lawfully admitted nonimmigrant. My Form I-94, Arrival-Departure Record Number is ►
12. I am years of age and have resided in the United States since (Date) (mm/dd/yyyy)

Part 2. Information About the Beneficiary

This affidavit is executed on behalf of the following person:

1.a. Family Name (Last Name)
1.b. Given Name (First Name)
1.c. Middle Name
2. Date of Birth (mm/dd/yyyy)
3. Gender ☐ Male ☐ Female
4. A-Number (if any) ► A-
5. Country of Citizenship or Nationality
6. Marital Status
☐ Single or Single, Never Married
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated
☐ Marriage Annulled
☐ Other
7. Relationship to Sponsor

Beneficiary's Physical Address

8.a. Street Number and Name
8.b. ☐ Apt. ☐ Ste. ☐ Flr.
8.c. City or Town
8.d. State 8.e. ZIP Code
8.f. Province
8.g. Postal Code
8.h. Country

Beneficiary's Spouse (accompanying or following to join beneficiary)

9.a. Family Name (Last Name)
9.b. Given Name (First Name)
9.c. Middle Name
10. Date of Birth (mm/dd/yyyy)
11. Gender ☐ Male ☐ Female

Beneficiary's Children

Child 1

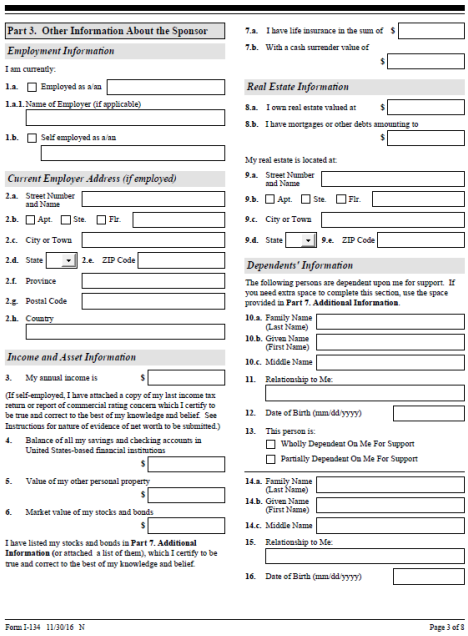
12.a. Family Name (Last Name)
12.b. Given Name (First Name)
12.c. Middle Name
13. Date of Birth (mm/dd/yyyy)
14. Gender ☐ Male ☐ Female

Child 2

15.a. Family Name (Last Name)
15.b. Given Name (First Name)
15.c. Middle Name
16. Date of Birth (mm/dd/yyyy)
17. Gender ☐ Male ☐ Female

If you need additional space to complete this section, use the space provided in **Part 7. Additional Information**.

Form I-134 11/30/16 N — Page 2 of 8



Part 3. Other Information About the Sponsor

Employment Information

I am currently:

1.a. ☐ Employed as a/an
1.a.1. Name of Employer (if applicable)
1.b. ☐ Self employed as a/an

Current Employer Address (if employed)

2.a. Street Number and Name
2.b. ☐ Apt. ☐ Ste. ☐ Flr.
2.c. City or Town
2.d. State 2.e. ZIP Code
2.f. Province
2.g. Postal Code
2.h. Country

Income and Asset Information

3. My annual income is $

(If self-employed, I have attached a copy of my last income tax return or report of commercial rating concern which I certify to be true and correct to the best of my knowledge and belief. See Instructions for nature of evidence of net worth to be submitted.)

4. Balance of all my savings and checking accounts in United States-based financial institutions $
5. Value of my other personal property $
6. Market value of my stocks and bonds $

I have listed my stocks and bonds in **Part 7. Additional Information** (or attached a list of them), which I certify to be true and correct to the best of my knowledge and belief.

7.a. I have life insurance in the sum of $
7.b. With a cash surrender value of $

Real Estate Information

8.a. I own real estate valued at $
8.b. I have mortgages or other debts amounting to $

My real estate is located at:

9.a. Street Number and Name
9.b. ☐ Apt. ☐ Ste. ☐ Flr.
9.c. City or Town
9.d. State 9.e. ZIP Code

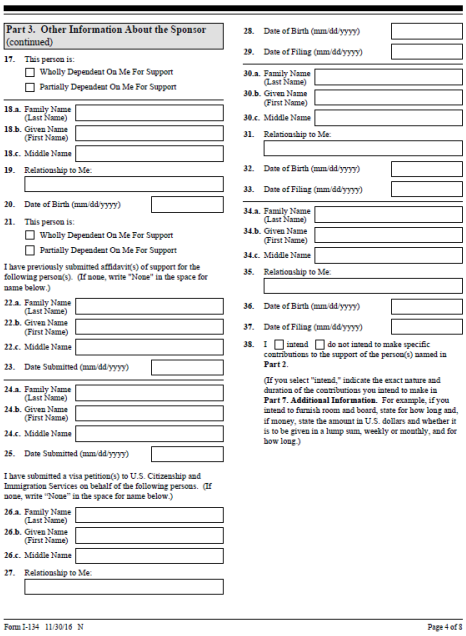
Dependents' Information

The following persons are dependent upon me for support. If you need extra space to complete this section, use the space provided in **Part 7. Additional Information**.

10.a. Family Name (Last Name)
10.b. Given Name (First Name)
10.c. Middle Name
11. Relationship to Me:
12. Date of Birth (mm/dd/yyyy)
13. This person is:
☐ Wholly Dependent On Me For Support
☐ Partially Dependent On Me For Support

14.a. Family Name (Last Name)
14.b. Given Name (First Name)
14.c. Middle Name
15. Relationship to Me:
16. Date of Birth (mm/dd/yyyy)

Form I-134 11/30/16 N — Page 3 of 8



Part 3. Other Information About the Sponsor (continued)

17. This person is:
☐ Wholly Dependent On Me For Support
☐ Partially Dependent On Me For Support

18.a. Family Name (Last Name)
18.b. Given Name (First Name)
18.c. Middle Name
19. Relationship to Me:
20. Date of Birth (mm/dd/yyyy)
21. This person is:
☐ Wholly Dependent On Me For Support
☐ Partially Dependent On Me For Support

I have previously submitted affidavit(s) of support for the following person(s). (If none, write "None" in the space for name below.)

22.a. Family Name (Last Name)
22.b. Given Name (First Name)
22.c. Middle Name
23. Date Submitted (mm/dd/yyyy)

24.a. Family Name (Last Name)
24.b. Given Name (First Name)
24.c. Middle Name
25. Date Submitted (mm/dd/yyyy)

I have submitted a visa petition(s) to U.S. Citizenship and Immigration Services on behalf of the following persons. (If none, write "None" in the space for name below.)

26.a. Family Name (Last Name)
26.b. Given Name (First Name)
26.c. Middle Name
27. Relationship to Me:
28. Date of Birth (mm/dd/yyyy)
29. Date of Filing (mm/dd/yyyy)

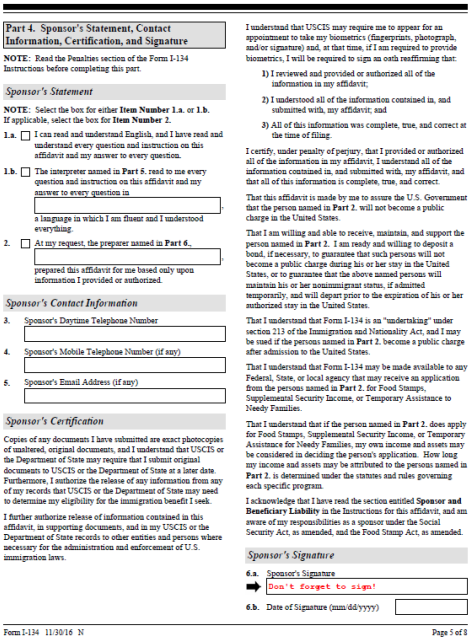
30.a. Family Name (Last Name)
30.b. Given Name (First Name)
30.c. Middle Name
31. Relationship to Me:
32. Date of Birth (mm/dd/yyyy)
33. Date of Filing (mm/dd/yyyy)

34.a. Family Name (Last Name)
34.b. Given Name (First Name)
34.c. Middle Name
35. Relationship to Me:
36. Date of Birth (mm/dd/yyyy)
37. Date of Filing (mm/dd/yyyy)

38. I ☐ intend ☐ do not intend to make specific contributions to the support of the person(s) named in **Part 2.**

(If you select "intend," indicate the exact nature and duration of the contributions you intend to make in **Part 7. Additional Information.** For example, if you intend to furnish room and board, state for how long and, if money, state the amount in U.S. dollars and whether it is to be given in a lump sum, weekly or monthly, and for how long.)

Form I-134 11/30/16 N — Page 4 of 8



Part 4. Sponsor's Statement, Contact Information, Certification, and Signature

NOTE: Read the Penalties section of the Form I-134 Instructions before completing this part.

Sponsor's Statement

NOTE: Select the box for either **Item Number 1.a.** or **1.b.** If applicable, select the box for **Item Number 2.**

1.a. ☐ I can read and understand English, and I have read and understand every question and instruction on this affidavit and my answer to every question.

1.b. ☐ The interpreter named in **Part 5.** read to me every question and instruction on this affidavit and my answer to every question in _____, a language in which I am fluent and I understood everything.

2. ☐ At my request, the preparer named in **Part 6.**, _____, prepared this affidavit for me based only upon information I provided or authorized.

Sponsor's Contact Information

3. Sponsor's Daytime Telephone Number

4. Sponsor's Mobile Telephone Number (if any)

5. Sponsor's Email Address (if any)

Sponsor's Certification

Copies of any documents I have submitted are exact photocopies of unaltered, original documents, and I understand that USCIS or the Department of State may require that I submit original documents to USCIS or the Department of State at a later date. Furthermore, I authorize the release of any information from any of my records that USCIS or the Department of State may need to determine my eligibility for the immigration benefit I seek.

I further authorize release of information contained in this affidavit, in supporting documents, and in my USCIS or the Department of State records to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws.

I understand that USCIS may require me to appear for an appointment to take my biometrics (fingerprints, photograph, and/or signature) and, at that time, if I am required to provide biometrics, I will be required to sign an oath reaffirming that:

1) I reviewed and provided or authorized all of the information in my affidavit;

2) I understood all of the information contained in, and submitted with, my affidavit; and

3) All of this information was complete, true, and correct at the time of filing.

I certify, under penalty of perjury, that I provided or authorized all of the information in my affidavit, I understand all of the information contained in, and submitted with, my affidavit, and that all of this information is complete, true, and correct.

That this affidavit is made by me to assure the U.S. Government that the person named in **Part 2.** will not become a public charge in the United States.

That I am willing and able to receive, maintain, and support the person named in **Part 2.** I am ready and willing to deposit a bond, if necessary, to guarantee that such persons will not become a public charge during his or her stay in the United States, or to guarantee that the above named persons will maintain his or her nonimmigrant status, if admitted temporarily, and will depart prior to the expiration of his or her authorized stay in the United States.

That I understand that Form I-134 is an "undertaking" under section 213 of the Immigration and Nationality Act, and I may be sued if the persons named in **Part 2.** become a public charge after admission to the United States.

That I understand that Form I-134 may be made available to any Federal, State, or local agency that may receive an application from the persons named in **Part 2.** for Food Stamps, Supplemental Security Income, or Temporary Assistance to Needy Families.

That I understand that if the person named in **Part 2.** does apply for Food Stamps, Supplemental Security Income, or Temporary Assistance for Needy Families, my own income and assets may be considered in deciding the person's application. How long my income and assets may be attributed to the persons named in **Part 2.** is determined under the statutes and rules governing each specific program.

I acknowledge that I have read the section entitled **Sponsor and Beneficiary Liability** in the Instructions for this affidavit, and am aware of my responsibilities as a sponsor under the Social Security Act, as amended, and the Food Stamp Act, as amended.

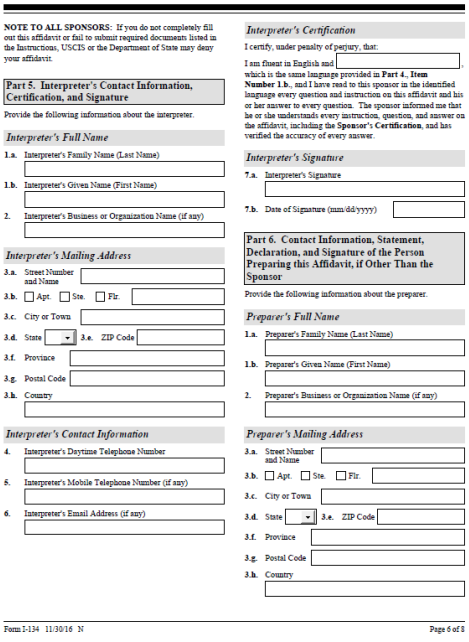
Sponsor's Signature

6.a. Sponsor's Signature

➡ Don't forget to sign!

6.b. Date of Signature (mm/dd/yyyy)

Form I-134 11/30/16 N — Page 5 of 8



NOTE TO ALL SPONSORS: If you do not completely fill out this affidavit or fail to submit required documents listed in the Instructions, USCIS or the Department of State may deny your affidavit.

Part 5. Interpreter's Contact Information, Certification, and Signature

Provide the following information about the interpreter.

Interpreter's Full Name

1.a. Interpreter's Family Name (Last Name)

1.b. Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name (if any)

Interpreter's Mailing Address

3.a. Street Number and Name

3.b. ☐ Apt. ☐ Ste. ☐ Flr.

3.c. City or Town

3.d. State **3.e.** ZIP Code

3.f. Province

3.g. Postal Code

3.h. Country

Interpreter's Contact Information

4. Interpreter's Daytime Telephone Number

5. Interpreter's Mobile Telephone Number (if any)

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____, which is the same language provided in **Part 4., Item Number 1.b.**, and I have read to this sponsor in the identified language every question and instruction on this affidavit and his or her answer to every question. The sponsor informed me that he or she understands every instruction, question, and answer on the affidavit, including the **Sponsor's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7.a. Interpreter's Signature

7.b. Date of Signature (mm/dd/yyyy)

Part 6. Contact Information, Statement, Declaration, and Signature of the Person Preparing this Affidavit, if Other Than the Sponsor

Provide the following information about the preparer.

Preparer's Full Name

1.a. Preparer's Family Name (Last Name)

1.b. Preparer's Given Name (First Name)

2. Preparer's Business or Organization Name (if any)

Preparer's Mailing Address

3.a. Street Number and Name

3.b. ☐ Apt. ☐ Ste. ☐ Flr.

3.c. City or Town

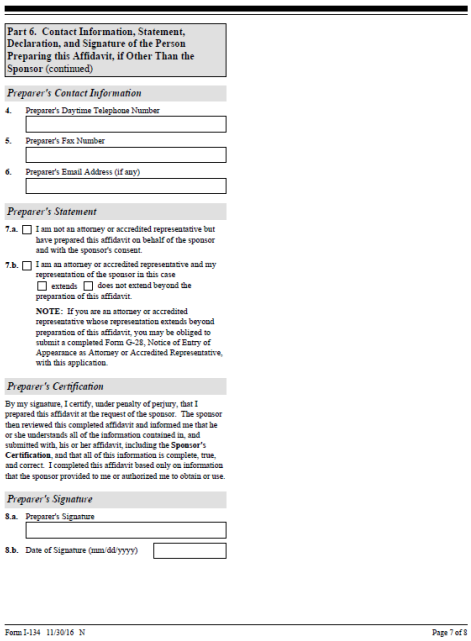
3.d. State **3.e.** ZIP Code

3.f. Province

3.g. Postal Code

3.h. Country

Form I-134 11/30/16 N — Page 6 of 8



Part 6. Contact Information, Statement, Declaration, and Signature of the Person Preparing this Affidavit, if Other Than the Sponsor (continued)

Preparer's Contact Information

4. Preparer's Daytime Telephone Number

5. Preparer's Fax Number

6. Preparer's Email Address (if any)

Preparer's Statement

7.a. ☐ I am not an attorney or accredited representative but have prepared this affidavit on behalf of the sponsor and with the sponsor's consent.

7.b. ☐ I am an attorney or accredited representative and my representation of the sponsor in this case ☐ extends ☐ does not extend beyond the preparation of this affidavit.

NOTE: If you are an attorney or accredited representative whose representation extends beyond preparation of this affidavit, you may be obliged to submit a completed Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative, with this application.

Preparer's Certification

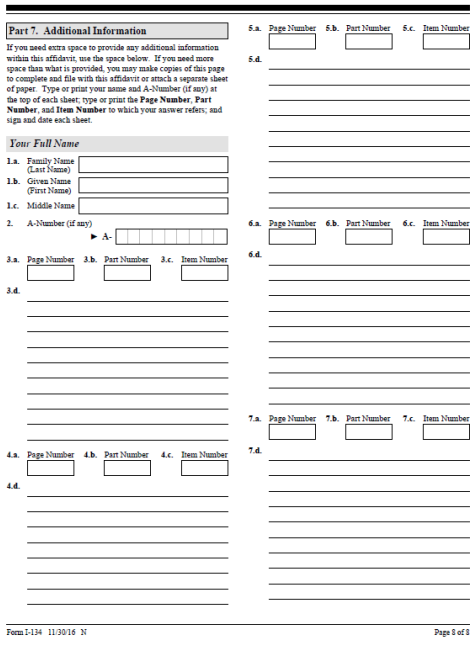
By my signature, I certify, under penalty of perjury, that I prepared this affidavit at the request of the sponsor. The sponsor then reviewed this completed affidavit and informed me that he or she understands all of the information contained in, and submitted with, his or her affidavit, including the **Sponsor's Certification**, and that all of this information is complete, true, and correct. I completed this affidavit based only on information that the sponsor provided to me or authorized me to obtain or use.

Preparer's Signature

8.a. Preparer's Signature

8.b. Date of Signature (mm/dd/yyyy)

Form I-134 11/30/16 N — Page 7 of 8



Part 7. Additional Information

If you need extra space to provide any additional information within this affidavit, use the space below. If you need more space than what is provided, you may make copies of this page to complete and file with this affidavit or attach a separate sheet of paper. Type or print your name and A-Number (if any) at the top of each sheet; type or print the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet.

Your Full Name

1.a. Family Name (Last Name)

1.b. Given Name (First Name)

1.c. Middle Name

2. A-Number (if any) ► A-

3.a. Page Number **3.b.** Part Number **3.c.** Item Number

3.d.

4.a. Page Number **4.b.** Part Number **4.c.** Item Number

4.d.

5.a. Page Number **5.b.** Part Number **5.c.** Item Number

5.d.

6.a. Page Number **6.b.** Part Number **6.c.** Item Number

6.d.

7.a. Page Number **7.b.** Part Number **7.c.** Item Number

7.d.

Form I-134 11/30/16 N — Page 8 of 8

15.2.3.D I-151 Alien Registration Receipt Card

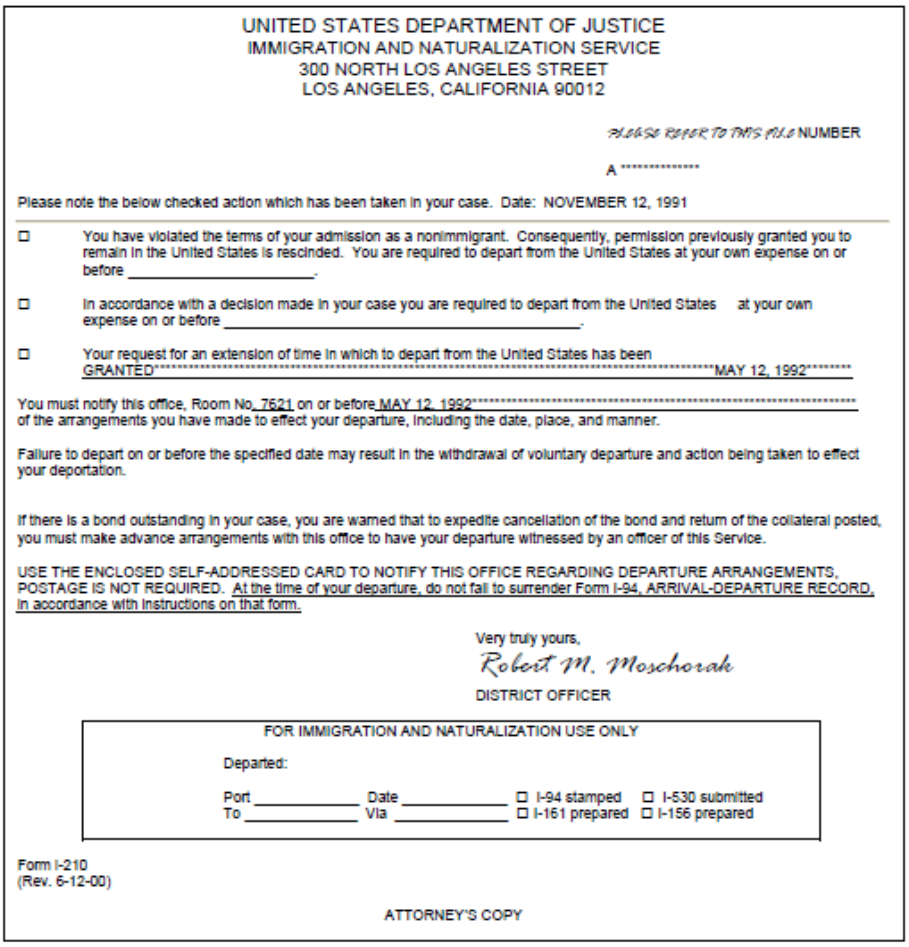
Issued in the past by USCIS to lawful permanent resident noncitizens, this card is no longer issued and is no longer considered a valid verification document. USCIS is conducting a program to replace Form I-151 with the more recent Permanent Resident Card, Form I-551. This program was extended to March 20, 1996. USCIS will continue to honor the I-151 cards in order to avoid confusion over employment rights and entitlement benefits, such as the Supplemental Nutrition Assistance Program (SNAP), for those lawful permanent residents who either have not yet applied for the new card or are awaiting receipt of the document. USCIS requests that workers urge noncitizen recipients to apply for the new I-551 Permanent Resident Card as soon as possible. Individuals seeking to replace their Permanent Resident Cards may be referred to the USCIS toll-free number, (800) 755-0777, for information on how and where to apply for the new card.





15.2.3.E I-210 Voluntary Departure

“Voluntary Departure” is a status that allows a noncitizen to remain in the U.S. for either a specific or an indefinite period of time. The period of time given for voluntary departure varies. Voluntary departure can be granted by the USCIS before deportation proceedings have begun or by an Immigration Judge during deportation proceedings. A person who has been granted voluntary departure may be eligible for employment authorization.



UNITED STATES DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE
300 NORTH LOS ANGELES STREET
LOS ANGELES, CALIFORNIA 90012

PLEASE REFER TO THIS FILE NUMBER

A **********

Please note the below checked action which has been taken in your case. Date: NOVEMBER 12, 1991

☐ You have violated the terms of your admission as a nonimmigrant. Consequently, permission previously granted you to remain in the United States is rescinded. You are required to depart from the United States at your own expense on or before _____.

☐ In accordance with a decision made in your case you are required to depart from the United States at your own expense on or before _____.

☐ Your request for an extension of time in which to depart from the United States has been GRANTED**********MAY 12, 1992**********

You must notify this office, Room No. 7621 on or before MAY 12, 1992********** of the arrangements you have made to effect your departure, including the date, place, and manner.

Failure to depart on or before the specified date may result in the withdrawal of voluntary departure and action being taken to effect your deportation.

If there is a bond outstanding in your case, you are warned that to expedite cancellation of the bond and return of the collateral posted, you must make advance arrangements with this office to have your departure witnessed by an officer of this Service.

USE THE ENCLOSED SELF-ADDRESSED CARD TO NOTIFY THIS OFFICE REGARDING DEPARTURE ARRANGEMENTS. POSTAGE IS NOT REQUIRED. At the time of your departure, do not fail to surrender Form I-94, ARRIVAL-DEPARTURE RECORD, in accordance with instructions on that form.

Very truly yours,
Robert M. Moschorak
DISTRICT OFFICER

FOR IMMIGRATION AND NATURALIZATION USE ONLY

Departed:

Port _____ Date _____ ☐ I-94 stamped ☐ I-530 submitted
To _____ Via _____ ☐ I-161 prepared ☐ I-156 prepared

Form I-210
(Rev. 6-12-00)

ATTORNEY'S COPY

15.2.3.F I-512 Parole Authorization

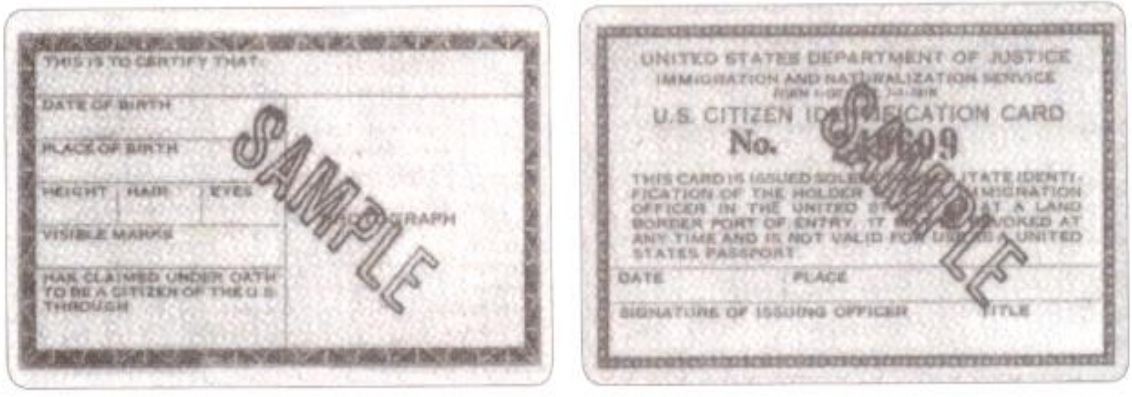
Noncitizens who are not eligible for a visa or for refugee status can be paroled into the U.S. for emergent or compelling reasons in the public interest. There are special parole procedures for Cubans paroled into the U.S. and those who have applied for lawful permanent resident (LPR) or another immigration status. They can apply for advance parole, if they must leave the U.S. If there was an application for advance parole before leaving the country, and the individual received it, then that will allow them to reenter the U.S. from short trips abroad. Persons granted parole status shall indicate why they were granted parole.

The card looks similar to the current Employment Authorization Document (EAD) but will include text that reads, "Serves as I-512 Advance Parole." A card with this text will serve as both an employment authorization and Advance Parole document.



15.2.3.G I-197 U.S. Citizen Identification Card

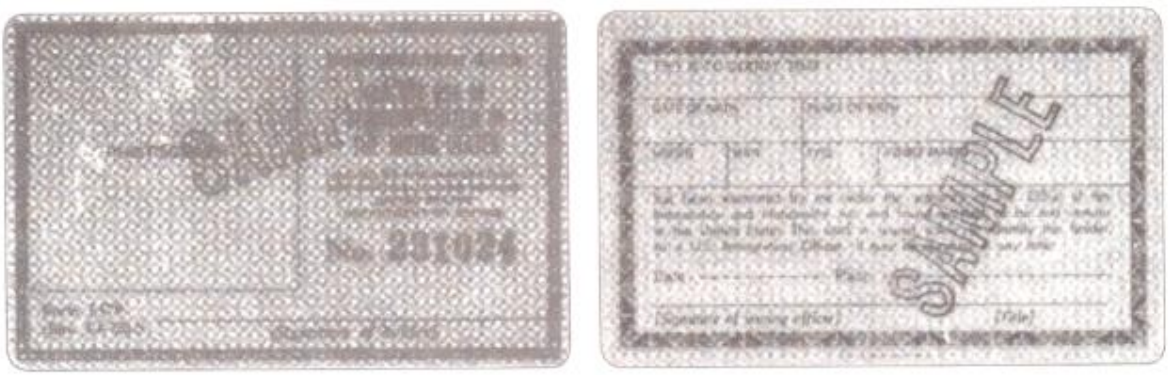
Issued by USCIS to U.S. citizens. Although USCIS no longer issues this card, it is valid indefinitely.



I-197 – front and back

15.2.3.H I-179 Identification Card for Use of Resident Citizen in the U.S.

Issued by USCIS to U.S. citizens who are residents of the U.S. Although USCIS no longer issues this card, it is valid indefinitely.



I-179 – front and back

15.2.3.I I-221S Order to Show Cause

An Order to Show Cause (OSC) is a document that begins formal deportation proceedings. Anyone who has been issued an OSC can be taken into USCIS custody or released either on his own recognizance or after posting a bond. Information regarding the terms of release will be attached to the OSC. Noncitizens released from USCIS custody must attend their immigration hearings or they will be ordered deported.

U.S. Department of Justice
Immigration and Naturalization Service — Order to Show Cause and Notice of Hearing

ORDER TO SHOW CAUSE AND NOTICE OF HEARING
(ORDEN DE PRESENTAR MOTIVOS JUSTIFICANTES Y AVISO DE AUDIENCIA)

In Deportation Proceedings under sections 242 of the Immigration and Nationality Act.
(En los tramites de deportacion a tenor de las seccion 242 de la Ley de Inmigracion y Nacionalidad.)

United States of America:
(Estados Unidos de America:)

File No. A71
(No. de registro)

Dated July 10, 1992
(Fechada)

In the matter of (En el asunio de): Mr. Delgado (Respondent) (Demandado)
Address (Direccion): c/o U. S. Immigration and Naturalization Service
Service Processing Center
2001 Seaside Avenue
San Pedro, California 90731

Telephone No. (Area Code) (No. de telefono y codigo do area)

Upon inquiry conducted by the Immigration and Naturalization Service, it is alleged that:
(Segu las indagaciones realizedas por el Servicio de Inmigracion y Naturalizacion, se alega que:)

1) You are not a citizen or national of the United States:
(Ud. No es ciudadano o nacional de los Estados Unidose)

2) You are a native of Mexico (Ud. Es nativo de) (Mexico) and a citizen of Mexico (y ciudadano de) (Mexico):

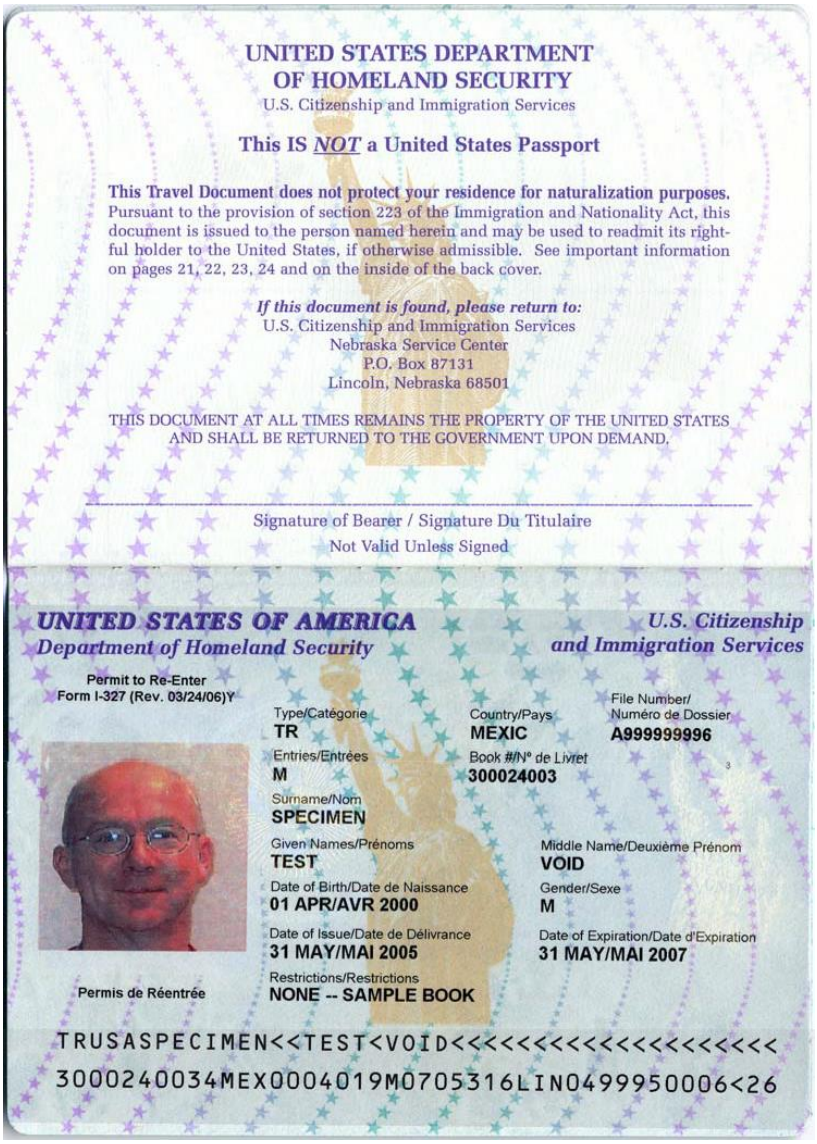
3) You entered the United States XXXX near San Ysidro, California (San Ysidro, California) on or about an unknown date in (el dia o hacia esa fecha) October, 1991 (una fecha desconocida en octubre de 1991):
(Ud. Entro a los Estados Unidos XXXX cerca de)

4) You were not then inspected by an Immigration Officer;
(Ud. No fue inspeccionado entonces por un funcionario de inmigracion)

Form I-211 (Rev. 6/12/92)N

15.2.3.J I-327 Reentry Permit

This document is given to an LPR who will be traveling outside of the U.S. for an extended period of time. It is given to the LPR prior to departure to facilitate reentry into the U.S.



UNITED STATES DEPARTMENT
OF HOMELAND SECURITY
U.S. Citizenship and Immigration Services

This IS *NOT* a United States Passport

This Travel Document does not protect your residence for naturalization purposes. Pursuant to the provision of section 223 of the Immigration and Nationality Act, this document is issued to the person named herein and may be used to readmit its rightful holder to the United States, if otherwise admissible. See important information on pages 21, 22, 23, 24 and on the inside of the back cover.

If this document is found, please return to:
U.S. Citizenship and Immigration Services
Nebraska Service Center
P.O. Box 87131
Lincoln, Nebraska 68501

THIS DOCUMENT AT ALL TIMES REMAINS THE PROPERTY OF THE UNITED STATES AND SHALL BE RETURNED TO THE GOVERNMENT UPON DEMAND.

Signature of Bearer / Signature Du Titulaire
Not Valid Unless Signed

UNITED STATES OF AMERICA
Department of Homeland Security

U.S. Citizenship and Immigration Services

Permit to Re-Enter
Form I-327 (Rev. 03/24/06)Y

Type/Catégorie
TR

Country/Pays
MEXIC

File Number/
Numéro de Dossier
A999999996

Entries/Entrées
M

Book #/N° de Livret
300024003

Surname/Nom
SPECIMEN

Given Names/Prénoms
TEST

Middle Name/Deuxième Prénom
VOID

Date of Birth/Date de Naissance
01 APR/AVR 2000

Gender/Sexe
M

Date of Issue/Date de Délivrance
31 MAY/MAI 2005

Date of Expiration/Date d'Expiration
31 MAY/MAI 2007

Restrictions/Restrictions
NONE -- SAMPLE BOOK

Permis de Réentrée

TRUSASPECIMEN<<TEST<VOID<<<<<<<<<<<<<<<<<<<<
3000240034MEX0004019M0705316LIN0499950006<26

15.2.3.K I-551 Permanent Resident Card

This card is proof of LPR status. It is commonly called a Green Card, even though some cards are different colors. Until recently, these cards had no expiration date, but cards being issued currently expire 10 years after the date they are issued. At the end of the 10 years, the LPR does not lose his status, but must simply renew the card. Conditional permanent residents are issued cards that are coded “CR” and expire after two years. All I-551 cards contain codes showing how the noncitizen obtained LPR status—whether through work skills or as the relative of a U.S. citizen. Some codes are important in determining whether the noncitizen is eligible for public benefits. Noncitizens who legalized under the general amnesty program have codes W16, W26, or W36 on their cards. Noncitizens who legalized under the Special Agricultural Worker (SAW) program are issued cards containing codes S16 or S26. These codes indicate that the noncitizen may be disqualified for five years from receiving certain federal benefits.

15.2.3.K.1 Between January 1977 and August 1989





15.2.3.K.2 Revised 1989



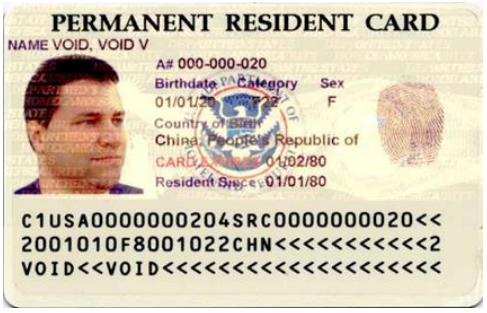


15.2.3.K.3 Revised 1992





15.2.3.K.4 December 1997





15.2.3.K.5 Revised May 1, 2017



15.2.3.K.6 How to Read an Amnesty Noncitizen's I-551

The Immigration Reform and Control Act of 1986 (IRCA) created two amnesty programs to enable undocumented noncitizens to legalize their status. The Section 245A program legalized noncitizens unlawfully in the U.S. prior to January 1, 1982. The Section 210 program, also called the SAW program, legalized certain farm workers. Noncitizens who legalize their status under IRCA are issued I-551 cards after final adjustment to LPR status.

Ordinarily, the I-551 issued to amnesty noncitizens was a pinkish color and had no expiration date (the "old card" example below.) The USCIS then began issuing a salmon-colored I-551 with the person's name, date of birth, alien number, and an expiration date. The salmon card expires 10 years after it is issued. After 10 years, the person does not automatically lose his status; instead, he must simply renew the card.

- "TEMP RES ADJ DATE" – month, day, and year when the person became a temporary resident (date on the example is November 16, 1876.) This is backdated to the date the noncitizen filed for temporary residency. Add five years to calculate when the disqualification for receipt of certain benefits ends.

  If there is not TEMP RES ADJ DATE line, the person did not get LPR status through amnesty.

- Code that tells whether the legal status came under the 245A or the 210 SAW program.

  245A – codes W16, W26, or W36 210/SAWs – code S16 or S26.

- Data adjusted to LPR status.

  On new card: month, day, year (in example: May 8, 1990).

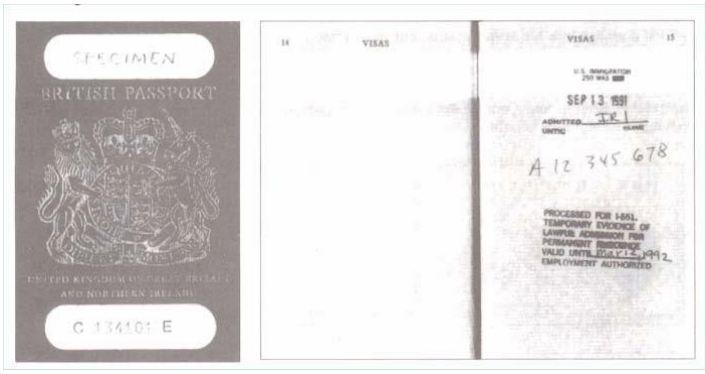
  On old card: month, day, year (in example: February 18, 1989).

  Use this date to calculate when the person will be eligible for naturalization.

  An LPR is eligible for naturalization five years after being granted LPR status (three years if married to a U.S. citizen.) For §245A amnesty noncitizens, this date is calculated from the date the noncitizens applied for permanent resident status. For SAWs, it dates from either December 1, 1989, or December 1, 1990. The application for naturalization can be submitted three months before the five-year (or three-year) period expires.

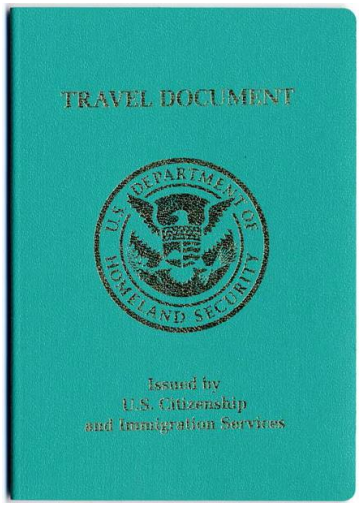
15.2.3.K.7 I-551 Stamp in Foreign Passport

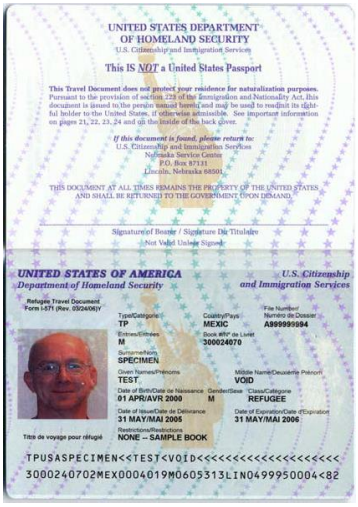
When a noncitizen is first admitted to the U.S. as an LPR, his passport is stamped with temporary proof of LPR status. This stamp will have an expiration date. This is proof of admission as a lawful permanent resident.



15.2.3.L I-571 Unexpired Refugee Travel Document

Issued by USCIS to noncitizens who have been granted refugee status. The expiration date is stated on page four.





15.2.3.M I-688 Temporary Resident Card

Issued by USCIS to noncitizens granted temporary resident status under the Legalization or SAW program. It is valid until the expiration date stated on the face of the card or on the sticker(s) placed on the back of the card.



15.2.3.N I-688A Employment Authorization Card

Issued by USCIS to applicants for temporary resident status after their interview for Legalization or SAW status. It is valid until the expiration date stated on the face of the card or on the sticker(s) place on the back of the card.



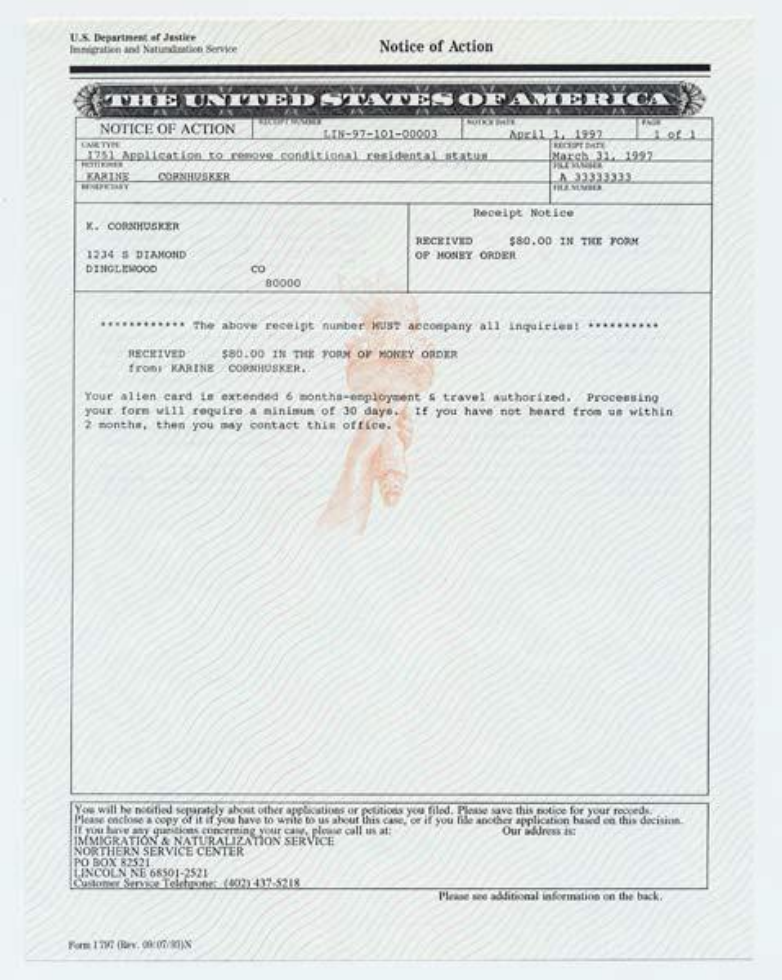
15.2.3.O I-688 B Employment Authorization Card

Issued by USCIS to noncitizens granted temporary employment authorization in the U.S. The expiration date is noted on the face of the card.



15.2.3.P I-797 Family Unity Approval Notice

Amnesty noncitizens' spouses and children who have been in the U.S. since before May 5, 1988, may be eligible for Family Unity. Noncitizens granted Family Unity will receive an I-797. Family Unity recipients can use the I-797 to apply for an I-688 B, employment authorization document.



U.S. Department of Justice
Immigration and Naturalization Service

Notice of Action

THE UNITED STATES OF AMERICA

NOTICE OF ACTION	RECEIPT NUMBER	NOTICE DATE	PAGE
	LIN-97-101-00003	April 1, 1997	1 of 1

CASE TYPE	RECEIPT DATE
I751 Application to remove conditional residental status	March 31, 1997
PETITIONER: KARINE CORNHUSKER	FILE NUMBER: A 33333333
BENEFICIARY	FILE NUMBER

K. CORNHUSKER

1234 S DIAMOND
DINGLEWOOD CO
80000

Receipt Notice

RECEIVED $80.00 IN THE FORM OF MONEY ORDER

********** The above receipt number MUST accompany all inquiries! **********

RECEIVED $80.00 IN THE FORM OF MONEY ORDER
from: KARINE CORNHUSKER.

Your alien card is extended 6 months-employment & travel authorized. Processing your form will require a minimum of 30 days. If you have not heard from us within 2 months, then you may contact this office.

You will be notified separately about other applications or petitions you filed. Please save this notice for your records.
Please enclose a copy of it if you have to write to us about this case, or if you file another application based on this decision.
If you have any questions concerning your case, please call us at: Our address is:
IMMIGRATION & NATURALIZATION SERVICE
NORTHERN SERVICE CENTER
PO BOX 82521
LINCOLN NE 68501-2521
Customer Service Telephone: (402) 437-5218

Please see additional information on the back.

Form I-797 (Rev. 09/07/93)N

15.2.3.Q N-560 or N-561 Certificate of U.S. Citizenship

Issued by USCIS to individuals who:

- Derived citizenship through parental naturalization; or
- Acquired citizenship at birth abroad through a U.S. parent or parent; or
- Acquired citizenship through application by U.S. citizen adoptive parent(s); and
- Pursuant to Section 341 of the Act, have applied for a certificate of citizenship.



15.2.3.R N-550 or N-570 Certificate of Naturalization

Issued by USCIS to naturalized U.S. citizens.



15.2.3.S Decision Granting Asylum

Both the USCIS and the judges of the Executive Office of Immigration Review, where deportation cases are heard, can grant asylum to an individual fleeing persecution. Below are examples of documents issued to noncitizens granted asylum. Not all documents are the same.

UNITED STATES SEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
OFFICE OF THE IMMIGRATION JUDGE
Los Angeles, California

File No: A 704100000

In the Matter of

Fulgencio F.

Respondent

IN DEPORTATION PROCEEDINGS

Order of the
Immigration Judge

This matter having been initiated by the Immigration & Naturalization Service upon the filing of an Order to Show Cause, and the Respondent having been found to be subject to deportation on the charge(s) set forth therein; and the Respondent having made application for relief from deportation under Sections 208(a) and 243(h) of the Immigration and Nationality Act; and a hearing having been held on said applications, and the Court being fully informed of the facts, and having made an oral decision at the conclusion of the hearing setting forth the basis upon which the Respondent is found QUALIFIED for the relief sought; therefore, upon this order being final.

IT IS ORDERED that the Respondent's application for relief from deportation under Sections 208(a) ~~and 243(h)~~ OF THE Immigration and Nationality Act be and is hereby GRANTED, and

IT IS FURTHER ORDERED that deportation proceedings against the Respondent ~~be TERMINATED.~~

Appeal: Waived Reserved

Date: 3/27/91

ROY J. DANIEL
Immigration Judge

A copy of this Order has been served upon the Respondent and the Immigration Service.

U.S. Department of Justice

Immigration and Naturalization Service

District Director

300 North Los Angeles Street
Los Angeles, CA 90012

Dear

This refers to your Request for Asylum in the United States.

I have concluded, upon consultation with the Bureau of Human rights and Humanitarian Affairs, Department of State, that you have established a well-founded fear of persecution upon return to your homeland. Therefore, in accordance with section 208(a) of the Immigration and Nationality Act, your request for Asylum in the United States is granted as of Feb 02 1990.

Your asylum status may be terminated if it is subsequently determined you are no longer a refugee within the meaning of section 101(a) (42) (A) of the Immigration and Nationality Act, or that you pose a danger to the community or to the security of the United States.

You are authorized to remain in the United States until FEB 01 1991 at which time you must arrange to be interviewed to determine your continuing eligibility for asylum. Employment is authorized during this period. If you plan to depart the United States, it will be necessary for you to obtain prior permission to return.

You may apply for permanent residence under section 209(b) of the Immigration and Nationality Act upon being physically present in the United States for at least one year after asylum was granted.

Please keep this office informed of any change in your address.

Sincerely,

Robert M. Moschorak

Robert M. Moschorak
Acting District Director

15.2.3.T Order Granting Suspension of Deportation

A noncitizen in deportation proceedings who has been in the U.S. at least seven years, and can prove good moral character and extreme hardship, can be granted suspension of deportation and lawful permanent resident status. The documents used by immigration judges to grant suspension of deportation vary. An example is shown below.

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
OFFICE OF THE IMMIGRATION JUDGE
Los Angeles, California

In the matter of: File: A 29-259-000

Maria Guandalupe
Respondent

In Deportation Proceedings

SUMMARY OF THE ORAL DECISION AND ORDER OF THE IMMIGRATION JUDGE

This is a summary of the oral decision entered on 10/23/91.
If the proceedings should be appealed, the Oral Decision and Order will be transcribed and will become the official decision in this matter.

_____ Respondent's application for voluntary departure was denied and he/she was ordered deported to _____ or _____.

_____ Respondent's application for voluntary departure was granted to XXXXXXXXXX, with an alternate order of deportation to _____, or _____.

_____ Respondent's application for asylum/withholding of deportation was granted/denied.

_____ Respondent's application for section 212© waiver was granted/denied.

_____ Respondent's application for _____ was granted/denied.

_____ Proceedings were terminated.

_____ Other: _____

_____ Service/Respondent waived appeal.

_____ Service/Respondent reserved appeal until _____.

ORDER: It is ordered that if no appeal is filed, the decision is to be implemented by the District Director of the Immigration & Naturalization Service.

10/27/91
Date

Nathan W. Gordon
Nathan W. Gordon
Immigration Judge

15.3 CITIZENSHIP AND NONCITIZENS

15.3.1 INTRODUCTION

All noncitizens are subject to immigration laws that regulate their entry and set the conditions of their stay. There are various immigration documents that might be carried by a noncitizen who is legally in the United States (U.S.), and all noncitizens lawfully in the U.S. should have some kind of immigration document.

The first step in determining eligibility for federal benefits is the identification of the noncitizen's immigration status. Then, other considerations relevant to their specific situations have to be taken into account; if it appears that a noncitizen qualifies for a particular federal program, it should be insured that receipt of that benefit will not affect that person's immigration status.

NOTE: See Section 7.4 for additional information regarding the requirements for documentary evidence of citizenship and identity for Medicaid.

The HR-1 (OBBB) changed the structure of and omitted some statuses from the qualified noncitizens list referred to in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193), without amendment to the act. When implemented, the PRWORA significantly changed federal means-tested public benefit eligibility for individuals who are not citizens of the U.S. Federal means-tested public benefits must be provided to eligible citizens or nationals of the U.S. Individuals who meet the eligibility requirements for these benefits but who are not citizens or nationals of the U.S. are eligible only as provided in Section 15.7. Those noncitizens must also meet documentation and verification requirements as required.

15.3.2 DESCRIPTION OF IMMIGRATION CATEGORIES

15.3.2.A U.S. Citizenship

When determining U.S. citizenship, the U.S. is defined as it is in the Immigration and Nationality Act (INA). It includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swains Island are also regarded as U.S. citizens.

Note: Although the islands included in the Compact of Free Association (COFA), Marshall Islands, Micronesia, & Palau, are not considered acquired U.S. territories, they currently remain status eligible for all benefits, even with non-immigrant status, as verified in SAVE.

15.3.2.B Noncitizens

Eligibility for noncitizens is based on whether the noncitizen is a qualified or non-qualified noncitizen, regardless of whether the noncitizen entered the U.S. on or after August 22, 1996 (the date of enactment of P.L. 104-193). However, the list of statuses considered to be "qualified" has been revised to reflect policy changes due to the implementation of the HR-1, One Big Beautiful Bill Act made effective July 4th, 2025. The previous categories of lawful permanent residents and noncitizens with Permanent Residence Under Color of Law (PRUCOL) no longer apply.

The term "qualified noncitizen" includes, but is not limited to, noncitizens who are lawfully admitted for permanent residence in the U.S. under the INA; Cuban or Haitian Entrants; Amerasian immigrants and Compact of Free Association (COFA) Migrants. See Section 15.7 for extended definition.

15.3.2.C American Indian Born in Canada

American Indians born in Canada living in the United States (U.S.) under §289 of the Immigration and Nationality Act (INA) or alien members of a federally recognized Indian tribe under§4(e) of the Indian Self-Determination and Education Assistance Act. See Section 15.7.5, Medicaid.

The following documents can be used for proof of an American Indian bloodline:

- Birth or baptismal certificate issued on a reservation
- Tribal records
- Letter from the Canadian Department of Indian Affairs

- School records

15.4 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENT (SAVE) AND 40 QUALIFYING QUARTERS OF COVERAGE

15.4.1 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENT (SAVE)

At the time of application, all individuals who apply for benefits are required to declare in writing whether they are citizens or nationals of the United States (U.S) or noncitizens. This is accomplished by the completion of the Declaration of Citizenship/Noncitizen. All noncitizen clients are required to have status determined by inquiry submission to the SAVE system. Eligibility workers are required to verify status eligibility at initial application or redetermination. Status may only be verified during a certification period if a change is reported.

NOTE: If the applicant satisfies the eligibility requirements for the benefits requested, and if the applicant provides documentation of his status as a qualified noncitizen and completes the written declaration—under penalty of perjury—that he is a qualified noncitizen, the applicant's eligibility for benefits must not be delayed, denied, reduced, or terminated under the program on the basis of the applicant's immigration status during the period of time it takes to verify his immigration status through the SAVE verification request to the Division of Family Assistance (DFA).

If the applicant is a noncitizen, he must present original documentation of noncitizen registration. Noncitizens without documentation must be referred to the United States Citizenship and Immigration Services (USCIS) Office in Pittsburgh, Pennsylvania.

NOTE: Acceptable verification may consist of the applicant or DFA submitting a request to a federal agency for verification of information, which bears on the status of the noncitizen. The individual must be certified pending the results of the investigation for up to six months from the date of the original request for verification.

15.4.1.A Determining Noncitizen Eligibility

The Worker should make every attempt to determine the client's benefit eligibility prior to a request for noncitizen status verification.

15.4.1.B Verified Immigration Status

Immigration status must be verified for WV WORKS, the Supplemental Nutrition Assistance Program (SNAP), and Medicaid benefits. If any member of the household is a noncitizen, a copy of the front and back of the immigration identification documentation must be forwarded to the SAVE Coordinator.

The documentation is verified by the USCIS through automated or manual methods. All USCIS responses are sent to the requesting Worker with information regarding the noncitizen's eligibility for benefits.

However, when the automated responses reads "Initiate Secondary Verification," an email is sent to the Worker advising that an additional request has been sent for information.

When the response is received from SAVE, the information will be forwarded to the Worker.

15.4.2 40 QUALIFYING QUARTERS OF COVERAGE FOR SNAP

Only certain excepted classes of qualified noncitizens are eligible for SNAP. This exception includes noncitizens who are lawfully admitted to the U.S. for permanent residence and who have worked or can be credited with 40 Qualifying Quarters. Under certain conditions, the Qualifying Quarters of parents or spouses can be added to the noncitizen's record to achieve the needed 40 Qualifying Quarters. Each noncitizen immigrant in the household is considered an applicant. Qualifying Quarters earned after December 31, 1996, cannot be counted if the noncitizen spouse or parent received certain federal means-tested public benefits during the period for which the Qualifying Quarters were credited.

NOTE: A Consent of Release of Information from Social Security Number (SSN) holders other than the applicant must be obtained.

15.4.2.A Determining the Number of Qualifying Quarters

15.4.2.A.1 Individuals Whose Qualifying Quarters Are Used

The Worker must determine which individuals with Social Security Numbers (SSNs) can be included in the Qualifying Quarters count. The following are individuals who may be included in the count of Qualifying Quarters, and the conditions under which their Qualifying Quarters are counted:

- The applicant

  Always use his Qualifying Quarters.

- The applicant's natural parents

  Unless the child was adopted by others, consider only quarters earned from the time of birth through the calendar quarter the applicant attains age 18.

- The applicant's adoptive parents

  Consider only quarters earned from time of birth through the calendar quarter the applicant attains age 18.

- The applicant's stepparent if the step relationship still exists

  Death of the stepparent does not terminate the relationship. Consider quarters earned only while the relationship was in existence and through the calendar quarter the applicant attains age 18.

  NOTE: The stepparent's relationship to the child is based on the marital relationship to the child's natural parent. If the martial relationship ends, other than by death, the step relationship ends and the stepparent's Qualifying Quarters can no longer be counted.

- The applicant's current spouse as long as the marriage exists

  Consider the spouses quarters earned only during the marriage. If the marriage ends in divorce, the applicant cannot use any quarters earned by the former spouse. If the only qualifying quarters were those of the former spouse, the noncitizen cannot use the quarters and may lose eligibility.

- The applicant's former spouse(s), only if the marriage ended in death while still married

  Consider only the quarters earned during the marriage.

15.4.2.A.2 Determination of 40 Qualifying Quarters

The Worker must determine if it is possible for the applicant to meet the 40 Qualifying Quarters by using all applicable quarters for the applicant and each of the relevant individuals. Use the following process:

Step 1: Determine the number of years the applicant and each of the relevant individuals lived in the U.S. and add the number of years.

Step 2: If the total is less than 10 years, determine whether the applicant, his parents, or spouse ever commuted to work in the U.S. from another country before coming here to live, or if while a legal resident of the U.S., worked overseas for a U.S. company or in self-employment.

Step 3: If yes, determine the number of years and add to the total.

Step 4: If the total is at least 10 years, see Total Quarters for Relevant Individuals below.

If the total is less than 10 years, the applicant does not meet the 40 Qualifying Quarters requirement.

15.4.2.B Total Quarters for Relevant Individuals

The Worker must determine how many years in the total are from each of the relevant individuals. Quarters can be used from more than one individual.

- Four quarters in each year can be credited from each individual. Credit the applicant's own quarters first. If the applicant may meet or does in fact meet the 40 Qualifying Quarters exception by using his own and/or other relevant individuals' Qualifying Quarters information, the Worker processes the case in the eligibility system and generates a 40 Qualifying Quarters data exchange. See Section 6.3.
- If the relevant individuals have possible Qualifying Quarters that can be used, see Requesting the Qualifying Quarters History below.
- If the applicant will not meet the 40 Qualifying Quarters, then verification of the appropriate information should be sent to the SAVE Coordinator. See Obtaining Consent of Release of Information below.
- If the process shows the applicant will not meet the 40 Qualifying Quarters, the applicant is ineligible.

15.4.2.C Requesting the 40 Qualifying Quarters History

When the applicant(s) is approved in the eligibility system, a 40 Qualifying Quarters data exchange is made.

- An automatic referral is made to the Social Security Administration (SSA) through the eligibility system.
- All responses are sent to the Worker with information regarding the noncitizen's 40 Qualifying Quarters history.

15.4.2.D Obtaining Consent of Release of Information

- The Worker must obtain the Consent for Release of Information forms from individuals not in the assistance group (AG).
- To authorize release of Qualifying Quarters, when an individual refuses or cannot be located after reasonable efforts, only the pertinent quarters will be disclosed by the SSA. Therefore, a Request for Quarters of Coverage History Based on Relationship should be used to request this information.
- The completed form(s) must be forwarded to the SAVE Coordinator for verification with a cover memorandum.
    - The information is submitted to the SSA and all responses are sent to the Worker.

15.4.2.E Non-Covered Employment—Applicant Disabled

When an applicant does not meet the 40 Qualifying Quarters requirement with the SSA 40 Qualifying Quarters documentation and alleges he had additional work that is not included on the 40 Qualifying Quarters documentation, the following may be used to help establish the existence of earnings.

- Review the 40 Qualifying Quarters response with the applicant to determine if Qualifying Quarters are missing from the record.
- If Qualifying Quarters are not missing from the response, make a determination based on the information obtained.

- If Qualifying Quarters are missing from the 40 Qualifying Quarters response, then obtain information from the individual for quarter of coverage determination. This information must be sent to the SAVE Coordinator for a determination.

15.4.2.F Information to Credit Qualifying Quarters

The following are examples that can be used to establish earnings. This information must be obtained from the applicant and sent to the SAVE Coordinator for a determination of covered/non-covered employment.

Questions to ask the applicant for documentation should include:

- Name and address of employer
- Date of employment
- Amount of earnings
- Type of business or self-employment
- Rate of pay
- Type of work performed
- Any evidentiary proof he has of employment/earnings

Documentation used to establish the earnings and the amount include the following:

- Form W-2 (Wage and tax statement) and W-2c (Statement of Corrected Income and Tax Amount)
- Employer-prepared earnings statement
- Statement of earnings signed by the custodian of the employer's records
- Internal Revenue Service (IRS) copy of the employee's tax return
- Timely filed tax return for a self-employed individual; be sure that the proof of filing, canceled check, money order, or copy of Schedule C bearing the IRS time stamp, indicates the return was filed within three years, three months, and 15 days after the year in which the self-employment income was derived
- Other evidence of self-employment that allows you to determine that a business did exist and that a profit was earned; comparison of bills, vouchers, and receipts are examples of evidence you may use to make a determination
- Pay envelopes, vouchers, and similar unsigned employer earnings statements to the employee, a state agency, or a federal agency

- Union records
- Individual's copy of a federal or state tax return
- Records of state unemployment insurance agencies
- Individual's personal records and statements
- Any other evidence of probative value

When the Worker establishes that non-covered earnings exist, send copies of documentation as described above to the SAVE Coordinator for a determination. Responses are forwarded to the requesting Worker.

15.5 SPONSORED NONCITIZENS

15.5.1 INTRODUCTION

The requirements for deeming income and assets do not apply to sponsors of immigrants who entered the United States (U.S.) before December 19, 1997.

Deeming of income and assets applies to immigrants with equally enforceable Affidavit of Support for sponsorship affidavits filed on or after December 19, 1997. All federal means-tested programs must count the income and resources of a noncitizen's sponsor and that of the sponsor's spouse in determining the noncitizen's eligibility for WV WORKS, the Supplemental Nutrition Assistance Program (SNAP), and Medicaid. The sponsor's/sponsor's spouse's income and resources are considered to be available to the sponsored noncitizen in determining the sponsored noncitizen's eligibility for these benefits.

NOTE: The sponsor is an individual, not an organization, institution, or group.

15.5.2 DEEMING THE SPONSOR'S INCOME AND ASSETS

The income and assets of the sponsor and his spouse are counted in their entirety and are considered available to the sponsored noncitizen in determining the sponsored noncitizen's eligibility for benefits. See Section 15.5.3.C for countable assets and income requirements of an ineligible sponsored noncitizen. No allowances are made for the needs of the sponsor, his spouse, the sponsor's family, or other sponsored noncitizen families. The sponsor's income and assets are counted in their entirety for all noncitizens sponsored by the specific sponsor. Deeming applies to all noncitizens sponsored by individuals.

Most noncitizens who are sponsored by an Affidavit of Support are not eligible for SNAP, Medicaid, and WV WORKS. Deeming ends when a noncitizen has 40 Qualifying Quarters of work. See Section 15.4.

- Deeming will apply for SNAP benefits purposes only to those who qualify under the military service provision.

- Medicaid and WV WORKS have no 40 Qualifying Quarters requirement and deeming applies for WV WORKS. Deeming applies for Medicaid except for modified adjusted gross income (MAGI) groups.

NOTE: In Medicaid cases where the noncitizen is eligible by the MAGI methodology, no asset tests of any individual may be used.

After the five years, the income and assets of the sponsor, as well as the income and assets of the current spouse who is living with the sponsor, are deemed to the noncitizen to determine the noncitizen's eligibility for benefits.

- Deeming the sponsor's income usually makes the sponsored noncitizen ineligible for means-tested public benefits. The noncitizen is ineligible until all information needed to determine the income and assets of the sponsor and the sponsor's spouse is provided.
- All other program eligibility requirements must be met.

15.5.3 EXCEPTIONS TO DEEMING

15.5.3.A Battered Noncitizens/Noncitizens Subjected to Extreme Cruelty

The phrase "battered or subjected to extreme cruelty" includes, but is not limited to, being the victim of any act or threatened act of violence, including any forceful detention, that results or threatens to result in physical or mental injury. Psychological or sexual abuse or exploitation, including rape, molestation, incest (if the victim is a minor), or forced prostitution are considered acts of violence.

- If the battered noncitizen lives in the same household as the batterer, there is no exemption.
- If the battered noncitizen is not living in the same household, there could be an exemption. Battered noncitizens and noncitizens whose child or parent has been battered may be exempt from the deeming provision. The exemption is for a 12-month period, provided that there is a substantial connection between the need for benefits and the battery.
- The sponsored noncitizen must provide documented proof that battery or extreme cruelty in the U.S. exists. Documented proof can include the following:

- An applicant may submit his own affidavit, under penalty of perjury, that describes the circumstances of the abuse. The statement does not require notarization.
- A petition filed with United States Citizenship and Immigration Services (USCIS) on behalf of the battered noncitizen.
- A protection order issued against the abuser.
- A record of criminal conviction of the abuser, with whom the applicant was living, for committing an act of violence against the applicant, or his child or family member with whom they were living.
- Reports or affidavits from police, judges, and other court officials; medical personnel; school officials; clergy; social workers; counselling or mental health personnel; and other social service personnel.
- Sworn affidavits from third parties who have personal knowledge of the battery or cruelty.

- The sponsored noncitizen must provide documented proof of non-residency with the batterer. Relevant credible evidence supporting the claim of non-residency can include, but is not limited to, the following:
  - A civil protection order requiring the batterer to stay away from the applicant or the applicant's children or parent or evicting the batterer from the applicant's residence.
  - Employment records, utility receipts, school records, hospital or medical records, rental records, or records from a building or property manager.
  - An affidavit from a staff member at a shelter for battered women or homeless persons, family members, friends, or other third parties with personal knowledge, or from the battered applicant.
  - Any other records establishing that the applicant or the applicant's child or parent no longer resides with the abusive spouse, parent, or family member.
- The applicant must meet the requirements for qualified noncitizen status by appropriate immigration documentation for which they are applying, and all other eligibility requirements for the specific benefits should be determined.
- The Worker must provide the Systematic Alien Verification for Entitlement (SAVE) Coordinator with the documented proof from the noncitizen that battery or extreme cruelty exists regarding the abuse of the noncitizen, the noncitizen's child, or the noncitizen child's parent. If further action is needed, the SAVE Coordinator will notify the Worker.

15.5.3.B Indigent Noncitizens

After taking into account the noncitizen's own income, plus any cash, food, housing, or other assistance provided by other individuals (including the sponsor), if the Worker determines that a sponsored noncitizen would—in the absence of the assistance provided by the agency—be unable to obtain food and shelter, then the amount of income and resources of the sponsor or the sponsor's spouse attributed to the sponsored noncitizen shall not exceed the amount actually provided for a period of one year after the date such determination is made.

NOTE: The Indigent Noncitizen must meet all other eligibility program requirements for the specific benefits, Medicaid, and/or WV WORKS; not have 40 Qualifying Quarters of work; and meet the requirement for qualified noncitizen status.

In this instance, the Worker must provide the SAVE Coordinator with the name of the sponsor and sponsored noncitizen(s) receiving benefits and the type of benefits received. If further action is needed, the SAVE Coordinator will notify the Worker.

15.5.3.C Ineligible Sponsored Noncitizen

The assets and income of the sponsor and the sponsor's spouse must not be included in determining the assets and income of an ineligible sponsored noncitizen.

15.6 DEEMING OF NON-QUALIFIED NONCITIZENS INCOME AND/OR ASSETS

15.6.1 METHOD USED IN DEEMING

The income and assets of non-qualified noncitizens are considered when determining eligibility for those individuals for whom the noncitizens are financially responsible (spouses and children). The method to be used in deeming is based on the particular category of assistance being evaluated.

15.6.1.A SNAP

The ineligible noncitizen is not included in the assistance group (AG). The income of all ineligible noncitizens and/or illegal noncitizens is prorated to the Supplemental Nutrition Assistance Program (SNAP) AG using the method described in Section 4.4.4.

Assets of ineligible noncitizens and illegal noncitizens are counted in their entirety.

Ineligible noncitizens include:

- Noncitizens who were ineligible prior to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) due to noncitizen status; or
- Noncitizens made ineligible due to PRWORA; and
- Noncitizens made ineligible because the household was unable or unwilling to provide documentation of noncitizen status.

15.6.1.B WV WORKS

Ineligible/illegal noncitizens are excluded from the AG and the needs group (NG). They are included in the income group (IG).

15.6.1.C Parents/Caretaker Relatives

The ineligible/illegal noncitizen is excluded from the AG and the NG. They are included in the IG.

15.6.1.D AFDC-Related Medicaid and Other Medicaid Coverage Groups for Families and/or Children

See Chapter 23 for the specific coverage groups. Non-qualified noncitizens are excluded from the AG. They are included in the NG and IG.

15.6.1.E SSI-Related Medicaid and Other Medicaid Coverage Groups Based on Age, Blindness, and Disability

See Chapter 23 for the specific coverage groups. Non-qualified noncitizens are excluded from the AG. The income and assets of the non-qualified noncitizen who is the spouse or parent of an eligible individual are considered in the same manner as the income and assets of any other ineligible spouse or parent of an eligible individual. Follow the instructions in Section 4.14.4.D. When deeming is appropriate according to that section, the non-qualified noncitizen is included in the NG and IG.

15.7 BENEFIT PROGRAMS

To be eligible for WV WORKS, Medicaid, the West Virginia Children's Health Insurance Program (WVCHIP), or the Supplemental Nutrition Assistance Program (SNAP), an individual applying must be a resident of the United States (U.S.) as a citizen or a legal noncitizen and meet eligibility requirements for each program. Among those ineligible are noncitizen visitors, tourists, diplomats, and students who enter the U.S. temporarily with no intention of abandoning their residence in a foreign country. See Section 15.7.5, Medicaid, for exceptions for pregnant women and children age 18 and under.

NOTE: When a noncitizen applies for SNAP benefits or WV WORKS benefits, the Worker must send a copy of their Permanent Resident Card, front and back, to the Division of Family Assistance (DFA) Systematic Alien Verification for Entitlement (SAVE) Coordinator.

A non-qualified noncitizen or ineligible noncitizen residing in the U.S. who requires emergency medical care may qualify for Medicaid for the length of time medically required to avert the medical emergency. See Section 15.7.6.

15.7.1 SNAP

A person must be a U.S. citizen, a national of the U.S., or a qualified noncitizen to qualify.

15.7.1.A Categories Eligible for SNAP

Alien Group	Pre-OBBB Eligibility	Post-OBBB Eligibility
Non-Citizen U.S. National	Eligible Immediately	Eligible Immediately
Lawful Permanent Residents (LPR)	Eligible after a 5-year waiting period, as long as they meet all other SNAP financial and non-financial eligibility requirements.	Eligible after a 5-year waiting period, as long as they meet all other SNAP financial and non-financial eligibility requirements.

	LPRs may still be eligible for SNAP without a waiting period if the meet one or more of the following conditions: • Are under 18 years old • Have 40 Qualifying Work Quarters • Are Blind or Disabled • Were Lawfully residing in the U.S. and 65 or older on August 22, 1996 • Have a U.S. military connection	LPRs may still be eligible for SNAP without a waiting period if the meet one or more of the following conditions: • Are under 18 years old • Have 40 Qualifying Work Quarters • Are Blind or Disabled • Were Lawfully residing in the U.S. and 65 or older on August 22, 1996 • Have a U.S. military connection • Are admitted to the United States as an Amerasian Immigrant • Are certain American Indians born abroad • Are certain Hmong or Highland Laotian tribal members
Cuban and Haitian Entrants (CHE)	Eligible Immediately	Eligible Immediately
Compacts of Free Association (COFA) Citizens	Eligible Immediately	Eligible Immediately
Children Under Age 18 in any SNAP-eligible Alien Group who is Blind or Disabled	Eligible Immediately	Eligible Immediately
LPRS with 40 Qualifying Work Quarters	Eligible Immediately	Eligible Immediately

Individuals in any SNAP-eligible Alien Group who is Blind or Disabled	Eligible Immediately	Eligible Immediately
Individual in any SNAP-eligible Alien Group lawfully residing in the U.S. and was 65 or older on August 22, 1996	Eligible Immediately	Eligible Immediately
Individuals in any SNAP-eligible Alien Group who has a Military Connection	Eligible Immediately	Eligible Immediately
Deportation Withheld	Eligible Immediately	Not Eligible
Amerasians	Eligible Immediately	Eligible Immediately
Certain American Indians Born Abroad	Eligible Immediately	Not eligible unless an LPR, then eligible immediately
Hmong or Highland Laotian Tribal Members	Eligible Immediately	Not eligible unless an LPR, then eligible immediately
Iraqi and Afghan Special Immigrants (SIV)	Eligible Immediately	See “Post-OBBB Eligibility” for LPR
Conditional Entrants	Eligible Immediately	Not eligible unless an LPR. See “Post-OBBB Eligibility” for LPR
Battered Aliens	Eligible Immediately	Not eligible unless an LPR. See “Post-OBBB Eligibility” for LPR
Victims of Severe Trafficking and Certain Family Members	Eligible Immediately	Not eligible unless an LPR. See “Post-OBBB Eligibility” for LPR
Refugees	Eligible Immediately	Not Eligible

Individuals Granted Asylum	Eligible Immediately	Not Eligible
Parolees	Eligible after a 5-year waiting period	Not Eligible
Certain Afghan Nationals Granted Parole Between July 31, 2021, and September 30, 2023	Eligible Immediately	Not Eligible
Certain Ukrainian Nationals Granted Parole Between February 24, 2022, and September 30, 2024	Eligible Immediately	Not Eligible
LPR Pursuant to Section 249 of the INA (8 USC 1259)	Eligible after a 5-year waiting period	See “Post-OBBB Eligibility” for LPR

5-year waiting period

The 5 year-year waiting period requirement and exceptions which are established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) did not change. The 5-year waiting period begins on the date the alien obtains status as a qualified alien or enters the U.S. in a qualifying status. Individuals who adjust from a status not eligible for SNAP under section 6 (f) of the FNA to lawful permanent residents (LPR) are not required to wait 5 years after becoming an LPR.

Alien Group Pre-LPR-Adjustment	Subject to 5-year Waiting Period After Adjusted Status to LPR
Refugees	No
Individuals Granted Asylum	No
Deportation Withheld	No
Cuban and Haitian Entrants (CHE)	No
Amerasians	No

Compacts of Free Association (COFA) Citizens	No
American Indians Born Abroad	No
Hmong or Highland Laotian Tribal Members	No
Iraqi and Afghan Special Immigrants (SIV)	No
Certain Afghan Nationals Granted Parole Between July 31, 2021, and September 30, 2024	No
Certain Ukrainian Nationals Granted Parole Between February 24, 2022, and September 30, 2024	No
Victims of Severe Trafficking	No
Conditional Entrants	Yes
Battered Aliens	Yes
Individuals Granted Parole for a Period of at Least One Year	Yes

- Aliens who adjust status to LPR from one of the groups exempt from the 5-year waiting period in section 403 of PRWORA (8 USC 1613), are not required to wait 5 years after becoming an LPR.
- The 5-year waiting period begins on the date the alien obtains status as a qualified alien or enters the U.S. in a qualifying status under 8 USB 1613.
- These groups include lawful permanent residents, asylees, refugees, parolees, individuals granted withholding of deportation or removal, conditional entrants, Cuban or Haitian Entrants, battered aliens, and alien victims of a severed from of trafficking, certain American Indians born abroad, and Hmong or Highland Laotian tribal members.
- Refugee, individuals granted asylum, deportation withheld, Cuban and Haitian entrant, Amerasian, individual in a SNAP-eligible alien group with a military connection, individual in a SNAP-eligible alien group who is under age 18, American Indian born abroad, and Hmong or Highland Laotian tribal member.

- An individual has “adjusted status to LPR” when they have received an approval notice and Permanent Resident Card (Green Card) from the United States Citizenship and Immigration Services (USCIS). An individual is not considered an LPR if they have applied to adjust status and have not yet received a decision.

Provided other SNAP eligibility requirements are met, someone in one of the above “YES” groups in not subject to the 5-year waiting period of the person.

- Is under 18 years old;
- Has 40 qualifying work quarters;
- Is blind or disabled;
- Was lawfully residing in U.S. and 65 or older on August 22, 1996; or
- Has a U.S. military connection.

Verification for SAVE

United States Citizenship and Immigration Services (USCIS) documents generally contain the date an alien entered the country or adjusted to the immigration status reflected on the document. If an alien does not have USCIS documentation, the State agency can verify the date of entry into the United States or date status was given by submitting a request for additional verification through the Systematic Alien Verification for Entitlements (SAVE) program. State agencies with questions about SAVE should contact SAVE.help@uscis.dhs.gov.

15.7.1.B Ineligible Noncitizens

All others are ineligible noncitizens and are prohibited from participating in SNAP. These include:

- Visitors, tourists, students, and diplomats who lawfully reside in the U.S. in a non-qualified status and are not exempt from the immigrant restrictions
- Undocumented immigrants, such as individuals who entered the country as temporary residents and overstayed their visa, or who entered without a visa
- Noncitizens who have applied for eligible status but who have not been approved.
- Noncitizens whose status is questionable or unverified
- The children of any of these individuals even those under the age of 18. If the child is a US citizen or they are an eligible alien then this does not apply to them.

NOTE: When the Worker believes that any member of a household applying for benefits is ineligible to receive SNAP benefits because the member is present in the U.S. in violation of the law, he must report this immediately in writing to the DFA Policy unit and/or SAVE Coordinator. The memorandum must include the name of the noncitizen involved, case name, address, the reason the Worker believes the client is an illegal noncitizen, and copies of any United States Citizenship and Immigration Services (USCIS) documents that have been presented. The SAVE Coordinator forwards this information to USCIS. The local office receives a copy of the letter sent to USCIS.

The Worker has reason to believe the household contains an illegal noncitizen when:

- Any household member or the authorized representative states that illegal noncitizens are present in the household, or USCIS documents presented by the assistance group (AG) are determined to be forged.
- A formal order of deportation is presented by an AG member during the eligibility determination process. When the Worker determines that a household member cannot be included in the AG because he is an ineligible noncitizen, the Worker must follow the procedure described above for reporting the illegal noncitizen to the SAVE Coordinator if the illegal noncitizen applies for benefits, even if the application is withdrawn.

15.7.2 WV WORKS

A person must be a U.S. citizen, U.S. national, or an eligible noncitizen qualified to receive benefits.

15.7.2.A Eligible Noncitizen

Qualified Noncitizens-No 5 Year Bar Required

- Individuals with Lawful Permanent Resident status in combination with the following statuses:
- Section 207 (c), in effect after March 31, 1980- Aliens Admitted as Refugees.

- Section 203 (a) (7), in effect prior to April 1, 1980- Individuals who were Granted Status as Conditional Entrant Refugees.
- Section 208- Aliens Granted Political Asylum by the Attorney General.
- Section 212 (d) (5)- Aliens Granted Temporary Parole Status by the Attorney General, or
- Individuals who are Aged, Blind, Disabled
- A Cuban Haitian Entrant

Qualified Noncitizens-5 Year Bar Required

- Conditional Resident
- All other Aliens who were adjusted to Lawful Temporary or Permanent Resident Status

Statuses No Longer Qualified (as of July 4th, 2025)

- Temporary Protected Status
- Individuals with Nonimmigrant Visa (including survivors of trafficking or other serious crimes with T or U visas, persons with a work or student visa, and others)
- Individuals paroled into the United States for periods of less than 1 year
- Individuals granted employment authorization
- Individuals granted Deferred Enforced Departure or deferred action, including DACA recipients
- Individuals granted withholding of removal under the regulations implementing the Convention Against Torture

15.7.2.B Ineligible Noncitizens

Ineligible noncitizens include all other noncitizens, and also include the following:

- Visitors, tourists, students, and diplomats
- Undocumented immigrants
- Noncitizens who have applied for eligible status but who have not been approved
- Noncitizens whose status is questionable or unverified
- The children of any of these individuals even those under the age of 18. If the child is a US citizen or they are an eligible alien then this does not apply to them.

15.7.3 LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

All qualified noncitizens are evaluated for Low Income Energy Assistance Program (LIEAP) eligibility as any other LIEAP applicant. See Section 21.3.

15.7.4 EMERGENCY ASSISTANCE (EA)

All qualified noncitizens are evaluated for Emergency Assistance (EA) guidelines as any other EA applicant. See Section 20.2.

15.7.5 MEDICAID

15.7.5.A Medicaid Eligibility

A person must be a U.S. citizen, U.S. national, or a qualified noncitizen eligible to receive benefits.

- For the purposes of qualifying as a U.S. citizen, the U.S. as defined by the INA includes the fifty states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swains Island are also regarded as U.S. citizens for purposes of Medicaid.
- Individuals who meet the eligibility requirements of Medicaid, but who are not citizen or nationals, are Medicaid eligible only as provided below.

Applicants for Medicaid whose presented documents raise questions about their noncitizen status must provide documentation of their citizen/noncitizen status before eligibility can be determined.

15.7.5.B Medicaid-Eligible Noncitizens

15.7.5.B.1 Qualified Noncitizen

A qualified noncitizen is:

- A noncitizen who is lawfully admitted for permanent residence (LPR) under the INA and was admitted before August 22, 1996
- A noncitizen who is granted asylum under Section 208 of the INA, eligible for seven years from entry to U.S.
- A refugee who is admitted to the U.S. under Section 207 of the INA, including immigrants who have been certified by the U.S. DHHS to be victims of a severe form of trafficking in persons in accordance with the victims of Trafficking and Violence Protection Act of 2000 (P.L.106-386), and Afghan and Iraqi special immigrant visa holders eligible for seven years from entry to the U.S.
- A noncitizen whose deportation is being withheld under Section 243(h) of the INA, eligible for seven years from date of status
- An Amerasian immigrant under 584 of the FOEFRPAA who entered the U.S. within the last five years, participation limited to seven years from entry into the U.S.
- A Cuban or Haitian entrant under Section 501(e) of the REAA who entered the U.S. within the last five years, participation limited to seven years from entry
- An American Indian born in Canada to whom the provisions of 8 U.S.C. 1359 apply
- A member of an Indian tribe as defined in 25 U.S.C. 450B(e)
- An honorably discharged veteran, his spouse, and unmarried dependent children
- A noncitizen who is active duty in the U.S. Armed Forces, other than duty for training, their spouse, and unmarried dependent children
- The surviving spouse of a deceased veteran or service member, provided the spouse has not remarried and the marriage fulfills the following requirements:
    - Married for at least one year; or
    - Married before the end of a fifteen-year time span following the end of the period of military service in which the injury or disease was incurred or aggravated; or
    - Married for any period if a child was born of the marriage or was born before the marriage.
- Noncitizens receiving SSI
- Compact of Free Association (COFA) migrants, effective December 27th, 2020

- Ukrainian nationals who enter the United States as parolees on or between February 24, 2022, and September 30, 2024.
- Ukrainian nationals who are paroled into the U.S. after September 30, 2024 and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child.
- Eligible parolees can also include individuals other than Ukrainian nationals (i.e., individuals who are stateless or have another nationality) who last habitually resided in Ukraine.

Qualified noncitizens subject to a five-year waiting period:

- A noncitizen who is lawfully admitted to the U.S. for permanent residence (LPR) on or after August 22, 1996, and has been a qualified noncitizen for more than five years
- A noncitizen who is paroled into the U.S. under Section 212(d)(5) of the INA for at least one year and has been a qualified noncitizen for more than five years
- A noncitizen who is granted conditional entry pursuant to Section 203(a)(7) of the INA and has been a qualified noncitizen for more than five years
- A noncitizen who is a battered spouse or battered child the non-abusive parent of a battered child, or a child of a battered parent and has been a qualified noncitizen for more than five years

15.7.5.B.2 Lawfully Present Pregnant Women and Children Age 18 and Under

Lawfully present pregnant women and children age 18 and under, who meet the State residency requirements in Section 2.2, and who are otherwise financially eligible, may qualify for Medicaid.

An individual is considered to be lawfully present if he resides in the U.S., and:

- Is qualified noncitizen as defined above and in 8 U.S.C. 1641 (b) and (c);
- Is a noncitizen with a valid nonimmigrant status, as defined 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws, as defined in 8 U.S.C. 1101(a)(17);
- Is a noncitizen who has been paroled into the U.S. in accordance with 8 U.S.C. 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection, or pending removal proceedings;
- Is a noncitizen who belongs to one of the following classes:

- Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
- Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
- Granted employment authorization under 8 CFR 274a, 12(c);
- Family Unity beneficiaries in accordance with Section 301 of Pub. L 101-649, as amended;
- Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
- Granted Deferred Action status;
- Granted an administrative stay of removal under 8 CFR 241; or
- Beneficiary of approved visa petition who has a pending application for adjustment of status;

- Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:
  - Has been granted employment authorization; or
  - Is under the age of 14 and has had an application pending for at least 180 days.
- Has been granted withholding of removal under the Convention Against Torture;
- Is a child who has a pending application for special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
- Is lawfully present in American Samoa under the immigration laws of American Samoa; or

EXCEPTION: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs one through nine of this definition.

- Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C.7105[b]).

> **Lawfully Present Noncitizen Example 1:** A 23-year-old student is attending Marshall University on a valid student visa. She becomes pregnant and applies

for pregnancy Medicaid. She is financially eligible for the program. She is lawfully present and intends to reside in West Virginia. Because she is also financially eligible, she would be approved for pregnancy Medicaid.

Lawfully Present Noncitizen Example 2: A 23-year-old student is attending Marshall University on a student visa. He has his three children listed on the visa. Their household monthly income is under 138% of the Federal Poverty Level (FPL). He would only be eligible for emergency Medicaid, as he does not meet the guidelines for pregnant women nor children 18 years or under. His children would be eligible for children's Medicaid, as they are here lawfully present and intend to reside in West Virginia.

Lawfully Present Noncitizen Example 3: A Worker receives an application for Medicaid from a 19-year-old here on a valid work visa. He lives and works in Ohio but likes the hospitals in West Virginia better. He was told to apply at the local Department of Human Services (DOHS) office. The client is here lawfully present but does not intend to lawfully reside in West Virginia. The Worker processes the application and appropriately denies the application for not intending to reside in West Virginia.

Lawfully Present Noncitizen Example 4: A woman was lawfully admitted for permanent residence two years ago. She is now applying for pregnancy Medicaid. She is lawfully present and residing with the intent to live in West Virginia. She is also financially eligible for pregnancy Medicaid. The worker approves the application.

15.7.5.C Reasonable Opportunity Period

All applicants and clients, who have made a declaration of satisfactory immigration status, must be given a reasonable opportunity period to provide documentation to establish their immigration status when the DOHS is unable to verify the immigration information through SAVE.

If the immigration status cannot be verified through SAVE, the client must be notified and given 90 days to provide the required immigration documentation. The client is provided 90 days from the date the notice is received to provide the required documentation.

The client is approved for Medicaid or WVCHIP during the 90-day reasonable opportunity period, if otherwise Medicaid or WVCHIP eligible.

If documentation is not supplied within the 90-day reasonable opportunity period, Medicaid or WVCHIP is stopped after advance notice.

15.7.5.D Non-qualified Noncitizens

Non-qualified noncitizens are all other noncitizens and include the following:

- Visitors, tourists, students, and diplomats

  EXCEPTION: See Section 15.7.5.B.2 above for pregnant women and children 18 and under.

- Noncitizens who have applied for eligible status, but who have not been approved

  EXCEPTION: Battered spouses and children with a military connection.

- Noncitizens whose status is questionable or unverified
- Undocumented immigrants

15.7.5.E Noncitizens Who Receive SSI

A noncitizen who receives Supplemental Security Income (SSI) receives Medicaid benefits as long as he meets all other eligibility requirements for SSI.

15.7.5.F Qualified Medicare Beneficiaries (QMB)

The eligibility of a noncitizen who has Medicare coverage and meets the criteria to be a Qualified Medicare Beneficiary (QMB) is determined by whether or not the individual is a qualified noncitizen in one of the groups covered by Section 15.7.5.B above.

15.7.5.G Medicaid Emergency Service

Any noncitizen who is not an eligible qualified noncitizen can be considered for Medicaid emergency service. See Section 15.7.6 below.

15.7.6 EMERGENCY MEDICAID FOR NON-QUALIFIED NONCITIZENS

15.7.6.A Introduction

Any noncitizen who is not a qualified noncitizen is not eligible for Medicaid except in emergency situations.

15.7.6.B Eligibility of Non-Qualified Noncitizens

Non-qualified noncitizens who meet the residence and other Medicaid policy eligibility criteria are eligible for Medicaid only for treatment of medical conditions meeting the following requirements.

15.7.6.B.1 Eligibility Requirement for Emergency Services

To be eligible for emergency services, a noncitizen must meet all eligibility requirements of the Medicaid group for which they are applying. See Section 23.13.

NOTE: If a Social Security Number (SSN) is available, the noncitizen must provide it but must not be required to apply for an SSN.

15.7.6.B.2 Care and Services for Emergency Services

Care and services are necessary for the treatment of an emergency medical condition of the noncitizen, provided such care and services are not related to either an organ transplant procedure or routine prenatal or post-partum care.

The noncitizen must have, after sudden onset, a medical condition (including emergency labor and delivery) showing acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

NOTE: If a noncitizen is in need of ongoing emergency medical services, this must be approved by the Bureau for Medical Services (BMS) prior to the continuation of medical benefits.

15.8 REFUGEE AND ASYLEE ASSISTANCE PROGRAMS

15.8.1 INTRODUCTION

The Refugee Cash Assistance (RCA) program and the Refugee Medical Assistance (RMA) program provide cash and medical assistance to all eligible refugees, regardless of nationality.

Refugees who have an eligibility date before May 5th, 2025, are allotted a 12-month period of eligibility. Refugees who have an eligibility date on or after May 5th, 2025, are allotted a 4-month period of eligibility. For example, if a Refugee enters the U.S. on June 1st, 2025, and applies for RCA/RMA benefits on August 1st, 2025, the benefit may only be received for 2 months.

NOTE: It is a federal requirement that the State pursue reimbursement for RCA payments from the sponsor of a Refugee. This is not to be confused with the repayment/recoupment process which is initiated at the local office level.

The term “eligibility date” differs for each of the ORR eligible populations.

- Refugees - the date of eligibility is the date of entry into the U.S.
- Afghan Parolees - the date of eligibility is the date they arrived in their resettlement community/final destination after departing the Safe Haven. (This date can be verified by the Resettlement Agency).
- Asylees – they are eligible to access RCA/RMA beginning on the date they are granted asylum. (second paragraph is this section).

15.8.2 ASYLEE ELIGIBILITY SCREENING

All immigrants who have been granted asylum status will have in their possession United States Citizenship and Immigration Services (USCIS) documentation that shows proof of asylum status and the date asylum was granted.

15.8.2.A Asylee Status of Applicant

15.8.2.A.1 Documentation

In order to determine an asylee's eligibility in accordance with the Office of Refugee Resettlement (ORR) regulations, the Worker must confirm the individual's status and date of entry through appropriate USCIS documentation. The following documents will confirm both status and date of entry for asylees:

- USCIS Form I-94 Arrival/Departure Card, noting that the individual has been admitted under Section 208 of the Immigration and Nationality Act (INA)
- USCIS Form I-94 Arrival/Departure Card with the admission codes AS-1, AS-2 or AS-3
- USCIS Form I-94 Arrival/Departure Card with Visa 92 (or V-92)
- Order of an Immigration Judge granting asylum under Section 208 of the INA will serve as proof of asylee status if the USCIS has waived the right to appeal the case; the date on the Immigration Judge Order will serve as the date the individual was granted asylum

> *NOTE: If the Immigration Judge Order shows the* USCIS *has reserved its right to appeal, there is a 30-day waiting period from the date of the order before an approval consideration can be made. The Worker must submit copies of the Immigration Judge Order to the SAVE Coordinator. The SAVE Coordinator will complete an inquiry on or after the 31st day from the date on the Immigration Judge Order to find out whether the* USCIS *has appealed the case, and then notify the Worker of the eligibility status of the individual.*

- Asylum Approval Letter from an USCIS Asylum Office
- I-730 Approval Letter
- Written Decisions from the Board of Immigration Appeals (BIA)

15.8.2.A.2 Recommended Asylum Approval Letter

Recommended Asylum Approvals are not proof of asylee status. This letter is a notification from USCIS advising the applicant that his application has been recommended for approval and that an investigation of his identity and background will be conducted before final approval is issued.

15.8.2.B Asylee Status of Family Members

15.8.2.B.1 Family Members Included in Principal Asylee's Application

If the asylee includes his spouse and children on the asylum application, the family members have the same asylum grant date as the principal asylee.

Family members will be included on the principal asylee's asylum documents.

15.8.2.B.2 Family Members Outside of the U.S.

The family members should receive USCIS I-94 Arrival/Departure Cards noting the "entry" date.

The date that the family enters the United States (U.S.) will be the date to consider computing the benefit eligibility period.

15.8.2.B.3 Family Members in U.S.—Not Included on Principal Asylee's Application

The family will receive an I-730 approval letter with the date the application is approved. The approval date is the date to consider as the date asylum was granted.

USCIS should issue Form I-94 reflecting the approval date as "entry" date and status as asylee.

15.8.2.C SAVE Verification

Copies of USCIS documentation should be submitted to the State Refugee/SAVE Coordinator for USCIS verification of noncitizen status. However, processing of applicant's application is to be completed without waiting for SAVE verification. When the worker receives the SAVE verification, all copies should be filed in the case record.

15.8.3 REFUGEE ELIGIBILITY SCREENING

In order to be eligible for assistance for RCA and RMA, the refugee must meet the following requirements:

15.8.3.A Legally Admitted

15.8.3.A.1 Newly Arrived Refugees and Entrants

All newly arrived refugees or entrants will have in their possession an USCIS identification card. In order to determine that a refugee or entrant has entered the country legally, the Worker must request to see the USCIS identification card. This could be either an I-94 or an I-551.

The card should be reviewed for the following information.

➢ *Classification*

- All persons possessing an I-94 and who are eligible for RCA or RMA will have either the classification "refugee" or "entrant" on their I-94 or I-551.
- Amerasian, Vietnamese with American fathers, and their immediate relatives, spouse, children, mothers, siblings and sometimes stepfathers. The Amerasian teen and mother have AM codes, such as AM-1 or AM-3, on the I-94. Some relatives have "refugee" on the I-94 or I-551, and some also have AM codes.
- There are two classifications that could have questionable status. They are as follows:
    - Classification of "parolee" could be used, but most parolees are short-term admissions.
    - Individuals entering under "Private Sector Initiative" may have a refugee class, but the coding "Private Sector" normally prevents them from receiving RCA and RMA.

In these instances, the Worker should contact the State Refugee Coordinator.

➢ *Date of Entry*

Refugees who have an eligibility date before May 5th, 2025 are allotted a 12 month period of eligibility. For Refugees who have an entry date on or after May 5th, 2025, programs for RCA

and RMA are only offered for four months. The date of entry must be noted in the system or case record.

Note: The Office of Refugee Resettlement reduced the eligibility dates for RCA/RMA programs from 12 months to 4 months for individuals whose date of eligibility is on or after May 5th, 2025.

The term "eligibility date" differs for each of the ORR eligible populations.

- Refugees - the date of eligibility is the date of entry into the U.S.
- Afghan Parolees - the date of eligibility is the date they arrived in their resettlement community/final destination after departing the Safe Haven. (This date can be verified by the Resettlement Agency).
- Asylees – the date they are granted Asylum.

15.8.3.A.2 Household Composition

Make sure the file contains the correct Household Composition information. This includes the Alien Registration Number that is included on the I-94 or I-551.

15.8.3.A.3 Documentation of Noncitizen Identification

Submit copies of the identification card, front and back, and a copy of the Citizen/Noncitizen Declaration to the SAVE Coordinator, for verification of noncitizen status. Once noncitizen status is verified, the original verification and the information provided for verification, along with the copies of noncitizen identification card, must be filed in the case record.

15.8.4 ELIGIBILITY DETERMINATION FOR AFDC/MEDICAID FOR REFUGEES

15.8.4.A Parents/Caretaker Relatives or AFDC-Related Medicaid

If the applicant meets all requirements for regular Parents/Caretaker Relatives or AFDC-Related Medicaid, the application should be made for those programs. However, participation is limited to five years from entry into the U.S. for WV WORKS and seven years for Medicaid. If the applicant does not meet the requirements for one of these programs, then a determination should be made for RCA or RMA.

15.8.4.B Amount of Payment

The basic payment plan will be used in determining the amount of the assistance payment.

15.8.4.C Identification of Refugees in the Eligibility System

Individuals who are receiving assistance as refugees must be coded appropriately in the eligibility system.

It is extremely important that all refugees be coded appropriately.

15.8.4.D Registering for Employment Services

It is a condition of eligibility that all employable refugees who apply for the AFDC-Related Medicaid or the Refugee Assistance Program must register for work. All refugees applying for AFDC-Related Medicaid must register with the WorkForce West Virginia unless they are exempt from registration according to Section 15.8.4.F below. For any noncitizen individual who initially has no Social Security Number, a referral must be made to the Social Security Administration before policies regarding penalties for refusal to register may be imposed. See Section 15.8.11 REFERRALS TO THE SOCIAL SECURITY ADMINISTRATION to learn more about the referral process. DoHS allows a 60-day grace period to allow the individual to apply for, receive a determination, and obtain a Social Security Number, before completed registration for Workforce West Virginia Services is required. Referral to the current subrecipient providing Refugee Support Services, will constitute as meeting the minimum requirement during this grace period. RSS involves enrollment in courses that may also be defined as Employment Services; however, Workforce WV registration will remain a requirement.

15.8.4.E Work Registration Exemptions

The following individuals are exempt from registering for Employment Services:

- A child under 16 years of age.
- A child 16 – 18 and in school full time.
- A person who is ill, disabled, or over 65 years of age. The determination of illness or disability must be verified by a doctor's statement.
- A person whose presence in the home is required because of illness or disability of another member of the household. This must be verified by a doctor's statement.
- A caretaker who is caring for a child under the age of three. Only one parent or other relative in a case may be exempt.
- Any member of the assistance group (AG) who is enrolled and participating in a training program. The training program must be part of an employability plan that has been approved by the Division of Family Assistance (DFA) and/or Migration and Refugee Services and intended to have a definite short-term (less than one year) employment objective.
- Spouse of a registrant.

NOTE: Inability to communicate in English does not exempt the client from registering.

The following changes apply to the work registration exemption for the WV WORKS Program:

- The age of the child age three or older.
- A caretaker under the age of 20 without a high school diploma is mandatory, regardless of the age of the child.
- The spouse of a registrant is not exempt.

15.8.4.F Refusal to Register for Employment Service

It is a condition of eligibility for AFDC-Related Medicaid that the refugee register with WorkForce West Virginia unless exempt. If a refugee who is a mandatory registrant refuses to register, the refugee is to be sanctioned.

Sanction policies are the same for noncitizen individuals as for U.S. citizen individuals in IMM Chapter 14.5 SNAP Work Requirement Penalties.

Note: See IMM Chapter 15.8.4.D Registering for Employment Services for policy regarding a 60-day grace period specifically for noncitizen individuals

15.8.4.G Income

At the time of application and each re-determination, the sponsor should be contacted to determine the amount of income, if any, he voluntarily contributes to the refugee. Also, the name and address of the sponsor should be recorded in the case record.

If the refugee has excessive income for AFDC-Related Medicaid or RCA, the Worker will evaluate the client for the Medicaid or RMA programs.

15.8.4.H Assets

Assets will be treated in the same manner as any other applicant. If an asset is located in the refugee's homeland and is not available to the Refugee then these assets would not be treated as assets available to meet the needs of the client.

15.8.5 ELIGIBILITY DETERMINATION FOR WV WORKS/MEDICAID FOR ASYLEES

- If the applicant meets all requirements for WV WORKS and/or Medicaid, the application should be made for those programs. However, participation is limited to five years from date granted asylum for WV WORKS and seven years for Medicaid.
- The amount of payment follows the basic payment plan of the assistance payment.
- Individuals receiving this assistance must be coded appropriately as asylees in the eligibility system.
- All other conditions of eligibility for these programs must be followed with the exception of counting assets.

- Assets will be treated in the same manner as any other applicant. However, if an asset is located in the asylee's homeland and is not available to the asylee, then these assets would not be treated as assets available to meet the needs of the applicant.

15.8.6 ELIGIBILITY FOR REFUGEE CASH ASSISTANCE (RCA) AND REFUGEE MEDICAL ASSISTANCE (RMA)

The state must determine Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) eligibility under its Medicaid and WVCHIP state plans for each individual member of a family unit that applies for medical assistance.

A state that provides Medicaid to medically needy individuals in the state under its state plan must determine a refugee or asylee applicant's eligibility for Medicaid as medically needy.

A state must provide medical assistance under the Medicaid and WVCHIP programs to all refugees/asylees eligible under its state plan.

If the appropriate state agency determines that the refugee/asylee applicant is not eligible for Medicaid or WVCHIP under its state plans, the state must determine the applicant's eligibility for refugee medical assistance.

A determination is made for RCA or RMA following the same guidelines as for AFDC-Related Medicaid. The difference in the Refugee Program is that certain eligibility requirements are waived.

15.8.6.A Eligibility Requirements

The following eligibility requirements are waived for individuals.

15.8.6.A.1 Living With a Specified Relative

A child does not have to be living with a specified relative in order to be eligible for this program.

15.8.6.A.2 Having an Eligible Child in the Home

Individuals are not required to have an eligible child in the home in order to be eligible for an assistance payment.

> **No Eligible Children in Home Example:** If a husband and wife do not have any eligible children in the home, and they meet all other eligibility requirements, the case can be approved for this program.

15.8.6.A.3 Assignment of Support Rights

The eligibility requirement of assignment of support rights is waived for this program. If the applicant has child support as income, it will be treated as a resource against the assistance check.

15.8.6.B Full-Time Students in Institutions of Higher Education

RCA shall not be made available to refugees or asylees who are full-time students in institutions of higher education, unless it is appropriate English-language and job-related training, approved under an individual employability plan, and has a definite short term of less than one-year employment objective.

15.8.6.C Income

Income will be treated as it is treated for any other applicant, but only the income available to the refugee or asylee will be treated as income. Any income producing property that is in his homeland will not be considered available to meet the needs of the refugee/asylee.

Whenever a refugee or asylee applies for cash or medical assistance, the Worker must notify the Voluntary Placement Agency (VOLAG), or Refugee Resettlement and Immigration Services (RRIS) that provided for the initial resettlement of the refugee/asylee, of the fact that the refugee/asylee has applied.

The Worker needs to determine the following:

- Assistance the VOLAG is providing to the refugee/asylee.
- Whether the refugee/asylee has refused an offer of employment or has voluntarily quit a job without good cause.

- Name and address of the VOLAG, which may be obtained from the refugee/asylee.

The Worker can contact the RRIS at:

Refugee Resettlement and Immigration Services
(304) 343-1036

This notification can be completed by telephone, but a recording must be included in case comments for audit purposes. The VOLAG should also be notified of any adverse action taken on a case.

NOTE: If for some reason the refugee/asylee does not know the name of the VOLAG, contact the State Refugee Coordinator in the Division of Family Assistance.

If the refugee or asylee has excessive income for WV WORKS or RCA, the Worker will evaluate the client for the Medicaid or RMA programs.

15.8.6.D Assets

Assets will be treated in the same manner as any other applicant, with one exception. If an asset is located in the refugee's or asylee's homeland and is not available to the refugee/asylee, then these assets would not be treated as assets available to meet the needs of the client.

15.8.6.E Identification of Refugees/Asylees in the Eligibility System and Case Record

Individuals who are receiving assistance as refugees or asylees must be identified for federal reporting purposes. Data must be coded appropriately in the eligibility system.

15.8.7 REGISTERING FOR EMPLOYMENT

NOTE: For asylees, the inability to communicate in English is not considered an exemption from work registration/participation.

15.8.7.A WorkForce West Virginia

Recipients of RCA are not eligible for WV WORKS; therefore, they must register with WorkForce West Virginia.

A referral must be made to Catholic Charities of WV (CCWVA). The same sanctions and time limits apply when a refugee or asylee fails to register with WorkForce West Virginia as with failure to comply with Supplemental Nutrition Assistance Program (SNAP). However, with RCA cases, the Worker must notify CCWVA by utilizing form DFA-REF-1, of the refugee/asylee's failure to register so that they may evaluate and alleviate barriers in effort to prevent sanctioning.

Catholic Charities of WV

Phone Number: (304) 650-6221

Within three working days of the receipt of the memorandum, a Worker from CCWVA will counsel with the refugee/asylee to explain the implication of his refusal and the sanctions that will be implemented as a result of his failure to register.

If the refugee/asylee agrees to register before the sanction is made effective according to time-limits set in policy, he and his family will remain eligible for the program. If he still refuses to register, CCWVA will notify the appropriate DoHS office by utilizing form DFA-REF-2, and the sanctions will apply the same as for all other applicants.

15.8.7.B Refusal to Cooperate With WorkForce West Virginia

In order to be eligible to receive assistance through RCA, the refugee or asylee must cooperate with WorkForce West Virginia.

The following situations constitute failure to cooperate:

- The refugee/asylee refuses to answer a "call-in" to WorkForce West Virginia or Catholic Charities of West Viriginia (CCWVA).
- The refugee/asylee fails to supply WorkForce West Virginia and CCWVA with supplemental information regarding employment status.
- The refugee/asylee fails to report to an employer to whom he has been referred by WorkForce West Virginia or CCWVA.
- The refugee/asylee fails to accept a bona fide offer of suitable employment to which he has been referred by WorkForce West Virginia or CCWVA.
- The refugee/asylee fails to continue suitable employment.
- The refugee/asylee refuses to participate in an available and appropriate social service program, training program, or English as a Second Language (ESL) program.

If the refugee/asylee refuses to cooperate with WorkForce West Virginia, WorkForce West Virginia will send a notice to the Worker and the Refugee Social Service Agency. The following steps will be taken:

- The Supervisor will send a memorandum to the service provider, CCWVA, explaining the refugee/asylee's refusal to cooperate with WorkForce West Virginia.
- CCWVA will then determine if the refugee/asylee had good cause for not cooperating. The reasons for good cause can be found below.
- If the service provider determines that the client has good cause, then the Worker will send a memorandum to the Supervisor stating that fact and no negative action will be taken.

If CCWVA determines that the refugee/asylee did not have good cause, then the sanctions will apply as applied to other applicants.

15.8.7.C Criteria for Determining Suitable Work

The following criteria should be taken into consideration when determining what is suitable work for the refugee or asylee:

- The wage should not be less than the state minimum wage. If the job is exempt from the wage laws, the wage shall correspond with normal wages for similar work, but never less than three-fourths of the state minimum wage.
- Daily and weekly hours of work shall not exceed those customary to the occupation.

- No individual shall be required to accept employment if the position offered is vacant due to a strike, lockout, or other bona fide labor dispute.
- The individual shall be required to work for an employer contrary to his existing membership in the union governing the occupation. However, employment not governed by the rules of a union in which he has membership may be deemed appropriate.
- Assignments shall not be made that are discriminating in terms of age, sex, race, color, national origin, handicap, religion, or political belief.
- The job or training assignment must be related to the physical and mental capability of the individual to perform the task on a regular basis.
- Total daily commuting time roundtrip shall not normally exceed two hours, not including the transportation of a child to and from a childcare facility, unless a longer commuting time and distance is normally accepted in the community.
- The work or training site must not be in violation of applicable federal, State, and local health and safety standards.

15.8.7.D English as a Second Language Training

If the refugee or asylee is employed less than 100 hours per month, he must accept part-time English language training to be eligible for refugee assistance. RRIS will see to the availability of this training.

It will be the responsibility of the service provider, RRIS, to keep in touch with the refugee to determine if he is still participating in training.

If the refugee/asylee has quit his English training, the service provider will then counsel the refugee to explain to him why it is important for the refugee to continue the training.

After counseling, the service provider will determine if the refugee/asylee has good cause for not accepting the training. If the service provider determines that he has good cause, no penalty will be applied.

If it is determined that good cause did not exist, the service provider will send a memorandum to the Worker, and the Worker will apply the appropriate action detailed in Chapter 14.

15.8.8 SPECIFIC ELIGIBILITY REQUIREMENTS FOR REFUGEE MEDICAL ASSISTANCE PROGRAM ONLY

Except for the provisions stated in this chapter, the eligibility requirements for the Refugee Medical Assistance Program are the same as for regular Medicaid.

If a refugee or asylee who is receiving refugee medical assistance receives increased earnings from employment, the increased earnings shall not affect the refugee/asylee's continued medical assistance eligibility. The refugee/asylee shall continue to receive refugee medical assistance until he reaches the end of his time-eligibility period for refugee medical assistance, in accordance with CFR 400.100(b). In cases where a refugee/asylee obtains private medical coverage, any payment of RMA for that individual must be reduced by the amount of the third-party payment.

15.8.9 SNAP ELIGIBILITY

All refugees/asylees who apply for SNAP are considered as noncitizens lawfully admitted for permanent residence and are to be treated as any other SNAP applicant. However, participation is limited to five years from entry into the U.S.

For asylees only, the 40 Qualifying Quarters requirement is waived for the first seven years from granting of asylum status.

15.8.10 REFERRALS FOR SERVICE

The Worker will contact CCWVA for all refugees and asylees, approved or denied for any program, and submit it to the SAVE Coordinator and the Refugee Resettlement Program.

The Department of Human Services has a purchase-of-services contract with Catholic Charities of West Virginia (CCWVA). The purpose of this agreement is to provide necessary services to enable the refugee/asylee to become self-sufficient as soon as possible. Emphasis is placed on employment services, job placement, ESL training, counseling, translation by the bilingual staff, and cultural adjustment.

After the initial referral to the SAVE Coordinator, all referrals pertaining to service needs or to the refugee/asylee's refusal to cooperate with WorkForce West Virginia by refusing to participate in any available and appropriate training programs, employment programs, or ESL classes, will be made directly to CCWVA at the address below. This may be done by utilizing form DFA-REF-1 or a phone call. CCWVA will respond to the local worker after counseling the refugee/asylee or providing the service requested.

Catholic Charities of WV

Phone Number: (304) 650-6221

The local Social Service Coordinator or Supervisor is to be notified simultaneously with Catholic Charities of West Virginia whenever a serious problem, such as child abuse/neglect or the need for foster care, exists. While these and other emergency situations will require the expertise of the Department's Office of Children and Adult Services staff, they may also require the involvement of CCWVA. Most refugees/asylees have a very limited understanding of the English language and our culture and may need someone to translate for them. The language interpreting service currently in contract with DoHS should be utilized first; however, in a situation that a rare language in which a service cannot be provided, the local office should contact CCWVA, directly.

15.8.11 REFERRALS TO THE SOCIAL SECURITY ADMINISTRATION

15.8.11.A INTRODUCTION

There are several instances in which the DoHS is required to refer a non-citizen individual to the Social Security Administration. This section refers to non-citizens who have status or are treated with such status that is considered eligible for a benefit which requires registration with employment services or Work Force WV, as well as individuals potentially eligible for SSI.

When a referral is made, evidence of the referral must be documented in electronic storage. The HS-3, Inter-Agency Referral Form is utilized for this purpose. It is preferable to have comments noting the referral in the case as well.

Note: Case maintenance must include contacting the client as a follow-up to ensure a determination was made on any submitted applications by the SSA. If the non-citizen faces a challenge in any processes involved with the referral, including language barriers, the local DoHS office must refer the individual to the current organization contracted with the DoHS to provide Refugee Support Services for assistance. Contact the SAVE Coordinator at dohsbfasave@wv.gov for updated contact information for the current RSS Provider.

15.8.11.A.1 Referrals for SSI Benefits

All noncitizen individuals determined eligible for Refugee Cash Assistance or Refugee Medical Assistance, who are over the age of 65, and appear to meet eligibility requirements for Supplemental Security Income SSI at the time of application are referred to the Social Security Administration.

The local office will explore the noncitizen's potential of being eligible for SSI. If the Worker determines that the individual may be eligible, then the client must be referred to the Social Security Office to apply for SSI. If the client is approved for SSI, at the time of reception, RCA and/or RMA Benefits must be scheduled to close, after advanced notice.

15.8.11.A.2 Referrals for Social Security Card/Number

Referrals to the Social Security Administration should also be made for any noncitizen individual without a Social Security Card/Number at the time of application. This will facilitate registration with Workforce WV activities. The client will be allowed a 60-Day Grace Period to register with Workforce WV while the client's SSA application for a Social Security Number is pending. Please refer to the note in Section 15.8.11.1 INTRODUCTION for information regarding the requirement for case follow-up after a referral to the SSA.

15.8.12 TIME LIMITS FOR PARTICIPATION

The "Date of Entry" to the U.S. is very important and must be recorded in the case record.

The RCA and RMA programs are limited to four months for noncitizen individuals whose Date of Eligibility is on or after May 5th, 2025, 12 months for individuals whose Date of Eligibility falls before May 5th, 2025. The time limit (Duration of Allowable Issuances) begins from the date of eligibility and includes prorated months before the date of application. The Date of Eligibility is typically the Date of Arrival into the U.S.; however, for Asylees, the DOE is the grant date for the status. The State has no provisions for this program past the period of eligibility. Case Maintenance requires a termination of benefit, manually initiated by the local office, to comply with timeliness requirements.

15.8.13 SPECIAL STATUS FOR AFGHANS AND IRAQIS

15.8.13.A SNAP, Medicaid, and WV WORKS

The Consolidated Appropriations Act (CAA) of 2008 grants Afghans and Iraqi noncitizens special immigrant status.

NOTE: Afghans and Iraqis no longer have a time limit to receive benefits. Benefits are the same as Refugees. See Section 15.8.

15.8.13.A.1 Iraqis

The CAA of 2008 grants certain Iraqi noncitizens special immigrant status under Section 101(a)(27) of the INA. Individuals and family members granted this special immigrant status are eligible for resettlement assistance, entitlement programs, and other benefits, the same as refugees admitted under Section 207 of the INA. Family members of Iraqi special immigrants must show their own documentation of special immigrant status under Section 207.

15.8.13.A.2 Afghans

Afghans also fall under the CAA of 2008 and are granted special immigrant status under Section 101(a)(27) of the INA. Individuals and family members granted this special immigrant status are eligible for resettlement assistance entitlement programs and other benefits, the same as refugees admitted under Section 207 of the INA. Family members of Afghanistan special immigrants must also show their own documentation of special immigrant status under Section 207. See Section 15.8.8.

15.8.13.B Date of Entry

The following documents confirm both status and date of entry for Afghan and Iraqi special immigrants.

Applicant	Documentation
Principal Applicant of the Special Immigrant	Passport with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa) Category SI1 or SQ1, and a U.S. Department of Homeland Security (DHS) stamp or notation on passport or I-94 showing date of entry.
Spouse of Principal Applicant of the Special Immigrant	Passport with an immigrant visa stamp noting that the individual has been admitted under IV Category SI2 or SQ2, and DHS stamp or notation on passport or I-94 showing date of entry.
Unmarried Child Under 21 Years of Age of the Special Immigrant	Passport with an immigrant visa stamp noting that the individual has been admitted under IV Category SI3 or SQ3, and DHS stamp or notation on passport or I-94 showing date of entry.
Principal Applicant of the Special Immigrant Principal Adjusting Status in the U.S.	DHS Form I-551 Permanent Resident Card showing the nationality with an IV Code for this category (S16 or SQ6).
Spouse of Principal Applicant of the Special Immigrant Principal Applicant Adjusting Status in the U.S.	DHS Form I-551 Permanent Resident Card showing the nationality with an IV Code for this category (S17 or SQ7).
Unmarried Child Under 21 Years of Age of the Special Immigrant Principal Applicant Adjusting Status in the U.S.	DHS Form I-551 Permanent Resident Card showing the nationality with an IV Code for this category (S19 or SQ9).

15.8.14 CUBAN AND HAITIAN ENTRANTS

Cuban and Haitian entrants are eligible for ORR-funded benefits and services, such as refugee cash, medical assistance, and social services. They are also eligible for Federal Public Assistance for Needy Families to the same extent as refugees. See Section 15.8.4.

To determine if someone is a Cuban or Haitian Entrant, use the Refugee Education Assistance Act of 1980. The following documentation is acceptable for proof of status.

A national of Cuba or Haiti who was granted parole status as a Cuban/Haitian entrant, status pending, on or after April 21, 1980, or has been paroled into the U.S. on or after October 10, 1980, regardless of the status of the individual at the time assistance or services are provided.

Chart 1

Documents/Codes	Comments
An I-94 Arrival/Departure Card with a stamp showing parole into the U.S. on or after April 21, 1980.	I-94 may refer to §212(d)(5). I-94 may refer to humanitarian or public interest parole. I-94 may be expired.
An I-94 Arrival/Departure Card with a stamp showing parole at any time as a "Cuban/Haitian Entrant (Status Pending)."	I-94 may refer to §212(d)(5). I-94 may be expired.
CH6 adjustment code on the I-551.	Even after a Cuban/Haitian Entrant (Status Pending) becomes a permanent resident, he/she technically retains the status Cuban/Haitian Entrant (Status Pending). I-551 may be expired.
A Cuban or Haitian passport with a §212(d)(5) stamp dated after October 10, 1980.	Passport may be expired.

A national of Cuba or Haiti who is the subject of removal, deportation, or exclusion proceedings under the INA and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation, or exclusion has not been entered.

Chart 2

Documents/Codes	Comments
Department of Homeland Security DHS Form I-221	Order to show cause and notice of hearing
DHS Form I-862	Notice to appear
DHS Form I-220A	Order of release on recognizance
DHS Form I-122	Notice to applicant detained for a hearing before an immigration judge
DHS Form I-221S	Order to show cause, notice of hearing, and warrant for arrest
Copy of DHS Form I-589 date stamped by the Executive Office for Immigration Review (EOIR)	Application for asylum and withholding of removal; individual is subject of removal, deportation, or exclusion proceedings

Documents/Codes	Comments
Copy of DHS Form I-485 date stamped by EOIR	Application to register permanent residence or to adjust status; individual is subject of removal, exclusion, or deportation proceedings
EOIR-26	Notice of appeal; date stamped by the Office of the Immigration Judge
I-766 Employment Authorization Document with the code C10	Application for suspension of deportation/cancellation of removal submitted
I-688B Employment Authorization Document with the provision of law 274a.12(c)(10)	
Other applications for relief that have been date stamped by EOIR	
Other documentation pertaining to an applicant's removal, exclusion, or deportation proceedings	Example would be a notice of a hearing date before an Immigration Judge

A national of Cuba or Haiti who has an application for asylum pending with the DHS and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation, or exclusion has not been entered.

Chart 3

Documents/Codes	Comments
DHS receipt for filing Form I-589	Application for asylum and withholding of removal
I-766 Employment Authorization document with the code C08	
I-688B Employment Authorization Document with the provision of law 274a.12(c)(8)	This is an older version of the employment authorization document

15.9 VICTIMS OF HUMAN TRAFFICKING WHO ARE NON-U.S. CITIZENS ELIGIBILITY FOR REFUGEE CASH AND MEDICAL ASSISTANCE

15.9.1 INTRODUCTION

The Trafficking Victims Protection Act (TVPA) makes victims of a severe form of trafficking in persons eligible for federally funded or administered benefits and services to the same extent as refugees. They are eligible for federally funded or administered benefits and services, such as the Refugee Cash Assistance (RCA) program and the Refugee Medical Assistance (RMA) program that provides cash and medical assistance, WV WORKS, Temporary Assistance for Needy Families (TANF) & Medicaid. To be eligible for Supplemental Nutrition Assistance Program (SNAP) benefits, a trafficking victim must have Lawfully Permanent Resident Status; however, they are not subject to a 5-year waiting period after gaining the status, provided they meet other program eligibility criteria. Victims of Trafficking who have an eligibility date before May 5th, 2025, are allotted a 12-month period of eligibility. VOTs who have an eligibility date on or after May 5th, 2025, are allotted a 4-month period of eligibility.

Victims of Trafficking are considered to be in an eligible status as of the date they are certified as VOTs.

15.9.2 ELIGIBILITY SCREENING

Immigrants who have been granted Trafficking Victims Protection will have documents termed “Derivative T-Visas” in their possession. Victims of Trafficking who provide a T-2, T-3, T-4, or T-5 visa (“Derivative T-Visas”), or have that status stamped on their I-94 Arrival Record or passport, are eligible for federally funded or administered benefits and services (RMA, RCA, WV WORKS, Medicaid, SNAP benefits) provided they meet program eligibility criteria. See Section 15.8.

15.9.2.A T-Visa Noncitizen Under 21 Years of Age

When a noncitizen is awarded a T-Visa and was under 21 years of age on the date the T-Visa application was filed, the Derivative T-Visas are also available to this noncitizen's parents, spouse, children, and unmarried siblings who were under 18 years of age on the date on which such noncitizen's T-Visa application was filed.

15.9.2.B T-Visa Noncitizen 21 Years of Age or Older

When a noncitizen is awarded a T-Visa and was 21 years of age or older on the date the T-Visa application was filed, the Derivative T-Visas are available to this noncitizen's spouse and children.

15.9.2.C Date of Entry for Purposes of Eligibility for Some Benefits and Services

15.9.2.C.1 Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA)

Victims of Trafficking who have an eligibility date before May 5th, 2025, are allotted a 12-month period of eligibility. VOTs who have an eligibility date on or after May 5th, 2025, are allotted a 4-month period of eligibility. Victims of Trafficking are considered to be in an eligible status as of the date they are certified as VOTs.

15.9.2.C.2 Individual Already Present in the U.S.

For an individual who is already present in the U.S. on the date the Derivative T-Visa is issued, the date of entry for federally funded or administered benefits and services is the Notice Date on the I-797.

15.9.2.C.3 Individual Entering the U.S. With T-Visa

For an individual who enters the U.S. on the basis of a Derivative T-Visa, the date of entry for federally funded and administered benefits and services is the date of entry stamped on that individual's passport or I-94, Arrival Record.

15.9.2.D Application for Benefits

15.9.2.D.1 Accepting Derivative T-Visa Related Documents

When a Derivative T-Visa holder applies for benefits or services, follow normal procedures for providing services and benefits to refugees, except that the nonimmigrant T-2, T-3, T-4, or T-5 visa is accepted, or the I-797, Notice of Action, or the I-94, Arrival Record, with date of entry and status.

15.9.2.D.2 Contacting the SAVE Coordinator

The Worker must email or fax the documentation the immigrant has provided to the Systematic Alien Verification for Entitlement (SAVE) Coordinator, including the benefits for which the individual has applied. The SAVE Coordinator will respond with eligibility/verification information and notify the Federal Office of Refugee Resettlement (ORR) of the benefits for which the individual applied.

NOTE: At this time, the SAVE system does not contain information about victims of a severe form of trafficking or nonimmigrant noncitizen family members.

15.9.2.D.3 Receiving Response From SAVE Coordinator

Once the response is received from the SAVE Coordinator, the Worker takes the appropriate action regarding eligibility as outlined in Section 15.8.

Chapter 16

Specific SNAP Requirements

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
16.1				
16.2	10/1/19 4/1/20 6/6/22 10/1/24	777 784 824 855	16.2.1.G 16.2.2.B 16.2.1.G 16.2.4.A 16.2.4.C 16.2.2.A	Updated language to bring SNAP EBT card return requirements in line with federal regulations. Added clarification that a center cannot act as a client's authorized representative after a client leaves the facility. Replaced Rapids with eligibility system Homeless as adult or child under 18 Homeless as adult or child under 18 Removed authorized representative as cardholder and added the case name and EBT card should be in client's name only.
16.3	1/1/26	872	16.3	States that all purchase restrictions applicable to SNAP also apply to D-SNAP, including the prohibition on soda purchases.

16.1 INTRODUCTION

This chapter sets forth specific policy and procedures which apply only to the Supplemental Nutrition Assistance Program (SNAP), including special living situations and emergency SNAP assistance for disaster victims.

16.2 SPECIAL LIVING SITUATIONS

Some living situations require special information, instructions, or procedures. Special living situations are involved in determining assistance group (AG) composition. The eligibility information necessary to determine AG composition is contained in Chapter 3. Other information about such special situations is presented in this section, including information about group living facilities (GLFs), residents of drug/alcohol treatment and rehabilitation centers, shelters for battered persons, and homeless persons and residents of homeless shelters.

16.2.1 GROUP LIVING FACILITY

Residents of GLFs may be eligible when the requirements in Chapter 3 are met.

16.2.1.A Definition of GLF

For its residents to qualify for Supplemental Nutrition Assistance Program (SNAP), the GLF must:

- House no more than 16 residents;
- Be a public or private non-profit group home; and,
- Be certified by the State under Chapter 1616e of the Social Security Act or be certified under standards comparable to Chapter 1616e as implemented by the appropriate West Virginia State agency and approved by the Secretary of the U.S. Department of Agriculture (USDA).

To obtain the approval of the Secretary of the USDA, the following information must be sent to the Division of Family Assistance (DFA) Economic Services Policy Unit: name and address of GLF, contact person for GLF, copy of State certification or approval of operation, name of contact person in the appropriate State agency. Upon receipt of this information, the DFA Economic Services Policy Unit will obtain a written statement of the standards used to approve operation and forward it to the Food and Nutrition Services (FNS) Regional Office. The DFA Economic Services Policy Unit will respond in writing with the USDA decision.

Most of the facilities involved are approved by the Office of Children and Adult Services as Adult Family Care Homes. However, there may be others licensed by the Division of Health which may qualify if they are certified under Chapter 1616(e) of the Social Security Act.

All Adult Family Care Homes approved within the Department of Human Services (DOHS) are non-profit and are certified under Chapter 1616(e) of the Social Security Act.

Most Personal Care Homes licensed by the Division of Health are for-profit organizations. To determine if the Personal Care Home is non-profit, verification of tax-exempt status is required.

Each county office is responsible for verifying that the GLF meets these requirements. The GLF is responsible for providing sufficient documentation. Documentation of USDA Food and Nutrition Service (FNS) authorization is verification of certification by the State. See 16.2.1.C below. When the GLF is authorized by FNS, but is unable to document this fact, the Worker must contact the DFA Policy Unit. The DFA Policy Unit will contact FNS to confirm the authorization.

16.2.1.B When the GLF Is the Authorized Representative

When the GLF is the client's authorized representative, the client is approved as a one-person AG.

SNAP benefits may be used to purchase food for communal meals or for meals distributed to the residents individually. The GLF may permit the resident to use his SNAP benefits to purchase meals supplied by the facility or to purchase food. The overriding consideration is that each resident's SNAP benefits must be used for meals intended for that resident.

With Electronic Benefits Transfer (EBT), an individual employee of the GLF may be an authorized cardholder to receive an EBT card and access the SNAP benefit account for the client. The same hierarchy for card issuance applies as for any SNAP AG. See Chapter 1.4.19.

The GLF is responsible for notifying the Department of any changes in the individual's circumstances, including when the resident leaves the GLF. The GLF is also responsible for all overpayments, losses, misuse and fraudulent acts that occur while the client is a resident of the facility.

When the Residents Apply for Themselves

If the residents of the GLF apply on their own behalf or through their own authorized representative(s) who does not represent the GLF, normal processing procedures are followed. The GLF determines if residents should make application as one-person or multi-person AGs.

If a resident or group of residents apply on their own, they assume liability for any overissuances they may receive. They also have all of the responsibilities of any other AG, including reporting changes.

SNAP benefits may be turned over to the GLF to purchase food for meals consumed communally or individually. The residents may also keep the SNAP benefits and use them to purchase meals supplied by the GLF or to purchase food for their own meal preparation. When the resident applies for himself, he decides who, if anyone, is an authorized cardholder for him to use his SNAP benefits.

16.2.1.C Authorization by FNS as Retail Food Stores

Before the GLF is permitted to redeem SNAP through wholesalers, it must be authorized by the FNS of USDA as a retail food store.

Any GLF not acting as an authorized representative for all of its eligible residents requires FNS authorization as a retail food store, if the facility wishes its residents to purchase meals with SNAP benefits.

When the GLF is authorized to accept SNAP benefits, it may qualify for a point of sale (POS) terminal to use EBT benefits. The GLF may also credit SNAP benefits when a resident leaves the GLF. See 16.2.1.G below.

The GLF does not have to be authorized as a retail store for its residents to qualify for SNAP benefits.

16.2.1.D Responsibilities of the GLF

For its residents to receive SNAP, the GLF must accept the following responsibilities:

- Determine whether the facility will act as the authorized representative for all or part of its residents and which residents may apply individually or in groups on their own behalf;
- Verify the qualifications in 16.2.1.A above;
- Provide a monthly list of all participating residents to the Community Services Manager (CSM);
- Meet the requirements in 16.2.1.C above, if applicable; and
- Agree to random on-site visits that may be made by State Office staff.

It is suggested that the CSM, or designee, explain these responsibilities to the GLF at the time of the first inquiry about participation.

16.2.1.E Responsibilities of the Worker

The Worker has the following responsibilities:

- Accept and process any application made by or on behalf of residents of GLFs;
- Accept the GLF's determination of who will apply for the residents and how they are grouped into AGs;
- Explain how SNAP benefits and the EBT card may be used by eligible residents, and the requirements found in 16.2.1.D above, if applicable;
- Verify the GLF requirements 16.2.1.A above;
- Explain the responsibilities of the GLF; and
- Report any suspected misuse of SNAP benefits by the GLF to the DFA Policy Unit; complaints will be referred to the USDA.

16.2.1.F A Change in the Status of the GLF

When a GLF loses its FNS authorization as a retailer, the residents who applied on their own behalf continue to be eligible to participate. Those for whom the GLF was the authorized representative must be evaluated individually for eligibility. Upon loss of FNS authorization, SNAP benefits must not be used to purchase food or meals from the GLF.

16.2.1.G When the Resident Leaves the GLF

Residents who apply on their own behalf retain the use of their SNAP benefits and are entitled to take their remaining benefits with them if they subsequently leave the GLF at any time during the month.

A resident who applies on his own behalf and receives his benefits by EBT, requires no return of benefits. If, for some reason, he has a GLF employee as an authorized cardholder, he must request the removal of the cardholder or a change to another cardholder.

If a group of residents apply as one AG, and a resident leaves the GLF, that resident’s prorated monthly share of the remaining SNAP based upon the date the resident left the facility must be given to him by the facility or the other AG members, whichever is appropriate. The AG must decide how to let the individual who is leaving the GLF spend his portion of the SNAP benefits.

The individual's share is determined by dividing the dollar value of the remaining SNAP benefits by the number of persons in the AG, then using the proration table in Chapter 4 Appendix D to determine the prorated amount for the rest of the month.

When the GLF is the authorized representative and the resident leaves, the GLF has specific responsibilities to:

- Notify the DOHS through a SNAP Change Reporting Form that the client has left the facility, the client's new address if available and that the facility is no longer an authorized representative for the client.
- Provide the client with a SNAP Change Reporting Form once it becomes aware of the client's intent to leave and advise the client to return the form to the DOHS within 10 days.
- Provide the client with his EBT card within 5 days of the client's departure if the card was in possession of the facility. If the facility is unable to provide the EBT card to the client, then the facility must provide the EBT card to the DOHS by the end of the month when the client departs.
- Refund a prorated amount of the household's monthly allotment back to the client's EBT account based on the number of days in the month that the client resided at the facility. If the facility is authorized as a SNAP retailer and has POS equipment, then the center must process a refund to the client's EBT card. If the facility either (1) has an aggregate EBT card or (2) uses individual cards as an authorized representative, the DOHS must be notified so that the DOHS can transfer the prorated portion of the client's monthly allotment from a bank account owned by the facility to the client's EBT account.

> **EXAMPLE: GLF is authorized representative for a client in the facility. Client receives $100 for the entire month. The client leaves on the 18th. The current balance on the EBT card is $20. Since the prorated amount for $100 is $43, the GLF would have to refund the client the difference, or $23.**

If the GLF has taken benefits out of the account which must be returned and the GLF has POS equipment, the benefits can be credited to the client's EBT account. When the GLF is the authorized representative/payee for the client, the GLF's access to the account must be stopped immediately and a new payee entered in eligibility system. When the GLF does not have POS equipment and the transfer must be made, the DOHS must take action to add the benefits to the client's EBT card within 5 days of the date the DOHS is notified by the facility or the client of the needed transfer and refund.

16.2.2 RESIDENTS OF DRUG/ALCOHOL TREATMENT AND REHABILITATION CENTERS

16.2.2.A Who Is Eligible?

Residents of public or private, non-profit drug addiction or alcoholic treatment and rehabilitation centers and their children who live with them are eligible to participate in SNAP if all other eligibility requirements are met. They are required to use the center as an authorized representative and cardholder, when applying for and using SNAP benefits. The case name and the (Electronic Benefits Transfer) EBT card should be in the client's name only. Spouses who live with the residents in the center and who are not participants in a treatment program are ineligible to be included in the AG. See Chapter 2.2.

NOTE: For special considerations involving alcoholic treatment and rehabilitation programs located on Indian reservations, contact the DFA Policy Unit.

Drug addiction or alcoholic treatment and rehabilitation program means any drug addiction or alcoholic treatment and rehabilitation program under Part B of Title XIX of the Public Health Service Act, conducted by a private, non-profit organization or institution or a publicly operated community mental health center. "Under Part B of Title XIX of the Public Health Service Act" is defined as meeting the criteria which would make it eligible to receive such funds, even if it does not receive the funding.

The client must be a participant in the programs offered at the center to be eligible. Residence in one of the centers is presumed to mean participation, unless the Worker has reason to believe otherwise.

These programs need to be authorized by FNS to accept SNAP benefits as a retailer or operate under Part B of Title XIX of the Public Health Service Act, even though Title XIX funds may not be received by the program in order for the residents to qualify for SNAP benefits.

16.2.2.B Responsibilities of the Center

The center is responsible for notifying the Department of any changes in the individual's circumstances and when the resident leaves the center. In addition, the center is responsible for any misrepresentation or fraud that it knowingly commits in the certification of its residents. The center is also liable for all losses or misuse of SNAP benefits or EBT cards held for the residents and for all over issuances which occur while the individual is a resident of the center.

The center must provide the Department with a monthly list of all participating residents and is subject to periodic on-site visits made by State Office personnel.

When the resident leaves the center, the center has the same responsibilities outlined in 16.2.1.G above. The center can no longer act as the client's authorized representative for certification purposes or for obtaining or using benefits. The actions which are taken when the center experiences a change in status are the same as those specified in 16.2.1.F above.

The worker must notify the DFA Policy Unit in writing when the worker has reason to believe that a Drug/Alcohol Treatment and Rehabilitation Center is misusing benefits and/or the EBT cards in its possession. The DFA Policy Unit is required to forward these suspicions to the USDA.

16.2.3 SHELTERS FOR BATTERED PERSONS

Residents of abuse shelters for battered persons and their children qualify for SNAP benefits under the following circumstances, provided all other eligibility requirements are met.

16.2.3.A Who Is Eligible?

Adults and children residing in abuse shelters are exempt from the policy for residents of an institution in Chapter 2.2. Therefore, even residents who receive the majority of their meals from the shelter qualify, if otherwise eligible.

16.2.3.B Determining AG Composition

The AG composition is determined as for any other AG. See Chapter 3.2.

Considerations such as food storage or sharing living space are not used to determine AG composition.

16.2.3.C County in Which the Application Should Be Made

Residents of abuse shelters must apply in the county where the shelter is located, since that is their current county of residence.

16.2.3.D When the Resident Is Already Included in a SNAP AG

The individuals who leave the original AG are eligible as a separate AG, beginning the month of the separation. They are certified solely on the basis of their income, assets, and the expenses for which they are responsible.

16.2.3.E Special Income and Asset Considerations

The income of other persons usually in the resident's AG is not counted, unless the income, or a portion of it, is paid directly to the resident of the shelter.

See Chapter 5.6 for special consideration of jointly owned assets.

16.2.3.F Authorized Representatives and Cardholders

Some shelter residents are reluctant to leave the shelters because they fear for their safety. The resident may choose to use an employee of the shelter, another resident, or anyone else who is knowledgeable about the applicant's circumstances as an authorized representative to make application or conduct other business. The resident may select any individual as an authorized cardholder.

16.2.4 HOMELESS PERSONS AND RESIDENTS OF HOMELESS SHELTERS

Residents of shelters for the homeless are not considered residents of an institution and, if otherwise eligible, qualify for participation in SNAP. SNAP benefits may be used to purchase meals prepared by approved homeless meal providers.

16.2.4.A Definition of a Homeless Individual

For the purposes of this policy, a homeless individual is an adult or child who lacks a fixed or regular nighttime residence, or a person whose primary nighttime residence is one of the following:

- A supervised shelter designed to provide temporary accommodations, such as a congregate shelter;
- A halfway house or similar institution that provides temporary residence for persons who might otherwise be institutionalized;
- A temporary accommodation in the residence of another individual. Homeless is defined in this manner for up to a 90-day period. When the homeless individual(s) moves from

one residence to another, a new 90- day period begins. A 90-day period in one residence continues when there is a break in participation; or

- A place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings, such as a vehicle, a hallway, a bus station, a lobby or similar places.

16.2.4.B Definition of a Homeless Meal Provider

A homeless meal provider is a public or private non-profit establishment, such as, but not limited to, a soup kitchen or temporary shelter which is approved by the State and feeds homeless persons.

To accept SNAP benefits as payment for prepared meals, the homeless meal provider must:

- Be a public or private non-profit organization as defined by Chapter 501(c)(3) of the Internal Revenue Code (IRC).
- Be an establishment or shelter that serves meals to homeless persons. The Department must certify to FNS that this is true. It is the responsibility of the CSM or his designee to provide this certification to DFA by memorandum.
- One on-site visit must be made by the CSM or designee to confirm that the facility does, in fact, provide meals to the homeless. Once confirmed, the approval continues unless there is reason to question the status. If this occurs, another on-site visit is made, and the results reported to DFA.
- Serve meals that include food purchased by the meal provider. Homeless meal providers serving meals which consist entirely of donated foods are not eligible for authorization to accept SNAP benefits.

Meal providers must be certified by FNS to accept SNAP EBT benefits.

In determining the cost of prepared meals, the homeless meal provider may not require the client to pay more than the average cost of the food purchased in a meal served to the client. The average cost is determined by averaging food costs over a period of up to one calendar month. Costs incurred in the acquisition, storage, or preparation of the meals, as well as the value of donated food, are not used in determining the cost. However, voluntary payments in excess of the average cost may be accepted by the meal provider.

16.2.4.C SNAP Participation for Persons Who Are Homeless

Persons who are homeless qualify for participation in SNAP, if otherwise eligible, because there is no durational or fixed residency requirement.

NOTE: Homeless children under age 18, not under parental control of an adult, are considered an individual living alone and should be afforded the opportunity to apply as a one person household.

16.2.4.D AG Composition

The AG composition is determined as for any other AG. See Chapter 3.2.

Considerations such as food storage or sharing living space are not used to determine AG composition.

Not all residents of the shelter are included in one AG, even though they may eat their meals together.

16.2.4.E Authorized Representatives and Cardholders

Homeless AGs have the right to choose an authorized representative or cardholder. However, the homeless meal provider may not be the authorized representative or cardholder, even if the client lives where he receives his meals.

16.2.4.F Use of SNAP Benefits

Homeless AGs may use their SNAP benefits to purchase prepared meals from homeless meal providers, as long as the meal provider has been authorized to accept SNAP benefits according to 16.2.4.B. However, homeless meal providers may only request voluntary use of SNAP benefits for payment. If others have the option of eating free or making a monetary donation,

SNAP clients must be provided the same option of eating free or making a donation in money or SNAP benefits.

16.3 EMERGENCY SNAP ASSISTANCE FOR DISASTER VICTIMS

The decision to implement Disaster Supplemental Nutrition Assistance Program (D-SNAP), a modified version of the regular Supplemental Nutrition Assistance Program (SNAP), or to utilize regular SNAP depends on the nature of the disaster.

All purchase restrictions applicable to SNAP, including the prohibition on soda purchases under the soda restriction policy, also apply to D-SNAP benefits.

16.3.1 PRE-CONDITION FOR AUTHORIZATION OF THE DISASTER PROGRAM

The following pre-conditions must be met before the D-SNAP can be authorized:

- The President must sign a proclamation for an Individual Assistance Disaster Declaration in a designated area of West Virginia.
- Commercial channels of food distribution (wholesale and retail food outlets) must have been disrupted and subsequently restored.
- The regular SNAP must be unable to handle the increased number of households needing food assistance expeditiously.

Commercial channels of food distribution are disrupted under one or more of the following conditions directly caused by the disaster:

- Retail food outlets are closed.
- Normal operating hours of food outlets are reduced to the extent that a household's opportunity to purchase food supplies is significantly reduced.
- Power failure significantly restricts the operation of food outlets.
- Household access to retail food outlets is limited because of disruption to transportation such as damage to roads, bridges or disruption of public transportation.
- Unusually heavy demand for food exists such that a household's opportunity to purchase food supplies is significantly reduced.
- Delivery of food supplies to food outlets is disrupted to the extent that a household's opportunity to purchase food supplies is significantly reduced.

Commercial channels of food distribution will be considered restored when conditions of operations have been improved to the extent that households have reasonable access to food outlets with sufficient food supplies.

Authorization of disaster SNAP benefits to affected areas is issued by the United States Department of Agriculture (USDA).

16.3.2 DISASTER DECLARATION PROCEDURES

The Department of Human Services (DOHS) must determine if the regular SNAP can meet the needs of the affected area when a part of the state has been affected by a disaster. When the regular SNAP cannot respond due to the number of affected households, the DOHS must request and receive approval from Food and Nutrition Services (FNS) to operate D-SNAP or a modified SNAP. Requests should be addressed to the SNAP Director of the FNS Regional Office.

FNS will approve or deny the request to implement disaster certification and issuance procedures based on the information provided in the application. If the request is denied, the DOHS may request that FNS review the decision based on additional information when appropriate.

The President must first sign a proclamation of an Individual Assistance Disaster Declaration in a designated area of the state before the DOHS can submit a request to operate D-SNAP. D-SNAP can only be operated within the specified geographic area. All other disaster-related SNAP needs will be addressed through either regular SNAP or a modified version of regular SNAP.

The request should include at least the following information:

- Date and type of disaster;
- Description of the geographic areas;
- Statutory prerequisites;
- Food needs cannot be met by the regular SNAP;
- Number of households expected to apply;
- Expected length of the application period;
- Expected length of the benefit period;
- Residency requirement;
- Security plan;
- Crowd control measures;
- Fraud control measures;
- Process by which applications will be processed and benefits issued; and,
- Description of planned post-disaster review activities.

16.3.3 SPECIFIC ELIGIBILITY CRITERIA

Specific eligibility criteria vary for each disaster. Eligibility guidance will be given as the DOHS prepares to implement D-SNAP.

16.3.4 CLIENT NOTIFICATION AND FAIR HEARINGS

The Worker must advise the D-SNAP applicant of his eligibility status at the time the application is completed. If eligible, the applicant must be advised of the amount of the allotment and the period the benefits are intended to cover. This information is provided verbally and must be followed up in writing.

The Worker must notify applicants who are denied in writing using form FS-D-2 or by completing an DFA-NL-A for each individual denial. As with any other Department action, the client has the right to request a Fair Hearing. The denied applicant must be offered an immediate, on the spot, supervisory review of the Worker's action. This supervisory review is in addition to the right to a Fair Hearing, not a replacement for it.

Chapter 17

Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T)

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
17.1	12/1/23	844	17.1	Explaining SNAP E&T participating in WV WIOA State Plan
	11/1/25	870	17.1	Added a note regarding federal changes in work requirement policy.
	1/1/26	872		Removed sentence.
17.2	10/1/19	777	17.2.1	Updated DOHS worker responsibilities in regard to the SNAP E&T program
			17.2.2	Removal of the word mandatory from referral language
	8/1/20	791	17.2.1	Explanation of worker responsibilities.
	1/1/26	872	17.2.2	Added WIOA co-enrollment requirement; established referral maintenance (30 days, two contact attempts); disenrollment after 60 days.
17.3	12/1/17	747	17.3.2.E 17.3.5 17.3.1	Limiting SNAP E&T college placements to programs that meet the definition of career and technical education. Removed Drivers Education This change is made to allow greater flexibility with the Job Search Activity while more closely aligning our use of this activity with federal recommendations.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	2/1/18	751	17.3	Removed job search as an activity and replaced it with supervised job search
	10/1/19	777	17.3.1	Removed language for job search as an activity and replaced it with description of supervised job search.
			17.3.2.B	Clarify high school person to SNAP E&T.
	3/1/21	801	17.3.2 thru 17.3.3.D	Update terminology of SNAP partners
	4/1/21	803	17.3.3.D	SNAP E&T/WIOA last dollar in clarification
	5/1/21	804	17.3.1	Clarifying that supervised job search for SNAP E&T can take place in-person.
	6/1/21	805	17.3	Clarification of a voluntary participant in SNAP E&T
	1/1/26	872	17.3	Removed duplicate minimum wage sentence; added clarification that voluntary participants must not work below minimum wage and ABAWDs must complete 80 hrs/month.
			17.3.2	Added eligibility for age 17+ not in school (with approval for minors); added ABE detail; added note that ABE is not federally reportable but may still be used to support attainment/self-sufficiency.
			17.3.2.B	Removed language allowin g minors in after-school/weekend programs; clarified referrals limited to age 17+ not in school, or adults seeking HSE.
			17.3.3	Added that completions of career/technical/vocational programs count toward MSG ad Credential Attainment; required documentation.
			17.3.3.E	Added reimbursement rules: funding of last resort; vendor/participant payment rules; reimbursement categories and limits; verification required; HSE exams not allowable.
			17.3.8	Added MSG and Credential Attainment measures; required WORKS coding; added documentation standards and component alignment table.
17.4				
17.5	7/1/21	806	17.5	Added section.
	7/1/21	806	17.5	Establishing provider determinations for SNAP E&T
	11/1/25	870	17.5	Indicated an unfit for work designation for SNAP requires a supervisor/senior worker determination.
App A	10/1/20			Update SNAP E&T
	1/1/26	872		Added updated support service payment categories and limits (transportation, clothing, tools, licenses, training contracts, other expenses).
App B	1/1/26	872		Updated occupational categories; removed “Bus, Truck and Diesel mechanics”; replaced with “Bus, Truck

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				Mechanics and Diesel Engine Specialists.”

17.1 INTRODUCTION

The intent of the Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) program is to provide Supplemental Nutrition Assistance Program (SNAP) clients with opportunities to gain skills, training, or experience to improve their employment prospects and reduce their reliance on SNAP benefits. This is accomplished through the SNAP E&T Worker and participant developing a Personal Responsibility Plan (PRP), which includes an individualized Self-Sufficiency Plan (SSP). The PRP includes the DFA-SNAP-E&T-1 and the SSP. SNAP E&T must include case management services and at least one activity for each participating client.

West Virginia operates a voluntary SNAP E&T program. This means the state exempts 100% of work registrants from mandatory program participation. As such, screening and referral to the E&T program are considered functions of eligibility.

Note: Federal law continues to evolve regarding work requirements and exemptions. The Fiscal Responsibility Act of 2023 and H.R.1 (One Big Beautiful Bill) of 2025 expanded ABAWD exemptions. The Fiscal Responsibility Act of 2024 temporarily created exemptions of veterans, homeless individuals, and foster youth aging out until age 25, but these were removed by H.R.1 effective November 1, 2025.

17.2 AREAS OF RESPONSIBILITY

To operate the Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) program, the Department of Human Services (DOHS) Worker and the SNAP E&T Worker are responsible for duties as outlined in this section. Referrals are made to the SNAP E&T Worker through the eligibility system. The SNAP E&T Worker focuses on providing SNAP E&T participants with opportunities to gain skills, training, or experience to improve employment prospects.

17.2.1 DOHS WORKER RESPONSIBILITIES

The DOHS Worker is responsible for:

- Processing Supplemental Nutrition Assistance Program (SNAP) applications and determining eligibility;
- Managing the SNAP case;
- Determining work registration exemptions;
- Making decisions on determination of exemption from participation based on recommendations from the SNAP E&T Worker;
- Informing those exempt from registration that it is possible to volunteer for SNAP E&T;
- Referring the case to the SNAP E&T Worker in the eligibility system, if the client chooses to voluntarily participate in the SNAP E&T Program;
- Referring all clients subject to the SNAP work requirements, including exempt SNAP E&T participants, to WorkForce West Virginia; and
- Explaining to all clients who are subject to the ABAWD work requirements that volunteering for SNAP E&T alone does not equal the client participating. When a client volunteers to be referred to SNAP E&T, the worker must explain that the client will have to attend orientation, complete required paperwork, accept a mutually agreed upon/approved activity(ies) and verify completing 80 hours per month in the activity(ies) before the client will be considered participating in SNAP E&T
- Representing the DOHS in hearings, pre-hearing conferences, and providing testimony and documentation.

17.2.2 SNAP E&T WORKER RESPONSIBILITIES

The SNAP E&T Worker is responsible for:

- Accepting voluntary referrals for non-exempt Able-Bodied Adults Without Dependents (ABAWD) and other exempt SNAP clients who request SNAP E&T services;
- Notifying participants of appointments for orientation/enrollment, initial assessment, and development of the Personal Responsibility Plan (PRP), which includes the responsibilities of the program and the Self-Sufficiency Plan (SSP);
- Screening and scheduling participants for SNAP E&T activities;
- Supporting and following up on SNAP E&T activities, including reviews of contact reports or participation documentation;
- Entering data into the eligibility system for appropriate reporting for all SNAP E&T cases after referral;
- Preparing information for DOHS for hearings and pre-hearing conferences and providing testimony as appropriate;
- Notifying the DOHS Worker when SNAP E&T participants are not complying with program requirements using the SNAP E&T Notification form (DFA-SNAP-E&T-2); and
- Completing a monthly report that lists SNAP E&T participants served during each month of eligibility and the amount of money spent for each participant.
- Co-enrolling SNAP E&T participants with Workforce Innovation and Opportunity Act (WIOA) services whenever possible, ensuring maximum service integration.
- Referrals must be maintained for at least 30 days, with two contact attempts made within that timeframe, and outreach completed prior to any disenrollment from services.
    - Participants should be disenrolled after 60 days by the E&T worker.

o Exceptions to the 60-day rule may be made by the E&T case manager if the participant is waiting to be placed into a specific activity.

17.3 SNAP E&T ACTIVITIES

All participants will complete a Self-Sufficiency Plan (SSP), as part of the Personal Responsibility Plan (PRP). The activities available for placement are listed below. Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) funds may only be used to pay for activities after all other funding sources (Pell Grant, West Virginia Invest, etc.) have been used. If the same activity is offered through multiple vendors, participants must be placed in free programs prior to using SNAP E&T funds.

Participants are to be paid a maximum of $25 transportation reimbursement per month of activity, not to exceed actual cost. Participants are only required to verify when the situation is questionable. For Supervised Job Search and Job Retention activities, the payment will be made prior to, or when the activity begins, and must be taken into consideration when scheduling the activity.

West Virginia operates a voluntary SNAP E&T program; this means the client cannot lose their SNAP based on lack of participation in the program. A voluntary participant, who is not subject to the ABAWD work requirement may participate for more than 120 hours if the individual chooses to. A voluntary participant must not work for less than minimum wage (the higher of the applicable Federal or State minimum wage). For ABAWDs, E&T participation must equal at least 80 hours per month in qualifying activities to count toward work requirements.

17.3.1 SUPERVISED JOB SEARCH ACTIVITY

Supervised job search is a qualifying SNAP E&T activity only when it immediately precedes a qualifying placement. For example, a participant completes a vocational program activity, such as plumbing and is prepared to enter the workforce. The worker ends the vocational activity and places the participant in Supervised Job Search. The duration of this activity must not exceed two consecutive months. Supervised job search may be utilized when an individual is initially enrolled in SNAP E&T and other activities are not currently available, but the duration of this activity must not exceed two consecutive months before the client is enrolled in another qualifying activity.

NOTE: In order for hours to count toward the Able-Bodied Adults without Dependents work requirements, the total number of hours spent participating in supervised job search must be fewer than 50% of the total hours that the client participated during the month.

Participants who have satisfactorily completed another program activity may be placed in this activity. In order for a participant to be eligible to be placed in this activity more than once within a 12-month period, the first time a client is placed in this activity must be after initial enrollment due to a lack of currently available activities.

Supervised job search involves the SNAP E&T worker overseeing the client performing activities related to job search, including, but not limited to:

- Completing self-assessment for employment;
- Career exploration;
- Researching necessary career exploration;
- Preparing job search tools, including, but not limited to;
    - Writing a resume;
    - Creating a cover letter;
    - Obtaining references and letters of recommendation'
- Registering with WorkForce WV;
- Researching jobs and occupations;
- Filing out physical or electronic applications for employment;
- Scheduling appointments for interviews;
- Travel time for interviews;
- Interviews;
- Post interview follow up, if necessary.

Supervised job search must take place at approved locations. An approved location is defined as an area operated by or affiliated with a federal, state or local government agency. This can include not for profit, community and charitable organization. Supervised job search can occur

either in-person, remotely or both. To meet the definition of supervised job search the SNAP E&T client must be supervised/engaged by a skilled staff person, at least once monthly.

Hours for clients in supervised job search must be recorded by the worker or other supervisor on the DOHS Participation Time Sheet (DFA-TS-12) if the client is unable to provide verification through another allowable method.

17.3.2 BASIC/FOUNDATIONAL SKILLS

This activity includes placement in existing structured activities such as high school equivalency classes, Adult Basic Education (ABE), Literacy, English as a Second Language, and post-secondary education. High school equivalency, English as a Second Language, and ABE classes are operated by the County Board of Education. In some counties, private not-for-profit groups offer this type of activity with Workforce Development Board (WDB) funding. Participants in college and other post-secondary activities must use private funds or existing grants such as the Pell Grant, to cover the cost of tuition, books, and fees before SNAP E&T funding may be used. Skills training may be paid after all other resources are exhausted for vocational training not including college.

Participants under the age of 30 without a high school diploma or high school equivalency are required to enter remedial or secondary education activities if they are not working part-time or involved in another activity. Participants who are already in college courses are expected to continue participating or, as required, participate in another activity.

SNAP E&T services may be provided to individuals age 17 and older who are not enrolled in public or private school. In limited cases, 16-year-olds participating in approved training outside the school system may be referred with prior approval from the SNAP Policy Unit. SNAP E&T services are available for any individual age 18 and older seeking a high school equivalency. When traditional school placement is no longer appropriate, participants must be placed in ABE, vocational training, or another alternative setting.

Adult Basic Education (ABE) provides training in basic skills and may also be used to help prepare participants for the high school equivalency test.

Only those scheduled to attend classes at least 24 hours each month will receive reimbursement for transportation. Hours spent attending online classes from the participant’s home do not count toward the 24 hours.

The SNAP E&T Worker must refer participants to the appropriate program and monitor progress on a monthly basis. A time sheet (DFA-TS-12) must be completed for each month's participation

and be signed by each service provider. The SNAP E&T Worker must also work with participants to help eliminate barriers to participation by making referrals to other services available in the community. The SNAP E&T Worker must work with each service provider to determine the level of progress being made.

Participants who participate in these activities are expected to improve basic functioning levels and/or obtain a high school equivalency. Upon completion, participants may be required to enter either the Vocational Training or another more advanced, educational activity.

In order for non-exempt Able-Bodied Adults without Dependents (ABAWD) to meet the SNAP E&T participation requirement, the participant must attend the educational facility 20 hours per week. The minimum number of hours all other participants must meet to be in good standing with the program is equal to the negotiated hours found on the participant's SSP. For participants other than non-exempt ABAWDs, there is no minimum number of hours the participant must commit to on the SSP.

Note: Adult Basic Education is not a federally reportable E&T component in the SNAP E&T State Plan and is not reported to FNS. However, West Virginia will enroll participants into basic skills activities as necessary to promote educational attainment and long-term self-sufficiency.

The following describes educational activities that may meet a participant's work requirement.

17.3.2.A Literacy Program

When the participant cannot read, he may be placed in a literacy program. To qualify for such placement, the participant must test at or below standards set by the literacy program.

17.3.2.B English as a Second Language

Participants who cannot read, write, and/or speak English, may receive education in English language skills.

17.3.3 CAREER AND/OR TECHNICAL EDUCATION/VOCATIONAL TRAINING

Career and/or Technical Education

For non-exempt ABAWDs, attending undergraduate college classes part-time may meet the work requirement for a participant if the requirement of 20 hours per week is met. Otherwise, hours spent in class may help meet the requirement. If the 20-hour requirement is not met, the participant is not meeting the work requirement. For every credit hour the participant attends class, he will receive credit for one additional hour for study time. For participants not subject to ABAWD work requirements, there is no SNAP penalty for failing to meet the hours agreed upon in the SSP, but failure to meet obligations without good cause may lead to disenrollment from the SNAP E&T Program.

NOTE: SNAP student policy applies. See Section 3.2.1.E.

Some undergraduate courses require that student participants be placed in an unpaid work environment. Such undergraduate placements may also be used to meet the work requirement. These placements include, but are not limited to: student teaching, internships, clinical work assignments, and unpaid work experience. When the non-exempt ABAWD student participant does not participate in such activities for a sufficient number of hours to meet his participation requirement, he must also participate in another activity.

A release of information form may be used to obtain information about a participant's participation in education from institutions and other education activity providers. The form authorizes the SNAP E&T Worker to request such information.

The form must be read and explained to the participant prior to a specific placement or requirement. The form is signed by the participant at the time the SNAP E&T Worker needs to obtain specific information. After completion, the form is filed in the case record.

The program that a SNAP E&T participant may be placed in must meet the definition of career and technical education. Career and technical education are defined as a program that:

- Provides relevant technical knowledge and skills needed to prepare for further education and careers in current or emerging fields;
- Provides technical skill proficiency, an industry-recognized credential, a certificate, or an associate degree; and
- Includes competency-based applied learning that contributes to the academic employability skills, technical skills, and occupation-specific skills, and knowledge of all aspects of an industry, including entrepreneurship, of an individual.

Any course or program of study that a client is placed into must be able to be completed in four years or fewer. While the client may take longer than four years to complete the program, the program must be designed to be completed in four or fewer years.

VOCATIONAL TRAINING

Vocational Training enables participants to acquire the necessary knowledge and skills to compete in a specific occupation. This component may only be used when the training is likely to lead to employment. This activity is provided through existing resources available in the community on a non-reimbursable basis, until the resources have been exhausted.

This training must be preparation for a specific occupation and conducted by an instructor in a non-work site or classroom setting. Entry into this activity is selective and training is authorized only for programs that can be completed in one year or less.

NOTE: Exceptions may be made by the Division of Family Assistance (DFA) Policy Unit.

Non-exempt ABAWDs enrolled in Vocational Training are required to participate a minimum of 80 hours per month. The Vocational Training component is used to train participants in specific job skills for jobs that exist in the local labor market area. Participants in need of skill training must be referred to available vocational training schools, WDB sponsors, and industrial training programs that provide the training free to the participant. The participant may be referred to a facility that charges a fee, only after it is determined that cost-free training is not available.

The vocational training facility must report participant attendance and progress on a monthly progress report, DFA-TS-12. The SNAP E&T Worker must monitor and review the progress on a monthly basis. Vocational Training will vary according to training availability and the labor market needs of a particular area.

Participants who have obtained a high school equivalency or certification to become employed in a particular occupation, or to learn a skill in order to become employable, may be referred to Vocational Training facilities operated on the local level by the Board of Education.

SNAP E&T participants who complete career, technical, or vocational programs may count toward both the Attainment of Credential/Certificate measure and the Measurable Skill Gains measure, as applicable. Providers and workers should ensure that credential attainment is validated through documentation. Acceptable documentation may include transcripts, report cards, enrollment records, case notes, verification of enrollment, or copies of diplomas, certificates, or recognized equivalencies.

17.3.3.A SNAP E&T Worker Responsibilities

The SNAP E&T Worker must:

- Determine who should be referred to outside sources for training during the assessment process. See Section 17.4, and the development of the SSP;
- Make referrals to Vocational Training, WDB, third-party partners, and specific local programs;
- Monitor the attendance sheets, DFA-TS-12, monthly; and
- Maintain contact with the participant and service provider to ensure satisfactory progress is being made and to help eliminate barriers when needed.
    - Participants who fail to meet the required hours cannot be considered as making satisfactory progress, unless the participant is also in another component and meeting the hourly requirements.

17.3.3.B Placement Criteria

A participant, who is determined to have the ability to complete the course work and meets the entrance requirements, may participate when:

- The goal is to enter an occupation that requires completion of a vocational course prior to employment; or
- He has no job skills, obsolete or non-marketable skills, and must be retrained to find employment; or
- He does not have a High School Diploma/High School Equivalency, and the skill training has been identified as an alternative that will lead to employment.

17.3.3.C Placement Standards

The training institution and instructor must meet the licensing and certification standards of the appropriate governing agency. Unlicensed or uncertified instructors are not approved for training when licensing or certification standards exist.

17.3.3.D Contracts

Participants must be placed into training positions on a no-cost basis, if such positions are available through WDB, the Department of Education, Veterans Administration (VA), or other

providers, before additional training positions may be considered. These providers are not reimbursed unless all existing training positions have been filled.

NOTE: SNAP E&T and WIOA are both considered last dollar in programs. When a SNAP client is participating in both programs, the worker may use SNAP E&T contract funds prior to WIOA contract funds. SNAP E&T can be used to pay for a lesser training first, then if eligible the client could use WIOA for a more expensive training.

The SNAP E&T Worker may write contracts for participants, without DFA approval, for an amount not exceeding $600. Individual contracts exceeding $600 must be approved by DFA. Training must be reasonable and necessary and lead to employment immediately upon completion.

The SNAP E&T worker uses the SNAP E&T Training Agreement, DFA-SNAP-E&T-TA.

17.3.3.E Payment Limitations

Payments are limited to tuition, books, supplies, and expenses associated with completing the course of study. Costs for medical procedures, such as Hepatitis B vaccines or physical exams, are not included. There is a limit of $600 per individual contract. This limit cannot be exceeded without approval from DFA. To obtain approval, a written request must be submitted to the Director of DFA and include the participant's name, address, SSN, name of the training facility, and the occupation for which training is sought. The request must also include the usual pay rate for the occupation, as well as the current employment prospects and labor demands.

Participant reimbursements are considered funding of last resort and may be used only after other resources have been exhausted. Reimbursements may be issued directly to the participant (full allowable cost) or to a vendor (generally reimbursed at 50%, except for transportation and training contracts up to $600, which may be paid in full without additional approval). Allowable reimbursement categories are listed in the table below:

SNAP E&T Participant Reimbursements

Category	Limit	Notes
Clothing	Up to $1,000 lifetime	For required uniforms, scrubs, or footwear
Training Contracts	$600 without approval; up to $3,000 lifetime with Program Manager approval	Covers tuition, books, supplies, or training expenses
Professional Licenses/Certifications	Up to $300 lifetime	Includes license fees or certification exams
Tools	Up to $1,000 lifetime	For equipment required for employment or training
Transportation	$25 per month	Paid directly to participant for each active participation month

Verification of payment is required for most reimbursement requests, and some require supervisor or Program Manager approval in PATH before payment is issued.

High School Equivalency exams are not an allowable reimbursement, as all HSE preparation and testing are provided free of charge to West Virginia residents.

17.3.4 WORK ACTIVITY (SNAP COMMUNITY SERVICE NON-EXEMPT ABAWD ONLY)

This program is for non-exempt ABAWD SNAP E&T participants. These participants must be placed with agencies described below in order to meet the work requirement. The primary purpose of Community Service is to provide work experience and training to assist a participant who has limited work experience, is under-employed, or has no immediate employment opportunities.

Placements are only made with private not-for-profit agencies or public agencies. The SNAP E&T Worker is responsible for approving all work positions and for collecting monthly time sheets for each participant.

Participation hours for Community Services are governed by the Fair Labor Standards Act (FLSA). The maximum monthly participation obligation is determined by dividing the amount of SNAP allotment by either of the state or federal minimum wage, whichever is higher.

Participants are deemed to have met the required number of hours in the component if they participate for the maximum number of hours permitted by FLSA.

The SNAP E&T Worker must work closely with the local WV WORKS staff in making Community Service Placements. A SNAP E&T participant cannot be placed with an existing Community Work Experience Program (CWEP) sponsor.

17.3.4.A Who May Be a Community Service Sponsor

Community Service sponsors are limited to public agencies, such as federal, local, state, and not-for-profit employers. Public service projects are limited to fields such as health, social services, environmental protection, education, urban and rural development and re-development, welfare, recreation, public activities, public safety, and child care. A Community Service sponsor must not place a SNAP E&T participant at a site that has employees in layoff status.

17.3.4.B Requirements of the Sponsor

The Community Service Sponsor must meet the following requirements:

- Provide the participant with guidance and supervision necessary to participate in the work experience project;
- Provide safety equipment, special clothing, and tools needed to perform the assigned duties;
- Assume the cost of any required pre-employment medical examinations;
- Provide medical coverage in the event the participant is injured while volunteering at the work site; and
- Not schedule participants to work split shifts during the work period.

17.3.5 ON-THE-JOB TRAINING

On-the-job training (OJT) is a work-based learning activity characterized by learning and growing skills while in the workplace. OJT can be either part-time or full-time unsubsidized employment where the participant is compensated by wages. During this training, participants are familiarized with the policies and procedures of the workplace where they will be employed.

Part of on-the-job training is to face the challenges that occur during the performance of the job. An experienced employee or a manager is executing the role of the mentor who through written, or verbal instructions and demonstrations are passing on his/her knowledge and company-specific skills to the new employee. An on-the-job training component is a hands-on method of teaching the skills, knowledge and competencies needed for an efficient and effective work environment, learned in real-time.

This is a practical approach to learn new competencies through an employer and increase personal mobility. OJTs often provide the participant with additional skills to add to their resume, assist the participant with gaining a trust relationship with the employer, and participants are often offered additional employment opportunities through the OJT. OJTs allow the participant to make essential employer contacts.

The employer offers a mentoring relationship to participants and provides the case manager with important participant updates and submits a monthly timesheet to the agency.

17.3.6 PRE-APPRENTICESHIP/APPRENTICESHIP

Pre-Apprenticeship/Apprenticeship is a work-based learning activity. A pre-apprenticeship allows a participant to take an introductory unit in a specific trade or industry. Providing the knowledge needed for the participant to enter a Recognized Apprenticeship Program. An apprenticeship is a program that trains a participant to become skilled in a specific trade and leads to industry recognized credential attainment.

An apprenticeship is characterized by a structured training plan, with a focus on mastering a specific in-demand skill an employer needs to fill an occupation within the organization. Apprenticeships are typically 1-3 years in length. Apprenticeship programs are typically paid unsubsidized employment; pre-apprentice programs can be paid or unpaid employment.

This component focuses on short-term firsthand engagement with state and local industry certified professionals who know the skills and knowledge necessary to gain that will either transition the participant into an apprenticeship setting or prepare the participant for immediate employment upon completion of the program. This component is training objective specific. Each program is tailored to the information and work required for the field of study.

Service providers in this component will maintain regular contact with the participant's case manager and the Division of Family Assistance Policy unit. This contact will include providing participant updates, successes, if the participant leaves the program early, or if a Provider Determination is required. Providers will also provide a monthly timesheet for the participant.

17.3.7 JOB RETENTION

Job Retention is a component that is available to any SNAP E&T client who completes a component and is enrolled in employment while enrolled in SNAP E&T. A participant can be enrolled in part-time or full-time unsubsidized employment. Eligible participants must receive SNAP in the month of or the month following receiving an employment offer.

***NOTE**: If a participant receives employment that makes the participant over the income limit for SNAP, the participant may still continue enrollment in SNAP E&T for the duration of the Job Retention component.*

Job Retention can be provided no fewer than 30 days and no more than 90 days after receipt of employment. At minimum, the case manager will complete weekly check-ins and monthly face to face/virtual performance updates. During these meetings, case managers will continue to work through barriers to employment and provide resources to assist the participant. The goal of Job Retention is to assist the participant in retaining employment during the crucial time period when a participant may feel the cliff effect of loss of benefits.

Transportation reimbursement may be paid upfront for Job Retention. The only verification necessary is proof of employment.

17.3.8 MEASURABLE SKILLS

Measurable Skill Gains (MSG) and Credential Attainment are federal reporting measures used to track participant progress and outcomes in SNAP E&T. MSG reflects interim progress within a Federal Fiscal Year (FFY), such as improving an educational level, completing coursework, or reaching milestones in training. Credential attainment captures the completion of a recognized diploma, degree, certificate, or industry credential. This may be particularly critical for education or training services that are designed as part of a pathway to a longer-term program or credential.

Both measures align with Workforce Innovation and Opportunity Act (WIOA) standards, and documentation must be maintained to validate reporting. Acceptable evidence includes transcripts, test results, provider progress reports, employer evaluations, or copies of credentials, depending on the component.

Note: E&T workers must code measurable skill gains and credential attainment on the WORKS Programs Educational Testing screen.

The table below summarizes how MSG and Credential Attainment apply to each E&T component and the documentation that supports reporting.

17.3.8.A Component Alignment with Measurable Skill Gains and Credential Attainment

Component	MSG	Credential	Documentation
Basic/Foundational (ABE, Literacy, ESL)	✓ Level gain, transcript, progress	✓ HS equivalency diploma	Pre-/post-tests, transcripts, progress reports, test results
High School Equivalency	✓ Transcript, test passage	✓ Diploma/equivalency	Test scores, diploma, provider verification
Postsecondary Education	✓ Transcript/credits	✓ Degree, diploma, cert.	Transcripts, report cards, enrollment record, case notes
Career/Technical & Vocational Training	✓ Provider report, transcript, milestone	✓ Industry certification, license, diploma	Provider reports, transcripts, exam results, credential copy
On-the-Job Training (OJT)	✓ Employer evaluation, milestones, exam	× (unless linked to apprenticeship)	Employer evals, case notes, exam passage, progress report
Pre-Apprenticeship	✓ Coursework, milestones, exam	✓ Certificate if program issues one	Progress reports, transcripts, certificate, exam results
Apprenticeship	✓ Related instruction, exams	✓ Industry credential	Apprenticeship reports, trade exams, certificate/credential copy
Work Experience	✓ Progress report, milestones	✓ If leads to credential	Provider reports, case notes, employer verification, certificate copy

Job Retention	× Not applicable	× Not applicable	Case records, support logs (not MSG/credential)

17.3.8.B Credential Attainment

Credential attainment is a distinct outcome measure that captures the completion of a recognized diploma, degree, certificate of industry credential. Credentials include high school equivalency, postsecondary certificates, licenses, diplomas, and apprenticeship credentials.

Note: To validate reporting of credential attainment, E&T providers should maintain documented evidence of a participant's completion. Acceptable documentation may include:

- *Data matches with postsecondary or K-12 systems;*
- *Copies of enrollment record or school records;*
- *Case notes with provider verification;*
- *Transcripts or report cards; or*
- *Copies of diplomas, certificates, or licenses.*

17.3.8.C Counting Participants Across Components

If a participant is enrolled in multiple education or work-based learning components during a Federal Fiscal Year (FFY), the individual will be counted in each component.

- Example: Jane enrolled in a Vocational Training program in May, which led to a high school equivalency credential. In July of the same year, she entered a work-based learning program that culminated in a trade certificate. Jane would be reported once under Vocational Training (MSG and Credential) and again under Work-Based Learning (MSG and Credential).

For a summary of how measurable skill gains and credential attainment apply across components, see **17.3.8.A Component Alignment with Measurable Skill Gains and Credential Attainment.**

17.4 SNAP E&T PROGRAM

The Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) Worker must assist the participant in achieving self-sufficiency. To accomplish this, the SNAP E&T Worker must assess the participant's knowledge and skills and work with the participant to make informed decisions about the appropriate course of action. The SNAP E&T Worker must enter into a mutual agreement with the participant called a Personal Responsibility Plan (PRP). This plan details:

- The process to achieving self-sufficiency;
- Monitoring the participant's progress;
- Determining changing needs;
- Determining the need for supportive services; and
- Appropriate follow-up action based on the participant's performance.

17.4.1 CASE MANAGEMENT

The SNAP E&T Worker must use Work Programs (WP) in the case management system.

At each face-to-face telephone contact or virtual meeting with a (SNAP E&T) participant, the SNAP E&T Worker must offer the participant an activity if he is currently not participating in any. Procedures have been developed to track the offer of a placement and the actual acceptance of a placement. These must be noted in the case.

At the time a SNAP E&T participant actually begins the activity, the appropriate component code must be entered in the case management system to reflect the status. The start date and an anticipated end date must also be entered.

To meet the goals of the SNAP E&T program, the SNAP E&T Worker performs the following activities:

- The participant and Worker need to determine the best means for the participant to achieve self-sufficiency, accept personal responsibility, and, if applicable, to meet the work obligation.
- Establishes for the participant reasonable and appropriate requirements related to the participant's capability to perform the tasks on a regular basis, including physical capacity, skills, experience, family responsibilities, and residence. Reasonable and appropriate requirements must be based on the participant's proficiencies and skills as assessed.

- Monitors compliance progress to achieve self-sufficiency.
- Provides continuous assessment of the participant's needs, goals, and negotiates adjustments to the Self-Sufficiency Plan (SSP) as necessary.
- Develops employment and other work activity opportunities for the participant within the community.
- Makes referrals to other community services, as needed.
- Provides payment for supportive services, i.e. transportation, as appropriate.
- Identifies potential resources and makes appropriate referrals to access them.

This case management process provides for substantial flexibility in administration of the work component of SNAP E&T.

Self-sufficiency is defined as being able to provide for one's basic needs without relying on Supplemental Nutrition Assistance Program (SNAP) benefits. When a participant is not able to become completely self-sufficient, the goal must, at a minimum, be to reduce reliance on SNAP benefits as much as possible or maintain eligibility for SNAP benefits for certain clients.

17.4.2 ASSESSMENT

Assessment is the ongoing process of determining each participant’s goals, skills, needs, and challenges. Assessment begins at registration and continues until case management stops.

An in-depth assessment is necessary to discover the participant’s abilities to meet goals and to develop an ongoing plan to meet his goals.

The assessment must focus on information useful to both the participant and the SNAP E&T Worker in evaluating the participant's abilities.

As the participant’s circumstances change, it is necessary to change the terms of the SSP to assist the participant in becoming successful.

The assessment process must include a series of interviews and conversations with the participant. It may also include educational and/or aptitude or interest testing and interpretation of this information.

The SNAP E&T Worker must develop a plan to schedule educational, aptitude, and interest testing as appropriate and available. The test administrator is responsible for completing a release of information for each participant.

Upon receipt of test results, the SNAP E&T Worker must record the information in the eligibility system. An interview is scheduled with the participant, as soon as possible, to discuss the test results.

Participants who indicate substance abuse problems should be referred for evaluation and counseling prior to scheduling vocational testing. Determination of a substance abuse problem is based on statements made by the participant, not by the SNAP E&T Worker.

Note: As part of the assessment process, the Worker must also evaluate whether participation in an education or training activity can be tracked using federal educational reporting measures, including Measurable Skill Gains (MSG) and Credential Attainment. This ensures that progress toward educational and vocational goals is documented and reportable under SNAP E&T and aligns with WIOA practices.

17.4.3 DEVELOPMENT OF THE SELF-SUFFICIENCY PLAN (SSP)

The SSP is the product of negotiations between the participant and the SNAP E&T Worker. It is subject to renegotiation throughout the participant's receipt of SNAP. Initial and ongoing assessments aid the SNAP E&T Worker in providing reasonable guidance to the participant to attain his goals as part of the SSP.

The SNAP E&T Worker must explore family situations, education, work history, skills, aptitudes, and attitude toward work, employment potential, possible social services, and/or other support systems. Individual circumstances may require more or less exploration.

When developing the SSP, measurable benchmarks should include indicators that align with federal reporting measures, such as attainment of a credential, documented skill gains, or progression toward milestones. These benchmarks should be recorded so they can be tracked for both program accountability and participant progress.

The following assessments are mandatory and must be documented in the case management system:

- Education and Testing Assessment
- Job Readiness Assessment
- Employment History Assessment

The SNAP E&T Worker must explore all of the aptitudes, interests, and work goals presented by the participant to determine which are pertinent. The SNAP E&T Worker must determine what

resources are available to the participant and to the Department of Human Services (DOHS). The SNAP E&T Worker must outline steps and establish benchmarks to lead to the participant's self-sufficiency. In addition, the SNAP E&T Worker must explore other possibilities not presented by the participant and offer these to the participant as alternatives. The SNAP E&T Worker is expected to facilitate the participant's wishes, provided they are reasonable and will lead to self-sufficiency.

The SNAP E&T Worker should clarify the participant's goals and the necessary actions to reach the goals.

17.4.4 JOB DEVELOPMENT

Job development and the subsequent placement of participants in employment is the focus of SNAP E&T Program. The SNAP E&T Worker must have knowledge of the local economic base, develop and maintain a job openings base, and participate in various employment-related activities and initiatives. The SNAP E&T Worker must communicate with private employers, related organizations, and third-party partners to maintain a good working relationship within this group.

Job development and placement efforts must be coordinated closely with the local WorkForce West Virginia Office and with local WV WORKS staff. Participants must register with the WorkForce West Virginia office and keep registration current. The results of career-oriented testing are shared with the WorkForce West Virginia Office as needed. A Release of Information form, OFS-Release-1, must be signed by the participant prior to sharing information. The completed form must be placed in the case record. To increase the resources available to the participant, contacts are established and maintained with the Division of Rehabilitation Services (DRS), Department of Education, Community Action agencies, and other public and private organizations that could offer activities or support.

17.5 PROVIDER DETERMINATIONS

A provider determination is a determination by a SNAP E&T provider that a SNAP E&T participant is not an appropriate candidate for the particular activity. A SNAP E&T provider has the sole responsibility and authority to make provider determinations. A SNAP E&T provider can make a provider determination at any time in which the participant is referred to the activity until the completion of the activity.

SNAP E&T providers know best the skills and qualifications that will enable an individual to be successful in their programs. As such, providers have flexibility to establish the criteria used to make a provider determination. The provider may use any information available to the provider to make the determination.

NOTE: The Division of Family Assistance has the oversight authority to ensure SNAP E&T providers are not making unfair provider determinations or using provider determinations to discriminate against protected classes.

Within 10 days of making a provider determination the SNAP E&T provider must inform DOHS of the provider determination using the DFA-SNAP-E&T-PD form. If the provider is unable to provide the reason for the provider determination, DOHS must process the provider determination without a reason.

A non-exempt ABAWD cannot accrue a countable ABAWD month toward their 3-month period during the same month as a SNAP E&T provider determination. The next countable month is the first full month following the provider determination, where the individual does not meet the ABAWD work requirement or is not otherwise exempt.

DOHS worker responsibilities:

- Within 10 days of receiving the DFA-SNAP-E&T-PD form, DOHS must inform the SNAP E&T participant they are under provider determination.
- Explain to the SNAP E&T participant what a provider determination is and the next steps the agency will take. Document the provider determination in the case record.
- Explain to SNAP E&T participants who are also non-exempt ABAWDs they cannot accrue a countable ABAWD month during the month they are under provider determination.
- If no appropriate SNAP E&T activity is available, assess the SNAP client's mental and physical fitness for employment. When appropriate grant exemptions for ABAWD. A supervisor or senior worker must make the final determination as to who is considered unfit for work.

SNAP E&T worker responsibilities:

- When a provider determination is received, the SNAP E&T worker must schedule a meeting to reassess the Personal Responsibility Plan/Self-Sufficiency and attempt to place the participant in another program.
- Explain to SNAP E&T participants who are also non-exempt ABAWDs they cannot accrue a countable ABAWD month during the month they are under provider determination.
- If no appropriate SNAP E&T activity is available, inform DOHS to assess the participant for fitness for employment.

17.6 SNAP E&T THIRD-PARTY PROVIDERS

A SNAP E&T third-party provider is an organization that is in partnership with DOHS to provide necessary employment services to SNAP E&T participants. Providers are required to send participant information to DOHS to ensure individuals are SNAP certified.

Providers offer additional case management services, participant reimbursements and resources outside of DOHS. Providers are required to report to DOHS when there are participation updates, when Provider Determinations are made and when an individual stops participating. Providers sign off on a participant's monthly timesheet.

West Virginia SNAP E&T Third-Party Providers:

Blenko Glass Company

- A private-sector glassmaking firm offering SNAP E&T participants structured on-the-job training in traditional glassblowing and artisanal production. Training is structured as a multi-year apprenticeship model, blending paid work experience with skill development in a high-demand craft industry. This partnership expands SNAP E&T options into non-traditional but viable trades, emphasizing craftsmanship and long-term employment stability.
    - **Service areas: Cabell, Kanawha, Lincoln, Logan, Mason, Putnam**

BridgeValley Community & Technical College (CTC)

- Provides workforce development certificates, associate degrees, and targeted technical programs. For SNAP E&T, BridgeValley highlights short-term workforce credentials (e.g., 9-month Electrician Lineman program) and retention support services. The model includes advising, academic tracking, and wraparound support services to improve completion rates. BridgeValley has been a core partner in piloting E&T college partnerships and serves as the template to expansion to other CTCs.
    - **Service areas: Boone, Cabell, Fayette, Kanawha, Lincoln, Logan, Putnam, Raleigh**

Coalfield Development

- Provides on-the-job training and pre-apprenticeship programming called Workforce Readiness and Professional Success (WRAPS) and 36/6/3. WRAPS is a blend of on-the-job training in areas such as sustainable agriculture, construction/deconstruction, landscaping/lawncare and building maintenance, combined with personal development and professional trainings and certificates. Explores life goals, money management, time management, connection to resources for housing and legal issues. Provides health and safety training, resume and interviewing skills and environmental safety certificates, such as OSHA 10. WRAPS is a 6-month training program. 33/6/3 is an extension of WRAPS that includes a higher education component with local Vocational or Community and Technical College programs. Also, a felon friendly company.
    - **Service areas: Cabell, Kanawha, Lincoln, Mingo, Putnam, Wayne**

Goodwill of Kanawha Valley

- Offers a program called SNAP to Skills that assesses pre-employment services, assists individuals with technology deficiency, provides dress to success program and on-the-job training for individuals lacking employment history. Goodwill focuses on the disabled population. Also, a felon friendly company.
  - **Service areas: The Kanawha valley and the Mid-Ohio region**

West Virginia University Parkersburg (WVUP)

- Added for FY26 as the second community and technical college E&T partner. Provides short-term training, certificate, and associate degree programs with wraparound services modeled after BridgeValley.
  - **Service areas: Wood county and surrounding Mid-Ohio valley counties**

West Virginia Women Work

- Statewide nonprofit organization that supports and advocates for the education, employment and economic equity for all women. Step Up for Women is a pre-apprenticeship training program of WV Women's Work Inc. which provides hands-on training that cycles through introductory carpentry, electrical wiring and plumbing over the 12-week class. This program has a higher placement rate in either a full Apprenticeship or employment following completion of program.
  - **Service areas: Kanawha valley, Monongalia and surrounding areas**

Workforce Development Boards (WDBs)

- West Virginia's Workforce Development Boards (WDBs) are regional partners that connect SNAP E&T with the broader workforce system. They help ensure that E&T services are aligned with local labor market needs, support participants through training and employment activities, and coordinate resources across workforce and education programs. In SNAP E&T, WDBs primarily act as regional coordinators and connectors, expanding opportunities for participants while avoiding duplication of services. All 7 regional Workforce Development Boards are contracted with WV SNAP E&T to provide case management services to all E&T participants.

APPENDIX A –SNAP E&T SUPPORT SERVICES PAYMENTS

Payment Name	Payment Limits*	Components for Non-Exempt Able-Bodied Adults Without Dependents (ABAWD)	Components for Other SNAP E&T Participants

Transportation	Actual expenses, not to exceed $25 per month	• Supervised Job Search • Basic/Foundational Skills • College • Career Technical Education/Voc Tech • Work Activity • On-the-job-training • Pre-Apprenticeship/ Apprenticeship • Job Retention	• Supervised Job Search • Basic/Foundational Skills • College • Career Technical Education/Voc Tech • Work Activity • On-the-job-training • Pre-Apprenticeship/ Apprenticeship • Job Retention
Clothing	Up to $1,000 lifetime	Career Technical Education/Voc Tech/Apprenticeship	Career Technical Education/Voc Tech/Apprenticeship
Professional License/Certification	Up to $300 lifetime	Career Technical Education/Voc Tech/Apprenticeship	Career Technical Education/Voc Tech/Apprenticeship
Tools	Up to $1,000 lifetime	Career Technical Education/Voc Tech/Apprenticeship	Career Technical Education/Voc Tech/Apprenticeship
Training Contracts	Up to $600 without approval; up to $3,000 lifetime Program Manager approval	Career Technical Education/Voc Tech/Apprenticeship	Career Technical Education/Voc Tech/Apprenticeship
Other Expenses	Must be approved by DFA; limited to tuition, books, supplies, and expenses directly tied to training (excluding medical procedures or HSE exams)	Approved on case-by-case basis by DFA	Approved on case-by-case basis by DFA

APPENDIX B –STATE-APPROVED SNAP EMPLOYMENT & TRAINING OCCUPATION CATEGORIES

- Ambulance Drivers
- Animal Trainers
- Appraisers and assessors of Real Estate
- Accountants and Auditors
- Automotive and watercraft service
- Automotive body repair technicians
- Bakers
- Billing Clerks
- Bill and Account Collectors
- Billing and Posting Clerks
- Bus and Truck Mechanics and Diesel Engine Specialists
- Bus Drivers
- Butchers
- Cardiovascular technicians
- Carpenters
- Carpet installers
- Chefs and head cooks
- Chemical technicians
- Childcare workers
- Civil Engineering technicians
- Combined food preparation
- Community Health workers
- Computer network specialists
- Computer user support specialists
- Computer-controlled machine operators
- Construction laborers
- Counter and rental clerks
- Couriers
- Crane and tower operators
- Crossing guards and Flaggers
- Customer Service Representatives
- Dental Hygienists
- Diagnostic Medical Sonographers
- Dishwashers
- Dietetics technicians
- Electrical engineering technicians
- Electrical power installers

- Electricians
- English language literature instructors
- Excavating and loading
- Farmworkers and laborers
- Funeral attendants
- Furnace operators
- Gaming change workers
- Hazardous material removal
- Heavy and Tractor trailer truck drivers
- Helper – pipelayer, plumbers, pipefitters, production
- Highway maintenance
- Home health aides
- Hosts and Hostesses, Restaurant, Lounge, and Coffee Shop
- Industrial machinery mechanics
- Insurance Sales Agents
- Janitors and Cleaners
- Landscaping and Groundskeeping Workers
- Licensed Practical and Licensed Vocational Nurses
- LPN
- Machinists
- Maintenance and repair workers
- Medical Assistants
- Nursing Assistants
- Painters
- Paralegals and Legal Assistants
- Payroll and Timekeeping Clerks
- Pharmacy technicians
- Police and Sheriff's Patrol Officers
- Preschool teachers
- Public Safety Telecommunicators
- Refuge and Recycle specialists
- Registered Nurses
- Sales Representatives, Wholesale and Manufacturing
- Security Guards
- Special education teachers
- Telemarketers
- Waiters and Waitresses
- Welders, cutters, solderers, brazers

If the student is enrolled in a program of study which meets the standards of the SNAP E&T program, but does not prepare the individual for an occupation listed above, exceptions may be

made by the Policy Unit in obtaining information necessary to approve or disapprove the program for SNAP E&T eligibility.

Chapter 18

WV WORKS Activities/Requirements

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
18.1				
18.2	3/1/20	782	18.2.2	Changed language to transitional benefit
	6/1/22	822	18.2.3	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	5/1/23	836	18.2.3.F	Updated wording when on-line college classes may be used for a 60th month extension request past the 60th month of TANF benefits.
18.3				
18.4	7/1/21	806	18.4.4.B 18.7.1 18.7.4.B 18.7.14	Added Juneteenth to list of federal holidays ADARA-1 ADARA-1 dental service has increased to $5,000
	4/1/22	819	18.45	Clarified who must sign timesheets
	5/1/24	850	18.4.4.B	Removed Juneteenth as approved for Holiday hours.
18.5	10/23/17	747	18.7.16.A	New section was added to chapter outlining the substance abuse testing and referral process.
18.6				
18.7	12/1/17	747	18.7.16.	Added sanction information for providing false information on the DFA-WVW-DAST-1 and updated questionnaire scoring.
	5/1/18	758	18.7.3.C	The first full SSP and initial home visit must be completed with 30 days.
			18.7.13 & 18.7.13.A	Vision and Dental referrals are good for one year even if TANF benefit is sanctioned. Requests for referrals during that year are given a copy of the previous referral.
	7/1/18	761	18.7.16.B & C	Added clarification that an individual who is not cooperating with drug testing policy.
			18.8.1	The 5-day participation rule was removed
			18.9	Added clarification that a participant's activity must not include the sale/distribution of alcohol, tobacco, or firearms.
			18.19.3.G	Added wording to the relocation procedure for

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			18.19.3.L	transportation access Added clarification that a dependent child eligible for the high school achievement bonus must be included in the WV Works payment.
	4/1/19	770	18.7.3.C	Clarified the definition of annual home visit.
	4/1/19	770	18.7.16	Information must be from evidence not hearsay; clarifies DFA-WVW-DAST-1 in total points
	4/1/19	770	18.7.16.A	Clarified that drug test results from Children and Adult Services are also accepted.
	4/1/19	770	18.7.16.B	Clarified requirements for the protective payee.
	6/1/19	772	18.7.16.B&C	Added See 18.7.18.E
	6/1/19	772	18.7.16.E	Moved 10.5.5.B.4 and updated wording to add new section for TANF Protective Payee for drug use
	9/1/19	776	18.7.17.A	Clarified dated of drug tests
	9/1/19	776	18.7.2	Added Support Services Fact Sheet
	12/1/19	779	18.7.4.C 18.7.6 18.7.7	Clarifying when to complete Bridge to Stronger Families form Clarifying when to complete WV WORKS Goal Action Plan Clarifying when to complete Bridge to Stronger Families
	1/1/20	780	18.7.17	Clarified EAP a support service for WV WORKS drug testing
	3/1/20	782	18.7.13.A	Changed language to transitional benefit
	5/1/21	804	18.7.6	DFA-SSP-1 & DFA-SSP-1a must both be completed.
	1/1/21	814	18.7.1.A 18.7.2 18.7.5.A 18.19.3	Added goals to WORKS Bridge Model Added completion forms to required worker duties Clarified the usage of the strengths & Challenges Screen. Clarified that the system must be updated
	5/1/22	821	18.7.6.D.2	TASC has been replaced with High School Equivalency Test.
	6/1/22	822	18.7	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	11/1/23	842	18.7.14	Removed the word Donated from the vehicle program table of contents and manual section. Added language regarding drivers' education component.
	11/1/23	842	18.7.14. A	Added language for vehicle referrals and education component.
	8/1/24	853	18.7.14 18.7.14.A	Removed requirement for mechanic training with the vendor. Removed participants who are interested in an automotive technology career may be referred to the vendor for a training contract.
	9/1/24	854	18.7.18.B	Corrected reference error from previous change to

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			18.7.18.C 18.7.18.D	18.7.18.E
	11/1/24	856	18.7.14.A	Clarified GNMG referrals may be made for both post-employment options.
	3/1/25	861	18.7.5.C	When redetermination is aligned with another program, the home visit remains due annually.
	6/1/25	864	18.7.17.D	Removed maximum enrollment with CTC Student Services Specialist.
	1/1/26	872	18.7.16.B	Update the address for Legal Aid.
18.8				
18.9				
18.10	10/1/18	765	18.10.3	Job retention follow-up requirement added for 9-month and 12-month intervals.
	3/1/25	861	18.10.3	Clarified the usage of the Job Retention (JK) component.
18.11				
18.12	10/23/17		18.12.1	Substance abuse treatment and counseling participation are coded as Job Readiness.
	9/1/20	792	18.12	Clarified Participation Hours
	5/1/22	821	18.12.2	Clarified participation hours examples for JR/VT for SPOKES/EXCEL.
	2/1/23	831	18.12	Clarified precipitant in JR component.
	5/1/24	850	18.12 & 18.12.6	Removed references to EXCEL.
	9/1/24	854	18.12	Updated DFA to DFS.
18.12			18.12.1	Completed hours cannot be prorated or converted to JR. Hours during a 7 day period triggers a week of the 4-week limit. Components used along with JR are found in 18.10-18.18.
	9/1/24	854	18.12.2 18.12.2	Removed participants assigned to JR full time will have their participation hours counted in the same manner. Added and clarified examples.
	6/1/25	864	18.12.1	Add note to clarify JR hours.
18.13				

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
18.14				
18.15	5/1/18	758	18.15.1 & 18.15.1.A,B	Updated examples
18.16	4/1/18	756	18.16.1	Clarified that when one parent is attending college or vocational training, the additional parent must not be required to participate more than 10 hours per week.
	9/1/20	792	18.16.1	Participation bonus
	5/1/24	850	18.16.1.B	Removed references to EXCEL.
18.17				
18.18				
18.19	4/1/18	756	18.19.1	Clarified that certain supportive services may be made to remove challenges to participation.
			18.19.3.G, 18.19.3.H, 18.19.3.H, 18.19.3.L	Additional support services were added: Transportation may be paid under Other Work Activities for applicants who need transportation to complete required drug testing, the High School Diploma or Equivalency Bonus is now also available to dependent children in TANF cases, Relocation may now be used in the same area to remove transportation as a barrier.
	5/1/18	758	18.19.6	Corrected reference.
	10/1/18	765	18.19	Clarified that requests for supportive services must be approved or denied within 10 working days of the date of the signed time sheet or application.
			18.19.3.K	DUI offence payment may now be made to include fines and fees related to traffic, moving, and parking violations. The limit has increased to $750
			18.19.3.M	The 12-month self-sufficiency bonus has been reinstated.
	4/1/19	770	18.19.3.M	Updated income limits for self-sufficiency bonuses to 200%FPL.
	5/1/19	771	18.19.3.G	Moved misplaced section to 1.5.18
	9/1/19	776	18.19.5	Clarification on allowable supportive services
	9/1/19	776	8.19.15.A, B, D, E, F	Added lifetime limits to Caretaker Relatives and Child Only Cases
	9/1/19	776	8.19.15.A	Removed requirement for adult care
	12/1/19	779	18.19.5.B	Clarifying clothing support payment for Child-Only & Caretaker Relatives
	1/1/20	780	18.19.5	Clarified caretaker supportive services payments
	3/1/20	782	18.19.3.L&M	Changed language to transitional benefit

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	5/1/20	785	18.19.3.I	Clarified that towing expenses may be paid under vehicle repair.
	7/1/20	788	18.19.3.I	Clarified vehicle repair limits
	9/1/20	792	18.19.3.O	Participation bonus
	1/1/22	814	18.19.2	Clarified that the system must be updated
	4/1/22	819	18.19.3.H	Clarified who must sign timesheet
			18.19.3.O	Clarified who must sign timesheet
	5/1/22	821	18.19.3.L	TASC has been replaced with High School Equivalency Test.
	6/1/22	822	18.19.3.G	Changed Domestic Violence to sexual harassment and domestic violence, sexual assault, and stalking.
	6/1/22	822	18.19.2.	Benefits are added to the EBT card
	6/1/22	822	18.19.3.H	No receipt required
	6/1/22	822	18.19	Replaced check with payment
	7/1/22	824	19.2.1.D	Clarify WV WORKS expungement
	9/1/22	826	18.19.6	Updated form name DF-68
	5/1/23	836	18.19.3.A	Extracurricular activities limited to $1000 per child.
			18.19.5	Income limit for childcare is 250% FPL.
			18.19.5.A	Extracurricular activities limited to $1000 per child. Case manager keeps track in PIN comments
	5/1/24	850	18.19.5.C	Income limit for childcare is 250% FPL.
			18.19.5.A	Removed diapers, wipes and formula as these items are now available through Family Support Centers.
	11/1/24	856		Updated form name.
	2/1/25	860	18.19.8	Update the maximum monthly childcare payment
			18.19.5.C	amount to Early Care and Education's payment rate.
18.20				
18.21	6/1/22	822	18.21.3	Clarified recoupment of support service
18.22	4/1/19	770	18.22	Clarified that counseling/rehabilitation because of a positive drug test is not required once the WV WORKS benefit is closed due to employment.
	6/1/19	772	18.22.3	Removed sentence
	3/1/20	782	18.22	Change language to transitional benefit
	8/1/25	867	18.22.3	Add ways for participants to request support benefits.
App A				
App B				
App C				

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
App D	4/1/20	784		Replaced RAPIDS with eligibility system
App E				
App F				

18.1 INTRODUCTION

This chapter describes the work requirements of WV WORKS and the services available to assist participants in meeting these requirements and maintaining independence from cash assistance.

18.1.1 PROGRAM BACKGROUND

WV WORKS is West Virginia's Temporary Assistance for Needy Families (TANF) program. TANF is a cash assistance program funded under a block grant authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and is designed to help needy families achieve self-sufficiency. This cash assistance program replaced Aid to Families with Dependent Children (AFDC), which included cash assistance to families of unemployed parents (AFDC/U), on January 1, 1997. AFDC/U recipients were automatically eligible for Medicaid. All counties were phased into the WV WORKS Program by January 1998.

Through TANF, WV WORKS provides cash assistance along with a variety of employment and education related services to low income families with dependent children.

The emphasis of the PRWORA is on personal responsibility and employment. The purpose of WV WORKS is to help economically dependent, at-risk families become self-supporting. It is a work-oriented, performance-based, time-limited program that emphasizes employment and personal responsibility. Intensive interaction between the participant and the Case Manager is necessary to establish and maintain the Personal Responsibility Contract (PRC) between the Department of Human Services (DOHS) and the WV WORKS participant.

PRWORA prohibited any link between the block grant cash assistance program and automatic Medicaid eligibility. Therefore, only those WV WORKS participants who meet eligibility requirements for Medicaid are eligible.

The Deficit Reduction Act of 2005 (DRA) further defined what participation activities count towards meeting the federally mandated TANF work requirements. The DRA defined specific acceptable core activities and the non-core activities that may be used to meet participation requirements over the core hours.

WV WORKS expects parents and other caretaker relatives to support their own dependent children and those in their care. Every parent and other caretaker who is included in a payment and any non-recipient Work-Eligible Individual in the household has a responsibility to participate in an activity to help prepare for, obtain and maintain gainful employment.

The goals of WV WORKS are to:

- Achieve more efficient and effective use of public assistance funds;
- Reduce dependency on public programs by promoting self-sufficiency; and
- Structure assistance to emphasize employment and personal responsibility.

This chapter discusses the requirement that all adults in the assistance group (AG) and all non-recipient Work-Eligible Individuals must meet a work requirement and describes minimum participation rates to which the State must adhere. Based on the participant's participation in one or more of the activities described in Sections 18.10 - 18.18, the State's participation rate is determined. However, the goals of WV WORKS do not include meeting a participation requirement. Instead, the foundation of WV WORKS is self-sufficiency. There are, therefore, some activities which allow the participant to meet his work requirement, but which do not lead to self-sufficiency. The Case Manager may allow the participant to continue in the activity which meets the participation requirement while developing plans with the participant to begin another activity which will accomplish or lead to self-sufficiency.

The eligibility system provides automated support for WV WORKS work requirements by tracking the participant's involvement in employment and other activities and by providing for the storage and retrieval of information necessary for the assessment process.

18.1.2 DEFINITIONS

WORK-ELIGIBLE INDIVIDUAL

A Work-Eligible individual is a parent, a caretaker included in the WV WORKS AG, or a minor child head-of-household receiving WV WORKS assistance unless the individual is:

- A minor parent and not the head-of-household or spouse of the head-of-household; or
- A noncitizen who is ineligible to receive assistance due to his or her immigration status; or
- A recipient of Supplemental Security Income (SSI) benefits.

NON-RECIPIENT WORK-ELIGIBLE INDIVIDUAL

A non-recipient Work-Eligible Individual is not included in the WV WORKS benefit. He must still complete Orientation, a Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP) and be participating in a work activity; therefore, is work-eligible. Non-recipient Work-Eligible individuals include:

- Individuals convicted in federal or state court of having made a fraudulent statement or representation about residence to receive Temporary Assistance for Needy Families (TANF), WV WORKS, Medicaid, SNAP benefits or SSI are ineligible for 10 years from

the date of the conviction. The conviction must have occurred on or after August 23, 1996.

- Individuals who are fleeing to avoid prosecution, custody or confinement after conviction, for a felony or an attempt to commit a felony.
- An individual convicted of a felony under federal or state law when the offense involves the possession, use or distribution of a controlled substance, as defined in Section 102(6) of the Controlled Substance Act and when the offense occurred on or after August 23, 1996; or
- Individuals who are violating a condition of probation or parole which was imposed under federal or state law.
- A parent or other caretaker who has not reported that their child will be or has been out of the home for at least 30 days.

PERSONAL RESPONSIBILITY CONTRACT (PRC)

The PRC (form DFA-PRC-1) is a contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Case Manager, as the representative of the DOHS. Completion and signature of the PRC form is required prior to approving the WV WORKS AG.

A separate PRC is completed and signed by each adult and emancipated minor in a WV WORKS AG, and any non-recipient Work-Eligible Individuals in the household. The participant's signature indicates that he understands and accepts the responsibility inherent in the program.

The PRC is the same for all WV WORKS participants. It states the purpose of the WV WORKS Program and lists the participant's rights and responsibilities.

SELF-SUFFICIENCY PLAN (SSP)

The SSP (form DFA-SSP-1) is a negotiated contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Case Manager, as the representative of the DOHS. The SSP is specific to each participant. It lists the goals, as well as the tasks necessary to accomplish the goals, including specific appointments, assignments and activities for the adult/emancipated minor. In addition, the SSP identifies the circumstances which impede attainment of the established goals and specifies the services needed to overcome the impediments.

A separate SSP is completed for each adult and emancipated minor in a WV WORKS AG, and any non-recipient Work-Eligible Individuals in the household.

Completion and signature of the SSP is required to be completed within 10 days of the initial contact when the client expresses an interest in applying for WV WORKS. The SSP is a working document and revisions are made when either the participant or the Case Manager believes it necessary. Frequent changes are expected as the participant progresses toward his goal.

18.2 LIFETIME LIMIT FOR RECEIPT OF CASH ASSISTANCE

18.2.1 SIXTY-MONTH TIME LIMIT

NOTE: For cases that were active cash assistance recipients in January 1997, the first month of the lifetime limit is January 1997.

There is a lifetime limit of 60 months that a family may receive cash assistance under Temporary Assistance for Needy Families (TANF) and/or WV WORKS. The presence of even one Assistance Group (AG) member who has reached the lifetime limit renders the entire AG ineligible. Children who continue to reside with an adult or emancipated minor who received TANF and/or WV WORKS for 60 months are not eligible. The amount of the payment received has no bearing on the time limit, so that a payment of $1 counts as one month toward the 60-month limit.

NOTE: Work-Eligible adults and emancipated minors excluded from the AG are not subject to the 60-month time limit.

Sixty-Month Time Limit Example 1: A divorced woman and her two children have received WV WORKS for 60 months. The woman marries the father of one of her children and together they apply for a check. Although her husband has never received WV WORKS, the family is not eligible, and the application is denied.

Sixty-Month Time Limit Example 2: A married couple and their three children receive WV WORKS. In the 54th month, one parent is approved for Supplemental Security Income (SSI). The rest of the family is eligible to receive a check for an additional 6 months. In the 59th month the non-SSI parent dies. The case becomes a child-only case with no time limit.

Sixty-Month Time Limit Example 3: A mother and children had received 30 months of WV WORKS when the father moves into household. The mother is approved for SSI at 32 months. At the time she is approved, the father has received two months of WV WORKS. He and the children may receive benefits for up to 58 additional months.

Sixty-Month Time Limit Example 4: A man and his child receive WV WORKS for 60 months. The father cannot find employment and relinquishes custody of the child to a grandmother. The grandmother no longer has a dependent child of her own but received WV WORKS for 37 months before her youngest child

turned 18. She opts to be included in the check with her grandchild and may receive a check for up to 23 months.

NOTE: Although an SSI parent is not included in the AG, the child(ren) is ineligible for child-only WV WORKS benefits if the parent(s) received 60 months of TANF benefits.

EXCEPTION: Any month during which the adult lived on an Indian reservation or in an Alaskan Native village is not counted toward the 60-month limit if:

- *At least 1,000 individuals were living on the reservation or in the village; and*
- *At least 50% of the adults living there were unemployed.*

18.2.2 BENEFITS WHICH COUNT TOWARD THE LIMIT

Receipt of any of the following benefits counts as one month toward the 60-month limit when an adult or emancipated minor is included in the AG.

- TANF check from West Virginia or from any state that used TANF block grant money for the payment. See Appendix C of Chapter 1 for a list of states and when they converted to TANF.
- WV WORKS cash assistance when the benefit is funded by federal TANF/MOE funds or by a West Virginia Solely State Funded (SSF) Program.
- Cash assistance from the transitional benefit option of the West Virginia Employment Assistance Program (EAP).

EXCEPTION: When a TANF, WV WORKS or EAP check was received ineligibly, and is repaid in full, that month does not count toward the 60-month limit. The WV WORKS benefit cannot be repaid or returned to the Department unless the AG was ineligible.

The limit is not 60 months for each state of residence. The time limit applies to all benefits received throughout the United States and its territories as long as the benefits were received under the TANF Block Grant. Therefore, when a participant indicates he has been a resident of another state, the Case Manager must determine if he received cash assistance and, if so, if the program was funded under the Block Grant authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). States had until July 1997 to convert from the former Aid to Families with Dependent Children (AFDC) Program to a program funded under

the Block Grant. Many states converted to the new program early. Therefore, the Case Manager must contact the other state to determine when the benefits were received and for how many months. These months must be documented in case comments and in the case management system. Case Managers must fax the DFA-WVW-Verif-1, TANF verification – months used form to the other state to obtain written verification of the TANF months received in that state. Agency printouts or other written verification obtained from the state are also acceptable. That verification must be placed in the case record. If months prior to July 1997 are involved, the Case Manager must also determine how many months of benefits the participant received under the Block Grant program. See Chapter 1, Appendix C for a list of states and their effective dates of conversion to TANF.

The calculation of the number of months of TANF benefits received must be completed at the time of application. At that time, the number of months listed in the case management system should be adjusted and case comments should document why the adjustment was made.

18.2.3 PROVISIONS FOR AN EXTENSION OF THE TIME LIMIT

There are provisions which may allow a family to receive benefits for more than 60 months. The federal government imposes a limit on the percentage of the state's TANF caseload that is allowed to be exempt from the 60-month requirement.

- The limit is 20% of the average monthly number of WV WORKS AGs, minus the average monthly number of child-only AGs. This number is only valid on a statewide basis. Therefore, the percentage of extensions may vary greatly from county to county.

The Case Manager must not inform the participant that he is, or may be, exempt from the time limit during the 60-month eligibility period, unless written notice of approval has already been received from the 60-Month Extension Committee.

Once an extension is approved, the participant must continue to meet the criteria on which the extension was based each month of the extension period. In addition, the individual must be actively engaged in an activity or process designed to further the AG's goal of self-sufficiency, such as pursuing other resources. The Case Manager may close the case at any time during the extension period when the participant fails to follow through on requirements established for receipt of the additional months of WV WORKS. The Case Manager must continue to monitor the case each month to determine if the participant continues to meet the extension criteria identified at the time of the Committee's extension approval. Once the case is closed and the extension ends for failing to meet these requirements, the household is no longer eligible for the extension. The Case Manager must document the closure and notify the DFA Family Support Policy Unit.

A temporary extension of up to six months may be given only once for the adults and emancipated minors in the AG at the time the extension is approved, unless the extension is based wholly or in part on sexual harassment and domestic violence, sexual assault, and stalking. See Battered or Subjected To Extreme Cruelty below.

All extension requests must be made prior to the first day of the 60th month. Once an AG is closed due to receipt of TANF benefits for 60 months, every application that includes an individual who received benefits as an adult or emancipated minor for 60 months is denied. No extensions are approved after AG closure for this reason.

NOTE: Although the 60-month lifetime limit does not apply to a non-recipient Work-Eligible parent, if another parent is included in the AG, the time limit applies to the adult AG members.

EXCEPTION: Victims of sexual harassment and domestic violence, sexual assault, and stalking, who meet the criteria in Battered or Subjected to Extreme Cruelty below, may reapply for WV WORKS after the 60-month closure.

NOTE: All extensions are temporary. Unless specified below, an extension may only be approved for up to six months and may be approved only once.

A single parent household in which the parent meets one of the following criteria is eligible to be considered for an extension of the 60-month time limit. For a two-parent household, both parents must meet one of the following criteria for the AG to be eligible.

18.2.3.A Battered or Subject to Extreme Cruelty

18.2.3.A.1 Participants

For extension purposes these conditions are defined as follows:

- Physical acts that result in, or threaten to result in, physical injury; or
- Sexual abuse; or
- Sexual activity involving a dependent child; or
- Being the caretaker of a dependent child and being forced to engage in non-consensual

sex acts; or

- Threats of, or attempts at, physical or sexual abuse; or
- Mental abuse, including threats; or
- Neglect or deprivation of medical care; or
- sexual harassment and domestic violence, sexual assault, and stalking

NOTE: An extension based solely or in part on these criteria may be approved multiple times and may exceed the six-month limit. These multiple extensions need not be consecutive because participants may reapply after case closure.

The individual who meets the definition must accept a referral to a program that operates under a State license or through an agreement with the Department of Human Services (DOHS). In addition, the participant must participate in and follow any plans developed with the program.

Once an extension is approved based on the above criteria, the Case Manager must monitor the case for compliance. The WV WORKS check continues until the situation is resolved or the AG is no longer eligible for a check for other reasons. Normal redetermination procedures apply.

18.2.3.A.2 Application after 60-Month Closure

The Case Manager may approve applications for individuals who have received 60 months of WV WORKS but who meet the criteria outlined above. The Case Manager must notify the Extension Committee of the approval and send a completed extension form for its review.

As in any extension, the Case Manager must monitor compliance and close the case when the participant is no longer following a plan or when the situation has been resolved and sexual harassment and domestic violence, sexual assault, and stalking is no longer an issue. The Case Manager must notify the 60-Month Committee when the extension of benefits ends.

There is no limit to the number of times a household may reapply and be approved so long as the situation remains unresolved and the participant is in compliance.

18.2.3.B Providing Care for a Relative

For extension purposes, all of the following conditions must be met.

- It must be a single parent household, unless one parent is providing care for the other parent who is disabled; and
- The caregiver would normally be required to meet a work requirement; and

- Is needed at home to care for a disabled family member who resides in the home and is not a full-time student; and
- Medical documentation must be provided to support the need for the parent to remain in the home to care for and monitor the disabled family member; and
- No one else is available to provide this care; and
- Such care will not be necessary for more than six months, or the family has made other care arrangements that will be completed within six months, or the family is attempting to make other care arrangements, including application for a Medicaid waiver program.

18.2.3.C Late Onset of Incapacity

Participants who experience the onset of a temporary incapacity after the 55th month of WV WORKS may qualify for a one-time extension of up to six months while undergoing treatment for the injury or illness. The Case Manager must obtain a decision of incapacity from the Medical Review Team (MRT), and the decision must indicate that the individual will be able to engage in gainful employment following the period of incapacity. The MRT process must be started immediately upon receiving notice of the illness or injury so that a decision may be obtained from the MRT before the participant reaches his 60th month of benefits. Failure of the participant to accept or continue treatment for the illness or injury before the extension begins will result in denial of the request. Failure to cooperate following the beginning of the extension period will result in case closure.

If it is determined by the MRT or a doctor's report that the individual will be temporarily unable to engage in gainful employment for a period of time on or following his 60th month of eligibility, he may qualify for an extension of up to six months. The number of months granted will depend on the length of time that the MRT has determined him to be unable to engage in a gainful activity. The local office will be responsible for monitoring the medical status of the participant each month.

18.2.3.D Disabled

Disabled is defined as unable to engage in gainful employment, as determined by a medically qualified professional.

Because WV WORKS participants must be referred to the MRT if unable to participate for longer than a six-month period, it is assumed that an individual who states he is disabled will already have medically established his disability by the 55th month of TANF/WV WORKS

receipt. If not, he must apply for SSI and be referred to the MRT prior to approval of an extension. The Case Manager must complete the MRT application and evaluation as soon as possible before reaching the 60th month. An SSI denial based on failure to establish a disability does not automatically preclude an extension on this basis if the MRT finds the individual to be disabled. However, the individual must be actively appealing his SSI denial to qualify for an extension. If the individual has been found to be disabled by the MRT and his re-evaluation is due before his 60th month of benefit receipt, his case must be submitted for a re-evaluation by the MRT.

If it is determined that the individual is not disabled or is able to engage in gainful employment with no limitations, he does not qualify for an extension.

If it is determined that the individual is able to engage in gainful employment with some limitations, he may qualify for an extension of up to six months to locate suitable employment and must be referred to the Division of Rehabilitation Services (DRS) for a vocational evaluation and assessment.

If the MRT has determined, before or during the 60th month of benefits, that the individual will be temporarily unable to engage in gainful employment for a period of time extending beyond the 60th month of eligibility, he may qualify for an extension of up to six months. The number of months granted will depend on the length of time that the MRT has determined him to be unable to engage in a gainful activity. The local office will be responsible for monitoring the status of the participant on a monthly basis.

If an MRT re-evaluation is due during the extension period and the decision again finds the individual unable to participate, the extension will continue up to six months. In this situation, if the extension is continued longer than initially approved by the committee, the Case Manager must detail the reason for extending the months in case comments, notify the 60-Month Extension Committee for approval, and adjust the appropriate number of months in the eligibility system, not to exceed six. During the extension period, the Case Manager must monitor the case to make sure the participant continues to meet all other eligibility requirements.

> **Disabled Example:** Ms. Bluebell receives her 60th month of benefits in January 2016 and has been found to be disabled or incapacitated by the MRT with a re-evaluation due in February 2016. The Committee approves a one-month extension through February 2016. In February, the MRT determines that the disability continues and sets the next re-evaluation for August 2016. The extension may be extended through July 2016, which would be the sixth month of benefits over the 60-month time limit. The Case Manager will adjust five months in the eligibility system and document the decision and action in case comments. Ms. Bluebell must be placed in the AD component in Work Programs in addition to other component codes.

If it is determined that an individual is permanently unable to engage in gainful employment, he qualifies for consideration for an extension of up to six months to apply for, or appeal prior denials of, statutory benefits. Statutory benefits include, but are not limited to: Retirement, Survivors, and Disability Insurance (RSDI), SSI, Veterans Affairs (VA), and/or Railroad Retirement.

NOTE: The Case Manager must contact the extension applicant and give him information regarding the impact of receiving 60 months of TANF benefits. If the individual receives 60 months of WV WORKS benefits, he will be ineligible to receive child-only benefits if he is later approved for SSI. If the participant closes his case in the 59th month of benefits and is later approved for SSI, he may be eligible to receive child-only benefits for his child(ren). Comments regarding this discussion and the participant's decision must be recorded in case comments before the case information is submitted to the 60 Month Committee.

18.2.3.E Pregnancy/Age of Child

An AG may qualify for an extension when both of the following conditions are met.

- There is only one adult or emancipated minor living in the household; and
- The pregnant woman will be in her last trimester of pregnancy in the 60th month of TANF receipt; or the AG includes a child who will be less than six months of age in the 60th month of TANF receipt.

> **Pregnancy Example 1:** A pregnant woman with two children is approved for a six-month extension based on her pregnancy. The six-month period runs from January through June. The baby is born in February. Although the baby will not be six months old until August, the extension must end in June when she has received 66 months of TANF.
>
> **Pregnancy Example 2:** A pregnant woman with two other children lives with her boyfriend who is not the legal father of any of the children. She does not qualify for consideration under this extension criteria.
>
> **Pregnancy Example 3:** A mother lives with her two children. The youngest child was born in July and the household receives its 60th month of benefits in August. An extension is granted based on the age of the child. The extension will end in January when the child turns six months of age.

When based on a verified pregnancy, the extension remains in effect for up to six months. When the pregnancy does not end in a live birth, the extension, if already approved, remains in

effect for two months following the end of the pregnancy.

When based on the age of a child, the extension remains in effect through the month the child reaches six months of age.

18.2.3.F In a Vocational Training/Education Activity

The extension is based on maintaining satisfactory progress toward course completion in a vocational training or educational activity. Satisfactory progress is defined by the facility or course of study but must be expected to result in a measurable outcome, such as a diploma, degree, or certificate which will assist in attaining self-sufficiency.

To qualify for consideration of this extension, one of the following situations must exist:

- In his 55th month of TANF receipt, the participant is attending a vocational training or an educational activity; or
- In his 55th month of TANF receipt, the participant is enrolled to begin vocational training or an educational activity.

Vocational training is preparation for a specific occupation. The training is conducted by an instructor in a non-work site or classroom setting.

Educational activities are limited to literacy programs, high school, Adult Basic Education (ABE), vocational, and two- and four-year college programs. (Extension past the TANF 60-month time limit while attending on-line courses will be at the discretion of the 60-month committee) Some factors will be based on the institution the participant is attending such as but not limited to, in-state or out of state, and the ability of the participant to track attendance and hours for reporting purposes to the case manager.

When the person who is participating in the training/educational activity has a disability affecting his ability to make progress or extending the time necessary to complete the program, the Case Manager must take this under consideration when granting an extension. If the Case Manager determines the individual is progressing more slowly due to the disability, he will grant an extension. The participant is not required to graduate from the program within or by the end of the extension period.

The extension remains in effect for up to six months. The Case Manager is responsible for monitoring the attendance of the participant during the extension period. If his enrollment ends, the Case Manager must send notification and close the WV WORKS benefit.

18.2.3.G Agency Error

The 60-Month Extension Committee only may approve an extension based on agency error if during the extension request process, either the local office or the 60-Month Extension Committee does not act in a timely manner. This must occur between months 55 through 60. No repayment is required if the extension is not approved. This extension is limited to three months.

18.2.4 FORMAL CASE REVIEW IN 55TH MONTH

After a participant has received WV WORKS for 55 months, a formal case review must be conducted. The purpose of this review is to assess the progress of the household members towards achieving self-sufficiency and to determine what activities the participant needs to complete during the remaining months of WV WORKS eligibility. This review is not discretionary. The Case Manager must schedule the review. The participant's attendance at this conference should be included as an item on the last revision of the Self-Sufficiency Plan (SSP) completed before the meeting would normally be scheduled. The Case Manager must schedule the review by issuing a letter to the participant.

The review includes the participant, Case Manager, Supervisor, the Community Services Manager or his designee, Social Services, and any other representatives from agencies that might be of assistance to the participant. The participant may bring his own representative(s) to the meeting and is responsible for notifying anyone he wants to be involved in the process. This group determines what can be done before the participant reaches the 60-month time limit to move the family closer to becoming self-sufficient.

If the group decides an extension is appropriate and additional months are needed, all paperwork for an application for extension must be completed at this time including completion of a Request for Extension of WV WORKS 60-Month Time Limit form (DFA-WVW-100-B) and an Extension Request form (DFA-EX-1). The group will review the extension categories and their definitions to determine the appropriate category to use for the participant's request. A statement from the 55-month review group may be submitted to the 60-Month Extension Committee along with the other extension documents.

In order to ensure time frames are met, if the participant indicates he would like to apply for an extension based on disability, and the case has not been submitted to the MRT, the MRT process must begin immediately so a decision may be made in a timely manner. If the participant is pursuing an extension based on disability, the Case Manager must explain that if the participant opts to receive 60 months, he will be ineligible to receive child-only benefits if he is later approved for SSI.

If the participant fails to appear at the first scheduled review, the Case Manager must call the participant and reschedule the meeting. If the participant later requests one, his request must be honored when the process can be accomplished prior to receipt of the 60th month's benefit.

All scheduling, rescheduling and abandonment of the review process must be documented in case comments.

18.2.5 EXTENSION PROCEDURE

18.2.5.A Notify Participant

The process for determining if the AG is eligible for an extension begins in the 55th month of the 60-month lifetime limit when the participant is mailed a special notification letter about the end of his 60-month time limit (DFA-WVW-100-A).

18.2.5.B Return Form Requesting Extension

The participant must return the notice to the DFA Family Support Policy Unit as indicated on the notice for consideration of an extension of the time limit.

If the form is returned to any local DOHS office, the local office must forward it immediately to the DFA Family Support Policy Unit. If the Case Manager or Supervisor becomes aware of a participant who did not apply for an extension but who may be eligible for one, he must notify the DFA Family Support Policy Unit immediately by e-mail for consideration of an extension.

If the participant does not indicate he wants to be considered for an extension and the Case Manager and/or Supervisor do not recommend an extension for him, the family is ineligible after case closure due to the 60-month limit. Advance notice requirements apply, but benefits must not be continued pending a Fair Hearing decision should the AG request a hearing following case closure.

18.2.5.C Review Request for Extension

All requests for extension are made to a nine-member committee known as the 60-Month

Extension Committee, consisting of four regional representatives and five appointees from various state offices, including Social Services, WV WORKS, Division of Planning and Quality Improvement (DPQI), the MRT, and the DFA Family Support Policy Unit.

Once the forms are received in the state office, they are logged in and tracked to make sure information is obtained and a timely decision is made. The participant's Case Manager and the Case Manager's Supervisor are notified of the request. The Case Manager completes the Extension Request Form (DFA-EX-1) and forwards it along with any other information requested to the DFA Family Support Policy Unit. If the participant is requesting an extension due to a late onset illness or disability, the packet should include the MRT decision. The DFA-EX-1 must be signed by the Case Manager and Supervisor and include the local office recommendation regarding the extension. All requested information must be submitted within 30 days or the local office should notify the DFA Family Support Policy Unit regarding the reason for the delay. All such extensions are approved at the state office level by the 60-Month Extension Committee.

18.2.5.D Notify Parties of Request for Extension Review Result

18.2.5.D.1 Extension Approved

If an extension is approved, the Committee notifies the local office of the length of the extension and the requirements for compliance with the terms of the extension. The local office notifies the participant of the approval and the participant's responsibilities once the extension begins. The local office is responsible for monitoring the time limit to assure that it is not exceeded and that the participant remains eligible for the extension. The Case Manager adjusts the months in the eligibility system and documents the Committee's decision, reason for the extension, and number of months granted in case comments.

18.2.5.D.2 Extension Denied

If an extension is denied, the Case Manager must send notice of the decision, along with a Fair Hearing Request form to the participant. This must be documented in case comments. The participant may request a Fair Hearing, but benefits must not be continued pending the Fair Hearing decision.

- ***Pre-Hearing Conference***

During a pre-hearing conference, the Case Manager may determine that a verified change in the participant's circumstances has occurred and that a reconsideration of the participant's extension request is appropriate. The change must have occurred between the time of the initial request for extension and receipt of the 60th month of WV WORKS benefits. The Supervisor is responsible for approving the submittal of a request for reconsideration to the Extension Committee.

When such a change has occurred and been verified, or the Hearings Officer has ruled the county must request reconsideration, the Supervisor must notify the Committee over email that a reconsideration is being requested and include a description of the change, how it was verified, and the recommendation of the Supervisor for approval or denial.

➢ *Request for Reconsideration*

Submission of a request for reconsideration late in the 60-month time limit does not result in an automatic extension. No extension is applied unless the Committee approves an extension prior to case closure at the end of the 60th month, or criteria in Applications After 60-Month Closure above applies.

The Committee follows the same procedure for a reconsideration of an extension as for an original request. There is no limit on the number of times an extension request may be reconsidered, provided the AG has not received its 60th month of TANF/WV WORKS.

18.2.6 FAIR HEARING PROCEDURES

Any participant whose request for extension has been denied for any reason may request a Fair Hearing. Benefits, however, may not be extended beyond the 60th month or be reopened following a 60-month closure while a hearing or a decision by the Hearings Officer is pending.

The Hearings Officer may reverse the decision of the Extension Committee and grant an extension of up to six months, or he may rule that the Committee must reconsider the request.

The participant also has the right to a Fair Hearing when the reconsideration results in denial of an extension. The Hearings Officer may rule that the extension was denied in error and instruct the local office to extend benefits or reopen the case for the appropriate extension period.

18.3 PARTICIPATION RATES

West Virginia must meet established work participation requirements. Statewide standards are prescribed by federal law and rates increase over time.

- All Families – 50%
- Two-Parent Families – 90%

The State's participation rate is determined by the Administration for Children and Families (ACF), based on the information from a random sample of cases submitted by the State Office.

Statutory standards of 50% for all families and 90% for two-parent families' rates are adjusted by each state's caseload reduction credit.

The participation rate is determined not only by the total number of hours of the participant's participation, but also by the type of activity in which the adult(s) are engaged.

NOTE: See Sections 18.10 – 18.18 for clarifying details about work activities.

NOTE: No more than 20% of individuals, regardless of the number of parents in the home, may be considered to meet the work requirement by participation in Vocational Educational Training, Job Skills Training Directly Related to Employment, Education Directly Related to Employment, or Satisfactory Attendance at Secondary School or GED Program. Parents under the age of twenty, described in Section 18.4.3.A.2, are included in the count.

18.4 WV WORKS PARTICIPATION REQUIREMENTS

18.4.1 INTRODUCTION

Each adult and emancipated minor who receives WV WORKS benefits, and non-recipient Work-Eligible Individual, counts toward the state's participation rate. These are known as "Work-Eligible Individuals."

A Work-Eligible individual is a parent, a caretaker included in the WV WORKS AG, or a minor child head-of-household receiving WV WORKS assistance unless the individual is:

- A minor parent and not the head-of-household or spouse of the head-of-household; or
- A noncitizen who is ineligible to receive assistance due to his or her immigration status; or
- A recipient of Supplemental Security Income (SSI) benefits.

A non-recipient Work-Eligible individual is not included in the WV WORKS benefit. He must still complete Orientation, a Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP) and be participating in a work activity; therefore, is work-eligible. Non-recipient Work-Eligible individuals include:

- Individuals convicted in federal or state court of having made a fraudulent statement or representation about residence to receive Temporary Assistance for Needy Families (TANF), WV WORKS, Medicaid, SNAP benefits or SSI are ineligible for 10 years from the date of the conviction. The conviction must have occurred on or after August 23, 1996.
- Individuals who are fleeing to avoid prosecution, custody or confinement after conviction, for a felony or an attempt to commit a felony.
- An individual convicted of a felony under federal or state law when the offense involves the possession, use or distribution of a controlled substance, as defined in Section 102(6) of the Controlled Substance Act and when the offense occurred on or after August 23, 1996; or
- Individuals who are violating a condition of probation or parole which was imposed under federal or state law.
- A parent or other caretaker who has not reported that their child will be or has been out of the home for at least 30 days.

Each adult and emancipated minor who receives WV WORKS benefits and non-recipient Work-Eligible Individual 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 Sections 18.10 – 18.18.

Work-Eligible Individuals are those whose participation in work activities contributes in determining if the family counts in the calculation of the state's work participation rate, except for the following:

- Work-Eligible Individuals providing care for a disabled family member living in the home. Medical documentation must be provided to substantiate the need for the Work-Eligible Individual to provide this care.
- Single parents with a child under the age of one year. This is an exemption for a maximum of 12 months in a lifetime. See Section 14.9.

18.4.2 REQUIRED PARTICIPATION

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

18.4.2.A All Family Household

Families that do not meet the definition of a two-parent family are considered "All Family" Households regardless of the number of parents or other adults included in the household.

All Family Households include, but are not limited to, the following situations:

- Families with only one parent living in the home, whether he is included in the AG or is a non-recipient Work-Eligible Individual.
- Families with two parents with a common child living together and one is excluded from the WV WORKS payment due to one of the following reasons:
    - Minor parent who is not the head-of-household;
    - Ineligible noncitizen due to immigration status; or
    - SSI recipient.
- Families with one parent and one stepparent included in the benefit when they have no common child.

- Families with one or two non-parent caretaker relatives included in the WV WORKS payment.

18.4.2.A.1 Participation Requirement

➢ *Family Has Minimum Requirement of 128 Hours*

A minimum of 85 hours of minimum participation hours must be attributable to one or more of the Core Work Activities.

Therefore, no more than 43 of the minimum participation hours may be attributable to one or more of the Non-Core Work Activities.

NOTE: See Section 18.4.3.A.2 for requirements for parents under age 20. They are not subject to the 85-hour minimum rule.

NOTE: For single parents with a child under age six, the minimum participation requirement of 85 hours per month must be attributable to one or more of the Core Work Activities.

18.4.2.B Two-Parent Family

In a two-parent family, for these purposes only, neither parent is incapacitated or disabled according to the Social Security Administration (SSA) definition, and the family meets one of the following criteria:

- There are two natural or adoptive parents, who are Work-Eligible Individuals, of the same minor child living in the home and included in the same WV WORKS payment.
- There are two parents with a common child living together and one or both is excluded from the WV WORKS payment unless the exclusion is due to one of the following reasons:
    - Minor parent who is not the head-of-household;
    - Ineligible noncitizen due to immigration status; or
    - SSI recipient.

18.4.2.B.1 Participation Requirement

- ***Family Has Minimum Requirement of 150 Hours; Does Not Receive Federally Funded Child Care***

A minimum of 128 of the average minimum participation hours must be attributable to one or more of the Core Work Activities.

Therefore, no more than 22 of the average minimum participation hours may be attributable to one or more of the Non-Core Work Activities.

- ***Family Has Minimum Requirement of 236 Hours; Receives Federally Funded Child Care***

A minimum of 215 of the minimum participation hours must be attributable to one or more of the Core Work Activities.

Therefore, no more than 21 of the minimum participation hours may be attributable to one or more of the Non-Core Work Activities.

18.4.3 REQUIRED MONTHLY PARTICIPATION HOURS

Assistance Groups (AG) must complete federally established monthly hours of approved work activities in order to meet the participation requirement.

Required monthly participation hours listed in this section are minimum hours only. The number of required participation hours must be included on the participant's SSP, and in the eligibility

NOTE: For the initial month of benefit receipt, required monthly participation begins the first full week after eligibility has been confirmed. As part of the Stronger Family Job Retention column of the WV Bridge Model, the Case Manager must address challenges to participation before the individual is required to begin participation in an allowable activity. To determine the scheduled hours of participation for the initial month, the remaining business days, Monday through Friday, beginning with the Monday after eligibility is confirmed, are used. Actual hours of participation from the participation time sheet, DFA-TS-12, are entered as the completed hours.

system. Additional hours of participation may be assigned when appropriate. However, no sanction is applied if the minimum monthly hours are met.

Minimum Hours of Participation by Family Type			
All Family Household		Two-Parent Households	
Single Parent, Child Under Age 6	***All Family Household***	***Two-Parent Household***	***Two-Parent Household Receiving Federally Funded Child Care***
Minimum Monthly Hours	Minimum Monthly Hours	Minimum Monthly Hours	Minimum Monthly Hours
85	128	150	236

18.4.3.A All Family Household

The minimum number of hours of participation is 128 hours per month unless the household meets one of the two situations described in the next two sections.

Changes in the hourly requirement due to the child's age or changes in household composition are effective the month after the change occurs.

18.4.3.A.1 Single Parent of a Child under Age Six

A single Work-Eligible parent with a child under age six meets the work participation requirement by participating 85 hours/month. The scheduled hours in the eligibility system must not exceed the minimum monthly participation rate requirements. The parent may be required to participate more than 85 hours on their SSP or may volunteer to participate more than the required hours, but no sanction may be imposed as long as the minimum level is met.

NOTE: This situation only applies to households with only one adult parent living with a child.

18.4.3.A.2 Parent under Age 20

A Work-Eligible 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 for at least 85 hours/month; or
- Participates in vocational education for at least 85 hours/month.

When class is not available for 85 hours/month, an additional activity assignment must be made to meet the minimum required hours.

18.4.3.B Two-Parent Households

The minimum hours of participation for two-parent households depend upon the receipt of federally funded childcare. The participation requirement may be met by one or both parents. There is no requirement for each parent to participate equally.

When the family does not receive federally funded childcare, the minimum number of hours of participation is 150 hours per month. When the family receives federally funded childcare, the minimum number of hours of participation is 236 hours per month.

18.4.3.B.1 Parent under Age 20

In a two-parent household with a parent under the age of 20 who does not have a high school diploma, that parent must maintain satisfactory attendance at a secondary school (or the equivalent) or be enrolled in a vocational education program. If both parents are under the age of 20 and do not have a high school diploma, both must meet this requirement.

18.4.4 MISSED WORK ACTIVITY HOURS

This policy establishes the guidelines for the treatment of hours missed in 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 Case Manager must decide if the absence is excused or unexcused.

Participation for Work-Eligible Individuals is calculated on the actual hours of attendance or participation each month.

NOTE: In order to receive planned school break hours, holiday hours, or excused absence hours for missed work, the participant must have been scheduled to attend the activity at that time. The hours credited must not exceed the activity hours scheduled for that day.

The Case Manager records the excused absences as a monthly total and records how the total hours were computed in the eligibility system.

The following guidelines are used to determine actual hours of attendance/participation for planned school breaks, holidays and individual absences.

18.4.4.A Planned School Breaks

School breaks are not counted as participation hours. Only federally designated holidays which occur during the regular school year are counted as participation hours.

18.4.4.B Holidays

Only federally designated holidays may be counted as days worked when the participant would normally have been scheduled. These include New Year's, Martin Luther King Day, Washington's Birthday (President's Day), Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, and Christmas Day.

> **Missed Work Activity Example 1:** Mr. Ivy is scheduled Monday through Thursday in his activity. A federal holiday falls on a Friday. He must not receive participation credit for this holiday.
>
> **Missed Work Activity Example 2:** Mr. Ficus attends his activity six hours per day Monday through Friday. A federal holiday falls on a Monday. He receives six hours of participation credit for this holiday.

18.4.4.C Absences

18.4.4.C.1 Excused Absences

Excused absences of up to 16 hours/month, not to exceed a maximum of 80 hours in the 12-month period, including the current month and the preceding 11 months, may be counted as hours worked in that month.

Additional days/hours of absence may be considered excused if appropriate but must not count as hours of participation. Inclement weather and states of emergency are included in the 16 hours per month, maximum 80 hours/year excused absences which may count as participation.

> **Missed Work Activity Example 3:** Mr. Cactus attends his activity six hours per day Monday through Friday. He has a doctor's excuse for an appointment on a Monday. He receives six hours of participation credit for this absence.

If the participant will not meet the participation requirement when including the absence hours, do not count these absence hours for participation. Participation credit for excused absences must not be entered when sufficient hours have been entered for the work or educational activity to meet the minimum required participation rate.

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 Case Manager to determine if the absence is excused or unexcused based on contact with the employer/contractor and participant documentation. A determination of good cause may only be made by the Case Manager.

Absences must not be used toward calculating the monthly participation hours, unless the Case Manager has determined that the absences meet the definition of what may be excused, and the participant was scheduled to work that day. The Case Manager must document in comments why the absences are being excused and how the reason for the absence was verified.

18.4.4.C.2 Tracking Absences

A fixed calendar year is not used (i.e., January – December). The running total of excused absence hours credited for the most recent 12 months (defined as the most recent month plus the preceding 11 months) must be calculated each month.

For each month the Case Manager must record in Work Program comments the number of hours of excused absences counted towards participation for the current month. Each month, the preceding 11 months plus the current month must be reviewed to ensure the 80-hour limit is not exceeded in any 12-month period.

Tracking Absences Example 1: The timesheet for October 2016 is received. To determine the number of absence hours that may be used for October, the Case Manager must review all absence hours reported from November 2015 through September 2016.

Tracking Absences Example 2: During October, Mr. Oak was scheduled to attend vocational training 16 days at 8 hours per day for a total of 128 hours. Mr. Oak worked 13 days, missed 2 days and the school observed Columbus Day. He was ill one full day and had a doctor's statement to verify the illness. He states he missed the second day because he overslept. Since excused absences and federal holidays may be counted and credited as participation hours, his total hours for October are 120. Eight hours are entered for the holiday and eight hours are entered for the excused absence. The second missed day was not excused, and no credit is given. Since the client will not meet participation by allowing 8 hours for the excused absence, no hours will be entered for excused absences in the eligibility system.

These are separate entries in the eligibility system:

Scheduled Hours	Completed Hours	Excused Hours	Federal Holiday Hours
128	104	0	8

Tracking Absences Example 3: Ms. Pine was scheduled to participate 128 hours in a work activity for the month of October. She is scheduled to works 8 hours per day, Monday through Thursday, for the first four weeks of the month. There were no observed federal holidays for the month. Ms. Pine had medical appointments and was absent on the following dates: October 3 – 2 hours; October 11 – 4 hours; October 17 – 2 hours; and October 23 – 4 hours. These absences are all considered excused. Since she is scheduled to work 8 hours per day, up to 16 hours may be counted and credited as participation hours for the month. For October, she has 116 hours worked and 12 hours excused absences for a total of 128 hours. These are separate entries in the eligibility system:

Scheduled Hours	Completed Hours	Excused Hours	Federal Holiday Hours
128	116	12	0

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

Absences that are made up during the month are not reported as excused or unexcused.

Record the results of all contacts with the employer/contractor concerning this issue in the eligibility system. At the end of the month the participant's timesheet must correctly identify any absence. Any inconsistency or irregularity on the timesheet must be worked out with the employer/contractor.

18.4.4.C.3 Paid Vacation/Sick Leave

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

18.4.5 PARTICIPANT DOCUMENTATION

18.4.5.A Methods of Documenting Participation Hours

All hours of participation in activities must be verified. The Participant Timesheet, DFA-TS-12, is the standard timesheet used to document participation. When used, it is given to participants to report attendance and satisfactory progress in the activity. Some employers/contractors have their own timesheets. These are acceptable means of verification as long as these timesheets provide the necessary information and are signed by the site supervisor. Documentation is required and must be available from the activity site at least monthly to support what is reported for participation and may include electronic records. Monthly timesheets must be filed in participants' case records.

For Work-Eligible participants who are employed, other documents and methods may be used to verify work hours. Although timesheets and written confirmation from the employer may be used, the following alternative methods may also be used to document these hours:

- Pay stubs;
- Timecards signed by the employer;
- Sign-in/sign out sheets signed by the employer; or
- Work schedules signed by the employer.

For employment, based on valid documentation, hours may be projected for up to six months unless there is a change in the number of work hours. When this happens, then actual hours must be documented, and hours may be projected for the remainder of the six-month period. At the end of six months, current hours must be re-verified. The preferred method of verification of hours is 30 days of pay stubs to be used to project the participant's participation for up to a six-month period.

A timesheet signed by the participant and the provider listing the days worked must be submitted for transportation requests.

For the participant to be eligible for the Participation Achievement Bonus, a timesheet signed by the participant and the provider listing each day worked and the attended hours each day to show participation was met.

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

18.4.5.B Participation Calculation

18.4.5.B.1 Self-Employment

The calculation of monthly participation hours for self-employed Work-Eligible Individuals (those owning/operating their own business/service, providing childcare, etc.) is determined in the following manner:

$$\frac{\text{Gross Monthly Income – Monthly Business Expenses}}{\text{Federal Hourly Minimum Wage}}$$

If the number of recordable participation hours fall short of the minimum required hours, additional activity placement must be made by the Case Manager.

> **Self-Employment Example:** Ms. Oak provides childcare for her neighbor's two children, Monday through Friday from 8 a.m. to 5 p.m. The neighbor pays Ms.

Oak $170 per week. Ms. Oak claims no business expenses. Ms. Oak received $731 pay for August. Her hours of participation are:

$$\frac{\$731 - \$0}{\$7.25} = 100.83 \text{ (round to 101)}$$

$731 divided by $7.25 = 100.83 (rounded to 101 hours.) In this example, Ms. Oak has a work requirement of 128 hours per month; therefore, she must participate in another work activity for no less than 27 hours per month.

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

18.4.5.B.2 Other Allowable Activities

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

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

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

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

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

Time for excused absences as found in Section 18.4.4.C.1, up to 16 hours, is entered separately. Time for federally designated holidays is entered separately and is not converted to a weekly average.

Non-Paid Work Activities Example 1: Ms. Daisy participated 41 hours in JR and 88 hours in VT.

JR = 41 / 4.33 = 9.46 = 9

VT = 88 / 4.33 = 20.32 = 20

29 hours average participation per week

Non-Paid Work Activities Example 2: Mr. Willow is required to complete 128 hours in a core activity. He actually participates 103 hours in JR and will receive 8 hours for federally designated holiday. Attached to his time sheet were 2 doctor's statements for 16 hours of excused absences. Hours will be entered as follows:

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

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

18.4.5.B.3 Case Recordings

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

18.4.5.B.4 System Coding of Participation Hours

Participation hours for months in which WV WORKS benefits were received must be entered in the eligibility system as soon as possible but no later than the last day of the following month. The Case Manager must be certain to enter the hours of participation for the correct month.

Activity component enrollment can be backdated to the date of WV WORKS benefit confirmation and participation hours which are received after the above deadline are entered by the following quarterly deadlines:

	New Component Entry Deadline	Participation Hours Entry Deadline
Jan, Feb, March	April 30	May 5
April, May, June	July 31	Aug 5
July, Aug, Sept	Oct 31	Nov 5
Oct, Nov, Dec	Jan 31	Feb 5

18.4.6 LIMITATIONS ON COUNTABLE HOURS

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

- Truckers – Limited to entries of 240 hours/month, unless the participant is able to document more hours.
- Paid In-Home Care Providers – Limited to entries of 175 hours/month, even when 24-hour care is needed.
- All other allowable activities are limited to entry of 240 hours per month as completed.

18.4.7 DISABILITY/INCAPACITY – DEFINITION FOR TEMPORARY GOOD CAUSE

Disability and incapacity for a Work-Eligible Individual may be established with or without a physician's statement as described in the following sections.

NOTE: A two-parent family with one parent disabled or incapacitated according to this section is still considered a two-parent family for minimum participation rate requirements. The family may be temporarily granted good cause for not meeting the minimum requirements. See Section 14.9. Meeting either definition does not automatically exempt the family or individual from the 60-month or 24-month time limits described in Sections 18.2 and 18.8.

18.4.7.A Establishing Disability without a Physician's Statement

When the disability is obvious to the Case Manager, no verification is required. The Case Manager must record his findings and the reason for his decision in case comments.

If the disability is not obvious to the Case Manager, disability may be established according to other criteria below. If disability cannot be established according to this section, see Establishing Disability With A Physician's Statement below.

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

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

  For SSI and RSDI purposes, being certified for these benefits (approved, but not yet receiving payment withheld to repay, etc.) is the same as receiving them.
- The individual is a veteran with a service-connected or non-service-connected disability, rated or paid as total, under Title 38 of the United States Code.
- The individual is a veteran who is considered by the VA to be in need of regular aid and attendance, or permanently housebound, under Title 38 of the United States Code.
- The individual is a surviving spouse of a veteran and is considered by the VA to be in need of aid and attendance, or permanently housebound, under Title 38 of the United States Code.
- The individual is a surviving child of a veteran and is considered by the VA to be permanently incapable of self-support, under Title 38 of the United States Code.
- The individual has one of the following conditions:
  - Permanent loss of use of both hands, both feet or one hand and one foot.
  - Amputation of leg at hip.
  - Amputation of leg or foot because of diabetes mellitus or peripheral vascular diseases.
  - Total deafness, not correctable by surgery or hearing aid.
  - Statutory blindness, unless due to cataracts or detached retina.
  - IQ of 59 or less, which was established after attaining age 16.
  - Spinal cord or nerve root lesions resulting in paraplegia or quadriplegia
  - Multiple sclerosis in which there is damage of the nervous system because of scattered areas of inflammation which recurs and has progressed to varied interference with the function of the nervous system, including severe muscle weaknesses, paralysis and vision and speech defects.

- Muscular dystrophy with irreversible wasting of the muscles with a significant effect on the ability to use the arms and/or legs.
- Impaired renal function due to chronic renal disease, documented by persistent adverse objective findings, resulting in severely reduced function which may require dialysis or kidney treatment.
- Amputation of a limb, when current age is 55 or older.

- Recipients of federal, state or local government disability retirement, who receive such benefits due to one of the conditions specified above. This includes, but is not limited to, payments under Civil Service Retirement (CSR) and Federal Employee Compensation Act (FECA).
- Those individuals who receive federally- or state-administered supplemental benefits under Section 1616 (a) of the Social Security Act (optional state supplementation to SSI payments) provided that eligibility to receive the benefits is based upon the disability or blindness criteria used under Title XVI of the Social Security Act or under Section 212 (a) or Public Law 93-66. West Virginia has no such program.
- Recipients of annuity payments, under Section 2,(a),(1),(iv) of the Railroad Retirement Act of 1974, who also have been determined eligible to receive Medicare under the Railroad Retirement Act.
- Recipients of an annuity payment, under Section (2),(1),(1),(v) of the Railroad Retirement Act of 1974, who have been determined to be disabled based on the criteria used under Title XVI of the Social Security Act.
- Recipients of benefits from the following Medicaid coverage groups:
  - SSI-Related Medicaid
  - Aged and Disabled Waiver (ADW)
  - Intellectual/Developmental Disabilities (I/DD) Waiver
  - Traumatic Brain Injury (TBI) Waiver

18.4.7.B Establishing Disability with a Physician's Statement

The following criteria must be met to establish disability when the individual does not qualify according to Establishing Disability Without A Physician's Statement above.

18.4.7.B.1 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, and Nurse Practitioners.

18.4.7.B.2 Content of the Physician's Statement

Generally, the statement must contain enough information to allow the Case Manager to determine if the participant is disabled. If the physician makes a definite statement that the participant is permanently and totally disabled, no further information is needed. Usually, however, the physician describes the situation, and the Case Manager 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 participant'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.

18.4.7.B.3 Making the Determination

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

- If the condition is one listed in Appendix C of Chapter 13 as a guideline for presumptively approving an AFDC-Related Medicaid case, disability is established. No durational time limits are imposed.
- Any other condition must impose limitations on the participant'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.

18.4.7.C Establishing Incapacity

The definition of incapacity and the procedures for making the determination found in Section 13.3.3 apply here.

18.5 REQUIREMENTS FOR PARENTS UNDER AGE 18

There are special requirements for parents under the age of 18 to be eligible for WV WORKS cash assistance. The individual who is not age 18, is not married, has a minor child at least 12 weeks of ages in his or her care, and has not successfully completed a high-school education (or its equivalent) must meet the following two requirements:

- Remain in an educational activity to complete high school, obtain a high school equivalency diploma or vocational training. See Chapter 3 for more details; and
- Live with parent(s) or in other adult-supervised living arrangement. See Chapter 3 for more details.

Failure to meet the educational requirement results in ineligibility for an unmarried parent under age 18.

Failure to live with parent(s) or in another adult-supervised setting results in ineligibility for an unmarried parent under age 18 and the child(ren) of such parent.

NOTE: When another parent of the child who is age 18 or over resides in the home, the child may be eligible.

> **Parents Under Age 18 Example 1:** A 16-year-old mother lives with the 19-year-old legal father of her baby. The father and the baby may be eligible, although the mother is ineligible.
>
> **Parents Under Age 18 Example 2:** A 16-year-old mother is married to the 21-year-old father of her child. All members of the assistance group are eligible to be included in the check. As a parent under 20, the mother must meet the educational requirements required on the Personal Responsibility Contract/Self-Sufficiency Plan (PRC/SSP) or the case would be sanctioned.

18.6 CHILD SUPPORT REQUIREMENTS

Federal law mandates that efforts be made to locate absent parents, establish paternity and/or obtain support for the children. The specified relative receiving WV WORKS must cooperate with child support activities and redirect to the Bureau for Child Support Enforcement (BCSE) any child support payments received.

The major responsibility for this effort rests with the BCSE through its Child Support Specialists.

18.6.1 BCSE REFERRALS

Referrals to the BCSE are automated in the eligibility system. Participants who claim good cause are not required to cooperate with BCSE, but a referral is made.

All WV WORKS AGs which include a child under age 19 with at least one absent parent must be referred to BCSE. In addition, a currently unmarried minor parent who is unable to live with a parent(s) must be referred.

The Case Manager must appropriately code the eligibility system and complete the Acknowledgement of Automatic Assignment of Support Rights and of Cooperation Requirements, DFA-AP-1, to complete the referral to BCSE.

18.6.2 GOOD CAUSE

The WV WORKS participant is required to cooperate with BCSE unless good cause is established.

If the participant who refuses to cooperate asserts that one or more of the factors listed below is the reason for non-cooperation, a good cause claim has been made. A participant who refuses to cooperate and who gives as the reason some factor other than one of those listed below is considered to have refused to cooperate without claiming good cause.

18.6.2.A Definition of Good Cause

The participant has good cause for refusal to cooperate with BCSE if one of the following conditions exists:

- The child was conceived as the result of incest or forcible rape.
- Legal proceedings for the adoption of the child are pending.
- The participant is currently being assisted by the Department or by a licensed private social agency to resolve the issue of whether to keep the child or to relinquish him for adoption and the discussions have not gone on for more than three months.
- The participant's cooperation in establishing paternity or securing support is reasonably anticipated to result in:
    - Physical or emotional harm to the child for whom support is being sought; or
    - Physical or emotional harm to the parent or other specified relative with whom the child lives, which would reduce such person's capacity to care for the child adequately. A finding of good cause for emotional harm may only be based upon evidence of an emotional impairment that substantially affects the parent or other relative's functioning.
    - In determining good cause based in whole or in part upon the anticipation of emotional harm to the child, the parent or the other specified relative, the Case Manager must consider the following:
        - The present emotional state of the individual;
        - The emotional health history of the individual;
        - The intensity and probable duration of the emotional impairment; and
        - The extent of involvement of the child in the paternity establishment of support enforcement activity to be undertaken.

18.6.2.B Procedure to Determine Good Cause

The procedure to determine good cause is as follows:

- The child was conceived as the result of incest or forcible rape.
- Form DFA-AP-1A, Notice to Individual Who Has Claimed Good Cause for Refusal to Cooperate in Child Support Activities, must be completed by the Case Manager during a face-to-face contact with the participant who signed or was interviewed about the DFA-AP-1A.

  The Case Manager must be sure the participant understands the information on Form DFA-AP-1A. Two original forms must be completed and signed by the Case Manager and the participant. One original is given to the participant and the other filed in the case record.

- The participant has the primary responsibility for obtaining the verification needed to establish good cause. Refer to Chapter 7. The participant must provide the verifications within 20 days of the date good cause is claimed.
- In certain situations, it is acceptable to make a determination of good cause without verification. These situations are:
    - The claim of good cause is based on the anticipation that cooperation will result in physical harm to the specified relative or the child; and
    - The Case Manager believes, from the information provided by the participant, that:
        - The claim is credible without corroborative evidence;
        - Corroborative evidence is not available; and
        - The Case Manager and Supervisor agree that good cause exists.
- The Case Manager must determine if good cause exists within 45 days of the date good cause is claimed.
- If good cause is established, the Case Manager must refer the case to the Child Support Specialist in writing (DHS-1) and indicate the basis for good cause. The case is not acted on by BCSE. At each redetermination of eligibility, the Case Manager determines if good cause still exists. If good cause no longer exists the Case Manager must notify the participant and take appropriate action.
- If good cause is not established, the Case Manager initiates the PRC penalty by sending the participant a DFA-NL-C. The Case Manager notifies the Child Support Specialist that good cause was claimed, but not established, and that the penalty or sanction for refusal to cooperate has been applied.

18.6.2.C Data System Pending Good Cause

A letter is automatically generated to the absent parent(s) from the BCSE data system as soon as the case is referred through the eligibility system. Therefore, it is important that the participant be given the opportunity to establish good cause for not cooperating prior to the exchange between the two data systems.

When the participant refuses to cooperate or when the participant claims good cause before the BSCE referral, the claim of having good cause that is pending verification will prevent the automatic production of a notice to the absent parent.

If the case is approved or benefits are added to an existing case, prior to verification of the good cause claim, the claim of having good cause that is pending verification will prevent the

automatic production of a notice to the absent parent by the BCSE data system.

18.6.3 WHEN THE PARTICIPANT REFUSES TO COOPERATE, OR CLAIMS GOOD CAUSE FOR REFUSAL TO COOPERATE

If the participant indicates to the Case Manager that he does not intend to cooperate in BCSE activities, the Case Manager must determine if good cause exists for the refusal.

If good cause does exist, no BCSE action is required or taken and no penalty is applied to the participant. A DFA-AP-1A, Notice to Individual Who Has Claimed Good Cause for Refusal to Cooperate in Child Support Activities, must be completed. When there is evidence to immediately establish good cause, the Case Manager notifies BCSE at the time of the referral that good cause has been established.

If good cause does not exist or is not established, the WV WORKS case is referred to BCSE. The Case Manager must record in the eligibility system the circumstances involved in the determination of good cause. The Case Manager notifies BCSE at the time of referral that good cause was claimed but not established. If BCSE then notifies the Case Manager that the participant has failed to cooperate, the Case Manager sends the notification of sanction.

18.6.4 CASE MANAGER RESPONSIBILITIES

In addition, the Case Manager has the following responsibilities:

- To explain the requirements and benefits of BCSE services, including the right of the specified relative to claim good cause for refusal to cooperate.
- To refer appropriate cases to the Child Support Specialist. Referral is accomplished by data system exchange or DHS-1, Referral and Communications Form.
- To evaluate evidence presented if the participant claims good cause.
- To determine if good cause for failure to cooperate with BCSE exists
- To apply the Personal Responsibility Contract (PRC) penalty for refusal without good cause to cooperate or redirect child support payments for WV WORKS.
- To respond to eligibility system alerts and take the required action.

18.6.5 DFA-AP-1, ACKNOWLEDGEMENT OF AUTOMATIC ASSIGNMENT OF SUPPORT RIGHTS AND OF COOPERATION REQUIREMENTS

The purpose of the DFA-AP-1 is to assure that affected participants know of the automatic assignment of support rights to the State and understand the benefits, requirements and rights associated with BCSE.

18.6.5.A Who Is Required to Complete the DFA-AP-1

18.6.5.A.1 Applicants

The DFA-AP-1 must be completed when there is at least one child included in the AG who has an absent parent(s). This includes children who receive Supplemental Security Income (SSI) and are included in the WV WORKS AG.

18.6.5.A.2 Participants

The DFA-AP-1 must be completed for active cases as follows:

- When a child is in an assistance group (AG) with no parent and a parent is then added, that parent must sign.
- When a child who has an absent parent, including a child who receives SSI, is added to the AG.

18.6.5.A.3 Minor Parent

When a major parent, minor parent and the minor's child are included in the AG, the major parent is required to sign the DFA-AP-1 to assign support rights of the minor's child.

18.6.5.B Instructions for Completion

Instructions for completion are as follows:

- Complete in triplicate.
- Enter the case name and case number in the indicated spaces on the form.
- Enter a check mark in the block beside each paragraph number to indicate that the participant understands the information.
- The specified relative must sign the form. If the parent is also in the home, he must sign the form.
- The Case Manager and participant must sign all copies.
- Distribute copies to the participant, BCSE Child Support Specialist, and file one in the case record.

18.6.5.C Procedures When the Participant Refuses to Sign

When the participant refuses to sign the DFA-AP-1, the action taken depends upon the reason for the refusal. When the participant indicates that he will not sign the DFA-AP-1 and, in doing so, indicates that he will not cooperate with BCSE, the Case Manager must determine if good cause exists for the refusal.

If good cause does exist, no BCSE action is required or taken and no penalty is applied to the participant. If good cause does not exist, the WV WORKS case is referred to BCSE and a sanction is applied. The Case Manager must record in the eligibility system the circumstances involved in the determination of good cause.

When the participant indicates that he will not sign the DFA-AP-1 but indicates that he will cooperate with BCSE after referral, the WV WORKS case is referred to BCSE and no penalty is applied. The Case Manager must record in the eligibility system that the content and purpose of the form were explained to the participant, that he refused to sign, the reason given for the refusal, and that the participant has indicated that he will cooperate with BCSE after the referral. The Case Manager must provide the participant with an unsigned copy of the DFA-AP-1 and this must also be recorded in the eligibility system.

Refusal or other failure to sign the DFA-AP-1 does not constitute failure to cooperate with BCSE requirements as shown on the PRC. The above instructions are followed, and no sanction is applied.

18.6.5.D When the Participant Claims Good Cause for Refusal to Cooperate after a BCSE Referral

When the participant claims good cause after the referral, the Child Support Specialist refers the case back to the Case Manager for a determination of good cause. The Case Manager enforces the cooperation requirement; however, the Child Support Specialist must participate in the good cause determination in an advisory capacity. The Case Manager must give the Child Support Specialist an opportunity to review and comment on the good cause investigation and the decision. The Case Manager must consider the recommendation of the Child Support Specialist in making the final decision.

18.6.6 REDIRECTION OF CHILD SUPPORT PAYMENTS

All child support payments made on behalf of children who receive WV WORKS must be redirected to BCSE. The first $100 in child support collected for families with one child and $200 for families with more than one child eligible for Temporary Assistance for Needy Families (TANF) will pass through to families and will not count against WV WORKS, WV WORKS solely state-funded programs, Diversionary Cash Assistance (DCA), or Employment Assistance Program (EAP).

Exceptions are as follows:

- The case is exempt from referral to the Child Support Specialist due to good cause.
- The specified relative refused to cooperate with child support activities after referral to BCSE and good cause was established.
- If paternity has not been established, but the putative father voluntarily makes child support payments, such payments are not required to be redirected.

NOTE: While there is no penalty for Medicaid recipients who refuse to redirect support payments, they must be instructed that being referred to BCSE automatically triggers income withholding, whenever there is an existing court order for support and an identifiable source of income.

After receiving a referral, the Child Support Specialist arranges for support payments to be sent directly to BCSE rather than the specified relative. If direct payments to BCSE cannot be arranged, the participant must forward the payment to BCSE. Failure to do so will result in application of a sanction for WV WORKS for failure to cooperate with child support activities.

18.6.7 REDIRECTION OF SPOUSAL SUPPORT

Spousal support must be redirected when:

- The spousal support (alimony or separate maintenance) is court-ordered; and
- It is paid by the absent parent to the parent who is the caretaker relative.

All policies and procedures applicable to child support which must be redirected also apply to spousal support which must be redirected to BCSE.

See Chapter 4 for counting redirected support.

Spousal support is not redirected when any of the following conditions exist:

- The parent is not included in the payment;
- The caretaker relative receiving the spousal support is not the parent of the children receiving WV WORKS;
- The parent who is the caretaker relative is receiving spousal support from a spouse who is not the parent of the children receiving cash assistance; or
- The spousal support is not court-ordered.

Spousal support which is not required to be redirected is considered unearned income and is counted as income.

18.6.8 REDIRECTION OF CHILD/SPOUSAL SUPPORT IN SPECIAL SITUATIONS

If the absent parent is ordered by the court to make child support payments in the form of in-kind payments, such as provision of food or clothing, or third-party payments, such as direct payment of the rent or mortgage, the payment cannot be redirected.

If the court order specifies that part of the child support obligations is to be paid in cash and part by third-party or in-kind method, the portion paid in cash must be redirected.

A child may receive statutory benefits such as Retirement, Survivors and Disability Insurance (RSDI) or Veteran's Administration (VA) benefits, on the basis of his own entitlement, as a dependent of the absent parent who is the primary beneficiary. This benefit amount is not considered child support and is not redirected even though the court order may refer to such income as a source of support to the child, or even as child support.

18.6.9 PENALTIES FOR FAILURE TO COOPERATE

The Case Manager makes the decision about the application of a sanction. The case is sanctioned for failure to cooperate with BCSE requirements based on the PRC. If good cause does not exist, the WV WORKS case is referred to BCSE and a sanction is applied.

A minor parent (mp), who is included in the payment, must always cooperate for the MP's included child(ren) or a sanction is imposed, unless good cause exists. An included major parent (MP), or other caretaker, must cooperate for the mp and the MP's siblings, if any, or a sanction is imposed, unless good cause exists. In addition, an included MP must cooperate for the MP's included child(ren), as required by BCSE. Failure to comply, without good cause, results in application of a sanction.

Failure, without good cause, of either the mp or the MP to meet the cooperation requirements results in one sanction. Failure, without good cause, of both to cooperate may result in two sanctions. However, if there is more than one absent parent for either the mp or the MP, or both, failure, without good cause, results in one sanction for the case.

The WV WORKS benefit is sanctioned in the eligibility system.

Failure, without good cause, of a Caretaker Relative or Child Only case to meet the cooperation requirements, results in closure of the WV WORKS benefit. Upon reapplication after closure for this reason, the caretaker or parent must demonstrate good cause or agree to cooperate.

18.6.10 COMMUNICATION BETWEEN THE CASE MANAGER AND THE CHILD SUPPORT SPECIALIST

Communication between the Case Manager and the Child Support Specialist continues until the case is closed or the child whose parent(s) is absent is removed from the AG.

The Case Manager must notify the Child Support Specialist, in writing, of the following:

- A good cause determination is being made and the Child Support Specialist comments and recommendations are being requested prior to a final decision.
- The participant has requested a Fair Hearing as the result of the Department of Human Services' (DOHS) finding that good cause for non-cooperation is not established.
- Should the Case Manager become aware of information which could help the Child Support Specialist in obtaining support, this information must be shared.

The Child Support Specialist must notify the Case Manager, in writing, of the following:

- The participant refuses to cooperate in child support activities and the reason for the refusal.
- Information which affects eligibility or the amount of the payment.
- Change of address.
- Paternity is established.
- Participant refuses to redirect child support payments and/or refuses to repay child support payments which were not redirected.

Changes in case circumstances are automatically referred to BCSE through the data systems. When health insurance information is entered by BCSE, an eligibility system alert is sent to the Case Manager.

18.6.11 BCSE CASE CLOSURE OF WV WORKS CASES

BCSE closes a case after referral for reasons such as, but not limited to, the following:

- The non-custodial parental rights and responsibilities are terminated, and no arrears are owed.
- The non-custodial parent or alleged father is deceased and no further action, including a levy against the estate, can be taken.
- Paternity cannot be established because the alleged father's identity is unknown
- The non-custodial parent's location is unknown and BCSE has been unsuccessful in locating the person after exhausting all efforts.
- The non-custodial parent is a citizen of, and lives in, a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets; and there is no reciprocity with the other country.
- The non-custodial parent cannot pay support for the duration of the child's minority and the person has no income or assets which can be levied or attached for support for one of the following reasons:
    - The non-custodial parent is incarcerated and there is no chance for parole for the duration of the child's minority;
    - The non-custodial parent is receiving SSI and there is no income or assets to pay support and a doctor's statement or statement from SSA is provided to state that the non-custodial parent is permanently and totally disabled; or
    - The non-custodial parent has a medically verified permanent and total disability with no evidence of support potential.

When BCSE closes a case for one of the above stated reasons, the BCSE Child Support

Specialist enters the appropriate absence code and information about the absent parent is no longer exchanged with the BCSE data system. The code cannot be changed by the Case Manager. The code is retained in the eligibility system and no entry is required at redetermination. If the Case Manager receives information about the absent parent which he believes is pertinent and which may require action by BCSE, he sends a DHS-1 to the Child Support Specialist.

18.7 LOCAL OFFICE RESPONSIBILITIES

In addition to the responsibilities contained in other chapters of the Income Maintenance Manual (IMM), the Case Manager has responsibilities related to the work program aspect of WV WORKS. The Case Manager must assist the participant in all reasonable ways to achieve self-sufficiency.

The Case Manager must assist the participant in all reasonable ways to achieve self-sufficiency. The West Virginia Bridge Model is designed to emphasize family stability, well-being, job development and job readiness, employment, job retention and stronger families. By using this model, it is a full family, holistic approach to eliminate challenges and barriers, while focusing on the family dynamic to promote job readiness and employment in order to lead to stronger families and self-sufficiency. To accomplish this, the Case Manager must assess the participant's knowledge and skills, work with the participant and make informed recommendations about courses of action appropriate for each individual to develop a plan that is expected to lead to self-sufficiency. In addition, he must enter into an agreement with the participant concerning his involvement in the process of becoming self-sufficient, monitor the participant's progress to determine changing needs and the need for support service payments and take appropriate follow-up action based on the participant's actions.

The eligibility requirements of the Personal Responsibility Contract (PRC) and Self-Sufficiency Plan (SSP), is detailed in Chapter 1. Other requirements, particularly those dealing with the participant's continuing eligibility, are found throughout the IMM. Chapter 14 contains other information about the eligibility aspect of the work requirements. The following sections in this chapter are devoted to work activities and follow-up actions and contain information necessary for the Case Manager to assist the participant in becoming self-sufficient and in developing opportunities for him.

18.7.1 MOBILITY COACHING

Mobility Coaching is a research-informed approach to help families improve their well-being, meet their children's needs, and get out of poverty. Through strength-based coaching, Mobility Coaching supports low-income individuals to plan, strategize, reach, and sustain economic self-sufficiency. Mobility Coaching places participants with Case Managers to support them in meeting their goals. Case Managers work in close partnership with participants to create high levels of trust along with high expectations and a growth mindset to help participants succeed.

This approach incorporates motivational interviewing, and principles of trauma-informed care to help individuals facing significant stress function more effectively and get out of poverty. The core concepts underlying Mobility Coaching include: an individualized approach, a holistic approach of bridging all facets of an individual's life to gain and maintain stability, time, participant buy-in, and networking.

Using the bridge as the program frame and engaging in one-on-one partnerships, coaching is a participant-directed process designed to improve decision making, persistence, and resilience over time. Through repeated practice, this process becomes internalized.

18.7.1.A THE WEST VIRGINIA BRIDGE MODEL

The bridge is a framework that builds integrated, future-oriented decision-making, allows the participant to organize and achieve positive steps, and aids in the development of these skills, first as an adaptive device that supplements decision-making skill deficits and ultimately as a coaching tool for improving the participant's executive functioning skills. Trauma and chronic stress negatively impact brain development and executive functioning. The basic executive functioning skills are working memory, impulse control, and mental flexibility. These are the primary decision-making skills for problem-solving, goal setting, and goal attainment necessary to achieve and sustain economic independence. Mobility Coaching requires use of the Bridge as both an assessment tool and a framework within which a participant can set goals and chart a path to economic mobility and independence.

The West Virginia Bridge Model is designed to emphasize family stability, well-being, job development and job readiness, employment, job retention and stronger families. By using this model, it is a full family, holistic approach to eliminate challenges and barriers, while focusing on the family dynamic to promote job readiness and employment in order to lead to stronger families and self-sufficiency. To accomplish this, the Case Manager must assess the participant's knowledge and skills, work with the participant and make informed recommendations about courses of action appropriate for each individual to develop a plan that is expected to lead to self-sufficiency. In addition, he must enter into an agreement with the participant concerning his involvement in the process of becoming self-sufficient, monitor the participant's progress to determine changing needs and the need for support service payments and take appropriate follow-up action based on the participant's actions.

The goals for the WV WORKS Bridge Model Case Management process are:

- Increase the number of WV WORKS Customers who overcome employment challenges.
- Improve the Employability and Job Skills of WV WORKS Customers.
- Improve WV WORKS family functioning and well-being.
- Increase the Employment earning capacity of WV WORKS Participants.
- Improve the effectiveness and efficiency of the WV WORKS Program.

The West Virginia Bridge Model uses the Bridge to Stronger Families, DFA-WVW-Bridge, for the participant to discuss pillars of family stability, well-being, job development and job readiness, employment, job retention and stronger families with his Case Manager. Each of these pillars has five levels the participant can self-identify as fitting into. Once the participant has selected the statement which best describes his current situation, the Case Manager will discuss with him the area he would most like to change. This would move the participant to the next step of Mobility Coaching, which is goal setting.

18.7.1.B GOAL SETTING

Participants will often have challenges which must be first addressed before steps may be taken towards his goal(s). The Case Manager must assist the participant with removing these challenges by offering referrals or supportive services. The Case Manager then assists the participant in clearly stating his goal(s) and determining the steps needed to reach those goals. The Case Manager also assists the participant in imaging how his life will be different once he has reached those goals. Mobility Coaching uses the SMART (Specific, Measurable, Attainable, Relevant, Time-limited) goals format to set goals leading towards economic mobility. The WV WORKS Goal Action Plan, DFA-SSP-1a, may be used in conjunction with the Self-Sufficiency Plan, DFA-SSP-1, to outline each participant's goals.

18.7.1.C RECOGNITION

Bonuses are available as tangible rewards through supportive services to recognize goal achievement. In addition, goal achievement notifications are available in the case management system along with certificates which may be created by the Case Manager. Higher self-esteem of the participant, praise from the Case Manager and the satisfaction of reaching goals are intangible rewards. These can be the building blocks towards larger or long-term goals.

18.7.2 CASE MANAGEMENT

This case management process provides for substantial flexibility in administration of the work component of WV WORKS. Each Work-Eligible Individual must meet a work requirement and the State must meet, and maintain, an established participation rate. The Case Manager has the discretion to tailor the work requirements to the needs and goals of each family. Therefore, there are no mandatory procedures or processes that must be applied to each family. Instead, the Case Manager's reasonable and appropriate guidance and discretion are used to assist the participant in accepting personal responsibility and achieving self-sufficiency.
Self-sufficiency is defined as being able to provide for the family's basic needs without relying on WV WORKS monthly cash assistance. It is recognized that some families will not be able to become completely self-sufficient. For these families, the goal is to reduce the reliance on cash assistance as much as possible and to find additional resources before the family reaches the 60-month lifetime limit.

To meet the goals of WV WORKS, a Case Manager performs the following activities for WV

WORKS families:

- Determines initial and ongoing case and individual eligibility. When the WV WORKS family also receives Supplemental Nutrition Assistance Program (SNAP) and/or Medicaid, eligibility for these programs is also determined and maintained by the same Case Manager.
- Negotiates the SSP with the participant to determine the best means to achieve self-sufficiency and accept personal responsibility. The initial SSP is completed on a paper form, the eligibility system must be updated as soon as possible.
- Completes the initial SSP within 10 working days of the initial contact when the participant expresses an interest in applying for WV WORKS. The Case Manager may complete Work Program (WP) information after that time but must not require the participant to visit the office again to be present during the WP enrollment process.
- When the Case Manager determines that the participant has a potential disability and wishes to participate in the WV WORKS program activities, negotiates the SSP in a way that is appropriate for that individual and his needs to help him move toward self-sufficiency. In these cases, the SSP must be developed to address not only tasks that lead to employment but also considers the disabled individual's need for health care. Referrals should be made for all services and benefits for which the assistance group (AG) may be eligible, even if those services are available only through other agencies. WV WORKS participants who have a documented disability must be placed in the participant with a documented disability (AD) component in addition to other component codes.
    - The worker must use the DFA-ADARA-1 (Family Assistance Reasonable Accommodations Report Form) to capture any information about the barrier and the disposition of the reasonable accommodation request.
    - The worker must honor the right of the client to fair hearings regarding reasonable accommodations and is responsible for sending this information to the Office of Inspector General, Board of Review.
- Uses the eligibility system to make changes to the SSP and attaches changes to the initial SSP. All changes must be saved in the case management system.
    - When the participant requires smaller steps to meet his goal(s), a WV WORKS Goal Action Plan, DFASSP-1a, may be completed in addition to the SSP.
- Review the completed WV WORKS Self-Sufficiency Appraisal Form, DFA-WVW-3A at the initial home visit and reviews. Review the Self-Sufficiency Appraisal Addendum and Coaching Guide (DFA-WVW-CCG-2) at subsequent home visits, site visits, case staffing's and after any reported changes which would change a response. Update the Case Management System and PIN comments each time this form is reviewed.

- Complete a Bridge to Stronger Families, DFA-WVW-Bridge during home visit and in conjunction with 12/24/36/48-month evaluation meetings.
- Complete a DFA-WVW-CCG-2 in conjunction with 12/24/36/48-month evaluation meetings.
- Establishes, for the participant only, reasonable and appropriate requirements related to the participant's capability to perform the tasks on a regular basis, including physical capacity, psychological fitness, maturity, skills, experience, family responsibilities and place of residence. In addition, reasonable and appropriate requirements take into account the participant's proficiency and childcare and other support services needs.
- Monitors compliance with the PRC and SSP.
- Provides continuous assessment of the participant's needs and goals and negotiates adjustments to the SSP as necessary.
- Determines which participants are temporarily exempt from meeting the work requirement and assists the participant in becoming able to participate.
- Determines good cause for failure to comply with the PRC and SSP.
- Applies sanctions as appropriate.
- Develops employment and other work activity opportunities for the participant within the community.
- Makes referrals to other community services.
- Provides payment for support services, as appropriate.
- Identifies potential resources and makes appropriate referrals to secure them.
- Conducts a home visit or a work/activity-site visit a minimum of once each 12 months for all Work-Eligible Individuals requiring a PRC and SSP. Records results of these visits in the eligibility system.

18.7.3 CASE MANAGEMENT FOR CARETAKERS AND CHILD ONLY

Referrals for this program of assistance must have a dependent child in the home. The Case Manager is to assist the caretaker in developing opportunities for him and the children in his care. This case management process provides for substantial flexibility to tailor the referrals and supports to the needs and goals of each family. Therefore, there are no mandatory procedures or processes that must be applied to each family. Instead, the Case Manager's reasonable and appropriate guidance and discretion are used to assist the caretaker.

To meet the goals of WV WORKS, a Case Manager performs the following activities for WV WORKS caretaker and child only families:

- Determines initial and ongoing eligibility for caretaker and child only cases. When the WV WORKS family also receives Supplemental Nutrition Assistance Program (SNAP) and/or Medicaid, eligibility for these programs is also maintained by the Family Assistance Case Manager.
- Provides continuous assessment using from Caretaker Relative Assessment, DFA-WVW-3b, of the caretaker's needs and goals.
- Referrals must be made for all services and benefits for which the family may be eligible as needed, even if those services are available only through other agencies. Develops opportunities and identifies potential resources for the caretaker within the community and makes appropriate referrals to secure them.
- Provides a current List of Local Services and a Support Services Fact Sheet for Caretakers and Child Only Households.
- Provides payment for support services, as appropriate.
- DFA Family Support Policy Unit must be contacted for instructions to issue supportive services for caretakers.
    - Collateral
    - Clothing
    - Child Care
    - Driver's License Assistance
    - High School Diploma or Equivalency Achievement Bonus, See IMM 18.19.3.M
    - Vehicle Repair
    - Vehicle Insurance
    - Donated Vehicle Program
- Attempts an interim contact at each 6-month period which may be at the office, by phone or a home visit to ensure the caretaker's needs are being addressed. The caretaker is not required to participate to continue eligibility when the contact does not coincide with the annual redetermination.

18.7.4 OTHER WORK ACTIVITIES

As part of the Family Stability Well-being column of the West Virginia Bridge Model, the Other Work Activities (OW) component is to be used to track time spent on tasks leading to self-sufficiency or family stability. Individuals placed in this component are considered in the federal participation rate calculation. The OW component will also document the extent in which individuals are involved in other work-related activities that do not count toward the federal participation rates but lead to their self-sufficiency or family stability.

Allowable activities include all of the following, but may include other documented SSP activities, agreed upon by the participant and the Case Manager:

- Appointments with local resources that may be assisting with overcoming challenges;
- Arranging for childcare;
- Arranging for housing;
- Arranging for transportation or working with Good News Mountaineer Garage;
- Child Support meetings or hearings;
- Development of the SSP;
- Emotional Health Inventory (EHI);
- Learning Needs Screening;
- Legal Aid appointments;
- Orientation;
- Referral process for post-secondary education prior to enrollment
- Self-Sufficiency Evaluations with Case Manager;
- Test of Adult Basic Education (TABE) testing;
- Time spent with Case Manager during home visit;
- Work Keys testing;
- Working with Child Protective Services (CPS) for multi-disciplinary treatment (MDT) meetings;
- Working with local agencies; or
- Any other family stability service needed to improve the family's circumstances.

Assignment of any of these activities must be recorded in eligibility system comments. All OW activities must be reviewed monthly. The Case Manager must update the case comments with the information on the status of the participant. Hours of participation may be documented using a Participation Time Sheet (DFA-TS-12) or by the Case Manager's notes. The suggested amount of time a participant may be placed in the OW component is 60 days. For placement

beyond 60 days, the Division of Family Assistance (DFA) may be contacted for additional case management guidance. Certain support payments will be allowable with this component.

Every effort must be made to obtain countable hours for these participants (contacting a school for educational hours, anticipating hours from employer statement, contact a provider for substance abuse or mental health treatment, etc.). When there are absolutely no countable participation hours to enter for these participants, a minimum of one hour of OW should be entered and documented in comments for making these contacts to obtain countable participation hours.

NOTE: There should be no zero hour cases. Every Work-Eligible case should have at least one participation hour.

18.7.5 ASSESSMENT

The assessment of the Work-Eligible Individual's goals, skills, needs and challenges naturally centers on the participant. However, any assessment completed must be a family assessment since the participant is part of the family and is often considered head of the family. In addition, making life better for the family can be a motivational factor in the case management process. Assessment is an on-going process that occurs throughout case management.

18.7.5.A Family Assessment

A Family Assessment means evaluation of work skills, prior work experience, employability, education, and challenges to become self-sufficient, but not limited to, mental and physical health issues, lack of transportation, and childcare.

An in-depth assessment of the participant and his family is necessary to discover the family's challenges to meeting their goals and to develop plans to overcome them.

The assessment is limited to producing information useful to the participant, his family, and the Case Manager in evaluating the participant's and his family's challenges to meeting their goals.

Rather than being a fixed process with mandated procedures, assessment is an ongoing activity. As the participant's and family's circumstances change, their goals and/or challenges may change, resulting in changes in the actions or activities necessary for him and the family to succeed.

The assessment process necessarily includes a series of interviews/conversations with the participant. It may also include educational and/or aptitude/interest testing and interpretation of this information; identification of the participant's skills, abilities and interests; use of community resources; and research into possible employment opportunities.

The following information must be entered in the eligibility system:

- Education and Testing Assessment
- Employment History
- Self-Sufficiency Goals
- Job Readiness Assessment
- Family Strengths and Challenges

The WV WORKS Self-Sufficiency Appraisal Form, DFA-WVW-3A, is essential to the assessment process and its use is mandatory for all Work-Eligible Individuals. The purpose of the form is to gather pertinent information about the participant: work experience, what type of work the participant desires, educational background, family information and family support system, individual and family health, participant's finances, life situations, and goals.

This information, along with testing and other assessment information, is used to negotiate the participant's SSP. It is expected that the SSP will be a step-by-step plan to lead the participant and his family toward his goal of self-sufficiency. The Case Management system must be updated with the responses, including the Family Strengths and Challenge screen. every time the DFA-WVW-3A is reviewed even when there are no changes in circumstances. The Case Manager must also update PIN comments with the information on the status of the participant.

Each Family Strengths and Challenges Assessment identifies challenges which need to be addressed and strengths which need to be highlighted by the Case Manager. The overall score increases once the Case Manager has met the participant where they are and is supporting them to move up the Bridge toward self-sufficiency.

The Strengths and Challenges section in the Case Management system is designed as a measurement tool to determine if participants are better off when they leave the WV WORKS program than when they began. This section is used to measure program benchmarks and participant outcomes and is integral to determining performance. This also shows the successes and impacts that the innovations we are using are making and are meeting the goals for the WV WORKS Bridge Model Case Management process.

18.7.5.B Referrals for Participants with Disabilities

If at any time during case management, the participant indicates he is disabled or has a disability as outlined in Section 1.5, the Case Manager must use the DFA-ADARA-1 (Family Assistance Reasonable Accommodations Report Form) to make any appropriate referrals to

agencies that may be able to provide appropriate services to the participant. The DFA-ADARA-1 is placed in the participant file.

The worker must use the DFA-ADARA-1 to capture any information about the barrier and the disposition of the reasonable accommodation request.

The worker must honor the right of the client to fair hearings regarding reasonable accommodations and is responsible for sending this information to the Office of Inspector General, Board of Review.

18.7.5.C Home Visit

In order to gain as much information as possible prior to negotiation of the first full SSP, a home visit is required within 30 days of the date of application.

At a minimum, the Case Manager must review the completed DFA-WVW-3A (appraisal) form with the participant during the home visit. Results of the initial home visit must be documented in the eligibility system. The first full SSP and the appraisal form must also be completed within 30 days of the date of application, so the home visit must not be delayed until the last day. When the WV WORKS case is re-opened within three months of a home visit, a new initial home visit is not required. The DFA-WVW- 3A must also be completed or reviewed at initial home visit and reviews. Complete and review the Self-Sufficiency Appraisal Addendum and Coaching Guide (DFA-WVW-CCG-2) at subsequent home visits, site visits, case staffing's and after any reported changes which would change a response. A home visit is also required within 60 days prior to the third sanction. Those responses must be captured by updating the eligibility system.

EXCEPTION: When the participant is fully participating in an allowable work activity, the initial visit may be a site visit if the participant agrees. The Case Manager must protect the participant's confidentiality when completing any site visit.

The DFA-WVW-3A is designed for either the participant or Case Manager to complete and may be completed in the office or at the participant's home. Allowing the participant to take it home to complete gives him the opportunity to think about his strengths, what he wants to change about his life, and what he would like to obtain for himself and his family. If the Case Manager asks the participant to complete the form at home and return it prior to the home visit, there is no penalty for failure to return the self-completed form. Instead, the Case Manager will take another form to the home visit and complete it at that time.

If desired, the Case Manager may complete the first full SSP in the participant's home during

the home visit. After reviewing the appraisal form and all other assessment information, the eligibility system must be updated with this information as soon as possible after this. The product of the ongoing assessment process is a series of SSPs that reflect the participant's changing circumstances and tasks that move him toward self-sufficiency.

The Case Manager must complete an updated WV WORKS Self-Sufficiency Appraisal Form, DFA-WVW-3A form with the participant during the annual home visit and/or case review. A Bridge to Stronger Families, DFA-WVW-Bridge, is required to be completed or updated during the home visit.

The Case Management system must be updated with the responses, including the Family Strengths and Challenge screen. every time the DFA-WVW-3A or DFA-WVW-CCG-2 is reviewed even when there are no changes in circumstances. The Case Manager must also update the PIN comments with the information on the status of the participant.

The annual home visit is marked as completed in the case management system when a home visit and DFA-WVW-3A is completed within 60-days of the WV WORKS annual redetermination. The annual home visit does not change when the WV WORKS redetermination is aligned with another program.

Types of home visits include but are not limited to a visit within 30 days of application, visits for third and subsequent sanctions, annual home visits, and scheduled and unscheduled visits as needed for case management purposes.

18.7.5.D Missed Appointments

Failure, without good cause (see Chapter 14.9), to keep appointments to initiate or continue the assessment process indicates a failure/refusal to cooperate or participate.

The Case Manager may provide written notice of the appointment by including it on the initial SSP or by using any approved appointment forms. The written notice may be given to him during the interview or may be mailed. If no record of the issuance of the notice will be shown in the eligibility system or on a signed SSP, the Case Manager must record that such a notice was issued and include the date/time of the appointment. When a letter is mailed scheduling the appointment, the Case Manager must allow no less than seven calendar days. This period begins the day following the date the letter is requested in the eligibility system or when a manual letter is sent.

When an appointment is scheduled in writing and the applicant misses the appointment, a sanction may be imposed without making a second appointment, unless the applicant has good cause or contacts the Case Manager to reschedule the appointment. When an appointment is unscheduled, a sanction may not be imposed for failure to be available. Instead, the Case

Manager must schedule a second appointment in writing. Failure, without good cause, to keep the second appointment or reschedule it results in a sanction.

18.7.6 ASSESSMENT TESTING

In assessing the participant's current situation and negotiating the SSP, the Case Manager must explore family situations, education, work history, skills, aptitudes, attitude toward work, employment potential, possible social services or other support systems including physical, mental and emotional fitness, and the need for support service payments. Form DFA-WVW-3A may be used as an interviewing guide, but the areas explored are not limited to those on the form. Individual circumstances may require varying degrees of exploration. The Case Manager may include educational assessment testing. Assessment testing consists of the Learning Needs Screening, Mental Health Screening, TABE, and Work Keys. All Work-Eligible Individuals must be scheduled for assessment testing unless one of the exceptions exists below.

Assessment testing is administered by the Department of Education Assessment Specialists. Copies of assessment testing results will be forwarded to the Case Manager by the Assessment Specialist. However, under certain circumstances the assessment testing (TABE) may be administered by an Adult Basic Education (ABE) teacher, or other appropriate agency. An example of this would be expediting placement of a participant in an activity such as an ABE class, training, or employment. In this situation the Case Manager must request a copy of the assessment testing results. Test results must be filed in the participant’s record.

18.7.6.A Referral for Assessment Testing

The Case Manager completes referrals for assessment testing by forwarding a list of participants scheduled for testing to the Assessment Specialist. The test administrator is responsible for completing a release of information for each participant.

18.7.6.B Learning Needs Screening

The Learning Needs Screening, may be completed at the time TABE is administered. This is used to screen for possible learning disabilities. Based on the results of the Learning Needs Screening, referrals may be made to the Division of Rehabilitation Services (DRS) for further assessment and diagnosis of possible learning disabilities and/or for accommodations to be made in an ABE/or high school equivalency class, training program, or work site.

Completion of the Learning Needs Screening by the participant is voluntary. Participants declining to complete the Learning Needs Screening will be asked by the West Virginia Department of Education Assessment Specialist to sign the waiver form, DFA-WVW-40. The original waiver will be returned to the Case Manager for the participant's file and a copy will be given to the participant. The Case Manager will record in the eligibility system that the Learning Needs Screening has been offered to the participant, but he has declined.

If the participant indicates to the Case Manager that he wishes to decline to have the Assessment Specialist or full-time ABE teacher complete the Learning Needs Screening, the

NOTE: If a part-time ABE teacher administers the TABE, the Case Manager must schedule the participant in to have the Assessment Specialist administer the Learning Needs Screening. Besides the Assessment Specialists, only full-time ABE or Temporary Assistance for Needy Families (TANF) ABE teachers will complete the Learning Needs Screening. WV WORKS staff must not administer the Learning Needs Screening under any circumstances.

Case Manager must ask the participant to sign the DFA-WVW-40. However, the Case Manager must explain to the participant the importance of completing this screening and explain that the results of this screening could help provide further referrals and services to him. Refusal to sign the DFA-WVW-40 will not result in a sanction.

18.7.6.C TABE Testing

The purpose of TABE testing is to measure basic academic skills such as reading, math, language, and spelling through real-life and academic questions. Scores are given in grade level equivalents.

The Case Manager must schedule all Work-Eligible Individuals for TABE unless one of the exceptions listed below exists.

Based on the elements measured by each test, as found below, the Case Manager determines which test is more appropriate.

Copies of test results are to be requested for participants who have completed TABE, Work Keys, or other similar assessment testing at WorkForce West Virginia, ABE, One-Stop Centers, vocational training centers, etc.

18.7.6.C.1 Exceptions to Completing TABE Testing

Exceptions to completing TABE testing include:

- Participant has completed two or more years of college or is currently attending or is enrolled in the next scheduled term at a college or vocational/technical program which requires a high school diploma or equivalency. Under certain circumstances, however, testing may be warranted if the student has a known learning disability or his basic academic skills are deficient; or
- Participant is scheduled to begin a job which will make the family financially ineligible for a monthly WV WORKS check; or
- Other documented conditions exist that prevent effective assessment. These reasons must be documented in the case recording; or
- Participant completed TABE or other appropriate assessment testing at another agency, training facility, such as WorkForce West Virginia, ABE, or other agency unless one of the conditions listed below exists.

18.7.6.C.2 TABE Retesting Conditions

After the initial basic skills assessment (TABE), Work-Eligible Individuals are referred for re-testing under the following conditions:

- Two years have elapsed since the initial assessment;
- More than one year has elapsed and the participant wants to enroll in an education or training program; or
- Specific instances have occurred, such as a head injury that could impact learning ability.

18.7.6.D Work Keys

Work Keys assessment measures basic skill levels and determines how they compare to the skills required for specific jobs. Skill areas include Reading for Information, Locating Information, and Applied Math. Work Keys can be used to match participants to specific jobs for which they are qualified, determine skill gaps for desired jobs, and/or serve as an effective tool in employment portfolios.

Work Keys Occupational Profiles are available online at ACT WorkKeys Job Profiling. In addition, certain companies in West Virginia have specified those Work Keys skill levels required for their occupations. Participants falling below the specified skill level required in one

of the three skill areas may be referred to an ABE classroom to upgrade that specific area or areas.

18.7.6.D.1 Scheduling Work-Eligible Individuals for Work Keys

All Work-Eligible Individuals are to be scheduled for Work Keys testing under the following circumstances:

- Assessment testing indicates participant has a ninth grade or higher level in reading and math; and
- Guidance is needed to effectively determine appropriate job placement.

18.7.6.D.2 Referring Work-Eligible Individuals for Work Keys Retesting

All Work-Eligible Individuals are referred for Work Keys retesting as follows:

- Participant has successfully completed vocational skills training, or college; or
- Participant has upgraded basic skills in ABE or has passed the High School Equivalency Test; or
- Skill areas from initial Work Keys testing have been successfully upgraded as a result of referral and attendance in an ABE class or other training facility.

18.7.6.E Mental Health Screening – EHI

All Work-Eligible Individuals must be referred for mental health screening. The EHI will be completed by the West Virginia Department of Education Assessment Specialists at the time the TABE testing is scheduled. The purpose of this screening is to check for possible indicators of mental health and substance use issues. This screening is not a diagnosis. Positive results will require a referral to the appropriate mental health professional for a diagnosis and possible treatment. All EHI screening must be completed by the Assessment Specialists.

Completion of the EHI Screening is voluntary. Participants declining to complete the EHI must be asked by the Assessment Specialist to sign the waiver form, DFA-WVW-40. The original waiver is returned to the Case Manager. A copy is given to the participant. The Case Manager must record in the eligibility system that the EHI was offered to the participant, but he declined. The Case Manager must have the participant sign the DFA-WVW-40 when the participant declines to complete the EHI screening.

If the participant wishes to decline to have the Assessment Specialist complete the EHI, the Case Manager must ask the participant to sign the DFA-WVW-40. However, the Case Manager must explain to the participant the importance of completing this screening and explain that the results of this screening could help provide further referrals and services to him. Refusal to sign the DFA-WVW-40 will not result in a sanction.

NOTE: If the participant fails to show up for the EHI and/or Learning Needs Screening, the Case Manager must attempt to have the participant complete them or sign the DFA-WVW-40 at the first opportunity.

Work-Eligible Individuals are referred for additional EHI screening(s) under the following conditions:

- The Case Manager becomes aware of changes in the participant's mental health condition which indicate that new or additional mental health issues may exist.
- The participant previously declined to complete the EHI but is now willing to complete the screening.

The Case Manager must notify the Assessment Specialist when participants are scheduled to complete the EHI only.

Results of the EHI must be scored and returned to the local Case Manager for follow-up with the participant. If the screening indicates a referral is needed in one or more of the areas listed on the scoring key, The Case Manager must go over the results with the participant. If indicated, the Case Manager must offer the participant a referral to the appropriate available mental health agency or professional for diagnosis and follow-up unless the participant is already receiving services from a mental health professional. A face-to-face meeting between the Case Manager and the participant is the preferred method of reviewing the EHI. If the participant declines a referral and/or follow-up services the Case Manager must record this in the eligibility system.

18.7.6.F Case Manager Follow-Up

When the test results are received, the Case Manager records the information in the eligibility system and schedules an interview with the participant as soon as possible to discuss the test results as appropriate. At this interview, the Case Manager may provide the participant with a copy of the test results.

Staff may contact the Department of Education Assessment Specialist for questions or help in evaluating the results of TABE, Learning Needs Screening, or Work Keys. Special attention should be paid to the recommendations made by the Assessment Specialist for possible referral

to programs and services. Recommendations by the Assessment Specialist must be addressed, and appropriate referrals made by the Case Manager.

18.7.6.G Referrals to the DRS

Referrals to the DRS may be considered when either mental or physical disabilities are indicated.

The Case Manager may make a referral to DRS if the psychological evaluation/report from the mental health professional indicates there is a disability and the participant indicates he is willing to work. This also applies to participants with physical disabilities who want to work.

18.7.6.H Referral to the Medical Review Team (MRT)

If the Case Manager and/or Supervisor is unable to make a determination as to the participant's ability to participate in work activities based on the medical documentation available, they must submit the case to the MRT. See Chapter 13.8.1. Any participant who has had good cause for not participating for more than six months, due to a doctor's statement, must be referred to the MRT.

An MRT referral is made for adults not Medicaid eligible who's EHI indicates a referral is needed. The MRT referral must be made after the results of the EHI have been discussed with the participant. The MRT will confirm if a referral is needed. This is necessary in order to refer the participant to a mental health professional for a diagnosis.

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

18.7.6.I Referrals to WorkForce West Virginia - Assessment Testing Results

Workforce Innovation and Opportunity Act (WIOA)-funded employment and training programs require that TABE, and if appropriate, Work Keys be completed by participants referred to and enrolled in those programs. Therefore, the Case Manager must schedule participants for the appropriate assessment testing whenever possible. Case Managers making referrals to WorkForce West Virginia must forward copies of participants' TABE scores and Work Keys (if

completed).

The release of information provided by the West Virginia Department of Education (DOE) Assessment Specialists at the time of the assessment testing (and filed in the WV WORKS record) authorizes the release of this information to the WorkForce West Virginia centers. Release of assessment testing results to other agencies when appropriate requires completion of the OFS- Release-1.

18.7.6.J Assessment Testing Participation/Support Service Payments

Assessment testing (Learning Needs Screening, EHI, TABE, and Work Keys) administered by the Assessment Specialist in the local office or other designated testing location counts as OW hours. Transportation support service payments may be made for assessment testing attendance/completion.

18.7.6.K Substance Abuse

If the participant indicates substance abuse problems, the Case Manager should make a referral for evaluation and counseling prior to scheduling assessment testing. Any determination of substance abuse problems is based on statements made by the participant, not on the feelings or perceptions of the Case Manager.

18.7.7 THE PRC AND DEVELOPMENT OF THE SSP

The PRC contains information and requirements applicable to all Work-Eligible Individuals.

The eligibility system allows for the recording and printing the SSP. Changes must be saved in the case management system.

The promotion of self-sufficiency is accomplished primarily through the use of the SSP. The SSP is completed during a negotiation between the Case Manager and the adult(s) and/or emancipated minor(s) in each AG or non-recipient Work-Eligible Individual. During the negotiation, the participant and his family must be encouraged to provide information about the participant's and his family's goals for becoming self-sufficient and the means by which the goals may be achieved. If the participant does not have defined self-sufficiency goals, the Case Manager must encourage him to consider such goals in consultation with his family before the

SSP is updated.

The Case Manager must explore all of the desires and work goals presented by the participant and his family to determine which are possible, which can be accomplished with the resources available to them and to the Department of Human Services (DOHS), which can be accomplished in an appropriate time and, ultimately, which is most likely to result in self-sufficiency for the participant and his family. In addition, the Case Manager must explore other possibilities not presented by the participant and offer these to the participant as alternatives. At all times, the Case Manager is expected to balance the participant's wishes with his need to achieve self-sufficiency and the DOHS's goal of meeting federally established participation rates.

The SSP outlines the objectives and the steps needed to achieve self-sufficiency, as well as a time frame for the completion of program requirements. Specific duties are required. All requirements listed on the SSP must be reasonable and appropriate for the participant.

The SSP is subject to renegotiation throughout the household's receipt of cash assistance. Initial and ongoing assessment produces information that allows the Case Manager to provide reasonable guidance to the participant to attain his goals and forms the basis of the SSP. When the participant requires smaller steps to meet his goal(s), a WV WORKS Goal Action Plan, DFA-SSP-1a, may be completed in addition to the SSP. The WV WORKS Goal Action Plan, DFA-SSP-1a must not be used without a completed Self-Sufficiency Plan, DFA-SSP-1.

The SSP must be specific enough to provide direction for the participant and must reflect careful analysis of the participant's needs and potential. It must also be flexible enough to change as opportunities and situations warrant. Changes in occupational goals or activities to meet the participant's work requirement require revisions to the SSP. Each time the SSP is revised on a paper form, the participant and the Case Manager must initial and date the changes. When a new SSP is completed, both must sign and date the form.

NOTE: See Chapter 1 for information about the PRC as an eligibility requirement and about completion of an initial SSP and the first full SSP.

The participant must be provided with a copy of the SSP each time a new one is completed, or a revision is made to an existing one.

It may be possible for the participant to achieve self-sufficiency without a document defining specific activities. However, clarifying goals and actions to reach the goals helps the participant and Case Manager to focus on the most appropriate actions. This makes their efforts more productive. Although the primary concern should be the development of a meaningful SSP, the form itself is helpful to the participant in understanding the expectations. Committing the plan to writing also helps the Case Manager be more specific about his responsibilities. By signing the PRC and SSP, each party agrees to fulfill his respective responsibilities.

18.7.8 PERIODIC SELF-SUFFICIENCY EVALUATION (PSSE) 12/24/36/48 MONTHS

After a participant has received WV WORKS for 12 months, 24 months, 36 months, or 48 months, periodic self-sufficiency evaluations are required to be conducted in either one of two ways:

- Face-to-face meeting with the participant; or
- A Supervisor/Case Manager meeting to review the case.

It is the decision of the WV WORKS Supervisor after a formal consultation with the WV WORKS Case Manager about whether or not a face-to-face meeting is required at the 12/24/36/48-month self-sufficiency evaluation point. At its discretion, the local office may choose to include the Community Services Manager (CSM) in any decision about a face-to-face meeting. At a minimum, the Supervisor and Case Manager must meet and review the case; discuss the participant's progress, barriers, and other issues affecting the family's self-sufficiency; make necessary recommendations' and arrange appropriate referrals to other agencies and services as needed.

The Case Manager must arrange an office visit or home visit with the participant if the assessment and/or SSP forms need to be updated as a result of the 12/24/36/48-month evaluation meeting with the Supervisor. The Bridge to Stronger Families, DFA-WVW-Bridge, must be updated during these meetings. A full case recording must be made in comments with details of the face-to-face meeting or Supervisor/Case Manager consultation and recommendations from these 12/24/36/48-month evaluation. The DFA-WVW-CCG-2 must also be reviewed and updated during these meetings. Periodic Self- Sufficiency Evaluation Form (DFA-PSSE), an optional form, can be used at each evaluation.

NOTE: Failure, without good cause, of the participant to attend or otherwise cooperate in the scheduled evaluations results in application of a sanction only when a face-to-face meeting is scheduled. It is suggested that the evaluations be listed specifically on the SSP to avoid questions about notification of the requirement. However, the general statement on the SSP form about keeping all appointments will usually serve for application of a sanction.

18.7.8.A 12-Month PSSE

After a participant has received WV WORKS for 12 months, a self-sufficiency evaluation must be conducted as described above. If a face-to-face meeting is chosen, the evaluation must

include all Work-Eligible adults or emancipated minors in the household to evaluate the effectiveness of the self-sufficiency plan and to develop a new plan as needed.

The meeting must occur during the 12th or 13th month of receipt of WV WORKS benefits. The purpose of this meeting is to complete a mandatory case staffing which must include the participant, other parent in the household (even if the other parent is excluded from the AG), the Case Manager, the Supervisor, other DOHS staff as needed, any community resource person(s) directly working with the participant, and a representative of the participant's choosing.

At this meeting, any additional barriers to self-sufficiency should be identified and solutions to overcome those barriers explored. The participant should be encouraged to make decisions regarding those barriers and the solutions. At this meeting, the Case Manager must review the SSP and DFA-WVW-3A must be reviewed and updated as needed. The SSP must be printed for the updates to be saved and for the eligibility system generated report to be updated.

Any initial doctor's statement that indicates the participant is disabled longer than six months must result in a referral to the MRT. If the Case Manager receives a medical statement indicating the participant is disabled six months or less, an MRT referral must be made if the participant is still claiming he is disabled at the time the statement expires. Staff must not wait until the 24 months PSSE to refer an individual to the MRT. This should be done any time the participant claims a disability lasting longer than six months from the application date forward.

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.

18.7.8.B 24-Month PSSE

A face-to-face evaluation or Supervisor/Case Manager meeting to review the case must be completed during the 24th or 25th month of receipt of WV WORKS following the same procedure as the 12-month evaluation.

NOTE: If the requirements in Section 14.9.1.E regarding submitting a MRT application are not met by this time, it must be completed as necessary during the 24 month evaluation.

18.7.8.C 36-Month PSSE

Another face-to-face evaluation or Supervisor/Case Manager meeting to review the case must be completed after the participant has received WV WORKS for 36 months.

This evaluation must occur during the 36th or 37th month of WV WORKS receipt. It will serve the same purpose and follow the same pattern as the 12- and 24-month evaluations. The 36-month meeting must also include the CSM or his designee.

18.7.8.D 48-Month PSSE

An additional face-to-face evaluation or Supervisor/Case Manager meeting to review the case must be completed after the participant has received WV WORKS for 48 months. This evaluation must occur during the 48th or 49th month of receipt. It follows the same pattern as the 36-month evaluation.

18.7.8.E PSSE Exceptions

When an AG is receiving Employment Assistance Program (EAP), the 12/24/36/48-month evaluations are not required as long as the participant remains employed.

When an AG is closed prior to the 12th, 24th, 36th or 48th month and reapplies in the month an evaluation would normally be due, the evaluation is not completed prior to approval. Instead, the AG will be evaluated at the next scheduled interval that is three or more months in the future. This also applies when the AG is closed in the 12th, 24th, 36th or 48th month before the evaluation takes place. The Supervisor may decide on a case-by-case basis that the evaluation that is due in the month of application or within three months of that date needs to be completed.

NOTE: When a parent included in the AG resides with a non-recipient Work-Eligible Individual, both must attend the 12th, 24th, 36th, and 48th month evaluation meetings.

> **PSSE Exception Example 1:** An AG is closed effective August when the father finds full-time employment. He gets laid off at the end of September and reapplies for WV WORKS in October. The AG is due for a 24-month evaluation in October, but it is postponed until the 36th month because it is the next evaluation interval that is three or more months ahead.
>
> **PSSE Exception Example 2:** An AG is due for its 48-month evaluation in November 2016, but the AG is closed effective November before the evaluation

takes place. The AG reapplies in February 2017. The Case Manager does not back up and complete the missed 48-month evaluation. Instead, the 55th month case review is the next required contact. See Section 18.2.4 for information regarding the 55th month case review.

18.7.9 JOB DEVELOPMENT

Job development and the subsequent placement of Work-Eligible participants in employment are the primary focus of WV WORKS. The WV WORKS staff is expected to be visible in the community and participate in various employment-related activities and initiatives. The WV WORKS staff is expected to relate to private employers and related organizations professionally, honestly, and with integrity.

Job development and placement efforts must be coordinated closely with the local WorkForce West Virginia office. As appropriate, Work-Eligible participants are required to register with WorkForce West Virginia and to keep their applications current. To increase the resources available to the participant, contacts are established and maintained with DRS, Department of Education, Community Action Agencies, and other public and private organizations which could offer activities or support.

18.7.10 CHILD CARE REFERRAL

Childcare must be made available to any Work-Eligible participant who needs it in order to accept employment or to participate in another work activity. The participant must be referred to the appropriate Resource and Referral agency. Childcare must be arranged before placement.

18.7.11 MENTORING

When the Case Manager and the Work-Eligible Individual agree that the participant could benefit from a mentor for counseling and guidance, the participant may be assigned to a mentor. Mentoring may be accomplished by assigning a mentor to work individually with one or more participants. In addition, a mentor or team of two or more mentors may provide assistance to one or a group of participants. The method selected is based on the participant's needs and the resources available.

Being a mentor does not allow access to or knowledge of confidential information about the participant. The Case Manager must obtain the participant's written permission prior to providing such information to the mentor. A general waiver allowing information to be shared with the mentor is not sufficient; a waiver is required for each piece of information shared or one waiver may identify each piece of information. The participant may provide any personal or confidential information to the mentor that he chooses.

A mentor must:

- Be gainfully employed or retired from gainful employment;
- Have sufficient time available to provide guidance for the participant;
- Set the boundaries of the relationship, so that the participant is guided by, but not dependent upon, the mentor;
- Consult frequently with the Case Manager about guidance provided to the participant;
- Notify the Case Manager immediately upon deciding to terminate the relationship with the participant; and,
- Adhere to the DOHS's standards of confidentiality regarding case record information.

Being a mentor may include:

- Counseling and guidance in decision making;
- Handling crises;
- Providing reminders to keep medical appointments;
- Providing assistance in accessing resources;
- Arranging transportation;
- Arranging child or elder care;
- Providing emergency child or elder care;
- Planning so that household tasks are done in spite of work schedules and children;
- Improving employability;
- Learning to shop wisely;
- Planning meals; and,
- Providing guidance related to any other aspects of the participant's life that can lead him toward self-sufficiency.

A mentor must not:

- Be a relative or married to a relative of the participant;
- Have a relationship with the participant prior to becoming a mentor;

- Have a physically intimate relationship with the participant; or,
- Loan or give the participant money.

Mentoring may be particularly beneficial to minor parents or other young parents.

18.7.12 COURT FEES

When court fees are required for the appointment of a committee, the full amount of the court costs, excluding attorney fees, may be paid on a one-time-only basis.

Upon receipt of a written notification from the County Clerk's office, the Case Manager issues the supplemental payment.

18.7.13 SEXUAL HARASSMENT AND DOMESTIC VIOLENCE, SEXUAL ASSAULT, AND STALKING

The Case Manager must inform each applicant/program participant of the availability of services related to prevention of sexual harassment and domestic violence, sexual assault, and stalking. To protect the abused person when the information is offered to more than one adult or emancipated minor in the family at the same time, it must be stressed that the Case Manager is required to provide the information to all participants. The instructions about sexual harassment and domestic violence, sexual assault, and stalking assistance in Sections 1.2.3.E and 1.5 must be followed.

18.7.14 WV WORKS VEHICLE PROGRAM

The purpose of the WV WORKS Vehicle Program is to assist in eliminating transportation as a barrier to participation by providing the participant with an opportunity to obtain and own a vehicle. The Case Manager initiates the process by referring appropriate participants to the WV WORKS Vehicle Program. Supervisor approval is required.

The vendor also offers a driver’s education component, and a vehicle to be used to complete the road test.

18.7.14.A Appropriate Referrals

WV WORKS Work-Eligible Individuals and those eligible for continued support service payments may be referred. The following requirements must be met when determining an appropriate referral:

- Possession of a valid West Virginia driver's license; and
- The unavailability of public transportation; this includes but is not limited to:
    - The public transportation schedule and proximity to the residence
    - Childcare
    - Work or educational activities; and
- No road-worthy vehicle, or two-parent household when another vehicle is necessary; and
- The need to meet a work activity or continue employment; and
- No criminal driving record. This includes, but is not limited to, a DUI conviction in the past 3 years, a hit and run or flight to avoid arrest. Participants who have completed a State-approved driving class and have had their licenses restored may be referred; and
- Verification of proof of vehicle liability insurance; and
- An agreement to pay the vendor $1 for the appropriate donated vehicle.

Participation in any WV WORKS Vehicle Program is limited to once per individual in a lifetime. Extenuating circumstances may be sent to the DFA Family Support Policy Unit for special consideration. If a household contains two parents and two vehicles are required, each may be referred to the program. Once the recipient receives the donated vehicle, it may not be exchanged for a different donated vehicle for any reason.

The participant must be a Work-Eligible Individual in an active WV WORKS case or eligible for a transitional benefit option at the time of referral. When the referral for a donated vehicle is made near the end of a transitional benefit period, the receipt of the vehicle must still occur even if the participant's transitional benefit period has ended. Any referrals made should still receive a vehicle unless the participant has obtained a vehicle from another source, they are no longer a WV resident, or have been sanctioned for a reason other than lack of transportation. The participant must not be penalized due to the response time of the vendor.

If the participant already has a vehicle(s) registered in his name, he must provide documentation that:

- The vehicle(s) is junked; or

- The cost of repairs exceeds the limit specified in Section 18.19; or
- The other parent needs the vehicle for employment or to participate in an activity.

For the driver's education component, or a vehicle to be used to complete the road test, the participant must have an instruction permit prior to being referred. The vendor will meet the participant at the agreed upon location or the participant's home in an identifiable vehicle. Referrals for these programs are made using the DFA-CARS-1 and may also be made for Caretakers.

18.7.14.B Appropriate Referrals for Caretakers

The caretaker relative or child only case must meet all the requirements of the section above except for being a work-eligible individual. Caretakers are not required to be employed or attending any activity listed in IMM 18.9-18.18 in order to receive a referral for a donated vehicle. The vehicle must be needed to assist with the children in their care. All work-eligible individuals are considered for donated vehicles referrals first. Only when all work-eligible individuals have been considered and eligible individuals have been referred and there are vehicles remaining, then a caretaker relative may be referred for a donated vehicle. Caretaker involvement with Children and Adult Services is not required for a referral for a donated vehicle.

The referral process and vendor responsibilities are the same as work-eligible individuals below.

18.7.14.C Referral Process

Referrals to the WV WORKS Donated Vehicle Program vendor are made using form DFA-CARS-1 and must include a copy of the participant's driver's license or Division of Motor Vehicles (DMV) printout. The form is self-explanatory and all requested information on the form is mandatory.

When the vendor notifies the Case Manager of approval or denial for participation in the program, the Case Manager must record the appropriate information in the eligibility system. If the vendor notifies the Case Manager that the participant is not a suitable candidate for the program, the vendor must provide a written explanation.

18.7.14.D Vendor Responsibilities

Upon receipt of the DFA-CARS-1, the vendor completes an evaluation process with the participant, and if the participant is determined eligible, the vendor completes the transfer of a roadworthy vehicle to the participant within a reasonable time frame after receipt of the completed referral. The vehicle will be under a mandatory 30-day warranty period as required under State law. Once the warranty period has expired or is voided, supportive services may be used, if otherwise eligible.

18.7.15 VISION AND/OR DENTAL SERVICES

Providing dental and vision services are a cooperative effort between the WV WORKS Program and the Office of Maternal, Child and Family Health (OMCFH).

Referrals must still be made for dental services even if the recipient has medical coverage. Receipt of Medicaid has no bearing on referrals for dental services.

Caretakers may receive a dental and/or vision referral if they are employed or are seeking employment.

Recipients of SSI may be referred to a separate program available through OMCFH for dental assistance only.

The WV WORKS staff's responsibility is limited to:

- Completion of form DFA-R-1 to refer Work-Eligible Individuals to OMCFH;
- Certifying that the participant is eligible to receive vision and/or dental services; and
- Explaining to the participant the importance of keeping his scheduled appointments and the deadline for obtaining services.

Referrals for both dental and vision services are made on a single form, the DFA-R-1, Pre-Employment Services Project Referral. The distribution of the color copies is shown on the bottom of the form. The Case Manager must ensure that the bottom copy of the referral form is legible when the form is completed. If it is not, the Case Manager must write over the information on the bottom copy and scan into the case record.

The referral for vision/dental services is time limited. Services must be completed within one year of the referral date shown on the DFA-R-1. The Case Manager must enter the date (mm/dd/yy) on the form at the time the referral is made. Distribution of copies of the form in a timely manner is crucial. The Case Manager must check to ensure a referral has not been made within the last year. If one has been made within the last year, a copy of the previous referral is given with current balances updated. No new referral form is given.

The Case Manager must also enter the amount of the maximum dental service on an initial

referral. This amount is $5,000 and is shown as the balance following Dental Services. Vision Services are limited to an exam, one pair of frames, and lenses for the first year, and an exam and lenses every other year following.

After a referral expires, the Case Manager may issue the participant another one, provided the participant meets eligibility criteria as explained below and has not received the maximum allowable benefit. On a second or subsequent referral for dental services, regardless of the date of the first referral, the Case Manager must obtain the amount of the remaining balance by contacting OMCFH and. enter it on the DFA-R-1. Vision referrals may be made annually for qualified individuals.

OMCFH has signed agreements with service sites which detail the allowable services, reimbursements, scope of services, etc. In addition, OMCFH will provide a list of all providers to the appropriate county. The participant may choose his own provider from this list and must make his own appointments.

There is a maximum lifetime limit on the payment for these services. This limit is monitored by OFMCH. Closure of the vision and/or dental services case by OFMCH occurs when services are completed, or the maximum allowable benefit is reached. An appropriate notice is sent to the local office to file in the case record.

To be eligible to receive vision and/or dental services, the participant must be in either of the two following groups, described below.

18.7.15.A Participating

To qualify based on participation in an activity, the participant must meet both of the following requirements:

- The participant must be a Work-Eligible Individual in an active WV WORKS case, Poverty Level (PL) period, or EAP participant, when the referral is made. Receipt of Diversionary Cash Assistance (DCA) does not qualify the individual for these services. Once the referral is made, it is valid for one year whether or not the WV WORKS case remains open or is sanctioned; and
- The individual is participating in an activity listed in Sections 18.10 through Section 18.18. The participation rate required to qualify for these services is the rate shown on the individual's SSP.

18.7.15.B Sole Barrier to Participation

When the sole barrier to the participant's participation in a work activity listed in Section 18.9 is the need for vision and/or dental services, a referral may be made. Once the referral is made, it is valid for one year, whether or not the WV WORKS case remains open or is sanctioned.

18.7.16 LEGAL AID OF WV (LAWV) WV WORKS LEGAL SUPPORT PROJECT

The purpose of the WV WORKS Legal Support Project is to assist in eliminating the need for legal services as a barrier to work or self-sufficiency.

18.7.16.A Appropriate Referrals

Work-Eligible Individuals in an active WV WORKS case and those eligible for continued support service payments may be referred for legal matters including, but not limited to:

- Obtaining Supplemental Security Income (SSI) or Retirement, Survivors, and Disability Insurance (RSDI);
- Issues surrounding sexual harassment and domestic violence, sexual assault, and stalking situations;
- Employment related rights;
- Housing (landlord-tenant issues);
- Visitation orders or parenting plan compliance;
- Expungement of criminal records; or
- Driver's license suspension or fines.

NOTE: LAWV does not pay fines or fees.

If the Case Manager has questions regarding other possible services, he should contact LAWV at 304-343-3013 or 1-866-255-4370.

Child-only TANF cases with legal obstacles may also be referred for legal matters including, but not limited to:

- Obstacles to work;
- Obstacles to self-sufficiency; or
- Legal issues involving child safety and welfare.

18.7.16.B Referral Process

Referrals to the WV WORKS Legal Support Project are made by using the Referral to Legal Service Provider Referral Form located on the DFA Intranet site. The form is self-explanatory and all requested information on the form is mandatory. The Case Manager must fax, email, or mail the Legal Service Provider Referral Form to:

Legal Aid of West Virginia
123 Washington Street, West Suite 101
Charleston, WV 25302
Fax: (304) 345-5934

18.7.16.C Vendor Responsibilities

LAWV will fax an Action Form to the local office within 30 working days of receiving the referral. When the vendor notifies the Case Manager of approval or denial for participation in the program, the Case Manager must record the appropriate information in the eligibility system. LAWV will be responsible for determining the level of representation and services rendered.

NOTE: At no time shall any participant be sanctioned for failure or refusal to comply with or accept legal support services.

18.7.17 COMMUNITY AND TECHNICAL COLLEGE PROJECT

The Community and Technical College Project places a Student Service Specialist at each West Virginia Community & Technical College (WVCTC). The primary goal of the Student Service Specialist at each WVCTC is to help students successfully navigate the enrollment process, find and select an appropriate higher education academic program, and to offer ongoing support of those students. The secondary goal is to help these same students make a successful transition into the workforce and/or continued post-secondary education.

18.7.17.A Appropriate Referrals

Work-Eligible Individuals in an active WV WORKS case must have a high school diploma or equivalent to be referred to the Student Service Specialist, even when the WVCTC does not require this for admission. Receipt of EAP, PL, or DCA does not qualify the individual for this service. The goal of the referred participant must be employment in an occupation that requires

completion of a WVCTC program of study.

First priority for available slots should be given to any WV WORKS participant who is currently enrolled and attending the WVCTC. Once the participant is no longer enrolled, attending, or has made unsatisfactory progress at the WVCTC, the slot is opened, and a new referral may be sent. If the participant later re-enrolls, a new referral may be made as long as slots are available. It is recommended the Case Manager include a requirement for the participant to contact the Student Service Specialist a minimum of twice per month on the SSP. At no time shall any participant be sanctioned for failure or refusal to comply with or accept a referral to the Student Service Specialist.

18.7.17.B Referral Process

Referrals to the WVCTC are made by using the DFA-WVW-70 Form. The Case Manager must fax or scan the DFA-WVW-70 to the Student Service Specialist. The WVCTC may also require additional releases of information under the Family Educational Rights and Privacy Act (FERPA) and those should also be submitted to the Student Service Specialist.

18.7.17.C Participation and Supportive Services

Participation for this activity is coded and reported per Sections 18.10 - 18.18. All supportive services available for these activities are available to participants in the WVCTC project. Additional support services for challenges faced by participants in the WVCTC project must be sent to the DFA for consideration of payment approval.

18.7.17.D Vendor Responsibilities

The Student Service Specialist will assist with:

- Completion of the application for admission to the WVCTC, the Free Application for Federal Student Aid (FAFSA), and any other grant or scholarship for which the student may qualify.
- Completion of Boot Camp and with connecting the student with appropriate study skills, test taking strategies, time management, and organization needed to successfully complete the academic program.

- Connecting the student with supportive services offered through the DOHS or other agencies as needed to overcome barriers to program completion.
- Monitor class attendance and ensure signed participant time sheets are submitted by the fifth of each month to the local DOHS.

18.7.18 SUBSTANCE ABUSE TESTING AND REFERRAL

All adult and emancipated minor applicants who would be included in the WV WORKS Assistance Group (AG) and non-recipient work-eligible individuals must complete a Drug Use Questionnaire, DFA-WVW-DAST-1, or are ineligible for this benefit. An applicant for these purposes means any individual who has not received WV WORKS for a full calendar month. Receipt of EAP's is considered a supportive service payment and is not considered WV WORKS payment for this purpose. This questionnaire must be completed within ten business days of the initial contact showing interest in applying for this benefit in addition to all other eligibility requirements. Any applicant who provides false information on the Drug Use Questionnaire is ineligible for WV WORKS assistance for 12 months. The false information must be from evidence and not hearsay. Any individual who scores one or more points or answers "Yes" to question eleven must be referred for drug testing; all other applicants are treated in the same manner as any other WV WORKS applicant. Responses of N/A on the DFA-WVW-DAST-1 are not counted as a point and must not be used towards the total points.

NOTE Question eleven: "Have you been convicted of a drug-related offense within the last three years?" refers to felonies and misdemeanors.

The cost of the initial drug test is not the responsibility of the applicant. The Drug Use Questionnaire is the only method which may be used to determine reasonable suspicion for drug use.

The Case Manager must add any individual who answers "Yes" to question eleven and who has a negative drug test to the WV WORKS AG. These individuals are added retroactive to the date of application for WV WORKS.

18.7.18.A Drug Testing

Individuals who have been determined to have reasonable suspicion for drug use must register

for drug testing within two business days. The Case Manager must give a Chain of Custody Form to the applicant with the case number entered and this form must be taken to the testing site. Should unforeseen circumstances prevent the applicant from registering for drug testing within two business days, the Case Manager may allow additional time.

Drug test results from Children and Adult Services are also accepted when the test was completed within seven working days of the WV WORKS application date.

Negative results will be posted to the county's account on the vendor's website. When the results of the drug testing are negative, no further action is needed by the participant. He is then treated in the same manner as any other WV WORKS participant. Positive results are emailed directly to the county contact person and are not posted online. Once drug testing results are received, WV WORKS benefits are approved retroactive to the date of application for WV WORKS.

18.7.18.A.1 Applicant Disagrees with Results

When the results of any drug testing are positive and the individual does not agree with those results, the individual can:

- Provide a valid prescription, current prescription bottle, or written verification by a health care provider authorized to prescribe the controlled substance to the address listed on the chain of custody form within 24 hours of the positive test. Applicants should be encouraged to provide this verification when completing the drug test. Once a valid prescription is presented, the vendor will update the results to negative. When a valid prescription is not presented, the positive results will stand; or
- Request retesting using the same drug panel at an alternative site at his own expense. The alternative site must be comparable to the approved vendor and must not be the applicant's primary physician. Retesting must be completed within two business days of the positive result. When the results of the drug re-testing are negative, no further action is needed by the participant.

These individuals are then treated in the same manner as any other WV WORKS participant.

18.7.18.B First Positive Drug Testing Result

All positive drug testing results require the Case Manager to refer the individual to a substance

abuse treatment and counseling program and a job skills program. The participant must enroll in the substance abuse treatment and counseling program and the job skills program within seven business days. Should unforeseen circumstances prevent the applicant from enrolling in a treatment and counseling program within seven business days, the Case Manager may allow additional time to enroll.

If the individual fails to complete or refuses to participate in the substance abuse treatment and counseling program and job skills program as required, he is ineligible for WV WORKS. They are considered a non-recipient work-eligible individual and must choose a protective payee for the WV Works payment for the other members of the WV Works AG. This ineligibility will continue until the time the individual enrolls and is successfully attending a substance abuse treatment and counseling program and job skills program. Once he can document successful completion, he may reapply for these benefits six months after the completion and must submit to random drug testing.

Upon completion of the substance abuse treatment and counseling program and job skills program, the individual is subject to a random post-treatment drug test. These individuals are then treated in the same manner as any other WV WORKS participant.

The protective payee must satisfactorily complete the Drug Use Questionnaire within seven business days of this choice and is chosen by the parent. When there are two parents in the home, the second parent may be the payee if the Drug Use Questionnaire was successfully completed. The second parent is not required to complete a Protective Payee Verification. The designated person shall be an immediate family member, or if an immediate family member is not available or declines the option, another person may be designated. The protective payee must submit a form monthly, DFA-WVW-Verif-2, documenting how the benefits were spent. See 18.7.18.E.

Job readiness classes in existence throughout the state will be the skills programs these individuals are required to attend.

18.7.18.C Second Positive Drug Testing Result

Any individual who tests positive after a second drug test will be required to participate in a second substance abuse treatment and counseling program and job skills program. The participant must enroll in the substance abuse treatment and counseling program and the job skills program within seven business days. Should unforeseen circumstances prevent the applicant from enrolling in a treatment and counseling program within seven business days, the Case Manager may allow additional time to enroll.

These individuals will be ineligible for WV WORKS for a period of 12 months or until they have

completed a substance abuse treatment and counseling program and job skills program, whichever is shorter. The 12-month period of ineligibility is the current month plus the 11 previous months.

If the individual fails to complete or refuses to participate in the substance abuse treatment and counseling program and job skills program as required, he is ineligible for WV WORKS. They are considered a non-recipient work-eligible individual and must choose a protective payee for the WV Works payment for the other members of the WV Works AG. This ineligibility will continue until the time the individual enrolls and is successfully attending a substance abuse treatment and counseling program and job skills program.

Upon completion of the substance abuse treatment and counseling program and job skills program, the individual is subject to a random post-treatment drug test. During the period of ineligibility due to the second positive drug test, he is considered a non-recipient work-eligible individual and must choose a protective payee for the WV WORKS payment for the other members of the WV WORKS AG.

The protective payee must satisfactorily complete the Drug Use Questionnaire within seven business days of this choice and is chosen by the parent. When there are two parents in the home, the second parent may be the payee if the Drug Use Questionnaire was successfully completed. The second parent is not required to complete a Protective Payee Verification. The designated person shall be an immediate family member, or if an immediate family member is not available or declines the option, another person may be designated. The protective payee must submit a form monthly, DFA-WVW-Verif-2, documenting how the benefits were spent. See 18.7.18.E.

Once the period of ineligibility has ended, these individuals are then treated in the same manner as any other WV WORKS participant.

18.7.18.D Third Positive Drug Testing Result

Any individual who tests positive for a third drug test is permanently ineligible for WV WORKS. They are considered a non-recipient work-eligible individual and must choose a protective payee for the WV WORKS payment for the other members of the WV WORKS AG.

The protective payee must satisfactorily complete the Drug Use Questionnaire within seven business days of this choice and is chosen by the parent. When there are two parents in the home, the second parent may be the payee if the Drug Use Questionnaire was successfully completed. The protective payee shall be an immediate family member, or if an immediate family member is not available or declines the option, another person may be designated. The protective payee must submit a form monthly, DFA-WVW-Verif-2, documenting how the benefits

were spent. See 18.7.18.E

18.7.18.E Protective Payee for a Positive Drug Test

The primary person must choose a designated person as a protective payee to receive WV WORKS for the other members of the AG, when the applicant refuses to complete the Drug Use Questionnaire or after a second or third positive drug test.

The protective payee may be an immediate family member, or any other person designated by the client. This individual must satisfactorily complete the Drug Use Questionnaire, DFA-WVW-DAST-1. When there are two parents in the home, the second parent may be the payee if the Drug Use Questionnaire was successfully completed. The second parent is not required to complete a Protective Payee Verification.

The protective payee must submit the Protective Payee Verification, DFA-WVW-VERIF-2, monthly documenting how the WV WORKS benefits were spent.

When the DFA-WVW-VERIF-2 has not been returned by the protective payee by the 5th of the following month, an attempt must be made to contact the protective payee and the WV WORKS participant to obtain the form. A good cause appointment must be scheduled for both the protective payee and the WV WORKS participant. If the protective payee returns to completes the DFA-WVW-VERIF-2 form, then no other action is needed, and the WV WORKS benefit remains open. When the good cause appointment is not kept or the DFA-WVW-VERIF-2 has not been completed, the WV WORKS participant will have 10 days from the date of the scheduled good cause appointment to choose another protective payee. The new protective payee must successfully complete the Drug Use Questionnaire. If a new protective payee has not been chosen within the 10 days, the WVW Benefit will be closed and a reapplication will be needed for the following month.

18.7.18.F Required Referral to Children and Adult Services

The following individuals require a referral to Children and Adult Services by calling the Child Abuse Hotline in addition to the above requirements:

- Any individual who refuses to submit to drug testing as a result of a drug use questionnaire.
- Any individual who fails to complete or refuses to participate in substance abuse treatment and counseling program and job skills program as required; or

- Any individual who has had their benefits suspended and has not designated a protective payee or whose benefits have been terminated due to a failed drug test.

The Case Manager must make a comment only that a referral has been made.

18.8 REQUIREMENT FOR BEING ENGAGED IN WORK

18.8.1 WORK PARTICIPATION AS AN ELIGIBILITY REQUIREMENT

WV WORKS is a work participation program. Starting on the first day that WV WORKS benefits are received, a Work-Eligible Individual is subject to the work requirement. Therefore, the participant must be placed in a work activity as soon as possible. This placement should occur when the benefit is approved, concurrently with the initial assessment of the participant's skill, prior work experience, and determination of employability.

18.8.1.A Job Ready

Job readiness is defined as being able to find, acquire, and keep a job or attend an activity with little or no outside help.

When the Case Manager determines that the participant is ready to participate at application, he approves the application, enrolls the participant, requests any necessary support payments, and makes any necessary referrals. The participant and Case Manager must develop a plan that is based on the participant's interests, needs and abilities.

The activities in which the participant may be enrolled are outlined in Sections 18.10 - 18.18.

If the participant initially has good cause for not participating, or has challenges which must be first addressed, he is temporarily excused from participating. See Good Cause below.

18.8.1.B Good Cause

An individual who has applied and is approved for WV WORKS benefits must have good cause for not participating in a work activity no later than the end of the second month of benefit receipt or is ineligible. If the participant is determined to have good cause, the situation must be reviewed and documented monthly.

When the participant initially has a documented good cause for not participating, or has challenges which must be first addressed, he is temporarily excused from participating. The Case Manager approves the benefit, enrolls the individual in the appropriate component, and makes any referrals needed to overcome the exemption or good cause reason.

See Sections 14.7 and 14.9 for temporary exemptions and good cause. See Section 18.7.2 for Other Work Activities.

The Case Manager closes the WV Works benefit by the end of the second month of benefit receipt when the initial home visit has been scheduled, attempted and documented; and the WV Works recipient has:

- Not verified the good cause reason, or
- Is not engaged in a work activity

Upon reapplication after closure for this reason, the participant will be evaluated for appropriate placement, if good cause does not exist.

> **Work Participation Example 1:** Mr. Spruce applies for WV WORKS benefits for himself and his two children on August 2. He completes the application, orientation, and initial Personal Responsibility Contract (PRC) and SSP on August 6 and the case is confirmed on August 6. The Case Manager determines Mr. Spruce needs to arrange childcare. Mr. Spruce states that his mother will provide childcare for his children while he completes his activity. He is given two working days to arrange for childcare and he is assigned to begin a Community Work Experience Program (CWEP) activity on August 8. On the first day of his scheduled placement, his Case Manager contacts the CWEP sponsor and finds that he did not report for his placement.
>
> The Case Manager schedules a good cause interview for August 19. The Case Manager continues to follow up with the sponsor and determines Mr. Spruce failed to report. Mr. Spruce comes in for his good cause interview and states his son had a cold and he chose to stay home with him. Since the grandmother was available to provide care and he failed to contact the sponsor or his Case Manager regarding his absence, and there is no verification of the illness, he is determined not to have good cause. The advance notice requirements apply, and his WV WORKS benefit is closed.
>
> **Work Participation Example 2:** Ms. Lilac, a Work-Eligible Individual, applies for WV WORKS on January 3. The PRC, SSP, orientation, and application are completed on January 10. The benefits are confirmed and backdated to January 3. Ms. Lilac shows up for her placement on January 14 and January 15, but then

fails to report again. A good cause appointment is scheduled for January 26. Ms. Lilac fails to keep the good cause appointment and the WV WORKS benefit is closed. Since the good cause letter was requested by the Case Manager after adverse action deadline, February benefits are issued. Ms. Lilac receives a closure notice and comes in to reapply on February 5. She goes to the placement as scheduled beginning February 7. Because Ms. Lilac has already received February benefits, the Case Manager has time to check on her progress and ensure she is attending the activity before March benefits are approved. If she fails to participate and complete her assigned hours, the benefits are not approved for March.

Work Participation Requirement Example 3: Ms. Tulip, a 19-year-old single parent with one child, applies for WV WORKS on September 26. She completes her application, orientation, SSP, and PRC on October 3 and opts not to receive benefits for September. She completes the assessment process and she has not graduated from high school. The only transportation available is a neighbor who has agreed to transport her to the library once a week so she can work on her high school equivalency diploma. She can attend the class once a week for six hours.

She is scheduled to this activity for six hours a week. Although this activity does not meet the federal requirements for her work participation hours, she is assigned to this activity because she has good cause for not meeting her required hours. She must attend this activity by November 1 or she is ineligible for WV WORKS. Her transportation issues must be reviewed monthly until the situation is resolved and she can meet her full participation requirement.

18.8.2 WORK PARTICIPATION AS AN ELIGIBILITY REQUIREMENT AT 24 MONTHS OF BENEFIT RECEIPT

All work-eligible parents or caretakers whose households are receiving WV WORKS cash assistance are required to participate in a work activity when the participant is ready to engage

NOTE: The five-hour requirement that applies to 24-month limit cases does not apply to applicants who have received less than 24 months of WV WORKS benefits. If a participant demonstrates good cause for not meeting his work requirement, the situation must be re-evaluated monthly. If he does not continue to have good cause for not meeting his participation hours, he must be assigned to an activity and meet his required participation hours or the sanction process begins.

in work, or when the participant has received program benefits for 24 months, whichever is earlier. When a participant has received 24 months of WV WORKS benefits, being engaged in work is an eligibility requirement. The months of WV WORKS benefits do not have to be consecutive. Work, for the purpose of meeting the 24-month limit, is defined as participation in one or more activities for a minimum of five hours per week (averaged).

The activities in which the parent or caretaker may participate and be considered engaged in work include, but are not limited to, the following:

- Unsubsidized employment;
- Subsidized public or private sector employment;
- Job Search and Job Readiness Assistance;
- On-The-Job Training (OJT) programs, such as Employer Incentive Program (EIP) contracts, may be utilized as long as the participant is assigned a number of hours that will meet his participation requirements;
- Community Work Experience, such as Joint Opportunities for Independence Program (JOIN), CWEP, or other work experience programs available in the community;
- Community Service programs are those structured programs in which WV WORKS participants perform work that provides a direct benefit for the community and are supervised directly by a community agency;
- Provision of child care for another TANF recipient engaged in a Community Service activity; or
- Enrollment in any educational activity including high school, high school equivalency training, college, technical or vocational school, or job skills training.

NOTE: Although the 60-month lifetime limit normally does not apply to a non-recipient Work-Eligible parent, if another parent is included in the assistance group (AG), the time limit applies to the adult AG members. The 24-month work requirement may be met by one or both parents, including any non-recipient parent in the household.

Any activity must be structured so that documentation is possible. A combination of these activities may be utilized to meet the participation requirements.

Good cause for not being engaged in work which meets the above definition at the end of the

NOTE: The WV WORKS benefit is not stopped and no notice of pending closure is sent for failure to meet the 24-month work requirement without first completing the evaluation procedure outlined below.

24-month limit is determined according to the criteria in Section 14.9. Participants are not automatically exempt from the five-hour per week participation requirement due to being in one of the exemption components in Section 14.7. Good cause must be reviewed monthly and documentation is required.

The procedure to follow prior to notification of AG closure is as follows:

Step 1: The Case Manager must conduct a home visit to discuss the 24-month work requirement, explain the consequences of failing to meet this requirement and to gather information described below. An office visit or telephone call cannot be substituted for the home visit.

NOTE: SNAP and Medicaid eligibility must be evaluated separately, based on the policy of those programs.

Step 2: After the home visit, the Case Manager and/or Supervisor must file a written report in the case record and a detailed recording about the circumstances surrounding AG closure. This report must contain, at a minimum, the following information. Any other information deemed appropriate should be included.

- Case name, case number, county of residence, address, telephone number
- Number of parents and number of children in the home
- Number of office visits in the past 12 months
- Number of home/work site visits in the past 12 months
- Number of referrals provided to the AG for help in finding their own placement(s) of five hours or more, and date(s) of those referrals
- Number of sanctions that have been or are currently being imposed and information about sanctions still pending
- Whether or not the participant met his work participation requirement in any of the past 12 months, and if so, which months and why the participation ended
- Any special or unusual circumstances in the family
- Case Manager and/or Supervisor decision, including reason, about whether or not the family should continue to be eligible beyond 24 months without meeting the minimum five-hour work requirement.

Step 3: If the decision is to close the WV WORKS AG, the appropriate notice procedures are followed.

When the case is closed due to failure to meet the work requirement at the end of the 24-month limit, the parent or caretaker must actually be engaged in work, according to the above definition, prior to approval for the 25th month. See Section 1.5, to determine the beginning date of eligibility when the participant reapplies after losing eligibility because the 24-month work requirement was not met.

EXCEPTION: A parent with a newborn child has good cause while the child is less than 12 weeks of age for failure to meet the 24-month work requirement.

When the AG is closed at or after the end of 24 months for some reason other than failure to meet the 24-month work requirement, and a reapplication is made, the AG must be approved, if otherwise eligible, and the caretaker(s) given the opportunity to engage in a work activity for at least the minimum five hours per week. If the AG does not comply, a home visit must be completed prior to case closure.

18.9 WORK REQUIREMENT ACTIVITIES

To meet the State's participation rate found in Section 18.3, participants must be engaged in certain work activities listed below for the number of hours specified in Section 18.4.3. More details on each type of activity are in Sections 18.10 – 18.18.

Questions about participant participation in programs or activities not clearly identified in Sections 18.10 – 18.18 must be forwarded to the DFA Family Support Policy Unit for clarification and, if appropriate, guidance for placement in the correct Work Programs (WP) component.

NOTE: The definitions of All Family Households and Two-Parent Families in Section 18.4.2 apply here.

A participant may participate in more than one work activity simultaneously.

A participant's activity must not include the sale/distribution of alcohol, tobacco, or firearms.

18.9.1 DEFINITION OF ACTIVITIES

18.9.1.A Core Work Activities

For purposes of meeting the minimum required core hours of participation, following are the nine Core Work Activities, which are described in detail in the subsequent sections:

- Unsubsidized employment
- Subsidized private sector employment
- Subsidized public sector employment
- On-the job training (OJT)
- Job Search and Job Readiness Assistance
- Work Experience
- Community Service Programs
- Vocational Educational Training
- Providing Child Care to an Individual who is participating in a Community Service Program

18.9.1.B Non-Core Work Activities

If the minimum required core activity hours are met, following are the three Non-Core Work Activities which may be used to meet the remaining hours of required participation:

- Job Skills Training Directly Related to Employment
- Education Directly Related to Employment
- Satisfactory Attendance at Secondary School or in a Course of Study Leading to a High School Equivalency Diploma

18.9.1.C Federal and State Law for Educational Activities

Educational activities may be a Core or Non-Core Work activity, including but not limited to:

- Vocational Training
- Literacy Skills
- English as a Second Language (ESL)
- College (does not include graduate school)
- Job Skills Related to Employment
- Education Related to Employment
- Adult Basic Education (ABE) to improve basic skills (for those already possessing a high school diploma or high school equivalency diploma)
- Attendance in a Secondary Schools or High School Equivalency Program

Federal law and West Virginia State law differ in the way educational activities are used.

18.9.1.C.1 Federal Law

Under federal law, an educational activity is mandatory for these two groups:

- Parents under the age of 20, who do not have a high school diploma or its equivalent.
- Unmarried minor parents under age 18 who do not have a high school diploma or its equivalent, when the infant is at least 12 weeks old. See Section 3.4.1.B.

Any individual who does not fall into either of these two groups is restricted in the number of education hours which can be used to meet the federal participation requirement.

18.9.1.C.2 State Law

Under West Virginia State law, those who are not mandatory under federal law for participation in educational activities may select other educational options which do not meet federal work participation requirements.

Any WV WORKS participant may elect to participate in any educational activity, regardless of any federal restrictions described above.

- The participation must be full-time as defined by the institution or course of study, regardless of the number of hours of actual participation.
- The participant must not be required to participate in any other activity to increase his participation hours to the minimum federal requirement.
- However, the participant may voluntarily participate in any other activity, but no sanction may be imposed for failure to participate in that other activity.
- If the educational activity is college, it is limited to one two- or four-year undergraduate degree program unless otherwise agreed upon by the Case Manager and the supervisor that the further addition of the education will help the employability of the participant in finding employment and becoming self-sufficient.
- Participants in educational activities must be making satisfactory progress as determined by the program in which they are enrolled.

18.10 EMPLOYMENT (UNSUBSIDIZED AND SUBSIDIZED)

The long-term goal of WV WORKS is placement of the participant into appropriate full-time unsubsidized employment. When this is not possible, part-time unsubsidized, part-time or full-time subsidized employment and other activities must be explored.

For the sole purpose of entering full- or part-time designations in the eligibility system, the following definitions apply:

- Part-time employment is working an average of under 30 hours per week.
- Full-time employment is working an average of at least 30 hours per week.

The participant's entry into employment may be the result of job development by the Department of Human Services (DOHS) staff, the efforts of other employment agencies, or the result of the participant's own efforts. If the number of hours of employment does not meet the participant's work requirement, additional activities must be required. Hours of employment count toward the participant's work requirement each month that he actually works and receives a WV WORKS benefit.

18.10.1 UNSUBSIDIZED EMPLOYMENT

Unsubsidized employment is work with earnings provided by an employer who does not receive a subsidy for the creation and maintenance of the employment position, or through self-employment.

Self-employment activities include individuals who have earned income. This includes but is not limited to those who for example: own/operate a business/service, sell products on commission, or provide child care. See Section 18.4.5.B for calculation of participation hours for these individuals. If the minimum required participation hours cannot be met following this monthly calculation, then assignment to additional core and/or non-core activities will be necessary.

NOTE: An employer who receives only a tax credit is considered to be providing unsubsidized employment.

18.10.1.A Employment Standards

The following describes employment standards for Unsubsidized Employment:

- Unsubsidized employment is appropriate when the starting wage is at or above the applicable state or federal minimum wage.

18.10.2 SUBSIDIZED PRIVATE AND PUBLIC SECTOR EMPLOYMENT

The WV WORKS components for Subsidized Employment are:

- Full-time subsidized private sector employment (FV)
- Part-time subsidized private sector employment (PV)
- Full-time subsidized public sector employment (FB)
- Part-time subsidized public sector employment (PB)

Subsidized employment is work with earnings provided by an employer who receives a subsidy for the creation and maintenance of the employment position

To place an individual in subsidized employment, the displacement/replacement policy found below and the employment standards found below apply.

18.10.2.A Displacement/Replacement

Placement of WV WORKS participants into subsidized employment must not dislocate, displace, or otherwise have an adverse effect on an employer's regular labor force. The following apply:

- The regular employees must not suffer a reduction in work hours, overtime, fringe benefits or the opportunity for advancement.
- The employer must not decline to hire a regular employee in anticipation of a WV WORKS placement.
- The employer must not have employees in lay-off status.
- The employer must not allow a reduction in his regular labor force with the intent of increasing the labor force with WV WORKS placements.

- WV WORKS placements must not cause a relocation of employees from one geographical area to another.
- The regular employees at a work site must be informed that WV WORKS placements may not cause any dislocation and that they may file a grievance if they feel their job has been adversely affected by WV WORKS placements. See Appendices A and B.
- WV WORKS placements must not be made at job sites involved in any abnormal labor condition, such as a strike or lockout.
- Subsidized employment placements must not provide more than 50% of the employer's labor force.

18.10.2.B Employment Standards

Subsidized employment must meet the employment standards listed below. When the subsidized employment does not meet all of the criteria, the participant has good cause for refusing or failing to take action to secure the position.

- The employer must not be in violation of the Civil Rights Act, the Americans with Disabilities Act or any other law governing the equal treatment of employees in the workplace.
- The employment must not impair existing contracts for service or collective bargaining.
- The starting wage must be at or above the applicable state or federal minimum wage.
- A participant must receive the same benefits as a non-subsidized employee who performs similar work.

18.10.2.C Employment Subsidy Program

The Employment Subsidy Program (ESP) is a statewide subsidized employment placement program. Local WV WORKS staff or Regional Job Developers refer work-ready WV WORKS participants to employers for placement in full-time private or public subsidized employment positions.

Priority is to be given to those WV WORKS participants who require necessary work experience and job skills in order to enter unsubsidized employment. ESP placements will be for up to six months. Reimbursement will be 100% of the individual's wage.

Work-Eligible and non-recipient Work-Eligible Individuals in active WV WORKS cases may be referred for an ESP placement. The ESP placement cannot begin until the ESP agreement is signed by all parties.

WV WORKS staff will negotiate and sign the ESP Agreement, DFA-ESP-1, when placing individual WV WORKS participants in ESP positions. WV WORKS staff will distribute the ESP Agreement in the following manner:

- One original provided to the ESP Employer
- One copy to local WV WORKS staff for filing
- One copy to the DFA Family Support Policy Unit

Copies of all ESP contracts must be scanned to the Division of Family Assistance (DFA) to ensure the available funding is not exceeded.

All ESP placements will be at least 30 hours per week.

The Participant Time Sheet, DFA-TS-12, and the Employer Reimbursement Request, DFA-ESP-2, will serve as the employer's request for an ESP reimbursement. Both forms will be provided monthly by the employer to the local DOHS office. Payment is made to the business/vendor via support services with copies going to DFA Family Support Policy Unit. A BA-67 is not required.
The DFA-ESP-1A, the ESP addendum, is used when there is a contract change required. For example, the participant has received a raise in pay.

18.10.3 JOB RETENTION FOLLOW-UP

Job retention interviews are designed to monitor the participant's progress towards self-sufficiency, current employment situation, and to discuss any barriers or challenges being experienced by the participant that could result in job loss or fewer work hours. The goal is to prevent the loss of employment and to intervene should the participant face any crisis. The results of the interviews are recorded on form DFA-WVW-JR-1. The form must be completed at the 30-day job retention interview and may be simply reviewed at the 90-day retention period interview. At the Supervisor's discretion, a new form may be used for each interview.

As part of the West Virginia Bridge Model, the Case Manager must complete follow-up contacts with the employed Work-Eligible Individual in the closed WV WORKS case at the 30-day, 90-day, 9-month and 12-month intervals following assistance group (AG) closure and placement in PL component or Employment Assistance Program (EAP) starting date. At the discretion of the county office, the Job Retention (JK) component may be used between the 6th and 12th month for continuous enrollment in work programs.

The participant has the right to refuse to participate in the job retention follow-up process and is not required to respond to the Case Manager's request for a visit.

- The 30-day follow-up contact may be made by a face-to-face contact which may be held at the participant's home, work site, at a location agreed upon by the participant and the Case Manager, or by phone. The Case Manager will decide if the 30-day job retention follow-up is done face-to-face or by phone. If after three attempts the Case Manager is unable to reach the participant by phone, a full case recording must be made.
- The 90-day job retention contact will be accomplished by a letter which the Case Manager requests in the eligibility system.
- The 9-month job retention contact must be accomplished by a face-to-face contact which may be held at the participant's home, work site, local DOHS office, or at a location agreed upon by the participant and the Case Manager.
- The 12-month job retention contact may be made by phone. If after three attempts the Case Manager is unable to reach the participant by phone, a full case recording must be made.

18.10.3.A 30-Day Job Retention Contact

The 30-day job retention interview must include, but is not limited to the following:

- Current employment situation, status and progress.
- Concerns such as transportation, child care, ability to pay current living expenses, possible emergencies, health, family's health, and other family situations.
- Discussion of necessary support services, vision and dental services, and if other agency services are being provided as necessary and appropriate.
- Information regarding other agency and community services available to address any identified needs.

Form DFA-WVW-JR-1 must be filed in the participant's case record. The Case Manager must also complete eligibility system recordings. In addition, any pertinent information not shown on the form must be recorded.

When possible, the Case Manager must contact the participant's employer during the job retention process. It is recommended the employer contact be made only after discussion with the participant. The Case Manager must not contact the employer if the participant expressly asks that this not be done. This prohibition does not apply when the Case Manager needs to determine the reason a participant was terminated from a job or verify employment information such as pay rate, hours scheduled, and start date to determine eligibility for DOHS programs. The Case Manager must still be careful not to jeopardize the participant's job or adversely affect

his work environment. A signed Release of Information is recommended.

18.10.3.B 90-Day Job Retention Contract

If the participant responds to the 90-day follow-up letter indicating he needs additional assistance or services, the Case Manager must contact the participant to address these issues.

The 90-day follow-up review must be made before the case is transferred to an Economic Service caseload. In addition, those cases due for Supplemental Nutrition Assistance Program (SNAP) redetermination in the third month after case closure must have the redetermination completed prior to transferring the case to an Economic Service caseload.

EXCEPTION: WV WORKS cases which are eligible for continued support services payments must remain in the WV WORKS caseload.

18.10.3.C 9-Month Job Retention Contact

As part of the West Virginia Bridge Model, the Case Manager must complete a follow-up contact with the employed Work-Eligible Individual in the closed WV WORKS case in the ninth month following AG closure or EAP starting date.

The 9-month job retention contact must be accomplished by a face-to-face contact which may be held at the participant's home, work site, local DOHS office, or at a location agreed upon by the participant and the Case Manager.

This contact is required to determine if any community referrals are needed to continue progress towards self-sufficiency and must have been completed before the 12-month self-sufficiency bonus is issued.

18.10.3.D 12-Month Job Retention Contact

The 12-month job retention contact may be made by phone. If after three attempts the Case Manager is unable to reach the participant by phone, a full case recording must be made.

This contact is required to determine if any community referrals are needed to continue progress towards self-sufficiency and must have been completed before the 12-month self-

sufficiency bonus is issued.

18.11 ON-THE-JOB TRAINING

On-the-Job Training (OJT) means training in the public or private sector that is given to a paid employee while he is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance on the job. OJT programs must be supervised daily by an employer, work site sponsor, or other responsible party. Upon satisfactory completion of the training, the employer is expected to retain participants as regular employees without receiving a subsidy.

There are two types of OJT programs:

- Employer Incentive Program (EIP); and
- Other Agency OJT Programs.

18.11.1 EMPLOYER INCENTIVE PROGRAM (EIP)

The EIP is administered by the West Virginia Department of Human Services (DOHS). The EIP contracts are negotiated by local WV WORKS staff.

The EIP provides participants, hired by either public or private employers, with subsidized training and employment. Prior to the placement, the employer must make a commitment to retain the employee after the completion of the contract. It is the “a hire-first program,” with training paid for by the DOHS.

The EIP provides participants with structured skill training, the opportunity to improve skill level, and provides those who are marginally-employable with an opportunity to become employed. The expected outcome at the conclusion of the contract is unsubsidized employment.

18.11.1.A Who May Be an EIP Employer

Any employer, including a public agency, not-for-profit organization, and private business which is licensed to conduct business in West Virginia, is eligible to be an EIP employer, provided all business tax payments are current. In addition, the employer must agree to the requirements specified below.

18.11.1.B Requirements of the Employer

To become an EIP employer, the employer must abide by the following requirements:

- The employer must guarantee appropriate standards for employment. See Section 18.10.2.B.
- The employer must guarantee there will be no displacement/replacement. See Section 18.10.2.A for the definition of displacement/replacement. Also see Appendix A and B.
- EIP placements must not provide more than 50% of the employer's labor force.
- The employer must make a commitment to retain the participant at the conclusion of the contract.
- The employment must not be temporary or seasonal.
- The employer must pay wages, not commissions. However, commissions may be paid in addition to the wage specified in the EIP contract.
- The working conditions and fringe benefits of the EIP employee must be the same as for any other employee in the same class.
- The occupation must require a training period of at least 200 hours.
- The job must be within the scope of the participant's assessment and must be one he may be reasonably expected to learn.
- The employer must guarantee at least 30 hours of employment per week. The maximum number of hours per week is 40.
- The employer must not have employees in lay-off status in the occupation/job title for which the contract is being negotiated.
- Employers must keep daily attendance records for each participant. When the DFA-TS-12 is used, it must be completed in its entirety and signed by both the participant and supervisor monthly when all training/work hours have been completed. The participation documentation must be received by the Case Manager by the fifth working day of the following month. A copy is retained by the contractor for audit purposes.

The DFA-TS-12 may also serve as the employer's request for an EIP payment or the employer may submit a request for payment on the business letterhead. The Case Manager must review the DFA-TS-12 for accuracy prior to issuing payment.

18.11.1.C Standards for Contract Development

The standards for contract development are:

- An EIP contract may be written for one job slot only.
- The EIP contract may be written for a minimum of 200 hours and a maximum of 600 hours.
- The starting wage must be equal to or above the current minimum wage.
- The cost of an EIP contract depends on the length of training and the participant's starting hourly wage. The maximum EIP payment allowed the employer is 50% of the participant's hourly rate of pay times hours worked.

> **Contract Development Example:** $9 per hour x 300 training hours = $2,700 x 50% = $1,350, the total cost of EIP contract.
>
> The number of EIP training hours are based upon the starting wage as shown in the following chart.

Beginning Hourly Wage	EIP Training Hours
$8.75 through $8.99	200
$9.00 through $9.99	300
$10.00 through $10.99	400
$11.00 through $11.99	500
$12.00 or more	600

When the training site is outside of West Virginia, the EIP contracts are only written with private employers.

Contracts are not written for employers in a highly mobile industry.

Contracts are not written for occupations that require certification and/or licensure, such as for a certified nursing assistant (CNA), licensed practical nurse (LPN), or registered nurse (RN), if the schooling/training results in the certificate or license.

The EIP placement cannot begin until the EIP agreement is signed by all parties.

18.11.2 OTHER AGENCY OJT PROGRAMS (OJ)

This would include any OJT programs or contracts that may exist for individuals written by other local, county, or state agencies such as WorkForce West Virginia, Division of Rehabilitation Services (DRS), etc.

Programs offered by other agencies must be submitted to the Division of Family Assistance (DFA) Family Support Policy Unit to ensure they meet the statutory definition of OJT as outlined in the Federal Register. Questions or clarifications regarding OJT programs must also be submitted to the DFA Family Support Policy Unit.

18.12 JOB SEARCH AND JOB READINESS ASSISTANCE (JR)

Job Search and Job Readiness Assistance (JR) means the act of seeking or obtaining employment and preparation to seek or obtain employment. Strategic Planning in Occupational Knowledge for Employment and Success (SPOKES) are the primary programs for this work activity. Programs are designed to improve work attitudes and behavior, center on general workplace expectations to help participants prepare for work, and to help participants to successfully compete in the labor market.

This activity must be supervised no less frequently than daily. Daily supervision does not necessarily mean daily in person. The Case Manager or other responsible party provides oversight, knows what the participant is supposed to be doing, and is responsible for ensuring that the participant is actually performing these tasks. Contact may be by phone or electronic where available.

Programs offered by other agencies must be submitted to the Division of Family Support (DFS) Policy Unit to ensure they meet the statutory definition of JR as outlined in the Federal Register. Questions or clarifications regarding JR programs must also be submitted to the DFS Family Support Policy Unit.

Once the participant has met their allowable hours and time is still needed for completion, the participant may remain in this component. As long as the participant meets the required participation hours, a participation bonus must still be paid even though his hours will no longer count towards Federal participation requirements. Participants may remain in this component beyond allowable Federal limits when this will lead to employment or overcome barriers to employment.

18.12.1 TIME LIMITS

There is a limit on the number of weeks that JR may be used to meet the individual's work requirement.

- The limit is six weeks for the last 12-month period; no more than four weeks may be consecutive.
- The six week limit is 120 completed hours for an individual with 20 hours per week work requirement or 180 completed hours for an individual with 30 hours per week work requirement.
- Completed hours are not converted or prorated. Actual hours are used.
- Any hours of participation in job search and job readiness during the course of a 7-day period triggers a week of the 4-week limit.

- If a participant participates longer than this period, the participation hours will not count in meeting the work requirement.
- The 12-month period is the current month plus the 11 previous months.
- Any holiday or excused absence hours that are used for participation credit for the JR component count toward the time limits.

NOTE: Any completed hours over 80 for a one-parent household, or over 120 for an all-family household in the JR component in one calendar month do not count towards participation.

Due to the four consecutive week limit, each month that a participant is enrolled full-time in this component, he must also be enrolled in another allowable component for an average of five or eight hours monthly to meet required monthly participation. This can be any other component listed in 18.10-18.18.

Participants in substance abuse treatment and counseling programs and job skills programs required as a result of a positive drug test are placed in this component for the duration of the programs regardless of time limits for this component. After 6 months in this component, the Case Manager must meet with the instructor/counselor and the participant to determine if progress towards program completion is being made before the participant may remain in this component. Determinations to remain in this component must be reviewed monthly and the Case Manager must update the case comments with the information on the status of the participant. After 12 months in this component the Family Support Policy Unit must be contacted for approval to remain in this activity component.

18.12.2 DETERMINING PARTICIPATION HOURS

The customer service portion of SPOKES is considered Vocational Training (VT) for participation purposes and receipt of the Vocational Educational and Employment Achievement Bonus.

> **First Month Example 1:** Mr. Holly has a 13-year-old son and is assigned to SPOKES for 128 hours a month, 30 hours per week. SPOKES is a revolving ten-week course, he begins SPOKES class on October 1. He must be placed in the JR component for the 120 hours a month (4 weeks) and then placed in the VT component for 8 hours. His time would be entered as below. The Case Manager must also add study hours during the VT class time. Mr. Holly completed 120

hours of JR, 4 hours of VT and 4 hours of study time, so hours are entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	120	120	0	0
VT	8	8	0	0

Second Month Example 1.1: Continuation from above. In November, Mr. Holly would still be in the VT component for 68 hours November. He would then be placed back in the JR component for 60 hours (2 weeks) for the remainder of the month.

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	60	60	0	0
VT	68	68	0	0

For the 3rd month Mr. Holly will need to be placed in a new component as he has used up his six weeks of JR. If West Virginia has been declared a needy state by the ACF then the time limit for JR will increase to 12 weeks, see IMM 18.12.3.

First Month Example 2: Ms. Fern is assigned to SPOKES 20 hours/week. She is also attending ABE to work on receiving her high school equivalency diploma. She is placed in the JR component for the 80 hours (4 weeks) and then placed in an additional activity for the remaining 5 hours, which can be AB. She completed 80 hours of Job Readiness, 3 hours of ABE and 3 hours of study time, so hours are entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	80	80		
AB	5	6		

Second Month Example 2.1: For the second month Ms. Fern will work on her ABE and finish out her 2 weeks of Job Readiness. She completed 23 hours of AB, 40 hours of Job Readiness and 23 hours of study time, so hours would be entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	40	40		
AB	46	46		

Example 3: Mr. Pine is assigned SPOKES 30 hours/week. During the second week, he is offered a job at the beginning of the following month. The SPOKES instructor moves him to the customer service portion so that he can receive the Vocational Education and Employment Achievement Bonus. He completed 30 hours of Job Readiness, 50 hours of Customer Service (Vocational Training) and 50 hours of study time, so hours are entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	120	30		
VT	8	100		

First Month Example 4: Two parent household and the father will stay home to care for the children, mother, Mrs. Lily, attends SPOKES. She is required 150 hours a month for a 2-parent household, only 120 hours can be JR, 4 consecutive weeks. She is also working on obtaining her high school equivalency. She will attend JR for 120 hours and ABE for 30 hours to receive her 150 hours. She completed 120 hours JR, 15 hours in ABE and 15 hours of study time, so her hours would be entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	120	120		
AB	30	30		

Second Month Example 4.1: Mrs. Lily will continue to work in ABE and finish out her 2 weeks of JR. She completed 45 hours of ABE and 60 hours of JR, so her hours would be entered as follows:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
JR	60	60		
AB	90	90		

For the third month she can continue in ABE until she obtains her high school equivalency as long as she is making satisfactory progress towards program completion.

18.12.3 ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF) DECLARATION OF NEEDY STATE

West Virginia may qualify to count up to 6 additional weeks for participation credit in JR when declared a needy state by the ACF. When this occurs the time limit will be 12 weeks for the last 12 month period; 240 completed hours for an individual with 20 hours per week work requirement or 360 completed hours for an individual with 30 hours per week work requirement. No more than four of these weeks may be consecutive. All other activity requirements and restrictions remain the same.

Changes in the hourly requirement due to changes in West Virginia's status as a needy state are effective the month after the change occurs.

JR Time Limit Example 1: Mr. Pine has a 20 hours per week participation requirement. He attends substance abuse treatment five hours per week and works 15 hours per week for a total of 20 countable participation hours. The substance abuse treatment is counted as JR and may be counted as participation for up to 120 or 240 hours.

Participation for JR may be counted as follows: Five hours of participation could be counted for each week and recorded in the eligibility system. This would total 20 hours of participation or the first week of the 6- or 12-week limit of JR.

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
PU	65	65		
JR	20	20		

JR Time Limit Example 2: Mr. Elm has a child age three and he participates in JR for 40 hours each week for two weeks; this uses the four consecutive weeks of his 6- or 12-week limit and any participation hours in JR for the next week must not be counted toward meeting his work requirement.

NOTE: Each parent in a two-parent household has his own limit.

JR Time Limit Example 3: Ms. Birch's youngest child turns six in March. Beginning in April, she will be required to complete 30 hours per week and the Case Manager may count up to 180 or 360 hours of participation for the last 12-month period.

JR Time Limit Example 4: Ms. Maple is a single parent with a seven-year-old daughter. She has a participation requirement of 30 hours per week. In January, she has a new baby. If 120 or 240 hours have already been counted in JR in the last 12 months, then participation in JR cannot be counted again until the total is less than 120 or 240 hours in the last 12-month period.

JR Time Limit Example 5: Ms. Hawthorne is a single custodial parent of a two-year-old child and participates in mental health treatment for five hours a week; 20 hours monthly. Because the State is a needy State, the State qualifies to count an individual for 12 weeks of participation in this activity in a 12-month period; therefore, the State may count up to 240 hours in this activity in a 12-month period for Ms. Hawthorne. If this is her only activity in job search and job readiness assistance, Ms. Hawthorne's mental health treatment would count all year long since she would only reach 210 hours in a full year.

18.12.4 JOB READINESS

Job Readiness must be a structured and supervised program and includes two types of activities.

- Preparation for seeking or obtaining employment. This includes activities such as preparing a resume or job application, training in interviewing skills, instruction in work place expectations, training in effective job seeking, parenting, financial literacy, relationship education, and life skills training.
- Substance abuse treatment, mental health treatment, or rehabilitation activities.

18.12.5 JOB SEARCH

Job Search must be a structured and supervised activity which may include the following:

- Making contacts with employers by phone
- Making contacts in person
- Use of the internet to learn of suitable job openings, applying for jobs, and interviewing for jobs

The Employer Contact Form, DFA-WVW-25, may be used to verify time spent on self-directed job search.

NOTE: Travel time to and from job interviews does not count as participation hours. However, the travel time between multiple interviews on the same day at different locations may be counted as participation.

Structured Job Search follows a recognized Job Search model that is provided by a contractor, another agency, or by Case Managers. Existing programs offered through WorkForce West Virginia, the Department of Education (DOE), and other agencies must be used first when services are available without cost. These providers are not reimbursed, unless all existing training positions have been filled and it is necessary to create additional positions for WV WORKS participants, or if there is a contractual agreement between the Department of Human Services (DOHS) and a grantee.

Referrals to SPOKES are limited to those participants who have at least a fourth grade academic level in reading and math. Exceptions to this requirement may be made only after WV WORKS staff consults with, and receives approval from, the local SPOKES staff.

> **Job Search Example:** Mr. Oak attends a structured job search activity from October 6 to October 31 at the WorkForce West Virginia Center and completes four weeks of supervised job search for 30 hours each week. On December 4, he is placed in a SPOKES class full-time. Although his Case Manager may leave him in the SPOKES activity through completion, his attendance in SPOKES may only count for the first two weeks in meeting the federal work participation requirement unless West Virginia had been declared a needy state, then his attendance may count for up to eight more weeks, no more than four of which may be consecutive.

18.12.6 JOB RETENTION

The job retention component of SPOKES is designed for participants who have completed or

nearly completed that program and who have returned due to losing employment. When a participant returns due to loss of employment and has not completed the initial modules, then he should be referred for the entire program.

18.13 WORK EXPERIENCE

Work Experience is defined as a work activity, performed in return for cash assistance, which provides an individual with an opportunity to gain the general skills, training, knowledge, and work habits necessary to obtain employment. All Work Experience activities must be supervised daily by an employer, work site sponsor, or other responsible party. The Work Experience components are governed by the Fair Labor Standards Act (FLSA). See Section 18.15.

In addition to other structured Work Experience opportunities that may be available in the community, the following two Work Experience programs are offered by the Department of Human Services (DOHS).

18.13.1 COMMUNITY WORK EXPERIENCE PROGRAM (CW)

The Community Work Experience Program (CWEP) is a work activity for parents or other caretaker relatives age 18 and older. The primary purpose is to provide work experience and training to assist a client who has limited work experience, is under-employed or has no immediate employment opportunities.

NOTE: WV WORKS clients must not participate as a volunteer with Community Service at any active CWEP contract site regardless of whether or not there is a current CWEP placement at that site.

18.13.1.A Who May Be a CWEP Sponsor

CWEP sponsors are limited to public agencies, such as federal, local, state and not-for-profit employers. It is limited to public services projects in fields such as health, social services, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public activities, public safety and child care.

18.13.1.B Requirements of the Sponsor

The CWEP sponsor must abide by the following requirements:

- The sponsor must provide the client with guidance and supervision necessary to participate in the work experience project.

- The sponsor must provide safety equipment, special clothing and tools needed to perform the assigned duties.
- The sponsor must assume the cost of any required pre- employment medical examinations.
- The sponsor must guarantee that the client is not expected to work more than 8 hours/day, unless the normal work day exceeds 8 hours.
- The sponsor must schedule the client for a minimum of 4 hours/day. An exception to this is the last day of the contract, the last day of the week or month to even out the work requirement, or a make-up day.
- The sponsor must not schedule the client to work split shifts.
- The sponsor must pay the client for any work in excess of his obligation. The rate of pay and overtime rate must be the same as for regular employees.

  The client may not volunteer to work for the assigned sponsor in excess of his obligation without pay.
- The sponsor must adhere to the displacement/replacement policy in Section 18.10.2.A.
- The sponsor must provide Worker's Compensation or comparable coverage.

18.13.1.C Standard for Contract Development

The standards for contract development are as follows:

- The nature of the placement must meet the requirements of local employers and must involve skills needed in the local work force.
- Placement at the same site must not exceed 12 consecutive months. Reassignment to another CWEP site may occur immediately. However, reassignment to the same site may only occur after 6 months of not participating in CWEP at that site.
- The contract form, DFA-CWEP-3 with attachments, is an agreement between a sponsor and local WV WORKS staff and establishes the number and type of positions to be filled by the employer.
- The contract number will begin with the word CWEP. Each contract is assigned a 6-digit control number. The first 2 digits are the fiscal year; the second 2 digits are the county number. The last two digits are assigned sequentially beginning with 01.

  > **Contract Number Example:** CWEP-04-22-14 (CWEP contract negotiated in FY 2004 by Lincoln County, contract number 14).

- Contracts are completed in triplicate. One copy is distributed to each of the following: the sponsor, the client's case record, and the DFA Family Support Policy Unit.
- A detailed job description, form DFA-JD-1, Job Experience Description, must be attached to each contract for each position.
- All contracts are renegotiated annually. If the circumstances warrant it, a contract may be renegotiated earlier.
- Renewal (renegotiation) of CWEP contracts are completed using the CWEP Addendum/Renewal, DFA-CWEP-3A. Renewals are to be completed prior to July 1. In addition to the Addendum/Renewal, staff must have Job Experience Descriptions, DFA-JD-1, completed and signed by the sponsor if there are any new or changed job descriptions. These job descriptions must be attached to the Addendum/Renewal. It is not necessary to complete an entire contract, DFA-CWEP-3, on renewals. In addition, the fiscal year and contract sequence number does not change on renewed contracts. Placements must not be continued with a CWEP sponsor past June 30 if there is not a signed CWEP Addendum/Renewal contract with that sponsor. Contracts not negotiated within 90 days after the expiration date of the existing agreement require a new contract, DFA-CWEP-3.
- A contract may be terminated by either party with 30 days written notice.

18.13.1.D Determining the Hours of Participation

The Department of Labor (DOL) has mandated that the requirements of the Fair Labor Standards Act (FLSA) of 1938 be applied when determining the maximum hours of CWEP participation.

NOTE: A CWEP Individual Participation Agreement, DFA-CWEP-1, must be completed as a condition of placement in a CWEP position. The original DFA-CWEP-1 is provided to the contractor, the second copy is placed in the participant's case record, and the bottom copy is given to the participant. The client must not work more hours for the CWEP sponsor, regardless of the amount calculated below. A new DFA-CWEP-1 is required to increase or decrease hours when the client's WV WORKS and/or SNAP benefits increase, decrease, or there is a change in the state or federal minimum wage used to calculate the number of participation hours assigned.

18.13.2 JOINT OPPORTUNITIES FOR INDEPENDENCE PROGRAM (JN)

The Joint Opportunities for Independence Program (JOIN) is a State-operated employment program that provides clients the opportunity to participate in a work program that closely resembles full-time employment. The participant may receive work experience in the private or public sector to improve his present job skills or to train him in new job skills. The work experience must meet local labor market demands.

A client is eligible if he has the necessary motivation, employment potential, education, previous work history and skills to benefit from the program. A placement should match the client's interests as determined during the assessment process. No client may participate in JOIN for more than 12 months, nor for more than 40 hours per week.

Prior to placement, a JOIN participation agreement must be completed. The client must be given copies of the job description and informed of the job requirements and general working conditions.

A review of the client's progress must be conducted at the end of the first 6 months of participation or earlier, to determine if there is satisfactory progress toward the goal of employment. The expected result of JOIN participation is employment, either at the JOIN training site or with another employer. The possibility of obtaining employment at the JOIN training site must be evaluated.

Any contractor who repeatedly fails to commit to hiring placements may be denied future contracts. The client must be given the opportunity to evaluate his own placement and be involved in the review process.

NOTE: WV WORKS participants must not participate as a volunteer with Community Service at any active JOIN contract site regardless of whether or not there is a current JOIN placement at that site.

18.13.2.A Who May Be a JOIN Contractor

Any employer licensed to conduct business in West Virginia is eligible to be a JOIN contractor, provided all business tax payments are current. In addition, the potential contractor must agree to the requirements specified below.

18.13.2.B Requirements of the Contractor

To become a JOIN contractor, the following requirements must be met:

- JOIN placements may not exceed the number of full-time employees already on the contractor's payroll.
- The contractor must provide an orientation for the client that outlines the work schedule, job description, contractor's expectations, pay schedule, holidays and the workplace standards for special clothing, reporting absences, breaks and mealtimes.
- The contractor must report all attendance problems immediately to the DOHS.
- The contractor must not assign the client to work more than an eight hour day, unless the normal work day exceeds eight hours.
- The contractor must not schedule split shifts.
- The contractor must schedule the client to work the appropriate number of hours per week. Hours worked in excess of the established number must be paid solely by the contractor, at the prevailing wage rate. All such income must be reported to the Case Manager.
- Contractors must keep daily attendance records for each client using form DFA-TS-12. It must be completed in its entirety and signed by both the client and supervisor monthly when all work hours have been completed. The DFA-TS-12 must be received by the Worker by the 5th working day of the following month. A copy is retained by the contractor for audit purposes.
- The contractor must provide a representative, when requested, to attend any Pre-Hearing Conference or Fair Hearing the client may request.
- The contractor must advise his regular employees of their right to file a grievance, if they feel their job has been adversely affected by the JOIN program and must adhere to the displacement/replacement policy.
- The contractor must guarantee appropriate standards for employment.
- The contractor must provide Workers' Compensation or comparable coverage and pay into Social Security.
- The contractor must agree to provide safety equipment, special clothing, or tools not covered by the JOIN contract.
- The contractor must guarantee adequate supervision.
- The contractor must provide the JOIN client $1.00 for each hour of participation. This training allowance must be paid on the regularly scheduled payday. The contractor must

withhold applicable local, state or federal wage taxes.

18.13.2.C Contract Requirements

A contract must be negotiated between the local WV WORKS staff and the contractor.

The contract, form DFA-J-3, is completed in triplicate, and signed by the authorized representatives of the contractor and the Department. The original is placed in the client's case record, a copy is forwarded to DFA Family Support Policy Unit, and the contractor receives a copy.

The contract number will begin with the word JOIN. A contract number of six digits is assigned. The first two digits are the current fiscal year; the second two digits are the county number. The last two digits are consecutively-assigned numbers beginning with 01.

> **JOIN Contract Number Example:** JOIN-03-33-15 (JOIN contract negotiated in FY 2003 by McDowell County, contract number 15).

A job description must be attached to each contract. The job description must be written by the contractor and must describe a job in the workplace that the client may qualify for at the end of the contract period, using form DFA-JD-1.

The job description(s) must include the following items:

- Job title
- Minimum educational level required for the position
- Weekly work schedule
- Special licenses required
- Special physical requirements
- Tools required
- Description of the job duties and responsibilities
- Special safety concerns or hazardous conditions
- Name of the supervisor
- Name of the individual responsible for evaluations and time sheets

Case Managers must monitor each placement to ensure that the contractor is in compliance with the contract. Any contract may be canceled with 30-days' notice when the contractor does not comply. Any contractor who shows a pattern of non-compliance may be denied future contracts. Renewal (renegotiation) of JOIN contracts are completed using the JOIN Addendum/Renewal form, DFA-J-3A. These renewals are to be completed prior to July 1 or the new state fiscal year. In addition to the Addendum/Renewal, staff must have Job Experience

Descriptions, DFA-JD-1, completed and signed by the sponsor if there are any new or changed job descriptions, which must be attached to the Addendum/Renewal. It is not necessary to complete an entire contract, DFA-J-3, on renewals. In addition, the fiscal year and contract sequence number does not change on renewed contracts. Under no circumstances will placements be continued with a JOIN sponsor past June 30 if there is not a signed JOIN Addendum/Renewal contract with that sponsor. Contracts not negotiated within 90 days after the expiration date of the existing agreement require a new contract, DFA-J-3.

18.13.2.D Determining the Hours of Participation

The Department of Labor (DOL) has mandated that the requirements of the Fair Labor Standards Act of 1938 be applied when determining the maximum hours of participation.

NOTE: A JOIN Individual Participation Agreement, DFA-J-1, must be completed as a condition of placement in a JOIN position. The original is provided to the JOIN sponsor, one copy is placed in the participant's case record, and the bottom copy is given to the participant.

NOTE: There may be some fluctuation in the number of hours worked each week to meet the requirements of the contractor. This is acceptable as long as the total number of hours per month is met, but not exceeded.

18.13.3 OTHER WORK EXPERIENCE PROGRAMS (WE)

This would include any other Work Experience programs offered in the community. Programs offered by other agencies must be submitted to the DFA Family Support Policy Unit for review and approval to ensure they meet all requirements for the Work Experience component. Other Work Experience programs are regulated by the Fair Labor Standards Act (FLSA).

18.14 COMMUNITY SERVICES PROGRAMS (CS)

Community Service Programs (CS) are those structured programs in which WV WORKS participants perform work for the direct benefit of the community through public or nonprofit organizations. This could include public or private volunteer organizations. CS is limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care. CS must be supervised daily.

The CS component is governed by the Fair Labor Standards Act (FLSA). Participants assigned to this component must also be enrolled in the FLSA (FL) component.

CS participation is a self-initiated volunteer activity on the part of WV WORKS participants. Participant selection of a volunteer position with a community agency is acceptable if the agency and position meet the definition of Community Service under the first paragraph of this section. The Case Manager may provide participants with a known list of local appropriate Community Service sites. However, the Case Manager must not direct or “place” participants at any particular volunteer site.

The Case Manager is responsible for contacting the community agency selected by the participant in order to confirm what tasks the volunteer work entails, how the placement will enhance the participant’s job skills and experience, the days and number of hours of work which will be completed each week, and what service is being provided to the community.

The Case Manager must then complete a Volunteer Job Description which will include the information above in addition to the expected length of time of participation for the participant and how the participation will enhance the ability of the participant in his transition to employment. A copy of the Volunteer Job Description must be placed in each participant’s case record. Volunteer positions should be reviewed on a monthly basis to determine the usefulness of the participant’s participation and if placement in another activity may be more appropriate. A template of the Volunteer Job Description is in Appendix E.

Under no circumstances will Community Service participation be allowed at active Community Work Experience (CWEP) and Job Opportunities for Independence Program (JOIN) contract sites, nor at a site which has employees in layoff status.

18.15 FAIR LABOR STANDARDS ACT (FLSA)

The Department of Labor (DOL) has mandated that the requirements of the Fair Labor Standards Act (FLSA) of 1938 be applied when determining the maximum hours of CWEP, JOIN, Other Work Experience, and Community Service participation.

In this section is the explanation of determining the appropriate hours to be assigned to an FLSA regulated component and how the case management system is used to track these requirements.

18.15.1 DETERMINING THE HOURS OF PARTICIPATION

The following procedure is used to determine the monthly maximum number of hours of participation. The monthly placement obligation for all FLSA regulated components is based on the amount of SNAP benefits and WV WORKS cash assistance a family is eligible to receive during a month, including any amount withheld from the check to repay a previous overpayment and any amount not paid due to a sanction.

NOTE: The minimum wage used for the calculation is the federal or state minimum wage, whichever is higher.

The maximum monthly participation obligation is based on the following process:

Step 1: Determine the amount of the WV WORKS benefit prior to any previous overpayments.

Step 2: Determine the amount of the assistance group's (AG) Supplemental Nutrition Assistance Program (SNAP) benefit. This is the amount actually received by the AG, plus any amount withheld to repay a previous over-issuance.

NOTE: When WV WORKS participants are included in the same SNAP AG with non-WV WORKS clients, a separate calculation must be performed, as follows, to determine the share of the SNAP benefits belonging to the WV WORKS participants.

- *Divide the SNAP allotment by the number of people in the SNAP AG.*
- *Multiply this amount by the number of people in the WV WORKS AG. Drop all cents. The result is the amount of SNAP benefits used to determine the obligation.*

Step 3: Add the WV WORKS benefit and SNAP benefit.

Step 4: Add Child Support Incentive (CSI) and pass-through payment to the result of Step 3.

Step 5: Subtract the amount of current child support retained for the month by the Bureau for Child Support Enforcement (BCSE) from the result of Step 4. Only current support payments are subtracted, not arrearages or other payments. Use the amount of child support retained by BCSE two months prior to the month for which the obligation is calculated.

Step 6: Divide the result of Step 5 by the federal or state minimum wage, whichever is higher. This is the client's maximum monthly obligation. The resulting figure is rounded down to the nearest whole number.

Determining Hours of Participation Example 1: The household consists of Mr. and Mrs. Rhododendron and their two children. Mrs. Rhododendron receives Supplemental Security Income (SSI) and she is not included in the WV WORKS AG. When determining Mr. Rhododendron's CWEP obligation, Mrs. Rhododendron's portion of the SNAP allotment is not included. The family's total SNAP allotment is divided by the number of people in the SNAP AG and this amount is multiplied by the number of people in the WV WORKS AG. Drop all cents, and this amount is what is used to determine Mr. Rhododendron's CWEP obligation.

$640.00	Rhododendron family's SNAP allotment
÷ 4	Number of people in the SNAP AG
$160.00	Individual SNAP allotment
x3	Number of people in the WV WORKS AG
$480.00	SNAP amount used to determine Mr. Smith's CWEP obligation

Add the AG's monthly benefits of:

$374	WV WORKS Benefit
+$480	SNAP Benefit Used
$854	
÷ $8.75	

97.6 hours = 97 core participation obligation hours

Determining Hours of Participation Example 2:

$422	WV WORKS Benefit
+ $640	SNAP Benefit
$1,062	
+ $225	CSI and Pass-through
$1,287	Total
-$50	Child Support Retained by BCSE
$1,237	
÷$8.75	

141.37 hours = 141 assigned participation obligation hours

Under no circumstances is the client required to participate more than 40 hours in one week.

Participants assigned to CWEP, JOIN, Other Work Experience, or Community Service components must also be enrolled in the FLSA (FL) component. FL is not a work component, it is an eligibility system reporting mechanism which indicates the point where the individual is deemed to be meeting his Core participation requirements based on the FL calculation. The actual hours are scheduled using the WV WORKS FLSA Computation Sheet, DFA-WVW-FLSA-1 or in the eligibility system and are entered in the FL and Work Experience components and documented in Work Program comments.

Required hours based on the FLSA calculation are entered as scheduled hours for the FL component unless the FLSA calculation exceeds the minimum participation requirements. The scheduled hours in the eligibility system must not exceed the minimum monthly participation rate requirements. The participant may be required on their SSP to participate for the FLSA computed hours, but no sanction may be imposed as long as the minimum level is met. Thorough case comments must be made.

At the end of the reporting period, the Worker must record the actual hours completed in the appropriate Core components, CW, JN, WE, or CS, and the hours scheduled by FLSA computations are re-entered in the FL component as completed hours. The scheduled and completed hours entered for FL component will be the same as the FLSA calculation. Refer to the FSPU-12 desk guide or Appendix E.

There may be some fluctuation in the number of hours worked each week to meet the requirements of the contractor. This is acceptable as long as the total number of hours per month is met, but not exceeded.

If the hours reported in the Core work activity equal the number of hours assigned in the FLSA-related activity component, the participant will be deemed to be meeting the Core participation

requirement, and no additional core hours may be required.

18.15.1.A Meeting the Minimum Hours in FLSA Regulated Components

	Single Parent, Child Under Age 6		All Family Household		Two-Parent Household		Two-Parent Household Receiving Federally-funded Child Care	
	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours
Core Hour Requirement	85	20	85	20	128	30	215	50
Work Components: Participation Requirements	85	20	128	30	150	35	236	55

The minimum monthly required core hours of 85 (Single Parent, All Family) and 128 or 215 hours/month (Two-Parent Household) are met if the calculation of the CWEP obligation hours equals less than the minimum average core hours requirement. When this occurs, the Worker must assign additional core or non-core work activities not regulated by FLSA to meet the applicable minimum total of 128, 150, or 236 average participation hours/month.

> **Minimum Core Hours Example 1:** Ms. Violet is required to complete 85 hours in a Core activity. She is assigned 67 hours monthly in CWEP using FLSA calculations. The assigned monthly hours of 67 are entered for the work activity, CW, as well as the FL component. When the timesheet is received, actual hours are entered for the work activity, CW. The scheduled hours are re-entered for the FL component. If Ms. Violet completes the 67 hours as scheduled, she is deemed to be meeting her Core requirement.
>
> **Minimum Core Hours Example 2:** In the same scenario as above, Ms. Violet is assigned 67 monthly hours. She actually participates 50 hours for the month and has 12 hours of excused absence for the month. There were no holidays.
>
> The following figures are entered in the eligibility system:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
CW	67	50	12	--
FL	67	67	--	--

Because she did not complete the number of hours scheduled, she is not deemed to be meeting her Core requirement. If she would have worked the 67 hours as assigned, she would have been deemed to have worked the 85 required core hours. The 12 hours excused would not actually be used, since the addition of these hours would not meet the participation requirement of 67 hours.

Minimum Core Hours Example 3: An All Family Household with children over age six for participation purposes:

$374 WV WORKS Benefit

+$504 SNAP Benefit

$878

÷$8.75

100.34 hours = 100 core participation obligation hours

The required core hours are 100. The required total participation hours are 128.

Since the participant in this example is required to participate 128 hours per month, and the FLSA calculations permits this individual to complete 100 hours/month, the participant must be assigned 100 hours per month in the CWEP activity and 28 additional hours in another activity not regulated by the FLSA, such as JT. There were no excused absences or holidays. The participant participates his required hours.

The following figures are entered in the eligibility system:

Component	Scheduled Hours	Completed Hours	Monthly Excused Hours	Monthly Holiday Hours
CW	100	100	--	--
FL	100	100	--	--
JT	28	28	--	--

When the time sheet indicates the client participated the monthly assigned CWEP hours (including applicable excused absences and holidays) and this equals the required hours, the Case Manager must record that the required core activity hours are deemed to be met. When the actual hours participated are less than required, the Worker must record that the core hours are not deemed to be met.

NOTE: The participant's SSP must include the number of monthly obligation hours required while in this activity. The monthly obligation hours must be recalculated whenever benefit amounts or minimum wage changes occur and the Personal Responsibility Contract (PRC) must be updated accordingly.

18.16 VOCATIONAL EDUCATIONAL TRAINING/COLLEGE

18.16.1 VOCATIONAL EDUCATIONAL TRAINING (VT)

Vocational Educational Training includes organized educational programs that are directly related to the preparation of participants for employment in current or emerging occupations requiring training other than a baccalaureate or advanced degree. This activity is limited to those programs that prepare participants for one specific trade, occupation, or vocation. This training is conducted in a non-work site or classroom setting.

Vocational Educational Training programs should be limited to activities that give participants the knowledge and skills to perform a specific occupation. These programs, while they may last longer than 12 months, and are in an approved Vocational Educational Training program, may not be counted for participation purposes for more than 12 months. If the participants continues to meet their required hours in the activity, the participant will still be eligible for the Participation bonus**.** Participants in Vocational Educational Training must be supervised daily.

For distance learning, countable participation hours only include classes which allow for monitoring of the participant while logged in and summarize what is achieved during the period engaged.

Although Vocational Educational Training may only be used for 12 months to meet federal participation requirements, a participant in one program that lasts longer than 12 months who continues to make good progress must be allowed to complete the course of training. Participants meeting these requirements must not be placed in additional activities while they continue to make satisfactory progress in their course of study. Vocational training exceeding 18 months must be approved by the Division of Family Assistance (DFA) Family Support Policy Unit.

For two-parent households where one parent is attending vocational educational training or college, the additional parent must not be required to engage in more than ten hours per week in a work activity. Good cause may be granted to the second parent for not participating in an allowable activity depending on household circumstances or if he is providing child care for a child who is under the age of six.

Some Vocational Associate Degree Programs may combine coursework with actual work. For these courses, the actual work placements may be counted as On-the-Job Training (OJT), if paid, or Work Experience if unpaid.

Masters or Doctorate programs must not be counted as Vocational Educational Training or

college for any period of time.

Vocational Educational Training must be provided by education or training organizations, which include but are not limited to:

- Vocational-technical schools
- Community colleges
- Postsecondary institutions
- Proprietary schools
- Non-profit organizations
- Secondary schools that offer vocational education

Attendance in all two-year or four-year college programs must be counted under Vocational Educational Training for a maximum of 12 months lifetime. Previously counted months of vocational training for individuals must be considered towards the 12 months allowable.

The customer service portion of Job Search and Job Readiness Assistance programs is considered Vocational Educational Training for participation purposes.

NOTE: Minor parents attending high school in a vocational educational track should be counted as participating under "satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence" to avoid triggering the lifetime 12-month limit on the use of Vocational Educational Training.

Questions regarding types of training allowable under Vocational Educational Training are to be directed to the DFA Family Support Policy Unit.

18.16.1.A Placement Criteria

An individual, who has demonstrated the ability to do the course work and who meets the entrance requirements, may participate in Vocational Educational Training when:

- His goal is an occupation that requires completion of a vocational course prior to employment;
- He has no job skills, or has only obsolete or non-marketable skills and must be retrained to find employment; or
- He does not have a high school diploma/or equivalent, and the skill training has been identified as an alternative which can lead to employment.

18.16.1.B Standards

The training institution and instructor must meet licensing and certification standards of the appropriate governing agency. Unlicensed or uncertified instructors are not approved for training when licensing or certification standards exist.

A participant's evaluation for an appropriate skill training situation must include appropriate testing when the individual does not have a high school diploma or equivalent.

No participant may be assigned to Vocational Educational Training unless the Case Manager is assured the participant will accept training-related employment upon completion of the training.

Participants in educational activities must be making satisfactory progress as determined by the institution in which they are enrolled. Once the participant has made unsatisfactory progress as defined by the institution, an educational activity may no longer be counted as the work activity until the participant regains satisfactory progress. The Case Manager should use discretion in activity placement. Strategic Planning in Occupational Knowledge for Employment and Success (SPOKES) are allowable educational activities.

18.16.1.C Training

Participants must be placed into training positions on a no-cost basis if such positions are available through WorkForce West Virginia, Department of Education (DOE), Veterans Affairs (VA) and other providers, before additional training positions are developed.

Case Managers staff may write training contracts for individuals without the DFA approval for an amount up to $600. Individual contracts which exceed $600 must be approved by the DFA. Group contracts are written by county staff, but must be approved by the DFA, regardless of the amount. The training contract must be completed before the participant's first day.

18.16.1.D Payment Limitations

Payments are limited to the cost of tuition, books, supplies and expenses associated with completing the course of study. Costs for medical procedures, such as Hepatitis B vaccines or physical exams, are not included. There is a cost limit of $600 per individual. This cost may be exceeded only with approval from the DFA.

To obtain approval to exceed the limit, a written request must be submitted to the Director of DFA and must include:

- Participant's name;
- Participant's address;
- Participant's Social Security Number (SSN);
- Name of the training facility;
- The occupation for which training is sought;
- The usual pay rate for the occupation; and
- The current employment prospects and labor demands.

18.16.1.E Calculation of Participation Hours

The calculation of hours for Vocational Educational Training follows the process below:

Step 1: Determine the participant's total monthly hours as reported on his timesheet. This may include only the number of actual hours spent in class as well as time spent performing clinical requirements or lab time required for approved programs.

Step 2: Add one hour of unsupervised homework time for each hour of class time. One hour of unsupervised homework time for each hour of class time may be counted as participation. No additional hours of study may be reported, unless they are monitored hours in an approved educational program.

Step 3: Add supervised homework hours, if applicable. The total hours for unsupervised plus supervised homework time must not exceed the homework time required or advised by the educational program.

Step 4: Add the actual monthly classroom hours plus all homework time and enter the sum.

Step 5: Enter allowable time for excused absences if necessary.

Step 6: Enter hours for any classes missed due to a federal holiday that occurred during that month separately as a monthly total.

> **Calculation of Participation Hours Example:** Ms. Fern attended class 59 hours for the current month. In addition, she had four hours of excused absence and six hours credit for a federal holiday.
>
> 59 hours of class time attended during the month
>
> +59 hours unsupervised homework time
>
> 118 hours of actual participation

+ 4	hours of excused absence
+ 6	hours credit for federal holiday
128	

18.16.1.F Verification of Hours and Payment of Support Services

The participant must submit a monthly timesheet, DFA-TS-12, to document the number of days and hours he has attended during the month. The timesheet must be signed by the participant and the educational supervisor. Faculty, instructors, student service specialists, instructional aides, lab supervisors, study hall supervisors, contractors, and educational providers are examples of educational staff that may be responsible for the daily supervision of participants for verification of hours.

The Case Manager will request enrollment and schedule information at the beginning of each term. Copies of grades are required at the completion of each term to ensure the participant is maintaining satisfactory progress. Enrollment, schedule, and grades must be included on the Self-Sufficiency Plan (SSP).

NOTE: Use of one day in any month in the time limited component of VT uses one month of the 12 month lifetime limit. Support payments made after VT component closure for VT activities may be made under the current component for this reason.

> **Use of One Day in Any Month Example:** Ms. Pine's summer class ends on June 30; her case manager disenrolls her from the VT component at that time and enrolls her in JR. After her time sheet is received in July, her Case Manager opens the VT component for one day to make the transportation payment. The month of July will then count as one of her 12 lifetime months in VT. To keep from using one of Ms. Pine's months, the Case Manager pays her June transportation under the JR component and makes thorough case comments.

18.16.2 COLLEGE (CL)

Although college attendance does not count toward meeting the federal participation requirements, the West Virginia State Code specifies that full-time college enrollment and attendance is an acceptable participation activity for the WV WORKS program. See Section 18.9.1.C.2, "Under West Virginia State Law" regarding full-time attendance and satisfactory progress requirements.

Care must be made to correctly identify 18-month or two-year vocational programs being provided by colleges and community colleges and that participants in those programs are enrolled in the Vocational Educational Training.

NOTE: See Section 18.16.1 regarding counting up to 12 months of college as Vocational Educational Training.

Some undergraduate courses require that students be placed in an unpaid work environment. Such undergraduate placements may be used to meet the federal work requirement. These placements include, but are not limited to: student teaching, internships, clinical work assignments and unpaid work experience. The portion including actual work must be counted as OJT if paid, or Work Experience if unpaid.

NOTE: Participants enrolled and attending college part-time must be enrolled in Job Training when the educational program meets the requirements of Section 18.18.1.

NOTE: Participation in College Work Study is employment.

Participants in all other four-year degree programs must be enrolled in the College component and no additional hours are assigned to the participant as long as they are enrolled full-time and continue to make satisfactory progress.

Participants in educational activities must be making satisfactory progress as determined by the institution in which they are enrolled. Once the participant has made unsatisfactory progress as defined by the institution, an educational activity may no longer be counted as the work activity until the participant regains satisfactory progress. The Case Manager should use discretion in activity placement.

Hours of participation for college are assigned according to the number of hours they attend class, plus one hour of study time per class hour.

School holidays that are not federal holidays must be counted as one of the excused absences. Summer breaks and semester breaks must not be counted toward participation. All other absences must meet the excused absence policy of no more than 16 hours per month and not more than 80 hours per 12-month period.

18.16.2.A Meeting the State Requirement

The participant in the College component must not be assigned to participate in any other activity to meet the federal work requirement when he chooses to attend college, as long as he attends full-time as defined by the institution.

18.16.2.B Participation Calculation

The calculation of College hours of participation follows the same process as Vocational Educational Training. See Section 18.16.1.E.

> **Participation Calculation Example:** Mr. Hickory attends class 60 hours for the month. The following hours of participation are entered in the eligibility system:
>
> 60 attendance hours
>
> +60 unsupervised study hours
>
> 120 total monthly participation hours

NOTE: Please note that some College students may actually attend more hours than enrolled credit hours. This may occur when the student is required to participate in a lab, library activity, etc. which does not count towards his semester credit hours. This is significant when the credit hours are less than full-time during the current semester. In this case, the Case Manager must count all participation hours, confirm the details with the participant, and make a full case recording in the eligibility system regarding the circumstances.

18.16.2.C Payment of Support Services

The participant must submit a monthly timesheet, DFA-TS-12, to document the number of days he has attended during the month. The timesheet must be signed by the participant in order to receive support services.

The Case Manager will request enrollment and schedule information at the beginning of each term. Copies of grades from each grading period will be obtained to ensure the participant is maintaining satisfactory progress towards program completion. Enrollment, schedule, and grades must be included on the SSP.

18.17 PROVIDING CHILD CARE FOR A COMMUNITY SERVICE PARTICIPANT (CC)

Providing child care services without payment to an individual who is participating in a community service program means providing child care to enable another Temporary Assistance to Needy Families (TANF)/WV WORKS participant to participate in a community service program. Participants must be supervised daily.

Participants in this component must be working closely with a Child Care Agency to obtain certification to become a certified West Virginia Child Care Provider. This certification should be obtained within six months. The Child Care Agency must supervise the participant's activity on a daily basis and submit the DFA-TS-12 timesheet each month. If the participant is not working with a Child Care Agency to obtain certification, then the activity must not be counted towards participation.

In addition to the timesheet provided by the Child Care Agency, the participant must also submit a timesheet each month. Parents for whom the participant is working must sign this timesheet each day that care is provided for their child. The Case Manager may use information on this timesheet to check against the timesheets being provided by the Community Service Agencies for which the parents are working. This will ensure that the information being reported is complete and correct.

NOTE: This activity does not include providing child care to enable a TANF/WV WORKS participant to participate in any of the other allowable work activities.

NOTE: In a two-parent family, or in a family with a parent and stepparent, one parent or stepparent cannot count as participating in a work activity by providing child care for his or her own child or stepchild while the other parent or stepparent participates in Community Service. Also, no more than one Work-Eligible Individual may receive credit for caring for the child(ren).

18.18 NON-CORE WORK ACTIVITIES

Job Skills Training Directly Related to Employment, Education Directly related to Employment and Satisfactory Attendance at Secondary School or High School Equivalency Program are allowable work activities in which participation hours are allowed as long as the minimum core hours of participation are met in one or more of the nine core activities.

The following policies apply to all three work activities described below:

- For distance learning, countable participation hours only include classes which allow for monitoring of the participant while logged in and summarize what is achieved during the time period engaged.
- One hour of unsupervised homework time must be counted as participation hours for each hour of class time under any of the three activities listed below. Supervised homework may count if the hours of participation can be documented.
- The total number of homework hours credited towards participation must be documented in Work Programs comments and must be based on the number of homework hours required or advised by the educational program.

Participants in educational activities must be making satisfactory progress as determined by the institution in which they are enrolled. Once the participant has made unsatisfactory progress as defined by the institution, an educational activity may no longer be counted as the work activity until the participant regains satisfactory progress. The Case Manager should use discretion in activity placement.

NOTE: If the participant is under the age of 20 and does not have a high school diploma or its equivalent, the requirement to participate in educational activities must be included in the Self-Sufficiency Plan (SSP). The three activities listed below, although they do not meet the federal definition of Core Work Activities, are acceptable full-time activities for WV WORKS participants under State Law. See Section 18.9.1.C.2, regarding full-time attendance and satisfactory progress requirements.

18.18.1 JOB SKILLS TRAINING DIRECTLY RELATED TO EMPLOYMENT

This activity is defined as education and training for job skills required by an employer to provide an individual with the opportunity to obtain employment or to advance or adapt to the changing demands of the workplace. Job skills training can include customized training to meet the needs of a specific employer or general training that prepares an individual for employment. This

training can include literacy instruction or language instruction when such instruction is focused on skills needed for a job or combined in a unified whole with job training.

NOTE: Education leading to an associate or baccalaureate degree may also be counted under job skills directly related to employment so long as it is directly related to a specific job or occupation. Participants attending such programs part-time must be coded under this component.

18.18.2 EDUCATION DIRECTLY RELATED TO EMPLOYMENT

Education directly related to employment, in the case of a participant who has not received a high school diploma or a certificate of high school equivalency, means education related to a specific occupation, job, or job offer. This activity includes training courses designed to provide the knowledge and skills for specific occupations or work settings and may also include adult basic education and English as a Second Language (ESL). Literacy skills and tutoring fall under this activity. When required as a pre-requisite for employment by employers or occupations, it may also include education leading to a high school equivalency diploma.

18.18.3 SATISFACTORY ATTENDANCE AT SECONDARY SCHOOL OR HIGH SCHOOL EQUIVALENCY PROGRAM

Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a participant who has not completed secondary school or received such a certificate, means regular attendance, according to the requirements of the secondary school or equivalent program.

NOTE: For parents under 20 who do not have their high school diploma or equivalency, attendance at a secondary school or high school equivalency program is a requirement.

This activity, unlike education directly related to employment, is not restricted to those for whom obtaining a high school diploma or equivalent is a prerequisite for employment. It may include other related educational activities, such as adult basic education or language instruction if it is linked to attending a secondary school or leading to a high school diploma or equivalent.

Participants must be making “good or satisfactory progress” in order for this activity to count. A standard of progress established by the educational institution must be monitored such as grade point average and a time frame in which the participant is expected to complete such education. The Case Manager must collaborate with the teacher(s) or instructors to monitor this standard of progress.

18.19 PAYMENT FOR SUPPORT SERVICES

Payment for support services is authorized to assist WV WORKS participants in securing or maintaining employment or participating in other activities.

The type and amount of any payment made must be based on need, i.e., without receiving the payment in that amount the participant is not able to participate in an activity. The Case Manager and the participant must discuss available services and assess needs during the interview and assessment process, and at reviews. The participant may also request services as needs arise. Disposition to approve or deny the application for supportive services must be made within 10 working days of receipt of the signed time sheet or request.

Support services may be issued during any month for which a WV WORKS payment is made. In addition, some former Work-Eligible Individuals in a previous WV WORKS case continue to be eligible for support service payments as long as the conditions in Section 18.22 are met. This Section contains information about support services available to active assistance group (AG) members and non-recipient Work-Eligible Individuals in the household.

18.19.1 WHO IS ELIGIBLE

Those who meet all of the following criteria are eligible for payment of support services:

- Work-Eligible Individual in an active WV WORKS case for the month for which the support service payment is intended.
- Non-recipient Work-Eligible Individuals who are not in the AG, as long as they meet all other eligibility requirements.
- A non-recipient parent, stepparent, or caretaker relative receiving Supplemental Security Income (SSI) who has chosen to volunteer to participate in a work activity.
- Participating, or preparing to participate, in a work activity listed in Sections 18.10 – 18.18.
- For individuals who are preparing to participate, certain support service payments may be made under Other Work Activities to remove challenges to participation.
- Has not received and is not expected to receive a Diversionary Cash Assistance (DCA) payment which covers the month for which the support service is requested.
- Did not receive WV WORKS fraudulently or is not subject to repayment for the total monthly allotment.

18.19.2 GENERAL REQUIREMENTS

The following general information applies to all support services payments, whether provided to an active participant or to a former participant eligible for continued support services according to Section 18.22:

- The amount of the payment is based on the need, but may not exceed the maximum amounts.
- When the participant participates in more than one activity, payment may be made for each activity. However, the total may not exceed the maximum payment for each type of expense.

NOTE: If a case must be reopened in order to process Support Service payments, Supervisory approval is required to reopen the case.

> **Support Services Requirement Example:** The lifetime limit for clothing is $1,000. During an earlier eligibility period, Ms. Orchid received $400 in support payments for clothing. She reapplies for WV WORKS and during the next 12 months, she then receives $100 for clothing during a Community Work Experience Program (CWEP) placement and then a $100 payment for clothes during Job Search which is her total allowable amount for the 12 month period. She finds employment and only has $400 of her lifetime limit for clothing remaining because the maximum payment cannot exceed $1,000. ($400 + $100 + $100 + $400 =1,000)

- The Case Manager must make a recording in the eligibility system each time a payment is made, explaining the need for the payment and the reason for the amount issued. This comment must include the calculations used to determine the correct payment. For transportation, recordings must include the daily rate and the number of days for which the payment is made.
- Support service maximum time limits and amount limits are usually based on each individual participant, not on each family. Therefore, if two parents are participating, each is eligible for a maximum payment amount in the time-limited period, except for relocation payments.
- Requests for any support service payment or bonus payment received more than three months past the month of participation or achievement are ineligible. Requests for exceptions due to extenuating circumstances may be sent to the DFA Family Support Policy Unit for consideration.
- Multiple payments may be issued for the same category of support services as long as the maximum amount is not exceeded.

- Payments must be made by vendor payment when possible. A vendor may be a private individual or a licensed business. Each vendor must be assigned a number to allow payment to be made through the eligibility system. Self-employed participants who render services to other participants are also assigned a vendor number to be paid for those services.

  When using vendor payments, the Case Manager must protect the participant's confidentiality. No referral form to a vendor may specify that the participant is a recipient or how the goods or services obtained with the vendor payment are used. Agreements with some employers or other activity providers may require that this information be included and the terms of that agreement must be followed. However, it is expected that vendor payments and referrals for goods or services not associated with employers or activity providers will protect the participant's confidentiality.

  The system pulls down vendor payments once a week on Friday after the close of business. Payments are processed and batched through OASIS the following week. Checks are printed the following Friday.

  In situations where a payment must be made directly to the WV WORKS participant, the individual's personal identification number (PIN) is the vendor number. In these situations, the Case Manager must also document why the payment must be made to the WV WORKS participant.

  For support service payments issued to the participant, benefits are added to the EBT card during overnight batch once the payment has been approved. Payments that have been available for 365 days from the date of last use are expunged. See Section 10.3.3.
- All payments are requested in the eligibility system.
- Any payment made to a vendor requires an itemized invoice or written estimate of the charges. The invoice must be on the vendor's invoice form, or on his business letterhead. The invoice is filed in the case record.
- When payment is made to a vendor, the invoice or estimate must not include sales tax. When payment is made to reimburse the participant, sales tax is included.
- Recoupment of overpayments is accomplished by entering the category code as ADCW on the Benefit Recovery Referral Screen and explaining in the comments section that the referral is for a Support Service Payment.
- Misdirected, lost or stolen checks are handled according to Section 12.3.
- Support service payments cannot be made by direct deposit.

- Support service payments may not be made for ongoing living expenses, such as rent/mortgage and utilities. This includes the cost of installing new utilities and telephone hook-ups.

  EXCEPTION: Pre-paid phone cards may only be purchased to enable the participant to make activity-related calls when the participant has no home telephone.

  EXCEPTION: The BA-67 form is not required when there is a contract for payment signed by a vendor such as Employer Incentive Program (EIP), Employment Subsidy Program (ESP), or Training Contract.

- The BA-67 form must be used when guaranteeing or promising payment for support services such as clothing, payment of rent for relocation, etc. The procedures outlined by the Bureau for Family Assistance Office of Finance and Administration for issuing and tracking the BA-67 must be followed.
- When a request for a support service payment has been made, but no payment is issued, the Case Manager must notify the participant of the denial using form DFA-WVW-NL-2. The Case Manager must provide a narrative explanation of the reason the payment is denied in terms the participant can easily understand. The action must be recorded in the eligibility system.

  Under no circumstances is it correct to give or mail a DFA-WVW-NL-2 to a participant without a Case Manager-composed explanation of the reason for the denial.

  The DFA-WVW-NL-2 offers the participant the right to a Fair Hearing on this denial and must be mailed or given to the participant with a Hearing request form.
- EBT Support Service Payments must only be used for the item of need and must not be used or accessed in adult entertainment establishments, casinos, gaming establishments, or liquor stores. This provision only applies to establishments which previously and exclusively sell these products and does not include other establishments which also offer gaming activities or sell these products in addition to other goods.

18.19.3 ALLOWABLE SUPPORT SERVICE PAYMENTS

The Case Manager must determine whether or not a need for support services exists. When the Case Manager identifies a need, it is the Case Manager's responsibility to inform the participant about available support services and to follow through to ensure the need is met when possible.

Under no circumstances must the participant be required to identify the specific support service he needs as a condition of receipt. All actions related to support service payments must be recorded in the eligibility system.

Additional information about the specific types of support services that are allowed is contained in this item. No other support service payments may be made.

All support service payments, except transportation, must be approved by a Family Support Supervisor or a person designated to complete supervisory functions in the eligibility system (back-up Supervisor). Supervisors and back-up Supervisors cannot approve support payments which they have entered into the system themselves. A back-up Supervisor may not approve payments entered by a Supervisor. Payments entered by a Supervisor must be approved by another Supervisor. Each Supervisor, back-up Supervisor, or Case Manager may cancel their own payment requests in the eligibility system.

Support Service payments may be cancelled prior to the close of business on the same day of the week in which it was requested by contacting the system helpdesk with the participant's name, payment type and amount.

Work-Eligible Individuals may be participating in more than one activity simultaneously and entered as such in the eligibility system.

The following sections include tables showing the categories of support service payments available and listing the WV WORKS activities and eligibility system components for which such payments may be made.

18.19.3.A Collateral Expenses

Collateral payments may be made for items such as grooming expenses, testing fees, Criminal Identification Bureau (CIB) checks, or other expenses necessary to obtain employment or to participate in a work activity.

Payments for collateral expenses must not be used to pay for medical treatment or items such as eyeglasses, dentures, physical examinations, doctor visits, prescriptions, etc.

Under no circumstances may a collateral payment be made to assist a participant with traffic fines.

Collateral payments are not issued for ongoing household expenses such as rent, deposits, utilities, property taxes, etc.

When a specific support service, such as transportation, commercial driver’s license (CDL), etc., shows that such payment is not allowed for the participant’s approved work activity, collateral

funds must not be used to pay the expense. In addition, payment may not be made from collateral expenses to supplement other allowable support services when the participant has reached the maximum amount.

> **Collateral Expenses Example:** Payment for a CDL is not permitted for those in the Joint Opportunities for Independent Program (JOIN). Therefore, the CDL needed must not be paid for from collateral expenses for the JOIN participant.
>
> **Collateral Examples for Children of WV WORKS participants:** Include but are not limited to higher education entrance exam testing and application fees, tutoring costs, graduation cap and gown, extracurricular activities fees, fees for college classes and books taken in high school, diapers, wipes or formula.

Payment may be made for ***collateral*** expenses as follows:

WV WORKS Activity	System Component	Limitations
College	CL	$450 per 12-month period
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.B Clothing

Clothing may be authorized for a verified offer of employment, or to attend short-term training that is expected to lead directly to employment.

This expense includes uniforms or work clothing, including shoes or boots, but may include dress clothing when the participant accepts a job that requires it.

Payments must be made incrementally, as long as the maximum amount is not exceeded. Lay-away payments for clothing must not be made under any circumstances.

Requests for exceptions due to extenuating circumstances may be sent to the DFA Family Support Policy Unit for consideration.

Payment may be made for ***clothing*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	$200 per 12-month period; $1,000 per lifetime
Job Search and Job Readiness	JR	
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.C Tools and/or Equipment

Tools and equipment may be purchased when there is a verified offer of employment, the need for the tools has been verified by the employer and the employer does not furnish them. The purchase of tools may also be authorized for training and education activities. Verification of the cost must be provided.

Payment may be made for ***tools and equipment*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	$1,000 per lifetime
Continued Support Services/Job Retention	PL	
Education Related to Employment	ED	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Skills Training Related to Employment	JT	
Other Agency's OJTs	OJ	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.D Driver's/Chauffeur's License

Payment must not be made from this category for the test required due to traffic violations or for classes required for driving under the influence (DUI) convictions.

Payment may be made for ***driver's and/or chauffeur's license*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	$50 per lifetime
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.E Commercial Driver's License (CDL)

Payment must not be made for the test required due to traffic violations or for classes required for DUI convictions. See Item K below for DUI-related expenses.

Payment may be made for a ***CDL*** as follows:

WV WORKS Activity	System Component	Limitations
Continued Support Services/Job Retention	PL	$100 per lifetime
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Skills Training Related to Employment	JT	
Other Agency's OJTs	OJ	
Vocational Educational Training	VT	

18.19.3.F Professional License

A professional license may be paid for when required to work in a specific occupation. The participant must have a job offer, or the Case Manager must be reasonably certain that the participant can obtain employment after obtaining the license.

Payment is limited to the cost of the license when not included in the cost of the course and obtaining the license is part of the course completion. Payment may be made for a ***professional license*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	$300 per lifetime
Continued Support Services/Job Retention	PL	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Vocational Educational Training	VT	

18.19.3.G Relocation

A participant may be relocated to a different area of the State or to a different state when an offer of unsubsidized employment has been verified.

- The move must be more than one hour in normal traffic before relocation payments may be approved.
- The payment may include such items as a rental vehicle, mileage for a personal vehicle, and initial living expenses in the new employment area.
- These expenses must be verified and documented in case comments. For any cost that cannot be verified, the Case Manager must justify why the payment was made and the calculations used to determine the payment.

In addition, payments may be made to relocate victims of sexual harassment and domestic violence, sexual assault, and stalking when the safety of the participant and/or the children is compromised. To qualify for payment, the requirements in Section 14.9.1.B must be met and the current living situation must be unsafe. Funds may not be used to move someone to a shelter but may be used to move from a shelter to a residence.

Payment may also be made for relocation within the same general vicinity only when relocating to an area where public transportation is available. Proximity to public transportation must be one mile or more and be reduced to one mile or less. Relocation for this reason does not require an offer of employment. The Case Manager must take the participant's system of support into consideration when relocating to access transportation. Once the participant has relocated to an area where public transportation is available, transportation must no longer be considered a challenge to participation. Relocation for this purpose must be sent to DFA Family Support Policy Unit for approval.

The lifetime limit applies, regardless of the reason for the relocation. If the available relocation amount has been used and sexual harassment and domestic violence, sexual assault, and stalking becomes an issue for the family, contact the DFA Family Support Policy Unit regarding approval.

When both parents in a two-parent household have verified offers of employment, the household may receive a payment up to the $1,500 lifetime limit to meet their moving expenses. The amount paid is divided between the two parents and half of the payment is disbursed equally between the two parents.

A participant's receipt of relocation services through support payment does not make that individual ineligible for the continued service options (EAP/PL). Nor does it make the participant ineligible for TANF for 3 months, unless associated with DCA payment. See 1.5.18.

Payment may be made for ***relocation*** expenses as follows:

WV WORKS Activity	System Component	Limitations
Continued Support Services/Job Retention	PL	$1,500 per lifetime per household
Employment Assistance Program	EA	
Employment: Unsubsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Temporary Barrier – Sexual harassment and domestic violence, sexual assault, and stalking	TV	

18.19.3.H Transportation

The participant must attend an allowable activity for each day that a transportation payment is issued.

- Payments are made to a participant who is beginning to participate in an activity to ensure that transportation is not a barrier. A prepayment of $60 may be authorized for the month of approval only for travel. This prepayment must be deducted from the subsequent transportation payment requested for the initial month.
- Transportation payments may be authorized only if expenses have been incurred or are reasonably expected to be incurred. The full amount does not have to be issued.
- Payments made for private transportation are intended to cover more than the cost of fuel. Daily payments for travel include a portion of the following expenses: fuel, insurance, vehicle maintenance, minor repairs and parking.
- General limitations, in addition to those in Section 18.19.2, are as follows. Limitations specific to an activity are shown in the chart below.
    - Participants who must travel one mile or less to their place of employment or other participation site are not eligible for payment. In making this determination, consideration must be given to the distance traveled to deliver children to day care.
    - Those who ride school buses or other conveyances without cost are not eligible for transportation payments for the days such conveyances are used.
    - Those who use public transportation are reimbursed for the actual cost of the service.

- Transportation stipends received from another source must be deducted from any transportation payments requested.
- When participants share private transportation, only the owner of the vehicle is entitled to a payment. However, if the owner of the vehicle charges the other passengers, the passengers may be reimbursed for their charges. Members of the owner's AG may not be reimbursed when traveling in the same vehicle.
- Under no circumstances must a participant be required to provide a receipt for transportation payments.
- Requests for transportation received more than three months past the month of participation are ineligible. Requests for exceptions due to extenuating circumstances may be sent to the DFA Family Support Policy Unit for consideration.
- Payment may be made under Other Work Activities to applicants who need transportation assistance to complete required drug testing.
- A timesheet signed by the participant and the provider listing the days worked must be submitted for transportation requests.
    - Exception: For those attending college, only the participant needs to sign.

NOTE: Participants in temporary barrier components may receive $15 daily transportation to attend assessment testing or to meet with a resource agency assisting with barrier removal activities.

- A BA-67 is not required for transportation payments made to a vendor.

Payments may be made for ***transportation*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	Payments may not exceed $15 per day; $345 per month
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment Assistance Program	EA	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	

Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Activities	OW	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.I Vehicle Repair

For vehicle repairs, the vehicle to be repaired must be titled or leased in the State of West Virginia in the name of a Work-Eligible adult included in the household. The vehicle may be jointly owned as long as a Work-Eligible adult in the household is one of the joint owners.

- Funds must not be used to purchase a vehicle.
- Funds may be used for state inspection stickers and license plates.
- Funds may be used to pay for driver's education for those without a driver's license.
- Funds may be used for towing to a garage for estimates or repairs.
- Any support service payment plus other available resources for repairs must make the vehicle roadworthy.
- Insurance is not paid under this category.

Payment may be made for ***vehicle repair*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	$2,000 lifetime per work-eligible individual
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment Assistance Program	EA	

Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Activities	OW	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.J Vehicle Insurance

The vehicle for which insurance is paid must be titled or leased in the State of West Virginia in the name of a Work-Eligible Individual. The vehicle may be jointly owned as long as a Work-Eligible adult in the household is one of the joint owners.

Each insurance payment made on behalf of a participant to a vendor or to reimburse a participant for a payment that has been made is limited to:

- State minimum liability;
- Uninsured motorist; and
- Underinsured motorist coverage.

Each payment to a vendor is limited to a six-month coverage increment and must list the State as the payee. Any additional insurance coverage requested by the participant is only paid or reimbursed when there is a lien on the vehicle and the participant provides verification that the bank requires additional coverage.

NOTE: The insurance purchased must meet state minimum coverage requirements. The participant may purchase enhanced coverage at his own expense.

A BA-67 is not required for vehicle insurance payments made to a vendor.

Payment may be made for ***vehicle insurance*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment Assistance Program	EA	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	$1,500 per Lifetime
Job Skills Training Related to Employment	JT	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Activities	OW	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.K DUI Offenses

Payment may be made for costs related to reinstatement of driver's licenses which have been revoked due to substance abuse.

- Allowable expenses include, but are not limited to:
  - DUI classes
  - Licenses reinstatement fee
  - New licenses
  - Ignition interlock systems.
- Expenses that may not be paid are:
  - Test for drug/alcohol use

- Treatment programs
- Any other medical cost.

- The participant must be enrolled in and attending a substance abuse treatment program conducted by a certified treatment specialist. However, treatment cannot be paid.
- Payment limited to costs related to one offense only. All paid costs must be related to the same offense.
- Payment for Ignition Interlock is limited to the initial Division of Motor Vehicles (DMV) fee and three months of service.

This supportive service may also be used to make an up-front payment to work-eligible individuals whose only barrier to obtaining their driver's license is unpaid fines. This applies to any work-eligible individual with a transportation barrier to attend school or work.

The participant must have accepted a referral for Legal Aid of West Virginia for assistance with fines before payment may be made for this purpose.

The payment must be paid directly to a vendor to ensure the elimination of the fine when possible. The participant may be reimbursed only after a receipt of the fine payment is provided.

Use of this support payment must be to pay for fines and fees related to traffic, moving, and parking violations only.

Once the fine has been paid, the participant must then obtain their driver's license. For individuals who receive a prepayment of this supportive service and then do not subsequently participate, future prepayments from supportive services must not be made.

Payment may be made for ***DUI-Related expenses*** as follows:

WV WORKS Activity	System Component	Limitations
College	CL	$750/One offence
Community Service Programs	CS	
Continued Support Services/Job Retention	PL	
CWEP	CW	
Education Related to Employment	ED	
EIP	EI	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	
Job Skills Training Related to Employment	JT	
JOIN	JN	

Other Agency's OJTs	OJ	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Satisfactory Attendance at Secondary School or ABE Program	HS, AB	
Vocational Educational Training	VT	

18.19.3.L High School Diploma or Equivalency Diploma Achievement Bonus

Any Individual or their dependent child included in an active WV WORKS case or either of the transitional benefit options who passes the high school equivalency diploma, graduates from Adult Basic Education (ABE) class or obtains his high school diploma is eligible for an achievement bonus. This includes dependent children in child-only cases.

This is a one-time only payment. Payment may be made only to those individuals without a high school diploma or equivalent, who pass the High School Equivalency Test or obtain a high school diploma. It is not necessary to wait until the diploma is issued.

Parents who are under age 18 and unemancipated at the time the High School Equivalency Test is passed or the high school diploma is received are also eligible for this bonus.

The full amount of $100 must be paid for each individual or their dependent child who obtains their high school diploma or equivalent. Payment for dependent children is issued to the primary person in the case. A dependent child eligible for this bonus must be included in the WV Works payment.

Payment may be made for the ***high school equivalency diploma*** or ***High School Diploma Achievement Bonus*** as follows:

WV WORKS Activity	System Component	Limitations
Applies to any active WV WORKS participant or their dependent child who obtains a high school equivalency diploma or high school diploma. This includes dependent children in child only cases.	AB, CC, CS, CW, EA, ED, EI, FB, FU, FV, HS, JN, JR, JT, OJ, PB, PL, PU, PV, VT, WE	$100 per individual

18.19.3.M Self-Sufficiency Achievement Bonuses

An achievement bonus is paid for retaining employment. To be eligible for this payment, the participant must maintain West Virginia residency during the entire employment period.

- For receipt of these bonus payments only, gross family income must be 200% or less of the current Federal Poverty Level (FPL), excluding Supplemental Security Income (SSI).
- Paid to each former Work-Eligible Individual who is employed full-time during each of the months following AG closure.
- Payment is made at the end of the specified month. The WV WORKS case must have been closed for the entire transitional benefit period.
- Full-time employment is defined as 100 hours per month.
- The amount of the payment must be equal to the maximum payment for the specified time period, the employment hours may be averaged over the time period as 100 hours per month.
- The person employed is not required to be working for the same employer as when the AG was closed.
- Any full-time employment qualifies.
- There is no minimum earnings level to qualify for this bonus.

There are no supportive services issued between the 6-month self-sufficiency payment and the 12-month self-sufficiency payment, however referrals to community agencies must be made if a situation is presented which would result in job loss or fewer work hours. In addition, the Case Manager is required to contact the participant during the ninth month of employment for a job retention follow-up to determine if any community referrals are needed to continue progress towards self-sufficiency.

Payment may be made for the ***Self-Sufficiency Achievement Bonuses*** as follows:

WV WORKS Activity	System Component	Limitations
Continued Support Services/Employment Assistance/Job Retention	EA, PL	$250/6 months $500/12 months

18.19.3.N Vocational Educational and Employment Achievement Bonus

Any Work-Eligible Individual in an active WV WORKS case who completes a Vocational Educational Program is eligible for an achievement bonus if he accepts an offer of full- or part-time employment within 90 days of graduation. For receipt of this bonus, part-time employment is defined as a minimum of 20 hours per week.

The employment does not have to be related to the field of study to be eligible for the bonus.

This is a one-time only payment. Payment may be made only to those active participants who complete vocational educational training and who accept full- or part-time employment. It is not necessary to wait until the vocational certificate or diploma is issued, however written verification of the employment must be obtained.

The customer service portion of SPOKES is considered Vocational Training (VT) for participation purposes and receipt of the Vocational Educational and Employment Achievement Bonus.

The full amount of $250 must be paid.

Payment may be made for the ***Vocational Educational Training Achievement Bonus*** as follows:

WV WORKS Activity	System Component	Limitations
Vocational Educational Training	EA, PL, VT	$250 per lifetime

18.19.3.O Participation Achievement Bonus

Participation achievement bonus is described below:

- Participant may use Holiday or Excused Absence Hours to meet minimum participation hours for receipt of this bonus.
- In a two-parent household where both parents are participating to meet the minimum requirement, each parent may receive the bonus. Refer to Section 18.4.2.B for minimum participation requirements.
- Time sheets received more than three months past the month of participation are ineligible for this payment.
- The participation bonus may still be paid when the participant has met his required hours even if he has exceeded the time limit in the component.
- For the participant to be eligible for the Participation Achievement Bonus, a timesheet signed by the participant and the provider listed each day worked and the attended hours each day to show participation was met.

The full amount of $50 per month per participant must be paid.

Payment may be made for ***participation achievement bonus*** as follows:

WV WORKS Activity	System Component	Limitations
Community Service Programs	CS	$50 per month per participant
CWEP	CW	
EIP	EI	
Employment Assistance Program	EA	
Employment: Unsubsidized, Subsidized, Full- or Part-time	FU, FV, FB, PU, PV, PB	
Job Search and Job Readiness	JR	
JOIN	JN	
Other Agency's OJTs	OJ	
Other Work Experience Programs	WE	
Providing Child Care for Community Service Participant	CC	
Vocational Educational Training	VT	

18.19.4 CORRECTING THE SUPPORT SERVICE PAYMENT AMOUNT

When the Case Manager discovers that a support service payment has been requested for less than was intended, an additional payment for the difference is requested in the eligibility system.

18.19.5 ALLOWABLE SUPPORT SERVICE PAYMENTS FOR CARETAKERS

The Case Manager and the caretaker must discuss available services and assess needs during the interview, assessment process, and at reviews. The participant may also request services as needs arise; form DFA-SS-2 must not be required. Disposition to approve or deny the application for supportive services must be made within 10 working days of receipt of the request. DFA Family Support Policy Unit must be contacted for instructions to issue supportive services for caretakers. Support services may be issued during any month for which a WV

NOTE: Children and Adult Services must be contacted by the case manager to ensure other referrals or demand payments are not available for the caretaker before any support service payment is requested; all payments must be based on need.

WORKS payment is made. A home visit may be required if furnishings are requested. Caretakers and child only households are not required to be employed or attending any activity listed in IMM 18.9-18.18 in order to receive supportive services. Their income and assets are not considered unless they choose to be included in the benefit. These payments are designed to assist with the children in their care.

The Case Manager must make a recording in the eligibility system each time a payment is made, explaining the need for the payment and the reason for the amount issued. This comment must include the calculations used to determine the correct payment.

All support service payments must be approved by a Family Support Supervisor or a person designated to complete supervisory functions in the eligibility system (back-up Supervisor). Supervisors and back-up Supervisors cannot approve support payments which they have entered into the system themselves. A back-up Supervisor may not approve payments entered by a Supervisor. Payments entered by a Supervisor must be approved by another Supervisor.

If lifetime limits of support services have been met, contact DFA Family Support Policy Unit for approval of additional support services

NOTE: Questions on allowable support service payments may be sent to DFA Family Support Policy Unit.

18.19.5.A COLLATERAL

Payment may be authorized under this category for caretaker relatives or child only cases for the TANF eligible children in their care. Payment may be made for items needed to aid with the care of these children when there are no other available resources. The limit is $450 per 12-month period.

> **Collateral Examples:** Include but are not limited to higher education entrance exam testing and application fees, tutoring costs, graduation cap and gown, extracurricular activities fees, fees for college classes and books taken in high school or required children's furnishings.

18.19.5.B CLOTHING

Payment may be authorized under this category for caretaker relatives or child only cases who

are not eligible to receive a demand payment from Children and Adult Services. Clothing is only authorized for the TANF eligible children in their care as determined by the Case Manager based on need. The limit is $200 per 12-month period per eligible child and $1,000 lifetime.

18.19.5.C CHILD CARE

Payment is limited to caretaker relatives who need childcare provided for TANF eligible children in their care who are under the age of thirteen. The caretaker relative may be attending training, other education activities or be employed. The Case Manager may also pay for childcare to be provided while caretaker relatives attend medical or personal appointments or are participating in other non-work-related activities.

The caretaker relative must not be eligible for childcare payment from another source. He must apply for childcare assistance annually and receive a denial due only to excessive income from a Child Care Resource and Referral Agency or Division of Early Care and Education. All other eligibility requirements to receive childcare assistance must be met.

Providers approved by Division of Early Care and Education must be used and are paid monthly using current childcare payment rates once attendance sheets are received.

Payment under this category is limited to $1125 monthly per child and will be issued under collateral payment type. Payment rates are available online on the Division of Early Care and Education Child Care Assistance Policy and Procedure Manual Appendices.

18.19.5.D DRIVER'S LICENSE ASSISTANCE

Payment may be made for a driver's license or state identification card for the caretaker relative or child only case. The limit is $50/lifetime.

18.19.5.E VEHICLE REPAIR

For vehicle repairs, the vehicle to be repaired must be titled or leased in the State of West Virginia in the name of the caretaker relative or child only case. The vehicle may be jointly owned if the caretaker relative or child only case is one of the joint owners.

- Funds must not be used to purchase a vehicle
- Funds may be used for state inspection stickers and vehicle registration
- Funds may be used to pay for a driver's education for those without a driver's license
- Any support service payment plus other available resources for repairs must make the

vehicle roadworthy
- Insurance is not paid under this category

The limit is $2,000/lifetime

18.19.5.F VEHICLE INSURANCE

The vehicle for which insurance is paid must be titled or leased in the State of West Virginia in the name of the caretaker relative or child only case. The vehicle may be jointly owned if a caretaker relative or child only case in the household is one of the joint owners.

Each insurance payment made on behalf of a participant to a vendor or to reimburse a participant for a payment that has been made is limited to:

- State minimum liability
- Uninsured motorist; and
- Underinsured motorist coverage

Each payment to a vendor is limited to a six-month coverage increment and must list the State as the payee. Any additional insurance coverage requested by the participant is paid or reimbursed when there is a lien on the vehicle and the participant provides verification that the bank requires additional coverage.

The limit is $2,000/lifetime

18.19.6 SUPPORT SERVICE PAYMENT RETURNED BY THE PARTICIPANT TO THE LOCAL OFFICE

For any support service payment returned to the local office, the Case Manager must complete an DF-68, The Financial Clerk or their designee attaches the check and mails both to the Accounts Receivable, Office of Accounting. The Accounts Receivable, Office of Accounting Unit disposes of the payment according to the instructions on the DF-68.

18.19.7 SUPPORT SERVICE PAYMENT AND BA-67 REPLACEMENT PROCEDURES

See Section 12.3 for instructions.

18.19.8 RECOUPMENT OF SUPPORT SERVICE PAYMENTS

Recoupment of support service overpayments is accomplished by entering the category-code as ADCW on the Benefit Recovery Referral Screen and explaining in the comments section that the referral is for a Support Service Payment. If the payment is returned, it is sent with an DFA-68 to:

Accounts Receivable
Office of Accounting
321 Capitol Street, 1 Davis Square
Charleston, WV 25301

The Case Manager must identify the returned payments by indicating “Work Support” in the upper right corner. Do not include an account number for deposit of the funds.

When a Case Manager discovers a participant has received an improper cash refund of support service monies instead of goods or services, the amount of the refund will be considered an overpayment of support services and must be recouped.

When a Case Manager issues a support service payment to an individual, a receipt showing that the payment was used as intended may be required. When a receipt is required, it must be provided within 30 days of payment issuance. A DFA-6 or verification checklist must be sent to the participant requesting the receipt. If the participant fails to provide a receipt within this time frame, then recoupment of that support service is required.

> **Example:** A vendor is no longer accepting vouchers for laptops. The Case Manager issues a support payment to the participant for the cost of a laptop on May 15 along with a DFA-6 requesting a copy of the receipt by June 15. If the participant has not returned a copy of the receipt by June 15, then he is referred to repayment for the support payment issued for the laptop.

For individuals participants who receive a prepayment of supportive services under Other Work Activities and then do not subsequently participate, future prepayments from supportive services must not be made.

18.20 PAYMENTS TO EMPLOYERS AND TRAINING FACILITIES

The following instructions apply to issuing payments to employers and providers of skills training.

18.20.1 EMPLOYER INCENTIVE PROGRAM (EIP) EMPLOYERS

EIP employers are reimbursed up to 50% of the participant's gross wages. Payments are issued monthly and are based on information from the time sheet, DFA-TS-12.

18.20.2 EMPLOYMENT SUBSIDY PROGRAM (ESP) EMPLOYERS

ESP employers are reimbursed 100% of the participant's gross wages. Payments are issued based on information from the time sheet, DFA-TS-12 and Employer Reimbursement Request, DFA-ESP-2.

18.20.3 PROVIDERS OF VOCATIONAL SKILLS OR LIFE SKILLS TRAINING

A training contract payment can be made only in response to an invoice from the service provider and payment must be made directly to the vendor. Care must be taken to ensure that the payment limit is not exceeded for any contract. Supervisors must monitor the negotiation of these contracts and the payments made to vendors to determine if problems exist and to take corrective action, as necessary.

Payment may be made for life skills training such as, but not limited to: parenting and financial literacy. Existing programs offered by other agencies must be used first when available without cost.

18.21 CORRECTIVE PAYMENT PROCEDURES

18.21.1 CORRECTIVE PAYMENTS

Corrective payments may be requested by WV WORKS Supervisors for the following:

- Support Services for which a participant is eligible.
- Training contracts approved by the Division of Family Assistance (DFA) Family Support Unit exceeding $600.

The individual for whom the payment is being requested must be enrolled in the case management system at the time the payment is requested. The individual must have been previously enrolled in the activity associated with the request.

18.21.2 CORRECTIVE PAYMENT PROCEDURE

The procedure for requesting corrective payments by the WV WORKS Supervisor is as follows:

- Email the DFA Family Support Unit with the following information:
    - Name of participant
    - PIN number
    - Type of corrective payment - training contract or Support Service payment type
    - Payment amount requested
    - Reason for request/explanation of circumstances

  The Case Manager must make a full recording regarding the circumstances surrounding the request for a corrective payment.
- Place documentation in the participant's case record. The DFA Family Support Unit may request copies of these documents prior to approval of a corrective payment.

  > **Documentation Example:** A copy of the bill or receipt for payment, copy of training contract.
- Complete case management system actions.

18.21.3 REASONS FOR CORRECTIVE PAYMENTS

Corrective payments for Support Services and training contracts may be made only under the following circumstances:

- The maximum support service payment amount has been exceeded and a promise of payment has been made to a vendor using a BA-67.
- Payment made to incorrect vendor and vendor will not return the payment to the Department of Human Services (DOHS).
- The local office has been billed for transportation payments for multiple months by the vendor exceeding the current month maximum.
- Payment due to Fair Hearing decision.
- Transportation payment is owed to the participant for a previous month or months and will exceed the current month maximum.
- Payment made to but never received by the participant and the maximum has been or will be reached (Investigations and Fraud Management (IFM) fraud investigation related only).
- State Office approved Vocational Training Contract exceeds $600.
- Other reason approved by State office.

Replacement of Support Services payments to participants must not be made by Supervisors or Case Managers under any circumstances.

For any additional situations not listed above, please contact the DFA Family Support Unit.

18.21.4 DISPOSITION OF CORRECTIVE PAYMENT

The DFA Family Support Unit will notify the WV WORKS Supervisor, via email, regarding the approval or denial of the corrective payment.

18.22 TRANSITIONAL BENEFIT

Work-Eligible Individuals may choose between two transitional benefit options any time the WV WORKS case is closed due to employment and the participant has reported employment within ten days of the employment begin date. The closure may be at the participant's request, but the participant must be employed.

When the participant accepts employment and the WV WORKS benefit is closed, the Case Manager advises the participant regarding the benefits of each option and the participant chooses the one best suited to the needs of his family. The participant signs the WV WORKS transitional benefit Option form, DFA-WVW-15, to document the decision. The participant has 30 days from the effective date of closure to sign the DFA-WVW-15 to document his decision. The participant is ineligible to receive either option if the form is not returned in the specified time frame or if the employment is not reported timely. The Case Manager must note which option the participant has chosen in the eligibility system. The participant receives one copy of the form and another is placed into the case record. This participant's decision is binding for the transitional benefit.

Both options are considered transitional benefit services. If an individual reapplies for WV WORKS within three months of the last day of the effective month of the closure due to employment, the assistance group (AG) members or non-recipient Work-Eligible are not required to complete another orientation or Personal Responsibility Contract (PRC). An updated Self-Sufficiency Plan (SSP) is still required.

Any individual who has had a positive drug test as a result of the Drug Use Questionnaire, DFA-WVW-DAST-1, is encouraged to continue attending counseling / rehabilitation during the transitional benefit period. Substance abuse sanctions in Section 14.8.2 are not applied for failure to continue with this requirement once employed.

The options are described below:

- Option 1 – This option is a continuation of support services and payments any time a WV WORKS benefit is closed due to employment which meets the requirements outlined below. Services include case management; support service payments; continuation of and payment for activities such as, but not limited to, job search, job readiness, and skills training. Employed former WV WORKS participants must apply to receive continued support service payments, see Section 18.22.
- Option 2 – This option is the West Virginia Employment Assistance Program (EAP). This program enables the employed former WV WORKS participant to continue to receive the Temporary Assistance for Needy Families (TANF) payment he received prior to becoming employed by use of a 100% earned income disregard for the EAP period. The family must elect to receive the EAP payment instead of continued support service payments. Participation hours for this employment may be projected for up to six months

by using either pay stubs or a written statement from the employer. If it is apparent that the hours may vary substantially, the EAP participant must provide a time sheet or pay stubs each month to verify the hours. A PRC or SSP is not required for the transitional benefit period.

> **Transitional Benefit Example:** Ms. Peony, a WV WORKS participant reports employment. The income reported is greater than the program limit, so the WV WORKS benefit closes for March. The Case Manager contacts Ms. Peony and explains the two transitional benefit options; she chooses the EAP option. The Case Manager mails the DFA-WVW-15 to Ms. Peony to obtain her signature, but she fails to return the completed form. In May, Ms. Peony comes in for a Supplemental Nutrition Assistance Program (SNAP) review with the completed form and returns it to the Case Manager. Ms. Peony is not eligible for EAP benefits since she did not return the form within 30 days from the date of closure in March.

When the AG is closed due to imposition of a sanction, no continued support service payments are issued. Because the participant was not employed at the time the benefits ended, he is not eligible for either employment option even if he later becomes employed during the transitional benefit period.

When there is no break in receipt of WV WORKS, such as closures due to a late review or during a good cause period and the individual reports employment, he may still receive a transitional benefit period.

NOTE: If he meets all eligibility requirements, an employed, non-recipient Work-Eligible Individual who was living with a child who was receiving assistance is also eligible to choose one of these transitional benefit options. These services, support payments, and employment assistance are handled in the same manner as for former participants who were included in the WV WORKS AG.

18.22.1 ELIGIBILITY REQUIREMENTS FOR TRANSITIONAL BENEFIT OPTIONS

Individuals who meet all of the following requirements may choose a transitional benefit option:

- Gross family income is 150% or less of the current Federal Poverty Level (FPL), excluding Supplemental Security Income (SSI); and
- The family resides in West Virginia; and
- The family's countable assets must be below the TANF asset limit; and

- One adult in the family, who lives in the household, meets all of the following requirements:
    - Is employed;

      For the EAP, this must be full-time employment defined for a one-parent family as 128 hours or more per month or 85 hours for a single parent with a child under six; and defined for a two-parent family as 150 hours or more per month or 236 hours when the family receives federally funded child care. For a two-parent household, the hours required may be met by combining the work hours of both parents.
    - Due to employment, the AG exceeds the program income limit or requested the benefit be closed due to employment;
    - Received a monthly WV WORKS benefit, not solely a Diversionary Cash Assistance (DCA) payment, as a Work-Eligible Individual or was in the household as a non-recipient Work-Eligible Individual; and
    - Has a dependent child in the home.

NOTE: When the Case Manager determines that the AG exceeds the income limits for the transitional benefit period or no longer meets the above requirements, the family is notified that the period is ending taking adverse action notification requirements into consideration. Refer to each program section in Chapter 10 for action needed on reported changes when verification is not returned.

Transitional Benefit Options Example 1: Ms. Heather receives WV WORKS for herself and her two children. She marries a man who is employed and his earnings close the case effective April. The six-consecutive-month period begins on May 1 and ends October 31. In August, the family requests support services to fix the husband's car. Even though the family is within the transitional benefit period, the request must be denied. The household is not eligible for either of the transitional benefit options because the working adult has not received WV WORKS.

Transitional Benefit Options Example 2: Mr. Balsam has been receiving WV WORKS for himself and his two children. He acquires some equipment and begins his own lawn service. He begins receiving income from his business and requests that his benefit be closed. He reports his weekly income and the Case Manager determines that he is working the equivalent of 15 hours per week. Since he is a single parent with a child under six, he must be working at least 20 hours to qualify for EAP, but he is still eligible to receive support services through the support services option after he signs the DFA-WVW-15.

Transitional Benefit Options Example 3: A husband and wife receive WV WORKS for their four children. The 16-year-old child quits school and moves out on his own effective October. He starts working at a fast-food restaurant in October and requests support services to help maintain his employment. Even though he is within the time frame for receipt of transitional benefit services and is working, he is ineligible for either program because he was not included in the AG as an adult and there is no dependent child living with him.

Transitional Benefit Options Example 4: Rose receives WV WORKS for herself and her two children. She is working part-time and marries a man who is working full-time. Counting his income makes the AG ineligible for WV WORKS effective November. She signs the DFA-WVW-15 and opts to receive transitional benefit payments. The six-consecutive-month period begins December 1 and continues through May 31.

In February, the husband has a wreck and they request support services to repair the vehicle. He meets all of the requirements except he was not a WV WORKS participant. However, because the wife was working and was a Work-Eligible Individual, she meets all of the requirements, so the family qualifies for support services to repair his vehicle.

18.22.2 DETERMINING THE TRANSITIONAL BENEFIT PERIOD

The transitional benefit services eligibility period begins the month after the effective month of closure and continues through the end of the sixth month. Case management services must be provided throughout the continuation of support services or employment assistance period. However, only cases eligible for WV WORKS support service payments or EAP must remain in the WV WORKS caseload.

Determining the Transitional Benefit Period Example 1: A WV WORKS AG is first closed effective November. Mr. Birch chooses the Support Service Payment option. He receives support service payments for transportation for December and January. In March, he begins riding with another employee and support service payments for transportation stop. The employee who was providing transportation to the participant leaves his job in April and Mr. Birch has no reliable transportation to get to work. The Case Manager and Mr. Birch agree to repairs to the vehicle he drove before he began carpooling. He receives a support service payment for repairs and begins receiving transportation payments again in late April. In June, his car needs new brakes and he requests help to pay for the repairs. His six consecutive months ended on May 31 so his request for payment must be denied. Transportation payments also end in May.

> **TRANSITIONAL BENEFIT Period Example 2:** An AG is closed effective May 30 due to the receipt of a lump sum payment. At the time of closure, it is determined that the family will remain ineligible for WV WORKS through September. The family has already spent all of the lump sum payment by the end of June. The parents reapply for WV WORKS in June and are denied. In July, the mother and father both begin working part-time. They both request support services in July to help with transportation. Neither is eligible because the family remains in a period of ineligibility due to receipt of the lump sum payment. They ask for assistance again in August and September and remain ineligible for support services. In October, they again request assistance, although their period of WV WORKS ineligibility is over, they are ineligible to receive support payments because they do not meet the eligibility requirements since closure reason was not due to employment.

For participants who choose the Employment Assistance option, the EAP payments must be stopped before adverse action in the final month so that no payment is issued for the next month. Advance notice requirements apply. The Case Manager must update the eligibility system.

EAP repayment is completed by following IMM 11.3.

18.22.3 SUPPORT SERVICE PAYMENTS

Although the participant must actually request support services and apply for a support payment prior to the issuance of the payment, it is the Case Manager's responsibility to ensure that the participant is aware he is eligible for continued support service payments and inform the participant of the services available. The Case Manager must note in the eligibility system that the individual has opted to receive support service payments and place the DFA-WVW-15 into the case record. The decision is binding for the transitional benefit period.

The Case Manager is responsible for identifying or for soliciting from the participant his statement of need.

All support service payments for the transitional benefit services period must be entered in the eligibility system by the last work day in the month following transitional benefit services closure. Payment may be made in the month after transitional benefit services closure for expenses from the final month of transitional benefit eligibility. Payment may not be made for any expenses from the month following transitional benefit closure.

All requests for continued support service payments may be made on application form DFA-SS-2, electronically, or verbally.

EXCEPTION: Payments for transportation require completion of a DFA-TS-12.

18.22.3.A Application Form, DFA-SS-2

Form DFA-SS-2 may be completed in a face-to-face interview, mailed, scanned, faxed, or left at the front desk to give to the Case Manager. A supply of these forms must be available to the participant without having to see a Case Manager. It is suggested that a supply of forms be provided to the participant to mail in as needed. Any additional information may be obtained by telephone or by mail.

Except for ongoing transportation needs, the Case Manager is required to talk to the participant prior to acting on the DFA-SS-2 to confirm the identity of the person making the request and to discuss the need for the payment. Failure to be available at a pre-determined time for these confirmations does not result in application of a sanction; it results only in denial of the requested payment.

NOTE: Although non-recipient Work-Eligible Individuals are not included in the AG, they are eligible to receive continued support services and payments as long as they meet all other eligibility requirements.

18.22.3.B Participant Notification, DFA-WVW-NL-3

If any support service payment is issued to, or on behalf of the participant, the participant is sent a notice at the end of that month that identifies all payments made to the participant, or on behalf of the participant. This letter is automatically generated and sent from the eligibility system.

If payment is denied the participant must be notified using form DFA-WVW-NL-3.

The Case Manager must issue this notice upon denial and provide a narrative explanation of the reason the payment is denied, in terms the participant can easily understand.

Participant Notification Example 1: A non-recipient Work-Eligible individual's family last received WV WORKS in January and applies for payment for vehicle repairs in August.

The Case Manager includes the following statement in the letter:

Your last WV WORKS benefit was for January. Payments may be made to former WV WORKS participants for only six months after the last benefit. Since you applied for the payment in August, you are not eligible to receive this payment. Your eligibility for these payments ended in July.

Participant Notification Example 2: Crocus, a former participant, last received WV WORKS four months ago. Five months ago, her youngest child turned 19.

The Case Manager includes the following statement in the letter:

Our records show that Ficus is your youngest child and he turned 19 on _____. Since he is now an adult, you do not meet the requirement of having a dependent child in your home.

Under no circumstances is it correct to give or mail a DFA-WVW-NL-3 to a participant without a narrative Case Manager-composed explanation of the reason for the denial.

The DFA-WVW-NL-3 offers the participant the right to a Fair Hearing on this denial and must be mailed or given to the participant with a Hearing request form.

NOTE: Continued support service payments are made to those who exhaust 60 months receipt of TANF if an adult in the household was employed during the 60th month of receipt and they otherwise meet the qualifications in this section.

18.22.4 EMPLOYMENT ASSISTANCE PROGRAM (EAP)

The Employment Assistance Program allows the employed former WV WORKS participant to continue to receive benefits through a 100% earned income disregard for the transitional benefit period following WV WORKS closure.

EAP recipients must continue to cooperate with the Bureau for Child Support Enforcement (BCSE) and child support must continue to be redirected while receiving the EAP payment.

Additions to the AG after the EAP has begun do not increase the EAP payment amount. The unearned income of the added individual(s) must be considered. Home visits and self-sufficiency evaluations are not required during the EAP period.

The Case Manager must explain that EAP payments count against the 60-month time limit for receiving TANF and explain the effect of the EAP on other benefits the family may receive.

The family may decide at any time during the transitional benefit period that they no longer wish to receive the EAP payment and may not receive support service payments instead. Once the EAP is discontinued, no additional EAP may be issued unless the individual is found eligible for a new transitional benefit period.

While receiving EAP, the employed parent must be placed in an employment activity in addition to the EAP. The other parent in a two-parent household must be enrolled in the EAP and may be enrolled in any other activity they are participating in.

All support service payments for the transitional benefit services period must be entered in the eligibility system by the last workday in the month following transitional benefit services closure. Payment may be made in the month after transitional benefit services closure for expenses from the final month of transitional benefit eligibility. Payment may not be made for any expenses from the month following transitional benefit closure.

EXCEPTION: When a participant's hours are reduced by the employer to below what is required for EAP, the participant may receive support services for the remainder of his original transitional benefit period only when the following conditions are met:

- *He remains over income for WV WORKS benefits; and*
- *His hours were reduced through no fault of his own.*

Once the participant has chosen the EAP benefit and has signed the DFA-WVW-15, the Case Manager must update the eligibility system to lock in the transitional benefit period. If the participant reports a reduction of hours or a job loss and no longer meets the requirements of Section 18.22.1, then the Case Manager must adjust the months of eligibility in the eligibility system to end the EAP benefit. The Case Manager enters the last month of EAP eligibility, taking adverse action deadlines into consideration.

NOTE: This program is not available to participants who will reach their 60-month time limit within the transitional benefit period of eligibility.

18.22.4.A Projecting Hours of Participation in the EAP

The hours of participation for participants in the EAP may be projected for up to six months. The number of hours projected are based on the 30 days of pay stubs or signed wage statements from the employer. These hours may be used to project the participant's hours for up to the six-month limit, unless the Case Manager becomes aware of a change or the participant reports a

change in circumstances that requires recalculation. The pay stubs or wage statements must be from the preceding 30-day period and may include hours for which the participant was paid, but did not work, including paid leave and paid holidays. If the wage statements/pay stubs available are not representative of continuing circumstances, the actual hours must be reported each month by using a time sheet, employer's statement, or pay stubs and participation hours are not projected. See Section 4.5.1 for WV WORKS budgeting methods.

> **Projecting Hours of Participation Example:** Ms. Juniper has been receiving WV WORKS for 15 months. She obtains employment and requests that her WV WORKS benefits be closed for February. The Case Manager receives an employer's statement that Ms. Juniper is expected to work 30 hours per week. She chooses to receive the EAP and signs the DFA-WVW-15. The Case Manager enters 128 hours monthly in the eligibility system for each of the following six months. Any car repair payments, insurance, transportation or bonuses are issued through the EAP component.

18.22.4.B Calculating the EAP Benefit Amount

Step 1: Add the countable unearned income of the AG and any disqualified person(s). The resulting amount is the countable income.

The amount of child support pass-through is excluded as unearned income for EAP. See Section 4.5.2.B.

Step 2: Determine the maximum WV WORKS benefit amount for the AG size, using Chapter 4, Appendix A.

Step 3: If the amount arrived at in Step 1 equals or exceeds the amount in Step 2, the AG is ineligible.

If the amount arrived at in Step 1 is less than the amount in Step 2, the AG is income eligible and the amount from Step 1 is subtracted from the amount in Step 2.

Step 4: Subtract any repayment amount from the amount remaining. This amount is found in the eligibility system. The result is the EAP benefit amount. The Case Manager must send an email to the Repayment Investigator (RI) for his county so the repayment amount will be credited to the participant's account.

> **Calculating the EAP Benefit Amount Example:** Mr. Rose was eligible for a WV WORKS benefit of $340, but was receiving a payment of $306 due to a repayment amount of $34. When calculating his EAP benefit amount, $34 is subtracted in Step 4 and an email is sent to the RI for that county.

APPENDIX A: GRIEVANCE RIGHTS FOR REGULAR EMPLOYEES OF CWEP, JOIN AND EMPLOYER INCENTIVE PROGRAM

A.1 DEFINITION

The Department of Human Services (DOHS) acknowledges that CWEP, JOIN, EIP, and ESP work assignments shall not:

- Result in the displacement of currently employed Case Managers, including partial displacement such as a reduction in hours of non-overtime work, wages, or employment benefits;
- Impair existing contracts for services or collective bargaining agreements;
- Result in the employment or assignment of a participant or the filling of a position when any other person not supported under this program is on layoff from the same or a substantially equivalent job within the same organizational unit, or when an employer has terminated any regular employee or otherwise reduced its workforce with intention of filling the vacancy so created by hiring a participant whose wages are subsidized under this program;
- Shall not infringe in any way upon promotional opportunities of persons currently in jobs not funded under this program; and
- Shall not result in the filling of any established unfilled position vacancy by a participant assigned to the WV WORKS program. (This applies to CWEP and JOIN only.)

A.2 PROCEDURES TO FOLLOW IN ORDER TO RESOLVE REGULAR EMPLOYEE GRIEVANCES

- The grievance must be filed within 90 days of the date that the perceived displacement occurred.
- Each worksite will be provided with Employee Grievance Posters and grievance procedures and forms. The posters shall be placed in locations conspicuous to employees.
- The procedures for resolving complaints by regular employees or their representatives that a work assignment of a WV WORKS participant violates the above prohibition are as follows:

Step 1: The grievant attempts to resolve the complaint with his/her immediate supervisor within two (2) days of the alleged occurrence. A conference or hearing can be held.

The supervisor shall give a written response to the grievant within three (3) days. The grievant may accept the decision or proceed to:

Step 2: The grievant requests a review from the employer within two (2) days. The employer gives a written response to the grievant within five (5) days. Grievant accepts the decision or proceeds to:

Step 3: Written WV WORKS Grievances form is forwarded by the employer within two (2) days to the local WV WORKS Supervisor.

The WV WORKS Supervisor will forward the grievance form to the DOHS Hearing Officer within two (2) days of receipt of the form from the employer. The Hearings Officer will generally render a decision within fifteen (15) days. The Case Manager will record case comments for the participant's statement concerning the date, and will also record why it cannot be reasonably anticipated.

Step 4: The decision of the Hearings Officer may be appealed by the grievant within 30 days after the receipt of the Hearings Officer's decision. The appeal must be sent to the:

Office of Administration Law Judges
U.S. Department of Labor
Vanguard Building
Room 600
1111 20th Street, N.W.
Washington, D.C. 20036

The Appeal Shall Contain:

- The full name, address and telephone number of the appellant;
- The provisions of the Statute or regulations believed to have been violated;
- A copy of the original complaint filed by the appellant with the State; and
- A copy of the State's funding and decision regarding the appellants complaint.

The Office of Administrative Law Judges will request the following from the Hearings Officer:

- Upon receipt of an appeal the Office of Administrative Law Judge shall request from the State agency and the State shall, within 30 days of such request, certify and file with the Office of Administrative Law Judges the entire administrative record of the matter under appeal. The DOHS shall send copies of this record to the Assistant Secretary for

Employment and Training and the Assistant Secretary for Family Support at the addresses set forth in Step four of this section.

- Upon receipt of the above information, the Assistant Secretary for Employment and Training shall review the record and through the Office of the Solicitor of Labor, file, if appropriate, a brief or a report with the Office of Administrative Law Judges for that office's consideration. DOHS and the Assistant Secretary for the Family Support may also file a report with the Office of Administrative Law Judges.
- The decision of the Office of Administrative Law Judges outlined in Step four of this section shall be the final decision of the Secretary of Labor on the appeal.

APPENDIX B: GRIEVANCE RIGHTS FOR CWEP AND JOIN PARTICIPANTS WITH RESPECT TO ON-THE-JOB WORKING CONDITIONS, WORKERS' COMPENSATION COVERAGE AND WAGE RATES

B.1 DEFINITION

The Department of Human Services acknowledges that CWEP and JOIN participants will have the right to request a Grievance with respect to:

- On-the-job working conditions which include:
    - Employment or training be related to the capability of the participant to perform the tasks on a regular basis, including physical capacity, skills, experience, family responsibilities and place of residence.
    - The total daily commuting time to and from home to the work or training site to which the participant is assigned shall not normally exceed two (2) hours, not including the transporting of a child to and from child care, unless a longer commuting distance and time is generally accepted in the community, in which case the round trip commuting time shall not exceed the generally accepted community standards without the participant's consent.
    - No participant shall be required, without his or her consent to remain away from his or her home overnight.
    - The conditions of participation are reasonable, taking into account in each case the proficiency of the participant and the child care and other supportive service needs of the participant.
    - For training to be appropriate, the nature of the training shall meet local employers' requirements so that the participant will be in a competitive position within the local labor market. The training must also be likely to lead to employment which will meet the appropriate working conditions identified above.
    - Health and safety standards. Participants are subject to the same health and safety standards established under State and Federal law, that otherwise apply to other individuals in similar assignments.
    - Non-discrimination. No persons shall be discriminated against on the basis of race, sex, national origin, religion, age or handicapping condition, and all participants will have such rights as are available under any applicable Federal,

State or local law prohibiting discrimination.

- Workers' Compensation And Tort Claims Protection
    - Each participant must be covered by Workers' Compensation
- Wage rates used in calculating the hours of participation for CWEP

B.2 PROCEDURE TO FOLLOW RESOLVE A CWEP OR JOIN PARTICIPANTS GRIEVANCE

- The grievance must be filed within 90 days of the date that the perceived infraction occurred.
- At the time of the placement each CWEP or JOIN participant will be advised of their right to the Grievance Procedure.
- The procedure for resolving complaints by CWEP or JOIN participants or their representatives that a work assignment of a CWEP or JOIN participant violates the above prohibitions are as follows:

Step 1: The grievant attempts to resolve the complaint with his/her immediate supervisor within two (2) days of the alleged occurrence. A conference or hearing can be held.

The supervisor shall give a written response to the grievant within three (3) days. The grievant may accept the decision or proceed to:

Step 2 The grievant requests a review from the employer within two (2) days. The employer gives a written response to the grievant within five (5) days. Grievant accepts the decision or proceeds to:

Step 3 Written JOBS Grievance for is forwarded by the employer within two (2) days to the local WV WORKS Supervisor.

The Work and Training Supervisor will forward the grievance form to the DOHS Hearing Officer within two (2) days of receipt of the form from the employer. The Hearing Officer will generally render a decision within fifteen (15) days.

Step 4 The decision of the Hearings Officer may be appealed by the grievant within 30 days after the receipt of the Hearings Officer's decision. The appeal must be sent to the:

Office of Administration Law Judges
U.S. Department of Labor
Vanguard Building
Room 600
1111 20th Street, N.W.
Washington, D.C. 20036

The Appeal Shall Contain:

- The full name, address and telephone number of the appellant;
- The provisions of the Statute or regulations believed to have been violated;
- A copy of the original complaint filed by the appellant with the State; and
- A copy of the State's funding and decision regarding the appellants complaint.

The Office of Administrative Law Judges will request the following from the Hearings Officer:

- Upon receipt of an appeal the Office of Administrative Law Judge shall request from the State agency and the State shall, within 30 days of such request, certify and file with the Office of Administrative Law Judges the entire administrative record of the matter under appeal. The DOHS shall send copies of this record to the Assistant Secretary for Employment and Training and the Assistant Secretary for Family Support at the addresses set forth in Step four of this section.
- Upon receipt of the above information, the Assistant Secretary for Employment and Training shall review the record and through the Office of the Solicitor of Labor, file, if appropriate, a brief or a report with the Office of Administrative Law Judges for that office's consideration. DOHS and the Assistant Secretary for the Family Support may also file a report with the Office of Administrative Law Judges.
- The decision of the Office of Administrative Law Judges outlined in Step four of this section shall be the final decision of the Secretary of Labor on the appeal.

APPENDIX C: INSTRUCTIONS FOR COMPLETING DFA-EIP-1

An DFA-EIP-1 must be completed for each individual placed into the Employer Incentive Program (EIP). Group contracts are not acceptable. In addition, all agreements must be negotiated and signed by all parties prior to the initial start date. Payment to the employer will be based on the hours of work shown on the appropriate time sheet.

Section I

WV DOHS Office Address:	Local DOHS Office address and telephone number
Agreement Number:	Authorized Representative: Person authorized by employer to sign EIP Agreement The agreement number shows agreement, the State Fiscal Year, the county number and the sequential agreement number for that county > **Agreement Number Example:** EIP-06-01-05 is for Fiscal Year 2006 (06), Barbour County (01), sequential EIP Agreement number 5 (05)
Participant Name:	Name of person being assigned
Social Security Number (SSN):	Participant's SSN
PIN:	Participant's PIN

Section II

Employer:	Names of Employer
Address:	Address where reimbursement is to be mailed and phone number.
Vendor Number:	Assigned by fiscal office
FEIN:	Federal Employer TAX Identification Number
Worker's Comp Number:	Employer's Worker's Compensation Number

Section III

Effective EIP Training Dates:	Date the placement is to begin and the estimated ending date
Employer's Product or Service:	The business in which the employer is engaged
Payment Schedule:	Monthly itemized invoice. EIP payments are made monthly upon receipt of the DFA-TS-12 or other appropriate time sheet

Section IV

Identify the total fixed price the EIP Agreement cannot exceed. Enter the dollar amount the Agreement cannot exceed. (Example: $5.15 x 200 ÷ 50% = $515.00)

Section V

Signatures:	Enter signatures, titles, date signed

Section VI

Location and Person in Charge:	Enter the location of the placement and the person in charge
Statement of Employer's Need for EIP:	A brief statement of the Employer's need for the EIP is to be entered here. (If additional space is needed attach a separate sheet of paper.)
Job Description:	A brief job description is to be entered here. (If additional space is needed attach a separate sheet of paper or the OFS-JO-1 may be used.)

Section VII

Concurrence of the Collective Bargaining Agent:	If the occupation is subject to collective bargaining, enter the name, title and union affiliation of the bargaining representative.

Section VIII

General Provisions to the EIP Agreement:	The employer's authorized representative must read this section. His signature signifies that these conditions will be followed.

APPENDIX D: INSTRUCTIONS FOR COMPLETING TRAINING AGREEMENT DFA-TA-34

An DFA-TA-34 must be completed for each individual placed into a jobs skills/vocational training activity. The agreement must be negotiated and signed by both parties prior to the enrollee/ participant training start date. Invoices for payment will be on the training facility's regular invoice form or letterhead. Invoices should be submitted to correspond with Part V of the agreement payment schedule. Payments will be made via eligibility system supportive service to the provider for the cost of the course. Expenses incurred by a participant will be completed according to instructions in Chapter 24. An original and one copy of the DFA-TA-34 is to be completed. The original should be filed in the participant's case record with the second copy being given to the contractor. If desired, the WV WORKS Supervisor may also keep a copy in an office file.

D.1 INTRODUCTION

- Contract Number- The contract or agreement number is entered here. Each WV WORKS Unit is responsible for maintaining a register of numbers to avoid duplication in the numbering system. The numbers will consist of four parts. The first part will be the letters ST which denote Skills Training. The second part will be the last two digits of the fiscal year. The third part will be the county number. The fourth part will be the number of the contract in sequence. Thus the sixth Skills Training agreement negotiated by Barbour County during fiscal year 2004 will be numbered ST-04-01-06.
- Eligibility System Vendor Number- Enter the eligibility system Vendor number. The contract cannot be signed until this vendor number is recorded on the DFA-TA-34.
- Subcontractor/Authorized Representative- Enter the name of the training facility and the name and address of the individual authorized to sign the agreement on its behalf.

D.2 SECTION I

- Enter the beginning and ending dates of the training program and the number of weeks this agreement will cover.
- Registrant's name, social security number and case number.

D.3 SECTION II

- Enter name or type of training.
- Enter number of weeks required for completion of the course.
- Enter number of hours the registrant will be required to attend each week.
- Enter the address of the facility.
- Enter the name of the person in charge of the training.
- The Subcontractor must provide a description and outline of the training to be provided which is to be attached to the DFA-TA-34.

D.4 SECTION III

- Enter the total dollar amount that the sum of the payments cannot exceed.

D.5 SECTION IV

- All costs to provide the training must be identified. (For example: books, cost of the course, etc.)

D.6 SECTION V

- Payments are to be made based on the itemized invoice provided by the Subcontractor for the expenses incurred each month.

D.7 SECTIONS VI-XIII

- The Subcontractor must read and signify by signing that these statements are understood.

D.8 CONCLUSION

- The WV WORKS Supervisor or designee signs for the WV WORKS Program. The authorized representative of the training facility signs for the Subcontractor.

APPENDIX E: WV WORKS VOLUNTEER JOB DESCRIPTION TEMPLATE

This template should be used by the local office to determine the job description for a self-initiated Community Service volunteer placement found by the client. The Worker should obtain this information from the agency for which the participant will be working. The information may be obtained via phone or in person. A copy of this job description must be placed in the case record.

Agency Information

Agency Name: _____

Address: _____

Phone: _____

Volunteer agency contact who is providing this information: _____

Volunteer agency contact responsible for timesheets: _____

Types of Community Services provided by the agency (health, environment, services to senior citizens, etc):

Volunteer Position Information

Volunteer Job Title: _____

List skills, experience, and education necessary, including any special training, license, equipment or clothing required:

How long should it take to learn the position and skills associated with the job? _____

How often should this volunteer position be reviewed? _____

Description of how this volunteer position meets the participant's needs:

Date Set for Review of volunteer position: _____

_____ _____

WV WORKS Worker's Signature Date

WV WORKS Volunteer Job Description Template (New 10/06)

APPENDIX F: FLSA DESK GUIDE

	Single Parent, Child Under Age 6		All Family Household		Two-Parent Household		Two-Parent Household Receiving Federally-funded Child Care	
	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours	Minimum Monthly Hours	Average Weekly Hours
Core Hour Requirement	85	20	85	20	128	30	215	50
Work Components: Participation Requirements	85	20	128	30	150	35	236	55

The minimum monthly required core hours of 85 (Single Parent, All Family) and 128 or 215 hours/month (Two-Parent Household) are met if the calculation of the CWEP obligation hours equals less than the minimum average core hours requirement. When this occurs, the Worker must assign additional core or non-core work activities not regulated by FLSA to meet the applicable minimum total of 128, 150, or 236 average participation hours/month.

- The scheduled hours in the eligibility system must not exceed the minimum monthly participation rate requirements.
- The parent may be required on their Self-Sufficiency Plan (SSP) to participate for their FLSA computed hours, but no sanction may be imposed as long as the minimum level is met.
- The scheduled and completed hours entered for the FL component will be the same as the FLSA calculation.
- At the end of the reporting period, the Case Manager must record the actual hours completed in the CS Core component and the scheduled hours as assigned by FLSA computations are recorded as completed in the FL component.
- If the hours reported in the CS component match the hours reported in the FL component, the participant will be deemed to meet the Core participation requirements.
- The Case Manager must make thorough case comments.

Chapter 19

School Clothing Allowance

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
19.1				
19.2	6/1/21 7/1/22 7/1/25	805 824 868	19.2 19.2.1.D 19.2.1.A 19.2.1.B 19.2.1.C 19.2.2.A	Replaced voucher with benefit Clarify WV WORKS expungement Add an exception for the 2025 SCA season, these AGs must apply. Add an exception for the 2025 SCA season, all families must apply. For the 2025 SCA season, these families must apply for SCA. A governor's letter will not be included for the 2025 season.
19.3	12/1/19 4/1/20 7/1/20 9/1/20 9/1/20 6/1/21 7/1/22 7/1/25	779 784 788 792 792 805 824 868	19.3.1.N 19.3 19.3.1.J 19.3.1.C&D 19.3.1.J 19.3 19.3.1.N 19.3.1 19.3.1.N & 19.3.2.A	Clarifying note Changed inROADS to WV Path Clarified applications Clarified date of application for SCA Clarified requirements Replaced voucher with benefit Clarify WV WORKS expungement. Add an exception for the 2025 WVSCA season, no DFA-WVSC-1 will be mailed by the system, and no automatic issuance will occur. All families must submit an application for this program of assistance. A governor's letter will not be included for the 2025 season.
19.4	7/24/18 12/1/19 6/1/21 6/1/21 7/1/21 7/1/22	763 779 805 805 806 824	19.4.3.A 19.4.9 19.4 19.4.13 19.4.5 19.4.9-10	SB 186 Changed SCA to include 4-year-olds Clarifying note Replaced voucher with benefit Ineligibility of adopted children receiving SCA Income limit for SCA was increased Changed form to IG-IFM-BENPAY-1
App A				

App B	9/1/20 6/1/21	792 805		Updated instructions for SCA issuance by EBT Replaced voucher with benefit

19.1 INTRODUCTION

This chapter sets forth specific policy and procedures which apply to the WV WORKS School Clothing Allowance (SCA) program and the West Virginia School Clothing Allowance (WVSCA) program.

19.2 WV WORKS SCHOOL CLOTHING ALLOWANCE INFORMATION

19.2.1 APPLICATION PROCESS

The application process for WV WORKS School Clothing Allowance (SCA) is the same as for WV WORKS applicants, with the following special considerations, described below.

19.2.1.A Open WV WORKS Assistance Groups (AG) and Employment Assistance Program (EAP) AGs

When a WV WORKS or EAP AG is open before the last working day of June and benefits are issued for July, an SCA benefit for each eligible child is automatically issued to the primary person in the case. Benefits for these cases are issued during the initial mailing issuance.

EXCEPTION: For the 2025 SCA season, these AGs must apply.

19.2.1.B WV WORKS Applications Approved During July of The Current Program Year

When a WV WORKS application is approved, effective on or after July 1 of the current program year, and includes a benefit for July, SCA must be requested in the eligibility system in order for benefits to be issued to SCA-eligible children included in the AG.

EXCEPTION: For the 2025 SCA season, all families must apply.

The procedure for benefit issuance is as follows:

- The eligibility begin date must be no later than July 31 of the current program year to request the benefit on the benefit request screen.
- For WV WORKS AGs approved during July, and for which a benefit has been requested, benefits are added to the EBT card during overnight batch following confirmation of the SCA benefit.
- After the initial issuance, benefits are issued to the EBT card during overnight batch following confirmation of the SCA benefit.

19.2.1.C Applications Approved after Deadline in June and Prior to Last Working Day in June of the Current Program Year

For AGs with an eligible child included and approved for WV WORKS between the June system deadline and the last working day in June, benefits will be issued to the EBT card during overnight batch following confirmation of the SCA benefit.

For the 2025 SCA season, these families must apply for SCA.

19.2.1.D The Benefit

All eligible AGs will receive benefits on the EBT card. The benefit must be used at participating retailers for clothing appropriate for school.

Households choosing direct deposit for the WV WORKS benefit will receive SCA on their EBT card.

EBT School Clothing funds must only be used for clothing appropriate for school and must not be used or accessed in adult entertainment establishments, casinos, gaming establishments, or liquor stores. This provision applies only to establishments which primarily or exclusively sell these products and does not include other establishments which also offer gaming activities or sell these products in addition to other goods.

All EBT provisions in Section 1.5.17.B also apply to the SCA benefit.

NOTE: Foster parents receive one check for all children in the foster home. This is handled by the Bureau for Children and Families (BCF) Office of Child and Adult Services. No Division of Family Assistance (DFA) application is necessary.

NOTE: See Section 1.4.17.C for Categorical Eligibility for the Supplemental Nutrition Assistance Program (SNAP). Categorical Eligibility due to SCA receipt will expire on October 31st of the program year. Benefits that have been available for 365 days from the date of last use are expunged. See Section 10.3.3.

19.2.2 NOTIFICATION

Notification is required.

19.2.2.A Approvals

Instructions to the client and the Governor's letter are included with all SCA benefits upon approval.

EXCEPTION: A governor's letter will not be included for the 2025 season.

19.2.2.B Denials

WV WORKS denials result in consideration of eligibility for SCA when the response to the request for SCA is "Y" in the eligibility system.

19.3 WEST VIRGINIA SCHOOL CLOTHING ALLOWANCE

19.3.1 APPLICATION PROCESS

An Application for West Virginia School Clothing Allowance (WVSCA), form DFA-WVSC-1, will be mailed to families with school-age children who received WVSCA in the previous program year and who are included in an active Supplemental Nutrition Assistance Program (SNAP) or Medicaid assistance group (AG) in June of the current program year. Active SNAP AGs who have indicated they want to be evaluated for automatic issuance of School Clothing Allowance (SCA) if determined eligible by the deadline for the current program year will not be mailed WVSCA application forms and will be included in the automatic issuance. When there is a child in the case who is less than 5 or older than 17, the eligibility system will send a DFA-WVSC-1 during the regular mass mailing. All other applicants must complete a DFA-WVSC- 1, DFA-2, or use WV PATH to apply for WVSCA.

EXCEPTION: For the 2025 WVSCA season, no DFA-WVSC-1 will be mailed by the system, and no automatic issuance will occur. All families must submit an application for this program of assistance.

19.3.1.A Application Forms

The Application/Redetermination form, DFA-2, or the Application for West Virginia School Clothing Allowance, DFA-WVSC-1, is used. When a DFA-2 is used, a DFA-WVSC-1 is not required. A DFA-2 may only be required when application is made for another benefit at the same time. Applicants may also use WV PATH to apply at wvpath.wv.gov.

Applicants who receive their applications through the mass mailing completed in mid-June may use the information accompanying the application to electronically sign the application. Individuals submitting applications using WV PATH must electronically sign the application.

19.3.1.B Requests for Applications

The Department of Health and Human Resources (DOHS) responds to requests for applications to be mailed to potential applicants and accepts applications submitted by mail. If an individual

requests the application by telephone, the application is mailed on the date of the telephone call. If the individual requests the application by letter, an application form is mailed on the day the request for the application is received in the local office.

19.3.1.C Complete Application

The application is considered complete when the client signs a DFA-WVSC-1, DFA-2, or the Document for Protection of Application Date (DFA-5), which contains, at a minimum, his name and address.

NOTE: This includes applications received by electronic means, such as fax, email, or scan.

When the WV PATH application is submitted with an electronic signature, the application is complete. The WV PATH application must be submitted by the close of business on the last day of the intake month.

NOTE: If 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 case record with the subsequently printed DFA-2. He must not be required to return to the office to sign the DFA-2 when a DFA-5 has been signed. In this instance, the application is considered complete when the DFA-5 is signed.

For a paper application, the application is complete when the client signs a DFA-2 or DFA-5 which contains, at a minimum, his name and address. All applications for school clothing must be received or postmarked no later than the last day of the intake month. If the client requests other programs of assistance on the DFA-2, please refer to those sections for the date of application.

19.3.1.D Date of Application

The date of the application is the date that the DFA-2 or DFA-WVSC-1 was submitted with at least the applicant's name and address, or the date the electronic signature is submitted in WV PATH.

If the DFA-WVSC-1 is received by mail, the date of application is the date the form is postmarked or received. When the form is received prior to July 1 of the program year, it may

not be processed in the eligibility system before July 1.

19.3.1.E Interview Required

No interview is required when the DFA-WVSC-1 or WV PATH is used. When the client is being interviewed for an application or redetermination for another program, form DFA-2 is used.

19.3.1.F Who Must Be Interviewed

No interview is routinely required, but when an interview is conducted, a specified relative with whom the child lives with must participate in the intake interview.

If the child is living with only one specified relative who is unable to participate in the interview, a representative may participate in the intake interview. A written statement, signed by the specified relative, which gives the representative authority to apply on his behalf, is required.

19.3.1.G Who Must Sign

The specified relative with whom the child lives must sign the DFA-WVSC-1 or submit an electronic signature.

Only one signature is required.

19.3.1.H Content Of The Interview

In addition to the requirements outlined in Section 1.2, the following specific requirements apply:

- An applicant for WVSCA only is not required to cooperate with the Bureau for Child Support Enforcement (BCSE) but must be made aware of the services and referred, if appropriate.
- An explanation of Categorical Eligibility for SNAP benefits must include that, if approved for WVSCA, the AG is Categorically Eligible until October 31st of the program year. See Section 1.4.17.C.

19.3.1.I Due Date of Additional Information

The client and the Worker agree on the date by which additional verification must be obtained. The client must be given at least 10 days to return requested additional information.

19.3.1.J Agency Time Limits

As long as the application is made by the last day of July and the applicant returns the requested information in the time frame specified by the Worker, the WVSCA is approved, if the family is otherwise eligible. Applications received after July 31 of the current program year must be denied for being received out of season. All applications must be processed by August 31. WV PATH will accept applications from July 1 through July 31. Offices should make every effort to complete the applications in the order in which they are received. Applications must be processed within 30 days of the date of application. In order to maintain controls for receiving, processing and completing follow-up on applications and to ensure benefits are issued, the local office must retain an SCA application register or log that indicates, at a minimum, the client's name and when the application was received or postmarked.

19.3.1.K Agency Delays

If an application has not been acted upon within the required time limit due to agency error, corrective action must be taken immediately.

19.3.1.L Payee

The benefit is issued to the primary person in the case. This person must be the specified relative with whom the child lives.

NOTE: For EBT, the AG may have an authorized cardholder to spend benefits from the AG's EBT account.

19.3.1.M Beginning Date of Eligibility

Eligibility is determined for the month of July only. When additional information is required, the applicant must return the requested information within the time limit specified on the request for verification.

The eligibility system generates benefits in a daily cycle when eligibility is confirmed following overnight batch.

19.3.1.N The Benefit

All eligible AGs will receive EBT clothing benefits only.

An instruction sheet and a letter from the Governor accompanies the benefit.

NOTE: The payee should take valid identification with them at the time the benefits are redeemed. See Section 1.4.17.C for Categorical Eligibility for SNAP. Individual benefits that have been available for 365 days from the date of last use are expunged. See Section 10.3.3

EXCEPTION: A governor's letter will not be included for the 2025 season.

19.3.2 NOTIFICATION

Notification is required.

19.3.2.A Approvals

The eligibility system automatically issues an approval notice. In addition, instructions to the client and the Governor's letter are included with all WVSCA benefits issued from the State Office. Approval letters must not be used in place of the benefit to purchase clothing or piece goods.

EXCEPTION: A governor's letter will not be included for the 2025 season.

19.3.2.B Denials

The eligibility system automatically issues a denial notice.

19.4 COMMON ELIGIBILITY INFORMATION

19.4.1 COMMON ELIGIBILITY REQUIREMENTS

All appropriate WV WORKS requirements in Chapter 2 apply.

19.4.2 ELIGIBILITY DETERMINATION GROUPS

The Eligibility Determination Groups are the same as for WV WORKS. See Section 3.4. Recipients of adoption assistance must not be included in the benefit group for SCA.

19.4.3 SPECIFIC REQUIREMENTS

19.4.3.A Age and School Attendance

To be eligible for the WV WORKS School Clothing Allowance (SCA) or West Virginia School Clothing Allowance (WVSCA), the child must meet all of the following criteria:

- Be a resident of West Virginia, not visiting or on vacation.
- Meet the eligibility requirements or be eligible for WV WORKS for July of the current program year,
- For WV WORKS SCA only, be included in the WV WORKS benefit as a dependent child.
- Be enrolled in public Kindergarten through 12th grade, private Kindergarten through 12th grade that has been approved by the Board of Education, or a WV Public Prekindergarten that could be housed in a child care or Head Start center.
- Children who have reached the age 5 by July 1 and are enrolled in Kindergarten of the current program year.
- The following activities are not considered school enrollment:
  - Nursery School

- Correspondence or internet courses

- Homeschooling must be approved by the county Board of Education.

NOTE: The WV Works policy for including 18-year-olds requires that the 18-year-old be enrolled in secondary school, i.e., high school, high school equivalency, vocational training that substitutes for high school, etc. College is not secondary school. Therefore, the following apply:

• An 18-year-old in college is not eligible for the SCA.

• A 17-year-old in college meets the school enrollment requirement.

• An 18-year-old in high school meets the school enrollment requirement.

An individual who is included in the assistance group (AG) as a caretaker relative is not eligible for SCA, even when he meets the age and enrollment requirements.

Children who have reached the age 4 by September 1 and are enrolled in WV Public Prekindergarten of the current program year.

Maximum age requirement is met when the child is not yet age 19 on July 1 of the current program year.

School enrollment for children ages five through 17 is presumed by the eligibility system. The eligibility system will provide a benefit for any four-year-old enrolled when the system shows an enrollment status of full-time, less than half-time, or half time. The statement of a parent or other specified relative is sufficient, and no other verification is required to document enrollment.

NOTE: A five-year-old not enrolled in kindergarten is not eligible for the SCA just because the eligibility system presumes enrollment. Since so many five-year-olds are enrolled, the choice was to include five-year-olds and make those not enrolled the exceptions. The eligibility system should indicate if the five-year-old is not enrolled.

The eligibility system will provide a benefit for any four-year-old enrolled when the system shows an enrollment status of full-time, less than half-time, or half-time.

NOTE: See below for instructions on how to return the benefit when the child is not eligible.

The instruction sheet directs the SCA payee to return the benefit when the child is not enrolled in school, is no longer in the home, or will not be returning to school.

19.4.3.B Requirements Specific to WV WORKS Eligibility and Diversionary Cash Assistance (DCA) Clients

An applicant determined eligible for a WV WORKS payment is not required to accept the benefit to receive WVSCA. An applicant who does not wish to receive WV WORKS may withdraw his application and apply only for WVSCA.

An applicant who is approved for DCA for a time period that includes July is not automatically eligible for SCA. The DCA household must apply for WVSCA and be determined eligible.

19.4.4 REFUGEES AND CITIZENSHIP

The noncitizen and refugee requirements for WV WORKS in Chapter 15 apply.

19.4.5 INCOME

All WV WORKS income requirements in Chapter 4 apply. No deductions or disregards are applied. For SCA, income eligibility is based only on the month of July, the program month. When income has been previously verified within the last two months, additional income verification is not required. If appropriate, income must be updated in the eligibility system. If the gross non-excluded income is equal to or greater than 130% of the federal poverty level (FPL), the family is ineligible for WVSCA.

19.4.6 ASSETS

There is no asset limit for SCA or WVSCA.

19.4.7 POTENTIAL RESOURCES

For WV WORKS SCA, all appropriate WV WORKS resource development requirements in

Chapter 8 apply.

There are no potential resource requirements for WVSCA.

19.4.8 VERIFICATION

All appropriate WV WORKS verification requirements in Chapter 7 apply.

19.4.9 CORRECTIVE ACTION

Procedures regarding issuing benefits that were not automatically generated or not issued due to an incorrect birth date, relationship code, enrollment status, or when a child enters the household after SCA or WVSCA issuance can be found in the SCA Desk Guide issued for the current program year.

Corrective action is required in the following circumstances:

- When, as a result of Departmental error, the WV WORKS client did not receive the WV WORKS benefit and, therefore, no SCA;
- When the error is due to an incorrect birth date in the eligibility system;
- When an SCA-eligible child is added to an active WV WORKS AG after SCA benefits have been issued;
- When a WVSCA-eligible child is added to a case after WVSCA benefits have been issued;

If the client signs the IG-IFM-BENPAY-1 or gives verbal permission for removal of those benefits, then follow the procedure listed below.

- Supervisors in the local office may complete the IG-IFM-BENPAY-1 and remove the SCA benefits from the EBT account using the administrative terminal.
- If the supervisor is unable to remove the benefits, he/she just needs to note that in the email when the IG-IFM-BENPAY-1 form is scanned to the Repayment Investigator.
- The primary person may give verbal permission to remove the benefits.
- The following information must be in the recording on CMCC – e.g., Mrs. Jane Doe gave verbal permission to remove $200 from her EBT card for SCA benefits issued in error.
- The Worker would also write that on the signature line for the client and date it. Then they would send the client a copy of the IG-IFM-BENPAY-1.

- The Worker must scan the IG-IFM-BENPAY-1 to the Repayment Investigator for his/her county to complete the repayment process.
- An eligibility override will need to be completed in the correct case to issue SCA benefits using reason code 925 (WV WORKS SCA) or 926 (Governor's SCA).

NOTE: If the other primary person is willing to allow the other to have access to the SCA benefit. Please record in both cases and highlight around it to bring attention to the recording.

When a client returns clothing purchased with an SCA or WVSCA benefit, he must not receive a cash refund or store credit. He must exchange for purchases allowed by the SCA or WVSCA program.

19.4.10 OVERPAYMENT OF SCA

When SCA or WVSCA is received in error, it is subject to repayment according to the WV WORKS repayment policy. If the Worker learns, for example, that a child is no longer in the home or that a child who is a caretaker relative has received SCA or WVSCA, the overpayment of SCA or WVSCA must be repaid.

Whenever possible, repayment of the overpayment must be accomplished by the return to the local office of the benefit for which the client was not eligible.

Otherwise, normal repayment procedures in 11.3 apply. The following sub-sections outline actions which are taken to recover an overpayment by returning the benefit.

19.4.10.A Client Returns All Benefits

- The Financial Clerk gives the client a receipt for the benefits.
- If appropriate, the Worker takes action to correct the case.
- The Worker records comments in case comments to document case activity.

19.4.10.B Client Returns a Portion of the Benefit

- The Worker asks the client to return the amount of the benefit to which he was not entitled.
- The client completes and signs the IG-IFM-BENPAY-1 or gives verbal permission for removal of those benefits.
- The Supervisors in the local office may complete the IG-IFM-BENPAY-1 and remove the SCA benefits from the EBT account using the administrative terminal.
- The Financial Clerk issues a receipt to the client.
- The Worker records information in case comments to document the return of the benefit(s).

19.4.11 BENEFIT REPLACEMENT

Benefits are issued to EBT and are not replaced.

19.4.11.A Application Denial Is Reversed in a Fair Hearing

When a Hearings Officer rules in a Fair Hearing that the SCA or WVSCA denial was inappropriate, the Worker must issue the benefit to the applicant.

19.4.11.B Agency Delay/Error

If an application has not been acted on within the required time limit due to agency delay/error, corrective action must be taken immediately if the applicant is eligible. The Worker must issue the benefit to the applicant. However, the Worker must first contact the DFA Family Support Policy Unit for additional information.

19.4.11.C Destroyed Clothing Purchased With SCA Benefits

When clothing that has been purchased with SCA benefits is destroyed, such as in a house fire, replacement benefits cannot be issued. Instead, Emergency Assistance policy concerning replacement of clothing is followed if the AG is otherwise eligible.

19.4.12 VENDOR INFORMATION

Merchants who don't have EBT cash access will need to work with their processor so that an EBT school clothing purchase transaction will be accepted.

19.4.13 FOSTER CARE TO LEGAL GUARDIANSHIP

When a child who is in the state's custody and is in foster care through Social Services which pays the $600 per month per child, then this case goes to court, and the judge makes a ruling to give Legal Guardianship to the Foster Care parent. The judge also awards the $600 per month Foster Care payment to continue to be paid to the family.

Once this decision has been made, this is no longer considered a Foster Care case by Social Services but is now considered to be a Legal Guardianship case. The family then becomes ineligible for SCA through Social Services and will need to apply on the Family Assistance side.

- The income received is still out of the Foster Care funds and will still need to be listed in eRAPIDS as a Foster Care payment on the Unearned Income screen.
- The worker will go to the Current Benefit Received Screen in eRAPIDS and change the Yes to a No for the Foster Care question.

These actions will allow the system to look at the child for an SCA benefit. The child(ren) still must be in the care of a Specified Relative to be eligible for the SCA benefit.

When the child(ren) are not living with a Specified Relative and still meet financial eligibility, contact Children and Adult Services, Adoption Program Specialist who will evaluate for assistance from Social Services.

Recipients of adoption assistance must not be included the benefit group for SCA.

APPENDIX A: PUBLIC FORMS

FORM NUMBER	FORM TITLE
DFA-WVSC-1	Application for West Virginia School Clothing Allowance

APPENDIX B: SCHOOL CLOTHING ALLOWANCE PROGRAM INSTRUCTIONS

WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES WEST VIRGINIA SCHOOL CLOTHING ALLOWANCE PROGRAM

INSTRUCTIONS
(Please read carefully before using benefits.)

You should receive benefits for each of your eligible school-age children. If you do not, please contact your Worker in your local Department of Health and Human Resources Office as soon as possible.

Benefits can be used only for the purchase of your children's clothing and shoes. If you sew, you may purchase materials appropriate for making clothing.

All of your benefits do not have to be used in the same store. You can also use part of a benefits in one store and the rest of the benefits in another store.

If you purchase less than the amount of a benefit, the remainder cannot be refunded to you.

Chapter 20

Emergency and Special Assistance Programs

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
20.1				
20.2	7/1/18 6/1/19 9/1/22 9/1/23	761 772 826 840	20.2.4.B.3 20.2.4.A.4 20.2.4.A.2 20.2.2.L 20.2.3.D 20.2.4.F 20.2.4.G.2 20.2.4.G.3 20.2.4.H 20.2.4.H.1 20.2.4.H.2 20.2.4.H.3	Added a note to define a “cord” of wood. When and where to return Emergency Assistance security and/or damage deposit when paid by the agency. Updated form name DF-68 Clarified coding for title IV-A funding. Removed reference to medical treatment. Removed section for childcare. Removed section for medical assistance. Removed section for medical assistance. Removed section for emergency medical care. Removed section for outpatient medical service. Removed section for prescription med/medical equip. Removed section regarding payment for medical needs.
20.3	7/1/18	761	20.3.2.C 20.3.2.D 20.3.E 20.3.2.E.2 20.3.2.E.3 20.3.2.E.4 20.3.3, 20.3.4 20.3.4.A 20.3.4.B 20.3.4.B.4 20.3.5.B 20.3.5.C 20.3.5.E 20.3.6.C	Updated the responsible relatives to include the spouse Updated the maximum allowable payment information to include the income limit. Added information regarding a direct burial and defined it Added information regarding a direct cremation and defined it Updated the burial rate and the maximum allowable payment rate Update information regarding green burials Updated the burial rate Updated maximum payment Updated the burial rate Added date of death to the release of lien Updated list of responsible relatives Update instructions to include the new burial rate Updated to include the new burial rate Updated the examples to include the new burial rate

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	7/1/20	788	20.3.3	Rearranged Burial Process
	9/1/21	808	20.3.3.E & 20.3.4.C	Updated estate amount for burial
20.4	4/1/18	756	20.2.4.F	Child Care payments using Emergency Assistance funds were increased
20.4.3	9/1/19	776	20.4.3	Added WVAW for reduced rate
20.5	5/1/24	850	20.5	Moved Tele-Assistance to IMM 20.6 and Lifeline to 20.7. The new 20.5 if the main Summer EBT Section.
	5/1/25	863	20.5.1	Adding the provision that households may apply for Summer EBT (SEBT) all year round, but the benefit may only be made available during summer months.
			20.5.5.B	Updated which children are considered streamline certified (direct certified).
			20.5.6	Updated when an application is qualified, how and when to apply.
			20.5.6.A	Removed reference to WVDE.
			20.5.6.A.1	Updated federal income chart for Summer EBT.
			20.5.6.B	Updated verification requirements.
			20.5.6.B.1	Removed the entire citation.
			20.5.6.C	Updated reasons a student may be denied for Summer EBT.
			20.5.7.A	Updated how the NSLP school enrollment check will be conducted.
			20.5.8	Removed reference about using WVDE data.
			20.5.9.C	Removed reference to WVDE.
			20.5.10	Updated the local office/district responsibilities for Summer EBT.
	6/1/25	864	20.5.6.B	Specify the amount of time the agency must provide the SEBT household to return verification. Also, clarify when verification is necessary for students who attend a school outside of WV.
			20.5.7.B	Clarify that a student who resides in WV and attends a school outside of WV may be eligible for Summer EBT.
	1/1/26	872	20.5.4	Clarifies that Summer EBT benefits follow the same restriction as SNAP. Soda, including regular, diet, and zero-calorie varieties, nay mot be purchased with SEBT.
20.6	4/1/20	784	20.6.4	Changed inROADS to WV Path
20.7	4/1/20	784	20.7.5	Changed inROADS to WV Path

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
App A	10/1/21 4/1/22	809 819		Updated Emergency Assistance Income Limits Updated Emergency Assistance Income Limits
App B				
App C	3/1/19	769		DELETED: List of participating telephone companies

20.1 DEFINITIONS

AVAILABLE RESOURCES

Cash-on-hand, checking or savings account balances or other readily accessible funds not already obligated for food, shelter, or home heating.

BULK FUEL

Home heating or cooking fuel such as coal, fuel oil, liquefied petroleum gas (LPG), or kerosene which must be purchased in certain quantities and stored on site.

BURIAL RATE

The maximum allowable payment that the Department of Human Services (DOHS) will make toward the cost of a funeral.

CASH

For the purposes of Chapter 20, funds or money in the form of currency or any negotiable instrument that is in the possession of the applicant or any member of the assistance group (AG) at the time of application.

ELIMINATE THE EMERGENCY

Delaying or preventing the emergency from occurring for a period of not less than 30 days from the date the vendor is made aware of and accepts the DOHS's offer.

EMERGENCY

Being without or in immediate danger of being without a basic necessity, such as food, shelter, heat, etc., and having no available resources with which to obtain it.

FAMILY

For the benefits covered in Chapter 20, a group of two or more persons related by birth, marriage, or adoption who live together.

TIME LIMITATION

The federally mandated requirement that Emergency Assistance (EA) can be authorized just once to an eligible client for emergency situations during one 30-consecutive day period in any 12 consecutive months.

20.2 EMERGENCY ASSISTANCE

20.2.1 INTRODUCTION

The Emergency Assistance (EA) program is used to assist individuals and families in meeting a financial crisis when they are without available resources. EA is designed to provide short-term emergency financial assistance with which eligible individuals and families may obtain certain items or services needed to eliminate an emergency or crisis. Those who are in need of and qualify for EA may already be participating in an economic or social service program.

Individuals and families who receive EA may also be in need of and be eligible to receive regular ongoing medical, financial and/or social services from the Department of Human Services (DOHS).

As contained in the provisions under Title IV-A, as established by Section 406(e) of the Social Security Act, federal matching funds are available to assist families with eligible children under the age of 21 who are destitute because they are without immediate resources to meet their needs.

20.2.2 GENERAL ELIGIBILITY REQUIREMENTS

20.2.2.A Emergency Need Requirement

An applicant who meets the definition of being faced with an emergency need is one who:

- Is faced with an existing or imminent crisis of a nature that threatens the physical health, safety, and well-being of the applicant and his family; and
- Is without available resources with which he can immediately eliminate an existing crisis or prevent an imminent crisis.

When the applicant fails to meet either or both requirements indicated above, the application is denied. See Specific Items of Need in Section 20.2.4 for specific requirements.

20.2.2.B Time Limitation

EA can be authorized during one period of 30 consecutive days in any 12 consecutive months. Payments may be made to meet needs which arose before this 30-day period or needs which may extend beyond the 30-day period. The first day of the 30-day period of eligibility begins with the date the first Authorization for Payment (DFA-67) is approved for payment and ends 29 days later.

This limitation does not mean that only one item of need may be authorized during one period of 30 consecutive days in any 12 consecutive months. The applicant may request and be found eligible for more than one item of need during that period. However, when the applicant reapplies during the 30-day period of eligibility for an item of need for which he has already received the maximum allowable payment, the application is denied.

> **Time Limitation Example:** Mr. Ivy made an application for EA on May 5, 2016, because he received a notice of eviction for June 1, 2016. His application was approved and the DFA-67 was approved on May 6, 2016. Later, he returns on June 1, 2016 to request food and payment of a utility bill. Mr. Ivy is found eligible for payment of both items of need. He is not eligible to receive an additional authorization for EA until May 7, 2017.

20.2.2.C Time Limitation Exception

The time limitation policy applies only to authorizations for EA. If an application is denied or withdrawn, the applicant may receive an authorization for EA within twelve months provided he meets the eligibility requirements. The eligibility system maintains a control for all EA applications.

NOTE: The only exception to this is when the applicant qualifies for EA based upon natural or man-made disaster, and/or fire. See Emergency Needs Created by Natural or Man-Made Disasters in Section 20.2.2.N.

NOTE: EA applicants can receive Title IV-A funded benefits from only one program, either EA or Homeless, during one 30 consecutive day period in any 12 consecutive months.

20.2.2.D Residency and Citizenship

An applicant for EA must be a resident of West Virginia with the exception of transient individuals. See Specific Items of Need in Section 20.2.4 for specific requirements. The applicant must also be a United States (U.S.) citizen, a national of the U.S., or an eligible noncitizen (qualified noncitizen) as defined in Section 15.7.

20.2.2.E Assistance Groups (AG) Subject to a Penalty

When the applicant is a member of an AG for which any DOHS program benefit was reduced, denied, or closed because of a penalty for fraud, non-cooperation, or failure to pursue potential resources, the applicant and members of that program's AG are ineligible to receive EA.

In making this determination, the following guidelines apply:

- The applicant and members of the EA AG must have been an applicant for or client of the DOHS's program that was reduced, denied, or closed.
- The other DOHS program AG is in a penalty period at the time the application for EA is made.
- This policy applies to all other DOHS programs that apply penalties for non-cooperation, fraud, or failure to pursue potential resources.

NOTE: The above stated guidelines include all WV WORKS sanctions. AGs subject to WV WORKS sanctions are ineligible for EA only during the first three months of the sanction.

NOTE: For Supplemental Nutrition Assistance Program (SNAP) penalties, the AG is only ineligible for EA during the first three months of the penalty.

NOTE: For Medicaid penalties, the AG is ineligible until the day the failure to cooperate ceases.

When any of the situations described above exist, the AG is ineligible to receive EA until the penalty period ends or action is taken to pursue potential resources. This policy does not apply

to applicants who are denied because of failure to provide required information to establish eligibility.

In addition, this policy does not apply to persons who are excluded by law and are ineligible to receive benefits. See Section 3.2 for specific information about individuals excluded by law for SNAP. These individuals may apply in their own right for EA benefits.

20.2.2.F Income

20.2.2.F.1 *Income Policy*

The Worker must determine availability of income to the applicant and all other members of the AG. All countable gross income received by any member of the AG, beginning with date of application and ending 29 days later, must be counted in determining eligibility for EA.

When considering countable income to determine eligibility, the Worker must use the following guidelines:

- Verification must be requested for the following:
  - Income that has not been verified in the 30 days prior to the date of application; and
  - Changes in income.
- The total countable gross income of all members of the AG is compared to the Monthly Allowable Income Schedule in Appendix A.
- Income received prior to the 30-day period of consideration is an available asset if retained in the 30-day period of consideration.

NOTE: When an AG is determined income eligible and is authorized for payment, the AG is considered to be eligible as of the date of authorization and for the next 29 days. Income eligibility is not redetermined within that period if the AG identifies an additional item of need. AGs who were determined ineligible for payment must have their eligibility redetermined each time they reapply until determined eligible.

20.2.2.F.2 *Determination of Countable Income*

➢ *Income Exclusions*

The following sources of income are excluded for determining eligibility for EA:

- All student loans, grants, scholarships, and college work study programs.
- Any payments made to volunteers under Title II, Retired Senior Volunteer Program (RSVP), Foster Grandparents, Title III SCORE and AmeriCorps Community Enrichment Programs (ACE), and other programs of the Domestic Volunteer Service Act of 1973.
- Payments, allowances, or reimbursements for participants in programs administered by the Corporation for National and Community Service (CNCS) These programs may include, but are not limited to: ACTION, Action Programs, AmeriCorps, Sumer Youth Programs, University Year of Action, Urban Crime Prevention Program, Volunteers in Service to America (VISTA), and VISTA ACTION.
- Payments under the Alaskan Native Claims Settlement Act.
- Any payments received or funds held in trust for members of any Indian tribe under Public Laws: 98-64, 97-458, 98-123, and 98-124 referred to as "Indians Judgment Funds." Also, any funds from payment of relocation assistance to members of the Navajo and Hopi tribes under Public Law 93-531.
- Payments to Nazi Persecution Victims, which may include, but are not limited to: Austrian Social Insurance Payments, German Reparations payments or the Netherlands WUV payments.
- Payments from the Radiation Exposure Compensation Trust Fund.
- Payments from the Senior Companion Program funded under Title XX.
- SNAP benefits.
- The value of supplemental food program for Women, Infants, and Children (WIC) Public Law 94-105.
- Value of National School Lunch Program, Public Law 90-302.
- Japanese-American and Aleutian Restitution payments.
- North Vietnam – Department of Defense payments to certain persons captured or interned.
- Payment, allowances, or reimbursements for transportation and attendant care costs Under Title VI of the Rehabilitation Act of 1973, Title II, and Public Law 95-607.

- Payments from Community Service Employment Program (CSEP) as authorized under Title V of the Older Americans Act.
- Income tax refunds and rebates.
- Reimbursement for expenses incurred in connection with employment and/or training, limited to mileage, tools and clothing.
- Reimbursement for medical expenses or transportation costs incurred to obtain medical treatment.
- Grants and loans from the U.S. Department Housing and Urban Development (HUD) Community Development Block Grant Funds made to individuals to rehabilitate their private residence.
- All Workforce Innovation and Opportunity Act (WIOA) payments, except those considered as wages for on-the-job training.
- Victim Compensation Payments.

➢ *Income Deductions*

The only income deductions permitted are for those persons who are self-employed. After the Worker determines the amount of gross income to be received by the AG within the next 29 days after the date of application, 25 percent is deducted from the gross amount as the cost of doing business. The remainder is countable income which is compared to the income chart.

Self-employment consists of persons who receive regular income from self-employment or in a service type business, persons involved in seasonal self-employment, cash-crop farmers, and persons who care for other persons such as, but not limited to, personal care and adult family care.

➢ *Total Countable Income of the Assistance Group*

The total countable income of the entire AG must be considered, regardless of when the income is actually received in the 30-day period of income consideration.

> **Countable Income Example 1:** An individual who made application on November 1 received a paycheck on October 31 and will receive another paycheck on December 1. These two paychecks are not considered countable income. Only income received between November 1 and November 30 is considered as countable income. Any income received prior to the date of application and retained in the 30-day period may be considered an available asset.

> **Countable Income Example 2:** An individual makes application for EA on November 1. His anticipated countable income exceeds the maximum but will not be received until November 15. His emergency will occur on November 10, but he is ineligible because his income exceeds the maximum.

The Worker must use care in determining the actual dates the income is to be received.

20.2.2.G Assets

In determining eligibility for EA, the Worker must evaluate the availability of assets owned by members of the AG.

20.2.2.G.1 *Excluded Assets*

The following assets owned by AG members are excluded and not considered potentially available to eliminate or prevent the emergency:

- Homestead real property.
- Property which is producing income consistent with its current market value (CMV).
- Proceeds from the sale of a home or insurance received as a result of a destroyed home, when these proceeds are to be retained for the purchase or rebuilding of a new home or for repairs to a partially destroyed home.
- Assets not readily available because of legal proceedings.
- Burial trust fund up to $2,000 for each person in the AG.
- General household belongings such as furniture, appliances, clothing, etc.
- One automobile per AG.

20.2.2.G.2 *Potentially Available Assets*

The following assets owned by members of the AG are considered potentially available unless, as explained below, the assets cannot be converted or accessed in time to eliminate or prevent the emergency:

- Cash

- Savings and checking accounts, certificates of deposit (CDs), Christmas Clubs, and any other account in a financial institution.
- Stocks and bonds
- Livestock not being used to produce income consistent with its sale value nor house pets
- Automobile(s) when there is more than one automobile owned per AG
- Cash surrender value of life insurance policies
- Personal collections of value such as firearms, paintings, coin collections, etc.
- Non-homestead real property
- Business equipment not being used to produce income consistent with its current market value
- Recreational vehicles and equipment. See Section 5.1 for the definition. Personal recreational equipment such as toys, fishing equipment, etc., are excluded.

20.2.2.G.3 *Determining the Availability of Assets*

After the Worker determines that the applicant or any other AG member owns countable assets, he must evaluate whether such assets can actually be used in time to eliminate or prevent the emergency.

In making this evaluation, the Worker must consider the type of asset(s) involved and whether or not it can be used toward the item of need(s) in time to eliminate or prevent the emergency.

Assets, such as, but not limited to, cash on hand, checking or savings accounts, CDs or any other liquid instrument or account must be considered available as an asset and the AG is expected to use these assets toward the emergency.

NOTE: The application is denied if members of the AG refuse to use this asset.

Cash is defined as funds or money in the form of currency or any negotiable instrument that is in the possession of the applicant or any member of the AG at the time of application.

Income received prior to the date of application, and still available at the time of application, is considered cash. The Worker may request verification such as receipts or verbal statements that such cash is unavailable for use toward the emergency.

> **Cash Example 1:** A member of the AG receives a $400 paycheck the day before the application date. This paycheck is not counted as income; however, the Worker can request verification of how much of the $400 is available in the form

of cash. If the Worker determines that cash is available, the member must use the cash toward the amount required to eliminate the emergency.

Cash must always be considered an asset and must not be confused with income. However, the Worker must make sure that the AG is not faced with an additional emergency as a result of using the asset toward the emergency.

Cash Example 2: The applicant reports having $75 cash at the time of application. He has requested payment of an overdue electric bill and submitted a termination notice in the amount of $75. The Worker must deny the application for the electric bill because the cash must be used to pay the bill. However, the Worker must determine that the applicant is not faced with an additional emergency need during the 30-day period as a result of using the cash to pay his electric bill.

Cash Example 2.1: Using the example above, if the applicant states that he has budgeted $50 of the $75 for food for the next 30 days and will be faced with a food emergency if he uses it for the electric, the Worker will only consider $25 as available toward the emergency.

➢ *Non-Liquid Assets*

Assets such as recreational vehicles, non-income producing livestock, and business equipment usually must be sold and converted into cash to use toward the emergency.

The Worker must consider the following guidelines before he requests that the applicant convert a non-liquid asset into cash:

- Can the asset be converted into cash?
- If the AG makes a reasonable effort to pursue this action, will the resource be available in time to prevent an imminent emergency or immediately eliminate an existing emergency?

NOTE: "Reasonable effort" is defined as the AG actively attempting to convert the asset into an available resource to eliminate or prevent an emergency.

After giving careful consideration to the guidelines above, the Worker must decide whether or not to request a conversion of the AG's assets.

When the applicant or AG member is required to convert his assets to cash, he must receive a reasonable return or the fair market value rather than just the amount needed to eliminate or prevent the emergency.

If the AG member agrees to convert the asset, but fails in his attempt to do so, the Worker may request that he verify his attempt.

NOTE: The application must be denied if the AG member fails to cooperate in the conversion of non-liquid assets.

20.2.2.H Available Community Resources

Meeting the emergency needs of individuals and families without resources is a responsibility for the community in which they reside. This includes all social welfare related agencies and certain individuals within the community.

20.2.2.H.1 *Role of the DOHS*

The DOHS will assume a major role in meeting the emergency needs of eligible applicants through emergency financial assistance funds and/or referral of the applicant to other agencies or individuals within the community that have available resources which can prevent or eliminate the emergency.

In some communities, arrangements have been made for cooperative efforts between the DOHS and other community agencies in meeting emergency needs. Such arrangements should be maintained, and similar efforts established in other communities where they currently do not exist.

20.2.2.H.2 *Worker Responsibilities*

In evaluating the referral of an applicant for EA to a community resource, the Worker must determine that the resource is available to the applicant and will eliminate or prevent the emergency. In some situations, the applicant, after being referred to a community resource, may be required to make application for benefits from the agency to which he was referred. However, the Worker must consider the resource available until the applicant is refused or found ineligible to receive the benefits for which he applied.

The Worker must follow up with the applicant and/or the agency to determine if the benefits were actually received. If the agency or individual to which the applicant was referred cannot

eliminate or prevent the emergency, even though a cooperative effort with the DOHS, the Worker uses EA funds, provided all other eligibility factors are met. When a referral is made to a community agency, the Worker cannot make a final decision on the application until it is determined that the applicant actually received the benefits and that the emergency was eliminated or prevented.

When a referral is made to a community agency, the Worker must provide the following written notification to the applicant:

> "You are being referred to (name of agency or person) to pursue potential assistance to alleviate any need you may have for Emergency Assistance. If you do not receive assistance or the amount of the assistance fails to eliminate your emergency, please contact (name of local office) by (month, date and year) for a decision on your application."

The date entered on this notification must be within three days of the date of the application. The date of the application is counted as the first day. A copy of this notification must be retained.

When the emergency need is met by community resources, the application is denied.

20.2.2.H.3 *Applicant Responsibilities*

All applicants for EA must cooperate in a reasonable manner by accepting a referral to a community resource in order to eliminate or prevent an emergency.

EXCEPTION: When the community resource is likely to be a friend or relative of the applicant or a church he attends, permission must be obtained from the applicant before the Worker may contact this resource. This procedure gives consideration to the applicant's privacy.

All applicants who are referred to a community resource, but who do not receive the resource, must contact the Worker by the due date on the referral notification form.

Based on his knowledge of the applicant's capability, the Worker is required to make judgment on whether or not the applicant can follow through with a referral to community resources.

The Worker should not refer an applicant to a community resource if he is unable because of illness, physical or mental handicap, lack of transportation, etc., to follow through with the referral. However, the applicant is expected to take any action necessary to follow through with the referral, provided he is capable to do so.

The Worker must assist the applicant by contacting the receiving agency to make an appointment, if appropriate. In addition, the Worker must provide any other instructions, as appropriate, including directions to the agency's location, information needed for the application process, person to be contacted, etc.

Any applicant who is capable, yet refuses to cooperate or follow through in a reasonable manner when referred to an available community resource, is denied EA.

20.2.2.I Other DOHS Benefits

If there is an indication that the applicant may be eligible for Medicaid and/or SNAP, the Worker must explore this as a way to eliminate or prevent the applicant's emergency. WV WORKS must not be used to eliminate or prevent the applicant's emergency.

If the applicant is found eligible for Medicaid or SNAP and he can obtain the benefits in time to prevent the emergency, the applicant is expected to accept this as a resource instead of EA. If the applicant refuses to cooperate, his application for EA is denied.

If the applicant is eligible for Medicaid and/or SNAP but cannot obtain this assistance in time to prevent the emergency, the Worker completes the EA application and authorizes payment if the applicant is found eligible.

20.2.2.J Referrals to Office of Children and Adult Services

Individuals who request EA are often in need of other services administered by the Bureau for Children and Families (BCF) Office of Children and Adult Services. However, the client's refusal to accept ongoing services is not considered in determining the client's eligibility for EA.

> **Referral Example:** The Worker has determined a client is eligible to receive EA and that the client is in need of money management counseling. The Worker may offer to refer the client, but the application is not denied if the client refuses the referral.

20.2.2.K Work Stoppage and Strikes

The fact that the individual is participating in a work stoppage is not considered when determining eligibility for EA. All applicants for EA who are voluntarily or involuntarily participating in a work stoppage or strike are evaluated as any other applicant.

20.2.2.L Specific Eligibility Requirements for Federally Matched EA (Title IV-A)

If an AG meets certain eligibility requirements, a percentage of the cost of emergency financial assistance will be reimbursed to the DOHS by the U.S. Department of Health and Human Services (HHS). The DOHS may receive this reimbursement for any AG which includes children under the age of 21, providing the child lives with a specified relative.

Special coding in the eligibility system is required. The Title IV-A box must be checked for families with children under the age of 21 providing the child is living with a specified relative.

20.2.2.M Defining the Elimination of the Emergency/Vendor Refuses to Eliminate the Emergency

“Eliminate the Emergency” is defined as delaying or preventing the emergency from occurring for a period of not less than 30 days from the date the vendor is made aware of and accepts the DOHS’s offer. The client must be informed of this so there is no misunderstanding about how long the emergency will be delayed. This time period is most important for rent and utilities. The client must be informed that the DFA-67 voucher must be taken to the vendor without delay, if applicable.

When the client is otherwise eligible for or approved for EA, yet the vendor refuses to eliminate the emergency, payment must be denied to the vendor. This may occur when the vendor is not satisfied with the amount of payment. Payment is not made to any vendor who refuses to eliminate the emergency.

If payment has already been made to the vendor, reimbursement must be requested from the vendor. If the vendor refuses to reimburse the DOHS, a fraud summary must be completed and sent to Investigations and Fraud Management (IFM). The client must locate a new vendor with assistance from the Worker, if necessary. When a vendor refuses to eliminate the emergency, the application is denied only when another vendor cannot be located by the applicant and/or Worker to eliminate the emergency.

20.2.2.N Emergency Needs Created by Natural or Man-Made Disasters

Natural disasters are catastrophic events and are limited only to floods, high winds, severe electric storms, earthquakes, hail, blizzards, heavy snowfall, and sub-zero temperatures.

Man-made disasters are catastrophic events and are limited only to fire, explosions, falling objects, exposure to toxic elements such as gas, chemicals or other poisonous substances and dangerous situations created by automobile, airplane, and train crashes.

In order to be eligible for payment, the emergency need must have been created by any of the catastrophic events referred to above.

When an applicant requests EA as a result of a fire that has destroyed the applicant's living quarters, the Worker must verify through a collateral contact with the local fire department that the fire did occur and that the item of need was destroyed.

When an applicant requests EA as a result of natural or man-made disaster, the Worker must determine, as in any application for EA, the existence of resources available to the applicant prior to the approval and authorization for payment of the request for assistance.

The Worker must determine whether or not insurance benefits are available prior to the authorization of EA. In addition, the Worker must determine that disaster related resources through such agencies as HUD, Red Cross, Community Services Administration, Rural Housing Service, Federal Emergency Management Agency (FEMA), Volunteer and other local organizations, etc., are not available prior to the authorization of EA.

When such resources are available, the Worker must refer the applicant to these resources. The Worker, therefore, provides a referral service to eliminate or prevent an emergency.

When an area or locale has been declared a disaster area and Federal and/or State aid is forthcoming, but not immediately available to eliminate emergencies, the Worker must carefully evaluate the nature of the applicant's emergency to determine if the Federal and/or State aid will eliminate or prevent the emergency.

If the Worker feels that authorization for payment of EA must be made, he must obtain verification of need through a collateral contact with the responsible local agency or person who is in charge of assessing the damages or loss to the community.

Applicants who have received EA within the last 12 consecutive months, including the current month of application are not denied EA as a result of natural or man-made disasters if they are otherwise eligible for such benefits. However, EA payments are made from 100 percent state funds.

20.2.3 APPLICATION PROCESS

20.2.3.A Application Forms

20.2.3.A.1 *DFA-2 and DFA-EA-1*

These forms are used for all EA applications. See Section 1.3 for use of the DFA-2 forms and the proper use of the DFA-5 form.

20.2.3.A.2 *DFA-RR-1*

The sections of this form titled “Emergency Assistance” and “For All Programs” must be completed and signed, when using the DFA-2. The DFA-RR-1 is not required when using the DFA-EA-1. See Section 1.3.

20.2.3.A.3 *Completion of Form DFA-6 and/or Verification Checklist*

When the Worker does not have sufficient information to make a decision, it is necessary to complete Form DFA-6 or verification checklist to inform the applicant of the additional information needed. All requests for verification must be made using the DFA-6 form and/or verification checklist.

The Worker must clearly state on the form what items must be returned by the applicant, as well as the date by which the information must be returned.

The failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the application will be considered failure to provide verification and will result in a denial of the application.

20.2.3.B The Intake Interview

The Worker must conduct the intake interview for the purpose of obtaining a thorough knowledge of the applicant's current financial situation, determining if the applicant meets the EA eligibility requirements, and determining the specific item(s) of need for which he is requesting payment.

The time limitations must be explained to the applicant during the intake interview. When the applicant is not currently receiving any type of assistance from the DOHS, the Worker should give particular attention to the possibility of the applicant's eligibility for regular financial assistance, Medicaid, and/or SNAP. The intake process ends when the Worker has gained sufficient information from which he can make a decision on the application.

20.2.3.C Who Must Complete the Application?

The person who applies for EA must be an adult AG member, preferably one in whose name the bills are listed or the adult who handles the financial matters of the AG. In most situations, this person is the head of the household or the person who has accepted responsibility for and is knowledgeable about other members of the AG.

When the person who should apply for benefits is unable or unwilling to do so, the Worker must determine if someone else appointed by the AG in writing can apply for the AG. The Worker must consider the nature of the crisis and if a suitable person is available to apply.

20.2.3.D The AG

The AG consists of one or more persons who live together. One exception to this is when a person pays for the privilege of living in the household. In this situation, that person and his income are not considered in determining eligibility of the AG. However, the payment made to the AG is counted as income of the AG.

AG members receive a communal benefit from the EA payment. This means that everyone in the group benefits from the payment. The AG must include at least one member who has not benefited from an EA payment during the last 12 months to be eligible for payment.

> **AG Eligibility Example**: Ms. Cedar was a member of an AG that received an EA payment. Six months later, she is a member of another AG who has not received

EA. The second AG applies for EA and is approved, if otherwise eligible, because not all members have received EA.

20.2.3.E Action on the Application

The Worker must approve or deny the application in the eligibility system. A decision must be made on all applications as soon as possible, if the emergency currently exists, or prior to an imminent emergency but no later than three business days from the date of application.

Action on the Application Example 1: An applicant submits a notice of termination from a utility provider on Monday which states that the service will end in five days. A decision must be made on the application no later than Wednesday. The date of application is counted as the first day.

Action on the Application Example 2: An individual applies for payment of a utility bill on Friday. He does not have the notice of termination to verify the emergency and is given a DFA-6 by the Worker to submit the termination notice no later than Tuesday. The applicant fails to submit the notice. The Worker must make a decision on Tuesday. In the absence of verification, the application is denied. The applicant may reapply immediately.

20.2.4 SPECIFIC ITEMS OF NEED

The following section describes the specific eligibility requirements of the various emergency needs and services provided by the EA program. Verification requirements and instructions for determining the amount of payment are also included.

Only the items listed below qualify as items of need for EA.

A description of the maximum allowable payment for each item is included. The AG is not automatically eligible for the maximum allowable payment when other resources are used with the EA payment or when the amount required to eliminate the emergency is less than the maximum allowable payment amount. Applicants who refuse to accept the benefit which is offered by the DOHS are denied.

Since the EA program, administered by the Division of Family Assistance (DFA), and the Homeless Program, administered by the Office of Children and Adult Services, offer the same or similar services, it is important to define the relationship between these two programs in order to best serve the client in the most efficient manner.

"Homeless" applicants who are referred to the EA must be:

- Facing or in immediate danger of becoming homeless; or
- Homeless transients for which transportation arrangements to their communities are incomplete; or
- Applicants rendered homeless because their living quarters have been destroyed.

All other applicants who are identified as homeless using the definition provided in Chapter 33,000 of the Social Services Manual, are referred to the Homeless Program. That definition of homeless is when a person does not have access to nor the resources to obtain shelter.

Clients receiving benefits from one program as identified above shall not be eligible for concurrent benefits from the other.

20.2.4.A Shelter

The applicant must be a resident of West Virginia.

A tenant-landlord relationship must have existed for payment of rent on behalf of applicants who are facing eviction. This relationship exists when rent or room and board payments are made by the applicant to the landlord or family who are the original tenants. Payment must be cash or in-kind.

NOTE: This policy does not apply to homeless applicants. See Applicants Who Are EA Eligible Homeless below.

The maximum allowable payment for the AG is determined at the time of application and remains the same during the 30-day period of eligibility. Therefore, when the AG is found eligible for more than one shelter payment within the 30-day period of eligibility, the original maximum allowable payment cannot be exceeded.

20.2.4.A.1 *Rent*

➢ *Applicants Facing Eviction*

The applicant must provide verification that a legal notice of eviction or wrongful occupation has been filed with the local magistrate. The hearing will typically be scheduled seven to 10 days from the date the notice is served. The client must be encouraged to apply before the hearing date to avoid further legal action. This includes action taken against mobile homeowners who are forced to vacate their rental space.

If the client does not apply until after the hearing and must vacate the residence, alternative housing must be explored, if the client is otherwise eligible. If he is rendered homeless before the date of application, he is not eligible for EA and must be referred to the Homeless Program.

NOTE: Applicants facing eviction due to condemnation of their property must provide a legal notice of eviction from the appropriate authority condemning the property. Appropriate authorities include, but are not limited to, Health Departments or the State Fire Marshall's Office.

➢ *Applicants Facing Eviction from a Motel or Hotel Room*

In addition to the requirement of a legal notice of eviction or wrongful occupation, the applicant must have paid for lodging at the hotel or motel for at least 30 days prior to the date of the notice.

➢ *Applicants Who Are EA Eligible Homeless*

The definition of EA eligible homeless shall include only the following circumstances:

- Homeless transients for which transportation arrangements to their communities are incomplete; or
- Applicants rendered homeless because their living quarters have been destroyed.

The Worker must obtain the following types of verification to substantiate this situation:

- A collateral contact with the appropriate local agency or responsible person who is responsible for making damage assessment of destroyed living quarters.
- Verification of homeless stranded transients may be obtained through a collateral contact with the appropriate agency or responsible person in the community.

20.2.4.A.2 *Mortgage*

When the applicant is faced with foreclosure because of delinquent mortgage payments, he must verify his emergency by submitting a signed statement from the lending institute that indicates imminent foreclosure. The term "mortgage" is used here to define payments made by the applicant for his home or mobile home with the intent of obtaining ownership of such property.

20.2.4.A.3 *Overnight Lodging*

Authorization for payment of overnight lodging is only made for homeless applicants as defined in Applicants Who Are EA Eligible Homeless above.

The Worker must thoroughly explore available resources, such as alternate temporary housing with friends and relatives. The Worker must obtain permission from the client to pursue such resources.

When resources of this type are not available, payment is made only pending the completion of a plan for permanent housing.

The plan for permanent housing must include how the transient will complete his travel arrangements and how applicants who are homeless will obtain permanent housing.

20.2.4.A.4 *Determining the Amount of Payment*

➢ *Rent*

▪ *Eviction, Lockouts and Homeless*

Regardless of the type of shelter or the time unit by which it is being paid, the maximum allowable payment for shelter cannot exceed:

- One month of rent when the client pays on a monthly basis, or
- Four weeks of rent when the client pays on a weekly basis, or
- Thirty days of rent when the client pays a daily rate.

▪ *Delinquent Rent*

Depending on the number of months the rent is delinquent, the Worker will proceed as follows:

- One Month Only: In this situation, the Worker will authorize payment for the appropriate amount to the vendor (landlord) for one month of rent. No dollar limit is placed on the value of one month's rent since amounts vary considerably.
- More than One Month: In this situation, the Worker, before authorizing payment, must evaluate the existence of alternate housing for the applicant. The existence of alternate housing facilities must fulfill all of the following guidelines:

- It must be available to the applicant prior to the date of eviction, i.e. the landlord must agree to accept the applicant as his tenant.
- It must approximate the current living quarters of the applicant as closely as possible in regard to rental costs, condition, size, utility costs, and location.
- It must not be condemned or unfit for human habitation.

When the above conditions exist, the Worker will negotiate with the present landlord to obtain the least possible payment to eliminate or prevent the eviction.

The Worker must use care in handling this type of situation. Available alternate housing must exist before such negotiations are initiated. Factors affecting the alternate housing, particularly the cost, availability, etc., must be thoroughly evaluated. When alternate housing does exist, the Worker may add the cost of a reasonable deposit to the amount of rent to be authorized not to exceed one month's rent.

NOTE: When alternate housing does not exist for individuals who are more than one month delinquent in their rent payments, the Worker may offer payment to avoid the eviction up to a maximum of two month's rent to the original landlord.

As indicated above, no limits are placed on the amount of one month's rent. If either the landlord or client refuses to make arrangements to pay the remaining balance of rent to the landlord, the application is denied.

- ***Examples***

Delinquent Rent Example: Mr. Geranium and his family are facing eviction. Mr. Geranium is delinquent for five months' rent at $150 per month. The landlord is demanding the total rent bill of $750 to be paid. Satisfactory alternate housing for Mr. Geranium and his family is available for $160 per month. The Worker will offer the landlord $160 toward the total delinquent rent of $750 with the remainder of the rent ($590) to be worked out between landlord and Mr. Geranium. If the landlord refuses to accept this payment, the Worker will authorize payment of $160 to the new landlord of the alternate housing. If the present landlord accepts the payment of $160 toward the delinquent rent bill, it must be understood that the landlord and Mr. Geranium will make the arrangements regarding payment of the remaining balance.

Eviction Example 1: Ms. Magnolia, an applicant, has an eviction notice and was paying $50 per month for rent. She is not behind in her rent but can no longer live there. Ms. Magnolia has found an apartment for $550 a month and also needs a $550 deposit. The Worker has determined that a customary amount for rent in

the area is $250 per month. The landlord does not accept HUD. This is not considered acceptable alternative housing as it does not approximate the current living quarters in cost and is considered an unreasonable amount for the area.

Eviction Example 1.1: Same situation as above except the landlord does accept HUD. Once Ms. Magnolia is approved, her rent will be $100 per month. This is acceptable alternative housing as it does approximate the current cost and is a reasonable amount for the area.

➢ *Security and Damage Deposits*

When alterative housing is used, the Worker will authorize payment for one month of rent and a reasonable security and/or damage deposit, if necessary, to the landlord when suitable housing is obtained.

NOTE: A reasonable security and/or damage deposit is defined as the amount that is customary to the community up to, but not exceeding, the amount of one month of rent. Once the client has vacated the rental property the security and/or damage deposit or any portion thereof, previously paid by the Agency should be returned if applicable by either the landlord or client. The deposit and form DF-68 should be returned to the following address:

Accounts Receivable
Office of Accounting
321 Capitol Street, 1 Davis Square
Charleston, WV 25301

➢ *Mortgage*

The Worker must contact the lending institution and first offer payment of the past due interest, not to exceed the total monthly mortgage amount, to eliminate the emergency.

If the lending institution refuses to prevent foreclosure, the Worker may offer payment of both interest and principal or the total monthly mortgage amount for a maximum payment of one month.

The procedure of alternate housing is not used when the foreclosure of a mortgage is involved. However, if the applicant becomes homeless, as a result of actual foreclosure, the Worker must evaluate his eligibility for an emergency rent or overnight lodging payment as in any homeless applicant situation when the client and his family are EA Eligible Homeless.

➢ *Overnight Lodging*

The Worker authorizes payment to the facility at the going per diem weekly or monthly rate up to a maximum of one week of lodging.

When overnight lodging must be extended beyond one-week, alternate temporary housing must be explored. If alternate temporary housing cannot be arranged, Supervisory approval must be obtained for payment beyond one week, up to a maximum of 30 days.

20.2.4.B Utilities and Bulk Fuel

20.2.4.B.1 *Services Covered*

The payment of utility services included under the EA program include those services needed by the AG for heating, cooking, lighting, and sanitation. Telephone service is included only when the AG is in need of telephone service because everyone living in the home is 65 years of age or older or is disabled or temporarily incapacitated for at least the next 30 days. See Section 13.15.

20.2.4.B.2 *General Requirements*

Payment may be authorized for clients who are without utility services or who face imminent termination of these services. When a utility service, other than telephone service, has been disconnected, the application for EA must be made within 30 days of the date the service was terminated to meet the emergency need requirement described in Section 20.2.2.A. Supervisory approval is required to make an exception to this requirement when the AG is otherwise eligible and the service has been terminated for more than 30 days. Exceptions may only be granted on a case-by-case basis when the extenuating circumstances warrant it. These include, but are not limited to, delayed application due to illness or disability, and other situations that are beyond the client's control.

In determining whether or not the applicant is eligible for payment of utility services, the following requirements must be met:

- The applicant must submit a written notice of termination from the provider that indicates a specific date on which the service was or will be terminated, and the amount of the overdue bill; or
- The applicant must submit a written statement from the provider, such as fuel oil, bottled gas, or coal company, that indicates no future orders will be filled; and
- The utility services must be in the name of the applicant or a member of the AG except, in the following situations:
    - When the Worker determines that the utility service is not in the name of the applicant or AG member because that person is deceased, has left the household with no intention to return, or the applicant is unable to pay the security deposit; or
    - The Worker determines that the utility service is in the name of the landlord, mobile home park owner/manager, etc., this person becomes, in effect, the utility provider. Therefore, the applicant must obtain a written notice of termination as specified above from this provider.
- The service address must be in West Virginia.
- When the water and sewage is billed separately, it is legal for the supplier to terminate water service for the non- payment of sewage even when the water bill is current. In these situations, a notice of termination for water service may be submitted by the applicant for an overdue sewage bill. This is accepted as verification of the emergency.

NOTE: An electronic notice may be accepted in place of termination notice or written statement from the provider.

20.2.4.B.3 *Determining the Amount of Payment*

In determining the amount of payment, the Worker must consider the following:

- The type of utility service being requested for payment.
- The amount of the overdue utility bill which covers a billing period up to 30 days.
- The average daily amount of the overdue bill when the overdue billing period exceeds 30 days.

- Reconnection charges required by the utility provider when the service was terminated in the 30 days prior to the date of application.
- Service charges required by the utility provider to start service in new living quarters when the applicant moved to new housing due to eviction, fire, condemnation, etc., or some other emergency that has forced the applicant to move.

NOTE: Utility deposits are not included as an item for payment by the EA program.

- Late fees added to delinquent or overdue payments are considered as part of the overdue bill and are not deducted from the overdue bill when computing the average daily amount.
- Payments made by the client in an attempt to reduce or eliminate the overdue bill are not deducted from the ongoing overdue bill when computing the average daily amount.
- The amount of any one-time payment, such as from the Low-Income Energy Assistance Program (LIEAP) or a community agency made or that will be made, but not yet credited to the account, is not deducted from the ongoing overdue bill when computing the average daily amount. It is subtracted from the minimum payment due before determining the amount the DOHS will pay through the EA program. The Worker must inform the company of the pending payment from the other source and determine if this will prevent the emergency. If so, the EA application is denied. However, the receipt of EA does not affect eligibility for Emergency LIEAP.
- Regular monthly payments made on behalf of the client from other agencies, plus reductions from the 20% utility discount program are deducted from the ongoing overdue bill before computing the average daily amount.

➢ *Payment Amount for Gas, Electric, Water and Sewage*

NOTE: Sewage utility service does not include garbage pick-up service.

When the client is eligible to receive payment for any of the utility services indicated above, the Worker must consider the following:

- When the overdue amount covers a billing period up to 30 days, the Worker shall authorize payment for the 30-day amount to the vendor.
- When the overdue amount covers a billing period greater than 30 days, the Worker determines the average daily amount of the overdue bill. The average daily amount multiplied by 30 days is the maximum amount of the EA payment. Utility bills often have an overdue amount and an amount labeled "due." The "due" amount is not considered for payment nor is this amount used to calculate the amount of the payment.

> **Payment Amount Example:** An applicant submits an overdue utility bill in the amount of $235 which accumulated over a period of 93 days. Since the overdue bill is over 30 days, it is necessary to determine the average daily amount multiplied by 30 days. The amount of payment is computed as follows: $235 divided by 93 days = $2.53 x 30 days = $75.90.

The Worker must explain to the applicant that payment may be made up to the calculated maximum amount. The Worker must contact the utility provider to determine if this payment will eliminate the emergency.

The Worker must inform both the applicant and the provider that payment of the remaining balance must be worked out between the provider and the applicant. The Worker is not involved in these negotiations.

- When the overdue amount has a Budget Accrual Reconciliation or Settlement amount, this is the amount of a bill in excess of the monthly budget bill which accumulates during the length of the budget period, usually 12 months. The client is responsible for paying that amount of the total annual bill not covered by the monthly budget payments.

  The amount of payment is determined by dividing the number of days over which a budget overrun occurred into the total amount of the overdue budget settlement bill. It is necessary to contact the utility company to determine the number of days in which overruns occurred, unless the applicant can supply this information.

  If the utility company or the applicant cannot or refuses to provide this information, the total number of months in the entire budget period is used to determine the amount of payment.

  The length of the budget period is usually 365 days unless information otherwise is obtained.

  Complicating this procedure are situations in which the overdue budget settlement bill is combined with or added to a routine overdue bill on the same notice of termination. In these situations, the amount of the overdue budget settlement bill must be separated from the amount of the routine overdue bill. A daily average is then determined for each overdue bill in excess of 30 days. The two amounts are multiplied by 30 and the two are added to determine the amount of payment.

> **Overdue Bill Example:** The total amount of the overdue bill on the termination statement is $235.50. The overdue budget settlement bill is $85.50. Budget overruns occurred during 243 of the 365-day budget period.
>
> The regular overdue bill is $150, accumulated over a period of 45 days.
>
> <u>Computation of overdue budget bill:</u>
>
> $85.50 divided by 243 - $0.35 x 30 days = $10.50

Computation of regular overdue bill:

$150.00 divided by 45 days = $3.33 x 30 days = $ 99.90

The amount of payment is $110.40 ($10.50 + $99.90).

- When the applicant has made a partial payment(s) toward the original overdue bill, the Worker must consider the following:
    - The average daily cost of the original overdue bill must first be computed.
    - The average daily cost multiplied by 30 equals the maximum amount of payment.

Partial Payments Example: An applicant submits an overdue utility bill in the amount of $211.72. This bill was the remainder of an original overdue bill which accumulated over a period of 183 days and totaled $296.73. The applicant made a partial payment of $85.01 which left a balance of $211.72.

$296.73 divided by 183 days = $1.62 average cost/day.

$1.62 x 30 = $48.60 maximum amount of payment.

NOTE: When the utility bill balance remaining after the applicant has made a partial payment is less than the average cost/day times 30 days, that is the payment amount.

➢ *Payment Amount for Telephone Service*

When an applicant meets the criteria for telephone services, the Worker authorizes payment only for basic charges for up to 30 days, plus federal tax. Payment is not authorized for long-distance calls, wires, or other special services. There is no time limit for disconnected telephone service when the requirements in Section 20.2.4.B.1, Services Covered, above are met. However, eligibility for the telephone assistance programs in Sections 20.5 and Section 20.6 must be explored first.

➢ *Payment Amount for Bottled Gas, Fuel Oil, Coal and Wood*

When the applicant uses energy that is not regulated by the Public Service Commission (PSC), the Worker must determine the amount of payment by referring to the chart below for a 30-day supply of fuel.

NOTE: A cord of wood, when neatly stacked, occupies a volume of 128 cubic feet.

Type	Unit	Maximum Amount
Bottled Gas	Gallons	135
Bottled Gas	Pounds	300
Coal	Tons	1
Fuel Oils	Gallons	150
Wood	Cords	1

When the client has an emergency need for wood pellets or any other type of bulk fuel not listed in the chart, the Worker will work with the vendor to determine a reasonable amount.

The following statement must be entered on all DFA-67 forms authorizing any type of liquid fuel: "The client must specify the correct grade and type of fuel."

When the provider refuses to make a delivery because of an existing unpaid balance, the Worker must allow the client and provider to determine what item will be paid. Payment cannot be authorized for both items. If the client and vendor agree to payment of the unpaid balance, the amount authorized cannot exceed the equivalent cost of the maximum amount of fuel shown in the chart above.

If either or both parties refuse to accept payment as outlined in this section, the application is denied.

20.2.4.C Food

Payment may be authorized for applicants who have an emergency need for food. However, in the majority of instances, emergency food needs can be met by using SNAP benefits, provided the applicant meets the eligibility requirements of SNAP. If the applicant refuses to accept SNAP as a resource to meet his emergency food needs, the application for EA is denied.

When the applicant is found eligible for SNAP, the SNAP application must be processed as soon as possible to prevent or eliminate the emergency. If the applicant needs food prior to the receipt of his SNAP benefits, the Worker may authorize payment for emergency food if the applicant is otherwise eligible.

When the applicant is ineligible for SNAP, for a reason other than failure to meet the residency requirement, the Worker will authorize payment for emergency food, provided the applicant is otherwise eligible.

When SNAP clients apply for emergency food, the Worker must carefully evaluate the reason for the request. The Worker must determine if the need was created by an unusual or catastrophic event, such as when food which was purchased with SNAP is destroyed. In this case, the Worker must first evaluate the replacement of food purchased with SNAP. See Section 12.2. If the need was created by the misuse of the benefits, the Worker must determine if an actual emergency need for food exists.

To determine the amount of payment, the Worker uses the SNAP allotments in Chapter 4, Appendix A. Only the maximum monthly allotment, based on the AG size, is used to determine the daily food allowance. Payment may only be authorized for a maximum period not to exceed seven days.

> **Food Emergency Example:** A seven-person AG is approved for SNAP benefits. The Worker anticipates the receipt of benefits in seven days. The AG has an immediate need for food and meets the eligibility criteria for EA. The Worker computes the amount of payment as follows**:**
>
> Step 1: Determine the maximum monthly allotment for a seven-person AG.
>
> Step 2: Divide this amount by 30 days to determine the daily amount.
>
> Step 3: Multiply the daily amount times seven days to determine the amount of payment that may be authorized.

If the applicant cannot prepare food where he resides, authorization may be made for payment to purchase food at a cafeteria or a low-cost restaurant. This method may also be used to provide meals for a transient AG returning home.

To determine the payment, the Worker needs to consider the following:

- The maximum payment per day must not exceed the maximum monthly allotment divided by 30 days.
- The number of days for which the AG may be approved is up to, but not exceeding, seven days.
- The Worker must thoroughly discuss this arrangement with the client to ensure he understands how the funds can be used.

When the AG must use a local restaurant or cafeteria, the Worker authorizes payment to the local vendor.

When the clients are transients returning home and must use non-local restaurants or cafeterias, the Worker authorizes payment so that a check can be issued to a responsible AG member.

20.2.4.D Household Supplies or Furnishings

Household supplies or furnishings are considered items of need for EA only when a fire or some other man-made or natural disaster has destroyed such items. The only exception to this is when household supplies or furnishings are needed for a homeless person or family for whom the DOHS is seeking, or has located, housing. The applicant must be a West Virginia resident. Requests for non-residents must be sent to the DFA Policy Unit prior to approval.

Emergency household supplies or furnishings may include one or more of the following basic items: bedding, eating and cooking utensils, towels and linens, soap, and/or a necessary good used appliance, limited to a refrigerator or stove.;

A maximum payment of up to $100 per eligible AG may be authorized to a vendor for household supplies and furnishings. Because of the limited maximum payment, the Worker must assist the client in planning his purchases wisely. The client should be discouraged from selecting convenience items rather than basic needs. The Worker must carefully evaluate the client's actual need for the items requested.

20.2.4.E Clothing

An applicant may receive payment for emergency clothing only when his clothing was destroyed by a fire or some other man-made or natural disaster, or when a child, not yet age 18, is abandoned without adequate clothing.

A maximum payment of up to $75 per eligible AG member may be made to a vendor for clothing.

20.2.4.F Transportation

Payment for emergency transportation service may be authorized as described below.

20.2.4.F.1 *Transients*

A transient is an individual who is traveling or passing through a locality and experiences an emergency that makes it necessary to return to his home community. The home community does not need to be in West Virginia. The definition of transient does not include individuals who are visiting within the locality or who arrived with the intent to obtain temporary to permanent employment or otherwise remain within the locality on a temporary or permanent basis. In addition, an individual who finds temporary or permanent employment within a locality, but later decides to return to his home community does not meet the definition of a transient.

A transient must be without resources with which to purchase the item or service that will enable him to return to his community. Prior to authorizing payment, the Worker must verify by a collateral contact that the transient has a place to live or that another agency will assist him to become reestablished in the community to which he wishes to return. Applications for transportation by transients must not be denied if the maximum payment does not complete the travel arrangements. However, the Worker must determine how far they can travel and whether or not there is another agency in that location to help them.

20.2.4.F.2 *Determining the Amount of Payment*

➢ *Transients*

The amount of payment depends upon the type of transportation to be used and the one-way distance. However, the maximum payment cannot exceed $50 per AG member, regardless of the type of transportation used or the one-way distance.

Payment may be authorized for the cost of gasoline, oil, and minor auto repairs for a privately-owned automobile or for use of a common carrier, restricted to bus, train, or taxi.

If a common carrier must be used, payment up to $50 of the established one-way fare per AG member is made to the vendor.

If an automobile is used, payment may include mileage one way for the cost of gasoline and oil, based on the current State reimbursement rate, and minor automobile repair. The total payment for either mileage or minor repairs or a combination cannot exceed $100 per AG. Form DFA-67 is completed and made payable to the recipient. If payment is authorized only for minor automobile repairs, the check is made payable to the vendor.

20.3 INDIGENT BURIAL PROGRAM

20.3.1 INTRODUCTION

The purpose of the Indigent Burial Program is to provide a decent burial for persons who die and have no resources to pay for the interment costs at the time of death.

20.3.2 ELIGIBILITY REQUIREMENTS

When making the decision regarding the eligibility for payment of the burial rates, the Worker must give consideration to the following criteria.

20.3.2.A Residence

The deceased must have been a resident of West Virginia at the time of death in order to be eligible for a burial payment. (See exception below.) Individuals who have left West Virginia for the purpose of residing in other states, or who have become residents in other states, and later decease are ineligible for Burial Program benefits.

The Worker must verify residency of the deceased. Examples used to verify residency include, but are not limited to, current state issue Driver's License/ID card, current utility bill, current rent, or mortgage receipts, current landlord's statement, current written statement from neighbors and employment records.

EXCEPTION: One exception applies to the residence requirement. This occurs when a non-resident of West Virginia deceases while traveling or visiting in the state and has no family, friends, or institution in the state of his residence that will assume responsibility for the funeral arrangements or otherwise claim the body. The Worker must verify that this situation exists before the case may be found eligible for payment.

20.3.2.B Need

Resources of the deceased shall consist of readily available liquid assets such as, but not limited to, life insurance policies, burial trust funds, cash, checking and/or savings accounts, certificates of deposits, etc.

The Worker must verify the availability of these liquid assets prior to approval of the burial application. If the information is not known by the responsible relative it must be explained to the responsible relative they are attesting there are not sufficient resources by signing the DFA-67-A and DFA-BU-1, and that a claim will be placed against the estate of the deceased.

If the applicant indicates that, for an adult burial, the deceased had at least $2,200 in available resources, the Worker must find the application ineligible for benefits. The income limit for the deceased must not have been more than 133% of the FPL. The income verification would just be for the deceased if the applicant is not a responsible relative. The income counted would be for the 30 days prior to the date of death. The SNAP budgeting rules would be followed for counting the deceased's income.

20.3.3 APPLICATION PROCESS

20.3.3.A General Instructions

Although it is preferable that the application for payment of burial expenses be made by the surviving spouse or other close relative, the application may be made by the person who has accepted responsibility for making burial arrangements. This includes, but is not limited to, the Funeral Home Director, friends, and neighbors. All applicants must be at least the age of 18.

- Form DFA-BU-1, Application for Burial Benefits, will be used in taking applications for payment of burial expenses.
- Form DFA-BU-2, Affidavit of Responsible Relative, is used to determine whether certain relatives, who are designated under State Law as liable for burial expenses, are financially able to make payment of all or part of the maximum payment allowed by the Department. In order to maintain the Department's policy of developing all possible resources, other relatives who are not designated under State Law as liable for burial expenses are also evaluated as to their ability and willingness to pay all or part of the appropriate burial rate.

20.3.3.B Applicant

If an applicant (i.e., one who is liable or one who simply wishes to pay the allowable amount) indicates that he agrees to make the allowable payment of $2,200 to the funeral home, the Worker must deny the application for payment of burial. See Section 20.3.3.E

If the applicant agrees to pay any amount less than the allowable amount or indicates that he cannot make any payment toward the allowable amount, the Worker must approve the application for a burial payment providing all other eligibility requirements are met.

20.3.3.C Responsible Relative

A responsible relative is a relative who is liable for the burial costs of the deceased, i.e., spouse, children, parents, or siblings. If the applicant is a responsible relative, then the Worker must verify their income.

20.3.3.D Application Submittal Deadline

Payment for burial expenses cannot be made unless the application form, DFA-BU-1, has been completed and the applicant found eligible for payment and the date of interment or cremation did not occur more than 30 days prior to the date of application. The application form must be signed in blue ink.

20.3.3.E Decision on the Application

After the applicant has completed the application form, DFA-BU-1, and the Affidavit of Responsible Relative, DFA-BU-2, the Worker can take the appropriate action on the application:

- All questions on the application form must be answered by the applicant and signed and dated by the applicant when appropriate. The DOHS will not make payment if the DFA-BU-1 form is not completed or completed improperly.

- When the applicant is a liable relative, the DFA-BU-2 must be completed. If not, the application must be denied.
- If the relative who signed the DFA-BU-2 form agrees to pay for the burial costs, the application must be denied.
- If the applicant indicates in Section D of the DFA-BU-1 form that the deceased had sufficient resources to pay for the burial costs, the application must be denied.
- If the applicant indicates in Section F of the DFA-BU-1 form that sufficient resources will be applied toward the burial that is equal to or exceeds $2,200, the application must be denied.

After consideration is given by the Worker to the above items, he will make a decision regarding the eligibility for payment of burial costs and make a recording on the application form to support his decision.

When the Indigent Burial application is denied, the Worker must send a completed DFA-BU-4 notification to the person who made application for the burial. In addition, a copy of the DFA-BU-4 must be sent to the funeral home that provided burial services for the deceased. If the application was made by the Funeral Home Director or staff, when no relatives, friends, or other persons are available, the original DFA-BU-4 is sent to the funeral home directly. The DFA-BU-4 form is found on the Division of Family Assistance (DFA) intranet site.

The reason for the denial must be stated on the notice. In addition, the Fair Hearing and/or Conference Request form, DFA-FH-1, must be included with the denial letter and sent to the applicant. A copy of the denial letter must be sent to the funeral home and a copy must be placed in the deceased's file.

20.3.4 FORMS

20.3.4.A DFA-BU-1, Application for Burial Benefits

The DFA-BU-1 is the application completed for payment of burial benefits. The DFA-BU-1 form is found on the Division of Family Assistance (DFA) intranet site.

20.3.4.B DFA-BU-2, Affidavit of Responsible Relative

The DFA-BU-2 is the affidavit used to determine whether responsible relatives that are designated under State Law as liable for burial expenses are financially able to make payment of all or part of the maximum payment amount of $2,200. The DFA-BU-2 form is found on the Division of Family Assistance (DFA) intranet site.

20.3.4.C Completion of Form DFA-BU-1, Application for Burial Benefits

Form DFA-BU-1 must be completed when an individual is applying for burial assistance. Payment for burial expenses cannot be made unless this form has been completed, the applicant found eligible for payment, and the date of interment or cremation did not occur more than 30 days prior to the date of application.

Generally, the county in which the individual resided at the time of death will assume the responsibility for accepting the application and making payment for eligible individuals. When the individual did not die in the county of his residence, the following instructions will apply:

- When the deceased dies in another county or state while visiting or receiving medical treatment, the county of residence will assume responsibility for accepting the application and making payment.
- When the deceased dies in a state institution or nursing home, that facility will contact relatives who will take charge of the burial arrangements. In most situations, the relatives will have the deceased returned to the county in which he resided prior to his death. When this occurs, the county in which the deceased has been returned will accept the application and process payment.
- Situations may occur, however, when the person who has taken charge of the burial arrangements, including the institution or nursing home administration, may wish to inter the deceased within the county in which the institution or nursing home is located. When this occurs, that county will accept the application and process payment.
- When a non-resident of West Virginia dies while visiting or traveling through the state, the county in which he dies will assume the responsibility for accepting the application and, if eligible, process the payment. This procedure applies only when the deceased's interment will take place in West Virginia.
- However, situations may occur when someone from another county has taken responsibility for the burial arrangements and wishes to have the deceased interred in that other county. When this occurs, the other county will accept the application and process payment.
- If so desired by the applicant, a burial application can be received via the mail. If the applicant wants to apply through the mail, the Worker will mail the application forms with

an accompanying letter of instructions that include a deadline for returning the completed application through the mail. The instructions will also request a copy of the death certificate and the deceased's Social Security Number if not included on the certificate. After the application is received through the mail, the Worker will carefully review the completed application form and make a decision regarding eligibility or request the applicant to supply additional information.

The following instructions must be followed when completing Form DFA-BU-1:

- Section A and B, Identifying Information: The required identifying information in these two sections is self-explanatory. If the deceased was a non-resident of West Virginia at the time of death, the applicant must explain why the deceased is to be buried in West Virginia. This explanation is needed in order to assure that family and relatives have been notified and are aware that the deceased will be buried in West Virginia.
- Section C, Your Relationship to the Deceased: If the applicant indicates that he is a child, parents or siblings of the deceased (responsible relative), he must complete Form DFA-BU-2, Affidavit of Responsible Relative. If the applicant indicates that he is not a liable relative, he will be requested to complete Form DFA-BU-2 for the purpose of developing potential resources. A funeral home that is applying on behalf of the deceased does not need to complete the DFA-BU-2.
- Section D Need and Estate of the Deceased: The applicant must place an "X" on the line next to the statement which indicates his knowledge of whether the deceased's estate had sufficient resources equal to the maximum allowable payment. When the applicant indicates the estate has at least $2,200 in resources to pay for the burial costs, the case will be found ineligible for a burial assistance.
- Section E, Heirs of the Deceased: The applicant must complete this section which involves questions about the heirs of the deceased. An Heir is a person legally entitled to the property of another on that person’s death.
- Section F, Resources: The applicant must indicate the type and amount of resources received or to be received toward the burial expenses. It will be the responsibility of the applicant to report this accurately and completely. It may be necessary for the applicant to contact the Funeral Home Director regarding this item to ensure accuracy. Finally, the Worker should inform the applicant that the DFA-67-A, Burial Billing Form, submitted by the Funeral Home Director will be compared with Section F for discrepancies.
- Section G, Multiple Burials: The applicant must read the statement regarding the policy on multiple burials and place an “X” in “I Agree”, or “I Do Not Agree”, or “Not Applicable”.
- Section H, Signatures: The applicant must read each of the three statements and place an "X" in "Yes" or "No" prior to signing and dating the application form. The Worker should ask the applicant if he understands each of the three statements and verbally explain any of the statements that the applicant does not understand.

The applicant must sign and date the application form. The Worker must enter the following information in the recording section:

- Action taken on the application - This will include approval, denial, or pending status of the application. In addition, the Worker will indicate if the DFA-BU-2 form was completed by a responsible relative and any other information as required.
- The Worker must also indicate whether the deceased was receiving any program benefits from the DOHS at the time of his death.

20.3.4.D Liability of Responsible Relatives

As indicated in the Public Welfare Law §9-5-9, liability of relatives for support, certain relatives of the deceased who are financially able shall be responsible to pay the expenses of burial. These relatives are listed in the order of priority:

- The spouse (even if living apart, if they are still legally married)
- The children
- The parents
- The siblings

"Financially able" is defined as the responsible relative's financial ability to make payment toward or the entire maximum payment allowed by the DOHS. The income of the responsible relative must be verified. The income limit is 133% of the FPL. The needs group and income group would consist of the responsible relative and those living with the responsible relative, at the time of application. The most recent 30 days of income would be counted starting with the date of application. The budgeting rules would follow SNAP Policy. The applicant has 3 days to provide income verification or the application will be denied if income is not verified within that time. The income of the deceased is not counted.

In many situations, other relatives (spouse, nephew, niece, etc.) who are not legally liable for payment of burial costs will take the responsibility for arranging the burial and make applications for burial expenses.

20.3.4.E Completion of Form DFA-BU-2, Affidavit of Responsible Relative

The purpose of the DFA-BU-2, Affidavit of Responsible Relative is used to determine financial ability of those responsible relatives who are liable for the burial costs of the deceased and to

determine sufficient ability of other relatives who wish to contribute to the burial costs but are not liable.

The DFA-BU-2, will be completed by the applicant in the following manner:

- When the applicant is a relative who is liable for the burial costs of the deceased, Form DFA-BU-2 must be completed. If the relative refuses to complete the form, the application is denied.
- When the applicant is a relative who is not liable for the burial costs, the Worker will request the relative to complete the form for the purpose of developing resources. He may refuse to complete the form and the application is not denied.
- When the applicant is not a relative of the deceased, he completes the form for the purpose of developing resources but does not sign the form.
- A funeral home that is applying on behalf of the deceased does not need to complete the DFA-BU-2.

The completion of the form is self-explanatory. The Worker shall explain to the person signing the form that witness signatures are required only when the person signs the form with his "mark". In this situation, the persons who act as witnesses must actually see the person place his "mark" on the form.

20.3.4.E.1 *Responsibilities of the Funeral Home Director*

The Funeral Home Director will complete the DFA-67-A form, Burial Billing Form. The signature must be in blue ink. If any questions arise in completing the form, the Funeral Home Director should consult the Funeral Home Director Handbook or contact the Worker for questions about form completion.

20.3.4.E.2 *Responsibilities of the Worker*

The Worker and his Supervisor will enter their signatures and date upon the completed DFA-67-A form in blue Ink. In addition, the Worker must compare the resources reported by the Funeral Home Director on the DFA-67-A form with the resources reported by the applicant on the DFA-BU-1 application form. Any discrepancies must be resolved by contacting the applicant and Funeral Home Director. Approval will be withheld until the discrepancies are resolved. If necessary, the Worker may request verification of statements or claims made by the applicant or the Funeral Home Director. The purpose of this procedure is to provide authorization for

payment since payment to the Funeral Home Director is handled through the Office of Accounting.

NOTE: The Worker, his Supervisor, the Financial Clerk, and the Funeral Home Director or his designee, must sign their appropriate sections on the original DFA-67-A in blue ink only.

Red Ink on the original document is reserved for Auditors use only.

20.3.4.E.3 *Responsibilities of the Financial Clerk*

The Financial Clerk will receive the DFA-67-A, Burial Billing Form, from the Funeral Home Director. Upon receipt of this invoice, the Financial Clerk will be responsible for pre-auditing and editing. Items to be reviewed before submittal for payment are:

- Federal Employer Identification Number (FEIN) in the upper right-hand corner
- County number and mailing address
- Legible vendor name and mailing address
- Correct payment amount on Line Item 7 or Item 9
- Date of death
- Date of interment
- Proper signatures and dates entered (blue ink on original)

Upon completion of the audit, the Financial Clerk must stamp the DFA-67-A with a certification stamp and sign and date the spaces made by the stamp in blue ink. The financial clerk must also print their name beside their signature. The original and two copies of the DFA-67-A will be submitted to the DFA in the burial packet. The burial packet consists of the DFA-67-A (

and two copies), DFA-BU- 1, DFA-BU-2, if applicable, and DFA-BU-3. The completed packet must be submitted to the DFA Policy Unit no later than 3 business days after the receipt from the customer. All back-up material pertaining to the burial will remain in the local office.

In order for the Financial Clerk to have a record of burials submitted for payment, a Log for Burial Payments must be maintained in each local office. On this log, the following items are suggested:

- Date the DFA-67-A was received for payment
- Name of vendor
- Name of deceased
- Date the DFA-67-A was submitted to the DFA

- Date the Accounts Payable Monthly Burial Report was received from the DFA

When the Funeral Home Director indicates on the DFA-67-A form (Item 10) that he has applied for, but did not receive, certain resources at the time of burial, the Financial Clerk must develop a control to contact the Funeral Home Director every 60 days from the date entered on the DFA-67-A form to determine if he received the resource.

If the Funeral Home Director receives any resources at a later date, he is required to reimburse the DOHS if these resources:

- Are in excess of the exempted resource amount; or
- When added to the resource received at the time of burial are in excess of the exempted resource amount.

> **Reimbursement Example:** A Funeral Home Director submits a DFA-67-A for a burial. Resources received at the time of burial are $550. Since the resource of $550 did not exceed the exempted resource amount of $1,200, the Funeral Home Director received a check for $1,000 from the DOHS. Later, the Financial Clerk has determined that the Funeral Home Director received additional resources in the amount of $1,300.
>
> Total resources received by the Funeral Home Director comes to $1,850 ($550 + $1,300 = $1,850). The exempted resource amount was exceeded by $650 ($1,850 - $1,200 = $650).
>
> The Funeral Home Director must reimburse the DOHS for $650.

Computation procedures when the actual cost of burial is less than the amount of payment requested from the DOHS and/or resources due to the Funeral Home Director.

In order to use this computation procedure, it is necessary to compute the amount of payment requested from the DOHS as outlined on the DFA-67-A, Burial Billing Form, Item 2 through Item 7.

The actual cost incurred in providing the burial is used in computing the amount of payment entitled to the funeral home.

20.3.5 DEVELOPMENT OF RESOURCES

The development of resources is a joint responsibility of both the DOHS and the Funeral Home Director. However, the DOHS's responsibility in the development of resources is limited to the estate of the deceased and only in situations when the estate is sufficiently valued to obtain up to the $1,000 reimbursement to the DOHS.

The Funeral Home Director may develop resources from many different sources. Whenever the Funeral Home Director develops an amount of resources that exceeds the exempted resource amount of $1,200, the DOHS will deduct this amount from the burial rate. When the Funeral Home Director receives resources, which exceed the exempted resource amount after payment is received from the DOHS, the DOHS must be reimbursed by the Funeral Home Director.

Development of Resources Example 1: The Funeral Home Director receives payment of resources on a burial for $500.

$500	Resources
- $1,200	Exempted resource amount
$0	Excess
$1,000	Burial rate
- $0	Excess
$1,000	Amount of payment received by the Funeral Home Director from the DOHS
$500	Resources
+$1,000	Burial payment
$1,500	Maximum allowable payment (total payment received by the Funeral Home Director)

In this example, the Funeral Home Director is entitled to receive $700 in additional resource before the maximum allowable payment of $2,200 is reached. Assume further that the Funeral Home Director receives $800 in additional resources after the burial payment from the DOHS was received. The Funeral Home Director must reimburse the DOHS $100 because the maximum allowable payment was exceeded by $100.

20.3.5.A Types of Resources

It is the responsibility of the person who made the burial arrangements and the Funeral Home Director to apply for and develop the following potential resources which may be available to meet burial expenses:

- Statutory Death Benefit Plans
  - Social Security Administration
  - Veterans Affairs (VA)
  - Workers' Compensation

- United Mine Workers of America
- Other statutory death benefits

- Private Death Benefit Plans
  - Life Insurance
  - Prepaid Burial Trusts
  - Other private death benefit plans
- Contributions from friends and relatives
- Automobile Liability Insurance
- Other

20.3.5.B Treatment of Resources

All resources are treated the same, regardless of whether or not the deceased was a recipient of public assistance or any other type of benefit from the DOHS or other agencies. Please note that the treatment of resources discussed in this section is exclusive of resources received by the DOHS from the deceased's estate as discussed above.

20.3.5.B.1 *Resources Obtained for Burials*

Resources of up to $1,200 may be obtained toward the cost of a burial for a total maximum payment of $2,200 before the resources are deducted from the burial rate.

	Resource Payment	Program Benefit	Total Payment to Funeral Home
Example 1	$1,800	$400	$2,200
Example 2	$1,000	$1,000	$2,000

20.3.5.B.2 *Resources Due to the DOHS*

The DOHS is entitled to receive resources from the following sources:

- The deceased's estate; and
- The amount of resources developed by the Funeral Home Director which exceeds the exempted resource amount.

20.3.6 MAXIMUM ALLOWABLE PAYMENT

The income limit for the indigent burial program is 133% of the federal poverty level. This would be the income limit for the responsible relative. The household size and income would include all individuals that reside in the same household as the responsible relative. **The deceased and their income would not be included in this.** There is no asset test for the responsible relative.

If the applicant is not considered a responsible relative (spouse, child, parents, siblings) then the income does not need to be verified. The income limit applies to responsible relatives only.

If a responsible relative applies and is over the income limit someone else **cannot reapply in place of the responsible relative.** The burial would remain denied once a responsible relative comes forth and is found over the income limit.

The maximum allowable payment is the limit on the amount of payment that can be received by the funeral home when the Department of Human Services (DOHS) participates in the payment of a burial. The extent of the DOHS's participation, or the amount of the program benefit, is determined by the burial rate and, when applicable, the amount which exceeds the maximum allowable payment.

The maximum allowable payment is not to be confused with the burial rate. The maximum burial rate is the amount the DOHS will make toward the cost of all funeral-related expenses. The maximum burial rate is $1,000.

The maximum allowable payment is also used to establish eligibility for a burial payment in relation to the resources of the deceased and to contributions made by responsible relatives.

Finally, the maximum allowable payment is used to establish the amount of resources (i.e., payment received from sources other than the DOHS) that may be received by the funeral home before the maximum burial rate is reduced.

The maximum allowable payment for burials may not exceed $2,200. The amount of resources that are exempted before being applied to the burial rate is $1,200 (exempted resources amount of $1,200 + burial rate of $1,000 = $2,200). Therefore, the DOHS will not participate in the burial costs when the total amount of resources received by the Funeral Home Director for a burial is $2,200 or more. When the amount of resources exceeds $1,200 but is less than $2,200, that amount, the excess, is less than $2,200 this amount will be deducted from the burial rate from the $1,000. The income limit is 133% of the FPL.

> **Example:** The Funeral Home Director receives payment of resources on a burial for $1,450.

$1,450	Resources
- $1,200	Exempted resource amount
$250	Excess
$1,000	Burial rate
- $250	Excess
$750	Amount of payment received by the Funeral Home Director from the DOHS
$1,450	Resources
+ $750	Burial payment
$2,200	Maximum allowable payment (total payment received by the Funeral Home Director)

20.3.6.A Direct Burial Rate

The direct burial rate of $1,000 is the maximum amount that will be paid by the DOHS. This rate applies to all burials. Under no circumstances is this rate negotiable regardless of the specific burial plan desired by the applicant.

20.3.7 INTERMENT PLANS

The following instructions describe the casket and merchandise that must be used when the DOHS makes payment for the burial. In addition, certain types of allowable interment plans are described.

The burial rate will include the casket and transportation. There is no extra allowance for local or long-distance transportation for the deceased. The burial is to be direct burial. Direct burial means the removal of the remains from the place of death, casket for the deceased and transportation to a West Virginia cemetery.

20.3.7.A.1 *Casket*

The following is a description of the type of casket which must be used when the DOHS is making payment of the burial rate.

The casket shall be at least, but shall not exceed, a flat top or oval top constructed with wood or wood products and covered with such exteriors as doeskin, lambskin, moleskin, plain or embossed cloth.

No casket other than that which is described above shall be used unless the Funeral Home Director does not have an appropriate casket or outside container available and he agrees to absorb the higher cost of the more expensive casket or outside container.

If anyone (e.g. relative, friend, etc.) provides a better or more expensive casket than that which is described above, the DOHS will not participate in the payment of the burial expenses.

20.3.7.A.2 *Direct Cremation*

Direct cremation is the preferred method under the indigent burial program. Direct burial is used in place of cremations pursuant to the decedent's religion or otherwise prohibited by federal law, state law or regulation in which case, burial will be substituted in place of cremation. Direct cremation includes the removal of the remains from the place of death; container; and crematory fees. The applicant and Funeral Home Director must understand that the burial rate ($1,000) and maximum allowable payment ($2,200) will apply to cremations as well as any other interment plan.

20.3.7.A.3 *Burial of Two or More Bodies in One Casket*

In certain rare situations, when it is warranted by the condition of the bodies, or when it is desired by the family, the DOHS will make payment for the burial of two bodies in one casket, but this payment is the same amount for a single body.

The next of kin or any persons who may be chargeable with the burial expenses of the deceased, or the person taking responsibility for making the burial arrangements, and the Funeral Home Director must agree to this type of interment. The Funeral Home Director also must notify the DOHS prior to the burial that two or more bodies are placed in the same casket and state the reason given for this type of arrangement.

> **Burial of Two or More Bodies in One Casket Example:** Two infants are buried in a casket. The DOHS will pay only the burial rate of $1,000 and apply the maximum allowable payment of $2,200.

20.3.7.A.4 *Green Burial*

Green Burials are no longer covered under the indigent burial program.

20.3.8 BURIAL PAYMENT PROCESS

The DFA-67-A, Burial Billing Form, is completed by the Funeral Home Director and submitted to the DOHS. It is used in the payment process for the purpose of determining the amount of payment to be made by the DOHS to the Funeral Home Director.

20.3.8.A Form DFA-BU-3, Affidavit of Burial Costs and Supporting Documentation

The DOHS will seek reimbursement of burial costs by filing an Affidavit of Burial Costs with the Office of the County Clerk having jurisdiction of the deceased's estate (the county in which the deceased maintained his residence or the county in which the deceased owned real estate). The Worker must attempt to obtain sufficient information about the deceased's estate in order to make decisions to seek reimbursements. If the Worker determines that the minimum value of the estate is $1,000 after the costs of administration are deducted, the Worker must seek reimbursement.

According to the West Virginia Code, supporting documentation must be included with the DFA-BU-3 form when it is submitted to the Office of the County Clerk. This documentation will be a copy of the DFA-67-A, Burial Billing Form, and a copy of the Accounts Payable Monthly Burial Report.

The Monthly Burial Report is a list of names of the deceased for each county with the vendor name, document I.D. number, warrant number, warrant date, and the amount of payment made by the DOHS to the vendor. This document fulfills the requirement that verification of an actual payment must be made just as the DFA-67-A form verifies that an actual request for payment was made by the vendor. The DFA-BU-3 form establishes that the DOHS has filed a claim against the estate. Each month, Accounts Receivable, Office of Accounting will prepare the Monthly Burial Report showing a list of deceased persons based on the DFA-67-A forms submitted for that month. The Financial Clerk will submit to the Office of the County Clerk one copy of the Monthly Burial Report, one copy of the DFA-67-A, and the original DFA- BU-3, Affidavit of Burial Costs, for each name on the list. When it has been determined that an estate does not exist or insufficient resources in the estate precludes the necessity of establishing a claim, the Financial Clerk will cross out the deceased's name on the list and not submit supporting documentation for that burial.

20.3.8.A.1 *Instructions for Completing Form DFA-BU-3*

The Financial Clerk will complete the DFA-BU-3 form on all cases. The Affidavit of Burial Costs is a form letter and is completed as follows:

➢ *Introductory Statement*

The Financial Clerk will enter the name and address of the County Clerk. The name of the deceased and the amount of the claim is entered in the spaces provided. The amount of the claim cannot exceed $1,000.

➢ *Affidavit and Verification*

The affidavit and verification process include the following:

- The Financial Clerk enters his name, the amount of the claim against the deceased's estate, and the name of the deceased in the spaces on the form.
- The Financial Clerk signs his name in the "Affiant" space and obtains the signature of the Notary Public.
- The DFA-BU-3, plus a copy of the DFA-67-A, Burial Billing Form, is attached to the Monthly Burial Report and submitted to the Office of the County Clerk.

20.3.8.B Reimbursement from the Deceased's Estate

When the Financial Clerk receives reimbursement from the deceased's estate for the amount of the burial costs paid by the DOHS, he will make a direct deposit of this reimbursement to the burial program for the fiscal year in which the burial was paid.

20.3.8.C Release of Lien against Estate

Following deposit of the reimbursement check from the deceased's estate for the amount of the burial costs paid by the DOHS, the Financial Clerk will forward a copy of a lien release packet. The lien release packet consists of the following:

- A copy of the DFA-67-A;

- A deposit ticket;
- A copy of the completed DFA-BU-3; and
- A copy of the warrant report.
- Date of death of client

A notarized release nullifying the lien against the estate is signed, and copies are sent to the Office of the County Clerk, the Financial Clerk, and the Office of Accounting.

20.3.9 CORRECTIVE ACTION

Corrective Action must be taken, regardless of who made the error. When the funeral home receives payments above the allowed resource amount of $1,200, the funeral home must reimburse the DOHS any amount which exceeds the allowed resource amount.

20.4 SPECIAL REDUCED RESIDENTIAL SERVICE RATE (20% UTILITY DISCOUNT PROGRAM)

20.4.1 GAS AND ELECTRIC COMPANIES

20.4.1.A Introduction

During the months of November through March, clients of one of the following benefits are eligible for a 20% discount from their gas and electric companies:

- Supplemental Nutrition Assistance Program (SNAP) and over age 60
- Supplemental Security Income (SSI) and at least 18 years old
- WV WORKS

The Department of Human Services' (DOHS) role is to send application packets to clients of the qualifying benefits and to supply the utility companies with lists of clients who have become ineligible for the discounts because they are no longer eligible for one of the qualifying benefits.

20.4.1.B Operation

In October, application packets are mailed to SNAP clients who are age 60 or older, SSI recipients who are at least 18 years old, and WV WORKS clients.

During the program months of November through March, application packets are mailed to new and reopened assistance groups (AG) that are approved for at least one of the qualifying benefits.

In addition, an application will be mailed to a client upon request if he is a client of a qualifying benefit and has lost or failed to receive his original application packet. If he is not a client of a qualifying benefit, he will receive a notice from the Division of Family Assistance (DFA) explaining why he is not eligible for the discount.

The client completes the application and submits it to the utility company. The utility company determines eligibility for the discount and applies the reduced rate to the eligible client's account. Approved applications are sent by the utility company to the DFA.

Each month, the DFA sends each participating utility company a list of its customers who have become ineligible for the discount because they are no longer receiving a qualifying benefit. The company removes the discount from those accounts.

Dependent upon the company, all discounts are removed by the end of March or April.

20.4.1.C Application

When the client receives the application, it contains the name and birth date of all eligible persons in the AG, effective date, case number, address, the Social Security Number for the primary person, and a date by which the application should be returned to the utility company. In addition, a waiver at the bottom of the form must be signed by the payee to allow the DOHS to verify eligibility of the AG for the gas and electric utility company.

20.4.1.D Role of the Local Office

The local office must:

- Refer inquiries about the program from utility companies to the DFA.
- Send the DFA the name, address, case number and Social Security Number of clients claiming to be qualified for the discount who reported they did not receive an application packet or whose original packet was lost or destroyed.

NOTE: If the client claims the original application has been lost or stolen and does not report a new address, the Worker must issue a duplicate form in the eligibility system. If a new address is reported by the client, then the new address, along with the case name, number, and Social Security Number must be forwarded to the DFA so the address can be updated and a new form issued by the DFA.

20.4.2 WATER COMPANY [WEST VIRGINIA AMERICAN WATER (WVAW) ONLY]

20.4.2.A Introduction

WVAW customers who receive one of the following benefits are eligible to receive the 20% utility discount. This program operates year-round.

- SNAP and over age 60
- SSI and at least 18 years old
- WV WORKS

The DOHS's role is to send application packets to clients of the qualifying benefits and to supply the water company with lists of clients who have become ineligible for the discount because they are no longer eligible for one of the qualifying benefits.

20.4.2.B Operation

Initial application packets have been mailed to the above clients. Application packets are mailed to new and reopened AGs that are approved for at least one of the qualifying benefits.

In addition, an application will be mailed to a client upon request if he is a client of a qualifying benefit and has lost or failed to receive his original application packet. If he is not a client of a qualifying benefit, he will receive a notice from the DFA explaining why he is not eligible for the discount.

The client completes the application and submits it to the water company. The water company determines eligibility for the discount and applies the reduced rate to the eligible client's account. Approved applications are sent by the water company to the DFA.

Each month, the DFA sends WVAW a list of its customers who have become ineligible for the discount because they are no longer receiving a qualifying benefit. The company removes the discount from those accounts.

20.4.2.C Application

When the client receives the application, it contains the name and birth date of all eligible persons in the AG, effective date, case number, address, the Social Security Number for the primary person, and a date by which the application should be returned to WVAW. In addition, a waiver at the bottom of the form must be signed by the payee to allow the DOHS to verify eligibility of the AG for the water company.

20.4.2.D Role of the Local Office

The local office must:

- Refer inquiries about the program from WVAW customers to the DFA.
- Send the DFA the name, address, case number and Social Security Number of clients claiming to be qualified for the discount who reported they did not receive an application packet or whose original packet was lost or destroyed.

NOTE: If the client claims the original application has been lost or stolen and does not report a new address, the Worker must issue a duplicate form in the eligibility system. If a new address is reported by the client, then the new address, along with the case name, number, and Social Security Number must be forwarded to the DFA so the address can be updated and a new form issued by the DFA.

20.4.3 SEWER COMPANY (West Virginia American Water (WVAW) ONLY)

20.4.3.A Introduction

West Virginia American Water sewer customers who receive one of the following benefits are eligible to receive the 20% utility discount. This program operates year-round.

- SNAP and over age 60
- SSI and at least 18 years old

- WV WORKS

The DOHS's role is to send application packets to clients of the qualifying benefits and to supply the sewer company with lists of clients who have become ineligible for the discount because they are no longer eligible for one of the qualifying benefits.

20.4.3.B Operation

Initial application packets have been mailed to the above clients. Application packets are mailed to new and reopened AGs that are approved for at least one of the qualifying benefits.

In addition, an application will be mailed to a client upon request if he is a client of a qualifying benefit and has lost or failed to receive his original application packet. If he is not a client of a qualifying benefit, he will receive a notice from the DFA explaining why he is not eligible for the discount.

The client completes the application and submits it to the sewer company. The sewer company determines eligibility for the discount and applies the reduced rate to the eligible client's account. Approved applications are sent by the sewer company to the DFA.

Each month, the DFA sends the sewer companies a list of its customers who have become ineligible for the discount because they are no longer receiving a qualifying benefit. The company removes the discount from those accounts.

20.4.3.C Application

When the client receives the application, it contains the name and birth date of all eligible persons in the AG, effective date, case number, address, the Social Security Number for the primary person, and a date by which the application should be returned to the sewer company. In addition, a waiver at the bottom of the form must be signed by the payee to allow the DOHS to verify eligibility of the AG for the sewer company.

20.4.3.D Role of the Local Office

The local office must:

- Refer inquiries about the program from the sewer customers to the DFA.

- Send the DFA the name, address, case number and Social Security Number of clients claiming to be qualified for the discount who reported they did not receive an application packet or whose original packet was lost or destroyed.

NOTE: If the client claims the original application has been lost or stolen and does not report a new address, the Worker must issue a duplicate form in the eligibility system. If a new address is reported by the client, then the new address, along with the case name, number, and Social Security Number must be forwarded to the DFA so the address can be updated, and a new form issued by the DFA.

20.5 SUMMER EBT (SEBT)

20.5.1 INTRODUCTION

Summer Electronic Benefit Transfer (Summer EBT or SEBT) is a summer feeding program that was authorized through Congressional action in the Consolidated Appropriations Act of 2023. The program is designed to supplement summer feeding for students who are out of school and missing meals provided through the National School Lunch Program (NSLP).

Summer EBT is a permanent program through USDA FNS beginning summer of 2024 and each subsequent summer operational period. In West Virginia, the compulsory school age is 6 - 17 years old. The agency must make the benefit available to students 7 - 14 days before the start of the operational period. Households may apply for Summer EBT all year-round, but the Department can only make the SEBT benefit available during the summer covered period. The benefit amount will be provided annually by USDA FNS.

20.5.2 STATE ADMINISTRATION

Summer EBT will be jointly administered by the West Virginia Department of Human Services Bureau for Family Assistance (DoHS BFA) and (WVDE) West Virginia Department of Education Child Nutrition. Each year the Governor of WV will determine which organization will be considered the “coordinating agency” and which will be the “partnering agency.”

The coordinating agency is generally the primary point of contact for the Summer EBT Program and is responsible for the complete and timely submission of any required plans, forms, and reports. The Plan for Operations and Management (POM) must be developed in cooperation with both State Summer EBT agencies and be reflective of the plans and administrative funding needs of both.

DoHS BFA and WVDE will collaborate with other groups such as the Bureau for Social Services, the Office of EBT Banking, and the State of West Virginia Office of the Inspector General. These groups are critical for providing support to the program administration of Summer EBT.

20.5.3 STATE OPT-IN

20.5.3.A Timeline of Requirements

Each year the Summer EBT agency opts-in to run a Summer EBT program, the timeline below must be followed.

August 15th – the date the state's Interim Plan for Operations and Management (POM) is due. The POM allows for DoHS to draw down administration of SEBT funds to begin program work.

January 1st – the date the state is required to submit the Notice of Intent to Operate a Summer EBT program.

February 15th – Final Plan for Operations and Management (POM) due to FNS. The POM is the Summer EBT state plan. The POM details all activities and requirements necessary for the program. The POM is required to draw down any program funds.

20.5.3.B Plan for Operations and Management (POM)

FNS will provide a state plan template for each program period. The POM must address administrative resolve, program eligibility, timeliness of benefits, data accuracy and funding mechanisms. The POM must also include the following attachments:

- Inter-Agency Agreement (between DoHS and WVDE)
- FNS-366A expenditure plan
- A budget narrative that corresponds with the FNS-366A
- Fair Hearing procedures for participants

20.5.4 OPERATION

Summer EBT will only be offered during the "summer operational period." The summer operational period will generally occur during June 1st – August 20th of each year. Prior to the

start of the operational period, applications will be made available to the public for the entire school year.

During the month of March, the agency will provide media information to the public regarding the availability of the application. The month of April will be the period when the random verification sample is pulled, and verification requests are sent to required households. May 1st will be the cutoff date for guardianship changes before benefit issuance.

A makeup issuance will occur yearly at the end of the operational period to cover students who may have become eligible during summer.

Summer EBT benefits follow the same restriction as SNAP. Soda, including regular, diet, and zero-calorie varieties, may not be purchased with SEBT.

20.5.5 ELIGIBILITY REQUIREMENTS

The student is eligible for the entire benefit based on being eligible for any amount of time during the school year. The student must be a resident of West Virginia at the time of benefit issuance. There are two different pathways that can make a student eligible for Summer EBT participation. The student meets a pathway if they:

- Are determined income eligible through an application process for Summer EBT; or
- Are streamlined certified based on categorical eligibility.

20.5.5.A Application for Summer EBT

Students who have been determined income eligible for free or reduced priced meals through a NSLP application are eligible for SEBT. While an NSLP application can determine eligibility for SEBT, the receipt of SEBT cannot confer eligibility for NSLP.

Most West Virginia schools are considered Community Eligibility Provision (CEP). CEP means there is a certain percentage of students who are considered low-income in a school or county, so the entire population of students receive school meals for free. Guardians of students who attend CEP schools cannot be required to complete an application for the NSLP. Therefore, an SEBT application must be made available and completed.

NOTE: Most CEP students will be required to apply for SEBT, if they are not already directly certified.

20.5.5.B Streamlined Certification (Summer EBT categorical eligibility)

Students who fall into any of the following categories are considered directly certified and categorically eligible. Therefore, they are not required to complete an SEBT application. A student is approved for streamlined certification if they are:

- Approved by an application for NSLP; or
- Receiving SNAP (including SNAP households certified at 200% FPL). Excludes children receiving a "zero-dollar benefit"; or
- Receiving WV WORKS/TANF; or
- Receiving Medicaid at or below 185% FPL (MGKF, MGKS, or MGPR only), or
- Receiving a Foster care payment (does not include Adoption or Kinship payments); or
- Is homeless as determined by WVDE; or
- Is a migrant as determined by WVDE; or
- Is a runaway as determined by WVDE; or
- Is attending WV Head Start as determined by WVDE.

***Notes**:*

- *WVCHIP is not a benefit program that determines streamline certification for SEBT. Students who receive WVCHIP will be encouraged to apply for SEBT.*
- *Students or a responsible party that is associated with the student may attest to a local Board of Education the student's status as homeless, a migrant, or a runaway. No additional verification is necessary unless the situation is considered questionable.*

20.5.6 APPLICATION PROCESS

Any students who are not streamlined certified are required to complete an application and be enrolled in a school that participates in the NSLP in the preceding school year. The state agency must make both an online and paper application available. The paper application will be available in all 54 DoHS offices. The paper application is intended to be an avenue for eligibility for families without internet access or capability. The deadline to submit an SEBT application to establish eligibility is August 20th of each year.

A social security number (SSN) is not required as an element of eligibility for the student or the parent/guardian applying for SEBT.

20.5.6.A Mandatory Application Elements

- Household composition
- All gross income of the total household assistance group
- Birth date of the student
- Guardian on file with DoHS
- Student's school
- If the student receives another DoHS-administered benefit
- The race/ethnicity of the student
- Residency status

20.5.6.A.1 Income Eligibility

Summer EBT takes into consideration all gross income in the household assistance group. The income limits for Summer EBT are equivalent to the limits of the NSLP. Students at or below 130% of the federal poverty limit can receive free meals. Students between 130% and 185% of the federal poverty limit can receive reduced-price meals. Income limits for NSLP and SEBT are adjusted annually for the period of July 1 – June 30.

Summer 2025 Income Chart

Federal Income Chart For School Year July 1, 2024 – June 30, 2025					
Household Size	**Yearly**	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	$27,861	$2,322	$1,161	$1,072	$536
2	37,814	3,152	1,576	1,455	728
3	47,767	3,981	1,991	1,838	919
4	57,720	4,810	2,405	2,220	1,110
5	67,673	5,640	2,820	2,603	1,302
6	77,626	6,469	3,235	2,986	1,493
7	87,579	7,299	3,650	3,369	1,685
8	97,523	8,128	4,064	3,752	1,876
Each additional Person:	9,953	830	415	383	192

Federal Income Chart For School Year July 1, 2025 – June 30, 2026					
Household Size	**Yearly**	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	$28,953	$2,413	$1,207	$1,114	$557
2	39,128	3,261	1,631	1,505	753
3	49,303	4,109	2,055	1,897	949
4	59,478	4,957	2,479	2,288	1,144
5	69,653	5,805	2,903	2,679	1,340
6	79,828	6,653	3,327	3,071	1,536
7	90,003	7,501	3,751	3,462	1,731
8	100,178	8,349	4,175	3,853	1,927
Each additional Person:	10,175	848	424	392	196

20.5.6.A.2 Income Defined

The following income types count toward consideration of SEBT eligibility. The countable income list includes, but is not limited to:

- Monetary compensation, including wages, salary, commissions or fees;
- Net income from non-farm self-employment;
- Net income from farm self-employment (See IMM 4.4.4.D.2 for applicable self-employment deductions);
- Social Security;
- Supplemental Security Income;
- Dividends or interests on savings or bonds or income from estates or trusts;
- Net rental income;
- WV WORKS;
- Unemployment compensation;
- Government civilian employee or military retirement, pensions or veterans payments;
- Private pensions or annuities;
- Alimony or child support payments;
- Regular contributions from persons not living in the household;
- Net royalties; and
- Other cash income.

Note: Other cash income would include cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources that would be available to pay the price of a child's meal.

20.5.6.B Verification

Verification for Summer EBT will be based on NSLP rules; at least 3% of all SEBT applications must be verified. Additionally, any SEBT applications that contain missing or incomplete earned or self-employment income will require verification. A Summer EBT guardian cannot be required to verify income at the time of application. Residency may require verification only if the eligibility worker finds the applicant's residency attestation questionable.

DoHS must send a verification checklist to the household if the SEBT case is pended for additional information. The agency must provide 15 days for the household to provide SEBT pending.

Verification of NSLP school enrollment is required to receive SEBT, but enrollment records will be provided through a secured file to DoHS by WVDE. WVDE is considered a verified upon receipt source for SEBT only. The eligibility worker must not require households to provide additional verification for school enrollment for West Virginia households. Verification is required for students residing in WV, but attending an NSLP school in a border state. This information will not be found on the WVDE NSLP spreadsheet.

20.5.6.C Denial Reasons

- The household is over the income threshold for their assistance group; or
- The student is not a resident of West Virginia; or
- The student does not attend a school that participates in the NSLP; or
- The student is already eligible for Summer EBT through Direct Certification; or
- The student has passed away.

20.5.7 USE OF DATA TO DETERMINE ELIGIBILITY

- PATH – statewide eligibility system for SNAP, WV WORKS, Medicaid, and Foster care data
- WVEIS – statewide database for school enrollment information
- PrimeroEdge – statewide system and application portal for Summer EBT applicants

The data sources above collect information that assist in determining eligibility for SEBT. All data sources are cross referenced to ensure that each qualified student only receives a single SEBT benefit.

20.5.7.A Enrollment Check

For students who must apply, a school enrollment check will be performed to ensure the student is/was also enrolled in a school that participates in the NSLP. WVDE will provide a master list of WV NSLP enrolled students. Eligibility workers must check the enrollment list prior to determining eligibility for any student who must apply.

For students who are determined eligible based on receipt of another qualified benefit, a school enrollment check will not occur. DoHS is responsible for ensuring only students aged 6 - 17 (who are streamlined certified) receive SEBT. A streamlined certified student who is less than 6 years of age or older than 17 years of age must apply to establish eligibility for SEBT.

NOTE: It is possible that some homeschooled students will receive SEBT based on receipt of a qualified benefit (streamlined certified). These children must receive SNAP, WV WORKS, Medicaid, or Foster care to be homeschooled and receive SEBT. There are no exceptions to this rule.

20.5.7.B Residency Check

Prior to Summer EBT benefit issuance, the state agency must ensure all students (regardless of how they are eligible) are West Virginia residents. Only students who reside in the state of West Virginia will receive WV SEBT. Students residing outside of state boundaries will need to inquire how to apply in another state. A student residing in WV but attending an NSLP school in a border state may be eligible for SEBT.

20.5.7.C Deduplication

Both lists (applicants and streamlined certified) of qualified students will be cross referenced from all data sources to ensure each qualified student only receives a single SEBT benefit. Any student whose record appears more than once will be removed to only produce a single benefit.

When a student is missed and is issued more than a single SEBT benefit, the additional benefits will be removed from the EBT card once discovered. These cases will not be forwarded to OIG, unless it is discovered the household used a benefit they were not qualified to receive.

20.5.8 SERVING VULNERABLE POPULATIONS

Students experiencing homelessness: WVDE will communicate Summer EBT information with participating schools and make information available to each Homeless Services Liaison within public school systems.

At every benefit application and redetermination, DoHS eligibility staff is required to discuss household living situations. This includes whether a family is unhoused or housing insecure. This allows the agency to better serve our more vulnerable families.

Foster students: Students in foster placement will receive benefits on the same schedule as non-foster students. DoHS will collaborate with the Bureau for Social Services for dissemination of program information to foster guardians and kinship placements.

PATH data will be utilized to issue benefits for foster students. DoHS Social Services will inform Family Assistance/Office of EBT when a child has changed residency. DoHS will work to ensure the current guardian receives the Summer EBT benefit on behalf of the student in state's care.

Lack of Social Security Number: West Virginia's Summer EBT plan will not require social security numbers for benefit issuance. Each student has a WVEIS number that is not affiliated with private social security numbers. The WVEIS number will be utilized for verification when guardians contact the Summer EBT hotline.

DoHS collects social security numbers for all students who are directly certified through receipt of a qualified benefit. Social security numbers for these students have been collected as a regulatory requirement of another public assistance program.

Households with Limited English Proficiency: 95% of West Virginia residents speak English as their first or preferred language. For the 5% of residents who are considered to have limited English proficiency, DoHS will utilize the agency's interpreter service that is regularly used for other DoHS benefits. Also, household notification will be available in Spanish upon request.

Households without Internet access: DoHS will provide county office notification using paper flyers. All 54 DoHS field offices will make paper Summer EBT applications available for households without or having limited internet access. All benefit determination notifications will be sent to the household in the form of a mass mailing. This includes families who qualify based upon direct-certification status.

Individuals with Disabilities: The state will comply with the Americans with Disability Act (ADA). DoHS is required to provide accommodations to individuals with disabilities who face a barrier to applying or participating in a program. These individuals include those in wheelchairs and other navigation devices. The state will provide ANY reasonable accommodation for individuals living with a disability. DoHS employs a statewide ADA Coordinator tasked with maintaining agency compliance with ADA standards and ensuring access for all DoHS clients, including those with disabilities.

20.5.9 ADMINISTRATIVE RESPONSIBILITIES

The following administrative functions are required to be carried out for the statewide implementation of Summer EBT in each program period.

20.5.9.A Erroneous Payments and Preventing Dual Participation

By design, West Virginia's Summer EBT Program should mitigate large instances of erroneous benefits being used. The application portal for SEBT is designed to limit students and children unaffiliated with a school that participates in the National School Lunch Program from successfully submitting an application. Further, the WV SEBT application portal can access students enrolled in an NSLP school, as well as pull to a direct certification list or indicator.

If a household with a directly certified eligible student does seek to apply in the WV SEBT application portal, and that student is enrolled in an NSLP-participating school, the parent/guardian completing the application will receive a pop-up notification box indicating a record for that student has been found and no application will be necessary. This logic and process would also be applicable to students who already have an approved free or reduced-price application on file for the current school year.

Since both the coordinating and partnering agencies have access to existing streamlined certification data for the State of West Virginia through an existing data sharing agreement, a special query can be run to compare the file of applicants through the WV SEBT application portal against the current list of direct certification students to determine if somehow a child presents on both lists. Duplicates can be removed so that an erroneous payment is not issued.

20.5.9.A.1 The Role of Investigations and Fraud Management, OIG

Upon discovery of a potential Summer EBT claim, the Department of Human Services refers the case to Investigations and Fraud Management (IFM) for evaluation. Should the alleged over-issuance be substantiated, a claim will be established against the primary household member or the household member who signed the application for Summer EBT benefits. Should the error be determined to be an inadvertent household error, no claim will be established against the household. Claims will not be written for under $125 unless it is determined that those benefits were intentionally obtained by fraudulent means or trafficked. Households may request a partial or complete repayment of benefits from any available balance on their Summer EBT card by

signing a benefit repayment form or giving verbal permission for the Investigator to do so. Summer EBT claims cannot be offset by reducing SNAP or WV WORKS benefit(s).

20.5.9.B Program Violators

To the maximum extent practicable, claims against households will be limited to situations where there is evidence that the household knowingly obtained benefits through fraudulent activities and/or trafficking Summer EBT benefits.

Administrative disqualification procedures will be initiated by the State agency in cases in which the State agency has sufficient documentary evidence to substantiate that an individual has intentionally made one or more acts of Intentional Program Violations (IPV), the definition of which shall consist of having intentionally:

1. *Made a false or misleading statement, or misrepresented, concealed, or withheld facts; or*

2. *Committed any act that constitutes a violation of Summer EBT benefits, Summer EBT regulations, The Consolidated Appropriations Act of 2023, or any State statute or policy from the Income Maintenance Manual (IMM) for the purpose of using, presenting, transferring, acquiring, receiving, possessing, or trafficking of Summer EBT benefits.*

   IPV claims must be established for trafficking-related offenses. Claims arising from trafficking-related offenses are the value of the trafficked benefits as determined by the individual's admission, adjudication, or documentation that forms the basis of the trafficking determination.

20.5.9.B.1 The Role of Investigation and Fraud Management, OIG

Referrals from the Department of Human Services must be sent to Investigations and Fraud Management (IFM) on any household who knowingly obtained benefits through fraudulent activities such as dual participation, making a false statement on the application for benefits, trafficking, or any other fraudulent means. After the investigation is completed, if the evidence substantiates the allegations, then an administrative claim(s) will be established against the applicant.

IPVs include making false or misleading statements, misrepresenting facts, concealing, or withholding information, and committing any act that violates the Consolidated Appropriations Act of 2023, SEBT regulations, or any State statute or policy found in the Income Maintenance

Manual related to the use, presentation, transfer, acquisition, receipt, or possession of Summer EBT benefits.

20.5.9.B.2 IPV Penalties

The client(s) who is found to have committed an IPV is ineligible to participate in the program for a specified time, depending on the number of offenses committed.

Persons who have been found guilty of an IPV are disqualified as follows:

- **First offense**: One year
- **Second offense**: Two years
- **Third offense**: Permanent

20.5.9.B.3 Establishing the Claim

An IPV can only be established in the following ways:

- The client will be provided with an Advanced Notice of Administrative Disqualification letter, **AND**
- The client signs a Waiver of Rights to an Administrative Disqualification Hearing (ADH) (Note: These forms are only used by IFM Workers and Hearings Officers. When the client waives his right to an ADH, the disqualification cannot be changed by a subsequent Fair Hearing.), **or**
- By an ADH decision, **or**
- By a Diversionary Consent Agreement**, or**
- By court decision.

20.5.9.C Fair Hearings

The Fair Hearing process for Summer EBT will be conducted in a manner consistent with fair hearings of other DoHS administered benefits. SEBT has been added to Chapter 700 of the Office of Inspector General's Common Chapters.

If a student family does not agree with the decision of DoHS, they are entitled to a fair hearing. The student family must complete the DFA-FH-1 and submit it to the local DoHS office within 90 days after the end of the summer operational period.

The Office of Inspector General, Board of Review (BOR) has the oversight authority to ensure an equitable fair hearing process. The Board of Review is the only body that can make fair hearing determinations. Final decisions by the BOR are appealable to the Intermediate Court of Appeals of West Virginia.

20.5.9.D Replacement

DoHS will replace up to the total allotment of the Summer EBT issuance for instances of food loss (purchased with SEBT) due to a disaster or household misfortune. Mass power outages are not required to be verified. For individual power outages, the outage must have lasted for at least 4 hours to qualify for replacement.

The student family may request replacement more than once but may never receive more than the total of the summer allotment. The student family must complete a DFA-SNAP-36 form and submit it to the local county DoHS office. The form must be completed within 10 days of the reported disaster or household misfortune.

The Family Assistance Policy unit will review any questionable replacement requests and make the final determination for SEBT replacement. Once approved for SEBT replacement, the student family will receive the replaced benefit within 30 days of the request being processed.

Note: The DFA-SNAP-36 form is a DoHS form only. WVDE will not collect requests for SEBT replacement. The student family must contact the local DoHS office for a replacement request.

20.5.9.E Expungement

Expungement for Summer EBT cases will be 122 days following issuance of the SEBT benefit. The issuance date is the date benefits are loaded onto the EBT card. Student families will receive a notice 30 days prior to expungement. Student families are encouraged to use all SEBT benefits prior to the 122-day expungement.

20.5.10 ROLE OF THE LOCAL OFFICE

- Accept Summer EBT applications (DFA-SEBT-1) and determine program eligibility in PATH.
- Accept fair hearing requests and represent DoHS during fair hearing procedures. Comply with the Board of Review to provide an equitable fair hearing process.
- Accept DFA-SNAP-36B forms and verification (if necessary) and issue replacement SEBT when necessary.
- Provide eligibility information to households for students receiving Summer EBT.
- Provide general program information to all student families who inquire about Summer EBT.
- Make referrals regarding erroneous payments and program violations to the Investigations and Fraud Management (IFM OIG).
- Each county should provide at least one local area DoHS staff member to act as the county Summer EBT liaison. This person(s) will receive targeted information about SEBT and will work with state level DoHS staff in the implementation of Summer EBT.

20.6 TEL-ASSISTANCE

20.6.1 INTRODUCTION

The Tel-Assistance Program allows reduced rate telephone service to qualified low-income clients. The monthly cost for Tel-Assistance service is lower than other local telephone services offered. Only one Tel-Assistance service is permitted per household and the household is not allowed to receive services from multiple providers. For example, a household may have Tel-Assistance service on their landline OR their wireless phone, but not both.

The Department of Human Services (DOHS) has the following responsibilities for the programs:

- To inform clients of their eligibility;
- To assist clients in verifying their eligibility;
- To determine continuing eligibility of clients; and
- To inform the telephone company of a client's eligibility.

20.6.2 STATE ADMINISTRATION

The Tel-Assistance Program is administered at the State level by the Division of Family Assistance (DFA) Policy Unit. The DFA has the final responsibility of program planning, implementation, operation, and management.

20.6.3 LOCAL OFFICE RESPONSIBILITY

The local offices are responsible for distributing an application form, DFA-TA-2, and a fact sheet, DFA-TA-3, to any client who makes a request.

20.6.4 ELIGIBILITY REQUIREMENTS

To be eligible for Tel-Assistance service, the client must be receiving at least one of the following benefits:

- Emergency Assistance (EA)
- Federal Public Housing Assistance (FPHA)
- Low Income Energy Assistance Program (LIEAP)
- Medicaid
- National School Lunch Program, free program only
- Supplemental Nutrition Assistance Program (SNAP)
- School Clothing Allowance (SCA)
- Temporary Assistance for Needy Families (TANF)
- West Virginia Children's Health Insurance Program (WVCHIP)
- Any other means-tested state or federal program

NOTE: To qualify, the telephone bill must be in the name of the client receiving the service.

NOTE: Any adult member of the AG may apply for Tel-Assistance service.

20.6.5 APPLICATION PROCESS

20.6.5.A Eligibility System Issued Applications

The eligibility system includes a notice on each approval letter informing the client that, if interested in applying for Tel-Assistance, he may obtain an application from the local DOHS office or by using his WV PATH My Benefits account.

20.6.5.B Walk-In Applications

Local offices are supplied with the applications and fact sheets for distribution to any client who makes a request. The following procedure is used when an application is received:

- The Application and Fact Sheet are obtained by the client from the local office and completed.
- The application is forwarded to the telephone company.
    - The client is responsible for sending or taking the application to their selected telephone company.
    - The telephone company certifies service.

20.6.6 CLOSURE PROCESS

It is the responsibility of the client to notify the telephone company if he ceases to receive benefits from the DOHS or any other means-tested state or federal program that deemed him eligible for Tel-Assistance service, or if his annual income exceeds the income guidelines.

20.6.7 TELEPHONE COMPANY RESPONSIBILITY

20.6.7.A Notification of Eligibility

Participating telephone companies are responsible for notifying the client of eligibility, cost of service, denials, or termination of benefits.

20.6.7.B Question of Eligibility

The telephone companies are responsible for answering all questions of eligibility.

20.6.7.C Hearing Process

Establishing, maintaining, and conducting hearings which may result from the denial of benefits are the responsibility of the participating telephone companies.

20.6.8 FORMS

One or more of the following forms may be used to determine eligibility:

- Application, DFA-TA-2
- Fact Sheet, DFA-TA-3

20.6.9 PARTICIPATING TELEPHONE COMPANIES

Each participating telephone company may offer its own individual enhanced plan.

20.7 LIFELINE

20.7.1 INTRODUCTION

The Lifeline Program allows reduced rate telephone service to qualified low-income clients. The monthly cost for Lifeline service is lower than other local telephone services offered. Only one Lifeline service is permitted per household and the household is not allowed to receive services from multiple providers. For example, a household may have Lifeline service on their landline OR their wireless phone, but not both.

The Department of Human Services (DOHS) has the following responsibilities for the programs:

- To inform clients of their eligibility; and
- To assist clients in verifying their eligibility; and
- To determine continuing eligibility of clients; and
- To inform the telephone company of a client's eligibility.

20.7.2 STATE ADMINISTRATION

The Lifeline Program is administered at the State level by the Division of Family Assistance (DFA) Policy Unit. The DFA has the final responsibility of program planning, implementation, operation, and management.

20.7.3 LOCAL OFFICE RESPONSIBILITY

The local offices are responsible for distributing an application form, DFA-TA-2, and a fact sheet, DFA-TA-3, to any client who makes a request.

20.7.4 ELIGIBILITY REQUIREMENTS

To be eligible for Lifeline service, the client must be receiving at least one of the following benefits:

- Federal Public Housing Assistance (FPHA)
- Medicaid
- Supplemental Nutrition Assistance Program (SNAP)
- Supplemental Security Income (SSI)
- Veterans Affairs (VA) Pension or Survivors Pension
- Income-based Eligibility

NOTE: To qualify, the telephone bill must be in the name of the client receiving the service.

Clients residing on tribal lands may also use eligibility documentation from one of the following programs if their household income is at or below 135% of the Federal Poverty Guidelines:

- Bureau of Indian Affairs (BIA) General Assistance
- Tribal Administered Temporary Assistance for Needy Families (TANF)
- Head Start
- Food Distribution Program on Indian Reservations
- Supplemental Nutrition Assistance Program (SNAP)
- Supplemental Security Income (SSI)

NOTE: Any adult member of the AG may apply for Lifeline service.

20.7.5 APPLICATION PROCESS

20.7.5.A Eligibility System Issued Applications

The eligibility system includes a notice on each approval letter informing the client that, if interested in applying for Lifeline, he may obtain an application from the local DOHS office or by using his WV PATH My Benefits account.

20.7.5.B Walk-In Applications

Local offices are supplied with the applications and fact sheets for distribution to any individual who makes a request. The following procedure is used when an application is received:

- The Application and Fact Sheet are obtained by the client from the local office and completed.
- The application is forwarded to the telephone company.
    - The client is responsible for sending or taking the application to their selected telephone company.
    - The telephone company certifies service.

20.7.6 CLOSURE PROCESS

It is the responsibility of the client to notify the telephone company if he ceases to receive benefits from the DOHS or any other means-tested state or federal program that deemed him eligible for Lifeline service, or if his annual income exceeds the income guidelines.

20.7.7 TELEPHONE COMPANY RESPONSIBILITY

20.7.7.A Notification of Eligibility

Participating telephone companies are responsible for notifying the client of eligibility, cost of service, denials, or termination of benefits.

20.7.7.B Question of Eligibility

The telephone companies are responsible for answering all questions of eligibility.

20.7.7.C Hearing Process

Establishing, maintaining, and conducting hearings which may result from the denial of benefits are the responsibility of the participating telephone companies.

20.7.8 FORMS

One or more of the following forms may be used to determine eligibility:

- Application, DFA-TA-2
- Fact Sheet, DFA-TA-3

20.7.9 PARTICIPATING TELEPHONE COMPANIES

Each participating telephone company may offer its own individual enhanced plan.

APPENDIX A: EMERGENCY ASSISTANCE INCOME LIMITS

Number of Persons in the Assistance Group	Monthly Income Limit
1	$861
2	$1,281
3	$1,316
4	$1,366
5	$1,416
6	$1,466
7	$1,516
8	$1,566
9	$1,616
10	$1,666

For Assistance Groups of more than 10, add $50 for each additional person.

Also see Chapter 4, Appendix A.

APPENDIX B: PUBLIC FORMS

Form Number	Form Title
DFA-67-A	Burial Billing Form
DFA-BU-1	Application for Burial Benefits
DFA-BU-2	Affidavit of Responsible Relative
DFA-EA-1	Application for Emergency Assistance
DFA-TA-2	Tel-Assistance/Lifeline Application
DFA-TA-3	Tel-Assistance/Lifeline Fact Sheet

Chapter 21

Low Income Energy Assistance Program (LIEAP)

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
21.1	12/1/17	747	21.4.11	Maximum allowable payment increase for 2018 LIEAP to $700.
			21.7.1	Blanket Kit removed.
			21.7.2	Repair and replacement to include cooling unit. Income limit raised to 150% of the FPL.
	11/1/24	856	21.1	Removed automatic payments.
	11/1/25	870	21.1	Added /cooling throughout.
21.2				
21.3	6/1/20	787	12.3	Update LIEAP policy to allow past due notices.
	11/1/24	856	21.3.1.F	Added If a utility bill is not in the name of any of the AG members, but an AG member is responsible for that utility.
			21.3.2.C.3	If the AGs house is without heating and it is not possible to restore the heating in 18 hours of the time of application, a voucher can be given for one night's lodging if no shelters are available. This voucher requires prior authorization by the LIEAP Coordinator.
			21.3.2.F	Added reference to 21.2.1.F if the bill is not in the AG name.
			21.3.2.G	If the AGs house is without heating and it is not possible to restore the heating in 18 hours of the time of application, a voucher can be given for one night's lodging if no shelters are available. This voucher requires prior authorization by the LIEAP Coordinator.
	11/1/25	870	21.3.3.C.1	Added new section for Residential Dwelling Types.
			21.3.3.C.2	Added a sentence "The residence must be a form of a traditional dwelling", and removed note.
			21.3.1.C.5	Replace supervisory with LIEAP Coordinator.
			21.3.1.E	Replace regular LIEAP with Heating LIEAP, Cooling

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				LIEAP, and 1 Emergency LIEAP.
			21.3.1.F	Add verbiage to allow bills verified in the last two months to be used.
21.4	4/1/20	784	21.4	Changed inROADS to WV Path
	6/1/10	787	21.4	Update LIEAP policy to allow past due notices.
	2000		21.4.11.A	Maximum allowable LIEAP benefit increases to $1000.
	2022		21.4.11.A	Maximum allowable LIEAP benefit increases to $2000.
	11/1/24	856	21.4.4	Added new sub-bullet. Additional information for the previous bullet.
				Made corrections to examples.
	7/1/25	866	21.4.11.C	
	8/1/25	867	21.4.9.A	Removed note. The note is false information, LIEAP counts the income of the month of the application.
	11/1/25	870	21.4.2.A	Remove homeless shelters and add VA centers.
			21.4.7.B	Add the end of the third paragraph, “If the bill is verified in the last two months, attach that copy to the DFA-LIEAP-1.”
			21.4.9.A	Add the word “not” in the Income Verification Example.
21.5				
21.6				
21.7	5/1/19	771	21.7.2	Corrected Fiscal Year
	10/1/19	777	21.7.1	Change 150% FPL to 60% State Median Income (SMI).
			21.7.2	Change 150% FPL to 60% State Median Income (SMI).
	4/1/20	784	21.7.1	Changed inROADS to WV Path
	4/1/21	803	21.7.1	Changed phone number for DFA
	11/1/24	856	21.7.2	Corrected Fiscal Year. Change title to Repair and Replacement guidelines.
			21.7.3	Added Weatherization is completed with WC DOE WAP guidelines. They use a point system to ensure that the neediest clients receive assistance first.
	2/1/26	873	21.7.1.A	An informational flyer will now be mailed to clients instead of an application.
21.8	4/1/22	819		Added new section for LIHWAP
	11/1/24	856		Sunset of LIHWAP Program.
App A	12/1/17	747		

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	10/1/19 10/1/22 10/1/23 12/1/23 1/1/24 11/1/24 12/1/24	777 828 843 844 847 856 858		Update the income limits for LIEAP for FY 2020 Update the income limits for LIEAP for FY 2023 Update the income limits for LIEAP for FY 2024 Corrected the income limits for LIEAP for FY 2024 Corrected the income limits for LIEAP for FY 2024 Update the income limits for LIEAP for FY 2025. Corrected errors for income limits for LIEAP for FY 2025.
App B				
App C	12/1/17	747		
App D	12/1/17 10/1/19 10/1/22 10/1/23 12/1/23 11/1/24	747 777 828 842 844 856		 Update the income limits for LIEAP for FY2020 Update the income limits for LIEAP for FY2023 Update the income limit for LIEAP for FY2024 Corrected the income limit for LIEAP for FY2024 Change title to Repair or Replacement Income Levels. Update the income levels for Repair or Replacement for FY 2025.

21.1 INTRODUCTION

The Low-Income Energy Assistance Program (LIEAP) provides financial assistance to eligible assistance groups (AG) responsible for a home heating/cooling cost. It is not the purpose of this program to meet the entire cost of home heating/cooling needs; it is designed to partially offset the cost.

The program is time-limited and dependent on the availability of federal funds. It is subject to closure without prior notice when funds are deemed to have been exhausted. Funds are normally disbursed on a first-come, first-served basis, but may also be subject to disbursement based on need. When this occurs, priority is given to those groups of clients with the greater energy burden as demonstrated by income, AG size and heating cost.

Program operation is accomplished by mail-out applications, outreach, and an open application intake period for both Regular and Emergency LIEAP. Regular LIEAP assists eligible households with the cost of home heating/cooling through direct cash payments or payments to utility companies on their behalf. Emergency LIEAP is a crisis component available for households without resources facing the loss of a heating/cooling utility source.

21.2 LIEAP FORMS

One or more of the following forms may be used in connection with the application itself (DFA-LIEAP-1) and the processing of the LIEAP payment.

- The DFA-LIEAP-1a, Instructions for Completing the Application Form, also provides the current LIEAP income guidelines and directions for mailing the form and obtaining additional assistance.
- The DFA-LIEAP-1b, Supplemental LIEAP Form shelf document, is used to document the application process.
- The DFA-LIEAP-ERR-1 application for assistance with repair or replacement of a heating unit.
- The DFA-LIEAP-3, Repayment Agreement, is used to initiate the repayment process when a LIEAP payment has been issued in error.
- The DFA-LIEAP-4, Zero Income/Home Heating/Cooling Cost Verification form, is used when the client reports zero income.
- The DFA-67, Authorization for Payment, is used to authorize Regular LIEAP payments on behalf of the client experiencing a heating emergency.
- The DFA-LIEAP-5, Authorization for Delivery and Payment of Emergency/ Regular LIEAP, is used as an option to the DFA-67 when desired by the local LIEAP staff and accepted by the vendor.
- The DFA-67, Authorization for Payment, is an eligibility system-generated voucher for the authorization and payment of Emergency LIEAP.
- The DFA-LIEAP-6, LIEAP Application Log, can be used by the county DOHS office to track LIEAP applications and ensure timely processing and issuance of checks. Use of this form is optional, but the use of some type of log is mandatory.
- DFA-LIEAP-8, LIEAP Repayment Tracking Form, is used by the Repayment Investigator (RI) to track LIEAP overpayments.

In addition to the forms listed above, the LIEAP Fact Sheet is provided to local offices for distribution to the public.

21.3 ELIGIBILITY REQUIREMENTS

This section contains the eligibility requirements for both Regular and Emergency Low Income Energy Assistance Program (LIEAP), as well as other information about LIEAP.

21.3.1 REGULAR LIEAP

Eligibility for Regular LIEAP is based on a number of factors, including income, assistance group (AG) size, vulnerability to the cost of home heating, residence, and citizenship.

21.3.1.A Income

The total monthly gross income of the AG must not be more than the maximum allowable gross income amounts in the chart in Chapter 4, Appendix A. No income deductions or disregards apply, except in the determination of gross profit for self-employment. When the gross monthly income of the AG exceeds the maximum allowable income amounts, the group is ineligible for LIEAP and the application is denied.

21.3.1.A.1 Determining the Month Income Is Counted

Income received or expected to be received during the month of application is used to determine eligibility.

> **Determining the Month Income is Counted Example 1:** Application for LIEAP is made on December 30. The income the AG received during the month of December is used to determine eligibility.
>
> **Determining the Month Income is Counted Example 2:** Application for LIEAP is made by mail on November 16. The income received or expected to be received in the month of November is used to determine eligibility.

21.3.1.A.2 Determining Gross Monthly Income

When the AG has income, which is received on a regular basis and no changes are expected during the application month, the amount of earned and unearned income from each source must be converted to a monthly amount as follows:

- Convert weekly income by multiplying by 4.3.
- Convert biweekly (every two weeks) income by multiplying by 2.15.
- Convert semimonthly (twice per month) income by multiplying by 2.

When the client is not expected to receive a full month's income during the application month, the gross income is multiplied by the number of times it is anticipated that it will be received.

> **Determining Gross Monthly Income Example 1:** Ms. Daisy begins working on the third Monday of a month and she earns $300 per week. She expects to be paid only once during the month of application. Ms. Daisy's countable gross income for the month is $300.
>
> **Determining Gross Monthly Income Example 2:** Ms. Tulip, a per diem worker paid weekly, reports she is off work caring for a sick child. She has received only two paychecks during the month of application for $300 each and does not know when she will be able to go back to work. Ms. Tulip's gross monthly income is $600.

21.3.1.A.3 Sources of Income

All sources of income are considered in determining income eligibility.

- Self-employed clients are entitled to a 20% deduction from gross sales or receipts to determine monthly gross income.
- Non-recurring lump sums received in the month of application are excluded.

  > **Non-Recurring Lump Sums Example:** Child support arrearages are non-recurring lump sums. As such, they cannot be anticipated.

- Recurring lump sums are prorated over the period they are intended to cover.

  > **Recurring Lump Sums Example:** A yearly check for mineral rights is divided by 12 to determine the countable monthly income for LIEAP.

21.3.1.A.4 Income Exclusions

The following payments received by members of the LIEAP AG are not counted as income in determining eligibility for LIEAP:

- All student loans, grants, scholarships and college work study programs.
- Payments, allowances or reimbursements for participants in programs administered by the Corporation for National and Community Service (CNCS). These programs may include, but are not limited to: ACTION, Action Programs, AmeriCorps, Summer Youth Programs, University Year of Action, Urban Crime Prevention Program, Volunteers in Service to America (VISTA) and VISTA ACTION.
- Payments under Alaska Native Claims Settlement Act.
- Any payments received or funds held in trust for members of any Indian tribe under Public Laws: 98-64, 97-458, 98-123, 98-124 referred to as “Indians Judgment Funds.” Also, any funds from payment of relocation assistance to members of the Navajo and Hopi tribes under Public Law 93-531.
- Payments to Nazi Persecution Victims, which may include, but are not limited to: Austrian Social Insurance Payments, German Reparations payments or the Netherlands WUV payments.
- Payments from the Radiation Exposure Compensation Trust Fund.
- Supplemental Nutrition Assistance Program (SNAP) benefits.
- Value of supplemental food program for Women, Infants and Children (WIC), Public Law 94-105.
- Value of National School Lunch Program, Public Law 90-302.
- Payments, allowances or reimbursements for transportation and attendant care costs under Title VI of the Rehabilitation Act of 1973, Title II, Public Law 95-607.
- Payments from Community Service Employment Program (CSEP) as authorized under Title V of the Older Americans Act.
- Income tax refunds and rebates.
- Reimbursement for expenses incurred in connection with employment and training limited to mileage, tools and clothing.
- Reimbursement for medical expenses or for transportation costs incurred to obtain medical treatment.

- Grants and loans from the U.S. Department of Housing and Urban Development (HUD) Community Development Block Grant Funds made to individuals to rehabilitate their private residence.
- All Workforce Innovation and Opportunity Act (WIOA) payments, except those considered wages for on-the-job training.
- Veterans Affairs (VA) Aid and Attendance payments.
- Social Security Administration
    - Retirement, Survivors, and Disability Insurance (RSDI)
    - Supplemental security Income (SSI)

21.3.1.B Assistance Group (AG)

The AG consists of any individual or group of individuals who are living together in the same dwelling and for whom residential home heating is customarily purchased in common or for whom home heating is included in a rent or mortgage payment as a specified amount.

It is the responsibility of the client to list all individuals who are living in the home, regardless of whether or not they are family members or whether or not they share the cost of home heating. For the purpose of LIEAP eligibility, all household members are considered one AG.

When the AG includes a person(s) who has already received a LIEAP payment as part of another AG, he is not included in the AG and his income is not counted in determining eligibility.

> **Inclusion in the AG Example:** An employed woman and her two children are included in her mother's AG. The mother applies for and is approved for a LIEAP payment for an AG of four. Her daughter and grandchildren then move out of her home to live with the children's father. The father applies for LIEAP and reports an increase in AG size and income. His LIEAP application is approved for an AG of one and only his income is counted.

When an AG includes an illegal noncitizen, that person's income must be counted even though he cannot be included in the LIEAP AG.

21.3.1.C Vulnerability to the Cost of Home Heating/Cooling

In order to qualify for a LIEAP payment, an AG must be determined vulnerable or partially vulnerable to the cost of home heating/cooling.

21.3.1.C.1 Residential Dwelling Types

In order to qualify for a LIEAP payment the AGs must reside in an approved traditional dwelling type. This is for both LIEAP and Emergency LIEAP payments.

Approved – Traditional Dwelling types include a structure that provides a housing or residential environment that is affixed to a physical address. These structures include houses, apartments, townhomes, tiny homes, mobile homes, recreational vehicles (RV's), 5th wheels, and campers. Those that are fixed and no longer movable are vulnerable to the cost of home heating/cooling.

Non-Traditional Dwelling is a structure that provides temporary housing that is not affixed to a permanent physical address. These include but are not limited to tents, lean-to's, cars, vans, or buses that are still a form of movable transportation. These types of non-traditional dwellings are considered invulnerable to home heating/cooling.

NOTE: Questions as to whether an AG is vulnerable or invulnerable should be directed to the State LIEAP Coordinator.

21.3.1.C.2 Vulnerable AGs

Vulnerable AGs are those which must pay the primary heating/cooling cost for the home in which they reside. The residence must be in the form of a traditional dwelling. The expense for heating/cooling must be billed separately from the rent or mortgage payment of the residence, even if the AG combines these payments. When payments are combined, the amount billed for the heating cost must be stated on a rent receipt, lease, or other documentation.

AGs may also be considered vulnerable if there has been a documented increase in a rent or mortgage payment due to increased utility costs. The increase does not have to be permanent if the only reason for the increase is due to extreme weather changes that cause the AGs to use a large portion of utilities.

Clients who are temporarily away from home for medical, educational, or employment purposes, and who still must pay a heating/cooling cost for the dwelling, are considered vulnerable. This includes nursing home residents who are still maintaining a home and have a heating/cooling cost.

Vulnerability also exists when the AG must pay at least a part of the cost of home heating/cooling, whether they pay just part of the cost each month or alternate payments with a third-party.

The AG is partially vulnerable when a surcharge for excessive usage is already added or can reasonably be anticipated to be added to the rent amount.

21.3.1.C.3 Invulnerable AGs

Invulnerability means the AG has no home heating/cooling costs or is not responsible for payment of the heating/cooling cost. Clients who live in state institutions, hospitals and certain group living facilities, such as halfway houses and domestic violence centers, and those whose home heating costs are paid by a third-party, are considered invulnerable.

NOTE: Questions as to whether an AG is vulnerable or invulnerable should be directed to the State LIEAP Coordinator.

21.3.1.C.4 Terminated Service

AGs in dwellings where home heating/cooling service has been terminated and the account has been closed prior to the date of application are considered vulnerable if the home heating/cooling supplier agrees to restore service upon the approval of LIEAP or in combination with other payment(s).

NOTE: The Worker must not obligate a payment until all other needed payments have been obtained. Any payment obligated to a vendor, whether verbal or in writing, must be honored if the vendor restores service and it is later determined that other payments were never received.

21.3.1.C.5 Portable Heaters

Portable heating devices such as, but not limited to, electric and kerosene space heaters, are not considered primary sources of heating except when an emergent life-threatening situation exists, the dwelling is totally without a heating source, and the AG has no alternate housing available.

It is considered dangerous to AG members and detrimental to program goals to heat a dwelling with space heaters. Such use must not be encouraged. Exceptions require LIEAP Coordinator approval.

21.3.1.C.6 Public Housing Facilities

AGs residing in subsidized public housing facilities can be considered vulnerable or invulnerable depending on how they pay their home heating/cooling costs:

- Vulnerability exists when home heating/cooling costs are paid separately or directly to the utility, fuel supplier, or building operator. These costs usually reflect total monthly usage.
- Vulnerability may also include those situations in which surcharges for excess usage are already added to the rent or the addition to the rent can be reasonably anticipated.
- Invulnerability exists when home heating/cooling costs are included in the rent and based upon a fixed percentage of income or paid by the housing authority.

21.3.1.C.7 Zero Income Clients

When zero income clients report that their home heating/cooling costs are being paid by someone else, vulnerability can be determined by the manner in which the heating costs are being paid.

- Clients who report zero income but have someone else not living in the household who makes payment for the entire cost of home heating/cooling to the vendor on behalf of the client are considered invulnerable and therefore ineligible for LIEAP benefits.

> *NOTE: When a client for whom a third-party has been making home heating/cooling payments receives a past due bill or termination notice, the Worker must determine why the bill is no longer being paid, whether future bills will be paid, and whether or not the third-party intends to pay the disconnect if LIEAP is denied.*

- Clients whose only income is a contribution for heating/cooling costs from an individual outside of the AG are considered vulnerable and are not considered zero income clients.

21.3.1.D Residence and Citizenship

21.3.1.D.1 Residence

See Section 2.2 for the residence requirement.

21.3.1.D.2 Citizenship

See Chapter 15 for the eligibility requirements of citizenship or permanent noncitizen status.

NOTE: Only citizens and/or qualified noncitizens may be included in the LIEAP AG, but the income of the entire household is counted.

21.3.1.E Duplicate Payments

All eligible AGs are entitled to one Regular LIEAP, one Emergency Heating LIEAP, and one Emergency Cooling LIEAP payment per season only. Subsequent applications received from people who have already been found eligible for or who have received a Regular LIEAP payment in that season are denied. Cases requiring corrective or supplemental payments must be referred to the Office of Client Accounts as provided in Section 21.6.

NOTE: Supplemental LIEAP funds may be made available during the program year, therefore, it is possible that eligible AGs may be entitled to receive an additional LIEAP payment. The Division of Family Assistance (DFA) Policy Unit will notify the local offices if supplemental funds become available.

21.3.1.F Customer Account Number

The customer must provide a copy of their electric bill, the bill of their main heating/cooling source and the name of their heating vendor at the time of application or within 15 calendar days following the date the information is requested. A list of Public Service Commission (PSC)-regulated utility vendors is provided in Appendix B. Customers of vendors not listed must be issued a direct payment. If the utility has been verified in the last 2 months and the client number on the application matches what has been previously verified, no additional verification is needed.

NOTE: If electric is the main heating/cooling source, only a copy of the electric bill is required. If a utility bill is not in the name of any AG members, but an AG member is responsible for that utility, then documentation of the situation is required for verification of the bill. Examples: written statements from a person whose name the utility bill is in, or death certificate (or other verification of death) of the deceased member whose name the bill is in.

21.3.1.G Time Limits

Action must be taken to approve or deny a Regular LIEAP application within 30 days of the date it is received for processing by the Department of Human Services (DOHS). Verification is due within 15 days of the date the information is requested.

NOTE: Workers may deny an application after expiration of the verification due date when the information is not received. If the client returns the information within 30 days of the application date, the benefit may be approved without a new application. After 30 days, the client must reapply.

21.3.2 EMERGENCY LIEAP

Emergency LIEAP is the program component which assists clients in eliminating home/cooling heating crisis or emergencies.

A crisis is defined as being without home heating/cooling or being in danger of not having home heating/cooling and not having the resources to resolve the crisis without financial assistance. If the crisis threatens the loss of a utility, a past due bill or termination notice is required to be submitted with the application.

If the home heating/cooling crisis is the result of a natural disaster, state and/or national public health emergency, then payments may be issued to previously approved households. Under these circumstances, a past due bill, termination notice, or face-to-face interview is not required. If there is an intake period in which an application is required, a past due bill or termination notice may be requested, but face-to-face contact may be waived.

Eligibility requirements are the same as Regular LIEAP, except for the additional requirement of verifying a heating/cooling emergency.

NOTE: An electronic notice may be accepted in place of a past due bill or termination notice or written statement from the provider.

21.3.2.A Income

The income guidelines for Emergency LIEAP are the same as those for Regular LIEAP.

21.3.2.B Assistance Group (AG)

The AG guidelines for Emergency LIEAP are the same as those for Regular LIEAP.

21.3.2.C Vulnerability to the Cost of Home Heating/Cooling

AGs must meet the same definition of vulnerability as outlined in Section 21.3.1.C above. The conditions outlined below must also be met.

21.3.2.C.1 Emergency Home Heating/Cooling Need

To qualify for Emergency LIEAP, the client must have an emergency home heating/cooling need, defined as being without home heating/cooling or in immediate danger of being without

home heating/cooling and being without resources to eliminate the emergency. Clients must be informed that a past due bill, termination notice, or a low bulk fuel supply alone does not constitute an emergent need, and that fraudulent claims may result in fines and/or loss of future eligibility for LIEAP. Vendors may report when they have been unable to make a delivery because the client was not low on fuel.

When determining if the client meets this eligibility requirement, no consideration will be given to whether or not a Regular LIEAP application was previously approved, unless it is determined the vendor has failed to credit the payment. When this happens, the Worker must contact the vendor to determine what must be done to correct the problem.

In situations where the Regular LIEAP application is pending for additional information, the Worker must attempt to either approve or deny the Regular LIEAP application before taking action on the application for Emergency LIEAP.

The Worker must also contact the vendor to determine if the amount of the Regular LIEAP payment will eliminate the emergency. If not, the Worker may approve an Emergency LIEAP payment in an amount equal to the balance needed to eliminate the emergency.

> **Emergency Home Heating/Cooling Example 1:** Application for Regular LIEAP is received on the day before the component closes.
>
> The application is pended for a copy of the heating/cooling bill to verify the account number. The client returns the information within the allotted period in the form of a past due bill or termination notice and states he wants to apply for Emergency LIEAP. The Worker contacts the vendor and learns that the past-due amount is $89.50. The client is eligible for a Regular LIEAP payment of $200. The vendor agrees to stop the termination. The Worker approves the Regular LIEAP application. No Emergency LIEAP application is processed.
>
> **Emergency Home Heating/Cooling Example 2:** Mr. Rose applies for Emergency LIEAP and has a past due bill or termination notice in the amount of $315. The Worker discovers that a Regular LIEAP application was approved within the last month in the amount of $210. The vendor has not yet credited the payment to Mr. Rose’s account. It is further discovered that an error in entering the account number has caused the delay.
>
> The Worker is able to give the vendor the correct number and the payment is credited. The Worker then processes an Emergency LIEAP application in the amount of $105, the amount the vendor verifies is now the past-due amount.
>
> **Emergency Home Heating/Cooling Example 3:** Ms. Sunflower applies for Emergency LIEAP and has a past due bill or termination notice in the amount of $400. The Worker had previously approved Regular LIEAP in the amount of $220 for her. Upon contacting the vendor, the Worker learns that the payment

has not yet been received. The Worker obligates the full amount of the past due bill or termination and approves Emergency LIEAP in the amount of $180.

Emergency Home Heating/Cooling Example 3.1: Same as above, except the amount of the past due bill or termination exceeds the maximum allowable payment. The Worker cannot obligate the full amount unless he and Ms. Sunflower are able to obtain contributions for the remaining balance if it is below the maximum allowable payment for the current program year. If the contributions for the remaining balance are not obtained or obligated, the Emergency LIEAP application must be denied.

In those instances when it cannot be immediately determined that a vendor has received but not yet credited a Regular LIEAP payment, the Worker must approve the Emergency LIEAP payment for the full amount of past due bill or the termination notice, provided it does not exceed the amount for which he is eligible.

21.3.2.C.2 Verifying Use of Direct Payments

Clients who receive direct payment of Regular LIEAP benefits must verify that the payment was used for home heating by submitting a receipt with the Emergency LIEAP application. Failure to submit this verification of payment for home heating/cooling may result in denial of the Emergency LIEAP application unless verification can otherwise be obtained by the Worker.

NOTE: Receipts for the purchase of bulk fuel must be dated prior to the date of application for Emergency LIEAP. The Worker must consider the date of the receipt(s) when determining if an emergency exists.

Verifying Payment Example 1: A client applies for Emergency LIEAP on February 22. She does not have receipts for the purchase of bulk fuel with her but returns the next day with a receipt for 104 gallons. The receipt is dated February 22 and is in the amount of the Regular LIEAP check issued January 5. The Worker denies the application because the date of the receipt is not prior to the date of the Emergency LIEAP application.

Verifying Payment Example 1.1: Same situation as above, but the receipt is dated February 15, which is prior to the date of the Emergency LIEAP application. However, the client received 104 gallons of bulk fuel just one week before applying for Emergency LIEAP. According to the client, she uses about 150 gallons per month. Based on her statement, the Worker determines that the fuel should last at least another two weeks. The client has not claimed

extenuating circumstances (leak in tank, fuel stolen, etc.). The Worker denies the Emergency LIEAP application.

21.3.2.C.3 Determining the Emergency LIEAP Benefit

➢ *Home Heating/Cooling Suppliers Regulated by the PSC*

In order to be eligible for an Emergency LIEAP payment, the client's home heating/cooling supplier must agree to provide a minimum of 30 days of service beginning the date the vendor is made aware of and accepts the DOHS's offer. Payment will be denied if the supplier fails to agree to or otherwise does not carry out this requirement.

NOTE: Clients must be made aware that charges continue to accrue during this 30-day period and that failure to make subsequent payments may result in another past due bill or termination notice at the expiration of this time period. Emergency LIEAP payments are for past-due amounts and are not intended to cover future fuel use.

➢ *Bulk Fuel Suppliers*

The amount of bulk fuel required to eliminate an emergency is the minimum amount the bulk fuel supplier will deliver.

The minimum delivered amount may or may not last for 30 days or may last for more than 30 days, depending on such variables as severity of weather, size and degree of insulation of living quarters, etc.

The amount of the Emergency LIEAP payment is based on the minimum fuel delivery cost and the amount of the maximum household benefit. See Section 21.4.11.B.

➢ *Determining the Amount of Self-Delivered Bulk Fuel*

Emergency LIEAP clients who must self-deliver bulk fuel are eligible for the same amount as the minimum required by the vendor to deliver the bulk fuel.

Self-Delivered Bulk Fuel Example: The minimum delivered amount of propane in Mr. Pine's area is 100 pounds. He will self-deliver 100 pounds, since the amount of his Emergency LIEAP payment is sufficient to purchase that amount.

Payment terms may be arranged with the vendor by means of a credit purchase or prepayment.

A credit purchase means payment will be made after the fuel is delivered.

The supplier must be instructed in the recording section of form DFA-67, Authorization for Payment, to notify the local DOHS office of the final delivery. Transmittal of the payment is made upon notification.

Prepayment is made if the vendor refuses to permit a credit purchase, and the DFA-67 must indicate in the recording section that prepayment is being made for the specified amount of fuel. If possible, the unit amounts of fuel per delivery must also be indicated.

Approval is made for the total amount of payment and the vendor is paid in advance.

In either arrangement outlined above, only one payment is made for the total amount.

➢ *Non-Elimination of the Emergency*

In many situations, the amount required by the vendor to eliminate the emergency will exceed the amount of Emergency LIEAP entitlement. See 21.4.11.

When this occurs, the Worker must determine if the client is eligible for other programs in addition to LIEAP, such as, but not limited to, Emergency Assistance (EA), Community Resource Referrals, etc., in order to meet the vendor's demands.

If the vendor refuses to observe the guidelines set forth in this section, the LIEAP application is denied.

If the AGs house is without heating/cooling and it is not possible to restore the heating in 18 hours of the time of application, a voucher can be given for one night’s lodging if no shelters are available. This voucher requires prior authorization by the LIEAP Coordinator.

21.3.2.D Residence and Citizenship

21.3.2.D.1 Residence

See Section 2.2 for the residence requirement.

21.3.2.D.2 Citizenship

NOTE: Only citizens and/or qualified noncitizens may be included in the LIEAP AG, but the income of the entire household is counted.

See Chapter 15 for the eligibility requirements of citizenship or qualified noncitizens.

21.3.2.E Duplicate Payment

Eligible AGs may receive one Emergency Heating and one Emergency Cooling LIEAP payment per season only. The approved payment cannot exceed the total season LIEAP payment limits. However, the payment does not have to be for the primary source of heat/cooling, provided the client can show that a heating/cooling emergency will result from the receipt of a past due bill or the scheduled termination. If a past due bill or termination notice has been received on both electric and gas, Emergency LIEAP may be approved for the larger amount, providing the AG lacks the resources to pay the bill. Under no circumstances is the LIEAP payment split to cover both past due bills or terminations, regardless of the amount for which the client is eligible.

Cases requiring corrective or supplemental payments must be referred to the Office of Client Accounts as provided in Section 21.6.

NOTE: Supplemental LIEAP funds may be made available during the program year, therefore, it is possible that eligible AGs may be entitled to receive an additional LIEAP payment. The DFA Policy Unit will notify the local offices if supplemental funds become available.

21.3.2.F Customer Account Number

This requirement is satisfied by the past due bill or termination notice. Also see 21.3.1.F if the bill is not in the name of an AG member.

21.3.2.G Time Limits

The DOHS must ensure assistance is offered to resolve the home energy emergency to all eligible clients no later than 48 hours from the time of application completion. In most situations, fuel delivery can be made, or home heating/cooling service continued to prevent an emergency from occurring when the vendor has been informed that the client is eligible for Emergency LIEAP benefits.

NOTE: Some vendors require an extra delivery charge for deliveries outside the normal times or routes. This charge is added to the cost of the fuel to determine the payment amount.

When the eligible AG is faced with a life-threatening emergency, the DOHS must ensure assistance is offered to resolve the emergency no later than 18 hours from the time of application.

If the AGs house is without heating/cooling and it is not possible to restore the heating in 18 hours of the time of application completion, a voucher can be given for one night's lodging if no shelters are available. This voucher requires prior authorization by the LIEAP Coordinator.

The Worker must indicate that this time limit was met by the date entered on the DFA-67 or by a recording on the application.

When verification is requested, the customer is given five days to return the information.

21.3.3 OTHER PROGRAMS

Regular Heating/Cooling or Emergency LIEAP payments are not considered in determining eligibility for or the amount of a benefit for any public assistance program except Emergency Assistance (EA).

21.3.3.A Emergency Assistance (EA)

When an EA client requests benefits to eliminate a home heating/cooling emergency, the amount of any LIEAP payment made but not yet credited to the account, or that will be made, is

not deducted from the ongoing overdue bill when computing the daily average amount. It is subtracted from the minimum payment due before determining the amount the DOHS will pay through the EA program. However, the receipt of EA does not affect eligibility for Emergency LIEAP.

21.3.3.B 20% Utility Discount Program

The receipt of benefits under the 20% Utility Discount Program does not affect eligibility for Emergency LIEAP. Addition 20% Utility Discount Program can be found in IMM 20.4.

21.4 APPLICATION PROCESS

21.4.1 MAIL-OUT APPLICATIONS

The LIEAP mail-out contains an application form (DFA-LIEAP-1), an instruction sheet (DFA-LIEAP-1a). It is mailed to any household which received LIEAP during the previous LIEAP season. These applications are mailed prior to the program start date. The client may choose to return the completed form and information by mail or complete it online by use of West Virginia WV PATH.

The process below outlines guidelines for submitting the application through WV PATH:

- The client receives certain information in the mail-out which must be entered online in order to complete the WV PATH process.
- WV PATH brings current basic demographic information from the eligibility system into the online application.
- No signature page is required, and the application is considered electronically signed when the client uses this process and enters information from the letter and other requested identifying information.
- The online process is available for use through the end of the Regular LIEAP season.
- When an application is received through WV PATH, the signature and identity is considered verified. The application is considered complete when all verification is received, in addition to the electronically signed application.

NOTE: Due to system constraints, these applications will function the same as a redetermination but will appear in the WV PATH inbox during the batch process.

21.4.2 OUTREACH

21.4.2.A DOHS Role

Outreach is a federal requirement to ensure that potentially eligible, low-income AGs are made aware of and encouraged to apply for benefits. Outreach is accomplished as follows:

- DOHS mails applications as described above.
- DOHS provides LIEAP informational leaflets to all appropriate agencies and interested individuals.
- DOHS contracts with Area Agency on Aging (AAA) offices and the West Virginia Office of Economic Opportunity (WVOEO), which permit senior citizen centers, local Community Action Agencies, VA Centers, and other interested parties to receive LIEAP applications and information and referral services as desired. These are referred to as Sub-Grantee Agencies.
- Information and referral service organizations.

21.4.2.B The Role of the Sub-Grantee Agency

If the sub-grantee organization wishes to participate in LIEAP, the outreach role may consist of providing and accepting applications, reviewing the applications for completeness, obtaining required verification, and forwarding the completed applications to the local DOHS office for final disposition. This service may also include home visits as needed.

Instead of receiving or accepting applications, the sub-grantee agency may simply inform interested persons about LIEAP. Such activity involves providing the LIEAP Fact Sheet and referring those who wish to apply to the local DOHS office.

Sub-grantees interested in expanding their role may also provide follow-up counseling in energy conservation and/or money management.

21.4.3 OPEN APPLICATION INTAKE PERIOD

During the annual open application intake period, clients who did not receive a LIEAP mail-out application may apply for LIEAP at their local DOHS office or at any of the outreach locations listed above. The application is also available and may be completed through WV PATH.

21.4.4 SUB-GRANTEE AGENCY RESPONSIBILITIES

When an individual applies for LIEAP through an agency other than DOHS, the application process consists of:

- Assisting clients in filling out applications;
- Verifying income and other information as needed;
- Attaching copies of heating bills to the form; and
- Submitting the application to the local Department of Human Services (DOHS) office for processing in the eligibility system.
    - The applications must be submitted the same day or the next to the DoHS office.

Completed applications received from sub-grantee agencies must be accompanied by a list showing the name and address of each client and the total number of applications submitted. This list must be signed and dated by an authorized employee of the sub-grantee agency. The sub-grantee must keep a copy of the list for his records.

Clients who have received past due bills or termination notices or indicate they are experiencing a heating/cooling emergency must be referred to their local DOHS office.

21.4.5 DOHS RESPONSIBILITIES

The Worker's responsibilities are to:

- Process the application in the eligibility system;
- Determine if case has previous unpaid repayment;
- Determine eligibility;
- Determine the amount of the payment; and,
- Notify the client of the action taken.

When the Low-Income Energy Assistance Program (LIEAP) client wishes to apply for another program in addition to LIEAP, the DFA-2 may be used instead of the DFA-LIEAP-1 form to prevent the need to complete two application forms. Otherwise, the DFA-LIEAP-1 must be completed for all LIEAP clients.

In order to maintain controls for receiving, processing and completing follow-up on applications to ensure checks are issued, the local office must retain a LIEAP application register or log that indicates, at a minimum, the client's name, how and when the application was received (e.g., mail, office visit or from another agency) and if the application is for Regular or Emergency LIEAP. The DFA-LIEAP-6 form may be used for this purpose.

21.4.6 APPLYING FOR BENEFITS

Although it is not mandatory, the head of household should be encouraged to apply for benefits.

- Regular LIEAP applications may be mailed or delivered to the local DOHS office. Applications may also be submitted by use of WV PATH on the DOHS website. The Worker may request additional information if needed for eligibility determination, but incomplete applications must be denied.

Emergency LIEAP applications require a face-to-face interview at a DOHS office but may be taken in the home for clients who meet certain requirements. (If the home heating/cooling crisis is the result of a natural disaster, state and/or national public health emergency, then payments may be issued to previously approved households. Under these circumstances, a past due bill, termination notice, or face-to-face interview is not required.)

- Home visits are limited to those persons age 60 and over or disabled persons of any age who live alone and have no means of transportation to the local DOHS office in order to apply for Emergency LIEAP.
- The Community Services Managers (CSM) can permit outreach workers from a senior citizen center or Community Action Agency to take the application and/or DFA-67 forms to the client for completion and to obtain the necessary documentation to verify the emergency.
    - If the CSM permits employees from other agencies to take applications in the home, the employees must be trained to assist the homebound client to complete the application form, obtain the required verification and otherwise perform the necessary tasks required for DOHS to make a decision on the application.
- The DOHS will make the final decision regarding eligibility for and the amount of Emergency LIEAP benefits. Personnel from other agencies are not permitted to make this decision or inform the client about his eligibility.

21.4.7 COMPLETION OF FORM DFA-LIEAP-1

The DFA-LIEAP-1 consists of three sections, described below.

21.4.7.A Section I – Identifying Information

This section collects information about the client and the assistance group (AG) and is self-explanatory. All questions must be answered.

21.4.7.B Section II – Home Heating/Cooling Information

The client circles the correct number which applies to his circumstances. Item F of the DFA-LIEAP-1 must be completed, regardless of whether or not the client's home heating/cooling supplier is a Public Service Commission (PSC)-regulated utility or a bulk fuel supplier. The client must provide information for their primary heating and electric source.

A LIEAP client may indicate a different primary source of home heating from the source indicated on previous applications. When this occurs, the Worker must carefully review the reasons for the change. If the client is changing heat sources to avoid payment of a home heating bill that exceeds the amount of the Regular LIEAP payment, the LIEAP application must be denied. Otherwise, the difference may result from a change in residence, with the home heating bill at the old residence settled, or a change in the heating source at the same residence. In these situations, the change is permitted.

Item E of the DFA-LIEAP-1 must be completed, and a copy of the bill or a current receipt or invoice must be attached. Failure to supply this information will result in denial of the application. If the bill is verified in the last two months, attach that copy to the DFA-LIEAP-1.

Item F of the DFA-LIEAP-1 must be completed for data collection purposes. If the client does not complete this section, the Worker must attempt to collect this data. The Worker is required to record in case comments all actions taken to collect this data.

NOTE: After processing the application, the Worker must record in case comments the account number, the name on the account, and, if not the client, the relationship of this person to the client. Vendors cannot correctly credit an account when the name of the LIEAP client and the name on the account do not match.

21.4.7.C Section III – Signatures and Statements of Liability

Items A through G of the DFA-LIEAP-1 must be completed. If the client marks No on any item, the Worker must resolve any confusion or misunderstanding. If the client continues to answer No to any item, he should be informed that his benefits may be delayed or possibly denied.

The client must sign and date the application. If someone else assisted the client, that person must also sign and date the form.

21.4.8 COMPLETION OF FORM DFA-LIEAP-1b

Section I of the DFA-LIEAP-1b is provided for the use of sub-grantee staff. If the application was received by another agency or by mail, the appropriate space must be marked.

NOTE: The Worker or Other Agency must use shelf document DFA-LIEAP-1b to document the application process.

When the application is received by the DOHS directly from the client (via mail or office visit), the Worker skips Section I of the shelf document DFA-LIEAP-1b and goes on to complete Section II.

Section II is provided for the use of the DOHS Worker only. Other agencies do not complete this section.

When the application is received by the DOHS directly from the client (via mail or office visit), the Worker completes this section. Items C through G are intended for completion after the application is processed in the eligibility system.

When the application is received initially by another agency, Section I must be completed, and the other agency staff must enter his signature, title and the date before sending the form to the DOHS. The other agency never completes Section II.

In receiving applications for Regular LIEAP, workers from other agencies must observe the following guidelines:

- All questions on the application form must be answered, and all program policy must be followed.

- The application must be signed and dated by the client and the agency staff.

NOTE: If the application is not signed by both parties, it must be returned to the other agency for completion.

- If verification is required, the instructions outlined in Section 21.4.9 below must be followed. A copy of the heating/cooling bill must be attached to the application.
- Clients must be allowed no more than 15 calendar days to submit verification.
- Applications ready for processing by the local DOHS office must be sent to that office on a daily basis with a signed and dated word-processed or typewritten list with the name and address of each client.
- Applications held in excess of 30 days by any outside agency are not accepted.
- Clients must be informed that the DOHS staff will determine eligibility, provide written notification of the decision, and make payment to or on behalf of eligible AGs.

21.4.9 VERIFICATION

Verification is the process of documenting statements and information provided by the client. Although specific guidelines for verifying certain eligibility criteria are indicated below, the Worker may request verification of any information provided by the client in determining eligibility for LIEAP benefits.

The responsibility of the client in the eligibility determination process includes the effort to obtain required verifications. However, if the client is unsuccessful in his attempt to obtain the verification or if he has physical or mental impairments which limit his ability to perform this responsibility and he has no family members or other persons who will help him, the Worker will assist the client to obtain the verification.

The Worker must decide when and what information must be verified or when additional information must be obtained, particularly when information provided by the client is questionable or more information is needed to complete the eligibility determination or payment process.

Failure or refusal on the part of the client to obtain verification when required or requested by the Worker as outlined in the instructions below will result in a denial of the application.

21.4.9.A Income

Income from all sources for the AG must be verified when the client indicates a source of income for any AG member.

> **Income Verification Example:** The application form indicates Supplemental Security Income (SSI) as the source of income for one AG member and employment for another. The client must verify the amount of employment and not the SSI income.

Documentation may include paycheck stubs, award letters, and written statements from employers.

Although documentation should include earnings from the month of application, the Worker may use paycheck stubs and other documents showing earnings during the month prior to the month of application, provided the client indicates no change is expected. No verification from an earlier period is used.

When the client reports the AG has zero income during the month of application, he must verify how living expenses of the AG, defined as food, clothing, shelter, light, heat and incidentals, have been paid or how the AG members have managed without income for 30 days prior to the date of application. Form DFA-LIEAP-4, Zero Income Heating/Cooling Cost Verification Form, must be completed by the client.

21.4.9.B Vulnerability

Verification of vulnerability for clients who have home heating/cooling vendors regulated by the PSC is satisfied when the customer account number is entered on the application form and verified by the attached bill, provided the account is active.

This account number must be entered on the application unless the client can demonstrate that other circumstances exist (i.e., home heating/cooling costs are paid to the landlord).

EXCEPTION: Verification of vulnerability is mandatory for all zero income clients. Failure to provide this verification will result in the denial of the LIEAP application.

Bulk fuel users must submit a signed and dated bill from the bulk fuel vendor which indicates that a delivery was or will be made. When such verification cannot be provided, the client must submit the name, address or telephone number of a vendor who can verify that fuel deliveries have been made in the past or will be made for the current season.

The Worker must obtain written verification of all other arrangements not referred to above. Statements must be dated and signed.

Otherwise, the decision to verify vulnerability is at the Worker's discretion. In some instances, it will be necessary for the Supervisor or Worker to contact managers of public housing authorities in their areas to determine if the tenants are vulnerable or invulnerable to the cost of home heating/cooling. A screening procedure must be established with the Housing Authority to verify whether or not certain clients live in public housing. The housing authority managers should be informed that the client signs a release (item C in section III of the LIEAP application) which protects them from violating confidentiality.

21.4.9.C Social Security Number (SSN)

Verification of SSNs is at the discretion of the Worker. When a client indicates he has no SSN, the Worker must refer that person to the Social Security Administration (SSA) to apply for an SSN.

21.4.9.D Emergency Home Heating/Cooling Need

An emergency home heating/cooling need must be verified with a past due bill or written notice of termination from a PSC-regulated utility. When the home heating/cooling provider is a bulk fuel distributor, verification must be a written statement certifying that no future deliveries will be made without assurance of payment. If the bulk fuel provider refuses to provide such verification, the Worker may contact the provider by phone and note the results of the conversation in the recording block of the application and in case comments.

In situations involving bulk fuel users, the Worker may question whether the AG is actually or nearly without fuel. Since there is no past due bill or written notice of service termination, the Worker may need to check with the vendor to determine when the last delivery or purchase was made. The only other method of resolving this question is to make an on-site inspection of the fuel supply. Such action is permissible at the discretion of the CSM or the person acting on his behalf. Prior to taking such action, the Worker must obtain the client’s written permission and

must place documentation of the client's permission in the case record. It is appropriate at this point to remind the client that fraudulent claims could result in loss of future LIEAP benefits.

When home energy costs are included in the rent or some other special arrangement exists between the tenant and landlord, a written eviction notice dated and signed by the landlord is sufficient.

21.4.9.E Age of the Head of the Household

Verification of the age of the head of the household is also at the Worker's discretion. This information is used solely for statistical purposes and has no bearing on eligibility.

21.4.9.F Customer Account Number

The client is required to provide the customer account number. Failure to provide this information will result in denial of the LIEAP application.

21.4.9.G Home Heating/Cooling Payments in Shared Situations

Customers who indicate they share a utility meter or bulk fuel tank with another AG in a separate dwelling may qualify for Regular LIEAP.

When an Emergency LIEAP client indicates he shares either a utility meter or bulk fuel tank, the Worker must have his Supervisor contact the LIEAP Coordinator at the Division of Family Assistance (DFA) for guidance. In most cases, eliminating the emergency for one will eliminate it for the others sharing the meter or tank, but special circumstances may apply.

21.4.10 DETERMINING ELIGIBILITY

21.4.10.A Regular LIEAP Benefits

When the client has met all eligibility requirements outlined in Section 21.3 and has complied with the verification instructions in Section 21.4.9 above, the client may be found eligible for Regular LIEAP benefits.

Regular LIEAP payments are intended for the primary source of home heating/cooling only, depending on season. In a heating/cooling emergency, however, the payment may be applied to an old bill or to a reconnect and/or deposit to reinstate service, provided the client is guaranteed 30 days of service.

The Worker or Supervisor must contact the State LIEAP Coordinator for approval of Regular LIEAP for any other purpose.

21.4.10.B Emergency LIEAP Benefits

When the client meets all eligibility requirements outlined in Section 21.3 and has complied with the verification instructions in Section 21.4.9 above, the client may be found eligible for Emergency LIEAP benefits.

Emergency LIEAP payments are intended for the primary source of home heating/cooling, as well as for back bills, reconnect charges and/or deposits required to reinstate service, and extra delivery charges, as needed to provide or reinstate service.

NOTE: When a client files a complaint and is granted a temporary suspension of a termination a result of a PSC complaint, it does not affect eligibility for Emergency LIEAP and must not be used as a reason to deny an application.

21.4.10.C Alternate Use of LIEAP Benefits

With the approval of the State LIEAP Coordinator, an emergency Regular LIEAP (LIEAP requested for a utility that has an impending past due bill or termination) or Emergency LIEAP payment may be approved for electricity when past due bill or termination of this utility will result in a total inability to use the primary source of heat. For example, a gas furnace may not have a manual override to permit its use when electricity is not available.

NOTE: In order to be eligible for an alternate LIEAP payment, the AG must first be vulnerable to the cost of home heating/cooling.

In addition, Emergency LIEAP payments may be authorized to cover the cost of minor furnace repair or propane tank replacement when the client reports there is no acceptable alternate heat source or that space heaters are the only alternate source of home heating and alternate housing is not available.

NOTE: The Worker must make every attempt to verify the AG will be without home heating if the alternate source of heat is terminated.

21.4.11 DETERMINING THE AMOUNT OF PAYMENT

After the client is determined eligible for LIEAP, the Worker must determine the amount of the LIEAP payment.

21.4.11.A Maximum Allowable Payment

The maximum allowable payment of a combined Regular and Emergency LIEAP benefit cannot exceed the maximum per AG established for each program year, currently $2000.

21.4.11.B Regular LIEAP Payment

The chart in Appendix A shows the base amount of the Regular LIEAP benefit. Regular LIEAP benefits are automatically determined by the eligibility system based upon the income, the number of persons in the AG, and the type of energy used for home heating/cooling.

Percentage increments for certain types of energy are applied to the base amount to arrive at the amount of increment for each type of energy. The base amount plus the incremental amount represents the Regular LIEAP benefit. See chart below.

NOTE: Emergency LIEAP payments are not affected by the percentage increments.

Type of Home Heating	Percentage Increments
Natural Gas	1.198
Liquefied Petroleum Gas (LPG)	1.089
Coal	1.089
Wood	1.089
Electricity	1.750
Fuel Oil and Kerosene	1.089

LIHEAP Benefit Payment by income x heat source	Natural Gas 1.198	LPG 1.089	Coal 1.089	Wood 1.089	Electricity 1.750	Fuel Oil & Kero 1.089
$60.00	$71.88	$65.34	$65.34	$65.34	$105.00	$65.34
$65.00	$77.87	$70.79	$70.79	$70.79	$113.75	$70.79
$70.00	$83.86	$76.23	$76.23	$76.23	$122.50	$76.23
$75.00	$89.85	$81.68	$81.68	$81.68	$131.25	$81.68

$80.00	$95.84	$87.12	$87.12	$87.12	$140.00	$87.12
$85.00	$101.83	$92.57	$92.57	$92.57	$148.75	$92.57
$90.00	$107.82	$98.01	$98.01	$98.01	$157.50	$98.01
$95.00	$113.81	$103.46	$103.46	$103.46	$166.25	$103.46
$100.00	$119.80	$108.90	$108.90	$108.90	$175.00	$108.90
$105.00	$125.79	$114.35	$114.35	$114.35	$183.75	$114.35
$110.00	$131.78	$119.79	$119.79	$119.79	$192.50	$119.79
$115.00	$137.77	$125.24	$125.24	$125.24	$201.25	$125.24
$120.00	$143.76	$130.68	$130.68	$130.68	$210.00	$130.68
$125.00	$149.75	$136.13	$136.13	$136.13	$218.75	$136.13
$130.00	$155.74	$141.57	$141.57	$141.57	$227.50	$141.57
$135.00	$161.73	$147.02	$147.02	$147.02	$236.25	$147.02
$140.00	$167.72	$152.46	$152.46	$152.46	$245.00	$152.46
$145.00	$173.71	$157.91	$157.91	$157.91	$253.75	$157.91
$150.00	$179.70	$163.35	$163.35	$163.35	$262.50	$163.35
$155.00	$185.69	$168.80	$168.80	$168.80	$271.25	$168.80
$160.00	$191.68	$174.24	$174.24	$174.24	$280.00	$174.24
$165.00	$197.67	$179.69	$179.69	$179.69	$288.75	$179.69
$170.00	$203.66	$185.13	$185.13	$185.13	$297.50	$185.13
$175.00	$209.65	$190.58	$190.58	$190.58	$306.25	$190.58
$180.00	$215.64	$196.02	$196.02	$196.02	$315.00	$196.02
$185.00	$221.63	$201.47	$201.47	$201.47	$323.75	$201.47
$190.00	$227.62	$206.91	$206.91	$206.91	$332.50	$206.91
$195.00	$233.61	$212.36	$212.36	$212.36	$341.25	$212.36
$200.00	$239.60	$217.80	$217.80	$217.80	$350.00	$217.80
$205.00	$245.59	$223.25	$223.25	$223.25	$358.75	$223.25
$210.00	$251.58	$228.69	$228.69	$228.69	$367.50	$228.69
$215.00	$257.57	$234.14	$234.14	$234.14	$376.25	$234.14
$220.00	$263.56	$239.58	$239.58	$239.58	$385.00	$239.58
$225.00	$269.55	$245.03	$245.03	$245.03	$393.75	$245.03
$230.00	$275.54	$250.47	$250.47	$250.47	$402.50	$250.47
$235.00	$281.53	$255.92	$255.92	$255.92	$411.25	$255.92
$240.00	$287.52	$261.36	$261.36	$261.36	$420.00	$261.36
$245.00	$293.51	$266.81	$266.81	$266.81	$428.75	$266.81
$250.00	$299.50	$272.25	$272.25	$272.25	$437.50	$272.25
$255.00	$305.49	$277.70	$277.70	$277.70	$446.25	$277.70

21.4.11.C Emergency LIEAP Payment

Emergency LIEAP payments cannot exceed the maximum allowable payment for the program year. To determine if a payment can be made, the Worker must compare the amount available to the client and the amount needed to eliminate the emergency, as shown in the following examples.

NOTE: These examples are based on the maximum allowable payment of $2000. The maximum allowable payment is subject to change each program year.

Determining the LIEAP Payment Example 1: Ms. Iris receives a Regular LIEAP payment of $225 in January. In March, she applies for Emergency LIEAP. The amount required to eliminate the emergency is $100, and the maximum allowable amount for the AG is $2000.

$2000- $225 = $1775 (amount available to the AG)

$100 (the amount of the emergency) is less than $1775.

$100 is the amount of the Emergency LIEAP payment.

Determining the LIEAP Payment Example 1.1: Same as above except the amount required to eliminate the emergency is $1475. $2000 - $225 = $1775.

$1475 is less than the remainder of $1775.

$1475 is the amount of the Emergency LIEAP payment.

Determining the LIEAP Payment Example 1.2: Same as above except the amount required to eliminate the emergency is $1870.

$2000- $225 = $1775.

$1870 is greater than $1775.

$1870 - $1775 = $95. (Client Obligation)

> The amount of the Emergency LIEAP payment is $1775, provided the client can pay the $95 or otherwise obtain that amount from other agencies.

NOTE: A Regular LIEAP payment issued to and correctly credited to the client's account is never subtracted from the amount required to eliminate the emergency. Regular LIEAP payments issued to the wrong vendor are likewise not subtracted from the amount of the emergency. If it is determined that the vendor has received the payment but has not yet credited it to the AG's account, the Worker must first try to correct the problem. The vendor must then inform the Worker of the adjusted amount of the emergency.

When the amount required to eliminate the emergency exceeds the amount of the Emergency LIEAP payment, the application for Emergency LIEAP benefits is denied if the emergency is not eliminated. The client must find other resources or negotiate with the home heating/cooling supplier to accept the Emergency LIEAP benefit.

21.4.12 CLIENT NOTIFICATION

Clients must be notified of the eligibility decision within 30 days of the date of application. Notification is accomplished by an eligibility system-generated letter.

21.4.12.A Pending Regular LIEAP Applications

Regular LIEAP clients must be allowed 15 calendar days to respond to requests from the Worker for additional information. Failure to respond results in denial of the application. The Worker must notify the client of the eligibility decision within 30 days of the date of application.

21.4.12.B Pending Emergency LIEAP Applications

If verification and/or additional information is needed in order to make a decision on an Emergency LIEAP application, the appropriate request form must be completed and given to the client at the time of the intake interview. The client must be given five working days to return the requested information. The client must be notified of the eligibility decision as soon as possible but no later than 30 days from the date of application.

NOTE: Copies of all correspondence not completed in the eligibility system must be placed in the case record.

21.5 PAYMENT AND AUTHORIZATION PROCESS

Payments are made either to the vendor on behalf of the client or by direct payment to the assistance group (AG) as specified below.

21.5.1 REGULAR LIEAP BENEFITS

21.5.1.A Direct Payment

Direct payment to the AG of Regular LIEAP is made only in the following situations:

- The primary source of home heating is a bulk fuel such as fuel oil, liquefied petroleum gas, coal, kerosene or wood, and the client does not indicate that an emergency exists.
- Heating/cooling costs are included in the rent or mortgage payment as a specified amount.
- The Public Service Commission (PSC)-regulated home heating/cooling supplier which services the household has not entered into a contractual agreement with the Department of Human Services (DOHS).
- Home heating/cooling costs are paid separately to a landlord or other entity.

21.5.1.B Special Payments

There may be situations in which a vendor payment is not possible or appropriate. With the approval of the State LIEAP Coordinator, the Supervisor may authorize direct payment to the client or a mutually acceptable third-party. Approvals are made on a case-by-case basis only and may not be used to create a precedent for future payments.

21.5.1.C Vendor Payment

Vendor payments are made only in the following situations:

- The home heating/cooling provider is a PSC-regulated heating supplier that has entered into an agreement with DOHS.

- The heating/cooling bill is in the name of someone not living in the AG.
- A bulk fuel user is without or in immediate danger of being without fuel for home heating, the time required for a regular LIEAP issuance would not eliminate the emergency, and the following conditions apply:
    - The amount required to eliminate the emergency is equal to or less than the Regular LIEAP benefit; and,
    - The client verifies he will be without fuel for home heating prior to the receipt of a direct payment check and states he has no resources with which to purchase a temporary supply; and,
    - The bulk fuel supplier will not make a delivery unless it is pre-authorized by the Worker, but agrees to provide fuel for at least 30 days from the date he is made aware of and accepts the DOHS's payment; and,
    - The client agrees to the vendor payment instead of the direct payment.

21.5.1.D Use of Form DFA-67 for Regular LIEAP Payments

It may sometimes be necessary to use the DFA-67 to make vendor payment of Regular LIEAP benefits to prevent bulk fuel emergencies. When this occurs, the following instructions apply:

- Form DFA-67 is used to authorize the delivery in almost the same manner as described above for Emergency LIEAP. The difference is that no voucher is eligibility system generated. Instead, the Worker completes the DFA-67 as required to authorize delivery of the home heating service.
- Vendor payment is then made to the home heating/cooling supplier when the DFA-67 voucher is returned and is properly signed.

When completing this form, the dollar amount authorized must be identical to the amount of the correct LIEAP benefit payment chart at Appendix A.

NOTE: This procedure is also used to make payment to utility companies which did not enter into an agreement with the DOHS and a DFA-67 is demanded prior to the delivery.

The DFA-LIEAP-5 form, Authorization for Delivery and Payment of Emergency Regular LIEAP, may be used instead of the DFA-67 form, as follows:

- The Worker must first determine that the vendor accepts the form instead of the DFA-67 and guarantees delivery.
- The Worker must ensure that vendor payment and not direct payment is made.

- The vendor is not required to return the form to the county office to process payment.
- The Worker must use only the amount of the Regular LIEAP payment which the client is eligible to receive.
- The client's signature must be entered in the space on the form before the Worker can authorize payment on the client's behalf.
- The form may be faxed to the utility as appropriate.

21.5.2 EMERGENCY LIEAP BENEFITS

Payment of Emergency LIEAP benefits is made by vendor payment only, except as described in 21.5.1.B above.

21.5.2.A Authorization of the Emergency LIEAP Payment

The following procedure is used to authorize Emergency LIEAP vendor payments:

- Form DFA-67 must be completed as instructed below in item B, Completion and Processing of Form DFA-67.
- The completed form is given to the vendor to authorize the delivery of bulk fuel or to restore or continue the heating service.

NOTE: When payment is being authorized to PSC-regulated heating/cooling providers or to landlords, the first day of the 30-day period of service begins on the date the vendor is made aware of and accepts the DOHS's payment. The client must sign the form on the date he receives it from the Worker.

- The vendor signs and returns the form to the county office and the payment is processed by the DOHS Financial Clerk or designee.

21.5.2.B Completion and Processing of Form DFA-67 for Emergency LIEAP Payments

21.5.2.B.1 Case Identification Information

The Worker enters the necessary case identification information and the return address of the county DOHS office in the eligibility system.

21.5.2.B.2 Quantity of Fuel

The Worker must enter the quantity of fuel in the eligibility system. When bulk fuel deliveries are being authorized, the Worker, client and vendor must agree on the exact amount of fuel to be delivered. When electric or gas service is being authorized, the time period of the overdue bill must be entered. For all PSC-regulated heating providers or landlords, the Worker must also enter the beginning and ending dates of the 30-day period of service. The period of service begins on the date the vendor is made aware of and accepts the Emergency LIEAP payments and ends 29 days later.

21.5.2.B.3 Payment Authorization

The Worker must enter the dollar amount of the delivery in the eligibility system. All signatures and dates must be entered as indicated at the bottom of the DFA-67.

After the vendor returns the voucher to the county office, the Financial Clerk or designee clears it for payment in the eligibility system.

21.6 CASE MAINTENANCE AND CORRECTIVE ACTION

Adjustments in Low Income Energy Assistance Program (LIEAP) payment amounts result from Worker or client errors or decisions from Fair Hearings.

NOTE: Corrections or changes in payment amounts are not permitted at the county level after the check has been written. Workers or Supervisors must contact the State LIEAP Coordinator before taking any action resulting in the issuance of a payment other than the initial approval. Financial Clerks and designees must contact the State LIEAP Coordinator before attempting to enter payment information which does not match the amount of LIEAP approved for the assistance group (AG).

All changes affecting the amount of payment must be made by the Office of Client Accounts.

Corrective action must be initiated on all cases in which an error has occurred, regardless of who made the error.

21.6.1 CASES DENIED IN ERROR

When a case has been denied in error, the case must be re-entered in the eligibility system as an approval in order to generate payment. The Worker must notify the client in writing that his Regular and/or Emergency LIEAP application was denied in error and include the amount of the payment and to whom payment will be made. The Worker must record the corrective action in the recording space in Section IV of the application form and in the eligibility system case comments, as appropriate.

21.6.2 UNDERPAYMENTS

When a case has received an underpayment, the Worker must send a memorandum to the Office of Client Accounts that indicates the case name, address, case number, amount of the underpayment, amount of the correct payment, and the type of payment (vendor or direct) to be made on behalf of or to the AG, including the vendor number, as appropriate. The Worker will also notify the client in writing that an error has been made and is being corrected.

The Office of Client Accounts will write a check as instructed in the memorandum and make the necessary corrections in the eligibility system. Under no circumstances must staff in the local DOHS office attempt to issue a corrected payment.

21.6.3 CASES APPROVED IN ERROR

When an ineligible case is approved, an overpayment occurs, or an incorrect payment is made, regardless of who makes the error, the Worker must take the action outlined in Section 21.6.4 below. The State must be reimbursed for all payments issued in error.

An inappropriate payment results when a client incorrectly states the primary method of home heating/cooling on page 2 of the DFA-LIEAP-1 or during the intake interview. If it is determined prior to the Emergency LIEAP approval that the client received an inappropriate Regular LIEAP payment, the Emergency LIEAP application is denied. Otherwise, the client must repay the LIEAP benefit.

21.6.4 REPAYMENT

The repayment process involves notifying the client that repayment is necessary for a certain amount, obtaining the client's signature on an agreement form to repay a certain amount, receiving the funds from the client, and returning the funds to the Office of Client Accounts.

21.6.4.A Repayment Agreement

When the client and the Worker discuss repayment, the client must agree to repay by any of the three methods indicated on the DFA-LIEAP-3 form. The Worker must enter the client's name, the amount of repayment, type of payment (Regular or Emergency LIEAP), and the type of error (overpayment, incorrect payment, duplicate payment, case approved in error, etc.).

The Worker must ensure the client understands the statement concerning the disposition of the remaining balance when not paid by the due date. The client must sign and date the form along with the Worker and Supervisor. The original goes to the client and the copy is placed in the case record.

When repayment involves the energy needs of another AG, the repayment process is not complete until that AG receives the LIEAP benefit. The Worker must send a copy of the completed LIEAP repayment agreement to the Office of Client Accounts with instructions to write a check to the correct case.

21.6.4.B Refusal to Sign the Repayment Agreement or Make a Repayment

The Worker must explain the Fair Hearing process to the client if he refuses to sign the DFA-LIEAP-3 form. In addition, the Worker must follow up the discussion with a letter which states that certain LIEAP benefits the client may otherwise be entitled to receive will be affected by his refusal to sign the repayment agreement.

When the client refuses to make repayment, the amount owed is deducted from future LIEAP benefits. These deductions are assessed only after the Worker has completed the instructions outlined above. Repayment deductions can only be imposed during a program year following the program year in which the client refused to repay.

The Worker must record in the eligibility system case comments that the client may be eligible for LIEAP, but that payment must be reduced or withheld to satisfy repayment for a previous year.

21.6.4.C Tracking the Penalty

All Regular LIEAP cases must be screened to determine if repayment is due from a previous year. When a case is approved for Regular LIEAP and identified as one in which repayment is due, the Worker must ask the client to come to the office to discuss repayment. After the Worker explains the need for repayment, the client is given the following options:

- When the repayment amount is equal to the Regular LIEAP payment, the client makes repayment in full or the Regular LIEAP payment is withheld.
- When the repayment amount is less than the Regular LIEAP payment, the client makes repayment in full or the Regular LIEAP payment is reduced by the amount of the repayment and the balance is paid to the client.
- When the repayment amount is more than the Regular LIEAP payment, the client makes payment in full or the Regular LIEAP payment is withheld and deducted from the amount of the repayment. The client then receives written notice from the Worker of the balance due.

NOTE: Once payment arrangements are made with the client, the Worker must send a copy of the DFA-LIEAP-3 and the eligibility system-generated letter to the Repayment Investigator (RI) for their respective county so the payment may be tracked.

21.6.4.D Withholding the Regular LIEAP Payment

When it is necessary to withhold a LIEAP payment, the Worker must contact the State LIEAP Coordinator at the Division of Family Assistance (DFA) for instructions.

21.6.4.E Making Adjustments in the Regular LIEAP Payment

Adjustments to the LIEAP payment must be made by the Office of Client Accounts. In a memorandum addressed to the Office of Client Accounts, the Worker must provide the identifying information and explain how the Regular LIEAP payment must be adjusted.

21.6.4.F Client Notification

The client must receive written notification of all decisions made on the Regular LIEAP payment or repayment, any adjustments to the Regular LIEAP payment, and/or fulfillment of the repayment.

21.6.4.G Repayment by the Vendor

When the error involves payment to the wrong vendor, the vendor must return the payment to the State. The Office of Client Accounts notifies the Worker of the returned payment, and the Worker must provide the correct vendor number and instructions for reissuing the check.

When the vendor is unaware he has received a payment in error, the Worker must contact the vendor and request repayment. If the Worker is unable to effect repayment, the case is referred to the Office of Client Accounts and/or the State LIEAP Coordinator.

When the vendor has received a payment for an AG which subsequently is determined ineligible due to an error of any type, the vendor must be asked to return the payment. If the vendor refuses or otherwise fails to refund the money to the State, the client is responsible for making repayment as outlined above.

21.6.5 RETURNED CHECKS

Checks are sometimes returned by clients, vendors, or the United States Postal Service (USPS). The following sections provide instructions regarding these situations.

21.6.5.A Check Returned by the USPS

Checks returned by the USPS are sent to the Office of Client Accounts. The Office of Client Accounts will contact the local office requesting disposition of the check. The Worker must attempt to contact the client to obtain a new address or other information.

21.6.5.B Change of Payee

Supervisory approval is required to change the name of the payee. When the payee is deceased and the check needs to be rewritten in the name of a survivor (usually the spouse), a copy of the death certificate and a court order naming the survivor as administrator of the estate must be submitted to the Office of Client Accounts. A memorandum stating the case number, name and address of the old payee and the name and address of the new payee must accompany these documents.

21.6.5.C Check Returned by the Vendor

Checks are often returned by the vendor to the local office and to the Office of Client Accounts.

When this occurs, the reason for the check return must be obtained and an effort made to ensure the client receives the benefits to which he is entitled. The check may be rewritten by the Office of Client Accounts as a direct or vendor payment depending upon the client's wishes, provided he is eligible for the payment. This also applies when the vendor has returned only part of the LIEAP payment.

NOTE: Checks received in the local office must be forwarded to the Office of Client Accounts.

21.6.5.D Client Refuses to Accept the LIEAP Check

When the client refuses to accept the LIEAP or a vendor payment, the Worker must determine the reason for refusal and clarify any confusion on the part of the client. If the client continues to refuse the payment, it is returned to the Office of Client Accounts with a memorandum explaining why the check is being returned.

21.6.6 LOST, STOLEN OR DESTROYED CHECKS

LIEAP clients who claim that their checks were lost, stolen, or destroyed must complete an affidavit attesting to the specific occurrence. Form DFA-36, with the appropriate changes in terminology to reflect the LIEAP check, is used for this purpose. This request for a stop payment action must be made as soon as possible by sending the affidavit with a memorandum of explanation to the Office of Client Accounts. This action cannot be requested by telephone and no action will be taken without the written affidavit.

The client must be informed that he must wait up to 30 days from the date of the stop payment action in order to receive his check. No checks are written at the local level to replace lost, stolen or destroyed checks. After the check has been cleared by the State Treasurer’s office, payment is made promptly to the client. If the client is placed in an emergency situation as a result of the stop payment action, the client may submit an Emergency LIEAP application.

21.6.7 CLIENT REFUSES EMERGENCY LIEAP DELIVERY OF BULK FUEL

When the client refuses to accept a bulk fuel delivery, the Worker must first allow the client and vendor to work out a solution. The decision about what action will be taken must be made primarily by the client.

21.6.8 FRAUD

All suspected fraud situations involving clients and/or vendors must be referred to the State LIEAP Coordinator.

21.6.9 FAIR HEARINGS

Clients who apply for LIEAP have the right to a Fair Hearing if:

- The application is denied.
- The client believes the payment amount is in error.
- There was a delay in processing the application.
- The client believes that he has been discriminated against because of race, color, national origin, sex, age, disability, religion, or political beliefs.

The client must request a hearing within 60 days of receipt of the notification. The DOHS has 30 days after the hearing request is received to schedule the hearing, arrive at a decision, and initiate the appropriate action.

21.7 ADDITIONAL LIEAP SERVICES

21.7.1 Repair or Replacement

The purpose of the LIHEAP Repair and Replace Program (RRP) is to aid eligible households in need of the repair or replacement of malfunctioning or non-operable heating and/or cooling systems or have no source of heat.

This program is not completed through the West Virginia eligibility system, but the worker will need to make case comments that they gave the client a referral and application to take to the Community Action Agency to process.

This program is designed to help low-income people with a household income at or below 60% of the State Median Income. The subrecipient will be responsible for certifying income qualification for the applicant. During the initial point of contact, the applicant will be informed of the income guidelines and the requirement for income verification.

Households must also include at least one (1) individual who meets the following criteria:

- Child that is age 5 or under,
- Individual age 60 or over,
- Individual with a diagnosed disability.

The primary heating system must meet at least one of the following criteria to receive services:

- Have a non-operable or severely malfunctioning and/or unsafe heating system potentially endangering the household's health and/or well-being.
- Is using portable heating devices such as, but not limited to, electric and kerosene space heaters as a primary source of heat.
- Is using unvented gas/propane space heaters as a primary source of heat.
- Is using an unsafe fireplace or solid fuel.
- Have a fireplace or stove but do not have access to, or the means to purchase solid fuel.
- Is using any type of gas fired cooking appliance as a heating source.

21.7.1.A To Apply

Clients may apply for assistance for the repair or replacement of their heating/cooling unit by applying online at mylitt.com or they can be referred to their local Community Action Agency. The Informational flyer for the Repair or Replacement program can be mailed to a client but the client must submit the completed application to their local Community Action office and not the Department of Human Services.

21.7.2 Repair or Replacement Guidelines

This is separate from Weatherization Assistance Program (WAP).

The gross income limit is 60% of the SMI.

See Appendix D for the maximum allowable gross income levels for LIEAP FY 2025.

21.7.3 Weatherization Assistance Program (WAP) Referrals

When a referral is made to a Community Action Agency for Weatherization, the Worker must complete the DFA-WAP-1. This referral consists of case name, case number, case worker, date referred, agency name and worker signature.

In order to maintain controls for completing referrals to the Weatherization Program, the local office must retain a Weatherization referral log that indicates client's name, case number, case workers name, date referred, agency's name and case worker's signature. The DFA-WAP-2 form may be used for this purpose.

Weatherization is completed with WV DOE WAP guidelines. They use a point system to ensure that the neediest client receives assistance first.

21.8 Introduction to Low-Income Household Water Assistance Program (LIHWAP)

The Low-Income Household Water Assistance Program (LIHWAP) provides financial assistance to eligible assistance groups (AG) responsible for water/wastewater cost. It is not the purpose of this program to meet the entire cost of household water/wastewater; it is designed to partially offset the cost.

The program is time-limited and dependent on the availability of federal funds. It is subject to closure without prior notice when funds are deemed to have been exhausted.

This program was exhausted with a sunset date February 29, 2024.

APPENDIX A: REGULAR LIEAP BENEFIT PAYMENT CHARTS

LIEAP BENEFIT INCOME CHART

FY 2025 INCOME LEVELS

Gross Monthly Income 60% SMI to 150% FPL		Number in Benefit Group																			
From	To	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
$0	**$2,077**	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230	$235	$240	$245	$250	$255
$1,078	**$2,454**	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230	$235	$240	$245	$250
$2,455	**$2,832**		$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230	$235	$240	$245
$2,833	**$3,209**		$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230	$235	$240
$3,210	**$3,587**			$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230	$235
$3,588	**$3,965**			$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225	$230
$3,966	**$4,343**				$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220	$225
$4,344	**$4,720**				$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215	$220
$4,721	**$5,099**					$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210	$215
$5,100	**$5,475**					$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205	$210
$5,476	**$5,853**						$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200	$205
$5,854	**$6,230**						$130	$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195	$200
$6,231	**$6,301**							$130	$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190	$195
$6,302	**$6,372**							$125	$130	$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185	$190
$6,373	**$6,572**								$125	$130	$135	$140	$145	$150	$155	$160	$165	$170	$175	$180	$185
$6,573	**$6,769**								$120	$125	$130	$135	$140	$145	$150	$155	$160	$165	$170	$175	$180
$6,770	**$7,113**									$120	$125	$130	$135	$140	$145	$150	$155	$160	$165	$170	$175

$7,114	**$7,456**									$115	$120	$125	$130	$135	$140	$145	$150	$155	$160	$165	$170
$7,457	**$7,800**										$115	$120	$125	$130	$135	$140	$145	$150	$155	$160	$165
$7,801	**$8,144**										$110	$115	$120	$125	$130	$135	$140	$145	$150	$155	$160
$8,145	**$8,477**											$110	$115	$120	$125	$130	$135	$140	$145	$150	$155
$8,478	**$8,831**											$105	$110	$115	$120	$125	$130	$135	$140	$145	$150
$8,832	**$9,175**												$105	$110	$115	$120	$125	$130	$135	$140	$145
$9,176	**$9,519**												$100	$105	$110	$115	$120	$125	$130	$135	$140
$9,520	**$9,863**													$100	$105	$110	$115	$120	$125	$130	$135
$9,864	**$10,206**													$95	$100	$105	$110	$115	$120	$125	$130
$10,207	**$10,550**														$95	$100	$105	$110	$115	$120	$125
$10,551	**$10,894**														$90	$95	$100	$105	$110	$115	$120
$10,895	**$11,238**															$90	$95	$100	$105	$110	$115
$11,239	**$11,581**															$85	$90	$95	$100	$105	$110
$11,582	**$11,925**																$85	$90	$95	$100	$105
$11,926	**$12,269**																$80	$85	$90	$95	$100
$12,270	**$12,956**																	$80	$85	$90	$95
$12,957	**$13,300**																	$75	$80	$85	$90
$13,301	**$13,644**																		$75	$80	$85
$13,645	**$13,988**																		$70	$75	$80
$13,989	**$14,331**																			$70	$75
$14,332	**$14,675**																			$65	$70
$14,676	**$15,019**																				$65
$15,020	**$15,363**																				$60

APPENDIX B: PSC-REGULATED LIEAP VENDORS

The following gas and electric vendors are regulated by the Public Service Commission (PSC) and have signed an agreement with the Department of Human Services (DOHS) to accept LIEAP payments. These vendors are shown on the PSC web page as authorized to do business in West Virginia. Regular LIEAP payments must be issued to these vendors on behalf of their customers.

Vendor#	Vendor Name
000001209	A. V. COMPANY, INC.
000001205	ALLEGHENY POWER D/B/A MONONGAHELA POWER
000000878	ALLEGHENY POWER D/B/A POTOMAC EDISON
000001241	AMERICAN ELECTRIC POWER-ROANOKE
000001409	AMERICAN ELECTRIC POWER-WHEELING POWER
000001212	APPALACHIAN NATURAL GAS DBA: BLUEFIELD GAS
000000785	ASHFORD GAS COMPANY
000001127	BAZZLE GAS COMPANY/C/O ROSS L. WHARTON GAS
000000794	BLACK DIAMOND POWER
000003481	BLACK DIAMOND POWER - CLAY
000001211	BLACKSVILLE OIL GAS
000000808	CITY OF PHILIPPI ELECTRIC DEPARTMENT
000001298	CONSUMERS GAS UTILITY-HUNTINGTON
000001220	CONSUMERS GAS UTILITY-PENNSBORO
000001221	CONSUMERS GAS UTILITY-SPENCER
000005098	CRAIG-BOTETOURT ELECTRIC COOPERATIVE
000000834	DOMINION HOPE CUSTOMER CREDIT SERVICES
000019344	EAST RESOURCES, INC - 003 MANNINGTON
015643025	EAST RESOURCES, INC. - YAWKEY
000019938	EAST RESOURCES, INC. SPENCER
000001199	ELK POWER COMPANY
000000777	EQUITABLE GAS CO-CLARKSBURG
000001415	HARRISON RURAL ELECTRIFICATION ASSOC.

Vendor#	Vendor Name
000001580	J. A. & M. OIL & GAS CO.
000001418	LUMBERPORT SHINNSTON GAS
000001060	MEGAN OIL & GAS INC
000001962	MOUNTAINEER GAS COMPANY-LIEAP
000000895	SHENANDOAH VALLEY ELECTRIC
000001297	SOUTHERN PUBLIC SERVICE CO/MILTON
000001529	SOUTHERN PUBLIC SERVICE CO/LOGAN & MAN
000001648	SOUTHERN PUBLIC SERVICE CO/MONTGOMERY
000000908	STANDARD GAS
000000916	UNION OIL AND GAS
000001201	UNION POWER COMPANY-MULLENS
000000925	WELCH GAS CO OP

APPENDIX C: PUBLIC FORMS

Form Number	Form Title
DFA-LIEAP-1	LIEAP Application
DFA-LIEAP-1a	LIEAP Instructions
DFA-LIEAP-3	LIEAP Repayment Agreement
DFA-LIEAP-4	Zero Income/Home Heating Cost Verification
DFA-LIEAP-EER-1	Emergency Repair and Replacement Application

APPENDIX D: REPAIR OR REPLACEMENT INCOME LEVELS

The maximum allowable gross income levels for LIEAP FY 2026 are listed below.

Maximum Allowable Gross Income Levels for LIEAP FY 2026	
Household Size	Gross Monthly Income Limit
1	$2,454
2	$3,209
3	$3,965
4	$4,720
5	$5,475
6	$6,230
7	$6,372
8	$6,769
9	$7,456
10	$8,144
For each additional person, add $688.	

Chapter 22

West Virginia Children's Health Insurance Program (WVCHIP)

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
22.1	11/1/24	856	22.1	Includes pregnant women in the Introduction that was previously omitted. Also explains income limits for the Gold, Blue and Premium for the WVCHIP children and pregnant women groups.
22.2	7/1/19	774	22.2.3	Update policy to include WVCHIP Pregnancy
	7/1/19	774	22.2.5	Deemed Newborn coverage for WVCHIP Pregnancy coverage
	7/1/19	774	22.2.6.E	WVCHIP Medical ID cards are issued and replaced.
	1/1/21	799	22.2.3	Added Clarification
	8/1/22	825	22.2.3	Added clarification
	8/1/22	825	22.2.5	Remove closure
	8/1/22	825	22.2.6.C	Rolling Redetermination
	8/1/22	825	22.2.6.E	Show level of cost sharing
	4/1/23	835	22.2.6.A	Changed the Note to reflect the client must receive WV CHIP until March 31, 2023, and have a full re-determination before closure. Also provided additional requirements prior to closure.
	9/1/23	840	22.2.3	Change WV Chip becomes eligible for Non-Emer. Med.
	7/1/24	852	22.2.6.A	Removed Note requiring WV Childrens Health Insurance Program (WVCHIP) remain open after March 31, 2023 until a full redetermination is complete
	4/1/25	862	22.2.3	Removed the worker's responsibility to inform the client of its option to drop a child's existing health insurance. This will be performed in the notice.
22.3				
22.4	11/1/25	870	22.4.3	Clarifies when determining household composition for WVCHIP you count the unborn child in all calculations. Whereas for Medicaid you only count the unborn child towards the pregnant woman's eligibility.
22.5				
22.6				
22.7	8/1/22	825	22.7	Remove option of selection Medicaid

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	4/1/25	862	22.7.1	Established the policy for the BMS Third Party Insurance Verification Vendor as a data exchange used during WVCHIP applications to identify non-excepted health insurance information when the system does not already have existing creditable health insurance.
22.8				
22.9				
22.10				
22.11	8/1/22 8/1/22 1/1/24	825 825 845	22.11.1 22.11.2.B 22.11.1	WV CHIP required enrollment in Medicaid WV CHIP required enrollment in Medicaid Deleted section
22.12				
22.13				
22.14				
22.15				
22.16	8/1/22 8/1/22 11/1/24 4/1/25 3/1/26	825 825 856 862 874	22.16.1 22.16.4.C 22.16 22.16.1 22.16.1 22.16.5 22.16.1	Enrolling in private ins does not affect WV CHIP Change 13 calendar to 13 business days Lists all the Category Codes for the WVCHIP children group. Added the income limits for WVCHIP children Gold and Blue. Adding a note to modify that a child who is an inmate of a public institution can receive WVCHIP if the application is within 30 days of the release date, the client is in their continuous eligibility period or at redetermination. Updated the policy to reflect when an application is received the client must be determined otherwise eligible except for having creditable (non-excepted) health insurance. The BMS Third Party Insurance Exchange is a source of verification. Added language to include clients that do not have reasonable geographic access to care are also eligible for WVCHIP.
22.17	7/1/19 4/1/22 8/1/22	774 820 825	22.17 22.17.1-11 22.17.2.B	Added new policy WVCHIP Pregnancy coverage group Change postpartum period Change 13 calendar to 13 business days

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	8/1/22	825	22.17.2.F	Determine the level of cost sharing
	5/1/24	850	22.17.1.A.2	Added a reference to Section 10.9.4 for Extended Postpartum eligibility.
	11/1/24	856	22.17	Lists all the Category Codes for the WVCHIP pregnancy group.
Appendix A				
Appendix B	3/1/19	769		Update WVCHIP for 2019
	7/1/19	774		Updated to add WVCHIP Pregnancy to the WVCHIP
	3/1/20	783		Update WVCHIP
	3/1/21	802		Update WVCHIP
	3/1/22	817		Update WVCHIP
	3/1/24	848		Update WVCHIP
	3/1/25	861		Update WVCHIP
	3/1/26	874		Update WVCHIP

22.1 INTRODUCTION

The West Virginia Children's Health Insurance Program (WVCHIP) is administered through the Children's Health Insurance Agency within the Department of Human Services (DOHS, the Department). WVCHIP is a means-tested health insurance program for children from birth to age 19 and pregnant women. See 22.17 for WVCHIP Pregnancy. Applications are received through the Federally Facilitated Marketplace (FFM), the DOHS, or any entity approved to take applications on behalf of the DOHS. Eligibility determination by the FFM or the Department are equally valid.

Eligible clients are assigned to one of the following WVCHIP enrollment groups based on the countable income of the Income Group (IG):

- WVCHIP Children Gold – up to 150% of the federal poverty level federal poverty level (FPL) with limited co-payments
- WVCHIP Children Blue – over 150% of the FPL and up to 211% of the FPL with full co-payments
- WVCHIP Pregnancy Blue – over 185% of the FPL and up to 211% of the FPL with full co-payments
- WVCHIP Children and Pregnancy Premium – over 211% of the FPL and up to 300% of the FPL with monthly premiums and full co-payments
- Exempt – Federal regulations exempt Native Americans/Alaska Natives from cost sharing

Even though some policies and procedures for WVCHIP are the same as those for Medicaid, medical coverage under WVCHIP is not Medicaid. WVCHIP policies and procedures have been placed in this chapter to differentiate WVCHIP from Medicaid. Where policies and procedures duplicate those for Medicaid, reference is made to the appropriate Income Maintenance Manual (IMM) chapter.

22.2 APPLICATION/REDETERMINATION PROCESS

22.2.1 GENERAL INFORMATION

Applicants may apply or reapply for the West Virginia Children's Health Insurance Program (WVCHIP) through the Federally Facilitated Marketplace (FFM, the Marketplace), the Department of Human Services (DOHS), or the DOHS's designee. An eligibility determination made by the FFM is accepted by the DOHS and enrollment in WVCHIP is facilitated without delay.

For assistance, applicants may access the WVCHIP website or by contacting the WVCHIP Helpline at 1 (877) 982-2447.

Prior to approval for WVCHIP, the applicant must be determined ineligible for all Modified Adjusted Gross Income (MAGI) Medicaid coverage groups; therefore, the Children Under Age 19 Group procedures are applied when determining eligibility for WVCHIP. See Section 1.7 for details regarding the application process for the Children Under Age 19 Group. See Section 23.8, Medicaid Eligibility Between Coverage Groups, for consideration of all MAGI and non-MAGI Medicaid coverage groups.

When a denial occurs due to gross income more than 300% of the FPL, the applicant's electronic account will be transferred to the Marketplace for an evaluation for other healthcare benefits.

22.2.2 SHARED POLICIES – WVCHIP AND CHILDREN UNDER AGE 19 GROUP

The policies listed below are the same for WVCHIP as the Children Under Age 19 Group. The IMM citations for the Children Under Age 19 Group are included in the table.

Child Under Age 19 Medicaid Policy	IMM Location
Appeals Process	Section 9.3.7
Application Forms	Section 1.6.1 and 1.7
Application Procedures	Section 1.7
Citizenship Requirements	Section 7.4

Child Under Age 19 Medicaid Policy	IMM Location
Coordination with the Marketplace	Section 1.6.11.A
Definition of Residency	Section 2.2.3
Determining a Complete Application	Section 1.6.5
Determining the Date of Application	Section 1.6.3
Due Date of Additional Information	Section 1.6.4
Eligibility System Action	Section 1.6.8
Fair and Equitable Treatment	Section 1.2.1
MAGI-based Financial Methodology	Section 4.7
Redetermination Schedule and Special Procedures	Section 1.7.7
Reporting Changes to the Department	Section 10.7
Who Is the Child's Representative/Payee	Section 1.7.5
Who Must Sign the Application	Section 1.7.2

22.2.3 POLICIES THAT DIFFER BETWEEN WVCHIP AND THE CHILDREN UNDER AGE 19 GROUP

Differences between the Children Under Age 19 Group Medicaid and WVCHIP include the following:

- WVCHIP is not Medicaid. Families enrolled in WVCHIP have cost-sharing responsibilities in the form of copayments for hospital and doctor visits and some prescriptions. Some families will be responsible for monthly premiums.
- At application or redetermination, a child cannot have creditable private insurance and WVCHIP in the same month. However, if the child obtains creditable private insurance during the continuous eligibility period, the case remains open until the next determination. See Appendix A to determine if private insurance is creditable.
- An applicant who indicates he has other insurance coverage on the date of application is denied WVCHIP unless the applicant indicates that coverage will terminate soon after application. The application is accepted and enrollment in WVCHIP occurs the first of the month after other coverage is terminated.
- Eligibility is not backdated up to three months as is permitted for Medicaid. The only instances of allowable backdated WVCHIP coverage are identified in Section 22.16.4.C.

- Even though pregnancy services are covered by WVCHIP, a pregnancy and birth of a child born to a woman receiving WVCHIP should be reported. Her newborn is deemed WVCHIP eligible and eligible for 12-months of WVCHIP coverage without an application.
- The WVCHIP Helpline at 1 (877) 982-2447 and the DOHS's fiscal agent are the contacts to answer questions about services and/or the level of coverage. The WVCHIP staff provides a "Summary Plan Description" to all WVCHIP eligible individuals upon request.
- Failure to cooperate or accept Bureau for Child Support Enforcement (BCSE) services does not affect WVCHIP eligibility but is offered on a voluntary basis.
- Reimbursement for out-of-pocket expenses due to agency delays does not apply to WVCHIP.

22.2.4 AGENCY DELAYS

No application is denied solely because the processing time limit has passed and the Worker has failed to act.

Eligibility begins on the first day of the month of application, regardless of the reason for the delay. See Section 22.16.4.C for situations that result in backdating WVCHIP coverage.

NOTE: See Section 22.16 for procedures regarding WVCHIP Premium payment.

If the Worker decides that additional information is required, the Worker must immediately send a request for information. This includes notification that the application is pending receipt of that information and the start date of the WVCHIP coverage may be delayed if the information is not received by the due date.

22.2.4.A BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application. When the case is pending termination of other health insurance coverage, the earliest date of eligibility is the first day of the month when the other health insurance is not in effect.

> **Health Insurance Termination Example 1:** On September 5, 2013, Ms. Pine requests that her personnel department terminate her health insurance coverage. She applies for WVCHIP on November 5, 2013 and indicates private insurance coverage through November 30, 2013. The application is approved for WVCHIP and the start date is December 1, 2013.
>
> **Health Insurance Termination Example 2:** On September 5, 2013, Ms. Pine requests her personnel department terminate her health insurance coverage. Coverage terminated on October 31, 2013. She applies for WVCHIP on November 5, 2013. Because other coverage was not effective on the date of application, the application is approved for WVCHIP and the start date is November 1, 2013.

The Worker cannot backdate eligibility up to three months as is permitted for Medicaid. The only instances of allowable backdated coverage are identified in Section 22.16.4.C.

22.2.5 DEEMED WVCHIP NEWBORN

A child born to a WVCHIP client is deemed WVCHIP eligible when:

- The child's mother was eligible for, and receiving, WVCHIP or WVCHIP Pregnancy on the date of the child's birth; and
- The child is not eligible for Medicaid.

The child is deemed to have applied as of the date of the birth and is not required to submit an application.

The child receives WVCHIP continuously, regardless of changes in circumstances until his first birthday, unless:

- The child moves out of state.
- The child dies.
- The adult voluntarily requests closure of the child's eligibility.

- The child becomes Medicaid eligible.

Coverage begins from the first day of the month of the child's birth.

22.2.6 REDETERMINATION SCHEDULE AND SPECIAL PROCEDURES

22.2.6.A Redetermination Schedule and Procedures

See Section 1.7.7; the schedule and procedures are the same as those for the Medicaid Children Under Age 19 Group.

22.2.6.B Clients Found Ineligible at Redetermination

At the annual redetermination, when income exceeds the allowable income limit, the Assistance Group (AG) is closed and the electronic account will be transferred to the Marketplace for an evaluation for other health coverage benefits.

22.2.6.C Special Procedures – Rolling Redeterminations

When a change is reported during the certification period that affects eligibility, the Department must only request the information on the change reported. When the Worker receives the information, the client is evaluated for rolling redetermination. If the agency has enough information available to renew eligibility with respect to all the eligibility criteria, the agency must begin a new 12-month certification period.

The following scenarios are possible when a client reports a change in income:

Change	Outcome
An increase in income to a level above the WVCHIP eligibility level	The client remains eligible through the end of his 12-months of continuous eligibility and must be reevaluated at that time.

Change	Outcome
An increase in income to a level that would lead to an increase in cost sharing	The client remains at the current plan level through the end of his current 12-months of continuous eligibility and must be reevaluated at that time.
A decrease in income that makes the client eligible for Medicaid	The client must be enrolled in Medicaid without the option to remain enrolled in WVCHIP. See Section 22.11.2.B.
A decrease in income that makes the client eligible for a lower level of cost sharing	The Worker must redetermine eligibility that will result in a new plan level being assigned and start a new 12-months of continuous eligibility.
A change in income that does not affect eligibility or cost sharing level	The client has no change in benefits and starts a new 12-months of continuous eligibility.

> **Change of Income Example:** Cosmo Lotus is determined eligible from February 1, 2014, through January 31, 2015. On June 2, 2014, Ms. Lotus calls and reports a change in income. The information is provided to the Department on June 6, 2014. The Worker evaluates the information and determines enough information is available to renew eligibility. The benefit is given a new 12-months of continuous eligibility effective July 1, 2014 through June 30, 2015.
>
> **SNAP Redetermination Example:** A redetermination for Supplemental Nutrition Assistance Program (SNAP) benefits is completed on May 14, 2014. The WVCHIP certification period is April 1, 2014 through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to recertify. The WVCHIP certification period is renewed from June 1, 2014 through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

22.2.6.D Client Notification

The WVCHIP staff is responsible for all notifications related to medical coverage and payment of benefits once a child is enrolled.

The eligibility system automatically sends a notice to the child's household mailing address when:

- A WVCHIP application is approved or denied.
- Eligibility for a WVCHIP child continues at redetermination.
- A child loses WVCHIP eligibility.

See Chapter 9.

EXCEPTION: See Section 22.11 when advance notice requirements do not apply.

Eligibility is continued, pending a hearing, when the AG requests a hearing within the advance notice period.

Hearing requests related to health plans are referred to the WVCHIP Helpline at 1 (877) WVA-CHIP or 1 (877) 982-2447.

NOTE: See Section 22.16 for procedures regarding WVCHIP Premium coverage.

22.2.6.E The Benefit

The WVCHIP Medical ID card is included in all approval notices. Clients will receive one Medical ID card per case each time there is an approval or renewal for any household member. WVCHIP is responsible for providing enrollment materials, such as the benefit plan description, upon request.

The eligibility system determines the level of cost sharing for which the client is responsible (Blue, Gold, or Premium), based on countable income. The WVCHIP Help Line at 1 (877) 982-2447 handles any questions concerning co-payments.

EXCEPTION: Children who are members of a federally recognized American Indian or Native Alaskan tribe are exempt from premiums, deductibles, and co-payments. American Indian/Alaska Native (AI/AN) means: 1) a member of a Federally recognized Indian tribe, band or group; 2) an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et. Seq.; or 3) a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

The client can claim this exemption by calling the WVCHIP Help Line at 1 (877) 982-2447 to declare his tribal designation and confirm that it is listed as a federally recognized tribe.

Copies of client Explanation of Benefits (EOB) can be obtained from the Department's fiscal agent. The fiscal agent can also provide information about the status of medical claims or problems related to medical payments.

In compliance with the requirements of the Patient Protection and Affordable Care Act, Public Health Service Act, effective July 1, 2011, WVCHIP clients do not have an annual and/or lifetime benefit maximum.

22.2.6.F Agency Time Limit

The policy in Section 1.7.4 regarding Children Under Age 19 applies to WVCHIP. A child must first be determined ineligible for MAGI Medicaid before being eligible for WVCHIP.

22.3 COMMON ELIGIBILITY REQUIREMENTS

22.3.1 RESIDENCE

The child must be a West Virginia resident. See Section 2.2.3. The requirements are the same as those for Medicaid.

22.3.2 CITIZENSHIP STATUS

The Medicaid policy/procedures in Section 15.7.5 apply to the West Virginia Children's Health Insurance Program (WVCHIP). See Section 7.4 for citizenship verification requirements for WVCHIP.

22.3.3 COOPERATION WITH QUALITY CONTROL

Selected WVCHIP assistance groups (AG) are subject to the Payment Error Rate Measurement (PERM) review process. There is no penalty for clients for non-cooperation.

22.3.4 LIMITATIONS ON RECEIPT OF OTHER BENEFITS

WVCHIP coverage may be provided to individuals who receive any benefit administered by the Division of Family Assistance (DFA), except full-coverage Medicaid. An individual cannot receive full-coverage Medicaid and WVCHIP benefits at the same time.

At application and redetermination, ineligibility for MAGI Medicaid is an eligibility requirement for WVCHIP. If the applicant chooses to pursue eligibility for a non-MAGI Medicaid coverage group while enrolled in WVCHIP and is found to be eligible for a non-MAGI Medicaid coverage group, the applicant is no longer eligible for WVCHIP. See Section 23.8. The WVCHIP eligibility must be closed after advance notice.

Limitations on Receipt of Other Benefits Example: Mr. Oak and Ms. Dahlia are married and Ms. Dahlia has two children under age 19. The family applies for healthcare, listing Mr. Oak's wages from employment as the only household income. The children are over the income limit for Modified Adjusted Gross Income (MAGI) Medicaid, but under the limit for WVCHIP. The family asks to be considered for other healthcare benefits. The Worker knows that a stepparent's income cannot be used to determine Aid to Families with Dependent Children (AFDC)-Related Medicaid, and runs eligibility based on these rules, pending for asset information. WVCHIP is continued while the information is gathered on the supplement to the application, the DFA-SLA-S1, Application for Health Care Coverage. If the DFA-SLA-S1 is returned and the children are found eligible, the children are approved for AFDC-Related Medicaid and the WVCHIP eligibility is closed after advance notice. If the family is over the asset limit or fails to provide the required information to determine AFDC-Related Medicaid eligibility, the WVCHIP continues for the children.

22.3.5 NON-DUPLICATION OF BENEFITS

A WVCHIP client is prohibited from receiving WVCHIP benefits in more than one West Virginia county and/or more than one state at the same time. There is no disqualification penalty for receipt of duplicate benefits.

22.3.6 ENUMERATION

Only the individual seeking WVCHIP benefits is required to provide a Social Security Number (SSN). Other members of the household or tax filing unit may provide this information on a voluntary basis after the Worker explains the reason for the request and how the SSN will be used. Regardless of whether they provide their numbers, their disclosure is not a condition of eligibility.

When an individual seeking WVCHIP benefits does not have an SSN, or has applied but not yet received one, the eligibility decision is not delayed for this reason alone. The DOHS staff is responsible for obtaining the number.

SSN Example: A family applies for WVCHIP for their three-month old daughter who does not yet have an SSN. The application process continues without this non-financial verification and it is not necessary for either parent to provide his or

her own number. The Worker explains that financial information is needed in order to determine if the household's income is under the allowable income limit for WVCHIP and an SSN may allow him to match data regarding income from the federal Hub. For this reason, the father volunteers his SSN. Internal Revenue Service (IRS) information is returned that is reasonably compatible with the client's self-attestation and the child is approved.

22.4 ELIGIBILITY DETERMINATION GROUPS

22.4.1 THE ASSISTANCE GROUP (AG)

Only the West Virginia Children's Health Insurance Program (WVCHIP) child is included in the WVCHIP AG as an eligible client of WVCHIP coverage.

22.4.2 THE MODIFIED ADJUSTED GROSS INCOME (MAGI) HOUSEHOLD INCOME GROUP (IG)

See Section 3.7.2 for the MAGI methodology used for determining the MAGI household income group.

22.4.3 THE MAGI HOUSEHOLD NEEDS GROUP (NG)

See Section 3.7.3 for the MAGI methodology used for determining the MAGI household needs group.

A difference exists between Medicaid and WVCHIP when a pregnant woman is involved in the household composition.

For the WVCHIP MAGI household, in determining family size for the eligibility determination, a pregnant woman is counted as herself, plus the number of unborn children she is expected to deliver.

Example: Rose is a tax filer and claims her 14-year-old daughter, Lily, as a tax dependent. Rose is pregnant.

Rose is a tax filer. Using STEP 1, her household includes herself, her unborn child and Lily – Rose, the unborn child and Lily = Three.

Lily is a tax dependent. Using STEP 2, she did not meet any of the exemptions. Her household includes herself and her mother, Rose. However, because Rose is pregnant, Lily's household also includes the unborn child – Lily, Rose and her unborn child = Three. This differs from Medicaid as the unborn child only pertains to the pregnant woman's eligibility.

22.5 INCOME

22.5.1 MODIFIED ADJUSTED GROSS INCOME (MAGI) METHODOLOGY

The Patient Protection and Affordable Care Act, enacted March 23, 2010, amended by the Health Care and Education Reconciliation Act of 2010, enacted March 30, 2010, are together referred to as the Affordable Care Act (ACA). The ACA required a new methodology for determining how income is counted and how household composition and size are determined when establishing financial eligibility for all three Insurance Affordability Programs (IAP)—Medicaid, Children's Health Insurance Program (CHIP) and Advance Premium Tax Credits (APTC) through the Marketplace.

MAGI Methodology is used to determine financial eligibility for the West Virginia Children's Health Insurance Program (WVCHIP) and the following Medicaid eligibility groups:

- Adults
- Parents and Other Caretaker Relatives
- Pregnant Women
- Children Under Age 19

The same methodology is used to determine WVCHIP eligibility as is used for MAGI Medicaid groups. See Section 4.7.

22.5.1.A Determining the Household Size for WVCHIP

For the WVCHIP MAGI household, a pregnant woman is counted as herself, plus the number of unborn children she is expected to deliver.

22.5.1.B MAGI Income Disregard for WVCHIP

Note that the 5% FPL disregard is not applied to every MAGI eligibility determination and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

MAGI Income Disregard Example: A WVCHIP applicant has MAGI household income of 216% FPL. The 5% MAGI income disregard will not be applied because the highest income limit of any WVCHIP enrollment group for which the child may be eligible is 300% FPL. If the WVCHIP applicant's income is 305% FPL, then the 5% MAGI income disregard would be applied to bring the child's household income to below 300% FPL. WVCHIP coverage is approved.

22.6 ASSETS

There is no asset test for the West Virginia Children's Health Insurance Program (WVCHIP) eligibility.

22.7 DATA EXCHANGE

The data exchanges and matches described in Chapter 6 are applicable to the West Virginia Children's Health Insurance Program (WVCHIP). Changes in income during the 12-month continuous period of eligibility do not affect WVCHIP eligibility unless the client becomes Medicaid eligible as the result of a decrease in income. However, information from the matches must be recorded in case comments in the eligibility system.

22.7.1 BMS THIRD PARTY INSURANCE VERIFICATION VENDOR

The BMS Third Party Insurance Verification Vendor identifies creditable insurance at application for WVCHIP. The exchange of information occurs automatically as a final step after all other eligibility factors have been met.

The exchange takes place:

- On an individual basis
- Only during an initial application; and
- Only for individuals not covered by any creditable health insurance in the system but applying for WVCHIP coverage.

This includes individuals who were previously enrolled but are now closed.

If the data exchange indicates an applicant has creditable health insurance coverage, the system will automatically code the insurance screen with the information, allowing the worker to issue a proper denial notice on an individual basis.

If the data exchange does not return creditable health insurance but it is later discovered the individual was and continues to be covered, the WVCHIP coverage must be terminated in accordance with Section 22.11.1.

Note: When reported at application or redetermination that an individual is enrolled In creditable health insurance, the Worker must enter the insurance information into the system prior to determining eligibility. This is due to the fact it is designed to only attempt the exchange in the events listed above.

22.8 VERIFICATION

The verification policy and procedures described in Chapter 7 are applicable to the West Virginia Children's Health Insurance Program (WVCHIP).

WVCHIP-deemed newborns are exempted from citizenship verifications. See Section 7.4.2.

22.9 RESOURCE DEVELOPMENT

The Resource Development policies and procedures in Chapter 8 do not apply to WVCHIP cases.

22.10 CLIENT NOTIFICATION

See Section 22.2.6.D for the Worker's responsibilities for client notification related to the West Virginia Children's Health Insurance Program (WVCHIP).

22.11 CASE MAINTENANCE

Although West Virginia Children's Health Insurance Program (WVCHIP) issues the benefit to the client, action is taken on changes reported to the Department of Human Services (DOHS). Updated information can be reported to WVCHIP through the eligibility system.

22.11.1 CLOSURES

WVCHIP is notified of clients' ineligibility through an exchange of information with the eligibility system.

Eligibility under all Medicaid coverage groups must be explored for clients for all who become ineligible for WVCHIP prior to the end of the 12-month period of continuous eligibility. This does not mean that applications for all coverage groups must be taken and processed. See Section 23.8. If the Medicaid evaluation results in an approval, the client receives a new Medicaid certification and redetermination period.

A child may be determined ineligible prior to the expiration of the 12-month period of continuous eligibility only if the child:

- Moves out of state;
- Dies;
- Reaches age 19. The child is eligible until the end of the month in which he reaches the age limit. A child who reaches age 19 on the first day of the month remains eligible until the end of that month;

NOTE: If a child is receiving inpatient hospital services on the date he would lose eligibility due to attainment of the maximum age, eligibility must continue until the end of that inpatient stay.

- Becomes eligible for Medicaid. Medicaid eligibility starts the first of the month after the WVCHIP closure;
- Becomes eligible for Supplemental Security Income (SSI);
- Was approved or redetermined for WVCHIP in error and is not currently eligible; or

When one member's circumstances result in closure of the WVCHIP assistance group (AG), other WVCHIP member in the household, if otherwise eligible, continue to be eligible for the rest of their 12-month period of continuous eligibility, and are unaffected.

22.11.2 CHANGE IN INCOME OR NEEDS GROUP

22.11.2.A Increase in Income or Reduction in Needs Group (NG)

Any change in circumstances not listed in Section 22.11.1 above does not affect eligibility once the 12-month period of continuous eligibility is established. This includes an increase in income or a reduction in the number of people included in the Needs Group. See Section 22.11.2.C below for instructions on updating case information.

> **Increased Income Example:** A child is approved for WVCHIP beginning in March. His 12-month period of continuous eligibility ends in the following February. In August, his father changes jobs and the income of the family now exceeds 300% of the FPL. The child's eligibility under WVCHIP continues through February.
>
> **Return of Absent Father Example:** A child is approved for WVCHIP Premium beginning in September and ending the following August. A week after approval, his absent father returns to the family. The father works and his income exceeds 300% of the FPL. The child's eligibility under WVCHIP continues through August.
>
> **Reduction in Size of Needs Group Example:** A man and woman with two children apply for WVCHIP coverage for the children, ages 12 and 18, in April. The children are approved for coverage from April through the following March. In October, the 18-year-old attains the age of 19. His WVCHIP coverage must be stopped October 31st. At the point that the 19-year-old loses coverage and is removed from the Needs Group, the income of the parents exceeds 300% of the FPL for a Needs Group of three. However, the 12-year-old child's WVCHIP eligibility continues through March.

22.11.2.B Newly Eligible for Medicaid

When a WVCHIP child becomes income eligible for Medicaid during the 12-month period of WVCHIP continuous eligibility, notification of Medicaid eligibility is sent to the client. The client must be enrolled in Medicaid without the option to remain enrolled in WVCHIP.

No application is required. Medicaid is approved for a new 12-months of continuous coverage.

22.11.2.C Updates in Assistance Group (AG) Information

NOTE: See Section 22.16 for procedures regarding WVCHIP Premium coverage.

The case information in the eligibility system must be updated based on changes reported by the client and by other valid sources, even though the client is eligible for 12 continuous months of coverage. The Worker must evaluate changes made outside of the required annual redetermination cycle so that the child may be correctly evaluated for Medicaid.

Any change in the family's circumstances that could result in Medicaid eligibility for the child requires the Worker to reevaluate Medicaid eligibility.

22.11.2.D Pregnancy of a WVCHIP Client

When the Worker is notified that the WVCHIP child is pregnant, the Worker must evaluate eligibility for Pregnant Woman Medicaid coverage.

When a WVCHIP child becomes eligible for Medicaid as a Pregnant Woman, she may be determined Medicaid eligible as of the first day of the month of application, or up to three months prior to the month of application, provided all eligibility requirements were met. The client may choose the beginning date of eligibility and Medicaid eligibility may be established for the earliest month in which expenses not paid by WVCHIP were incurred. All case circumstances (including income, AG composition, marital status of the pregnant woman, etc.) are used as they existed in the month that the pregnant woman first met all Medicaid eligibility requirements.

WVCHIP eligibility must be closed at the end of the month of the determination of Pregnant Woman coverage prior to opening any backdated coverage under Medicaid

If the pregnant WVCHIP child is not found eligible for Medicaid, she remains on WVCHIP, which continues to pay for all services, including pregnancy services.

The newborn is automatically eligible for WVCHIP. See Section 22.16.2.

22.12 BENEFIT REPAYMENT

Medicaid Estate Recovery provisions do not apply to the West Virginia Children's Health Insurance Program (WVCHIP) clients.

Repayment by the client of incorrectly paid medical claims is the responsibility of WVCHIP and/or the Department of Human Services' (DOHS) fiscal agent.

Provider fraud determination is the responsibility of WVCHIP.

22.13 BENEFIT REPLACEMENT

The West Virginia Children's Health Insurance Program (WVCHIP) is responsible for the replacement of WVCHIP member cards. WVCHIP member cards are not replaced through the eligibility system. The Worker or client may contact the WVCHIP Helpline at 1 (877) 982-2447 or the Department of Human Services' (DOHS) fiscal agent.

22.14 DETERMINING DISABILITY, INCAPACITY AND BLINDNESS

Disability, incapacity, and blindness are not eligibility requirements for the West Virginia Children's Health Insurance Program (WVCHIP) client or his parent(s) or other caretaker(s).

22.15 WORK REQUIREMENTS

There is no work requirement for the West Virginia Children's Health Insurance Program (WVCHIP) client or his parent(s) or other caretaker(s).

22.16 SPECIFIC WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM (WVCHIP) REQUIREMENTS (MGCH-Gold, MGCB-Blue, MGCP-Premium, MNCH-Deemed Newborn Gold, MNCB-Deemed Newborn Blue)

22.16.1 REQUIREMENTS FOR WVCHIP CHILDREN

Income: 150% of the FPL WVCHIP Gold
211% of the FPL WVCHIP Blue
300% of the FPL WVCHIP Premium
No Spenddown Provision

Assets: N/A

Individuals are eligible for WVCHIP when all the following conditions are met:

1. At the time of application or redetermination, the child must not be financially eligible for a Modified Adjusted Gross Income (MAGI) Medicaid coverage group. An individual interested in receiving WVCHIP, but eligible for MAGI Medicaid, cannot choose WVCHIP instead of Medicaid, but he can refuse MAGI Medicaid.

   If the applicant chooses to pursue eligibility for a non-MAGI Medicaid coverage group while enrolled in WVCHIP and is found to be eligible for a non-MAGI Medicaid coverage group, the applicant is no longer eligible for WVCHIP. See Section 23.8.

2. The child is not yet age 19, regardless of school attendance or course completion date. He becomes ineligible the end of the month in which he attains age 19. Emancipation does not impact eligibility.

   EXCEPTION: When a child is receiving inpatient services on the date he would lose eligibility due to age, coverage continues until the child is discharged.

3. Household income, determined according to, is less than or equal to 300% FPL. See Chapter 4, Appendix A.

4. The child is not an inmate of a public institution.

EXCEPTION: An incarcerated child may be determined eligible when:

- *Their application date is within 30 days prior to their release date.*
- *At redetermination, if the only reason for the closure is they are inmates of a public institution.*
- *During their 12-month continuous eligibility period.*

5. The child is not a patient in an institution for mental diseases.
6. The child meets the Medicaid citizenship and related requirements found in Chapter 7. See Section 22.8.6 regarding enumeration.
7. The child does not have creditable individual, public or private employer group health insurance coverage or one that does not have reasonable geographic access to care. Most children with other health coverage will not qualify for WVCHIP. See Appendix A Definitions.

> **Requirements for WVCHIP Children Example:** Mr. Oak works for a grocery store and is eligible for individual or family health insurance coverage through his employer. He chooses not to enroll. His choice does not affect his children's eligibility for WVCHIP.

When an applicant drops his health insurance coverage, if otherwise eligible, his child may receive WVCHIP without a penalty the month after the insurance is no longer in effect. The parent is only required to drop the health insurance for the WVCHIP-eligible child.

A child who starts receiving other creditable health insurance coverage after WVCHIP approval does not lose WVCHIP coverage prior to the expiration of the current 12-month continuous eligibility period.

22.16.2 DEEMED WVCHIP NEWBORN

Income: NA Assets: NA

A child born to a WVCHIP client is deemed WVCHIP eligible when:

- The child's mother was eligible for, and receiving, WVCHIP on the date of the child's birth, and
- The child is not eligible for Medicaid.

The child is deemed to have applied as of the date of the birth and is not required to submit an application

Coverage begins the first day of the month of the child's birth.

22.16.3 MEDICAID REQUIREMENTS APPLICABLE TO WVCHIP

Consideration for all Medicaid groups must be made prior to closure of WVCHIP. This does not mean that applications for all coverage groups must be taken and processed; eligibility is determined based on case record information. See Section 23.8.

22.16.3.A Relationship to Children with Special Health Care Needs (CSHCN)

A child may be enrolled in both WVCHIP and CSHCN. WVCHIP follows the same policy as Medicaid. See Section 23.7 for additional detail.

22.16.3.B Child Support Requirements

WVCHIP children are not referred to the Bureau for Child Support Enforcement (BCSE) and are not required to pursue or accept child/spousal support as a condition of eligibility. The Worker must explain the availability of child support services on a voluntary basis. The eligibility system automatic referral to BCSE is blocked for WVCHIP children.

22.16.4 MEDICAID REQUIREMENTS THAT ARE DIFFERENT FOR WVCHIP

The policies listed below do not apply to WVCHIP or there is a difference in application of the policy.

22.16.4.A Assignment of Medical Support Rights

There is no requirement for the family to assign medical support rights to the Department.

22.16.4.B Certificate of Coverage When WVCHIP Coverage Ends

The Worker is not required to issue a DFA-HIP-1, Certificate of Medical Coverage, to the family.

22.16.4.C Backdating Coverage

The policy that allows Medicaid coverage to be backdated up to three months prior to the date of application does not apply to WVCHIP benefits.

Only the following situations require the Worker to backdate WVCHIP coverage:

- A newborn was born on or after the 21st of the month and the application for that child is not submitted until the following month. The Worker must backdate eligibility to include the first day of the birth month;

  > **Newborn Backdating Example 1:** The baby is born April 27 and the application is submitted May 13. Coverage should be backdated to April to include the baby's birth.
  >
  > **Newborn Backdating Example 2:** The baby is born on May 15 and the application is submitted June 2. Coverage will not be backdated to May to include the birth month.

- Failure of the Worker to request additional information in a timely manner and the delay results in a loss of coverage;
- Failure of the Worker to approve a complete application within 13 business days of receipt and the delay results in a loss of coverage;
- Inability of the Worker to approve coverage beginning the first of the following month when the applicant applies and/or establishes eligibility too late in the month, and the data system deadline for next month approval has passed;
- At the request of WVCHIP administration; or
- When a redetermination cannot be completed automatically and the client does not provide the additional information requested within 30 days, the benefit is closed. If the client provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be reinstated to the effective date of closure.

When approval is delayed due to Worker error and results in eligibility for backdated coverage, the client must be given the following options:

- Accept the backdated coverage for any period for which the child was eligible.
- Begin the coverage at a later time, if there are not incurred medical expenses for the past period.

Once an option is chosen and the AG is approved, the beginning date of eligibility cannot be changed.

> **Delay in Processing Example:** A client applies for WVCHIP for her children. Her application is received in the local office on September 4 and placed in the client's file instead of being processed. The client calls on October 20 to check the status of her application. On October 21, the application, date-stamped September 4, is found in the file and processed. The client has the option of accepting 12-months of coverage beginning in either September, October, or November. Because the children incurred no medical expenses for September, she chooses to begin coverage in October. The 12-months of coverage begins in October and ends in September of the following year. After approval, the 12-month eligibility period cannot be changed.
>
> **Spenddown Example:** On December 15, 2013, a child's family applies for Medicaid and the child is ineligible for all Medicaid coverage groups except AFDC-Related Medicaid. There is a $3,000 spenddown. Allowable bills equal to or greater than $3,000 must be provided to meet the spenddown by January 14, 2014, to be eligible for Medicaid. All other verifications and information necessary to determine eligibility is provided by the client on January 1. Bills in the amount of $2,345 were submitted on January 10, 2014 and failed to establish Medicaid financial eligibility. All requirements for WVCHIP were met January 1; therefore, coverage begins February.

22.16.4.D Relationship Between WVCHIP and Medicaid Coverage Groups

An individual cannot receive both program benefits at the same time. If the child is eligible for Medicaid, he must enroll in Medicaid. Both programs provide healthcare benefits, but services and/or amount of services differ. Certain medical providers will accept only one program's enrollees but not the others.

An individual must first be determined ineligible for a MAGI Medicaid coverage group before he can receive WVCHIP. If the applicant chooses to pursue eligibility for a non-MAGI Medicaid coverage group while enrolled in WVCHIP and is found to be eligible for a non-MAGI Medicaid coverage group, the applicant is no longer eligible for WVCHIP; see Section 23.8. The WVCHIP eligibility must be closed after advance notice.

22.16.4.E Long Term Care

If the child requires long-term care services and qualifies for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Aged and Disabled Waiver (ADW), Children with Disabilities Community Service Program (CDCSP), or Intellectually/Developmentally Disabled (I/DD) Waiver coverage groups, the child is then eligible for full coverage Medicaid and ineligible for WVCHIP.

WVCHIP does not qualify an individual for Medicaid payment of long-term care services, and long-term care services are not covered WVCHIP services.

22.16.5 CREDITABLE (NON-EXCEPTED) HEALTH INSURANCE

When the Worker receives an application showing that the family has non-excepted health insurance (see Appendix A), he must determine if the client is otherwise eligible for WVCHIP, except for having current non-excepted health insurance coverage prior to denial.

When the Worker receives an application without non-excepted health insurance listed, and the client is determined otherwise eligible for WVCHIP, a request is submitted by the eligibility system to the BMS Third Party Insurance Verification Vendor to look for non-excepted health insurance coverage information. See Section 22.7.

- If non-excepted health insurance information is returned, WVCHIP must be denied.
- In no information is returned, the WVCHIP can be approved.

If proof is submitted that insurance is dropped, WVCHIP eligibility can start without penalty the month after the insurance is no longer in effect, and without the need for a new application as long as the current application is not older than 60 days.

22.16.6 WVCHIP PREMIUM PAYMENT

The premium amount is based on the number of children in the family approved for WVCHIP Premium coverage. The premium amount for one child is $35 per month. The premium amount

for two or more children is $71 per month. The Department's fiscal agent issues a monthly invoice with the amount due.

The initial and ongoing premium payments may be made by check or money order, or online at the WVCHIP website. https://chip.wv.gov/pages/onlineservices.aspx The client's Personal Identification Number (PIN) or guardian's PIN should be included on the check. Premiums are due by the first of the month.

Local offices must not accept premium payments. Clients must mail payments to the West Virginia Treasurer's Office with the appropriate payment invoice or pay online. Send to:

WVCHIP
Post Office Box 40237
Charleston, WV 25364

22.17 WVCHIP PREGNANCY (Codes: MGPB-Blue, MGCR-Premium)

Income	Assets
300%	N/A

22.17.1 SPECIFIC WVCHIP PREGNANCY REQUIREMENTS

Effective July 1, 2019, individuals are eligible for WVCHIP Pregnancy when all the following conditions are met:

1. At the time of application or redetermination, the pregnant woman must not be eligible for a Modified Adjusted Gross Income (MAGI) Medicaid coverage group. An individual interested in receiving WVCHIP Pregnancy, but eligible for MAGI Medicaid, cannot choose WVCHIP Pregnancy instead of Medicaid, but she can refuse MAGI Medicaid.

   If the applicant chooses to pursue eligibility for a non-MAGI Medicaid coverage group while enrolled in WVCHIP Pregnancy and is found to be eligible for a non-MAGI Medicaid coverage group, the applicant is no longer eligible for WVCHIP Pregnancy. See Section 23.8.

2. The pregnant woman must be age 19 or older, regardless of school attendance or course completion date.

3. The pregnant woman's household income must be less than or equal to 300% FPL. See income limit in Appendix B.

4. The pregnant woman is not an inmate of a public institution.

5. The pregnant woman is not a patient in an institution for mental diseases.

6. The pregnant woman meets the Medicaid citizenship and related requirements found in Chapter 7. See Section 22.8.6 regarding enumeration.

7. The pregnant woman must not have creditable individual, public or private employer group health insurance coverage. Most women with other health coverage will not qualify for WVCHIP Pregnancy. See Appendix A for creditable coverage.

When an applicant drops health insurance coverage, if otherwise eligible, the client may receive WVCHIP Pregnancy without a penalty the month after the insurance is no longer in effect.

A pregnant woman who starts receiving other creditable health insurance coverage after WVCHIP Pregnancy approval loses coverage prior to the expiration of the current eligibility period.

22.17.1.A Postpartum Coverage

This coverage applies only to the postpartum pregnant woman. The newborn will be covered as a Deemed WVCHIP Newborn. See Section 22.16.2.

22.17.1.A.1 Eligibility for Postpartum Coverage

The pregnant woman is eligible for postpartum coverage provided that during the pregnancy, or within three months of the end of the pregnancy, the woman met all the following requirements:

- She applied for WVCHIP Pregnancy.
- She was eligible for WVCHIP Pregnancy.
- She received services through WVCHIP Pregnancy, and;
- She was determined eligible for coverage in West Virginia, regardless of coverage in other states.

If the pregnant woman applies within three months after the end of the pregnancy and is determined to have been eligible in one of the past months, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

A WVCHIP Pregnancy recipient is not referred to, or required to cooperate, with child support activities while pregnant nor during the postpartum period.

A WVCHIP Pregnancy recipient cannot be terminated or denied for failure to cooperate with Quality Control (QC) until the end of the postpartum period. After the postpartum period the sanction is applied.

22.17.1.A.2 Duration of Postpartum Coverage

A woman continues to be eligible for WVCHIP for 12-month postpartum, and the remaining days of the month in which the 12-month day falls. The 12-month postpartum period begins the following month after the pregnancy ends, and a redetermination is completed in the twelfth month of the postpartum period. If eligible for other Medicaid, or WVCHIP, that coverage must not begin until expiration of the postpartum period. See Section 10.9.4 for Extended Postpartum.

If no review takes place, WVCHIP Pregnancy coverage will automatically close after advance notice period.

22.17.2 APPLICATION/REDETERMINATION PROCESS

Common information about the application process found in Section 1.2 and 1.3 apply to WVCHIP Pregnancy.

22.17.2.A General Information

Applicants may apply or reapply for WVCHIP Pregnancy through the Federally Facilitated Marketplace (FFM, the Marketplace), DOHS, or the DOHS's designee. An eligibility determination made by the FFM is accepted by the DOHS and enrollment in WVCHIP Pregnancy is facilitated without delay.

For assistance, applicants may access the WVCHIP Pregnancy coverage group website or by contacting the WVCHIP Helpline at 1 (877) 982-2447.

Prior to approval for WVCHIP Pregnancy coverage group, the applicant must be determined ineligible for all MAGI Medicaid coverage groups. See Section 23.8, Medicaid Eligibility Between Coverage Groups, for consideration of all MAGI and non-MAGI Medicaid coverage groups.

When a denial occurs due to gross income more than 300% of the FPL, the applicant's electronic account will be transferred to the Marketplace for an evaluation for other healthcare benefits.

22.17.2.B Agency Time Limits

Eligibility system action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a completed application is received in the local office. If additional information or verification is required after the complete application is received, the worker must request it immediately to allow the client 10 days to provide it, and to complete the application process within business 13 days.

When a DFA-2 is used, the application for coverage as a pregnant woman must be processed within 13 business days of the date a complete application is received, even though the application for another program may not require faster processing.

22.17.2.C Beginning Date of Eligibility

22.17.2.C.1 Application while Pregnant

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

22.17.2.C.2 Application after Pregnancy Ends

When the client applies within three months of the termination of the pregnancy, eligibility may be backdated up to three months, prior to the month of application, in which she met all eligibility requirements.

22.17.2.D Referrals To The Office Of Maternal, Child And Family Health (OMCFH)

When the WVCHIP Pregnancy woman's application is denied for any reason, a referral is made to the OMCFH. A list of these denied applications is generated by the eligibility system and

made available to the OMCFH. This permits OMCFH to evaluate the client for other available government-sponsored health care.

22.17.2.E Redetermination

A redetermination is completed the twelfth month of the postpartum period. Redeterminations are scheduled 12 months after the pregnancy end date, or, if information about the pregnancy is not updated, 12 months after the pregnancy due date.

In no instance is WVCHIP Pregnancy stopped without consideration of eligibility under other coverage groups. This is determined before the client is notified her eligibility will end. If eligible for any other coverage group, the benefits must not begin until expiration of the postpartum period.

If the redetermination is not completed, coverage is automatically closed after the advance notice period.

Rolling Redeterminations do not apply to the WVCHIP Pregnancy.

22.17.2.F The Benefit

The WVCHIP Pregnancy Medical ID card is included in all approval notices. Clients will receive one Medical ID card per case each time there is an approval or renewal for any household member. In situations where retroactive eligibility is established, coverage will be validated appropriately for each back-dated month.

The eligibility system determines the level of cost sharing for which the client is responsible (Blue or Premium), based on countable income. The WVCHIP Helpline at 1 (877) 982-2447 handles any questions concerning co-payments.

In compliance with the requirements of the Patient Protection and Affordable Care Act, Public Health Service Act, effective July 1, 2011, WVCHIP clients do not have an annual and/or lifetime benefit maximum.

22.17.2.G Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

The eligible pregnant woman must be notified that she remains eligible for 12 months after the month in which her pregnancy ends.

WVCHIP Pregnancy eligibility ends on the last day of the 12-month postpartum period or on the last day of the effective month of closure.

22.17.3 COMMON ELIGIBILITY REQUIREMENTS

22.17.3.A Residence

The pregnant woman must be a West Virginia resident. See Section 2.2.3

22.17.3.B Citizenship Status

The policy/procedures in Section 15.7.5 apply to the WVCHIP Pregnancy coverage group. See Section 7.4 for citizenship verification requirements.

22.17.3.C Cooperation with Quality Control

The WVCHIP Pregnancy group is subject to the Payment Error Rate Measurement (PERM) review process. There is no penalty for clients for non-cooperation.

22.17.3.D Limitations on Receipt of Other Benefits

WVCHIP Pregnancy may be provided to individuals who receive any benefit administered by the Division of Family Assistance (DFA), except full-coverage Medicaid. An individual cannot receive full-coverage Medicaid and WVCHIP Pregnancy at the same time.

At application, ineligibility for MAGI Medicaid is an eligibility requirement for WVCHIP

Pregnancy. If the applicant chooses to pursue eligibility for non-MAGI Medicaid coverage group while enrolled in WVCHIP Pregnancy and is found to be eligible for non-MAGI Medicaid coverage group, the applicant is no longer eligible for WVCHIP Pregnancy. See Section 23.8. The eligibility must be closed after advance notice.

22.17.3.E Non-Duplication of Benefits

The WVCHIP Pregnancy client is prohibited from receiving any WVCHIP benefits in more than one West Virginia county and/or more than one state at the same time. There is no disqualification penalty for receipt of duplicate benefits.

22.17.3.F Enumeration

Only the individual seeking WVCHIP Pregnancy benefits is required to provide a Social Security Number (SSN). Other members of the household or tax filing unit may provide this information on a voluntary basis after the Worker explains the reason for the request and how the SSN will be used. Regardless of whether they provide their numbers, their disclosure is not a condition of eligibility.

When an individual seeking WVCHIP Pregnancy coverage does not have an SSN, or has applied but not yet received one, the eligibility decision is not delayed for this reason alone. The DOHS staff is responsible for obtaining the number.

22.17.4 ELIGIBILITY DETERMINATION GROUPS

22.17.4.A The Assistance Group (AG)

Only the pregnant woman is included. The unborn child(ren) is not included.

22.17.4.B The MAGI Household Income Group (IG) and Needs Group (NG)

The methodology for determining the MAGI household's IG and NG is the same as found in

Section 3.7.

The WVCHIP Pregnancy IG and NG of the pregnant woman include her unborn child(ren).

22.17.5 INCOME

The MAGI methodology is used to determine financial eligibility for the WVCHIP Pregnancy coverage group. The same methodology is used to determine WVCHIP Pregnancy eligibility as is used for MAGI Medicaid groups found in Section 4.7.

NOTE: For the WVCHIP Pregnancy MAGI household, a pregnant woman is counted as herself, plus the number of unborn children she is expected to deliver.

22.17.5.A MAGI Income Disregard for WVCHIP Pregnancy

Note that the 5% FPL disregard is not applied to every MAGI eligibility determination and should not be used to determine the MAGI coverage group for which an individual may be eligible. The 5% FPL disregard will be applied to the highest MAGI income limit for which an individual may be determined eligible.

MAGI Income Disregard Example: A WVCHIP Pregnancy applicant has MAGI household income 216% FPL. The 5% MAGI income disregard will not be applied because the highest income limit of any WVCHIP Pregnancy enrollment group for which the woman may be eligible is 300% FPL. If the WVCHIP Pregnancy applicant's income is 305% FPL, then the 5% MAGI income disregard would be applied to bring the woman's household income to below 300% FPL.

22.17.6 ASSETS

There is no asset test for the WVCHIP Pregnancy program eligibility.

22.17.7 DATA EXCHANGE

The data exchanges and matches described in Chapter 6 are applicable for WVCHIP Pregnancy.

22.17.8 VERIFICATION

The verification policy and procedures described in Chapter 7 are applicable to WVCHIP Pregnancy.

22.17.9 RESOURCE DEVELOPMENT

The Resource Development policies and procedures in Chapter 8 do not apply to WVCHIP Pregnancy.

22.17.10 CLIENT NOTIFICATION

See Section 22.2.6.D for the Worker's responsibilities for client notification related to WVCHIP Pregnancy.

22.17.11 CASE MAINTENANCE

Once eligibility is established, the pregnant woman's WVCHIP Pregnancy eligibility continues, without regard to any change in family circumstances, through the end of the month in which the 12-month postpartum periods ends.

22.17.11.A Closures

Eligibility under all Medicaid coverage groups must be explored for clients who become

ineligible for WVCHIP Pregnancy prior to the end of the period of eligibility. This does not mean that application for all coverage groups must be taken and processed. See Section 23.8. If the Medicaid evaluation results in an approval, the client receives a new Medicaid certification and redetermination period.

A WVCHIP Pregnancy client may be determined ineligible prior to the expiration of the eligibility period only if the pregnant woman:

- Moves out of state;
- Dies;
- Was approved for WVCHIP due to agency error;
- Was approved for WVCHIP because of client misrepresentation;
- Does not have verification of citizenship and/or identity after match with the FDH (refer to Chapter 6.3);
- Is approved for Supplemental Security Income (SSI) and is eligible for SSI Medicaid;
- Requests closure.

NOTE: The WVCHIP Pregnancy group does not close solely because the client begins receiving a Third-Party Insurance.

22.17.11.B Change in Income or Needs Group

22.17.11.B.1 Increase in Income or Reduction in Needs Group (NG)

Any change in circumstances not listed in Section 22.17.11.A above does not affect eligibility once the period of continuous eligibility is established. This includes an increase in income or a reduction in the number of people included in the NG.

Increased Income Example: A WVCHIP Pregnancy woman is approved in March. In August, the husband changes jobs and the income of the family now exceeds 300% of the FPL. The continuous eligibility remains the same.

Return of Absent Father Example: A WVCHIP Pregnancy woman is approved. A week after approval, her estranged husband returns. The husband works, and his income exceeds 300% of the FPL. The continuous eligibility remains the same.

The case information in the eligibility system must be updated based on changes reported by the client and by other valid sources during the certification period, even though the client is eligible for continuous coverage.

22.17.11.C Newly Eligible for Medicaid

When a WVCHIP Pregnancy woman becomes income eligible for Medicaid during the continuous eligibility period, the woman remains in WVCHIP Pregnancy for the duration of the pregnancy and the 12-month postpartum period. If the client chooses to close WVCHIP coverage they are not eligible for the remainder of the 12-month postpartum in Medicaid.

22.17.12 Benefit Repayment

Medicaid Estate Recovery provisions do not apply to WVCHIP Pregnancy. Repayment by the client of incorrectly paid medical claims is the responsibility of WVCHIP and/or the DOHS fiscal agent.

22.17.13 Benefit Replacement

The Medical ID card must be replaced any time a client reports she has not received the card or received the card and it is lost, stolen, or destroyed, and she requests a replacement.

When the client reports non-receipt of the Medical ID card, the Worker must check the eligibility system to determine if a card was issued and/or if an incorrect entry is found, the Worker must correct the information and reissue the benefit.

If the client's address is incorrect and the card has not been returned to Accounts Receivable or the local office, the Worker must correct the address in the eligibility system and issue a replacement card or verification letter for the correct period of eligibility.

22.17.14 Determining Disability, Incapacity and Blindness

Disability, incapacity and blindness are not eligibility requirements for WVCHIP Pregnancy.

22.17.15 Work Requirements

There is no work requirement for WVCHIP Pregnancy.

APPENDIX A: DEFINITIONS OF INSURANCE FOR WVCHIP

CREDITABLE (NON-EXCEPTED) INSURANCE BENEFITS

Benefits that affect WVCHIP eligibility include, but are not limited to, the following:

- A group health plan
- Health Insurance Coverage
- Medicare
- Medicaid
- Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Tricare or other health benefit plans for the United States uniformed services
- A medical care program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- The Federal Employees Health Benefits Program
- A public health plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage
- A health insurance benefits program for Peace Corps volunteers

EXCEPTED INSURANCE BENEFITS

Benefits that do not affect WVCHIP eligibility are as follows:

- Coverage only for accident, or disability income insurance, or any combination of the two
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Limited scope dental or vision benefits when offered separately from other insurance
- Benefits for long-term care, nursing home care, home healthcare, community-based care, or any combination of these when offered separately from other insurance
- Coverage only for a specified disease or illness if offered as independent, non-coordinated benefits

- Other benefits, similar to those above, under which benefits for medical care are supplemental or incidental to other insurance benefits and are provided under a separate policy

GROUP HEALTH INSURANCE COVERAGE

Health insurance coverage offered in connection with a group health plan.

GROUP HEALTH PLAN

An employee welfare benefit plan that provides medical care and services to employees or their dependents, as defined under the plan, directly or through insurance, reimbursement, or otherwise. Can be public or private.

HEALTH INSURANCE COVERAGE

Benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization (HMO) contract, offered by a health insurance issuer.

INDIVIDUAL HEALTH INSURANCE COVERAGE

Health insurance coverage offered to individuals. It does not include short-term, limited-duration insurance.

MEDICAL CARE

Amounts paid for any of the following:

- The diagnosis, cure, mitigation, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body
- Transportation primarily for and essential to medical care
- Insurance covering medical care as defined above

APPENDIX B: WVCHIP MONTHLY INCOME LIMITS AND ENROLLMENT GROUPS

AG Size	WVCHIP Gold	WVCHIP Blue WVCHIP Pregnancy Blue	WVCHIP Premium WVCHIP Pregnancy Premium
	Limited Co-Pays	Full Co-Pays	Full Co-Pays and Premiums
	Net Income Less Than or Equal To 150% FPL	Net Income Less Than or Equal to 211% FPL	Gross Income Less Than or Equal to 300% FPL
1	$1,995	$2,807	$3,990
2	$2,705	$3,806	$5,410
3	$3,415	$4,804	$6,830
4	$4,125	$5,803	$8,250
5	$4,835	$6,802	$9,670
6	$5,545	$7,800	$11,090
7	$6,255	$8,799	$12,510
8	$6,965	$9,798	$13,930
9	$7,675	$10,797	$15,350
10	$8,385	$11,795	$16,770
11	$9,095	$12,794	$18,190
12	$9,805	$13,793	$19,610
13	$10,515	$14,792	$21,030
14	$11,225	$15,790	$22,450
15	$11,935	$16,789	$23,870
16	$12,645	$17,788	$25,290
17	$13,355	$18,787	$26,710
18	$14,065	$19,785	$28,130
19	$14,775	$20,784	$29,550
20	$15,485	$21,783	$30,970

Chapter 23

Specific Medicaid Requirements

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
23.1				
23.2				
23.3				
23.4				
23.5				
23.6				
23.7				
23.8	10/1/20 1/1/23	794 830	23.8.2.C 23.8.3 23.8.2.C	Removed section Replaced word illegal Remove West Virginia from WV Foster Care.
23.9	10/1/20 9/1/22 1/1/23	794 827 830	23.9 23.9 23.9	Replaced word illegal Added Children with Serious Emotional Disorder Remove West Virginia from WV Foster Care.
23.10	7/1/19 6/5/20 10/1/20 4/1/22 1/1/23 8/1/23	774 789 794 820 830 839	23.10.3 23.10.14 23.10.13 23.10.3.A.2 23.10.5 23.10.12	Medicaid Pregnant Women increased from 158% to 185% of the FPL. Add requirement for COVID-19 testing Removed coverage Change postpartum period Added former foster children from other states must be covered in West Virginia if they aged-out on or after January 1, 2023 Update and clarify BCC policies and procedures.
23.11	9/1/22 1/1/23	827 830	23.11.5.C 23.9	Added language to include new Medicaid coverage group. Remove West Virginia from WV Foster Care.
23.12	4/1/18 3/1/19 3/1/22	755 769 818	23.12.1.A, 23.12.2.A, 23.12.3.A 23.12.1 23.12.3 23.12. 23.12	Reflect the December 2017 change in the way Medical ID cards are issued. Removed incorrect language about QMB income limit The upper income limit for QI-1 was corrected Updated Asset Limits for QMB, SLMB & QI Updated Asset Limits for QMB, SLMB & QI

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	3/1/23	832	23.12	Updated Asset Limits for QMB, SLMB & QI
	1/1/24	845	23.12	Updated Asset Limits for QMB, SLMB & QI
	10/1/24	857	23.12.1	Added language on how recipients of SSI and recipients entitled to premium-free Medicare Part A and/or in Part B are automatically eligible for QMB without an application and is managed through the MMIS system.
	1/1/25	859	23.12.1	Updated Asset Limits for QMB, SLMB & QI
			23.12.2	Updated Asset Limits for QMB, SLMB & QI
			23.12.3	Updated Asset Limits for QMB, SLMB & QI
	5/1/25	865	23.12.1	Removed a word and punctuation.
	6/1/25	864	23.12.3.B	Removed policy of backdating of QI-1 into the previous calendar year.
	1/1/26	872	23.12.1	Updated the resource standards for single and married QMB's.
			23.12.2	Updated the resource standards for single and married SLMB.
			23.12.3	Updated the resource standards for single and married QI.
23.13	10/1/20	794	23.13	Replace word illegal
23.14	6/1/24	851	23.14	Updated the FPL percentage to 500% for the ADAP program.
Appendix A	4/1/20	784		Replaced RAPIDS with eligibility system

23.1 INTRODUCTION

The West Virginia Medicaid Program provides payment for covered medical services to certified medical providers for eligible individuals, including adults, eligible members of families with dependent children, and those who are aged, blind, or disabled.

The determination of which medical services are covered under Medicaid and which medical providers are certified to accept Medicaid patients is the responsibility of the Bureau for Medical Services (BMS) and is not addressed in this Manual. Unless otherwise specified, the coverage group receives all services covered under Medicaid and is considered “full Medicaid.”

This chapter provides an overview of the Medicaid Program. In addition, each coverage group has specific requirements that must be met and procedures to follow that may not apply to other Income Maintenance programs or other Medicaid coverage groups. This includes income and asset criteria. No group is subject to a spenddown unless specifically noted. Information for West Virginia Children’s Health Insurance Program (WVCHIP) and AIDS Drug Assistance Program (ADAP) is also contained in this chapter.

In addition to the coverage groups described in this chapter that make up the Medicaid Program, WVCHIP, and ADAP, the Department of Human Services (DOHS) has special procedures in place to pay for certain necessary drugs for individuals not eligible for other benefits. See Chapter 28, Special Pharmacy.

Refer to Chapter 24 for information regarding eligibility for long-term care services, which include nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID) services and aged and disabled (ADW), traumatic brain injury (TBI) and intellectual and developmental disabilities (I/DD) waiver coverage groups, as well as Children with Disabilities Community Services Program (CDCSP).

Certain programs, including long-term care programs, require a medical and/or other determination by a community agency or government organization other than the Division of Family Assistance (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 be evaluated for any or all DFA programs.

23.2 ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

Provided they are legally able to do so, all adult Medicaid applicants and clients must assign to the Department of Human Services (DOHS) any right to medical support and payments for medical care from any third party. All other adults who have the legal rights to make assignment of medical support for themselves or for any other individual eligible for Medicaid must do so. An applicant for Supplemental Security Income (SSI) is required to assign third-party rights to the Department as part of his application for SSI.

NOTE: Applicants must provide accurate health insurance information at application and redetermination. Workers must enter any third-party insurance into the eligibility system.

23.3 CHILD SUPPORT REQUIREMENTS AND PROCEDURES

Medical support rights exist as a court order directed to the absent parent to provide monetary contributions or insurance for the benefit of the child. Any monetary contributions will be collected by the Bureau for Child Support Enforcement (BCSE) and then returned to Medicaid.

Clients may voluntarily request BCSE services. The client must complete a signed application to be returned to BCSE to process these services. The Worker must explain to the client the process for voluntarily requesting BCSE services.

Services provided by BCSE may be found on the WV BCSE website. Federal law mandates that efforts be made to locate absent parents, establish paternity, and obtain medical support for dependent children who receive Medicaid. These services are provided by the BCSE at no charge to the client. The client may apply by submitting a paper application, App-1-Interactive, to the BCSE. Enrollment into Medicaid coverage must not be delayed for an otherwise eligible individual pending cooperation with BCSE.

The legally responsible adult included in the case with the dependent child must be offered the opportunity to voluntarily receive BCSE services.

The Worker has the following responsibilities:

- When the responsible adult, who can legally assign rights, expresses an interest in voluntarily receiving services, provide a BCSE application, the App-1-interactive, and an explanation of where the application is submitted.
- To respond to any eligibility system alert indicating health insurance information has been entered by BCSE..

23.3.1 BCSE REFERRALS

Referrals to the BCSE are voluntary, free of charge, and must be made by paper application. The BCSE will ensure that information regarding their services and methods of application will be provided to all applicants.

23.3.2 BCSE CASE CLOSURE OF MEDICAID

BCSE closes a case after voluntary referral for reasons such as, but not limited to, the following:

- The non-custodial parent or alleged father is deceased and no further action, including a levy against the estate, can be taken.
- Paternity cannot be established because the alleged father's identity is unknown.
- The non-custodial parent's location is unknown and BCSE has been unsuccessful in locating the person after exhausting all efforts.
- The non-custodial parent is a citizen of, and lives in, a foreign country; does not work for the federal government or a company with headquarters or offices in the United States; has no reachable domestic income or assets; and there is no reciprocity with the other country.
- The non-custodial parent cannot pay support for the duration of the child's minority and the person has no income or assets that can be levied or attached for support for one of the following reasons:
    - The non-custodial parent is incarcerated and there is no chance for parole for the duration of the child's minority.
    - The non-custodial parent is receiving SSI and there is no income or assets to pay support, and a doctor's statement or statement from the Social Security Administration (SSA) is provided to state that the non-custodial parent is permanently and totally disabled.
    - The non-custodial parent has a medically verified permanent and total disability with no evidence of support potential.

When BCSE closes a case for one of the above stated reasons, the BCSE Child Support Specialist updates the system. After update, information about the absent parent is no longer exchanged with the child support enforcement system. The Worker cannot change the update. The code is retained in the eligibility system. If the Worker receives information about the absent parent that he believes is pertinent and that may require action by BCSE, he sends a Referral and Communications Form DHS-1, to the Child Support Specialist.

23.3.3 REDIRECTION OF SUPPORT AND INCOME WITHHOLDING

When a Medicaid referral is made to BCSE, the Child Support Specialist immediately implements income withholding for any child support the child may be receiving, whenever possible. This action may not be declined or terminated by the Medicaid client. Collection of support must, thereafter, be made through BCSE and distributed as non-public assistance (NPA) payments.

23.3.4 COMMUNICATION WITH THE CHILD SUPPORT SPECIALIST

Communication between the Worker and the Child Support Specialist continues until the case is closed and/or the child whose parent(s) is absent is removed from the benefit group.

The Worker must notify the Child Support Specialist, in writing, if any information is discovered in establishing paternal and/or medical support.

The Child Support Specialist must notify the Worker, in writing, of the following:

- Information that affects eligibility or the amount of the payment
- Change of address
- Paternity is established
- Information regarding a change in the cause of absence, if applicable, is secured

When health insurance information is entered by BCSE, an interface between the child support enforcement system and the eligibility system occurs and the eligibility system sends an alert to the Worker.

The eligibility system automatically refers changes in case circumstances to BCSE.

23.4 DATA SYSTEM INTERACTION

When health insurance information is entered by BCSE, the eligibility system alerts the Worker. Bureau for Child Support Enforcement (BCSE) and Bureau for Medical Services (BMS) data systems do not interface. The Worker must enter the health insurance information on the eligibility system, which will interface with BMS.

BMS must verify health insurance with the carrier before entering it in the BMS Third-Party Liability (TPL) data system. The eligibility system notifies the Worker when BMS updates TPL information, when there is an insurance carrier or policy number mismatch, or when the TPL information is not verified. If the Worker has any information that conflicts with the BMS-verified information, he must provide the information to the BMS TPL Unit by email or fax so that BMS can resolve any discrepancy. This ensures accurate information is entered in both data systems.

23.5 CERTIFICATE OF COVERAGE WHEN MEDICAID ENDS

All Medicaid clients who so request must be issued a Certificate of Coverage DFA-HIP-1 when Medicaid coverage stop.

23.6 HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

This program is used to assist Medicaid-eligible individuals who cannot afford available employer group health coverage. The Bureau for Medical Services (BMS) pays health insurance premiums, along with deductibles and co-payments, for Medicaid-eligible individuals when the available policy is determined cost effective.

This program can also assist recently unemployed individuals with Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits available from a former employer. Under COBRA provisions, most employees have 60 days to decide if they want to pay to continue under the employer's health plan after employment is terminated. Once an individual chooses to continue benefits, the benefits can be renewed for the next 18 months.

In addition to premiums, deductibles, and copayments, Medicaid pays for services not included in the insurance policy, but covered under Medicaid. To qualify for HIPP, there must be group health insurance available that covers at least one person who is Medicaid-eligible in West Virginia.

The individual may also call the DOHS's Third Party Liability (TPL) contractor at (304) 342-1604 to request an application or to obtain additional information about program requirements and the eligibility determination process.

23.7 RELATIONSHIP WITH THE CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM (CSHCN) (FORMERLY OFFICE OF HANDICAPPED CHILDREN)

The Children with Special Health Care Needs (CSHCN) program provides specialized medical care and care coordination services to children under 21 with certain chronic, debilitating conditions who meet financial and medical eligibility criteria. A child may be simultaneously eligible for, and receiving services from, the Medicaid Program and CSHCN. A child may be a CSHCN client when he applies for a Division of Family Assistance (DFA) Program. The West Virginia Children's Health Insurance Program (WVCHIP) uses the same policies and procedures with respect to CSHCN as Medicaid does. See Chapter 22 for further details about WVCHIP.

When an applicant's eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply for DFA Programs due to his pending status with the CSHCN Program, but must be evaluated for any or all DFA Programs.

23.7.1 NON-CSHCN CLIENTS WHO ARE APPLICANTS FOR DFA PROGRAMS

During the application process, when a Worker refers a child to the CSHCN Program, he gives the applicant the CSHCN-1 application form. A referral to the CSHCN Program must include the Medicaid eligibility status. If Medicaid is approved, the referral includes eligibility dates and, and if denied, it includes the reason for the denial.

If the child is approved for CSHCN and the Medicaid eligibility status changes from the time of referral, the Worker calls the CSHCN Program with the reason for the change.

Any time a Worker determines that a child may benefit from CSHCN services, the Worker makes a referral by telephone at (304) 558-5388, or toll-free at 1-800-642-9704 or 1-800-642-8522. The eligibility determination for CSHCN services is made by a CSHCN Specialty Consultant.

Covered CSHCN medical conditions are listed in the table below.

Covered CSHCN Medical Conditions	
Acute Fractures	Diabetes
ADHD	Hearing Loss
Asthma	Heart Defects

Covered CSHCN Medical Conditions	
Autism	Hemophilia
Bones (problems with)	Joints or Muscles
Cerebral Palsy	Kidney/Urological Conditions
Childhood Malignancies	Mental or Behavior Diagnosis
Cleft Lip/Palate	Myelodysplasias/Spina Bifida
Cystic Fibrosis	Neurological & Seizure conditions
Cosmetic Surgery	Plastic Surgery (certain conditions)
Dental Treatment (certain conditions)	Sickle Cell Anemia

23.7.2 CSHCN CLIENTS WHO ARE APPLICANTS FOR MEDICAID

When a CSHCN client applies for Medicaid, the Worker must call the CSHCN Program with the eligibility decision and eligibility dates or reason for the denial.

When a CSHCN client's Medicaid assistance group (AG) is closed and the client is no longer eligible for Medicaid, the CSHCN Program is notified by telephone and the reason for the closure is given.

The Children with Special Health Care Needs Program may be contacted at:

Children with Special Care Needs
Office of Maternal, Child and Family Health
West Virginia Bureau for Public Health
350 Capitol Street, Room 427
Charleston, WV 25301-3714
Toll-Free 1 (800) 642-9704 or 1 (800) 642-8522
OR (304) 558-5388

23.8 MEDICAID ELIGIBILITY BETWEEN COVERAGE GROUPS

The Worker must consider all the following information in determining eligibility and in establishing eligible cases.

23.8.1 CONSIDERATION OF ALL MEDICAID COVERAGE GROUPS

The client cannot be expected to know which Medicaid coverage group to apply for. When the client expresses an interest in applying for Medicaid, the Worker must explore eligibility for all Medicaid coverage groups.

The Worker does not have to take and process applications for all coverage groups, but Medicaid eligibility cannot be denied until the client has been considered for each coverage group. If the client is eligible under more than one coverage group, he is approved for the one that will provide him with the most benefits in the shortest time frame.

Certain programs, including long-term care programs, require a medical and/or other determination by a agency other than Division of Family Assistance (DFA) as part of the eligibility process. The financial determination is made by the Department of Human Services (DOHS). 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.

23.8.2 CONSIDERATION OF MAGI AND NON-MAGI COVERAGE GROUPS

Applicants who have income below the Modified Adjusted Gross Income (MAGI) standard and are determined eligible for coverage in a MAGI coverage group should be promptly enrolled into the MAGI coverage group. MAGI Medicaid groups are:

- Adult Group
- Parents/Caretaker Relatives
- Pregnant Women
- Children Under Age 19

West Virginia Children's Health Insurance Program (WVCHIP) is also a MAGI group.

The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group.

Clients who are determined to meet the eligibility requirements for coverage in both a MAGI category and a non-MAGI category at application may choose to enroll in the non-MAGI category.

The DOHS must request all additional information needed to evaluate the client's potential eligibility for a non-MAGI group when the client:

- Requests such a determination;
- Submits the application developed for non-MAGI coverage groups;
- Indicates potential eligibility on the single-streamlined application or renewal form; or,
- If the DOHS otherwise has information indicating such potential eligibility. For example, a referral for long-term care services from a community agency.

23.8.2.A Eligible for Non-MAGI Group

If the client is determined eligible for a non-MAGI coverage group, they are enrolled into this coverage group and the MAGI group is closed.

23.8.2.B Ineligible for Non-MAGI Group

If the client is ineligible for a non-MAGI coverage group, or a determination cannot be made because all necessary information was not provided, the client remains enrolled in the MAGI coverage group. The client is not required to provide any additional information needed to make a full eligibility determination for the non-MAGI coverage group.

23.8.2.C Notification

Information regarding potential eligibility for non-MAGI coverage groups, and the benefits and services afforded to the applicant in the non-MAGI coverage groups, will be provided to the applicant in the MAGI notice. Information regarding additional information needed to determine eligibility and how to apply will be provided to the applicant. The information should be sufficient to enable the applicant to make an informed choice.

When the applicant is determined ineligible for Medicaid or WVCHIP, their electronic account will be transferred to the Marketplace for a determination of eligibility for Advanced Premium Tax Credits (APTC) or Cost-Sharing Reductions (CSR).

The following tables show the coverage groups included in this chapter.

Full Medicaid	
Adults, Families, and Children	Parents/Caretaker Relatives (MAGI)
	Children Under Age 19
	Pregnant Women
	Adult Group
	Former Foster Children
	Continuously Eligible Newborns (CEN) (Parent is Categorically or Medically Needy)
	AFDC-Related – for Children and Adults
	Transitional (Phase I and Phase II)
	Extended Medicaid
	Adoption Assistance
	Foster Care
	Adoption Assistance (Non-IV-E)
	Foster Care (Non-IV-E)
	Breast or Cervical Cancer
Aged, Blind, or Disabled	Supplemental Security Income (SSI) Recipients
	Disabled Adult Children
	Blind Disabled Substantial Gainful Activity
	Essential Spouses of SSI Recipients
	Pass-Throughs
	Pickle Amendment Coverage
	Disabled Widows and Widowers
	Drug Addicts and Alcoholics
	SSI-Related/Non-Cash Assistance
	SSI-Related
	Long Term Care

Full Medicaid	
	Nursing Facility
	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
	Aged and Disabled Waiver (ADW)
	Intellectual and Developmental Disabilities (I/DD) Waiver
	Traumatic Brain Injury (TBI) Waiver
	Children with Disabilities Community Services Program (CDCSP)
	Medicaid Work Incentive Program (M-WIN)

Partial Medicaid Coverage	
Medicare Premium Subsidies	Qualified Medicare Beneficiaries (QMB)
	Specified Low-Income Medicare Beneficiaries (SLIMB)
	Qualified Individual (QI-1)
	Qualified Disabled Working Individuals (QDWI)
Emergency Care	Noncitizen Emergency Coverage

Non-Medicaid Health Programs	
Comprehensive Coverage	
Children	WVCHIP
	WVCHIP-Deemed Newborn
Pharmacy	
AIDS/HIV	AIDS Drug Assistance Program (ADAP)
Transplant and Antipsychotics	Special Pharmacy
Premium Assistance	
Commercial Premium Subsidies	Health Insurance Premium Payment (HIPP)

23.8.3 WHO RECEIVES LIMITED COVERAGE

All Medicaid coverage groups receive the full services the State offers to its Medicaid clients except the following coverage groups: QMB, SLIMB, QI-1, QDWI, and non-qualified noncitizens. The state also provides two other limited healthcare benefits, Special Pharmacy and ADAP. In addition, if applicable, any coverage group's long-term care services can be limited when a penalty for an uncompensated transfer of resources is applied. Refer to Chapter 24 to determine when to apply such a penalty.

23.8.4 BACKDATING MEDICAID COVERAGE

Unless specifically stated under the appropriate coverage group, Medicaid coverage may be backdated for up to three months prior to the month of application, provided all eligibility requirements were met at that time, and provided the client has accrued medical expenses.

23.9 RELATIONSHIP BETWEEN COVERAGE GROUPS

All Medicaid coverage groups are assigned to one of two categories: Categorically Needy and Medically Needy.

- **Categorically Needy Medicaid** clients are families and children; aged, blind, or disabled individuals; and pregnant women who are eligible to receive Medicaid because they fall into a certain category and meet financial criteria.

  The federal government mandates West Virginia to cover some Categorically Needy coverage groups; other coverage groups are optional.

- **Medically Needy Medicaid** clients are those who would be eligible for Categorically Needy benefits except that their income and/or assets are too high. Even though their resources are too high for Categorically Needy Medicaid eligibility, they have high medical needs and cannot afford to pay their medical bills. These individuals are allowed to "spenddown" their excess income to the Medically Needy Income Level (MNIL) by incurring medical expenses. The spenddown process is explained in Chapter 4.

The following tables show the relationship between the categories and coverage groups.

Medicaid Categorically Needy	
Mandatory (Federal Requirement)	**Optional (State Option with Federal Approval)**
Adults, Families, and Children Coverage Groups ** Administered by Office of Social Services*	
Parents/Caretaker Relatives	Adoption Assistance other than IV-E*
Children Under Age 19	Foster Care other than IV-E*
Pregnant Women	Children with Disabilities Community Services Program (CDCSP)
Adult Group	
Former Foster Children	
Continuously Eligible Newborn (CEN) Children (Parent is Categorical)	
Extended Medicaid	
IV-E Adoption Assistance*	
IV-E Foster Care*	
Transitional Medicaid	
Non-qualified Noncitizens – Emergency	

Medicaid Categorically Needy	
Mandatory (Federal Requirement)	**Optional (State Option with Federal Approval)**
Coverage	
Aged, Blind, or Disabled Coverage Groups	
SSI Recipients Deemed SSI Recipients • Disabled Adult Children • Blind Disabled Substantial Gainful Activity • Essential Spouses of SSI Recipients • Pass-Throughs • Pickle Amendment • Disabled Widows and Widowers • Drug Addicts and Alcoholics Qualified Medicare Beneficiaries (QMB) Specified Low-Income Medicare Beneficiaries (SLMB) Qualified Individual (QI) Qualified Disabled Working Individuals (QDWI)	SSI Related/Non-Cash Assistance Home and Community-Based Waivers • Aged and Disabled • Traumatic Brain Injury • Intellectual/Developmental Disability • Children with Serious Emotional Disorder Nursing Facility Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Breast and Cervical Cancer (BCC) Program Medicaid Work Incentive (M-WIN)

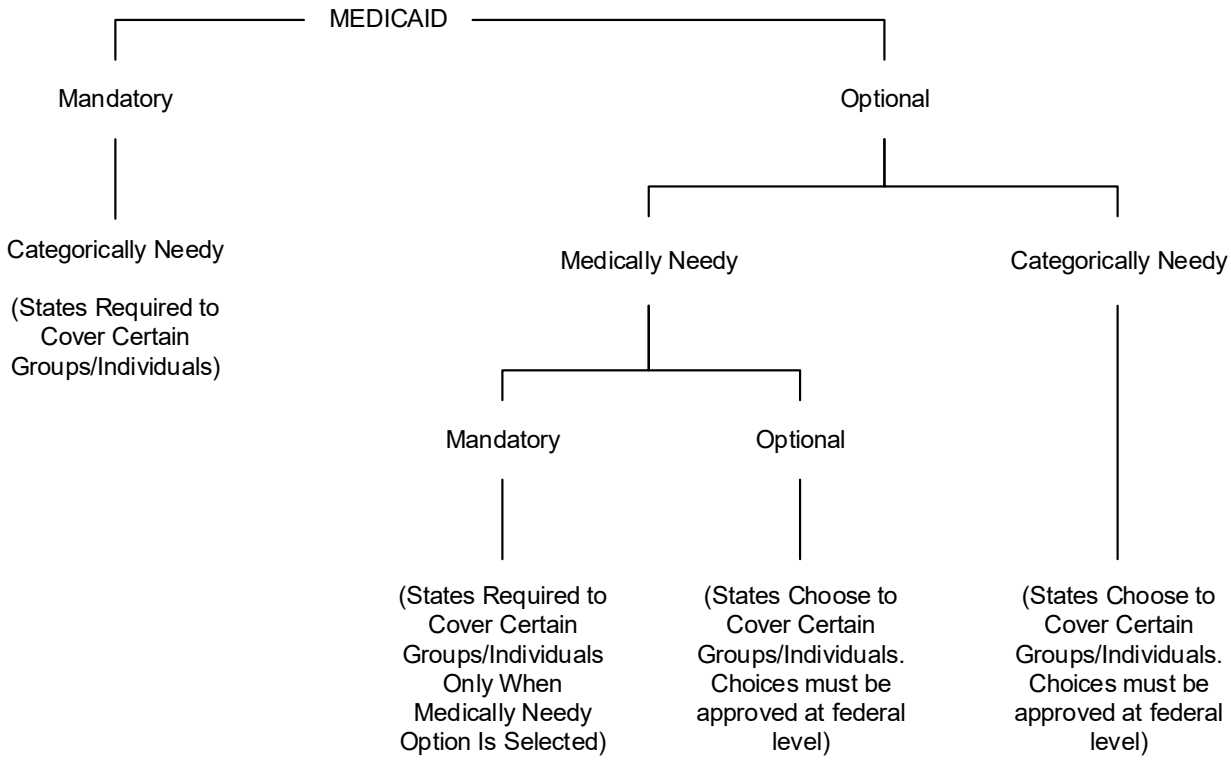
States do not have to provide coverage for any Medically Needy groups; they are optional. West Virginia has elected to cover the Medically Needy. When a state elects to provide coverage to the Medically Needy, the federal government mandates coverage of some individuals; other individuals are optional, as described in the table below.

Medicaid Medically Needy	
Mandatory (If State opts for Medically Needy Program)	**Optional (State Option with Federal Approval)**
Adults, Families, and Children Coverage Groups	
AFDC-Related Medicaid: Children Under 19 or Pregnant Women	AFDC-Related Medicaid: Parents and Caretaker Relatives
Continuously Eligible Newborns (CEN) Born to Medically Needy Women	
Aged, Blind, or Disabled Coverage Groups	
	SSI-Related Medicaid: Aged, Blind, or Disabled Individual

West Virginia also provides three optional non-Medicaid health care programs listed in the table below.

Optional Non-Medicaid Health Care Programs
WV Children's Health Insurance Program (WVCHIP)
AIDS Drug Assistance Program (ADAP)
Special Pharmacy

The following diagram illustrates the relationship between Categorically and Medically Needy Medicaid.



23.10 ADULTS, FAMILIES AND/OR CHILDREN

23.10.1 PARENTS/CARETAKER RELATIVES

Income	Assets
Parent/Caretaker Relative Medicaid Limit	N/A

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. Effective January 1, 2014, the Parents/Caretaker Relatives coverage group replaced the former Aid to Families with Dependent Children (AFDC) Medicaid coverage group for parents and other caretaker relatives.

A parent or caretaker relative is eligible under this coverage group when the following requirements are met:

- The parent or caretaker relative must be living in the household with a dependent child for whom he assumes primary responsibility. See Chapter 3 for the definition of a dependent child and specified caretaker relative.
- The income eligibility requirements described in Chapter 4 are met.

23.10.2 CHILDREN UNDER AGE 19

Income		Assets
Children < 1	158% FPL	N/A
Children 1-5	141% FPL	
Children 6 – 19	133% FPL	

Effective January 1, 2014, the Affordable Care Act combined prior coverage for children under the AFDC group, Qualified Child, and Poverty-Level Children coverage groups into one Children Under Age 19 coverage group. Twelve months of continuous Medicaid eligibility applies.

If a child is receiving inpatient services on the date he would lose eligibility due to age, eligibility must continue until the end of that inpatient stay.

A child is eligible for Medicaid coverage in this group when all of the following conditions are met:

- The child is not eligible for Supplemental Security Income (SSI) Medicaid;
- The child is under age 19, regardless of school attendance or course completion date; and,
- The income eligibility requirements described in Chapter 4 are met.

23.10.3 PREGNANT WOMEN

Income	Assets
185% FPL	N/A

Effective January 1, 2014, as a result of the ACA, the Pregnant Women coverage group combines prior coverage for pregnant women, Poverty-Level Pregnant Women, and Deemed Poverty-Level Pregnant Women into one coverage group.

A pregnant woman is eligible for Medicaid coverage in this when the income eligibility requirements described in Chapter 4 are met. Changes in income after eligibility has been established have no effect on continuing eligibility.

23.10.3.A Postpartum Coverage

This coverage applies only to the mother. The child must be covered as a Continuously Eligible Newborn (CEN).

23.10.3.A.1 Eligibility for Postpartum Coverage

The pregnant woman is eligible for postpartum coverage provided that during the pregnancy or within three months of the end of the pregnancy, the woman met all the following requirements:

- She applied for Medicaid (any coverage group);
- She was eligible for Medicaid (any coverage group);
- She received Medicaid services (any covered service, not limited to pregnancy services); and,
- She was determined eligible for coverage in West Virginia, regardless of coverage in other states.

If the mother applies within three months after the end of the pregnancy and is determined to have been eligible in one of the past months, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

A Pregnant Woman is not referred to, or required to cooperate, with child support activities while pregnant nor during the postpartum period.

A Pregnant Woman cannot have Medicaid terminated or denied for failure to cooperate with Quality Control (QC) until the end of the postpartum period. After the postpartum period the sanction is applied, even if she qualifies under another coverage group.

23.10.3.A.2 Duration of Postpartum Coverage

A woman continues to be eligible for Medicaid or WVCHIP for 12-month postpartum, and the remaining days of the month in which the 12-month day falls. The 12-month postpartum period begins the following month after the pregnancy ends, and a redetermination is completed in the twelfth month of the postpartum period. If eligible for other Medicaid, or WVCHIP, that coverage must not begin until expiration of the postpartum period.

If no review takes place, Medicaid coverage will automatically close after the advance notice period.

23.10.4 ADULT GROUP

Income	Assets
133% FPL	N/A

As a result of the ACA, the Adult Group was created effective January 1, 2014. Eligibility for this group is determined using Modified Adjusted Gross Income (MAGI) methodologies established in Section 4.7.

Medicaid coverage in the Adult Group is provided to individuals who meet the following requirements:

- They are age 19 or older and under age 65;
- They are not eligible for another categorically mandatory Medicaid coverage group:
  - SSI
  - Deemed SSI
  - Parents/Caretaker Relatives
  - Pregnant Women
  - Children Under Age 19
  - Former Foster Children
- They are not entitled to or enrolled in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met.

Parents or other caretaker relatives living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, WVCHIP, or otherwise enrolled in minimum essential health coverage (MEC).

23.10.4.A.1 Pregnant Women

If a woman indicates at application that she is pregnant, she is not eligible to be included in the Adult Group; she must be evaluated for the Pregnant Women coverage group. If a woman currently receiving Medicaid in the Adult Group later reports a pregnancy to the Department of Human Services (DOHS), follow instructions in Section 10.8.4. However, there is no requirement for a woman to report her pregnancy to the DOHS.

23.10.5 FORMER FOSTER CHILDREN

Income	Assets
N/A	N/A

The ACA established a new coverage group called the Former Foster Children group effective January 1, 2014.

In accordance with Section 1002 of the SUPPORT Act West Virginia must cover Former Foster Children who received Medicaid at the time they aged out of foster care, regardless of the state the individual lived in at the time of age-out effective for youth who turn 18 on or after January 1, 2023.

> **Example 1**: Gardenia was in foster care in Kentucky. She turns age 18 on April 19, 2023, and ages out. On August 6, 2023, she moves to West Virginia and applies for Former Foster Care. Because she aged-out after January 1, 2023, she is eligible for the benefit in West Virginia.
>
> **Example 2**: Daisy was in foster care in Kentucky. She turns 18 on November 21, 2022, and ages out. On February 12, 2023 she moves to West Virginia and applies for Former Foster Care. Because she aged-out prior to January 1, 2023, she is ineligible for Former Foster Care in West Virginia but evaluated for another Medicaid category.

Applicants must meet the following requirements:

- They are under 26 years of age;
- They have been in foster care under the responsibility of a state; and,
- They were receiving Medicaid on their 18th birthday, or the date they aged out of foster care, up to age 21.

Individuals eligible for both the Former Foster Children group and the Adult Group must be enrolled in the Former Foster Children group.

23.10.6 CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN)

Income	Assets
N/A	N/A

23.10.6.A Eligibility Criteria

A CEN (birth –12 months) is eligible for Medicaid until he reaches age 1, when all the following conditions are met:

- The child is not eligible for SSI Medicaid;
- If the child's mother was eligible for and receiving Medicaid from West Virginia in the month the child was born, an application is considered to have been made for the child. The application may be made up to three months after the child's birth; and,
- The child resides continuously in West Virginia during the entire CEN period. If the child leaves WV and returns, CEN coverage cannot be reinstated.

23.10.6.B Special Conditions

- Under SSI, a child born to an institutionalized woman is eligible on the date of birth only. Eligibility under all other Medicaid coverage groups must be explored immediately for these children.
- CENs must not be required to live with a specified relative.
- The child is not required to have a social security number (no enumeration requirement).
- There is no requirement that the CEN be evaluated for the Children Under Age 19 group. He must remain a CEN until he reaches age 1, as long as all CEN eligibility requirements are met.
- If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

23.10.7 AFDC-RELATED MEDICAID

Income	Assets	
Medically Needy Income Level (MNIL) Possible Spenddown	$2,000 – 1 person $3,000 – 2 people	Increases $50 for each additional coverage group member

Only children under 19, who would be eligible for Medicaid except that countable income/assets are too high, are required to be covered under AFDC-Related Medicaid. However, West Virginia has elected to cover caretaker relatives of such children. The caretaker relative(s) and the dependent children for whom they care are treated as a family unit.

Parents or Other Caretaker Relatives and dependent children and pregnant women are eligible for Medicaid when all the AFDC-Related Medicaid eligibility requirements are met, except as follows:

- No AFDC-Related case is denied due only to excess income. Instead, incurred medical bills are deducted from the family's income for the six-month Period of Consideration. This process is called spenddown and details of this procedure are in Chapter 4.
- Eligibility and the amount of the spenddown, if any, are determined using the MNIL, not the cash assistance payment level. The level of the MNIL is determined by each state, according to federal guidelines. By law, the MNIL cannot exceed 133% of the State's cash assistance payment level, rounded to the nearest $100 for a family of the same size.

Individual family members may be eligible for SSI-Related Medicaid as aged, blind, or disabled. Refer to Chapter 13. The Worker must take the action that will most benefit the client.

23.10.8 DEEMED PARENTS/CARETAKER RELATIVES

23.10.8.A Extended Medicaid

Income	Assets
N/A	N/A

An assistance group (AG) is eligible for Extended Medicaid for four months when both of the following conditions are met:

- The AG lost eligibility for Parents/Caretaker Relatives Medicaid due to receipt of new or increased spousal support; and,
- The AG received Parents/Caretaker Relatives Medicaid in at least three of the months during the six-month period that immediately preceded the first month of ineligibility for this coverage group Medicaid.

Extended Medicaid clients are not required to cooperate with or referred to Bureau of Child Support Enforcement (BCSE).

23.10.8.B Children Covered Under Title IV-E Adoption Assistance and Title IV-E Foster Care

Income	Assets
N/A	N/A

Families that receive Title IV-E Adoption Assistance or Foster Care payments from West Virginia receive a Medicaid card for the child only. This is provided by Social Services. Unless the child is also an SSI recipient, the Income Maintenance staff has no responsibilities related to determining this coverage.

When a child receives Title IV-E Adoption Assistance or Foster Care, and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Adoption Assistance or Foster Care from West Virginia, medical coverage is provided as a recipient of Title IV-E payments.

- When the assistance is provided by another state, coverage is provided as an SSI recipient.

23.10.9 TRANSITIONAL MEDICAID (TM)

Income	Assets
Phase I – N/A Phase II – 185% FPL	N/A

This coverage group consists of families losing eligibility for Parents/Caretaker Relatives Medicaid because of earned income. When a child loses eligibility as a Child Under Age 19 and his family is receiving TM, he is included in the AG, if otherwise eligible.

TM provides continuing medical coverage after Parents/Caretaker Relatives Medicaid eligibility ends and occurs in two phases, as described below.

There is no application required for Transitional Medicaid. When a Parents/Caretaker Relatives Medicaid case becomes ineligible, the Worker must automatically determine eligibility for TM. If the case is closed in error instead of being converted to a TM case, the case must be reopened without reapplication by the client.

Clients of TM are not referred or required to cooperate with BCSE.

23.10.9.A Phase I Coverage

23.10.9.A.1 Eligibility Requirements

To be eligible for Phase I coverage, all the following conditions must be met:

- The AG became ineligible for Parents/Caretaker Relatives Medicaid due to the amount of income from employment;
- In determining ineligibility for Parents/Caretaker Relatives Medicaid, the Worker must consider income of the AG and any individual who would normally be included in the AG, but who has been penalized;

- The AG received Parents/Caretaker Relatives Medicaid in any three or more months during the six-month period immediately preceding the first month of ineligibility for Parents/Caretaker Relatives Medicaid;
- The AG did not receive Parents/Caretaker Relatives Medicaid fraudulently during any of the six months prior to the first month of Parents/Caretaker Relatives Medicaid ineligibility; and,
- The family has a dependent child who would be included in the Parents/Caretaker Relatives Medicaid AG, if the family were eligible.

When the AG becomes ineligible for Medicaid for a combination of reasons, the Worker must determine if the amount of earned income (or the addition of an individual with earnings who has received Parents/Caretaker Relatives Medicaid in three of the past six months) had an effect on the ineligibility. Only when this is the case is the AG eligible for TM.

The steps below are to be followed to determine if such factors had an effect on ineligibility for Parents/Caretaker Relatives Medicaid:

STEP 1: Determine if the increase in earned income would have resulted in loss of Parents/Caretaker Relatives Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in Parents/Caretaker Relatives Medicaid standards.).

IF YES: The AG meets the requirement.

IF NO: Go to **STEP 2.**

STEP 2: Determine if events other than the increase in earned income would have resulted in loss of Parents/Caretaker Relatives Medicaid if earned income had stayed the same.

IF YES: The AG does not meet the requirement.

IF NO: Go to **STEP 3.**

STEP 3: Determine if the AG is ineligible for Parents/Caretaker Relatives Medicaid when all changes are considered.

IF YES: The AG meets the requirement. The increase in earnings was essential to the loss of Parents/Caretaker Relatives Medicaid eligibility. Without that increase, the AG would not have lost eligibility.

23.10.9.A.2 Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances result in case closure (after advance notice) before the expiration of the Phase I coverage. There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

➢ No Dependent Child

When there is no child in the home who would be eligible for Medicaid, the AG loses eligibility. Eligibility ends at the end of the first month in which the AG no longer includes such a child.

> **No Dependent Child Example:** Last dependent child leaves the home on February 10. The case is closed effective February. Advance notice is required.

➢ Fraud

When it is determined that Parents/Caretaker Relatives Medicaid benefits received in one or more of the six months prior to the start of Phase I coverage were received fraudulently, the AG is ineligible. Eligibility ends on the last day of the month in which the advance notice period expires.

➢ Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for Parents/Caretaker Relatives Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the AG becomes ineligible. Eligibility ends on the last day of the month in which the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

23.10.9.A.3 Eligible Situations

Provided the AG meets all of the eligibility requirements identified above, it is eligible for Phase I TM in the following situations:

- The AG was eligible for and receiving Parents/Caretaker Relatives Medicaid and the beginning of employment or change in payment rate had an effect on Parents/Caretaker Relatives ineligibility.
- The earned income of an individual who received Parents/Caretaker Relatives Medicaid in three of the last six months, and who is added to the AG, has an effect on the AG's Parents/Caretaker Relatives Medicaid ineligibility.
- The case becomes ineligible for Parents/Caretaker Relatives Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.
- The case becomes ineligible for one month only due to a temporary increase in hours worked or rate of pay.

23.10.9.A.4 Ineligible Situations

The AG is not eligible for Phase I coverage in the following situations:

- The AG becomes ineligible because of the earnings of an individual being added to the AG who has not received Parents/Caretaker Relatives Medicaid in three of the last six months.
- The AG becomes ineligible for a reason other than those listed above.
- There is an indication, with supporting evidence, that the AG received Parents/Caretaker Relatives Medicaid fraudulently during at least one of the six months prior to the first month of Parents/Caretaker Relatives Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to Investigations and Fraud Management (IFM) or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the AG is not eligible for Phase I coverage.

  There is no provision to discontinue Phase I coverage due to the AGs becoming eligible for Parents/Caretaker Relatives Medicaid again. Instead, the AG is dually eligible for Parents/Caretaker Relatives Medicaid and TM. See below for the significance of dual eligibility.

23.10.9.A.5 Beginning Date of Phase I Coverage

An AG is eligible for Phase I coverage beginning the month following the last month of Parents/Caretaker Relatives Medicaid eligibility. When Parents/Caretaker Relatives Medicaid is

continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the first month after advance notice would have expired and the client should have lost eligibility.

23.10.9.A.6 Client's Reporting Requirements/Periodic Review Letters

The client is required to report his gross earnings and day care costs for the first three months of Phase I coverage by the first workday after the 20th of the fourth month. He is also required to report the earnings and day care costs of any person in the home who is included in the Parents/Caretaker Relatives Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last three months of Phase I coverage by the first workday after the 20th of the first month of Phase II coverage.

The client reports using Periodic Review Letters. The periodic review letter dates throughout this section will vary due to adverse action deadline and non-workdays. See Appendix A.

The eligibility system mails the client the first required periodic review letter by the third Friday of the third month.

If the client returns the completed letter, he has met one of the eligibility requirements for Phase II coverage.

Failure to return the completed letter, without good cause, by the first workday after the 20th of the fourth month, automatically renders the AG ineligible to participate in Phase II, after advance notice, but has no effect on Phase I coverage.

The Worker must notify the client of the consequences of his actions when the letter is not returned by the due date without good cause or is returned but is incomplete. The client has a right to a Fair Hearing on this issue because future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The Worker and Supervisor make the good cause determination and must be based on reasonable expectations. Good cause generally will involve situations over which the client has little control.

The eligibility system notifies the Worker when the form is due. If the client provides the completed form within the 13-day notice period, he has met this part of the eligibility requirement for Phase II.

23.10.9.A.7 Special Agency Notification Requirements

During the fourth month of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

23.10.9.B Phase II Coverage

When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

23.10.9.B.1 Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The AG received Phase I coverage for the entire six-month Phase I period. The six-month period includes months for which the client was dually eligible for Phase I and Parents/Caretaker Relatives Medicaid, if applicable;
- The client completed and returned, in a timely manner, the periodic review letters sent to him, or had good cause for not returning it. The form is considered to be returned in a timely manner when it is received within the advance notice period;
- The family has a dependent child living in the home;
- The earned income amount meets the financial test as described in Chapter 4. For Phase II coverage, information from the PRL3 is used. Information from the PRL3 determines eligibility for months 7 – 12 of Phase II TM coverage. Information from the PRL8 determines continued eligibility for months 9 – 12 of Phase II and the PRL9 determines eligibility for month 12 of TM;
- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established; and,
- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client.

23.10.9.B.2 Beginning Date of Phase II Coverage

An AG is eligible for Phase II coverage beginning the first month after Phase I coverage ends. When Phase II coverage is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond six months past the end of Phase I coverage.

23.10.9.B.3 Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs. This information is used to determine financial eligibility for Phase II coverage. The PRL3 is mailed by the third Friday of the third month and must be completed and returned by the first workday after the 20th of the fourth month, unless the client establishes good cause.

The PRL8 is mailed by the third Friday of the six month and the completed form is due by the first workday after the 20th of the seventh month. The PRL9 is mailed by the third Friday of the 9th month and the completed form is due by the first workday after the 20th of the 10th month. All PRL forms must be returned by the due date, unless the client establishes good cause.

The Worker and Supervisor make the good cause determination, which must be based on reasonable expectations. Good cause generally will involve situations over which the client has little control.

The Worker must file the PRL forms in the case record. An eligibility system alert notifies the Worker that the forms are due.

23.10.9.B.4 Automatic Termination of TM

The eligibility system will automatically terminate TM eligibility at the end of eighth month if the PRL8 is not returned by the due date.

The eligibility system will automatically terminate TM at the end of the eleventh month if the PRL9 is not returned by the due date.

At the end of the TM Phase II, the eligibility system will automatically terminate coverage.

NOTE: When TM eligibility ends for any reason other than expiration of the time period, the Worker must evaluate eligibility of the AG for all other Medicaid coverage groups.

23.10.9.C Return to Parents/Caretaker Relatives Medicaid, Phase I and II

If an AG returns to Parents/Caretaker Relatives Medicaid during Phase I or Phase II, but otherwise meets the requirements for TM, the AG is dually eligible for Parents/Caretaker Relatives Medicaid and TM. If the AG again becomes ineligible for Parents/Caretaker Relatives Medicaid, Worker action depends upon the case circumstances at the time of the subsequent case closure as follows:

23.10.9.C.1 Otherwise Eligible for TM

If the AG meets all of the eligibility requirements listed in Section 16.10.9.A.1 above, the family is eligible for a new TM period, beginning with Phase I for six months and continuing through Phase II, if the Phase II requirements are met.

23.10.9.C.2 Not Otherwise Eligible for TM

When either of the two following conditions is met at the time of the subsequent case closure, the AG is eligible only for the remainder of the original TM period.

- The AG loses eligibility for a reason not related to employment.
- The AG loses eligibility for a reason related to employment but does not meet the requirement of having received Parents/Caretaker Relatives Medicaid in three of the preceding six months.

> **Dual Eligibility Example:** A Parents/Caretaker Relatives Medicaid AG becomes ineligible when the parent obtains full-time employment. The family receives TM for seven months, from March through September, but returns to Parents/ Caretaker Relatives Medicaid for two months, October and November. At the time the parent's job starts again, at the end of November, he has no longer

received Parents/Caretaker Relatives Medicaid in three of the six months prior to ineligibility. One of the eligibility requirements for TM is no longer met. However, because the AG was dually eligible for TM and Parents/Caretaker Relatives Medicaid, TM coverage continues for December, January, and February.

23.10.10 ADOPTION ASSISTANCE OTHER THAN IV-E

Income	Assets
N/A	N/A

Special-needs children under age 21 who have State adoption assistance agreements (other than those under Title IV-E) in effect and who cannot be placed for adoption without Medicaid coverage are eligible for Medicaid.

The Office of Children and Adult Services is responsible for eligibility determination for this coverage group for producing the Medicaid card. The Worker has no responsibilities related to this coverage group.

23.10.11 FOSTER CARE OTHER THAN IV-E

Income	Assets
N/A	N/A

Persons who receive foster care payments through the Department, but from a funding source other than Title IV-E, receive a Medicaid card for the foster child only. The Office of Children and Adult Services is responsible for eligibility determination for this coverage group and for producing the Medicaid card. The Worker has no responsibilities related to this coverage group.

23.10.12 WOMEN WITH BREAST CANCER OR CERVICAL CANCER: BREAST AND CERVICAL CANCER MEDICAID (BCC)

Income	Assets
N/A	N/A

A woman is eligible for Breast and Cervical Cancer Medicaid (BCC) if she is diagnosed with Breast or Cervical Cancer or certain pre-cancerous conditions, receiving cancer treatment and currently enrolled in the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). The client must also be:

- Uninsured or has insurance that meets an exception listed in Chapter 22 Appendix A,
- Under age 65,
- Not receiving Medicare, and
- Not eligible for any mandatory Medicaid Coverage groups.

No penalty applies for discontinuing insurance. Medicaid Coverage is not limited to charges related only to cancer treatment, and there is no limit to the number of eligibility periods for which a client may qualify.

Once a county office receives the initial required documentation from WVBCCSP, including the CDC Certificate of Diagnosis, the completed DFA-BCC-1 and the Letter of Eligibility verifying that the client is enrolled in the WVBCCSP, the Worker places the client in the Presumptive Phase of BCC. The client then submits a Medicaid application to determine if the client is eligible for a mandatory Medicaid coverage group. If the client is found eligible for a mandatory Medicaid coverage group, the Presumptive BCC is closed, and the client is placed in the new Medicaid Group. If it is determined that the client is not eligible for a mandatory Medicaid type, the Worker updates the client from Presumptive BCC to the Regular BCC.

IMPORTANT NOTE: *To be eligible for BCC Medicaid, you must first be a patient of the WVBCCSP. WVBCCSP has separate eligibility guidelines from BCC Medicaid. While BCC Medicaid does not have an income limit, the WVBCCSP has an income limit of 250% FPL. For more information on the West Virginia Breast and Cervical Cancer Screening Program, contact the WVBCCSP at 304-558-5388 or 1-800-642-8522.*

23.10.13 COVID-19 Testing Medicaid Coverage Group

The COVID-19 Testing Group is an optional Medicaid eligibility group established by section 6004(a)(3) of the Families First Coronavirus Response Act (FFCRA). The COVID-19 Testing Group provides coverage for uninsured individuals otherwise ineligible for health coverage for the purposes of receiving testing for coronavirus (COVID-19). Coverage under the COVID-19 Testing Group may be effective no earlier than March 18, 2020.

Applicants must meet the following requirements:

- They must be a West Virginia resident.
- They must be a U.S. citizen, U.S. national, or qualified immigrant.
- They must meet enumeration requirements.
- They must meet the definition of “uninsured individual”;
    - Uninsured individual is defined as any individual that does not have minimum essential coverage under Section 5000A(f)(1) of the Internal Revenue Code of 1986.
        - Government Sponsored programs:
        - Medicare Part A;
        - Medicaid;
        - CHIP;
        - Medical coverage received from an employer, including TRICARE;
        - Medical coverage received by Secretary of Veterans Affairs;
        - Health plan received from Peace Corps Volunteers;
        - Nonappropriated Fund Health Benefits Program of the Department of Defense;
- Employer-Sponsored Plan
    - Coverage under an eligible employer-sponsored plan
- Plans in the individual market
    - Coverage under a health plan offered in the individual market within a State
- Grandfathered health plan
    - Coverage under a grandfathered health plan

- Other coverage
    - Such other health benefits coverage such as a State health benefits risk pool
- They must not be actively enrolled in any Medicaid coverage groups;
- They must not be required to be assessed for other Medicaid coverage;
- They must be allowed to self-attest to income and insurance status.

23.11 AGED, BLIND, OR DISABLED

23.11.1 SSI RECIPIENTS

Income	Assets
SSI Payment Level	$2,000 Individual $3000 Couple

Supplemental Security Income (SSI) is a public assistance program administered by the Social Security Administration (SSA), which provides cash benefits to eligible aged, disabled, or blind individuals. There is no spenddown provision.

States have some options regarding Medicaid coverage for SSI recipients. West Virginia elected to cover all SSI recipients and to accept SSA's determination of eligibility for SSI as the sole eligibility determination for Medicaid. West Virginia is referred to as a "1634 state," based on the section of the Social Security Act that permits this.

Consequently, there is no application or eligibility determination process for SSI Medicaid. The Department depends upon SSA for the information needed to open, evaluate, and close continuing eligibility for SSI Medicaid cases. SSI Medicaid eligibility ends when SSI ends in most situations. See Section 10.14 for exceptions and closure procedures.

The Worker uses information from a data exchange between Department of Human Services (DOHS) and SSA to open the SSI Medicaid benefit.

Trust provisions apply to SSI Medicaid and must be explored prior to SSI Medicaid approval and at redetermination. Chapter 24 contains provisions related to an SSI recipient entering a nursing facility.

23.11.2 DEEMED SSI RECIPIENTS

23.11.2.A Disabled Adult Children (DAC)

Income	Assets
N/A	N/A

An individual is eligible for Medicaid as a Disabled Adult Child (DAC) when all of the following conditions are met:

- He is at least 18 years old;
- He became disabled or blind before reaching the age of 22;
- He was eligible for SSI based on disability or blindness; and,
- He lost SSI eligibility as a result of becoming entitled to or receiving an increase in child's insurance benefits.

Eligibility is determined by SSA and communicated to the DOHS through data exchange.

The client must not be required to apply for this coverage group.

23.11.2.B Blind, Disabled – Substantial Gainful Activity (SGA)

Income	Assets
N/A	N/A

Persons who receive SSI due to a disabling impairment, but who also engage in substantial, gainful activity, are eligible for Medicaid even though their SSI payments may stop. Eligibility for this coverage group is determined by SSA.

There are no special procedures for this coverage group and the client is not required to apply for Medicaid.

23.11.2.C Essential Spouse of SSI Recipients

Income	Assets
N/A	N/A

Under West Virginia's former Old Age Assistance (OAA), Aid to the Disabled (AD), and Aid to the Blind (AB) Programs, Essential Spouses are spouses of the aged, disabled, or blind person, who were not themselves aged, disabled, or blind. Essential Spouses were “grandfathered” into the SSI program based on eligibility for benefit categories that no longer exist. This means that the SSI benefit received by the eligible individual is based on the payment level of eligible spouses and is intended to meet the needs of husband and wife.

Essential Spouses are included in the SSI Medicaid case with their eligible spouses as long as they are included in the SSI payment.

Individuals continue to qualify as Essential Spouses until one of the following occurs:

- The eligible spouse becomes ineligible for SSI. Once the eligible spouse goes into a non-payment or terminated status, his spouse can never again qualify for SSI or Medicaid as an Essential Spouse of an SSI recipient.
- The eligible spouse and the Essential Spouse are no longer living together. The Essential Spouse becomes ineligible when SSA determines that the separation is not temporary or after 90 days, whichever occurs first. The Essential Spouse status cannot be regained if the couple begins living together again.
- The Essential Spouse becomes eligible for SSI in his own right.

Eligibility for this coverage group is determined by SSA. There are no special procedures for this coverage group and the client is not required to apply for Medicaid.

23.11.2.D Pass-Throughs

Income	Assets
SSI Payment Level	$2,000

Former SSI recipients who meet all of the following conditions are eligible for Medicaid:

- In August 1972, the individual was entitled to Retirement, Survivors, and Disability Insurance (RSDI) benefits.
- The individual would currently be eligible for SSI except that the increase in RSDI benefits that occurred on July 1, 1972, under Public Law 92-336, raised his income over the limit allowed under the SSI Program.

The central Buy-In Unit in BMS is responsible for identifying Pass-Through cases and for taking action necessary to continue Medicaid coverage for them. Refer to Chapter 25 for a more complete explanation of the Buy-In Unit's responsibilities. If a Pass-Through case is not enrolled in Medicare, the Buy-In Unit notifies the Worker to refer the client to SSA for Medicare enrollment.

The Worker accomplishes the referral using an SSA-1610, Public Assistance Agency Information Request and Report, with the following notation in red in the top right-hand corner of the form: "Referral for Medicare Enrollment - Buy-In."

It is possible that the Buy-In Unit will not identify a case that could be a Pass-Through case. When this happens, the Worker notifies the Buy-In Unit.

23.11.2.E Pickle Amendment Coverage (PAC)

Income	Assets
SSI Payment Level	$2,000 Individual $3000 Couple

An individual is eligible for Medicaid coverage under Pickle Amendment Coverage (PAC) if all of the following conditions are met:

- He was eligible for and received RSDI and SSI at the same time, for at least one month after April 1977.

An individual who received SSI, and was found retroactively eligible for RSDI for a month in which SSI was received, is considered to have received SSI and RSDI concurrently. RSDI payments are received the month following the month of entitlement. For example, the RSDI entitlement for December is received in January.

- He lost SSI for any reason, but would currently be eligible if the total amount of all RSDI Cost of Living Adjustments (COLAs) since the loss of SSI were deducted from his RSDI. This includes a COLA that results in the loss of SSI.
- The individual currently receives RSDI benefits.

When determining the COLAs to be deducted, include the increases received by the individual and his financially responsible spouse or parent. The procedure used is detailed in Section 4.11.

23.11.2.F Disabled Widows and Widowers

Income	Assets
N/A	$2,000

A widow or widower who loses SSI benefits when RSDI benefits begin is eligible for Medicaid when all of the following conditions are met:

- The client is a widow or widower who is at least age 50, but not age 65;
- He is no longer eligible to receive SSI benefits due to receipt of RSDI;
- He is receiving RSDI as an eligible widow/widower or is receiving any other type of RSDI benefits, but is also otherwise eligible for widow/widower benefits;
- He would be eligible for SSI benefits were it not for the receipt of RSDI;
- He received SSI benefits in the month prior to the first month of RSDI benefits; and,
- He is not entitled to Medicare, Part A.

The widow/widower remains eligible until entitled to Medicare, Part A. Eligibility is determined by SSA and communicated to the Department through data exchange. The client must not be required to apply for this coverage group. The Worker's only eligibility responsibility is to verify entitlement to Medicare, Part A.

NOTE: The Worker may discover other widows/widowers in his caseload that are eligible in this category but who do not meet the requirements listed above. These are widows/ widowers who lost SSI eligibility due to changes in the SSA reduction formula as part of the Social Security Amendments of 1983. Intake for this second group of widows/widowers ended 7-1-88. These individuals are eligible as long they reside in West Virginia.

23.11.2.G Drug Addicts and Alcoholics (DA&A)

Income	Assets
SSI Payment Level	$2,000 Individual

Drug addicts and alcoholics who meet one of the following conditions are eligible for Medicaid:

- They were found by SSA to be disabled, and drug addiction or alcoholism was material to the disability determination;
- They would be eligible for SSI except that they are suspended due to non-compliance with the treatment requirements or for the mandatory period for demonstrating compliance; or,
- Their SSI benefits were terminated due to the 36-month limit for SSI benefits provided under the SSI drug addiction and alcoholism provisions.

Potential eligibility is determined by SSA and communicated to the DOHS through data exchange. The client must not be required to apply for this coverage group.

23.11.3 SSI-RELATED

Income	Assets
MNIL Subject to Spenddown	$2,000 Individual $3,000 Couple

Individuals who meet the SSI definition of aged, blind or disabled are eligible for Medicaid when all of the following conditions are met. Aged means 65 years or over.

- Countable income is under the Medically Needy Income Limit (MNIL).

  The income eligibility requirement is detailed in Chapter 4. However, no SSI-Related case is denied due only to excess income. Instead, the Worker must deduct incurred medical bills from countable income for the six-month Period of Consideration. This process is called spenddown and details of this procedure are in Chapter 4.

Eligibility and the amount of the spenddown, if any, are determined using the MNIL. The level of the MNIL is determined by each state according to federal guidelines. By law, the MNIL cannot exceed 133% of the State's former AFDC cash assistance payment level, rounded to the nearest $100, for a family of the same size.

NOTE: Under some circumstances the MNIL for two people is used when determining eligibility for only one person. This is also explained in Chapter 4.

- Countable assets do not exceed the limits described in Chapter 5.

An aged, blind, or disabled person may also be eligible as a member of an AFDC-Related family. The Worker must take the action that will most benefit the client.

23.11.4 SSI-RELATED/NON-CASH ASSISTANCE

Income	Assets
SSI Payment Level	$2,000 Individual $3,000 Couple

NOTE: This coverage group is not subject to the spenddown provision.

Individuals who meet the SSI definition of aged, blind, or disabled are eligible for Medicaid when all of the following conditions are met. Aged means 65 years or over. All requirements in Chapter 13 for determining disability or blindness for SSI-Related coverage groups apply to this coverage group:

- Countable income must be under the SSI Maximum Payment level; see Chapter 4, Appendix A. The SSI-Related income eligibility determination methodology detailed in Section 4.14 applies to this coverage group. Income sources are the same as those in the SSI-Related column in the chart of income sources in Section 4.3 for this coverage group.
- Countable assets do not exceed the limits for the SSI-Related program described in Chapter 5. All SSI-Related asset methodologies found in Chapter 5 apply to this coverage group. Assets are the same as those in the SSI-Related group’s column in the list of assets in Chapter 5.5 for this coverage group.

23.11.5 LONG TERM CARE

23.11.5.A Nursing Facility (Code: MLTN) and Intermediate Care Facility/Individuals with Intellectual Disability (ICF/IID) (Code: MLTI)

Income	Assets
300% SSI Payment Level	$2,000 Individual $3,000 Couple

The Department of Human Services (DOHS) provides Medicaid to institutionalized individuals who would not otherwise be eligible for Medicaid if not in an institution. To qualify, an individual must meet the medical criteria for nursing facility or ICF admission, as well as financial criteria. SSI-Related Medicaid disability guidelines also must be met.

The determination of which income to count is the same as SSI-Related Medicaid, see Chapter 4. No income is deemed to the client. The client's monthly gross non-excluded income is compared to 300% of the maximum SSI payment for a single individual.

The determination of countable assets is the same as for SSI-Related Medicaid, see Chapter 5. The SSI-Related Medicaid asset limit for one person is used. When both spouses are institutionalized and apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility.

Details are found in Chapter 24.

23.11.5.B SSI-Related/Monthly Spenddown Group

Income	Assets
MNIL for one person	$2,000 Individual

An aged, blind or disabled individual residing in a nursing facility may have his eligibility determined as an SSI-Related/Monthly Spenddown Group client as another way to receive financial assistance for the cost of nursing facility services, see Section 24.7.

All SSI-Related policies and procedures apply to these cases, including the determination of a spenddown amount, with the following exceptions:

- Income is not deemed.
- The MNIL for one person is always used.
- The spenddown amount is determined on a monthly basis.

When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates for all Medicaid are found only on the DFA intranet page. The rates are updated semi-annually.

23.11.5.C Individuals Receiving Home and Community-Based Services under Title XIX Waivers

Income	Assets
300% SSI Payment Level	$2,000 Individual

The DOHS has elected to provide Medicaid to individuals who would be eligible for Medicaid if institutionalized and who would require institutionalization was it not for the availability of home and community-based services. To qualify, an individual must be aged/disabled, intellectually/ developmentally disabled, or have a traumatic brain injury. The waiver programs are:

- ADW (Aged and Disabled Waiver) (Code: MALH, MALW – pending waiver slot)
- I/DD (Intellectual/Developmental disability) Waiver (Code: MALM)
- TBI (Traumatic Brain Injury) Waiver (Code: MALH w/reason code 709)
- CSED (Children with Serious Emotional Disorder) Waiver (Code: MALM w/reason code 730)

Details about the AD (aged/disabled) Waiver, I/DD (intellectual/developmental disability) Waiver, CSED (Children with Serious Emotional Disorder) Waiver, and TBI (traumatic brain injury) Waiver are found in Chapter 24.

The determination of which income to count is the same as SSI-Related Medicaid, see Chapter 4. No income is deemed to the client. The client's monthly gross non-excluded income is compared to 300% of the maximum SSI payment for a single individual.

The determination of countable assets is the same as for SSI-Related Medicaid, see Chapter 5. The SSI-Related Medicaid asset limit for one person is used.

23.11.5.D Children with Disabilities Community Service Program (CDCSP)

Income	Assets
300% SSI Payment Level	$2,000 Individual

The DOHS has chosen the option of providing Medicaid to disabled children, up to the age of 18, who require an institutional level of care but can receive necessary medical services while residing in their family (natural or adoptive) homes or communities. The medical services must not be more expensive for the State than placement in a medical institution, such as a nursing facility, ICF/IID facility, and acute care hospital or approved Medicaid psychiatric facility for children under the age of 21.

This coverage group allows children to remain with their families by providing medical services in the home or community that are at least as cost-effective as care in a medical institution. It also eliminates the SSI requirement that the income and assets of parents and/or legal guardians be deemed to the children.

A child is eligible for Medicaid as a CDCSP client when all the following conditions are met:

- The child has not attained the age of 18.
- The child's own gross income does not exceed 300% SSI payment level.
- The child has been determined to require a level of care provided in a medical institution, nursing facility, ICF/IID, hospital, or psychiatric facility.
- The child is expected to receive the necessary services at home or in the community.
- The estimated cost of services is no greater than the estimated cost of institutionalization.
- The child would be eligible for an SSI payment if in a medical institution.
- The child has been denied SSI eligibility because the income and assets of his parent(s) were deemed to him, and as a result, the SSI income or asset eligibility test was not met.

Details for CDCSP are found in Chapter 24.

23.11.6 MEDICAID WORK INCENTIVE PROGRAM (M-WIN)

Income	Assets
250% FPL – When Unearned Income is at or below the SSI Payment Level No Spenddown Provision	$2,000 – Individual $3,000 – Individual with Spouse

The Medicaid Work Incentive (M-WIN) full-coverage Medicaid group was established to assist individuals with disabilities in becoming independent of public assistance by enabling them to enter the workforce without losing essential medical care.

To be eligible, the individual must:

- Be at least age 16, but not yet age 65;
- Be disabled as defined by the SSA;
- Be engaged in competitive employment; and,
- Pay all required enrollment fees and premiums.

See Chapter 26 for details.

23.12 MEDICARE PREMIUM SUBSIDIES

Individuals who meet all other Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), and Qualified Individuals (QI) eligibility requirements, but who are not yet enrolled in Part B, must be referred to the Bureau of Medical Services (BMS) Medicare Buy-In Unit by sending an email to: DoHSmedicarebuyin@wv.gov. The message must contain the applicant's name, address, date of birth, and Social Security Number. The Buy-In Unit contacts Social Security to facilitate enrollment. This avoids any late enrollment penalty that may apply to the individual and permits enrollment outside the yearly open enrollment period.

23.12.1 QUALIFIED MEDICARE BENEFICIARIES (QMB)

Income	Assets
100% FPL	$9,950 – Individual $14,910 – Couple

Medicaid coverage is limited to payment of the Medicare, Part A and Part B premium amounts and payment of all Medicare co-insurance and deductibles, including those related to nursing facility services. The Buy-In Unit pays the Medicare premium. Refer to Chapter 25 for details.

An individual or couple (spouses) is eligible for this limited Medicaid coverage when all the following conditions are met:

- The individual must be entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B. He must be entitled to Medicare in any of the following three ways:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - By having end-stage renal disease;
- The individual or spouses must meet the income test detailed in Chapter 4; and,
- The individual or spouses must meet the asset test detailed in Chapter 5.

NOTE: SSI Medicaid recipients who are also entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B are automatically determined to have met the above requirements and are deemed eligible for Qualified Medicare Beneficiary (QMB) without an application. There will not be a QMB category dually coded with MSS in the eligibility system at this time, instead the deemed QMB eligibility is being maintained in the MMIS system. The deemed QMB coverage begins the first day of the month following the month of eligibility.

23.12.1.A Medical ID Card Issuance

The Medical ID card is included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

23.12.1.B Period of Eligibility

The beginning date of QMB eligibility is the first day of the month following the month the application is approved.

The usual three-month period for backdating eligibility does not apply to QMBs. However, Section 1.16 describes some situations in which backdating applies.

When the individual falls within the QMB income range and qualifies for that coverage, he cannot be approved for SLIMB to obtain backdated premium payment.

23.12.1.C Reimbursement of Medicare Premium Amount

Once the Buy-In Unit includes the QMB client in the State Buy-In process, and thus begins the State's payment of the client's Medicare premium to the Social Security Administration (SSA), SSA refunds all the Medicare premiums withheld during the time that the State should have paid the premium.

Such reimbursement to the client does not affect the client's eligibility.

23.12.1.D Changes to Buy-In Status

The eligibility system notifies the Buy-In Unit when the case is closed.

23.12.1.E Nursing Facility Services

Those eligible as QMBs are eligible to have their QMB coverage pay the Medicare deductible and/or co-insurance for nursing facility services if Medicare is paying for nursing facility services.

If the client applies for Medicaid nursing facility services as described in Chapter 24 and is found eligible, he is treated as a dual eligible. However, if the client does not apply for Medicaid nursing facility services or is not eligible for them, his QMB coverage pays the Medicare co-insurance and/or deductibles related to nursing facility costs without a client contribution for his cost of care. See Section 24.7.2.A for additional information.

23.12.2 SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB)

Income	Assets
101 – 120% FPL	$9,950– Individual $14,910 – Couple

Medicaid coverage is limited to payment of the Medicare Part B premium. An individual or couple (spouses) is eligible for this limited Medicaid coverage when all of the following conditions are met:

- The individual must be enrolled in Medicare, Part A. He must be entitled in any of the following three ways:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - By having end-stage renal disease;
- The individual or couple must meet the income test detailed in Chapter 4; and,
- The individual or couple must meet the asset test detailed in Chapter 5.

23.12.2.A Medical ID Card Issuance

No Medical ID card is issued to those whose sole Medicaid coverage group is SLIMB. The Buy-In Unit is responsible for buying-in to Medicare, Part B, for the client. See Chapter 25 for details.

23.12.2.B Period of Eligibility

The beginning date of SLIMB eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met. When SLIMB eligibility ends, it ends effective the first day of the month following the month in which ineligibility occurs, or whenever the advance notice period ends.

When the individual falls within the QMB income range and qualifies for that coverage, he is not approved for SLIMB to obtain backdated premium payment.

23.12.2.C Reimbursement of Medicare Premium Amount

The information in Section 23.12.1.C above also applies to SLIMB cases.

23.12.2.D Changes in Buy-In Status

The information in Section 23.12.1.D above also applies to SLIMB cases.

23.12.2.E Nursing Facility Services

Eligibility for SLIMB alone does not cover the Medicare co-insurance and/or deductibles associated with nursing facility services. However, the client may be dually eligible for SLIMB and Medicaid nursing facility services as described in Chapter 24.

23.12.3 QUALIFIED INDIVIDUAL (QI)

Income	Assets
121 –135% FPL	$9,950 – Individual $14,910 – Couple

Medicaid coverage is limited to payment of the Medicare Part B premium. An individual or couple (spouses) is eligible for limited* Medicaid coverage when all the following conditions are met:

- The individual must be enrolled in Medicare, Part A. He must be entitled in any of the following three ways:
  - By being age 64 years and 9 months old or older;
  - By having been totally and continuously disabled and receiving RSDI or Railroad Retirement benefits for 24 months or longer; or,
  - By having end-stage renal disease;
- The individual or couple must meet the income test detailed in Chapter 4;
- The individual or couple must meet the asset test detailed in Chapter 5; and
- The individual or couple is not eligible for any full-coverage Medicaid group

Medicaid coverage is limited to payment of the Medicare, Part B premium. The Buy-In Unit pays the Medicare premium. Refer to Chapter 25 for details.

23.12.3.A Medical ID Card Issuance

No Medical ID card is issued to those whose sole Medicaid coverage group is QI. The Buy-In Unit is responsible for buying-in to Medicare, Part B, for the client. See Chapter 25 for details.

23.12.3.B Period of Eligibility

Eligibility may be backdated up to three months prior to the month of application. When QI eligibility ends, it ends effective the first day of the month following the month in which ineligibility occurs, or whenever the advance notice period ends.

23.12.3.C Reimbursement of Medicare Premium Amount

Once the Buy-In Unit includes the QI client in the State Buy-in process, and, thus begins the State's payment of the client's Medicare premium to SSA, SSA refunds all of the Medicare premiums withheld during the time that the State should have paid the premium.

Such reimbursement to the client does not affect the client's eligibility.

23.12.3.D Changes in Buy-In Status

The eligibility system notifies the Buy-In Unit when the case is closed.

23.12.3.E Nursing Facility Services

Nursing facility services are not covered under QI.

23.12.4 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

Income	Assets
200% FPL	$4,000 Individual $6,000 Couple

Medicaid coverage is limited to payment of the Medicare, Part A, premium when the client is not eligible for premium free Part A. An individual is eligible for this limited Medicaid Coverage when all of the following conditions are met:

- He is under age 65;
- He is disabled and no longer entitled to Social Security disability benefits and Medicare because he is employed full time and his earnings exceed the SSA limits. Disability is established by verification of the reason for RSDI and Medicare termination;
- He is eligible to purchase Medicare, Part A, as determined by SSA;
- His income meets the limits detailed in Chapter 4;
- His assets meet the limit detailed in Chapter 5; and,
- He is not eligible under any other full-coverage Medicaid group.

The Buy-In Unit is responsible for payment of the Medicare, Part A, and premium amount. To begin this process the Worker must forward to the Supervisor, Buy-In Unit, BMS, the following items:

- A copy of the application with "QDWI" written at the top of the form. A copy must be retained in the case record.
- A copy of the Medicare termination notice. The original must be retained in the case record.
- A copy of the client's Medicare card, whether or not Medicare entitlement has expired. A copy must also be retained for the case record.

Once the Buy-In Unit completes the buy-in process and the client is accepted by SSA, SSA will notify the individual that the State is now paying his Medicare premium.

23.13 NON-QUALIFIED NONCITIZENS – EMERGENCY COVERAGE

Income	Assets
Income limit of the Medicaid group for which the noncitizen is applying (i.e., would otherwise be eligible)	Asset limit of the Medicaid group for which the noncitizen is applying

A noncitizen who is not otherwise eligible for Medicaid as a Qualified Noncitizen, refer to Chapter 15 is eligible when all of the following conditions are met.

- The noncitizen must meet the income, asset, and non-financial considerations (except for noncitizen status) of any full-coverage Medicaid group, with the exception of the long-term care groups; and,
- He must be diagnosed as having a severe medical condition that could reasonably be expected to result in one of the following, without immediate medical attention:
    - Serious jeopardy to the noncitizen's health
    - Serious impairment to bodily functions
    - Impaired or abnormal functioning of any body part or organ

  Such medical conditions include labor and delivery. In judging sufficient severity, severe pain must be considered.

Applications from or on behalf of these noncitizens must be made within 30 days of the need for emergency medical care.

Individuals who apply based on disability must be approved by MRT, unless they receive a statutory disability benefit. See Chapter 13.

23.14 NON-MEDICAID HEALTH PROGRAMS

23.14.1 WV CHILDREN'S HEALTH INSURANCE PROGRAM (WVCHIP)

WVCHIP is not Medicaid. See Chapter 22 for WVCHIP policy, including deemed newborns.

23.14.2 PHARMACY PROGRAMS

23.14.2.A AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Income	Assets
500% FPL	N/A

The ADAP is also referred to as the AIDS Special Pharmacy Program or the ADAP WV Special Pharmacy Program.

Medicaid coverage is limited to payment for medications listed on the current WV ADAP Formulary for HIV/AIDS treatment. An individual is eligible for this limited Medicaid coverage when all the following conditions are met:

- The individual must have been diagnosed as HIV positive;
- The income of the individual, his spouse, and his dependent children who live with him must meet the income limits detailed in Chapter 4; and,
- He must be ineligible for any other Medicaid full-coverage group or be eligible as a Medically Needy client who has not met his spenddown.

Except for acceptance of the initial DFA-2 Medicaid and the two-page ADAP applications, eligibility determination for this coverage group is administered by BMS. Potential eligibility for or receipt of Medicare, Part D, does not affect the application or referral process for ADAP eligibility determination. The resource development policies in Chapter 8 do not apply to ADAP. For information related to special communication between the Worker and BMS, refer to Chapter 1.

If the client becomes eligible under any other coverage group or meets his spenddown, the Worker must notify BMS immediately and must specify the beginning date of Medicaid eligibility.

23.14.2.B Special Pharmacy

The Special Pharmacy Program helps pay for certain necessary drugs for individuals not eligible for Medicaid. These costs are paid from State funds and cover only the costs of immunosuppressant (antirejection) drugs after a patient has received a transplant and antipsychotic (atypical) drugs.

See Chapter 28 for details.

APPENDIX A: GUIDE TO TRANSITIONAL MEDICAID

PHASE I

Parents/Caretaker Relatives

1. Received Parents/Caretaker Relatives Medicaid in at least three of the last six months.
2. No indication of Parents/Caretaker Relatives Medicaid fraud.
3. Assistance group (AG) has a dependent child.
4. Enroll and maintain enrollment in employer's free medical plan, if available.

PHASE II

1. Received Phase I coverage for entire six months.
2. All Periodic Reporting Letters (PRL) forms are returned.
3. AG has a dependent child.
4. Income less than 185% federal poverty level (FPL). Use income of Parents/Caretaker Relatives Medicaid Income Group.
5. Parent continues to have earnings – unless good cause exists.
6. Enroll and maintain enrollment in employer's free medical plan, if available.

TRANSITIONAL MEDICAID (TM) FLOW

PHASE I

FIRST MONTH:	Start TM.
SECOND MONTH:	No action necessary.
THIRD MONTH:	PRL3 mailed to client on the 25th of the month.
FOURTH MONTH:	Alert that PRL3 is due by 21st to report earnings and day care expenses for first three months of Phase I. If not received send advance notice to client of ineligibility for Phase II.
FIFTH MONTH:	Alert that Phase I ends next month. No action necessary.
SIXTH MONTH:	PRL8 mailed to client on 25th of the month. Due by the 21st of the first month of Phase II.

NOTE: There is no provision to discontinue Phase I for failure to continue working.

NOTE: Failure (without good cause) to return completed PRL3 by due date results in ineligibility for Phase II. No effect on Phase I.

PHASE II

FIRST MONTH (Total of 7 mos.):	Alert that PRL8 due by 21st of month. Send advance notice to terminate TM if completed form is not received.
SECOND MONTH (Total of 8 mos.):	No action necessary. Phase II termination if PRL8 not received and good cause not established.
THIRD MONTH (Total of 9 mos.):	PRL9 mailed to client on 25th of month. Due by 21st of fourth month.
FOURTH MONTH (Total of 10 mos.)	Alert that PRL9 is due by 21st of month. Send advance notice to terminate TM if completed form is not received.
FIFTH MONTH (Total of 11 mos.):	No action necessary. Phase II termination if PRL9 not received and good cause not established.
SIXTH MONTH (Total of 12 mos.):	Alert that Phase II, TM is ending. Benefits automatically terminate. Determine eligibility under other Medicaid coverage groups.

ELIGIBILITY SYSTEM TRANSITIONAL MEDICAID PROCESS

ELIGIBILITY SYSTEM ~~RAPIDS~~ Category	ELIGIBILITY SYSTEM ~~RAPIDS~~ PRL Form	Eligibility Review Period	PRL Issuance Data	PRL Due Date	Closure Date and Reason Code
MEI, MGME	PRL3	Form determines eligibility for 7 – 12 months	25th day of the 3rd month	21st day of the 4th month	End of the 6th month. Code 011 – Failure to Comply With Periodic Reporting Requirements
MEI, MGME	PRL8	Form determines eligibility for 9 – 12 months	25th day of the 6th month	21st day of the 7th month	End of the 8th month. Code 011.
MEI, MGME	PRL9	Form determines eligibility for month 12	25th day of the 9th month	21st day of the 10th month	End of the 11th month. Code 011.

Alerts sent related to the above chart:

065 – The Worker receives a task or reminder approximately three days prior to adverse action.

064 – The Supervisor receives a task or reminder approximately two days prior to adverse action.

Chapter 24

Long Term Care

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
24.1				
24.2				
24.3				
24.4	4/1/18	755	24.4.1.C.11	Reflect the December 2017 change in the way Medical ID cards are issued.
			24.4.2	Clarified the current policy regarding the redetermination process.
			24.4.3	Changed title to Special Procedures Related to Application and Redetermination Processing
	4/1/20	784	24.4.1.C.1	Changed inROADS to WV Path
	6/1/24	851	24.4.2	Added language regarding the auto renewal process for Nursing Facility Medicaid redeterminations.
	4/1/25	862	24.4.2	Removed language referencing reasonable compatibility provisions.
24.5				
24.6	3/1/24	848	24.6.2	Added clarification that a child under age 19 receiving CSED is eligible for 12 months continuous eligibility
24.7	7/1/18	761	24.7.7	All appropriate material and examples were changed to reflect the updated SMS and FMA amounts.
	3/1/19	769	24.7.7	Updated SMS figures.
	7/1/19	773	24.7.7	Updated SMS figures.
	7/1/20	790	24.7.7	Updated SMS and FMA amounts
	7/1/21	806	24.7.7	Changed to reflect the updated SMS, FMA, and Community Spouse Housing Allowance amounts
	7/1/22	824	24.7.7	Updated rates
	7/1/24	852	24.7.7	All appropriate material and examples were changed to reflect the updated SMS, FMA, and Community Spouse Housing Allowance amounts.
	7/1/25	866	24.7.7	All appropriate material and examples were changed to reflect the updated SMS, FMA and Community Spouse Housing Allowance amounts.
	7/1/25	868		Corrected calculations for current Min. SMS.
24.8	1/1/18	749	24.8.2.B.3	Adding new policy to existing text that the individual can establish their own trust on or after December 13, 2016.
	1/1/18	750	24.8.1.B 24.8.4	New SSI amounts
	4/1/18	755	24.8.2.E.1	Added a “Note” regarding the current requirement to

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
				send a copy of an annuity to the Estate Recovery vendor
			24.8.2.D.1, 24.8.2.H, 24.8.2.J.1 24.8.2.J.2	Change numbers related to the State's average monthly nursing private pay rate for the calculation of transfer penalty lengths
	8/1/18	762	24.8.2.B.4	Update transfer policy to disallow penalty adjustments for partial returns of assets.
	10/1/18	765	24.8.2.D.1 24.8.2.H 24.8.2.J	Changed numbers related to the State's average monthly nursing facility private pay rate for the calculation of transfer penalty lengths
	1/1/19	768	24.8.1.B 24.8.4	New SSI amounts
	10/1/19	778	24.8.2.D-J	Updated the dollar amounts related to the State's average monthly nursing facility private pay rate for the calculation of transfer penalty lengths.
	1/1/20	780	24.8.1&4 24.8.4	Minimum community spouse asset limit increased Home Equity asset limit increased
	10/1/20	794	2.8.2	Updated amounts
	1/1/21	799	24.8.1&4	Updated amounts
	10/1/21	810	24.8.2	Updated amounts
	1/1/22	813	24.8.1.B & 24.8.4	Updated amounts Updated amounts
	1/1/23	830	24.8.1.B 24.8.4	Updated amounts Updated amounts
	1/1/24	845	24.8.1.B 24.8.4	Updated community spouse asset limit Updated Home Equity asset limit
	2/1/24	846	24.8.2.D.1 24.8.2.H 24.8.2.J.1 24.8.2.J.2	Updated amounts
	10/1/24	855	24.8.2.D.1 24.8.2.H 24.8.2.J.1 24.8.2.J.2	Updated amounts
	1/1/25	859	24.8.1.B 24.8.4	Updated community spouse asset limit Updated Home Equity asset limit
	12/1/25	871	24.8.2 24.8.2.B.6 24.8.2.B.7 24.8.2.C	Added the look back period for transfer of resources. Added documentation must be provided to support transfer was not to qualify for Medicaid. Refined the syntax. Clarification of transfer of property that is not permissible.
	1/1/26	872	24.8.1.D	Updated Community Spouse Resource Minimum and Maximum standard.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			24.8.4	Updated the Home Equity asset limit which changed to $752,000.
24.9				
24.10				
24.11				
24.12				
24.13	4/1/18	755	24.13.1	Reflect the December 2017 change in the way Medical ID cards are issued.
24.14				
24.15				
24.16				
24.17				
24.18				
24.19				
24.20				
24.21				
24.22				
24.23				
24.24				
24.25				
24.26				
24.27				
24.28	9/1/22	827		Added language to table box for new Medicaid coverage group.
24.29				
24.30				
24.31	4/1/18 10/1/18	755 765	24.31.2, 24.31.2.A 24.31.2 24.31.2.A	Change numbers related to the State's average monthly nursing private pay rate for the calculation of transfer penalty lengths Changed numbers related to the State's average monthly nursing facility private pay rate for the calculation of transfer penalty lengths

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	10/1/19 10/1/20 10/1/21 7/1/22 11/1/23 2/1/24 10/1/24	778 794 810 824 842 846 855	24.31.2, 24.31.2.A 24.31.2 24.31.2 24.31.1&2 24.31 24.31.2 24.31.2.A 24.31.2 24.31.2.A	Updated the dollar amounts related to the State's average monthly nursing facility private pay rate for the calculation of transfer penalty lengths. Updated amounts Updated amounts Updated amounts Updated CSED Updated amounts Updated amounts Updated amounts Updated amounts
24.32				
24.33				
24.34				
24.35				
24.36	7/1/20	790	24.36	Replaced title "Take Me Home Transition Program" and replaced all previous language
24.37	4/1/18 6/1/24 4/1/25	755 851 862	24.37.1.H 24.37.4 24.37.4	Reflect the December 2017 change in the way Medical ID cards are issued. Added language regarding the auto renewal process for Aged and Disabled Waiver (ADW) redeterminations. Removed language referencing reasonable compatibility provisions.
24.38				
24.39				
24.40				
24.41	4/1/18 6/1/24 4/1/25	755 851 862	24.41.1.H 24.41.2 24.41.2	Reflect the December 2017 change in the way Medical ID cards are issued. Added language regarding the auto renewal process for Intellectual and Developmental Disabilities (I/DD) Waiver redeterminations. Removed language referencing reasonable compatibility provisions.
24.42				

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
24.43				
24.44				
24.45	4/1/18 6/1/24 4/1/25	755 851 862	24.45.1.H 24.45.4 24.45.4	Reflect the December 2017 change in the way Medical ID cards are issued. Added language regarding the auto renewal process for Traumatic Brain Injury (TBI) Waiver redeterminations. Removed language referencing reasonable compatibility provisions.
24.46				
24.47				
24.48				
24.49				
24.50	4/1/18 4/1/20 6/1/24 4/1/25	755 784 851 862	24.50.1.J 24.50 24.50.2 24.50.2	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path. Added language regarding the auto renewal process for Children with Disabilities Community Services Program (CDCSP). Removed language referencing reasonable compatibility provisions.
24.51				
24.52				
24.53				
24.54				
24.55				
24.56				
24.57				
24.58				
24.59	9/1/22 6/1/24 4/1/25	827 851 862	 24.59.9 24.59.9	Added Children with Serious Emotional Disorder (CSED) Waiver- General Application Procedures Added language regarding the auto renewal process for Children with Serious Emotional Disorder (CSED) redeterminations. Removed language referencing reasonable compatibility provisions.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
24.60	9/1/22	827		Notification
24.61	9/1/22	827		Case Maintenance
24.62	9/1/22	827		Establishing Medical Necessity
Appendix A				
Appendix B				
Appendix C				
Appendix D	5/1/21 1/1/23	804 830		Amounts updated. Amounts updated.
Appendix E	10/1/18 5/1/25	765 863		Corrected contact phone number for Estate Recovery Updated Contract Agency's name and email address
Appendix F				

24.1 INTRODUCTION

This chapter describes the Department of Human Services' (DOHS) policies and procedures related to eligibility for long term care (LTC). LTC includes both institutional care and non-institutional Home and Community-Based Services (HCBS).

- Institutional care includes nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
- West Virginia's HCBS include four programs. These are for people who would otherwise need institutional level of care, but have chosen to receive care in the community.

  West Virginia has been granted waivers by the Centers for Medicare and Medicaid Services (CMS) to provide HCBS to several target populations:

  - Aged or disabled people under the Aged and Disabled Waiver (ADW)
  - Intellectually or developmentally disabled individuals under the Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver
  - Individuals with traumatic brain injury under the Traumatic Brain Injury (TBI) Waiver

  Additionally, West Virginia has opted to implement the Children with Disabilities Community Services Program (CDCSP) eligibility category, which allows for children who would otherwise need an institutional level of care to receive services in the community.

This chapter covers policies relating to individuals in two different situations:

- Clients who are already enrolled in or eligible for Medicaid who have a new need for LTC.
- Applicants who were not eligible for Medicaid at the time of application, but who may have become eligible because of their need for LTC.

All LTC programs require a determination of medical eligibility, as well as a determination of financial eligibility conducted by the Worker.

This chapter also sets out policies and procedures for determining if clients found eligible for institutional care must contribute to their cost of care.

This chapter is organized as follows:

- Section 24.1 – 24.3 applies to all LTC programs.
- Sections 24.4 – 24.15 cover information related to Nursing Facility services.
- Sections 24.16 – 24.27 cover information related to ICF/IID services.
- Sections 24.28 – 24.36 cover information common to the HCBS programs.
- Sections 24.37 – 24.40 provide information about the ADW.

- Sections 24.41 – 24.44 provide information about the I/DD waiver.
- Sections 24.45 – 24.48 provide information about the TBI waiver.
- Sections 24.49 – 24.58 provide information about CDCSP.

24.1.1 INFORMATION PROVIDED TO THE CLIENT

In determining eligibility for payment of LTC, the Worker must ensure that the client, or his authorized representative, is fully informed of the policies and procedures. This is necessary so that the client, his family, or his authorized representative is able to make informed decisions about the client's financial affairs. A face-to-face interview is not required, but there may be circumstances where the Worker may need to contact a client.

The applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature. See Section 24.4.1.C.5 for more information about authorized representatives.

When an applicant's medical eligibility for, or enrollment in, LTC programs is pending due to a waitlist for services or another reason, he must still be allowed to apply and must be evaluated for any or all assistance programs.

The Worker must not, under any circumstances, suggest or require that the client or authorized representative take any specific action in financial matters. The Worker must not act as a financial planner or make suggestions about the client's current or future financial actions, including those that could affect estate recovery. The Worker may respond to general estate recovery questions, but must refer the client or his authorized representative to the Bureau for Medical Services (BMS) or its contract agency for specific information. The Worker must not contact the BMS or their contract agency on behalf of the client, but must refer the client or authorized representative to the BMS contract agencies listed in Appendix E.

24.1.2 INQUIRIES FROM PROVIDERS AND STAFF

The Worker must refer all inquiries about billing issues from the nursing or ICF/IID facility to the BMS contract agency listed in Appendix E. The Worker must not contact BMS on behalf of the provider.

Questions from county staff about any aspect of LTC cases must be directed to BMS Medicaid Eligibility Policy Unit.

24.2 VERIFICATION

Routine verification requirements are outlined in Chapter 7. Additional verification requirements for long term care services are included in this chapter.

For Intellectual and Developmental Disabilities (I/DD) waiver services, follow the instructions for Supplemental Security Income (SSI)-Related Medicaid in Chapter 7.

24.3 RESOURCE DEVELOPMENT

When Medicaid eligibility is established, clients are required to retain or develop resources that can reduce Medicaid costs. See Chapter 8.

NURSING FACILITY SERVICES

24.4 APPLICATION/REDETERMINATION

Payment for nursing facility care is a service available to eligible Medicaid clients. Eligibility for payment for nursing facility services is determined in any of the following four ways, in priority order; also see Section 24.7.2.

1. Qualified Medicare Beneficiary (QMB) clients, when Medicare is participating in the nursing facility payment, or will participate when the client enters the nursing facility.
2. Full coverage Medicaid clients.
3. Nursing Facility coverage group – nursing facility residents who meet a special income test.
4. Supplemental Security Income (SSI)-Related/Monthly Spenddown – when the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

24.4.1 THE APPLICATION PROCESS

24.4.1.A QMB Clients

When a client needs nursing facility services and Medicare participates in payment, it may be to the client's advantage to receive payment for nursing facility services as a QMB-eligible until Medicare no longer participates. See Section 24.7.2 for additional information.

See Chapter 1 for the application process for QMB.

24.4.1.B Full Coverage Medicaid Clients

When the individual is a client under a coverage group which provides full Medicaid coverage at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined; however, the transfer of resources, trusts and annuities provisions outlined in

Section 24.8 apply. These additional eligibility requirements for payment of nursing facility services apply to all Medicaid clients, including SSI, Deemed SSI, and Modified Adjusted Gross Income (MAGI) coverage group clients, and require the client to submit an additional application form for payment of nursing facility services.

24.4.1.B.1 Application Form

All full coverage Medicaid clients who need Medicaid payment for nursing facility services must complete and return the Application for Long Term Care Services for Current Medicaid Recipients (DFA-LTC-5), at the initial application for nursing facility services. The DFA-LTC-5 is used to evaluate annuities, trusts, and resource transfers to determine if a transfer penalty applies.

24.4.1.B.2 Date of Application

The date of application for payment of nursing facility services for current Medicaid clients is the date the applicant submits a DFA-LTC-5 in person, by electronic transmission, or by mail, which contains, at a minimum, his name, address, and signature. Payment for nursing facility services is not approved until the DFA-LTC-5 form is completed, signed, and returned to the local office.

24.4.1.B.3 SSI and Deemed SSI

SSI and Deemed SSI Medicaid clients who need Medicaid payment for nursing facility services must complete the DFA-LTC-5 application form at initial application and annual redetermination. SSI and Deemed SSI clients were determined asset eligible for Medicaid by the Social Security Administration (SSA), however, the client must disclose information about transfer of resources, trusts, and annuities. Payment for nursing facility services is not approved until the DFA-LTC-5 form is completed, signed, and returned to the local office.

When the DFA-LTC-5 form is not returned at the annual redetermination, the payment for long term care (LTC) services is closed after advance notice.

24.4.1.C Nursing Facility Coverage Group and SSI-Related/Monthly Spenddown Group

If the applicant is currently residing in the nursing facility, is not eligible as a QMB client, and is not eligible to receive full coverage Medicaid without a spenddown, he must apply for Medicaid eligibility in the Nursing Facility coverage group or SSI-Related/Monthly Spenddown group.

24.4.1.C.1 Application Forms

The following application forms may be used:

- DFA-2;
- WV PATH;
- DFA-MA-1, Application for Long Term Medicaid and Children with Disabilities Community Service Program; or
- DFA-SLA-1 or DFA-SLA-2, Single-Streamlined Application (SLA) with supplement DFA-SLA-S1.

The DFA-RR-1 is required with the DFA-2.

24.4.1.C.2 Complete Application

The application is complete when the client or his authorized representative signs a DFA-2, WV PATH application, DFA-5, DFA-MA-1, or SLA which contains, at a minimum, the client's name and address.

24.4.1.C.3 Date of Application

The date of application is the date the applicant submits a DFA-2, WV PATH application, DFA-MA-1, or SLA, in person, by electronic transmission, or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address, and signature is received in the local office.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant, attached and filed in the case record with the subsequently printed DFA-2. The DFA-RR-1 must also be completed when the DFA-5 has been signed.

If a Medicaid client loses eligibility and does not receive payment for nursing facility services for one month, he must reapply and is subject to the current application requirements unless the loss of eligibility or payment was due to a delay or error caused by the Department of Human Services (DOHS).

If an individual transfers to a nursing facility in West Virginia, he must submit an application and his eligibility must be evaluated as any other applicant.

24.4.1.C.4 Interview Required

No interview is required.

24.4.1.C.5 Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

➢ *Authorized Representatives*

The applicant may designate an authorized representative to act on his behalf. Such a designation must be in writing and include the applicant's signature.

Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization to the DOHS.

The authorized representative is responsible to the same extent as the client being represented, including confidentially of any information regarding the client provided by the agency and agreeing to the terms of the Rights and Responsibilities.

Examples of documents the applicant may submit with the Medicaid application to verify he has designated an authorized representative include, but are not limited to:

- Single Streamlined Application (DFA-SLA-1, Appendix C)
- Application for Long Term Care Medicaid and Children with Disabilities Community Service Program (DFA-MA-1)
- Durable power of attorney (POA) and/or medical power of attorney documentation, unless limited in scope
- Court orders designating a guardian or conservator (signed by court)
- Healthcare surrogate documentation for an incapacitated applicant (signed by physician and surrogate)

24.4.1.C.6 Agency Time Limits

The Worker must give the applicant at least 10 days for any requested information to be returned.

The Worker must take eligibility system action to approve, deny, or withdraw the application within 30 days of the date of application.

24.4.1.C.7 Agency Delays

If the DOHS failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 and DFA-6a, if applicable, to the client and note that the application is being held pending. When the information is received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.

If the DOHS simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.

For these cases, timely processing may mean acting faster than the maximum allowable time. If an application has not been acted on within a reasonable period of time and the delay is not due

to factors beyond the control of the DOHS, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Chapter 10.

24.4.1.C.8 Payee

The client is the payee.

24.4.1.C.9 Repayment and Penalties

This does not apply to the Nursing Facility coverage group and SSI-Related/Monthly Spenddown Medicaid.

24.4.1.C.10 Beginning Date of Eligibility

➢ *Medicaid Eligibility*

Medicaid eligibility begins on the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

➢ *Payment for Nursing Facility Services*

Payment for nursing facility services begins on the earliest date the three conditions described below are met simultaneously. Payment for nursing facility services may be backdated up to three months prior to the month of application when all the conditions described below are met for that period.

- The client is eligible for Medicaid; and
- The client resides in a Medicaid-certified nursing facility; and
- There is a valid pre-admission screening (PAS) or, for backdating purposes only, physician's progress notes or orders in the client's medical records. Section 24.12 contains information about the PAS and details specific situations in which the progress notes or orders are used.

➢ *Examples*

Expired PAS Example: Mr. Birch is a patient in a hospital. The physician recommends nursing facility care to Mr. Birch's family and completes a PAS dated June 5, 2016. The family is undecided about placing Mr. Birch in a nursing facility and takes him home to provide care. They do not apply for Medicaid until August 16, 2016, which is the date Mr. Birch enters the nursing facility. Medicaid eligibility is established beginning August 1, 2016. The original PAS has expired. A new PAS is not completed until August 22, 2016. The Worker can request the physician's notes to verify Mr. Birch's medical necessity from August 16, 2016, through August 22, 2016. Medicaid nursing care payments begin August 16, 2016 using physician's notes.

Delayed Entry Example: Same situation as above except that the PAS is dated June 25, 2016. A new PAS is not required, but nursing facility payments cannot begin until August 16, 2016, which is the date Mr. Birch entered the nursing facility.

Excess Assets Example: Ms. Dahlia enters a nursing facility on August 16, 2016, and the PAS is signed August 16, 2016. However, she does not become Medicaid eligible until September 1, 2016, due to excess assets. Payment for nursing facility services begins September 1, 2016.

Backdating Example: Mr. Pine enters a nursing facility on October 10, 2016, and a PAS is signed on that date. On November 25, 2016, his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to August 1, 2016, to cover the cost of his recent hospitalization. Payment for nursing facility services begins on October 10, 2016.

24.4.1.C.11 The Benefit

A Medical ID card is issued for each eligible individual.

➢ *Ongoing Benefits*

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

➢ *Ending Date of Eligibility*

The ending date of eligibility is the last day of the month of the effective month of closure.

24.4.2 REDETERMINATION PROCESS

Redeterminations are completed annually, and no interview is required. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If auto renewal is successful, the worker will receive a System Generated Alert to complete the post eligibility process.

When the redetermination process cannot be completed automatically, the eligibility system alerts the Worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination may be completed by the client or his authorized representative. The redetermination form is due by the first day ot the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure.

24.4.3 SPECIAL PROCEDURES RELATED TO APPLICATION AND REDETERMINATION PROCESSING

24.4.3.A Authorized Representative Resides in Another State

If the authorized representative does not reside within the state of West Virginia, he may submit any required documentation electronically, or by mail, to the appropriate Worker in the appropriate county office. The authorized representative may also ask a nursing facility staff member who has knowledge of the client's financial circumstances to communicate with the Department and submit documentation on the client's behalf. However, applications and redeterminations must still be signed by the applicant, the spouse or the authorized representative.

24.4.3.B Authorized Representative Resides in Another County

When the authorized representative resides in another county, he may submit any required documentation electronically, or by mail, to the Worker in the county responsible for the case. The authorized representative may also choose to communicate with and submit documentation to the Department in his own county of residence. In this situation, the county receiving the documentation should forward it securely to the county responsible for the case the same day it is received.

24.4.3.C Correct County of Residence for Nursing Facility Applicants

Nursing facility residents are considered to reside in the county where the nursing facility is located. However, there may be instances when the client applies before entering the nursing facility.

The county in which the individual resides on the date of application will accept responsibility for processing the application.

- When the applicant resides in a nursing facility at the time of application, the county where the facility is located accepts responsibility for processing the application.
- When the applicant still resides in their home county at the time of application, the current county of residence accepts responsibility for processing the application. Once eligibility has been determined, the case and record should be transferred to the county of the nursing facility.

The county responsible for the application responds to all inquiries related to the application until an eligibility decision is determined. Once the application process is complete and eligibility is determined, the case is housed in the county of the nursing facility.

24.5 COMMON ELIGIBILITY REQUIREMENTS

Individuals receiving payment for nursing facility services must meet all common eligibility requirements in Chapter 2. This section contains additional residency requirements for nursing facility eligibility.

The client meets the residency requirement when he is living in, not visiting, West Virginia with the intention of remaining permanently or for an indefinite period.

24.5.1 EXPRESSION OF INTENT TO LIVE IN WEST VIRGINIA

Only a competent adult can express intent. An individual age 21 or over is presumed competent unless there is medical evidence to establish:

- An IQ of 49 or less; or
- A mental age of 7 or less; or
- Legal incompetence.

When the client is institutionalized, the client's intent is used to determine the state of residence.

For any institutionalized individual age 21 or over who is incapable of expressing intent and was not placed by a state agency, the state of residence is the state in which the individual is living.

24.5.2 MINORS

The state of residence for an institutionalized individual under age 21 is the state of residence of the child's parent(s) or legal guardian, if they currently live in the same state. If the child and his parent(s)/legal guardian do not live in the same state, the state the parent(s)/legal guardian lived in at the time the child was institutionalized is the child's state of residence. If a minor child has married or in some other way becomes emancipated, the child is considered capable of expressing intent.

24.5.3 PLACEMENT BY OUT OF STATE AGENCY

When an individual is placed in a nursing facility or institution in one state by a state agency in another state, he retains his residence in the state making the placement.

24.6 ELIGIBILTY DETERMINATION GROUPS

Eligibility may be determined under any full Medicaid coverage group using the eligibility determination groups for the appropriate coverage group. See Section 24.7.2 and Chapter 3. If the client is not eligible for a full Medicaid coverage group, the client is assessed for eligibility under the Nursing Facility coverage group and the SSI-Related/Monthly Spenddown group using the following guidance.

24.6.1 THE ASSISTANCE GROUP (AG)

Only the institutionalized individual is included. A Medicaid-eligible spouse must be in his own AG, whether he is also institutionalized or not.

24.6.2 THE INCOME GROUP (IG)

Only the countable income of the institutionalized individual is used to determine his eligibility.

24.6.3 THE NEEDS GROUP (NG)

The NG is composed only of the institutionalized individual. See Section 24.7 for applicable income standards.

24.6.4 CASE COMPOSITION

The case is composed of the institutionalized individual, a spouse living in the community, and any of the individual's dependents. A Medicaid-eligible spouse receives benefits in his own case, whether he is also institutionalized or not.

24.7 INCOME FOR ELIGIBILITY DETERMINATION

There is a two-step income process for providing Medicaid coverage for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid and there must be a determination to see if the client must contribute to the cost of care.

Medicaid eligibility can be established by virtue of being a Qualified Medicare Beneficiary (QMB) client, of being a member of a full Medicaid coverage group, by meeting a special income test for the nursing facility coverage group, or by meeting a SSI-Related/Monthly Spenddown. See Chapter 23 to determine which coverage groups provide full coverage Medicaid.

Once Medicaid eligibility is established, if applicable, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. The post-eligibility process is described in Section 24.7.3 below.

24.7.1 BUDGETING METHOD

See Section 4.6 for generally applicable information about determining income. Monthly income is determined based on averaging income over multiple months, if applicable, and converting or prorating income for time periods other than monthly from each source.

For each month of residence in a facility, all countable income must be used in determining eligibility and in post-eligibility calculations, even if he resides only one day in the facility. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

24.7.2 FINANCIAL ELIGIBILITY PROCESS

Eligibility for payment for nursing facility services is determined in any of the following four ways, in priority order.

24.7.2.A QMB Clients

When a client needs nursing facility services and Medicare is participating in the payment or will participate when the client enters the nursing facility, it may be to the client's advantage to

receive payment for nursing facility services as a QMB-eligible, until Medicare no longer participates. QMB covers all Medicare co-insurance and deductibles. QMB clients are exempt by law from the post-eligibility process and, therefore, have no contribution toward their cost of nursing facility services, as long as Medicare participates in the payment. See Chapter 23.

However, the Worker must use one of the following ways to determine eligibility, if it would be more beneficial to him than QMB. In addition, when Medicare stops participating in the cost of care, QMB eligibility no longer covers nursing care costs and eligibility must be redetermined according to the options below.

24.7.2.B Full Coverage Medicaid Clients

When the individual is a client under a coverage group that provides full coverage Medicaid at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined.

For all full coverage groups, the client must complete the Application for Long Term Care Services for Current Medicaid Clients (DFA-LTC-5) at application for LTC services to evaluate any annuities, trusts and/or other potential resources or transfers so the Worker can determine if there will be a penalty period. See Section 24.8.

All Medicaid coverage groups listed in Chapter 23 are full Medicaid coverage groups, unless there is a statement specifically to the contrary.

SSI-Related or AFDC-Related individuals who are required to meet a six month spenddown must have previously met their spenddown to be determined eligible under this provision.

Those SSI-Related or AFDC-Related individuals who have no spenddown are Medicaid eligible. Those who meet their spenddowns prior to the need for nursing facility care have met the requirement to be eligible, through the current period of eligibility (POE). After the POE during which nursing facility services begin, the client's eligibility is reviewed according to Section 24.7.2.C or Section 24.7.2.D below. Those who do not meet their spenddowns prior to the need for nursing facility care are reviewed for eligibility according to the two options described in Section 24.7.2.C and Section 24.7.2.D below.

These clients' contribution toward cost of care is determined in the post-eligibility process. There are no post-eligibility calculations for Modified Adjusted Gross Income (MAGI) coverage groups.

When an applicant is not receiving full coverage Medicaid, the following test is made to determine eligibility.

24.7.2.C Nursing Facility Coverage Group, Gross Income Test

If the client is not currently eligible by having QMB or full coverage Medicaid, Medicaid eligibility may be established as follows:

- If the client's gross countable monthly income is equal to or less than 300% of the current maximum Supplemental Security Income (SSI) payment for one person and the client is institutionalized, he may be eligible.
- SSI-Related Categorical Medicaid requirements (aged, blind or disabled) and asset guidelines must be met.

These clients' contribution toward cost of care is determined in the post-eligibility process. There is no spenddown amount for these clients.

24.7.2.D SSI-Related / Monthly Spenddown

If the client is not otherwise eligible by having QMB, full coverage Medicaid, or Nursing Facility coverage group, his eligibility as an SSI-Related Medicaid client with a monthly spenddown must be explored. All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount.

EXCEPTIONS:

- *Income is not deemed.*
- *The Medically Needy Income Level (MNIL) for one person is always used. See Chapter 4, Appendix A.*
- *The spenddown amount is a monthly period of consideration, rather than a six-month period.*

24.7.2.D.1 Spenddown Calculation

When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

If the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a six-month period of consideration (POC), but not for payment of nursing facility services.

The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates are found only on the Division of Family Assistance (DFA) intranet page. The rates are updated at least semi-annually. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the Department of Human Services (DOHS) Office of the Deputy Secretary, Division of Accountability and Management Reporting.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in Section 24.7.7.

24.7.3 POST-ELIGIBILITY PROCESS

The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, or certain QMB clients. MAGI Medicaid coverage groups and QMB clients for whom Medicare pays a full month do not contribute to the cost of their nursing facility care.

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 4.3 for excluded sources for the appropriate coverage group.

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care.

The client's spenddown amount, if any, as determined above, is added to the resource amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the nursing facility's Medicaid cost of care to determine eligibility. See Section 24.7.6.

24.7.3.A Income Disregards and Deductions

Only the items in the following sections may be deducted from the client's gross income in the post-eligibility process.

24.7.3.A.1 Client's Personal Needs Allowance (PNA)

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. For most residents, the monthly amount deducted is $50. However, for an individual who is receiving the reduced Veterans Affairs (VA) pension of $90, the monthly PNA is $90. Similarly, an individual receiving SSI will have his monthly allocation reduced to $30, which is his monthly PNA if he is in the facility for at least three months.

24.7.3.A.2 Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home. The community spouse must be included as part of the case and his living expenses taken into consideration to calculate the CSMA.

To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

- The minimum SMS. This is 150% of the monthly FPL for 2 persons; or
- The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS.

See Chapter 4, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts.

The remainder is the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs.

For the deduction to be applied, the determined amount must actually be paid to the community spouse. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA:

Step 1: Add the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). See Chapter 4, Appendix B. The shelter cost must be for the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.

Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 4, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.

Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 4, Appendix A.

Step 4: Add together the community spouse's gross, countable earned and unearned income.

Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse.

If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed.

If the calculated CMSA is less than the minimum SMS or the Community Spouse will experience extreme financial duress, a fair hearing can be requested by the client, community spouse or authorized representative to obtain more of the institutionalized spouse's income and/or assets. See Common Chapters Manual, Chapter 700, Section 710.27.

24.7.3.A.3 Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. This amount is deducted whether or not the individual actually provides the money to the family members.

For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross countable income from the minimum SMS. See Chapter 4, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up. This calculation ensures the FMA for each family member will not exceed one-third of the minimum SMS. See Chapter 4, Appendix A.

> **Rounding Example:** $201.07 = $202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

24.7.3.A.4 Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within six months. The amount may be deducted for up to six months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.

> **OLE Example:** Ms. Rose is admitted to a nursing facility for six months and then discharged to her home. Her condition worsens after four months and she is readmitted to the nursing facility again. She can receive the OLE again, if her physician certifies she is likely to return home again within six months.

24.7.3.A.5 Non-Reimbursable Medical Expenses (NRME)

Certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as “remedial expenses.”

Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual.

These allowable expenses are listed in Section 4.14.4.J.3. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income.

When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non- reimbursable from another source may be used as a deduction.

➢ *Deductible Premiums*

Deductible premiums include any portion of the Medicare Part D Premium that is not covered by the Low Income Subsidy (LIS). The incurred expense must be the responsibility of the client.

The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 7 for sources of insurance premium verification.

> **Institutionalized Person Carries and Pays Both Premiums Example:** An institutionalized individual, Mr. Spruce, carries the insurance and pays the premium for himself and his community spouse. The institutionalized spouse receives a deduction for the full premium amount.
>
> **Institutionalized Person Pays Premiums But Does Not Carry Insurance Example:** An institutionalized spouse, Mrs. Geranium, pays the premium for the insurance coverage that her community spouse, Mr. Geranium, carries for them both. The community spouse, Mr. Geranium, is admitted to the nursing facility. The insurance premium continues to be a deduction for Mrs. Geranium since she pays the premium.

➢ *Spenddown*

For all assistance groups (AG), except those with a community spouse, the amount of the client's spenddown, if any, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have.

➢ *Time Limits and Verification Requirements for Expenses*

▪ *Applicants*

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the three months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources and nursing facility expenses incurred during the three months prior period when the client was ineligible for Medicaid due to excessive assets. Only a current payment on, or the unpaid balance of, old bills incurred outside the period of consideration may be permitted as an NRME. See Section 4.14.4.J.3.

EXCEPTION: A deduction may be given if there is evidence of a payment in the three months prior to application, even when the expense was incurred prior to that time.

> **Eligible Ongoing Monthly Payments Example:** Mrs. Carnation applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August, and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the three-month period, since there is evidence of a payment in the three months prior to application.
>
> **Ineligible Monthly Payments Example:** Same situation as above, except that Mrs. Carnation did not make any payments during July, August, or September. Since she did not incur the expense in the three months prior to the month of application or the month of application and made no payments during the three-month period, no deduction is given.

▪ *Clients Residing in a Nursing Facility*

The request for consideration of a non-reimbursable medical expense must be submitted within one year of the date of service(s).

Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and
- An itemization of the services provided. When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill

from a nursing facility, a detailed itemization of the services must be provided. The itemization must include:

- The date of the service or expense;
- The specific medical service;
- The reason no payment was received by the facility; and
- The amount of the expense.

Charges billed to Medicare, Medicaid or private insurance must be accompanied by an Explanation Of Benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.

➢ *Additional Limits for Specific Expenses*

For the items or services listed below, the following limits apply:

- Eye examination and eyeglasses: $300 in a 12-month period
- Eyeglasses: Two pairs in a 12-month period, unless medical necessity is established. The $300 limit in a 12-month period applies.
- Dentures: $3,000 in a 12-month period, unless medical necessity is established
- Hearing Aids: $1,500 in a 12-month period, unless medical necessity is established

Medical necessity is determined by the Worker and/or Supervisor, based upon the documentation provided.

➢ *Expenses which Cannot Be Used*

The following expenses cannot be used as a deduction for non-reimbursable medical expenses:

- Durable Medical Equipment (DME), unless purchased by the client prior to Medicaid payment for nursing facility services, and the cost was not reimbursable from any source;
- Bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved;
- Medical expenses incurred during a period of Medicaid eligibility which are covered by Medicaid;
- Nursing facility expenses incurred during a period of Medicaid ineligibility for excess assets, when the reason for excess assets is non-payment of the client contribution;

- Co-insurance payments while the individual is Medicaid eligible and has Medicare or private health insurance;
- Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance;
- Charges incurred during temporary periods of Medicaid ineligibility when the reason is failure to complete a redetermination and the assistance group (AG) is subsequently reopened with no break in eligibility periods;
- Nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved preadmission screening (PAS); and
- Charges for bed hold days.

24.7.4 FIRST AND LAST MONTH CALCULATIONS

During the first month and last month in which Medicaid participates in the cost of care, the Worker must prorate the client's contribution to his cost of care when he does not spend the full calendar month in the facility. This policy applies only to the first and last months of nursing facility residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must pay his full contribution and be reimbursed by the facility if an overpayment occurs.

This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other nursing facility resident who expects to remain in the facility a full month.
- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.
- Determine the number of days the client resided or expects to reside in the facility in the calendar month. When the contribution is prorated for the last month of nursing facility residence, only days during which the client resides in the facility are calculated. Days during which the client does not reside in the facility, including bed-hold days, are not considered. Multiply the number of days by the daily contribution rate.
- The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, if necessary, the Worker can calculate how much the client retains for his personal needs and how much is contributed to the community spouse and other family members as follows:

- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA, or FMA for a full month.
- Divide the client's monthly PNA, CSMA, or FMA by the actual number of days in the calendar month. This is the client's daily deduction rate which is used for this purpose only.
- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction then round up.
- The result is the amount of income the client may retain for the PNA, CSMA, or FMA.

24.7.5 FULL MEDICAID AND QMB ELIGIBLE CLIENTS

When a client is eligible for payment for nursing facility services under a full coverage Medicaid group, and is also QMB eligible, he must pay his full monthly contribution, even when Medicare participates in his cost of care, unless Medicare participates for the entire month. When the contribution is prorated for the first or last month of care, it is prorated using the procedure above. The contribution is not prorated based on the date that Medicare begins or ceases participation. When the Worker learns that Medicare participated for an entire month for a QMB eligible client, a DFA-NH-3 must be completed manually by the Worker to change the contribution to $0 for that month.

24.7.6 DETERMINING THE CLIENT'S TOTAL CONTRIBUTION

If the individual is a full Medicaid coverage client or in the Nursing Facility Medicaid coverage group without a spenddown, the resource amount determined in the post eligibility process from above is his total cost contribution.

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care, unless the client has a community spouse. This amount is added to the resource amount determined above to determine the client's total monthly contribution toward the cost of his nursing care.

24.7.7 EXAMPLES

Single Individual with OLE, Categorically Needy Example: Mr. Maple, a full coverage Medicaid client, enters a nursing facility and wants Medicaid to pay toward his cost of care. He has $3,000 month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid client. Therefore, only post-eligibility calculations must be performed.

Post-eligibility calculations are as follows:

$3,000	Client's gross monthly countable income
-$50	Personal Needs Allowance
$2,950	Remainder
-$175	OLE

$2,775 Client's resource amount which is also his total contribution toward his cost of care.

Single Individual with OLE, Medically Needy Example: Same situation as above except the client is not a full coverage Medicaid client. His Medicaid eligibility must be established as SSI-Related/Monthly Spenddown.

Eligibility calculations are as follows:

$3,000	Income
-$20	SSI Income Disregard
$2,980	Remainder
-$200	MNIL for One Person
$2,780	Monthly Spenddown

The monthly Medicaid cost for his care in the facility is $4,383. Therefore, his spenddown is met for the month and post-eligibility calculations are performed for any additional contribution he must make.

Post-Eligibility calculations are as follows:

$3,000	Income
-$50	Personal Needs Allowance

$2,950	Remainder
-$175	OLE
$2,775	Remainder
-$185	Medicare Part B premium (non-reimbursable medical expense)
$2590	Remainder
-$2780	Spenddown (non-reimbursable medical expense)
0	Resource Amount

The client has no resource amount, so his total contribution is $2,780, his spenddown amount. The DOHS will not pay any part of the $2,780 because it is the client's spenddown and he is, by definition, liable for it.

Single Individual without OLE, Medically Needy Example: Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

Post-Eligibility calculations are as follows:

$3,000	Income
-$50	Personal Needs Allowance
$2,950	Remainder
-$2,780	Spenddown (non-reimbursable medical expense)
$170	Resource Amount

The client's total contribution toward his cost of care is:

$2,780	Spenddown
+$170	Resource Amount
$2,950	Total Contribution

Married Individual without Community Spouse, Medically Needy Example: Mr. Tulip is married, but has been separated from his wife for 10 years. He has one dependent child still living in his home. His monthly income is $3,000. The monthly Medicaid cost for his care is $4,600. Mr. Tulip is not eligible for the FMA, because there is no community spouse living in his home.

Eligibility calculations are as follows:

$3,000	Income
-$20	SSI Disregard
$2,980	Remainder

-$200	MNIL
$2,780	Monthly Spenddown

Post-Eligibility calculations are as follows:

$3,000	Income
-$50	Personal Needs
$2,950	Remainder
-$2,780	Spenddown (non-reimbursable medical)
$170	Resource Amount
+$2,780	Spenddown
$2,950	Total Contribution

Married Individual with Community Spouse, Medically Needy Example: Mr. Holly has the following income:

$2,000	Retirement, Survivors, and Disability Insurance (RSDI)
+$1,000	Retirement
$3,000	Total Income

He has a community spouse who has $785 per month RSDI income and $365 per month earned income, for a total of $1,150. His child receives $685 per month RSDI. The monthly Medicaid cost for his care is $5,322.

Eligibility calculations are as follows:

$3,000	Income
-$20	SSI Disregard
$2,980	Remainder
-$200	MNIL
$2,780	Monthly Spenddown

Post-Eligibility calculations for the Community Spouse Deduction and the Family Maintenance Deduction are as follows:

Community Spouse Deduction

$600.00	Shelter
+$504.00	Standard Utility Allowance (SUA)
$1104.00	Total Shelter/Utilities

-$793.13	30% Min. SMS (Community Spouse Housing Allowance)
$310.87	Excess Shelter/Utilities
+$2,643.75	Min. SMS
$2,954.62	
-$1,150.00	Total gross monthly countable income of Community Spouse
$1,805.00	CSMA (rounded up per CSMA calculation)

Family Maintenance Deduction

$2,643.75	Min. SMS
-$685.00	Income (Family Members)
$1,959.00	Remainder ÷ 3 = $653.00 FMA (rounded up per FMA calculation)
$3,000.00	Income (Institutionalized individual)
-$50.00	Personal Needs
$2,950.00	Remainder
-$1,805.00	CSMA
$1,145.00	Remainder
-$653.00	FMA
$492.00	Remainder
-$187.10	Medicare premium and doctor bill
$304.90	Resource and total contribution toward his care

The client has a $304.90 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.

24.7.8 SPLIT MONTHS

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's contribution to cost of care which must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to the first facility, no additional calculation is required. If not, the amount(s) paid to the

other(s) is determined in the same way. The DFA-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

Step 2: Multiply the number of days the client was in the first facility by the per diem rate for the facility. The result is the clients cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to the first facility.

If Step 1 is greater than Step 2, the Step 2 amount is paid to the first facility and the difference between Step 1 and Step 2 is paid to the second facility.

24.7.9 NOTIFICATION AND CALCULATION SHEETS RELATED TO COST OF CARE

All notification letters regarding the client's contribution to his cost of care must contain the following statement:

> "This resource must be paid for in-facility days and bed-hold days unless you are notified otherwise in writing."

24.7.9.A Notice of Client's Contribution toward His Cost of Care (DFA-NH-3)

The DFA-NH-3 is primarily used to notify the client or his authorized representative, the nursing facility administrator and the LTC Unit of the client's contribution to his cost of care. The DFA-NH-3 is not a substitute for any client notification letter. When appropriate, the DFA-NH-3 is attached to letters notifying the client about a change in benefits or a decision on an application. The IM-NL-LTC-1 calculation form should also be attached. When there is a related change in the CSMA and/or the FMA, the IM-NL-LTC-2 calculation form should also be attached.

The form is prepared when there is any change in the client's contribution toward his cost of care. The form is completed when the eligible client first enters the nursing facility, leaves a nursing facility, is transferred to a different nursing facility, or when the ineligible individual who is in a nursing facility becomes eligible for payment. When the client resides in more than one nursing facility in the same month and his contribution must be divided, see Section 24.7.8.

This form is also used to notify the Bureau for Medical Services (BMS) LTC unit that it is to pay for LTC Services for individuals who have requested a waiver of their denial of LTC services

based on the Undue Hardship Provision. These clients may be eligible for up to 30 days of payment for bed-hold days while awaiting a decision of the Undue Hardship Committee. When a DFA-NH-3 is sent to the LTC Unit indicating availability of payment for this reason, the payment is not processed automatically. Payment for bed-hold days while awaiting a decision is not made for individuals denied due to excessive home equity.

24.7.9.B LTC Post-Eligibility Calculations (IM-NL-LTC-1)

The IM-NL-LTC-1, sometimes known as the budget, is a calculation sheet used in determining eligibility for the Nursing Facility coverage group, based on 300% of the SSI payment level for an individual. It is also used to determine the client's contribution in the post-eligibility process, regardless of the method by which he was determined eligible. It must be sent to the client or his authorized representative with forms DFA-NL-A, DFA-NL-B, DFA-NL-C, and DFA-NH-3 for notification of all case activity involving income eligibility.

24.7.9.C Determination of Community Spouse and Family Maintenance Allowance for LTC programs (IM-NL-LTC-2)

The IM-NL-LTC-2 is a calculation sheet used to determine the CSMA and FMA for nursing facility cases. It must be sent to the client or his authorized representative with the appropriate notice of decision form and DFA-NH-3 for notification when there is a change in the CSMA or the FMA.

24.8 ASSETS

Applicants for nursing facility services must meet the asset test for their eligibility coverage groups, except for Modified Adjusted Gross Income (MAGI) groups. The asset level for those eligible in the Nursing Facility coverage group and Supplemental Security Income (SSI)-Related/Monthly Spenddown is the same as SSI-Related Medicaid When both spouses are institutionalized and both apply for nursing facility services, the SSI-Related Medicaid asset limit for a couple is used to determine eligibility. See Chapter 5 for the asset limit of the appropriate coverage group.

24.8.1 ASSET ASSESSMENTS

When an institutionalized person has a spouse in the community, once the Worker determines the value of the assets as governed by Chapter 5, he completes an Asset Assessment, described below. The purpose of the Asset Assessment is to allow the spouse of an institutionalized individual to retain a reasonable portion of the couple's assets and to prevent the impoverishment of the community spouse.

This section is not applicable to clients eligible for or enrolled in MAGI eligibility groups or couples where both spouses are institutionalized.

24.8.1.A When to Conduct an Asset Assessment

When determining eligibility for nursing facility services for an individual who has a community spouse, the Worker must complete a one-time assessment of the couple's combined countable assets, called an Asset Assessment.

A legally married individual and his spouse, although separated, are treated as a couple for the Asset Assessment, regardless of the length of the separation.

An Asset Assessment is completed when an institutionalized individual transfers to a nursing facility in West Virginia, even if one was previously completed in the former state of residence.

An asset assessment must be completed as of the first continuous period of institutionalization. The first continuous period of institutionalization is the date the client first enters the nursing facility and remains for at least 30 days or is reasonably expected to remain for 30 days at the time the individual enters the facility. The spousal limits in effect at the time the assessment is

completed are used. If requested by the client or authorized representative, the assessment may be completed prior to application as of the first continuous period of institutionalization.

Nursing facilities are required to advise all new admissions and their families that an Asset Assessment is available upon request from the local office. The agency has developed a statement concerning the availability of Asset Assessments. Nursing facilities provide this "Patient's Bill of Rights" as part of their admission package. See Appendix B.

When a Medicaid client in a MAGI coverage group applies for payment of nursing facility services, an Asset Assessment is not required. However, if a MAGI client is later determined eligible in a non-MAGI group, an Asset Assessment is completed with information using the date the client first entered the nursing facility.

The assessment is completed on form IM-NL-AC-1 or in the eligibility system.

When requested, the Worker must advise the individual(s) of the documentation required for the assessment. Verification of ownership and the fair market value (FMV) (see Section 24.8.2.A.1 for definition) must be provided. When it is not provided, the assessment is not completed.

The Worker documents the total value of all countable assets.

The following forms are used as part of the asset assessment:

- Notice of Decision – Asset Assessment (ES-NL-D, also known as the DFA-NL-D)

  This form is used when the client requests an Asset Assessment but has not formally applied for Medicaid. The ES-NL-D is used to notify the client that the results of an asset assessment cannot be appealed unless an application for nursing facility care is made. See Section 24.8.1.C. Form IM-NL-AC-1 must be mailed with the ES-NL-D. When the Asset Assessment is completed in the eligibility system, alternate notification is sent.

- Assets Computation and Asset Assessment (IM-NL-AC-1)

  This form is used to complete an Asset Assessment. The Asset Assessment may be completed in the eligibility system.

24.8.1.B Calculation of the Community Spouse's Share

The spouse's share is computed as follows:

Step 1: Determine the FMV of the couple's combined countable assets, as of the beginning of the first continuous period of institutionalization.

Step 2: Compare the amount from Step 1 to $32,532, the Community Spouse Asset limit. If the Step 1 amount is equal to or less than $32,532, all assets are attributed to the community spouse. If not, go to Step 3.

Step 3: Divide the Step 1 amount by 2 and compare to $32,532. If one-half of the Step 1 amount is equal to or less than $32,532, the community spouse is attributed $31,584 and the remainder belongs to the institutionalized spouse. If not, go to Step 4.

Step 4: When one-half of the Step 1 amount is greater than $32,532, one-half of the total assets (Step 1 amount) is attributed to the community spouse, not to exceed $162,660, the maximum community spouse asset limit.

Step 5: The amount not attributed to the community spouse is attributed to the institutionalized spouse.

If an application for nursing facility services is not made when the assessment is completed, the community spouse retains the amount attributed to him at the assessment, regardless of the couple's combined assets at the time of application.

24.8.1.C Notification Requirements

When the assessment is complete, the Worker must provide each member of the couple with a copy of the eligibility system asset assessment or the Assets Computation and Asset Assessment (IM-NL-AC-1). A copy of the IM-NL-AC-1 is retained in the case record.

The Worker must also notify the community spouse using the Notice of Decision – Asset Assessment form (ES-NL-D) or the appropriate eligibility system form that although the assessment may be made prior to application, it may not be appealed until a Medicaid application is made.

24.8.1.D Revisions to the Asset Assessment

The Asset Assessment may only be revised when the client, his spouse, the Hearings Officer or the Worker determine, with supporting documentation, that the initial determination was incorrect or based on incorrect information.

24.8.1.E Additional Asset Exclusions for Institutionalized Spouses

The institutionalized individual is eligible for Medicaid regardless of having assets over the allowable limit, if he is legally prevented from transferring the assets, which would otherwise make him ineligible, to the community spouse.

Certain asset-related denials of long term care (LTC) Services are subject to waiver due to the Undue Hardship Provision.

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard.

24.8.1.F Transfers of Assets to the Community Spouse

Once initial eligibility has been established, assets that were not counted for the institutionalized spouse must be legally transferred to the community spouse.

Assets cannot merely be attributed to the community spouse, but must actually be transferred to the community spouse if they are to be excluded in determining continuing Medicaid eligibility of the institutionalized spouse. Assets legally transferred to the community spouse based on the Asset Assessment are allowable transfers of resources.

To exclude assets attributed to the community spouse, the institutionalized spouse must indicate his intent to transfer the assets to the community spouse, and the transfer must take place within 90 days, unless a longer period is required to take the action.

Once Medicaid eligibility is established, the assets of the community spouse based on the Asset Assessment are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by the community spouse, no penalty is applied to the institutionalized spouse.

24.8.1.G Additional Asset(s) Received/Obtained

When the institutionalized spouse obtains an additional asset(s) after the community spouse's share has been calculated and initial Medicaid eligibility is established, the additional asset(s) is excluded when one of the following conditions exist:

- The new asset(s), combined with the other assets the institutionalized spouse intends to retain, does not exceed the asset limit for one person; and/or
- The institutionalized spouse intends to transfer the new asset(s) to the community spouse who has assets below the previously determined spousal amount. To exclude the additional asset(s), the institutionalized spouse or his authorized representative must promptly report receipt of the new asset(s) and provide the Worker with a written statement that he intends to transfer the new asset(s) to the community spouse within 90 days.
- The Qualified Long Term Care Insurance Partnership (LTCIP) Policy has paid benefits to or on behalf of the institutionalized spouse that equal or exceed the amount of the newly acquired countable asset.

The assets of the community spouse may still not exceed the amount determined in the previous Asset Assessment. This criterion would apply when another asset of equal or greater value than the additional asset(s) is no longer owned.

24.8.2 TRANSFER OF RESOURCES

Under the transfer of resources policy, the Worker must deny coverage of LTC Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) resources for less than fair market value (FMV) during the 60-month look back period.

The current asset and income transfer policy governs transfers made after February 8, 2006 and applies to payments made for institutional care on or after March 1, 2009.

This section outlines which transfers of resources are allowable (or permissible) and which result in a penalty that delays the applicant's eligibility for Medicaid coverage of LTC services. Whether the transfer is considered permissible depends on the timing of the transfer, whether the client was compensated, for whose benefit the transfer was made and other factors.

24.8.2.A Definitions

For purposes of Transferring Resources, the following definitions apply.

24.8.2.A.1 Fair Market Value (FMV)

The FMV is an estimate of the value of a resource, if sold at the prevailing price at the time it was actually transferred.

For a resource to be considered transferred for FMV, or to be considered transferred for valuable consideration, the compensation received for the resource must be in a tangible form, with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for FMV. Also, while relatives and friends legitimately can be paid for care they provide to the individual, it is presumed that services provided for free, at the time, were intended to be provided without compensation. Therefore, a transfer to a relative for care provided in the past normally is not a transfer of assets for FMV. However, an individual may rebut this presumption. See Transfers to Pay for Personal Care Services in Section 24.8.2.F.

24.8.2.A.2 For the Sole Benefit of

For a transfer or trust to be considered for the sole benefit of a spouse, disabled child, or a disabled individual under age 65, the transfer or trust cannot benefit any other in any way, either at the time of the action, or at any time in the future, except as provided below. The agreement must be in writing.

EXCEPTION: A trust may provide for reasonable compensation for a trustee to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

If a beneficiary is named to receive the funds remaining in a trust upon the individual's death, the transfer is considered made for the sole benefit of the individual if the Department of Human Services (DOHS) is named as the primary beneficiary for up to the amount paid for services to the individual. The designated beneficiary receives any remaining amount.

24.8.2.A.3 Institutionalized Individual

An institutionalized individual is:

- An individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution, and for whom payment is made for a level of care provided in a nursing facility; or,
- An individual who is a HCBS waiver participant.

For purposes of this section, a medical institution includes intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

24.8.2.A.4 Resources

Resources include all income and assets of the individual and of his spouse that are counted for SSI-Related Medicaid purposes.

This includes some income or assets which the individual or the spouse is entitled to, but does not receive, because of any action or inaction by:

- The individual or his spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

Resources to which an individual or spouse is entitled include resources to which the individual is actually entitled, or would be entitled if action had not been taken to avoid receiving the resources.

Examples of actions which cause income or assets not to be received are:

- Irrevocably waiving pension income;
- Waiving an inheritance;
- Not accepting or accessing injury settlements;
- Settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of the plaintiff; or

- Refusal to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.

24.8.2.A.5 Valuable Consideration

Valuable consideration means that an individual receives in exchange for his or her right or interest in a resource some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred resource.

24.8.2.A.6 Uncompensated Value

The uncompensated value is the difference between the FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the resource) and the amount received for the resource.

24.8.2.A.7 Look-Back Period

The look-back period is the length of time for which the Worker looks back for any resource transfers. The look-back period is 60 months, whether or not a trust fund was involved. The look-back time period begins the month the client is both institutionalized and has applied for Medicaid.

See Chapter 5 for further information about funds in revocable or irrevocable trusts.

24.8.2.B Permissible Transfers

The following types of transfers do not result in a penalty for transferring resources.

24.8.2.B.1 Transfer of the Home

When the client transfers his home as follows, no penalty is applied:

- To the client's spouse.
- To the client's minor child (under age 21).
- To the client's disabled child regardless of age. The Social Security Administration (SSA) definition of disability is used. Therefore, any person medically approved for or receiving disability-based Retirement, Survivors, and Disability Insurance (RSDI) and/or disability-based SSI meets the definition, as well as persons who are determined disabled by the medical review team (MRT). If no disability determination has been made, the case must be submitted for a MRT decision.
- To the client's sibling who has an equity interest in the home and who resided in the home for at least one year immediately prior to the client's institutionalization.
- To the client's child(ren) who was residing in the home for at least two years immediately prior to the client's institutionalization and who provided care to the individual which allowed him to remain at home rather than being institutionalized.

24.8.2.B.2 Transfers for the Benefit of the Spouse or Disabled Child

When the client transfers resources other than his home, as follows, no penalty is applied:

- To the client's spouse or to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.
- From the client's spouse to another person for the sole benefit of the client's spouse not to exceed the amount determined attributable to the community spouse during the Asset Assessment.
- To the client's disabled child regardless of age. The Social Security Administration (SSA) definition of disability is used. Therefore, any person medically approved for or receiving disability-based Retirement, Survivors, and Disability Insurance (RSDI) and/or disability-based SSI meets the definition, as well as persons who are determined disabled by the medical review team (MRT). If no disability determination has been made, the case must be submitted for a MRT decision.

All transfers to another person for the sole benefit of the client’s spouse or to the client’s disabled child must be accomplished by a written instrument of transfer, such as a trust, which legally binds the parties to a specific course of action and specifies the conditions under which the transfer was made, and names those who benefit from the transfer.

24.8.2.B.3 Transfer to a Trust

When the client or his spouse transfers resources to a trust that is excluded from consideration as an asset, no penalty is applied.

This section applies to any trust established on or after August 11, 1993. For trusts prior to August 11, 1993, see Chapter 5, Appendix B.

Generally, all trusts are counted as assets, regardless of their purpose, restrictions on distributions or on the trustee's discretion to distribute the funds, whether acted on or not. There are exceptions to this general rule, and trusts established by a will are treated differently from those not established by a will. In addition, sometimes revocable and irrevocable trusts are treated differently. Details are found below.

If a trust is made up of the client's resources and those of one or more other persons, only the amount established with the client's resources is counted.

For purposes of this item, the terms "individual" or "client" include:

- The client;
- His spouse;
- Any person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; and,
- Any person, including a court or administrative body, acting at the direction of, or upon the request of, the individual or the individual's spouse.

➢ *Trusts Established by Will*

A trust is treated as an asset only to the extent that it is available to the client. Clauses included in a trust that limit the trustee's use of the funds (e.g., exculpatory clauses) are recognized and the amount of funds affected by such exculpatory clauses is excluded.

Irrevocable trusts are excluded, regardless of the amount. There is no penalty for the placement of funds in an irrevocable trust.

➢ *Trusts Not Established by Will*

When the following two conditions are met, the trust policy contained below in this item is applied. If the two conditions are not met, the fund is treated as any other bank account.

1. An individual has established a trust when his resources were used to form all or part of the corpus of the trust.
2. Any of the following persons established the trust for the individual by any vehicle other than by will:
    - Individual;
    - Individual's spouse;
    - A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or
    - A person, including any court or administrative body, acting at the direction of, or upon the request, of the individual or the individual's spouse.

➢ *Excluded Trusts*

In the following four trust situations, the trust is totally excluded. In addition, establishment of these trusts is not treated as an uncompensated transfer of resources.

NOTE: For these purposes, the SSA definition of disability is used. Therefore, any person medically approved for or receiving SSI, based on disability, meets the definition, as well as persons who have been determined disabled by the MRT. If no disability determination has been made, the case must be submitted for a MRT decision. See Section 13.8.

1. A trust containing the assets of an individual, under age 65, who is disabled, and which is established for his benefit by a parent, grandparent, legal guardian, or a court. The individual may establish the trust for himself on or after December 13, 2016. The exception continues even after the individual becomes age 65, as long as he continues to be disabled. This is commonly known as a special needs trust.

   To qualify for the exception, a trust must contain a provision that the State will receive all amounts remaining in the trust upon the death of the individual, up to the total Medicaid payments made on his behalf.
2. A trust which contains the assets of an individual who is disabled and which meets all of the following conditions:
    - The trust is established and managed by a non-profit association;
    - A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools the funds in these accounts;

- Accounts in the trusts are established solely for the benefit of the disabled individual;
- Accounts in the trusts are established by the individual, his parent, grandparent, legal guardian or by a court; and,
- The trust must include a specific provision that amounts remaining in the individual's account that are not retained by the trust upon the client's death, must be used to reimburse the State for Medicaid and/or WV WORKS payments which were made on the individual's behalf.

NOTE: When an individual is approved for Medicaid and has an excluded trust described above, for which Medicaid must be the beneficiary, the Worker must fax a copy of the trust document and the Medicaid client's name, case number and name of the client's power-of-attorney or authorized representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Appendix E.

3. Burial trusts which meet all the following conditions:
   - The individual signs a contract with the funeral director promising prepayment in return for specific funeral merchandise and services;
   - The contract is irrevocable;
   - The individual pays the agreed-upon amount to the funeral director in the form of a direct cash payment, purchase or transfer of a life insurance policy or annuity which is assigned to the funeral director; and,
   - The funeral director, in turn, places the pre-need payment or device into a trust or escrow account which the funeral director establishes himself. If the client establishes the trust or other device himself, the amount may be considered a transfer of resources.
4. A trust established with a settlement or funds received from the following:
   - Factor VIII or IX Concentrate Blood Products Litigation, MDL 986, No. 93-C-7452, ND of Illinois
   - Ricky Ray Hemophilia Relief Fund
   - Walker v. Bayer Settlement which compensates hemophiliacs who contracted the Human Immunodeficiency Virus (HIV) from contaminated blood products

➢ *Revocable Trusts*

Once the Worker determines the trust was not established by a will and does not meet one of the exceptions above, the following rules apply:

- The corpus of the trust is considered an available asset.
- Payments from the trust to the client or for his benefit are counted as income.

➢ *Irrevocable Trusts*

Once the Worker determines the trust was not established by a will and does not meet one of the exceptions above, the following rules apply:

- If there are any circumstances under which payments from the trust could be made to the client or for his benefit, that portion of the corpus, or the interest, is an asset.
- If payments are made from the available corpus, or interest, to the client or for his benefit, the amount is treated as income.

▪ *Payment for the Client's Benefit*

Throughout this item "payments made on behalf of the client" or "for his benefit" means payments of any kind to another entity, such that the client derives some benefit from the payment. This may include, but is not limited to, clothing, television, payments for services or care rendered, whether medical or personal, payments to maintain a home, etc. Any payment for the benefit of the client is counted, even if it is not customarily counted in determining Medicaid.

In determining whether payments can or cannot be made from a trust, the Worker must take into account any restrictions on payments, such as use restrictions, exculpatory clauses, and limits on trustee discretion, which may be included in the trust.

> **Client Benefit Example:** If a trust provides that the trustee can disburse only $1,000 out of a $20,000 trust, only the $1,000 is treated as a payment that could be made to the client or for his benefit. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to, or for the benefit of the client.
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> **Restricted Use Example:** A trust contains $50,000 which the trustee can disburse only in the event the grantor needs a heart transplant. The full amount is payment which could be made under some circumstances, even though the likelihood of payment is remote if the client does not have heart problems.

In determining whether payments can or cannot be made from a trust, the Worker must take into account restrictions included in the trust on how payments can be made; the Worker must not take into account when payments can be made. When a trust provides, in some manner, that a payment can be made, even though that payment may be sometime in the future, the trust must be treated as providing that payment can be made from the trust.

➢ *Undue Hardship*

There is a hardship provision for LTC Medicaid which allows DOHS to exclude a trust when counting it results in undue hardship for the client. All decisions about undue hardship are made by the Undue Hardship Waiver Committee. Any requests for such a determination are submitted in writing and must show complete details about the undue hardship which will result. See "Undue Hardship" in Section 5.1 and Section 24.8.2.B.7 below.

24.8.2.B.4 Transferred Resources Returned

When the client reports assets transferred for less than FMV have been returned to the client, the Worker must verify this information. Any return of assets must be to the client rather than to another individual on his behalf or paid directly to the long term care facility.

When the transferred assets have been returned to the client in full, no penalty is applied. If a penalty has already been applied, a retroactive adjustment to the beginning of the penalty period is required.

However, the client must always be asset eligible as of the first day of the month for any months the transfer penalty period is adjusted. When all transferred assets have been returned in full, the returned assets must be counted in determining eligibility for LTC services during the retroactive period and ongoing, unless the asset would have otherwise been considered exempt. Advance notice is required before closing other ongoing Medicaid coverage. The client's contribution to cost of care must also be determined.

For new applications or new transfers reported after August 1, 2018, if the transferred assets are returned only in part, adjustments to the applied penalty period are not allowed. The applied penalty period continues uninterrupted for the full duration originally calculated. The returned assets are, however, considered in determining eligibility for all other Medicaid coverage groups during the transfer penalty. Advance notice is required before closing other ongoing Medicaid coverage.

> **Return of Transferred Funds Example:** Ms. Daisy transferred all the money from her savings account to her son in February. The Worker calculates the

transfer penalty period to be nine months, running March through November. In June, Ms. Daisy's son returns all the transferred assets. After appropriately verifying the returned assets, the transfer penalty is removed. However, the returned funds must be counted in determining eligibility retroactively back to March. These funds put Ms. Daisy over the asset limit from March through June, when they were returned. In June, Ms. Daisy uses the returned money to pay her nursing home bill for services received in March through June. Ms. Daisy is now under the asset limit and is otherwise eligible as of July 1. She is eligible for LTC services as of July 1. The Worker must ensure Ms. Daisy receives the LTC benefit beginning July 1. Ms. Daisy's contribution to cost of care must also be determined.

Partial Return of Transferred Funds Example: Mr. Elm transferred $60,000 from his savings account to his son in February. The Worker calculates the transfer penalty period to be five months, running March through July with remainder penalty in the month of August. In June, Mr. Elm's son returned only $30,000 of the transferred money. Since only part of the assets were returned, no adjustment to the penalty period is allowed. The partially returned funds are considered an available asset for Mr. Elm during the penalty period, and after advance notice, Mr. Elm's coverage under other Medicaid groups is closed due to excess assets. However, since the transfer penalty has already started, the penalty continues to run from March through July with the remainder of the penalty in the month of August.

Multiple Transfers with Partial Return Example: During the lookback period, Ms. Poppy transferred $20,000 from her savings account, a vehicle, a certificate of deposit, and some stocks to her daughter. The Worker calculates the penalty period by adding all the transfers together. The total transfer penalty period is nine full months, running January through September. In May, Ms. Poppy's daughter returns the entire $20,000 she received from the savings account, but she does not return any other assets. Even though Ms. Poppy's daughter returned one full asset, she did not return the full amount of assets used to calculate the applied transfer penalty. Therefore, no adjustment to the penalty is allowed. The partially returned funds are considered an available asset for Ms. Poppy during the penalty period, and after advance notice, Ms. Poppy's coverage under other Medicaid groups is closed due to excess assets. However, since the transfer penalty has already started, the penalty continues to run from January through September.

24.8.2.B.5 Client Intended Fair Market Return or Other Valuable Consideration

When the client or his spouse can demonstrate that he intended to dispose of the resource for FMV or for other valuable consideration, no penalty is applied.

24.8.2.B.6 Transfer Was Not to Qualify for Medicaid

When a transfer of resources was exclusively for a purpose other than to qualify for Medicaid, no penalty is applied.

NOTE: A transfer is assumed to be for the purpose of qualifying for LTC services. The burden is on the individual to prove otherwise. Documentation needs to be provided by the individual to support their reason for the transfer if it was not to qualify for Medicaid. The Worker and Supervisor can make this decision.

> **Transfer Intent Example 1:** Mrs. Rhododendron has a stroke and enters the nursing facility on October 15, 2016. Her daughter's home was in foreclosure and the mother transferred $5,000 to her on September 19, 2016 to prevent foreclosure. The Worker verifies the situation with the foreclosure notice dated September 4, 2016 and the mother's withdrawal and check to the daughter on September 19, 2016 for the exact amount of the foreclosure of $5,000. The Worker and Supervisor determine Mrs. Rhododendron did not transfer money to qualify for Medicaid.
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> **Transfer Intent Example 2:** Mr. Geranium, a widowed man, has failing health and transfers $25,000 to each of his children before he enters the nursing facility. The children are not disabled. The transfer is assumed to be for the purpose of qualifying for Medicaid.

24.8.2.B.7 Denial Would Result in Undue Hardship

If the Worker has determined the individual would be eligible for LTC services but is denied due to one of the following asset policies, an undue hardship may exist:

- Excessive home equity;
- Transfer to a non-permissible trust; and/or,
- A transfer of asset penalty.

For undue hardship to exist, the denial must result in:

- Depriving the individual of medical care to the extent that the individual's health or life would be endangered; or
- Depriving him of the ability to obtain food, clothing, shelter or other necessities of life.

➢ *Notice of Right to Request an Undue Hardship Waiver (DFA-NL-UH-1) and the Fair Hearing Request Form (DFA-FH-1)*

When the Worker determines the individual is otherwise eligible for LTC services except for one or more of the asset policies listed above to which an undue hardship provision applies, he gives the individual the Notice of Right to Request an Undue Hardship Waiver (DFA-NL-UH-1) and the Fair Hearing Request form (DFA-FH-1) at the time of the eligibility decision, which provides him the opportunity to request a waiver of the denial due to undue hardship. The individual, his authorized representative or a nursing facility staff member with the client's permission, can use these forms to apply for an undue hardship waiver.

➢ *Application for an Undue Hardship Waiver (DFA-UH-5)*

The Application for an Undue Hardship Waiver (DFA-UH-5) must be attached to the DFA-NL-UH-1. The DFA-UH-5 is the application for the waiver. It must be completed and returned to the Worker within 13 days of notice of the eligibility decision. Upon receipt, the Worker immediately mails, emails, or faxes it to the Bureau for Medical Services (BMS) Policy Unit for distribution to the Undue Hardship Waiver Committee.

The DFA-UH-5 must include a signature of the individual for whom the waiver is filed when the LTC facility is completing the request. It must include an explanation of any efforts made to resolve the asset issue that resulted in the LTC services denial. Documentation that supports these attempts must be attached. Details regarding the individual's undue hardship must be explained. If the DFA-UH-5 is not returned complete and timely, no additional notice occurs and the negative eligibility decision and any penalty applied remains.

An individual who resides in a facility and requests an Undue Hardship Waiver is eligible for payment of up to 30 bed-hold days from the date the DFA-UH-5 is received by the BMS Policy Unit until a decision is made by the Committee. The Committee has 60 days to make a decision concerning the Waiver request. Denial of payment of LTC services due to excessive home equity is not subject to payment of bed-hold days.

➢ *Decision for Request of Undue Hardship Waiver Form (DFA-NL-UH-2)*

If the waiver request is not appropriate for the Committee, it is returned to the local office which made the eligibility decision. The individual is notified of the Committee's decision via the

Decision for Request of Undue Hardship Waiver form (DFA-NL-UH-2). The Committee forwards the DFA-NL-UH-2 to the individual, with a copy to the Supervisor and Worker.

The decision of the Committee to deny the request can be overturned by a State Hearings Officer, therefore a DFA-FH-1 is sent. The local office must notify the BMS Policy Unit when a hearing request regarding the Committee's decision is received, and also advise the Regional Attorney. A member of the Committee will be available, via telephone, to participate in a Fair Hearing regarding the denial of the DFA-UH-5, but not to discuss the ineligibility for LTC services for reasons other than those related to excessive home equity, trust, and/or transfer issues.

24.8.2.B.8 Transfer of Resources Previously Disregarded by LTCIP Asset Disregard

If an individual in the Nursing Facility coverage group with income less than 300% of the SSI payment for one person transfers an asset that was previously disregarded by the LTCIP Asset Disregard, the transfer is not subject to a transfer penalty since the asset was previously disregarded.

If the individual obtains an additional countable asset that causes him to exceed the allowable asset amount, he must verify additional payments made to him or on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred.

The amount of the individual's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

> **LTCIP Example:** Mr. Sunflower is in a nursing facility and applies for Medicaid on November 1, 2016. Mr. Sunflower's income is less than 300% of the SSI payment for one person but he has $12,000 in individual assets consisting of $5,000 in an accessible money market and $5,000 in stocks. He verifies ownership of a $100,000 Qualified LTICP Policy issued after July 1, 2010, the date West Virginia implemented the LTCIP. He can also show insurance payments for a previous nursing facility stay in the amount of $10,000 to the nursing facility after July 1, 2010. The Worker disregards his money market and stocks and Medicaid eligibility is effective November 1, 2016.
>
> At redetermination, Mrs. Sunflower reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Sunflower were applied to disregard the value of the stock, and resulted in Mr. Sunflower being eligible for and receiving Medicaid, these same

insurance payments cannot be used again to disregard other assets. Should Mr. Sunflower's money market increase in value or if he acquires additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.

Mr. Sunflower's amount of assets that were protected at estate recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

24.8.2.B.9 Transfer on Death Deed

A client who transfers his property to a death beneficiary, while retaining the right to ownership, may execute a deed known as a transfer on death deed. This allows the owner to retain all rights of ownership, including the right to revoke the deed or transfer or encumber the property. At the owner's death, the property passes directly to the death beneficiary without going through probate. The deed must be recorded at the courthouse during the owner's lifetime to be valid. A transfer on death deed is not subject to a transfer penalty as the client still retains ownership in the property until their death.

West Virginia may file a Medicaid lien against the property of the Medicaid client during the client's lifetime. If the Medicaid lien still exists at the time of the Medicaid client's death, the lien would remain imposed against the property transferred to the death beneficiary of the transfer on death deed, under West Virginia law.

24.8.2.C Transfers That Are Not Permissible

All transfers not specified as permissible result in an application of a penalty. This also applies to jointly owned resources. The jointly owned resource, or the affected portion of it, is considered transferred by the client when any action is taken, either by the client or any other person, which reduces or eliminates the client's ownership or control of the resource. The transfer of property to a family member or other individual that does not meet the requirements for transfer of property listed in 24.8.2.B, for less than FMV which stipulates the client and/or their spouse have lifetime rights to the property, is not a permissible transfer and results in an application of a penalty.

24.8.2.D Transfers Related to a Life Estate

24.8.2.D.1 Transfer of Property with Retention of a Life Estate

A transfer of property with the retention of a life estate interest is treated as an uncompensated transfer.

To determine if a penalty is assessed and the length of the penalty, the Worker must compute the value of the transferred property and of the life estate, then calculate the difference between the two.

Step 1: To determine the value of the transferred property, subtract any loans, mortgages or other encumbrances from the fair market value (FMV) of the transferred property.

Step 2: Determine the age of the life estate holder as of his last birthday and the life estate factor for that age found in Chapter 5, Appendix A. Multiply the FMV of the transferred property by the life estate factor. This is the value of the life estate.

Step 3: Subtract the Step 2 amount from the Step 1 amount. The result is the uncompensated value of the transfer.

Step 4: Divide the Step 3 amount by the State's average monthly nursing facility private pay rate of $11,903. The result is the length of the penalty.

NOTE: The value of a life estate may be excluded as a homestead property, if the individual intends to return to it.

24.8.2.D.2 Transfer of a Life Estate

The value of a life estate interest is considered a transfer of resources when it is transferred or given as a gift.

24.8.2.D.3 Purchase of a Life Estate

The purchase of a life estate interest in another individual's home is treated as an uncompensated transfer, unless the individual who purchased the life estate interest resides in the home for at least one year after the purchase. The amount of the transfer is the entire amount used to purchase the life estate.

If the individual has resided in the home for at least one year after the life estate was purchased, determine the value of the life estate as follows.

➢ *No Intent to Return*

If the individual does not intend to return to the home in which the life estate was purchased, the value of the life estate is an asset, see Section 5.5.

When the individual has no intent to return due to domestic abuse, the life estate continues to be excluded until the individual establishes a new principal place of residence or otherwise takes action rendering the life estate no longer excludable.

➢ *Intent to Return*

The purchase of a life estate may be excluded as homestead property if the individual intends to return to the home and the individual resided in the home for at least one year after the purchase.

24.8.2.E Transfer to Purchase an Annuity

An annuity that is revocable or assignable is considered to be a countable asset. See Section 5.5.2 for more information on treating annuities as an asset.

24.8.2.E.1 Annuity-Related Transfers

NOTE: When an individual is approved for LTC Medicaid and has an excluded annuity described below, for which Medicaid must be the beneficiary, the Worker must securely forward a copy of the trust document and the Medicaid recipient's name, case number, and name of the recipient's Power of Attorney or legal representative, if applicable, to the current contract agency for Estate Recovery. Information about this agency is in Chapter 24, Appendix E.

➢ *Institutional Spouse is Annuitant*

An annuitant is defined as a person who receives an annuity.

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity;
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant/client or spouse;
- The annuity was purchased by or on behalf of the individual and one of the three following situations applies:

    1. The annuity is considered either:
        - An individual retirement annuity (according to Section 408 (b) of the Internal Revenue Code of 1986 (IRC); or
        - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Section 408§ of the IRC).

    OR

    2. The annuity is purchased with proceeds from one of the following:
        - A traditional IRA [IRC Section 408 § (a)]; or
        - Certain account or trusts which are treated as traditional IRAs [IRC Section 408§(c)]; or
        - A simplified retirement account [IRC Section 408 § (p)]; or

- A simplified employee pension [IRC Section 408 § (k)]; or
- A Roth Individual Retirement Account (IRA) (IRC Section 408A).

OR

3. The annuity meets all of the following requirements:
   - The annuity is irrevocable and non-assignable; and
   - The annuity is actuarially sound; and
   - The annuity provides payments in approximately equal amounts, with no deferred or balloon payments. Endowment Life Insurance Policies are considered balloon annuities and subject to a transfer penalty.

➢ *Community Spouse Is Annuitant*

Establishment of an annuity is treated as a transfer of resources, unless the annuity meets the following criteria:

- The individual disclosed to the State any interest the individual or his spouse has in any annuity; and,
- The State is named as the remainder beneficiary, or as the second remainder beneficiary after a community spouse or minor or disabled adult child, for an amount at least equal to the amount of Medicaid benefits provided when the annuity is purchased by an applicant or spouse.

If the annuity does not meet all stated requirements above, the full purchase value is considered the amount of the transfer.

24.8.2.E.2 Actuarial Soundness

In order for an annuity to be actuarially sound, the average number of years of expected life remaining for the individual who benefits from the annuity must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive FMV. The annuity is not, then, actuarially sound and a transfer of resources for less than FMV has taken place.

Periodic life tables can be found in the appendices as follows:

- For annuities purchased prior to February 8, 2006, use the Periodic Life Tables found in Appendix C. The penalty is considered to have occurred at the time the annuity was purchased prior to February 8, 2006. Only the amount that is not actuarially sound is treated as an uncompensated transfer.
- For annuities purchased on or after February 8, 2006, use the Period Life Tables in Appendix D of this chapter.

NOTE: The Deficit Reduction Act of 2005 (DRA) was signed into law on February 8, 2006. The DRA made significant changes to the policies for long term care asset transfers.

Meets Criteria Example: A 65-year-old man purchases a $10,000 irrevocable, non-assignable annuity on July 28, 2008 which is to be paid over 10 years in equal payment amounts, and names the State of West Virginia as the second remainder beneficiary after his disabled son. His life expectancy, according to Appendix D, is 16.05 years. The annuity is irrevocable, non-assignable, actuarially sound, provides equal payment amounts and the state is named as a secondary remainder beneficiary. No transfer of resources has taken place.

Life Expectancy Example: An 80-year-old man purchases a $10,000 annuity on January 1, 2006 to be paid over 10 years. According to Appendix C, his life expectancy is only 6.98 years. Therefore, the amount which will be paid out by the annuity for 3.02 years is considered an uncompensated transfer of resources that occurred at the time the annuity was purchased on January 1, 2006.

Unequal Payments Example: A 60-year-old woman purchases an annuity on March 13, 2007 which is to be paid over 10 years with a balloon payment in the tenth year. The annuity names the State of West Virginia as the remainder beneficiary and is considered an uncompensated transfer of resources since it does not provide for equal monthly payments.

Retirement Annuity Example: A 65-year-old woman retired from a company on December 21, 2007 with an annuity that was purchased by the employer as part of her bona fide retirement plan. The annuity is not considered an uncompensated transfer of resources since it was purchased on her behalf as part of her bona fide retirement plan.

24.8.2.E.3 Annuity-Related Transactions Other Than Purchases

➢ *Transactions Subject to Penalty*

Certain annuity-related transactions, which occur on or after March 1, 2009, are subject to a transfer penalty. These transactions include any action taken by the individual that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. These actions include, but are not limited to:

NOTE: Certain annuity-related transactions which occur on or after March 1, 2009 are subject to the policy implementation of the DRA.

- Additions of principal
- Elective withdrawals
- Requests to change the distribution of the annuity
- Elections to annuitize the contract and other similar transactions

Multiple penalties can be applied to the same annuity under certain circumstances.

> **Multiple Penalty Example:** A 60-year old woman served a six-month penalty period because the annuity did not provide equal monthly payments. She became eligible for LTC services payments, but three months later she made an elective withdrawal from the annuity. Another transfer of resources occurred and a penalty is applied.

➢ *Transactions Not Subject to Penalty*

Annuities purchased prior to March 1, 2009 which experience routine events and automatic changes that do not require any action or decision by the individual after March 1, 2009 are not subject to a transfer penalty. Routine changes include notification of an address change, death or divorce of a remainder beneficiary and other similar circumstances. Automatic changes are based on the terms of annuity which existed prior to March 1, 2009, and which do not require a decision, election or action by the individual to take effect. Changes beyond the individual's control, such as a change in law, a change in the policies of the issuer, or a change in the terms based on other factors, such as the issuer's economic condition, are not considered transactions that result in imposition of a transfer penalty.

Annuities and annuity-related transactions that are not subject to a penalty are still subject to applicable income and/or asset policies.

24.8.2.F Transfer to Pay for Personal Care Services

24.8.2.F.1 Non-permissible Transfer of Resources to Pay for Personal Care Services

Personal care services provided to an individual by a relative or friend are presumed to have been provided for free, at the time rendered, when a Personal Care Contract (PCC) did not exist. Therefore, a transfer of resources from an individual to a relative or friend for payment of personal care services is an uncompensated transfer without FMV received for the transferred resource and subject to a penalty, unless the services were provided in accordance with the requirements below. See Section 24.8.2.A.1 regarding FMV.

24.8.2.F.2 Permissible Transfer of Resources to Pay for Personal Care Services

A transfer of resources by an individual to a relative or friend to pay for personal care services rendered may be a permissible transfer if the personal care services were performed through an eligible PCC, also known as a personal care agreement or personal service contract. The PCC must meet all of the following criteria.

➢ *Requirements Regarding the Contract*

The following describes the requirements regarding the contract:

- A PCC exists between the individual or his authorized representative and the caregiver.
- The duration of the PCC is actuarially sound.
- The terms of the PCC are in writing between the individual or his authorized representative and the caregiver.
- The PCC is reviewed by the Worker for compliance;
- The terms of the Contract include:
    1. A detailed description of the services provided to the individual in the home;
    2. The frequency and duration of the services provided. The services must be measurable and verifiable and the compensation to the caregiver paid at a reasonable amount of consideration, i.e., money or property. Payment must be clearly defined either as a set amount or an amount to be determined by an agreed-upon hourly rate that will be multiplied by the hours worked; and,

NOTE: Reasonable payment is determined by comparing compensation paid by home care agencies, or other independent caregivers, for similar services in the same locale at the specific time period for which services were provided.

3. Services expected of the caregiver, if any, during any period the individual may reside in an assisted living, skilled nursing, or other type of medical or nursing care facility on a temporary basis between stays at home.

➢ *Requirements Regarding the Provision of Services*

The following describes the requirements regarding the provision of services:

- Services paid from transferred resources must be rendered after the written agreement was executed between the individual and the caregiver;
- A PCC may be in place at the time of the individual's stay in a nursing facility or a similar placement; however, it is assumed, unless proven otherwise, that personal care services during this time are provided by staff rather than the caregiver named in the PCC; and,
- At the time of the receipt of the services, the services must have been recommended in writing and signed by the individual's physician as necessary to prevent the transfer of the individual to residential care or nursing facility care. Such services may not include the mere providing of companionship.

➢ *Requirements Regarding the Transfer*

The following describes the requirements regarding the transfer:

- The transfer to the relative or friend acting as caregiver must have taken place at the time the personal care services were rendered;
- The transfer cannot be for services projected to occur in the future, but must be paid for at the time rendered; and,
- FMV must be received by the caregiver in the form of payment for personal care services provided to him. The Worker must determine if reasonable payment for personal care services occurred.

If the amount transferred to pay for personal care services is above FMV, the amount transferred in excess of FMV is subject to a transfer penalty.

> **Allowable PCC Example:** Mr. Daisy applies for Medicaid. He transferred $5,000 to his granddaughter to pay for personal care services provided to him for the last five months. The Worker reviews the PCC and contacts a community agency representative who indicates the payments made were similar to the rate paid by agencies at the same time period in the same locale. Since the payment was reasonable and the PCC meets all the criteria required in Section 24.8.2.F, the

$5,000 was a permissible transfer of resources for payment of personal care services and no penalty is applied.

Personal Care When in Facility Example: Since June 2015, Mr. Sage had a PCC in place that meets all of DOHS's requirements. On April 1, 2016, he is admitted to a LTC facility with all personal care services provided. Any transfer of resources to pay for personal care services rendered after April 1, 2016 would be subject to a transfer penalty.

Payment for Future Services Example: Mrs. Lily has a compliant PCC with payments stipulated to occur at the end of the month after personal care services are rendered. On February 27, 2016, Mrs. Lilly transferred $3,000 to her daughter for payment for services at $1,000 per month for January through March 2016. Since payment for March is for projected services, $1,000 of the payment is subject to a transfer penalty.

PCC while in Temporary Placement Example: Mrs. Hydrangea has a compliant PCC in place but is admitted to a LTC facility on a temporary basis for special treatment. The PCC remains in place; however, from the date of her admission, since personal care services are provided by the facility staff, only transportation to the facility is a service for which she can pay her caregiver if transportation is included in the terms of her PCC.

24.8.2.G Purchase of a Promissory Note, Loan, or Mortgage

Any purchase of a note, or any loan or mortgage is treated as an uncompensated transfer unless all of the following criteria are met:

- The repayment terms must be actuarially sound, based on the Period Life Table found in Appendix D;
- Payments must include the institutionalized spouse/individual in equal amounts during the term of the loan, with no payment deferrals or balloon payments; and,
- The note, loan or mortgage must prohibit cancellation of the debt upon the death of the lender.

If all of the criteria listed above are not met, the loan is treated as a transfer of resources. The amount of the transfer is the entire outstanding balance due on the loan as of the month of application for Medicaid LTC services.

See Section 5.5 to determine if the loan, mortgage/land sale contract, or promissory note is an asset.

24.8.2.H Treatment of Transfer of a Stream of Income or Right to a Stream of Income

When the client fails to take action necessary to receive income or transfers the right to receive income to someone else for less than CMV, the transfer of resources penalty is applied. The Worker must follow the steps described below.

Step 1: Verify the amount of potential annual income.

Step 2: Using the client's age as of his last birthday, determine the Remainder Interest Value in Appendix A.

Step 3: Multiply the Step 2 amount by the Step 1 amount to determine the uncompensated value.

Step 4: Divide the Step 3 amount by the average monthly nursing facility private pay rate of $11,903 to determine the penalty period.

NOTE: A partial month's penalty is imposed for the transfer of an individual or single income payment that is less than the monthly nursing facility private pay rate. See Transfer Penalty Section below for instructions about how to determine and apply partial month penalties.

24.8.2.I Treatment of Jointly-Owned Resources

Jointly owned resources include resources held by an individual in common with at least one other person by joint tenancy, tenancy in common, joint ownership or any similar arrangement. Such a resource is considered to be transferred by the individual when any action is taken, either by the individual or any other person that reduces or eliminates the individual's ownership or control of the asset.

Under this policy, merely placing another person's name on an account or resource as a joint owner might not constitute a transfer of resources, depending upon the specific circumstances involved. In such a situation, the client may still possess ownership rights to the account or resource and, thus, have the right to withdraw all of the funds at any time. The account, then, still belongs to the client. However, actual withdrawal of funds from the account, or removal of all or part of the resource by another person, removes the funds or property from the control of the client, and, thus, is a transfer of resources. In addition, if placing another person's name on the account or resource actually limits the client's right to sell or otherwise dispose of it, the addition of the name constitutes a transfer of resources.

If either the client or the other person proves that the funds withdrawn were the sole property of the other person, the withdrawal does not result in a penalty.

24.8.2.J Transfer Penalty

The transfer of resources penalty is a period of ineligibility for:

- Nursing facility services; and
- A level of care in any institution, equivalent to that of nursing facility services.

The client may remain eligible for Medicaid, but only services not subject to a penalty are covered. HCBS waiver groups will not continue their Medicaid eligibility during the transfer penalty, but will be evaluated for other coverage groups.

The penalty is applied as follows.

24.8.2.J.1 Start of the Penalty

The beginning date of each penalty period imposed for any uncompensated transfer of resources is the later of:

- The date on which the individual is eligible for and is receiving institutional level of care services that would be covered by Medicaid if not for the imposition of the penalty period; OR
- The first day of the month after the month in which assets were transferred and advance notice expires, when the individual receives LTC Medicaid; AND
- Which does not occur during any other period of ineligibility due to a transfer of resources penalty.

➢ *Penalty for Transfers during the Look-Back Period*

When resources have been transferred at singular or multiple points during the look-back period, add together the value of all resources transferred, and divide by the average cost to a private-pay patient of nursing facility services. This produces a single penalty period which begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

▪ *Penalty for Transfers during the Look-Back Period Examples*

Example 1: Mr. Ivy enters the nursing facility and applies for Medicaid in October 2024. The individual transferred $50,000 in April 2024. Based on the average private pay nursing facility rate of $11,903 a month, the penalty is four whole months, beginning October 2024 when Mr. Ivy was otherwise eligible for and receiving an institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty of $2,388 is imposed for February 2025. Mr. Ivy is required to pay this amount to the nursing facility, in addition to the calculated monthly contribution. See Length of Penalty below.

Example 1.1: Same situation as above, but during the penalty period the Worker discovers an additional, undisclosed transfer that occurred during the look-back period. The penalty period is recalculated to include the undisclosed transfer of resources.

Example 2: Ms. Fern enters a nursing facility in January 2024 and applies for Medicaid in October 2024 with a request for backdated coverage to August 2024. Ms. Fern transferred $19,000 in January 2024, $19,000 in February 2024 and $19,000 in March 2024. The Worker must calculate the penalty period by adding the transfers together. The total of $57,000 is divided by the nursing facility cost of $11,903. The penalty period is four whole months, beginning in August 2024, because the individual requested backdated coverage to August 2024, and was otherwise eligible for and receiving institutional level of care that would have been covered by Medicaid, if not for the imposed penalty. A partial month's penalty for December 2024 of $9,388 is also imposed. Ms. Fern is required to pay this to the nursing facility, in addition to his calculated monthly contribution. See Length of Penalty below for partial month penalties.

Example 2.1: Same situation as above, but after the penalty period ends and Ms. Fern is receiving Medicaid, the Worker discovers an undisclosed transfer occurred during the look-back period. A penalty is assessed, and advance notice of an additional transfer penalty is sent to Ms. Fern.

➢ *Transfers During a Penalty Period*

When an individual is in a penalty period and transfers additional resources during the penalty, a new penalty period begins as soon as the previous penalty ends.

All penalties for resources transferred on or after March 1, 2009 run consecutively.

- ***Transfers During a Penalty Period Examples***

> **Example 1:** Mr. Oak transfers $70,000 and is serving a five-month penalty beginning October 2024 through February 2025 with a partial month's penalty of $10,485 for March 2025. In November 2024, Mr. Oak receives an inheritance of $12,000 which he gives to a nephew. There is an assessed penalty of one whole month and a partial month's penalty of $97. The new penalty begins April 2025.
>
> **Example 2:** Ms. Orchid, approved for and receiving institutional level of care services, receives an inheritance of $100,000 in 2024 and gives the money to her grandson. Advance notice of the transfer penalty is sent in November and the penalty period begins December 1, 2024.

24.8.2.J.2 Length of Penalty

There is no maximum or minimum number of months a penalty may be applied. The penalty runs continuously from the first day of the penalty period, whether or not the client leaves the institution.

A partial penalty or extra payment is only applied in the last/partial month of the penalty period.

The penalty period lasts for the number of whole and/or partial months determined by the following calculation:

- Total amount transferred during the look-back period divided by the State's average, monthly nursing facility private pay rate of $396.76 per day or $11,903 per month.
- When the amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a dollar amount and added to the individual's calculated contribution to his cost of nursing facility care for his first month of eligibility.

The partial month's penalty is determined as follows:

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $11,903.

Step 2: Multiple the number of whole months from Step 1 by the average private pay rate of $11,903.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount which is added to the individual's calculated contribution.

Penalty Calculation Example: Mr. Cactus makes an uncompensated transfer of $24,534 in the month of application for Medicaid coverage of nursing facility services.

Step 1:	$24,534	Uncompensated transfer amount
	÷ $11,903	State's average monthly nursing facility private pay rate
	2.06	Number of months for penalty period
Step 2:	$11,903	State's average monthly nursing facility private pay rate
	x 2	Whole months in penalty period
	$23,806	
Step 3:	$24,534	Total uncompensated transfer amount
	-$23,806	Amount for two whole months in period
	$728	Partial month's penalty amount

If Mr. Cactus applies in July and is otherwise eligible, the penalty period runs for two full months from July through August, with a partial month's penalty calculated for September of $728. The September partial month's penalty amount of $728 is added to the calculated September contribution for his cost of care. If Mr. Cactus had a $500 monthly contribution, he would be required to pay $1,228 for the cost of care in September.

24.8.2.J.3 Who Is Affected by the Penalty

The institutionalized client is affected by any transfer described above when he or his spouse or any entity acting on their behalf or at their direction transfers an asset.

When the three following conditions are met, any remaining penalty period is divided equally between the institutionalized person and spouse:

- The spouse transferred resources which resulted in ineligibility for the institutionalized client;
- The spouse either is eligible for or applies for Medicaid and is, then, an institutionalized individual; and,
- Some portion of the penalty against the original institutionalized spouse remains when the above conditions are met.

If the penalty period is not equally divisible, the extra month in the penalty period is assigned to the spouse who actually transferred the resource.

When the penalty period is divided between spouses, the total penalty period applied to both spouses must not exceed the total penalty which remained at the time the penalty was divided.

When, for any reason, one spouse is no longer subject to a penalty, such as, when the spouse no longer receives nursing facility services, or dies, the penalty period which was remaining for both spouses must be served by the remaining spouse.

A recording in each affected case must specifically explain the division of the penalty period.

> **Division of the Penalty Period Example 1:** Mr. Aster enters a nursing care facility and applies for Medicaid. Mrs. Aster transfers a resource that results in a 36-month penalty against Mr. Aster. After 12 months into the penalty period, Mrs. Aster enters a nursing care facility and becomes eligible for Medicaid. The penalty period against Mr. Aster still has 24 months to run.
>
> Because Mrs. Aster is now in a nursing care facility, and a portion of the original penalty period remains, the remaining 24 months of the penalty must be divided equally between Mr. and Mrs. Aster.
>
> **Division of the Penalty Period Example 2:** Mr. Juniper is in a nursing facility and applies for Medicaid. Two months before his application he transferred resources to become eligible for Medicaid and a 10-month penalty begins. Two months into the penalty, Mrs. Juniper refuses an inheritance left to both of them because she is afraid it will adversely affect his future eligibility for nursing care coverage. The next month, Mrs. Juniper becomes eligible for HCBS. The Worker inquires about resource transfers and is told about the refusal of the inheritance. This is a transfer of resources. A penalty period is determined to be 12 months. Mr. Juniper continues to serve his 10-month penalty. The other penalty period begins the month after the 10-month period ends. His second penalty lasts six months (half of the 12-month period for his wife's transfer of their resource). Mrs. Juniper receives a six-month penalty period which begins the month she is otherwise eligible to receive an institutional level of care.

➢ *Application of the Penalty*

The only penalty for transferring resources is delayed or lost eligibility for nursing facility, ICF/IID, or HCBS care. The client is approved, if otherwise eligible, for any other applicable Medicaid coverage group.

24.8.3 HOMESTEAD PROPERTY EXCLUSION

A nursing facility resident is entitled to an exclusion of his homestead as a countable asset as long as he has intent to return to his homestead when/if discharged. It is not necessary that the client be medically able to return home to apply the exclusion. It is totally based on the client's intended actions, not whether he has the ability. The property to which the person intends to return must be the principal place of residence in which he resided before he went into the nursing facility. Principal place of residence is considered to be the person's primary residence and is typically the address used on a driver's license, for voting, and for tax purposes. If the client's homestead is a multi-unit dwelling, such as an apartment building, the entire property is excluded, not just the portion of the value which corresponds to the portion of the property in which he actually lived. When the client does not have intent to return due to domestic abuse, see Section 5.5.

The homestead property need not be in West Virginia. The homestead exclusion applies, regardless of the state in which it is located. The client's expressed intent to return to the homestead property does not necessarily affect his West Virginia residency. See Chapter 2 for residency details.

When the client's spouse or dependent relative resides in the primary residence, the homestead property remains excluded, regardless of the client's intent to return.

For purposes of the homestead exclusion only, a dependent relative is one who is dependent financially, medically or as otherwise determined dependent upon the institutionalized person, and includes a child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, including relations of the step or half, cousin or in-law.

When the home is rented or vacant this has no bearing on the homestead exclusion, however, when the individual places his home on the market, intent to return no longer exists and home is not excluded.

When the client is incapable of indicating his intent, his committee, legal representative or the person handling his financial matters will make the determination. The Worker must record the client's statement or intent in the case record. A written statement may be requested but no action may be taken to deny or stop benefits for failure to provide a written statement when the client has expressed his intent verbally or by gesture.

24.8.4 HOME EQUITY

When the equity value of an individual's home exceeds the current maximum allowable amount, he is ineligible for Medicaid payment for nursing facility or waiver services, unless his spouse, child under 21, or disabled adult child resides in the home. The current maximum allowable equity value is $752,000. Denial of LTC Services due to excessive home equity is subject to the Undue Hardship Waiver Provision.

24.8.5 Long Term Care Insurance Partnership (LTCIP) ASSET DISREGARD

24.8.5.A Introduction and Purpose

West Virginia's participation in the LTCIP is established by §9, Article 4E-1 of the West Virginia State Code. The LTCIP Asset Disregard results from a combined effort between Centers for Medicare and Medicaid (CMS), DOHS, LTC insurers, and the West Virginia Insurance Commission in accordance with Section 1917 of the Social Security Act. The LTCIP Asset Disregard provides an incentive to individuals to provide for their own LTC needs through the purchase of a Qualified LTCIP Policy, while protecting their assets.

24.8.5.B Definitions

For purposes of the LTCIP Asset Disregard only, the following definitions apply.

LTCIP ASSET DISREGARD

An asset disregard available to only individuals in the Nursing Facility coverage group, but whose resources exceed the allowable asset limit. Eligible individuals must have a Qualified LTCIP Policy issued by a Partnership State while residing in a Partnership State, with insurance payments made as of the date of the State's State Plan Amendment (SPA) that implemented the LTCIP. Assets are disregarded dollar-for-dollar in the amount of insurance payments made. Assets are protected at Estate Recovery in this same amount.

LTCIP POLICY VERIFICATION (DFA-LTCIP-1)

This form is given to the applicant for completion by the individual's insurance carrier or other individual who can attest to the policy's details and benefits paid. Other sources of verification are the Qualified LTCIP Policy, letter from the issuing state's governmental agency that regulates insurance, or verification from the issuing insurance agency indicating compliance of the Policy with Section 1917(b)(5)(A) of the Social Security Act.

PARTNERSHIP (QUALIFIED) STATES

States that are participating in the LTCIP. Each Partnership State has an approved State Plan Amendment (SPA) that indicates the date the State implemented the LTCIP. West Virginia's SPA implemented the LTCIP as of July 1, 2010.

QUALIFIED LTCIP POLICY

An LTC Policy that meets certain requirements of federal and state law. These policies are issued by Partnership (Qualified) States as of the date the State implemented the LTCIP.

RECIPROCITY

A reciprocal relationship exists between Partnership States that allows a resident with a Qualified LTCIP Policy in one Partnership State who later moves to another Partnership State, the same asset protection he previously had.

24.8.5.C Individuals Who May Receive the LTCIP Asset Disregard

The LTCIP Asset Disregard is available to only individuals in the Nursing Facility coverage group but whose individual resources exceed the asset limit.

24.8.5.D Verifications Required

When an individual states he has an LTC policy that has paid insurance benefits to him or on his behalf, the Worker evaluates him for the LTCIP Asset Disregard.

24.8.5.D.1 Verification of Client's Residency and Status of Policy-Issuing State at the Policy's Issuance

To be eligible for the LTCIP Asset Disregard, the policy owner must have been a resident of a Partnership State AND the issuing State must have been a Partnership State at the time the policy was issued.

- When a West Virginia resident verifies ownership of a Qualified LTCIP Policy issued by a West Virginia insurer or another Partnership State with an issuance date on or after July 1, 2010 and the individual verifies insurance payments made to him or on his behalf as of that same date, his individual resources may be disregarded dollar-for-dollar in the same amount as the insurance payments made. His resources are protected in this same amount at Estate Recovery.

  Partnership State Example 1: Mrs. Balsam applies for Medicaid on October 16, 2011 and states she has a West Virginia-issued LTC policy that has been paying insurance benefits to her since her institutionalization in August 2011. Her DFA-LTCIP-1 indicates her policy was purchased on April 1, 2010. Mrs. Balsam has an LTC policy but it is not a Qualified LTCIP Policy since West Virginia was not a Partnership State until July 1, 2010. Mrs. Balsam's assets cannot be disregarded.

  Partnership State Example 2: Mr. Zinnia is a lifelong West Virginia resident. He owns a Florida-issued Qualified LTCIP Policy purchased January 1, 2009 which is after the date Florida became a Partnership State (January 1, 2007). West Virginia became a Partnership State on July 1, 2010. Therefore, since Mr. Zinnia was not a resident of a Partnership State when his policy was issued, he is ineligible for the LTCIP Asset Disregard.

  Partnership State Example 3: Mr. Begonia is a lifelong West Virginia resident. He purchased a Qualified LTCIP Policy from Minnesota on September 1, 2010 and applied for Medicaid on February 11, 2011. Since Minnesota became a Partnership State on July 1, 2006, his Policy was issued by a Partnership State at the time of purchase and he was also a resident of West Virginia, another Partnership State at that time; therefore, as long as he verifies insurance payments made after July 1, 2010, he is eligible for the LTCIP Asset Disregard to be applied to his individual resources in the amount of insurance payments made.

- When a West Virginia resident was a former resident of a Partnership State and purchased a Qualified LTCIP Policy issued by that state, as long as his policy was issued as of the date of his former State's SPA that implemented the LTCIP and

insurance payments occurred as of that same date, he is afforded the same asset protection he previously had prior to becoming a West Virginia resident. The policy's benefits need not be exhausted before the LTCIP Asset Disregard is applied.

> **Partnership State Example 4:** Mr. Violet was a resident of Virginia before establishing West Virginia residency in January 2011. He purchased an LTC policy from Virginia on May 1, 2007 (the same day Virginia became a Partnership State). Mr. Violet verifies being institutionalized in Virginia and his $62,000 in assets were disregarded due to insurance payments paid on his behalf in 2009 and 2010 that exhausted his $75,000 Policy. His assets continue to be protected by the LTCIP Asset Disregard and he is eligible for West Virginia Medicaid.

- When an individual exchanges a Qualified LTCIP Policy issued by his former state of residence for a West Virginia policy, eligibility for the LTCIP Asset Disregard is evaluated based on the first State's SPA, policy issuance date and dates of insurance payments made.

> **Partnership State Example 5:** Mr. Carnation was formerly an Ohio resident. He exchanges his Ohio-issued Qualified LTCIP Policy for a West Virginia-issued Policy. He is evaluated for the LTCIP Asset Disregard based on the circumstances surrounding the first policy's issuance. Ohio became a Partnership State on September 1, 2007. His Policy was issued on January 1, 2008 and insurance benefits were made after this same date; therefore as long as insurance payments made on his behalf equal or exceed his individual resources, the LTCIP Asset Disregard can be applied.

24.8.5.D.2 Verification of the Qualified LTCIP Policy

The LTCIP Asset Disregard requires that the LTC policy be a Qualified LTCIP Policy. The DFA-LTCIP-1 is used to verify information about the individual's policy.

The following criteria are used to determine if the policy is qualified for the Disregard:

- The individual was a resident of a Partnership State when his policy was issued; AND

> *NOTE: When an individual exchanges his Qualified LTCIP Policy issued by his former state of residence for a West Virginia policy, eligibility for the LTCIP Asset Disregard is evaluated based on the first State's SPA date, policy issuance date, and dates of insurance payments made.*

- The policy meets the Internal Revenue Service's (IRS) Code of 1986 requirements related to the LTCIP; AND
- The policy's issuance date was no earlier than the effective date of the issuing Partnership State's SPA that implemented the LTCIP; AND
- The policy meets the specific rules of the National Association of Insurance Commissioners (NAIC); AND
- The policy includes the inflation protection based on the age of the insured at the time of purchase.

NOTE: Changes made to the LTCIP Policy after issuance will not affect the LTCIP Asset Disregard as long as the policy continues to be Qualified.

NOTE: The LTCIP Asset Disregard is not revoked if a State withdraws from the Partnership.

LTCIP Policy Example: Mr. Fern states he has an LTC policy that has paid him $35 per day for each day of his institutionalization and he requests the LTCIP Asset Disregard applied to his $3,000 in excessive assets. Mr. Fern provides the Worker with a copy of his policy. The policy does not indicate compliance with the IRS Code nor does it address inflation protection. The policy is not a Qualified LTCIP Policy and the applicant is ineligible for the Disregard.

24.8.5.D.3 Verification of Qualified LTCIP Insurance Benefits Paid

The DFA-LTCIP-1 is used to obtain information about the dates of, amount of Qualified LTCIP insurance benefits paid, and the remaining benefits available to the individual. When the individual does not complete this form, the Worker must verify the amount of insurance benefits paid to or on behalf of an individual as of July 1, 2010 when the individual is a West Virginia resident with a West Virginia-issued Qualified LTCIP Policy or owns a Qualified LTCIP Policy issued from another Partnership State.

24.8.5.E The Amount of the LTCIP Asset Disregard

Resources are disregarded dollar-for-dollar as the amount paid out by the insurance company.

24.8.5.F Applying the LTCIP Asset Disregard at Application and Redetermination

24.8.5.F.1 Applying the Disregard at Application

When there is a community spouse, the countable assets of the couple are combined and the asset assessment is completed. The LTCIP Asset Disregard is applied to the individual's assets at eligibility determination.

The amount of the Disregard is determined by the value of payments made to the individual or on his behalf since July 1, 2010. The policy's benefits need not be exhausted for the LTCIP Asset Disregard to be applied. The resource(s) to which the Disregard is applied may be disregarded in part or in entirety.

When a resource is disregarded in its entirety, the Worker indicates in the eligibility system that the resource is inaccessible and details in case comments that the LTCIP Asset Disregard was applied. The corresponding insurance payments made, date of last payment and the amount of benefits remaining in the policy are documented to track the assets that were protected.

> **LTCIP Asset Disregard at Application Example:** Ms. Tulip is eligible for the Disregard. She has a bank account with a balance of $27,000. Insurance benefits from her Qualified LTCIP Policy totaling $27,000 have been paid to her. In the eligibility system, an account totaling $27,000 is entered and listed as inaccessible. The Worker documents the application of the Disregard, dates of payments made that resulted in her becoming eligible for Medicaid and the amount of benefits remaining under Ms. Tulip's policy.

An asset to which the LTCIP Asset Disregard is applied in part and results in eligibility being established is entered in the data system as two assets, one inaccessible and one with the remaining value after the Disregard is applied. Documentation is detailed in case comments.

> **Partially Accessible Asset Example:** Mr. Daffodil has $12,000 in a savings account. He has a West Virginia-issued, Qualified LTCIP Policy that was purchased on August 1, 2010. The Worker verifies the policy has paid out $10,000 on Mr. Daffodil's behalf since that same date. The Worker applies the Disregard and enters a $10,000 savings account as inaccessible and then enters the remaining $2,000 as accessible in the eligibility system. The Worker details the information in case comments.

As long as the individual's assets remain the same, the protection of the resources that resulted in the client's eligibility continues throughout the client's Medicaid periods of eligibility. See below for policies governing when the individual's resources increase in value or he transfers a resource for less than the FMV.

NOTE: Even though a client is eligible for the Disregard and Medicaid, a determination is necessary regarding to whom the LTCIP insurance payment is made. The Worker must determine if the payments are income to the client or a third-party payment. If paid to the client, it is counted as income. If paid to the nursing facility, it is considered a third-party payment.

NOTE: If the client is applying for other benefits, the eligibility system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the Disregard.

24.8.5.F.2 Applying the Disregard at Redetermination

The Worker must track the assets of the client, insurance payments made to or on the client's behalf, and assets disregarded since the previous application.

Medicaid eligibility is reevaluated when the client reports transferring a previously disregarded asset, obtaining an additional asset, or an asset increasing in value.

A transfer of an asset that was previously disregarded is not subject to a transfer penalty.

If the value of the client's assets increase or the client obtains an additional countable asset that causes him to exceed the allowable asset amount, he will need to verify additional payments made on his behalf by the LTCIP Policy in addition to the amount of payments that were previously used to disregard the assets that were transferred. Additionally, the amount of the client's estate that was protected from Estate Recovery is reduced by the same amount as the value of the asset that was transferred.

> **LTCIP Disregard at Redetermination Example:** Mr. Tansy is in a nursing facility. On September 1, 2010, Mrs. Tansy applied for LTC services for her husband. The couple's assets are combined at asset assessment and the spousal share is attributed to Mrs. Tansy. Mr. Tansy's income is less than 300% of the SSI payment for one, but he has $10,000 in individual assets consisting of $5,000 in an accessible money market account and $5,000 in stocks. He is

asset-ineligible for LTC by $10,000. He verifies ownership of a $100,000 Qualified LTICP Policy which he purchased on July 12, 2010. The Worker verifies the policy's status and that his policy has paid for his care in July and August, paying $10,000 to the nursing facility. The Worker disregards his money market and stocks and Medicaid eligibility is effective September 1, 2010.

At redetermination, Mrs. Tansy reports transferring the stock to their son. The transfer is not subject to a penalty since the asset was previously disregarded. However, since insurance payments verified as paid by the LTCIP Policy on behalf of Mr. Tansy were applied to disregard the value of the stock, and resulted in Mr. Tansy being eligible for Medicaid, these same insurance payments cannot be used again to disregard other assets. Should Mr. Tansy's money market increase in value or the he acquire additional countable assets, he must verify additional payments by the insurance company before any other assets can be disregarded.

Mr. Tansy's amount of assets that were protected at Estate Recovery is also reduced from $10,000 to $5,000 since the previously disregarded stock was transferred to his son.

NOTE: If the client is no longer eligible for Medicaid under the 300% gross income test, his eligibility for other Medicaid groups is evaluated prior to closure and the eligibility system's asset screens are re-evaluated in accordance with each program's requirements and the absence of the LTCIP Asset Disregard.

24.9 NOTIFICATION AND FORMS

The applicant or his authorized representative must be notified in writing of the action taken on his application using form DFA-NL-A. The client, his authorized representative, and the nursing facility administrator must be notified in writing in advance of any action that results in a change in the level of benefits using the appropriate form. See Chapter 9 for general notification requirements. This section discusses additional notification procedures related to nursing facility cases.

24.9.1 NOTIFICATION TO CLIENT, AUTHORIZED REPRESENTATIVE, OR NURSING FACILITY

Any time the client or his authorized representative is notified of any changes in the client's eligibility, the nursing facility administrator must also be notified. If more than one nursing facility is involved, each administrator must be sent a copy of the ES-NH-3.

Below is a table of forms referenced in this chapter. It shows the form number, name, and description. The form number can vary on eligibility system generated notices.

Form	Name	Description
DFA-2	Application for Benefits	Application for benefits that can be used by all eligibility groups
DFA-5	Document for Protection of Application Date	When the applicant has completed the application, and there is a technical failure that prevents printing the DFA-2, Form DFA-5 must be signed by the applicant.
DFA-6	Request for Information	Also called the “verification checklist;” used to inform the applicant of additional information needed.
DFA-10	Appointment Letter for Office, Home, Phone	Notifies the client of the scheduled appointment time and date.
DFA-FH-1	Fair Hearing Request Form	Notifies client of right to fair hearing, often sent with other forms.
DFA-HS-3	Interagency Referral Form	Notifies the Social Security Administration when an SSI recipient enters or leaves a nursing facility.
DFA-LTC-5	Application for Long Term Care Services for Current Medicaid Recipients	Gathers information regarding transferred assets, trusts, and annuities.
DFA-MA-1	Application for LTC Medicaid and CDCSP	A shelf document used to apply for the following Long Term Care (LTC) Medicaid categories: Nursing Facilities Services, Intermediate Care Facilities (ICF) for Individuals with Intellectual Disabilities, Aged and Disabled Waiver (ADW), Intellectual Disabilities and Developmental Disabilities (IDD) Waiver, Traumatic Brain Injury (TBI) Waiver, and Children with Disabilities Community Service Program (CDCSP). It must only be used for applicants that are not eligible for Medicaid coverage using the Modified Adjusted Gross Income (MAGI) methodology.
DFA-NH-3	Notice of Contribution to the Cost of Care	Along with any appropriate letter, notifies client of initial or changed required contribution. This

Form	Name	Description
		is also sent to the nursing facility, BMS LTC Unit, and the client or his AR
DFA-NL-A	Notification Letter: Action Taken On Your Application	Notice of decision at application.
DFA-NL-B	Notification Letter: Action Taken On the Benefits You Receive from the DOHS	Notice of decision at redetermination.
DFA-NL-C	Notification Letter: Pending Change in the Benefits You Receive	Notice of decision related to a change in benefits.
DFA-NL-D	Notification Letter: Action Taken on Your Request for an Assessment of the Assets Belonging to Both You and Your Community Spouse	Informs client of results of an asset assessment, whether or not he has formally applied for Medicaid.
DFA-NL-UH-1	Notification of Right to Request an Undue Hardship Waiver	Sent with DFA-FH-1 and DFA-NL-UH-5.
DFA-NL-UH-2	Decision for Request of Undue Hardship	Sent with FH-1 to notify client of UH decision.
DFA-UH-5	Application for Undue Hardship Waiver	Application for undue hardship waiver.
IM-NL-AC-1	Assets Computation and Asset Assessment	Used to complete an asset assessment.
IM-NL-LTC-1	Long Term Care Calculations	Determines eligibility for Nursing Facility coverage group and contribution to cost of care.
IM-NL-LTC-2	Determination of Community Spouse and Family Maintenance Allowance for LTC programs	Calculates allowances for the community spouse and dependent family. Sent with applicable notice of decision form.
OFS-LTCIP	LTCIP Policy Verification	LTC insurance partnership policy verifications for eligibility for LTCIP disregard.

24.10 CASE MAINTENANCE

See Chapter 10 for policies and procedures for the appropriate coverage group.

24.10.1 NURSING FACILITY TRANSFER

When an individual transfer facilities in West Virginia a new Pre-Admission Screening (PAS) form must be obtained. See Section 24.12. See Section 24.9 for notification requirements and Section 24.7.8 for information regarding prorating payments between facilities. If an individual transfers to a nursing facility in West Virginia, his eligibility must be evaluated as any other applicant.

24.10.2 CHANGES REQUIRING REEVALUATION

Changes that affect the client's income, assets, medical eligibility, and/or post-eligibility calculations require reevaluation of Medicaid eligibility and/or the client's contribution toward his cost of care.

24.10.3 DISCHARGES AND CLOSURES

When a client is no longer in need of nursing facility care or returns home, eligibility for nursing facility services ends after the notice period expires.

Upon discharge, the Worker must:

- Determine if proration of the client's contribution to his cost of care is applicable. See Section 24.7.4.
- Notify the Bureau for Medical Services (BMS) Long Term Care (LTC) Unit.
- Take the appropriate data system action.
- If losing Medicaid coverage, evaluate the client for all Medicaid coverage groups.

24.11 BENEFIT REPAYMENT

24.11.1 CLIENT REPAYMENT

When payment for nursing care services is made for a client who is ineligible for such payment, for a lower amount, or for Medicaid, repayment is pursued as specified in Chapter 11.

24.11.2 PROVIDER FRAUD

When fraud on the part of a nursing facility or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.11.3 ESTATE RECOVERY

West Virginia has the authority to place liens on the estate or property of a Medicaid client who is either in a nursing facility or who receives benefits under a Home and Community-Based Waiver program, and who is age 55 or older, or who is determined to be permanently institutionalized. These liens cannot force the sale of real property during a person's lifetime.

The state will not impose a lien or will defer recovery from the estate when the individual qualifies for Medicaid under the Adult Group expansion provisions of the Affordable Care Act (ACA).

The Bureau for Medical Services (BMS) contracts with an agency to accomplish the recovery and to answer questions from interested persons. When the Worker receives inquiries about Estate Recovery, the Worker must refer the client to the current contract agency. Information about this agency is found in Appendix E. The Worker must not contact the contract agency on behalf of the client.

See Section 24.6 regarding the Long Term Care Insurance Partnership (LTCIP) Asset Disregard and its relation to Estate Recovery.

24.12 ESTABLISHING APPLICANT AS AGED, BLIND, OR DISABLED AND THE MEDICAL NECESSITY FOR NURSING FACILITY CARE

24.12.1 ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS

When the applicant for nursing facility services is not a Medicaid client under a full Medicaid coverage group, categorical Medicaid eligibility and financial eligibility must be established for the Nursing Facility coverage group or the SSI-Related/Monthly Spenddown group.

Disability or blindness, when not already established by the receipt of Retirement, Survivors, and Disability Insurance (RSDI) or Railroad Retirement benefits based on disability, must be established by the Medical Review Team (MRT).

All procedures in Chapter 13 for an MRT referral for the appropriate coverage group are applicable, and a presumptive approval may be made according to the guidelines in Chapter 13.

The Pre-Admission Screening (PAS) does not by itself establish disability. However, a copy of the PAS may be submitted to the MRT as medical information.

24.12.2 ESTABLISHING MEDICAL NECESSITY, THE PAS

24.12.2.A General Requirements

Before payment for nursing facility services can be made, medical necessity must be established for all clients. The PAS is the tool used for this purpose. The PAS is signed by a physician and then evaluated by a medical professional working with the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form, which is the only date used for establishment of medical necessity. The 60-day validity period applies, regardless of the reason for the completion. See below for situations when a PAS is not completed and payment for nursing facility care is requested for a prior period.

When the PAS indicates the client is not in need of nursing facility care, the application for Medicaid, unless withdrawn, is processed for any other coverage group for which the person qualifies, and all client notification procedures apply.

When the client no longer has medical necessity for long term care services, the nursing facility must notify the Worker.

There is no requirement that the name of the facility in which the client resides appear on the PAS.

24.12.2.B When the PAS Must Be Completed

For Medicaid to pay for nursing facility services, the PAS must be completed when:

- The client enters a Medicaid-certified nursing facility.
- The client transfers from one facility to another, even when the client moves from one facility to another governed by the same corporation, and even when 60 days has not passed since the completion of the PAS for the first facility.
- The client is admitted to an acute care facility and returns to the same nursing facility after 60 days.
- The client's condition changes to the extent that he no longer requires nursing facility services.
- Nursing facility care is approved for a limited time, a new PAS must be submitted by the facility before the end of the approved period.
- A private-pay patient applies for Medicaid, unless an approved PAS was completed within 60 days prior to the application.

This applies even if a PAS certifying medical need was completed at the time of admission to an approved facility. This also applies if a PAS was completed any other time before 60 days prior to the application. The new PAS certifies current need for nursing facility services.

A previously approved PAS may be used for backdated eligibility and payment for nursing facility services, so long as the client has remained in the same facility since completion of the previously approved form.

24.12.2.C Date of PAS Examples

Example 1: Mr. Rose enters a nursing facility as a private pay patient on October 18, 2016, and a PAS, which certifies his need for nursing care, is completed on that date. On February 1, 2017, he is still in the same nursing facility, and his family applies for Medicaid for his nursing facility care. Because the PAS completed at admission is more than 60 days old on February 1, 2017, a new PAS must be completed. If otherwise eligible, payment for services begins February 1, 2017.

Example 2: Mr. Begonia enters a nursing facility on September 2, 2016, and a PAS which certifies his need for nursing facility care is completed on that date. On September 30, 2016, his family takes him home to care for him. On October 16, 2017, his family places him in another facility and applies for Medicaid for his nursing care. A new PAS is required because he left the nursing facility for which the PAS was originally completed, and the new facility must have an original approved PAS.

Example 3: Mr. Calla enters a nursing facility on March 7, 2016, and a PAS, which certifies his need for nursing care, is completed on that date. On September 9, 2017, he is still in the same facility, and his family applies for Medicaid for his nursing care. They request payment for his care beginning June 1, 2017. Because the admission PAS, although approved, was completed more than 60 days prior to September 9, 2017, a new PAS must be completed. The approved PAS, completed March 7, 2016, is used to certify his need for nursing facility care from June 1, 2017, until the date of the newly approved PAS.

24.12.2.D Temporary Stays in Distinct Parts

Distinct part, as used in the following, means the part of the acute facility which provides nursing facility services.

When a nursing facility client is admitted to an acute care facility, moves to a distinct part of the facility, and then returns to the original nursing facility, special PAS requirements may apply.

The special PAS procedures are as follows:

- When the client moves from the acute care facility to a Medicare-only distinct part, no new PAS is required for the distinct part. However, a new PAS is required when the client returns to the original nursing facility.

- When the client moves from the acute care facility to a distinct part which is dually certified for Medicare and Medicaid, two PASs are required, one when the client enters a distinct part and another when he returns to the original nursing facility.

The table below shows when a PAS must be completed for stays in distinct parts.

Type of Distinct Part	Move to Distinct Part	Return to Nursing Facility
Medicare-only Distinct Part	Not required	Required
Dually certified for Medicare and Medicaid	Required	Required

24.12.2.E Procedures Related to the PAS

24.12.2.E.1 Who Completes the PAS

The provider completing the PAS may include, but is not limited to, a hospital, physician, nursing facility, or waiver agency.

24.12.2.E.2 Responsibilities of the Completing Provider

Responsibilities of the completing provider include:

- To submit the PAS to the level of care evaluator employed by the State's contract agency for review See Appendix E; and
- Once the review has been completed, to submit the original, reviewed PAS, with the admission documentation, to the provider of nursing facility services.

24.12.2.E.3 Responsibilities of the Level of Care Evaluator

Responsibilities of the level of care evaluator include:

- To determine the client's need for and level of care and to evaluate for the presence of mental illness or intellectual disability;

- To return the original form, with the review determination, to the originating provider. The possible review results are:
    - A = Nursing care needed
    - B = Personal care needed
    - C = No services needed
- To forward the original PAS to the appropriate agency for the Level II evaluation when the presence of mental illness or intellectual disability is indicated. See below.

24.12.2.E.4 Responsibilities of the Worker

Responsibilities of the Worker include:

- To forward the original PAS to the level of care evaluator when the PAS completer sends to the county office instead of the level of care evaluator.
- To obtain a signed copy of the current, approved PAS as verification of medical necessity at application and redetermination.

A new PAS is only required in the situations described above. A new PAS is not required at each redetermination. However, the Worker must verify that the client remains medically-eligible by obtaining a copy of the current PAS on file with the nursing facility.

> **PAS Example:** Mrs. Ginger completes a redetermination in June 2017. The Worker obtains a copy of the current approved PAS on file with the nursing facility. The PAS is dated May 21, 2016, approved for over six months and Mrs. Ginger has not left the facility since admission. The Worker has verified medical necessity at redetermination.

24.12.2.E.5 Level II Pre-Admission Screening and Annual Resident Review (PASARR)

Any client who applies for nursing facility services in a Medicaid-certified facility must be evaluated for the presence of mental illness, intellectual disability, or related conditions, as well as for the need for specialized services to address the individual's mental health needs or developmental disability. The level of care evaluator, after making the Level I decision of medical necessity, forwards the PAS to the mental health evaluator, if appropriate.

The date of the Level II evaluation has no bearing on the date that medical necessity for nursing care is established.

24.12.3 ESTABLISHING RETROACTIVE MEDICAL NECESSITY USING PHYSICIAN'S PROGRESS NOTES OR ORDERS

This procedure is used only for backdating eligibility for nursing facility care when no PAS exists for the period for which payment of services is requested. The progress notes or orders cannot be used to change an existing PAS which does not certify need for nursing facility care. Eligibility may only be backdated up to three months prior to the month of application.

In certain circumstances, which may be beyond the control of the client or his authorized representative, a client may be admitted to a Medicaid-certified nursing facility without a PAS. When this occurs and the client applies for Medicaid and payment of nursing facility services for a prior period, the Worker may obtain and use the physician's progress notes or orders in the client's medical records to establish medical need. A valid PAS for current eligibility must still be obtained.

This information is obtained from the nursing facility and the facility may request that the physician add such notes to the client's records. These records may also be used when application is made and payment requested for a deceased client when no valid PAS was completed.

The Worker must record the reason for the use of the progress notes or orders in case comments.

24.13 SPECIAL PROCEDURES RELATED TO COVERAGE GROUPS

Individuals already receiving full coverage Modified Adjusted Gross Income (MAGI) Medicaid, who become eligible for Medicaid payment of nursing facility services, must be dually coded in the data system as receiving nursing home coverage.

24.13.1 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

The Worker must notify the Social Security Administration (SSA) using the DFA-HS-3 when the SSI recipient enters or leaves a nursing facility.

When the institutionalized SSI recipient has an Essential Spouse (See Chapter 23) who is included in the assistance group (AG) and who appears on the same Medical ID card, the Essential Spouse remains eligible for SSI Medicaid, unless the State Data Exchange (SDX) information indicates the SSI is terminated. The Worker must use appropriate procedures to provide Medicaid to the nursing facility client and the Essential Spouse.

24.13.2 DEEMED SSI RECIPIENTS

Deemed SSI recipients can be Medicaid clients even though they do not receive SSI. When the Deemed SSI recipient enters a nursing facility and is eligible for payment for his care, his coverage group does not change.

24.14 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE (PNA)

This section is not applicable to clients who are in a Modified Adjusted Gross Income (MAGI) or Qualified Medicare Beneficiary (QMB) eligibility category.

Each nursing care patient is entitled to an allowance to meet his personal expenses. Any amount accumulated in the patient's personal expense account is an available asset. Responsibilities for the management of this allowance are outlined in this section.

24.14.1 NURSING FACILITY RESPONSIBILITIES

Funds in the personal expense account must not be used by the nursing facility to meet costs of services covered by the Medicaid nursing care payment. Examples of services and items covered by the nursing care payment are listed below. In addition, the facility must:

- Not charge a resident for any item or service not requested by the resident, or his authorized representative;
- Not require a resident to request any item or service as a condition of admission or continued stay; and,
- Inform the resident or his authorized representative requesting an item or service for which a charge will be made that there will be a charge for the item, and the amount.

When a facility has responsibility for a patient's Personal Needs Allowance (PNA), individual records must be kept with documentation of all disbursements made. Patient funds must be held in a separate account and not co-mingled with facility funds. Misuse of the personal funds by the facility is considered a fraudulent practice and any misappropriated funds must be repaid.

Because funds accumulated in the personal expense account are an asset, the facility is required to notify residents when they are within $200 of the asset limit.

When the patient is discharged, any unused amount remaining in his personal expense account is refunded to him by the facility.

24.14.2 CHARGES NOT PERMITTED

Nursing facilities may not charge a resident for the following examples of items and services:

- Routine, required nursing services.
- Use of equipment routinely used in the patient's care.
- Specialized rehabilitative services such as, but not limited to, physical therapy, speech language pathology, and occupational therapy.
- Required dietary services.
- Required activities program.
- Room/bed maintenance services.
- Basic personal laundry, not including dry cleaning, mending, hand washing, or other specialty services.
- Medically related social services.
- Personal hygiene items and services. Residents can purchase their own personal hygiene items if they choose, but the facility is required to provide them when needed, without charge. Examples of personal hygiene items and services that must be provided free by the facility include, but are not limited to:
    - Hair hygiene supplies
    - Comb and brush
    - Bath soap
    - Disinfecting soaps or specialized cleansing agents when needed to treat special skin problems or to fight infection
    - Razors
    - Shaving cream
    - Toothbrush and toothpaste
    - Denture adhesive and cleaner
    - Dental floss
    - Moisturizing lotion
    - Tissues
    - Cotton balls and swabs
    - Deodorant
    - Incontinence supplies and care

- Sanitary napkins and related supplies
- Towels and washcloths
- Hospital gowns
- Over-the-counter drugs
- Hair and nail hygiene services, but not cosmetic services
- Bathing

24.14.3 CHARGES PERMITTED

The following lists examples of items and services that the nursing facility may charge to the resident's personal expense account:

- Television/radio for personal use, including cable hook-up fee
- Telephone
- Personal comfort items, including smoking materials, lotions, novelties. and confections
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare
- Personal clothing
- Personal reading matter
- Gifts purchased on behalf of a resident
- Flowers and plants
- Social events and entertainment offered outside the scope of the nursing facility’s activity program
- Non-covered special care services, such as privately hired nurses or aides
- Private room, except when therapeutically required, such as isolation for infection control
- Specially prepared or alternative food specially requested, but not medically necessary, instead of the food prepared by the facility

24.14.4 WORKER RESPONSIBILITIES

At redetermination, the Worker verifies the accumulated balance in the client’s personal expense account. When the personal expense account, by itself or in combination with other assets, exceeds the asset limit, the case is closed after 13 days’ advance notice.

24.15 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payments are made to the nursing facility in accordance with daily rates established by the agency for each facility that has been approved for Medicaid participation. The Worker must refer all inquiries about billing matters to Provider Services and must not act as a liaison between the Bureau for Medical Services (BMS) or their contract agency and the facility. See Appendix E.

INTERMEDIATE CARE FACILITIES/INDIVIDUALS WITH INTELLECTUAL DISABILITIES

24.16 APPLICATION/REDETERMINATION

If the client is currently enrolled in, or eligible for, full-coverage Medicaid, he must still be assessed for medical eligibility. If found eligible, the client must be assessed to determine if he must contribute to his cost of care. These clients, including Supplemental Security Income (SSI) and Deemed SSI recipients, must complete the DFA-LTC-5 at application and annual redetermination for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to evaluate any annuities, trusts, and/or other potential resources or transfers unless they meet any listed exceptions. See Section 24.1.

If the client is not eligible for full-coverage Medicaid, he may be eligible the ICF/IID group if he meets certain income and asset standards. These applicants, including Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), and Qualified Individual – 1 (QI-1) clients, must complete the full application process. See Section 24.7. If found eligible, the client must contribute toward his cost of care.

If the client is not otherwise eligible, eligibility as an SSI-Related Medicaid client must be explored.

The application/redetermination process is the same as SSI-Related Medicaid, with the following exceptions that govern time limits on processing the application:

- As a result of the Medley, et al. vs Lipscomb court order, the Department of Human Services (DOHS) is required to determine an individual's eligibility for ICF/IID level of care and placement in a ICF/IID facility within three working days of receiving a completed application. Presumptive eligibility is determined using a DFA-ICF/MR-1. The case management agency, in conjunction with the admission committee from the certified ICF/IID facility, is responsible for determining the initial financial eligibility. This presumptive eligibility period may not exceed 30 days. The completed DFA-ICF/MR-1 is considered the initial application.

- The DFA-ICF/MR-1 form must be date-stamped when received in the local office. The three-working-day time limit begins the day after the DCA-ICF/MR-1 is received.

When the DFA-ICF/MR-1 form is received, the local office Community Services Manager (CSM) is responsible for:

- Having the case entered and approved for presumptive eligibility in the eligibility system within this three-working-day time limit.

- Assigning the case to a Worker. The Worker issues a DFA-6 to the client or his authorized representative to obtain any verification required to determine ongoing eligibility after the 30-day presumptive eligibility period. The DFA-6 has a 10-day time limit with the exception of spenddown cases.
- Assuring that a decision regarding ongoing eligibility is made within the 30-day presumptive period, once the required verification is received.

All ICF/IID applicants, other than those already admitted to and living in a certified facility, must apply for admission to the ICF/IID facility.

- The staff at the ICF/IID facility may use the DFA-ICF/MR-1 to presumptively determine medical and financial eligibility. When this is done, the procedures discussed above are followed; or
- When the application for ICF/IID is made using the DFA-2 or DFA-MA-1, and, thus no presumptive decision is made by the case management agency ICF/IID admission committee, the application is processed using SSI-Related Medicaid processing time limits.

NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply for any or all Division of Family Assistance (DFA) programs.

Eligibility is redetermined once a year and no interview is required.

24.17 COMMON ELIGIBILITY REQUIREMENTS

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) uses the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.18 ELIGIBILITY DETERMINATION GROUPS

24.18.1 THE ASSISTANCE GROUP (AG)

The resident of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is the only person in the AG.

24.18.2 THE INCOME GROUP (IG)

Only the income of the ICF/IID client is counted.

24.18.3 THE NEEDS GROUP (NG)

Monthly gross countable income is compared to 300% of the Supplemental Security Income (SSI) payment level for a single individual.

24.18.4 CASE COMPOSITION

Only the resident of the ICF/IID is included in the case.

24.19 INCOME

24.19.1 ELIGIBILITY

The determination of countable income sources for Supplemental Security Income (SSI)-Related Medicaid is used for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) cases. See Chapter 4.

The individual must have gross countable income at or below 300% of the SSI payment level. When income exceeds this limit, the client may be determined eligible for a monthly spenddown to the Medically Needy Income Level (MNIL) and become eligible. See Section 24.7.2.D.

24.19.2 POST-ELIGIBILITY

When the client has income at or below 300% of the SSI payment level or is eligible for a spenddown to the MNIL level, the post-eligibility process is used to determine the client's contribution to his cost of care. See Section 24.7.

Residents of an ICF/IID also receive an additional deduction of up to $65, in addition to the $50 personal needs allowance, when they have earned income from supportive or competitive employment in a sheltered workshop.

24.20 ASSETS

The determination of countable assets for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) cases is determined in the same way as for Supplemental Security Income (SSI)-Related Medicaid. Assets are compared to the limit for a single individual. See Chapter 5.

Transfer of resources, transfer of resources penalties, and spousal asset assessment policies apply, see Section 24.8.

24.21 NOTIFICATION

Notification policy and process is the same as it is for nursing facility services, as described in Section 24.9.

24.22 CASE MAINTENANCE

24.22.1 FACILITY TRANSFER

When an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) client moves from one facility to another, the Worker must change the address and vendor number in the eligibility system. When the new facility is in another county, the case record must be transferred as well.

When the client resides in more than one ICF/IID facility in the same calendar month, the Worker must determine the portion of the client's cost contribution that must be paid to each facility in accordance with Section 24.7. Because the ICF/IID rate varies based on the individual's medical assessment, a standard rate per facility is not posted on the Department of Human Services' (DOHS) Intranet site. The Worker must contact each facility for the individual's ICF/IID rate.

24.22.2 CHANGES IN INCOME

If a client's income increases to more than 300% of the Supplemental Security Income (SSI) payment level, he is ineligible and must be reevaluated for all other Medicaid coverage groups including SSI-Related/Monthly Spenddown. Appropriate client notification, including advance notice requirements and data system action, apply.

24.23 BENEFIT REPAYMENT

24.23.1 CLIENT REPAYMENT

When payment for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services is made for a client who is ineligible for such payment, only eligible for a lower benefit, or ineligible for Medicaid, repayment is pursued as specified in Chapter 11.

24.23.2 PROVIDER FRAUD

When fraud on the part of an ICF/IID service provider, facility, or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.23.3 ESTATE RECOVERY

Estate recovery applies to ICF/IID cases. See Section 24.11.

24.24 ESTABLISHING MEDICAL NECESSITY

Medical necessity for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) care is determined by the Bureau for Medical Services (BMS) contracted agency based on information provided by the ICF/IID facility on BMS forms DD-1 through DD-5.

The ICF/IID must submit the medical eligibility certification to the BMS contracted agency within 90 days of the date of placement in the ICF/IID.

The case management agency, in conjunction with the admission committee of the certified ICF/IID facility, may determine that applicants meet medical necessity requirements for placement in an ICF/IID facility on a presumptive basis not to exceed 30 days.

The first half of the presumptive application form, DFA-ICF/MR-1, is the medical certification that the ICF/IID placement is the least restrictive and best placement for the applicant, and must be signed by a licensed psychologist or other Qualified Intellectual Disabilities Professional (QIDP) on the day the applicant is admitted to the ICF/IID facility.

For applicants presumptively approved, the facility sends one copy of the DFA-ICF/MR-1 to the attention of the Community Services Manager (CSM) in the county where the ICF/IID facility is located, and one copy, along with the psychological/medical/social treatment plan that is compiled on forms DD-1 through DD-5, to the BMS contacted agency.

At the time of the client's presumptive approval, the psychological/medical/social treatment plan is submitted to the BMS contracted agency to document that the client meets medical necessity criteria. When the BMS contracted agency makes a determination, the CSM is notified. The effective date of a finding of medical necessity is indicated in the memorandum.

24.25 SPECIAL ELIGIBILITY SYSTEM INSTRUCTIONS

Supplemental Security Income (SSI) recipients and Deemed SSI recipients who participate in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are coded in the eligibility system. SSI and Deemed SSI recipients remain in the same category while also being dually coded as ICF/IID clients.

24.26 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE

See Section 24.14.

24.27 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payment to the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is the responsibility of the Bureau for Medical Services (BMS) and its contract agency. The BMS contract agency maintains a Provider Services helpline for vendor questions. See Appendix E.

COMMON WAIVER INFORMATION FOR AGED AND DISABLED WAIVER (ADW), INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD) WAIVER, CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER, AND TRAUMATIC BRAIN INJURY WAIVER (TBI)

24.28 COMMON ELIGIBILITY REQUIREMENTS

Waiver coverage groups use the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.29 ELIGIBILITY DETERMINATION GROUPS

24.29.1 THE ASSISTANCE GROUP (AG)

The waiver client is the only person in the AG.

24.29.2 THE INCOME GROUP (IG)

Only the income of the waiver client is counted. No income eligibility determination is required for Supplemental Security Income (SSI) and Deemed SSI recipients. Income is not deemed.

24.29.3 THE NEEDS GROUP (NG)

Gross countable income is compared to 300% of the SSI payment level for a single individual. No needs test is applied to SSI and Deemed SSI Medicaid clients.

24.29.4 CASE COMPOSITION

Only the waiver client is the primary person in the case, unless he is an SSI recipient with an Essential Spouse. See Section 23.11.

24.30 INCOME

Only the income of the waiver client is to be counted. No income is deemed to the client.

The determination of which income sources to count is the same as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 4.

The client's monthly gross countable income must be equal to or less than 300% of the maximum SSI payment for a single individual.

There is no post-eligibility process for this coverage group.

24.31 ASSETS

The determination of countable asset sources is the same as for Supplemental Security Income (SSI)-Related Medicaid. See Chapter 5. The SSI-Related Medicaid asset limit for one person is used. Assets are not deemed for clients of waiver services.

SSI and Deemed SSI Medicaid coverage groups have no additional asset test at application for waiver services however must be evaluated for transfer resources, trust, and annuities.

For transfers of resources and spousal assessment of assets, see Section 24.8, both apply to Aged and Disabled (ADW), Intellectual and Developmental Disabilities (I/DD), Children with Serious Emotional Disorder (CSED), and Traumatic Brain Injury (TBI) waiver services.

Exception: The effective date for the 60-month transfer of assets look back period, and for the spousal asset assessment, is the application date for HCB Waiver Medicaid.

24.31.1 TRANSFER OF RESOURCES PENALTY

The transfer of resources penalty for an applicant is a period of ineligibility for Home and Community-Based Waiver Medicaid. Medicaid eligibility will not continue in an HCB Waiver coverage group during the transfer penalty; the applicant must be evaluated for other Medicaid coverage groups.

The beginning date of the penalty period imposed for any uncompensated transfer of resources is the date on which the individual is financially eligible, medically eligible and enrolled in a slot for Home and Community-Based Waiver Medicaid.

When an individual is in a penalty period and transfers additional resources during the penalty, a new penalty period begins as soon as the previous penalty ends. All penalties for resources transferred on or after March 1, 2009, run consecutively.

A penalty period begins no later than the date the Department has determined the client:

- Meets all financial eligibility;
- Meets medical eligibility; and
- Has an available waiver slot for the client's placement

When a waiver services client transfers resources without receiving fair compensation, a penalty is applied after advance notice.

24.31.2 TRANSFER OF RESOURCES PENALTY PERIOD

The penalty period is determined using the following procedure and lasts for the number of whole and/or partial months determined by the following calculation.

The total amount transferred during the look-back period is divided by the State's average monthly nursing facility private pay rate of $396.76 per day, or $11,903 per month.

When the remaining amount of the transfer is less than the average monthly private pay cost of nursing facility care, the agency imposes a penalty for less than a full month. The partial month's penalty is converted to a number of days for which the individual is ineligible for payment for waiver services.

The partial month's penalty is determined as follows:

Step 1: The total amount transferred is divided by the State's average monthly nursing facility private pay rate of $11,903.

Step 2: Multiply the number of whole months from Step 1 by the average private pay rate of $11,903.

Step 3: Subtract the amount in Step 2 from the total amount of all transfers. The remainder is the amount used to determine the number of days the individual is ineligible for waiver services in the partial month of the penalty period.

Step 4: The Step 3 amount is divided by the average daily rate of $396.76 to determine the number of days of ineligibility in the last month of the penalty period.

24.31.2.A Asset Transfer Examples

> **Applicant Asset Transfer Example 1:** Ms. Freesia, a 70-year-old woman, applies for ADW services in July 2024 but transferred $164,000 in cash from her bank account to her daughter in January 2022. Based on the average private pay nursing facility rate of $11,903 a month Ms. Freesia is subject to a transfer of resources penalty for 13.77 months. She meets all financial and medical eligibility requirements. A waiver slot becomes open in August 2024. It is at that point she

has met all the criteria and her penalty period begins. The penalty begins in August 2024 and runs through August 2025 with a partial month's penalty of $9,261 or 23 days-imposed September 2025.

Applicant Asset Transfer Example 2: Same as above except Ms. Freesia transferred an additional $45,500, she received from an insurance settlement to her daughter in September 2024 causing an additional 3.8 months penalty. This penalty will begin in October 2025 and run through December 2025 with a partial month of $9,791 for 24 days imposed in January 2026.

Client Asset Transfer Example 1: Mr. Alder makes an uncompensated transfer of $24,534 after approval for ADW services and Medicaid.

Step 1:	$24,534	Uncompensated transfer amount
	÷$11,903	State's average monthly nursing facility pay rate
	2.06	Number of months for penalty period
Step 2:	$11,903	State's average monthly nursing facility private pay rate
	x 2	Whole months in penalty period
	$23,806	
Step 3:	$24,534	Total uncompensated transfer amount
	-$23,806	Amount for two whole months in penalty period
	$728	Partial month penalty amount
Step 4:	$728	
	÷ $396.76	Average daily rate
	1.83	Number of ineligible days for partial month

The partial penalty is imposed for the number of whole days only. If an ADW client transfers resources in July and advance notice is provided for August closure, the penalty period runs for two full months from August through September, with a partial month penalty of 1 day calculated for October. The individual becomes eligible for ADW on October 2 if he meets all other requirements.

Client Transfer Example 2: Ms. Ivy is receiving TBI services and transfers her home to her daughter without compensation in October 2024. The value of the home is $110,000. After advance notice, the penalty period is October 2024 through June 2025 for 9 whole months. A partial month penalty is calculated for July 2025, the 10th month, based on $2,873 remaining of the total penalty

amount. $2,873/$396.76 = 7 days of ineligibility in July 2025. Any fractional days are dropped, and the length of the penalty is based on the number of whole days. If otherwise eligible, payment for TBI services is approved effective July 8th, 2025.

Client Transfer Example 3: Mr. Juniper enters a nursing facility in October 2024 and applies for long term care services. He has a transfer penalty of 1.17 months. The whole month penalty is applied for October 2024 and the partial month penalty is added to his November 2024 contribution for his cost of care. He is approved for ADW services and will return to his home on November 1, 2024. The partial month penalty is recalculated into days for November 2023.

24.32 BENEFIT REPAYMENT

24.32.1 CLIENT REPAYMENT

When payment for waiver services is made for a client who is ineligible for such payment, or for Medicaid, repayment is pursued as specified in Chapter 11.

24.32.2 PROVIDER FRAUD

When fraud on the part of the waiver service provider, facility, case management agency, or other Medicaid provider is suspected, the procedures in Chapter 11 are followed.

24.32.3 ESTATE RECOVERY

Estate recovery liens apply to Aged and Disabled Waiver (ADW) clients, Traumatic Brain Injury (TBI) waiver clients, and nursing facility clients. See Section 24.11. Refer all questions to the contract agency for Estate Recovery. Information about this agency is found in Appendix E.

Estate recovery does not apply to Intellectual and Developmental Disability (I/DD) waiver cases, unless the I/DD client is age 55 or over and enters an institution.

24.33 SPECIAL ELIGIBILITY SYSTEM INSTRUCTIONS

24.33.1 CURRENT SSI AND DEEMED SSI RECIPIENTS

Supplemental Security Income (SSI) and Deemed SSI recipients receiving waiver services remain in the same SSI and Deemed SSI category in the eligibility system. SSI and Deemed SSI recipients are not dually coded.

24.33.2 ALL OTHERS

Clients eligible for waiver services who do not receive SSI or Deemed SSI are coded in the appropriate waiver category in the eligibility system.

24.34 MANAGEMENT OF THE PERSONAL NEEDS ALLOWANCE

The personal needs allowance does not apply to waiver services.

24.35 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payment to the case management agencies is the responsibility of the Bureau for Medical Services (BMS) and its contract agency. The BMS contract agency maintains a Provider Services helpline for vendor questions. All inquiries from case management agencies, service providers, or vendors about billing must be referred to Provider Services. See Appendix E.

24.36 TAKE ME HOME TRANSITION PROGRAM

The Take Me Home (TMH) Transition Program is a program of the West Virginia Bureau for Medical Services (BMS). The purpose of TMH is to identify qualifying residents of long-term care facilities who wish to return to their own homes and apartments in the community and provide them the supports and services they need to do so. Nursing Home residents wanting to return to the community with Take Me Home support, must be determined financially and medically eligible for either the Aged and Disabled Waiver (ADW) or the Traumatic Brain Injury Waiver (TBIW) program.

The West Virginia Department of Human Services (DOHS) Referral Form for the Medicaid ADW or TBIW Program (DHS-2.FRM) is submitted to the Worker to begin the financial eligibility determination process as outlined in this manual beginning in section 24.37.3. The DHS-2 form has two versions, one yellow and one white. The yellow DHS-2 form is required for initial financial eligibility determination and must be presented to the Worker to begin the initial financial eligibility determination process. Please note that a projected date of discharge is not required or needed to process the yellow DHS2 form for TMH clients.

The following procedure needs to be applied when processing the white DHS-2 form for a TMH client that has a probable transition date from a nursing facility to the community. The Waiver Case Management Provider or the Bureau of Senior Services (BoSS), or the Utilization Manager (UMC) must contact the Department of Human Services (DOHS) for an ADW or TBIW financial eligibility determination of a Take Me Home client. The Waiver Case Management Provider, BoSS, or the UMC must send the white DHS-2 form within two business weeks of the client's projected date of discharge. The Worker must evaluate the client's financial eligibility based on the current information in the case record. If financially eligible, the Worker completes the white DHS-2 form. The effective date for the white DHS-2 form is the projected date of discharge. Once the form is complete, the Worker submits the white DHS-2 form to the appropriate agency indicating the client's financial eligibility. This may be submitted by fax, scan, or mail.

The Worker records the action taken in the case record. The completed white DHS-2 form is valid for 30 days after the effective/projected date of discharge. When the white DHS-2.FRM expires, the entire white DHS-2 form process is void and the procedure is repeated as needed.

The Nursing Facility or Case Management Provider will contact the DOHS Worker when the actual discharge occurs. The Worker updates the eligibility system with the actual discharge date, evaluates financial eligibility to complete the procedure, and again comments that the action was taken.

Information about the Take Me Home Transition Program is found on the BMS website or by calling 1-855-519-7557

AGED AND DISABLED WAIVER (ADW)

24.37 APPLICATION/REDETERMINATION

The West Virginia Department of Human Services (DOHS) Referral Form for Medicaid Aged and Disabled Waiver (ADW) Program, Initiate Financial Eligibility (DHS-2.FRM) must be presented to begin the ADW financial eligibility determination process.

The DHS-2.FRM form has two versions, one yellow and one white.

- The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. Financial eligibility is determined for the ADW program before medical eligibility is initiated.
- The white DHS-2.FRM, along with the Notice of Decision letter, confirms the client is medically-eligible and that a funded waiver slot is available for the ADW program.

The steps in the application process are outlined in below.

24.37.1 GENERAL APPLICATION PROCEDURES

24.37.1.A Application Forms

New applicants must apply for ADW Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1. Current Supplemental Security Income (SSI) and Deemed SSI Medicaid clients must complete the DFA-LTC-5 form to evaluate for trusts, transfers, and annuities.

An interview is not required. If a face-to-face interview is requested by the client or their authorized representative, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his authorized representative.

24.37.1.B Complete Application

The application is complete when the client or his authorized representative signs the appropriate application form which contains, at a minimum, the client's name, address, and signature.

24.37.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.37.1.D Who Must Sign

The application must be signed by the applicant, the spouse or the authorized representative. See Section 24.4 for more information on authorized representatives.

24.37.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.37.1.F Application Processing Limits

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

24.37.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is:

- The first day of the month that the client is financially eligible and the Worker receives notice that the client is medically-eligible and awarded a funded slot for waiver services; or
- The first day of the month in which the individual is eligible for payment of ADW services after a transfer of resources penalty expires. See Section 24.29.

24.37.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

ADW services will only be paid on or after the ADW approval date.

24.37.2 STEPS IN THE APPLICATION PROCESS

Steps in the application process are as follows.

24.37.2.A Step One: Receipt of the DOHS Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM will originate from the ADW Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.37.2.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the ADW UMC.

24.37.2.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.37.2.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- The Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.37.2.A.4 Client Is Determined Financially Eligible

If the client is determined financially eligible for the ADW:

- The Worker confirms the pending ADW category. Financial eligibility for the ADW category is pended up to 90 days in the data system awaiting verification of medical eligibility and availability of a funded ADW slot. The client is notified by a system generated letter.
- The Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.

24.37.2.A.5 Client Is Determined Financially Ineligible

If the client is determined financially ineligible for the ADW:

- The Worker checks the box on the yellow DHS-2.FRM indicating the client is ineligible and faxes the form back to the UMC.
- The Worker then evaluates for all other Division of Family Assistance (DFA) programs. The client will be sent a denial letter by the eligibility system.

24.37.2.B Step Two: Receipt of the DOHS Referral Form for Medicaid Aged and Disabled Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the ADW program.

The white DHS-2.FRM originates from a case management agency if the client chooses the traditional service delivery model, or from the Bureau of Senior Services (BoSS) if the client chooses the personal options delivery model.

24.37.2.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid is not approved.

24.37.2.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid is not approved.

24.37.2.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker updates financial eligibility.

- If ADW financial eligibility was determined in the last 90 days and is in pending status, the Worker updates the system and approves Medicaid ADW program eligibility.
- If more than 90 days have passed since financial eligibility was determined, the client must be reevaluated for financial eligibility. Medicaid ADW is not approved. The client must submit a new application prior to the expiration date on the white form.

- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid ADW and faxes the form back to the originating agency.
- The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

NOTE: When the applicant's eligibility for or enrollment in this program is pending due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the ADW group, but must be evaluated for any or all DFA programs.

> **ADW Application Example:** Mr. Beech applies for ADW, which requires a medical eligibility decision by the ADW program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DOHS office and applies for the Supplemental Nutrition Assistance Program (SNAP). Although his medical eligibility for ADW has not been determined and a financial determination cannot be made by the Worker for ADW, his pending status for this program does not prevent his evaluation for all other Medicaid groups or DFA programs for which he may qualify.

24.37.3 WAIVER APPLICANTS CURRENTLY RECEIVING MEDICAID PAYMENT FOR NURSING FACILITY SERVICES

For ADW applicants currently receiving Medicaid payment for nursing facility services, the following steps are used.

24.37.3.A Step One: Receipt of the DOHS Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. The Worker must first evaluate the client's financial eligibility based on the current information in the case record.

Clients currently receiving Medicaid payment for nursing facility services in the Nursing Facility coverage group, or as an SSI or Deemed SSI recipient, have been determined financially eligible and are not required to complete a new Medicaid application upon receipt of the yellow DHS-2.FRM.

All other clients currently receiving Medicaid payment for nursing facility services must submit an appropriate waiver application form prior to the expiration date on the yellow DHS-2.FRM.

24.37.3.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the ADW UMC.

24.37.3.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.37.3.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- If the client is currently receiving Medicaid in the Nursing Facility, SSI or Deemed SSI coverage group, the Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.
- If not currently financially eligible, the Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date, if applicable. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.

- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.37.3.B Step Two: Receipt of the DOHS Referral Form for Medicaid Aged and Disabled Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the ADW program.

24.37.3.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid coverage for nursing facility services continues if all requirements are met.

24.37.3.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid coverage for nursing facility services continues if all requirements are met.

24.37.3.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker approves eligibility in the ADW category upon notification the client has been discharged from the nursing facility.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid ADW and faxes the form back to the originating agency.

The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

24.37.4 REDETERMINATION PROCESS

A redetermination of eligibility is completed once a year; a face-to-face interview is not required. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If the automatic redetermination process is successful, the worker will receive a System Generated Alert to confirm continued medical eligibility and waiver enrollment.

When the redetermination process cannot be completed automatically, the eligibility system alerts the worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure. The Worker must manually set an alert to schedule the redetermination for SSI and Deemed SSI waiver clients.

The same financial criteria used at application applies at each annual redetermination. Medical necessity must be verified annually at redetermination with a Notice of Decision letter or document from the UMC stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the Bureau for Medical Services (BMS).

24.38 NOTIFICATION

24.38.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.38.2 CASE MANAGEMENT AGENCY (CMA) OR THE BUREAU OF SENIOR SERVICES (BoSS)

At application, the Worker sends a copy of the completed white DHS-2.FRM to the originating agency within 30 days of completion of the application. This notifies the CMA of the financial eligibility decision and provides them with the Medicaid ID. The Worker retains a copy of the completed DHS-2.FRM for the case record.

The Worker must also notify the CMA, or the BoSS if the client is a Personal Options member, when an Aged and Disabled Waiver (ADW) client becomes ineligible for any reason, using the original form DHS-2.FRM, a DHS-1, or a free-format letter.

24.39 CASE MAINTENANCE

24.39.1 COUNTY TRANSFER

When an Aged and Disabled Waiver (ADW) client moves from one county to another, the case record must be transferred to the new county of residence.

24.39.2 CHANGES IN INCOME FOR THE ADW COVERAGE GROUP

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for ADW services. The Worker must:

- Notify the case management agency or the West Virginia Bureau of Senior Services (BoSS)
- Notify the client or his authorized representative by providing 13 days' advance notice
- Update the eligibility system
- Evaluate the client for all other Medicaid coverage groups

24.39.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that ADW services are no longer required, he is ineligible for the ADW coverage group. If this is the method by which he qualified for Medicaid, he must be evaluated for all other Medicaid coverage groups. ADW services are no longer paid under Medicaid.

If the ADW client's condition changes to the extent that care in a nursing facility is required, the following conditions must be met before Medicaid can pay for nursing facility services:

- A valid pre-admission screening (PAS) was completed on the date the client entered the nursing facility or within the 60-day period prior to entering the facility.
- The post-eligibility process to determine the client's contribution to his cost of care was completed. See Section 24.7.3 for instructions.
- All notification procedures outlined in Section 24.9 were followed.

- The redetermination cycle remains the same for the assistance group (AG). When this change occurs in the month of redetermination, it must be completed at the same time as the change from ADW to nursing facility services.
- When the individual is under age 65, not blind, and does not receive a disability benefit or meet any other criteria specified in Section 13.4, disability must be established by the Medical Review Team (MRT). See Section 24.12.1.

24.40 ESTABLISHING MEDICAL NECESSITY

Medical necessity is determined by the Bureau for Medical Services (BMS) Utilization Management Contracted agency (UMC). When the UMC sends the white DHS-2.FRM, along with the Notice of Decision letter, medical necessity is presumed to be determined.

The Worker has responsibility in this process to obtain the letter from the UMC as verification of medical eligibility at application and redetermination. The BMS, UMC, or case manager notifies the Worker when a client no longer meets medical necessity criteria for Aged and Disabled Waiver services.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD)

24.41 APPLICATION/REDETERMINATION PROCESS – I/DD

The application process for financial eligibility for Intellectual and Developmental Disabilities (I/DD) Waiver begins when the Worker receives a memorandum from the Bureau for Medical Services (BMS) contract agency listed in Appendix E. The memorandum (Notice of Decision Letter for medical eligibility) gives the date that medical necessity for I/DD Waiver services eligibility is established and verifies a funded slot is available.

24.41.1 GENERAL APPLICATION PROCEDURES

24.41.1.A Application Forms

Current clients of Supplemental Security Income (SSI), Deemed SSI, Parent/Caretaker Relatives, Children under Age 19, and Pregnant Women must complete only the DFA-LTC-5 to evaluate for annuities, trusts, and/or other potential resources or transfers when determined medically-eligible for I/DD.

All other new applicants must apply for I/DD waiver Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1.

24.41.1.B Complete Application

The application is complete when the client or his representative signs the appropriate application form which contains, at a minimum, the client's name, address, and signature. An interview is not required.

24.41.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address,

and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.41.1.D Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.41.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.41.1.F Application Processing Limits

Data system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.41.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is the later of the following:

- The date of initial medical eligibility which is established by the BMS contract agency; or
- The date on which the applicant was approved for financial eligibility.

24.41.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid

approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

I/DD waiver services will only be paid on or after the I/DD waiver approval date.

NOTE: When the applicant's eligibility for or enrollment in this program is pending he must not be refused the right to apply due to his pending status for the I/DD group, but must be evaluated for any or all Division of Family Assistance (DFA) programs.

24.41.2 REDETERMINATION PROCESS

I/DD cases are redetermined financially once a year. An interview is not required. The same financial criteria used at application applies at each annual redetermination. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If the automatic redetermination process is successful, the worker will receive a System Generated Alert to confirm continued medical eligibility and waiver enrollment.

When the redetermination process cannot be completed automatically, the eligibility system alerts the worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure. The Worker must manually schedule the redetermination for SSI and Deemed SSI I/DD waiver clients. SSI and Deemed SSI clients must complete the DFA-LTC-5 to complete an I/DD waiver redetermination.

Medical necessity must be verified annually at redetermination with a letter from the Utilization Management Contractor (UMC) stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the BMS.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of I/DD Waiver Services in the BMS due to circumstances beyond the individual's control.

Information about I/DD Waiver Services is found on the BMS website on the Office of Home and Community-Based Services page. The I/DD Waiver application (WV-BMS-IDD-01) needed to determine medical eligibility can be found on the BMS website and on the DFA intranet forms page.

24.42 NOTIFICATION

24.42.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.42.2 CASE MANAGEMENT AGENCY (CMA)

The Worker notifies the CMA when:

- The client's financial determination is made or the client's receipt of Supplemental Security Income (SSI);
- The Intellectual and Developmental Disability (I/DD) Waiver case is approved and the date the client is eligible for services;
- The I/DD client becomes ineligible for any reason.

The case manager notifies the Worker when:

- An application is required;
- The client no longer requires I/DD waiver services.

24.42.3 OTHER

The Bureau for Medical Services (BMS) contract agency notifies the Community Services Manager (CSM) when the client's medical necessity for I/DD waiver services is established.

24.43 CASE MAINTENANCE

24.43.1 COUNTY TRANSFER

When an Intellectual and Developmental Disability (I/DD) waiver client moves from one county to another, the case record must be transferred to the new county of residence.

24.43.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for I/DD waiver services.

The Worker must:

- Notify the Bureau for Medical Services (BMS) for the ending date of eligibility for I/DD;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Notify the case management agency;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.43.3 CLOSURE/DENIAL

When an I/DD case is closed or denied and an application is taken for nursing facility services, no waiver services are covered under Medicaid.

24.44 ESTABLISHING MEDICAL NECESSITY

The Bureau for Medical Services (BMS) contract agency determines medical necessity for Intellectual and Developmental Disability (I/DD) waiver services.

The BMS contract agency notifies the Community Services Manager (CSM) by memorandum of the Notice of Decision, client's name, and the date that medical necessity for I/DD waiver services was established.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of I/DD waiver services in the BMS due to circumstances beyond the client’s control.

TRAUMATIC BRAIN INJURY (TBI) WAIVER

24.45 APPLICATION/REDETERMINATION

The West Virginia Department of Human Services (DOHS) Referral Form for Medicaid Traumatic Brain Injury (TBI) Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) must be presented to begin the TBI waiver financial eligibility determination process.

The DHS-2.FRM form has two versions, one yellow and one white.

- The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. Financial eligibility is determined for the TBI waiver program before medical eligibility is initiated.
- The white DHS-2.FRM, along with the Notice of Decision letter, confirms the client is medically-eligible and that a funded waiver slot is available for the TBI waiver program.

The steps in the application process are outlined in Section 24.45.2 below.

24.45.1 GENERAL APPLICATION PROCEDURES

24.45.1.A Application Forms

New applicants must apply for TBI waiver Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1. Current Supplemental Security Income (SSI) and Deemed SSI clients must complete the DFA-LTC-5 form to evaluate for trusts, transfers, and annuities.

An interview is not required. If a face-to-face interview is requested by the client or their authorized representative, the appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his authorized representative.

24.45.1.B Complete Application

The application is complete when the client or his authorized representative signs the appropriate application form which contains, at a minimum, the client's name, address and signature.

24.45.1.C Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.45.1.D Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives. When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.45.1.E Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.45.1.F Application Processing Limits

Eligibility system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.45.1.G Beginning Date of Eligibility

The beginning date of Medicaid eligibility is:

- The first day of the month that the client is financially eligible and the Worker receives notice that the client is medically-eligible and awarded a funded slot for waiver services; or

- The first day of the month in which the individual is eligible for payment of TBI waiver services after a transfer of resources penalty expires. See Section 24.31.

24.45.1.H The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

TBI waiver services will only be paid on or after the TBI waiver approval date.

24.45.2 STEPS IN THE APPLICATION PROCESS

Steps in the application are as follows.

24.45.2.A Step One: Receipt of the DOHS Referral Form for Medicaid Traumatic Brain Injury Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

For Step One of the application process, the yellow DHS-2.FRM will originate from the TBI waiver Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.45.2.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the TBI waiver UMC.

24.45.2.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.45.2.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- The Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date. However, the application process does not have to be completed prior to the expiration date.
- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM, the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.45.2.A.4 Client Determined Financially Eligible for the TBI waiver

If the client is determined financially eligible for the TBI waiver:

- The Worker confirms the pending TBI waiver category. Financial eligibility for the TBI waiver category is pended up to 90 days in the data system awaiting verification of medical eligibility and availability of a funded TBI waiver slot. The client is notified by a system generated letter.
- The Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.

24.45.2.A.5 Client Determined Financially Ineligible for the TBI waiver

If the client is determined financially ineligible for TBI waiver:

- The Worker checks the box on the yellow DHS-2.FRM indicating the client is ineligible and faxes the form back to the UMC.
- The Worker then evaluates for all other Division of Family Assistance (DFA) programs. The client will be sent a denial letter by the eligibility system.

24.45.2.B Step Two: Receipt of the DOHS Referral Form for Medicaid Traumatic Brain Injury Waiver Program (DHS-2.FRM) WHITE FORM

For Step Two of the application process, the white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the TBI waiver program.

The white DHS-2.FRM originates from a case management agency if the client chooses the traditional service delivery model or the personal options delivery model.

24.45.2.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired, the Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid is not approved.

24.45.2.B.2 White DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid is not approved.

24.45.2.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker updates financial eligibility.
    - If TBI waiver financial eligibility was determined in the last 90 days and is in pending status, the Worker updates the system and approves Medicaid TBI waiver program eligibility.
    - If more than 90 days have passed since financial eligibility was determined, the client must be reevaluated for financial eligibility. The Medicaid TBI waiver is not approved. The client must submit a new application prior to the expiration date on the white form.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid TBI waiver and faxes the form back to the originating agency.
- The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the TBI waiver group, but must be evaluated for any or all DFA programs.

> **TBI Application Example:** Mr. Beech applies for the TBI waiver, which requires a medical eligibility decision by the TBI waiver program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DOHS office and applies for the Supplemental Nutrition Assistance Program (SNAP). Although his medical eligibility for the TBI waiver has not been determined and a financial determination cannot be made by the Worker for the TBI waiver, his pending status for this program does not prevent his evaluation for all other Medicaid groups or DFA programs for which he may qualify.

24.45.3 WAIVER APPLICANTS CURRENTLY RECEIVING MEDICAID PAYMENT FOR NURSING FACILITY SERVICES

For TBI waiver applicants currently receiving Medicaid payment for nursing facility services, the following steps are used.

24.45.3.A Step One: Receipt of the DOHS Referral Form for Medicaid Traumatic Brain Injury Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. The Worker must first evaluate the client's financial eligibility based on the current information in the case record.

Clients currently receiving Medicaid payment for nursing facility services in the Nursing Facility coverage group, or as an SSI or Deemed SSI recipient, have been determined financially eligible and are not required to complete a new Medicaid application upon receipt of the yellow DHS-2.FRM.

All other clients currently receiving Medicaid payment for nursing facility services must submit an appropriate waiver application form prior to the expiration date on the yellow DHS-2.FRM.

24.45.3.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the TBI waiver UMC.

24.45.3.A.2 Yellow DHS-2.FRM with Missing Expiration Date

If there is no expiration date on the yellow DHS-2.FRM, it should be faxed back to the UMC, noting there is no expiration date.

24.45.3.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

- If the client is currently receiving Medicaid in the Nursing Facility, SSI or Deemed SSI coverage group, the Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.
- If not currently financially eligible, the Worker completes the financial eligibility determination following the general application procedures above. A Medicaid

application must be received by the Worker prior to the DHS-2.FRM expiration date, if applicable. However, the application process does not have to be completed prior to the expiration date.

- If the client does not submit an appropriate Medicaid application form with the yellow DHS-2.FRM the Worker must send an application to the client.
- If the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker checks the box indicating the application was not completed and faxes the form back to the UMC.

24.45.3.B Step Two: Receipt of the DOHS Referral Form for Medicaid Traumatic Brain Injury Waiver Program (DHS-2.FRM) WHITE FORM

The white DHS-2.FRM, along with the Notice of Decision letter, confirms to the Worker the client was determined medically-eligible and awarded a funded slot for the TBI waiver program.

24.45.3.B.1 Expired White DHS-2.FRM

If the white DHS-2.FRM form is expired:

- The Worker checks the box indicating it is expired and faxes the form back to the originating agency. Medicaid coverage for nursing facility services continues if all requirements are met.
- If there is no expiration date on the white DHS-2.FRM, it should be faxed back to the originating agency, noting there is no expiration date. Medicaid coverage for nursing facility services continues if all requirements are met.

24.45.3.B.2 Current (Not Expired) DHS-2.FRM

If the white DHS-2.FRM is not expired:

- The Worker approves eligibility in the TBI waiver category upon notification the client has been discharged from the nursing facility.
- The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid TBI waiver and faxes the form back to the originating agency.

The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

24.45.4 REDETERMINATION PROCESS

A redetermination of eligibility is completed once a year; a face-to-face interview is not required. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If the automatic redetermination process is successful, the worker will receive a System Generated Alert to confirm continued medical eligibility and waiver enrollment.

When the redetermination process cannot be completed automatically, the eligibility system alerts the worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure. The Worker must manually set an alert to schedule the redetermination for SSI and Deemed SSI waiver clients.

The same financial criteria used at application applies at each annual redetermination. Medical necessity must be verified annually at redetermination with a Notice of Decision letter or document from the UMC stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the Bureau for Medical Services (BMS).

24.46 NOTIFICATION

24.46.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.46.2 CASE MANAGEMENT AGENCY (CMA)

At application, the Worker sends a copy of the completed white DHS-2.FRM to the originating agency within 30 days of completion of the application. This notifies the originating agency of the financial eligibility decision and provides them with the Medicaid ID. The Worker retains a copy of the completed DHS-2.FRM for the case record.

The Worker must also notify the originating agency when a Traumatic Brain Injury (TBI) waiver client becomes ineligible for any reason, using the original form DHS-2.FRM, a DHS-1, or a free-format letter.

24.47 CASE MAINTENANCE

24.47.1 COUNTY TRANSFER

When a Traumatic Brain Injury (TBI) waiver client moves from one county to another, the case record must be transferred to the new county of residence.

24.47.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for TBI waiver services.

The Worker must:

- Notify the case management agency (CMA) or the Bureau for Medical Services (BMS) contract agency listed in Appendix E;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.47.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that TBI services are no longer required, he is ineligible for the TBI coverage group. If this is the method by which he qualified for Medicaid, he must be evaluated for all other Medicaid coverage groups. TBI services are no longer paid under Medicaid.

If the TBI client's condition changes to the extent that care in a nursing facility is required, the following conditions must be met before Medicaid can pay for nursing facility services:

- A valid Pre-Admission Screening (PAS) was completed on the date the client entered the nursing facility or within the 60-day period prior to entering the facility.
- The post-eligibility process to determine the client's contribution to his cost of care was completed. See Section 24.7 for instructions.

- All notification procedures outlined in Section 17.6 were followed.
- The redetermination cycle remains the same for the assistance group (AG). When this change occurs in the month of redetermination, it must be completed at the same time as the change from TBI to nursing facility services.
- When the individual is under age 65 and does not receive a disability benefit or meet any other criteria specified in Section 13.4, disability must be established by MRT. See Section 24.12.

24.48 ESTABLISHING MEDICAL NECESSITY

Medical necessity is determined by the Bureau for Medical Services (BMS) Utilization Management Contract (UMC) agency. When the UMC sends the white DHS-2.FRM, along with the Notice of Decision letter, medical necessity is presumed to be determined.

The Worker has responsibility in this process to obtain the letter from the UMC as verification of medical eligibility at application and redetermination.

The BMS, UMC, or case manager notifies the Worker when a client no longer has a medical necessity for Traumatic Brain Injury (TBI) waiver services.

CHILDREN WITH DISABILTIES COMMUNITY SERVICE PROGRAM (CDCSP)

24.49 INTRODUCTION

The Children with Disabilities Community Service Program (CDCSP) is a West Virginia optional Medicaid eligibility category that allows a child under the age of 18 with a severe disability who is eligible to receive necessary medical services while residing in their family (natural or adoptive) homes or communities. The medical services must be more cost-effective for the State than placement in a medical institution, such as a nursing home, intermediate care facility for individuals with intellectual disabilities (ICF/IID), acute care hospital, or approved Medicaid psychiatric facility for children under the age of 21.

This coverage group allows children to remain with their families by providing medical services in the home or community that are more cost-effective than care in a medical institution. It also eliminates the requirement that the income and assets of parents and/or legal guardians be deemed to the children.

A child is eligible for Medicaid as a CDCSP client when all of the following conditions are met:

- The child has not attained the age of 18.
- The child has been denied Supplemental Security Income (SSI) eligibility or appears to be ineligible for SSI eligibility because the income and assets of his parent(s) were deemed to him, and as a result, the SSI income or asset eligibility test was not met.
- The child's own gross income does not exceed 300% of the SSI payment level.
- The child has been determined to require a level of care provided in a medical institution, nursing home, ICF/IID, hospital, or psychiatric facility.
- He is expected to receive the necessary services at home or in the community.
- The estimated cost of services is no greater than the estimated cost of institutionalization.
- The child would be eligible for an SSI payment if in a medical institution.

NOTE: The Worker must refer the family to the Social Security Administration (SSA) to apply for SSI if the family has not done so already, even though the Worker may be able to determine that the SSA would deny the child as a result of deeming the parents' income and/or assets.

The Worker must then obtain a copy of the SSI denial letter and retain it in the case record.

The Bureau for Medical Services (BMS) Long Term Care (LTC) Unit determines medical eligibility and notifies the local office and the case management agency of the decision in writing. Refer to Chapter 13 for details about determining medical eligibility.

24.50 APPLICATION

24.50.1 GENERAL APPLICATION PROCEDURES

24.50.1.A APPLICATION FORMS

The Application for Benefits (DFA-2), the Application for Long Term Care Medicaid and Children with Disabilities Community Service (DFA-MA-1), or the Application for Healthcare Coverage (DFA-SLA-1) with the Supplement for Healthcare Coverage (DFA-SLA-S1) is acceptable. Applications may also be submitted via WV PATH.

When medical eligibility for the Children with Disabilities Community Service Program (CDCSP) is established by the Bureau for Medical Services (BMS) and the Case Management Agency (CMA), a memorandum is sent to the Community Services Manager (CSM). The memorandum is given to the Worker who, with the completed application, determines financial eligibility.

The client must verify he has been denied Supplemental Security Income (SSI).

The following information is provided solely for the understanding of the process and not the responsibility of the worker:

- Additional forms related to medical eligibility and cost of services must also be completed as part of the eligibility determination process. This information is sent directly to the BMS by the CMA. See Section 24.55.
- BMS determines the annual cost of institutionalization, the annual cost of in-home care under the CDCSP, and the cost of the type of services necessary for the child to decide the cost-effectiveness of the proposed in-home plan.
- CDCSP-2A or 2B: This is the medical form the child's physician uses to submit necessary information to allow a determination of medical eligibility.
- CDCSP-6: This is the cost estimate worksheet for medical services that must be completed and used by the CMA to:
    - Assure the program plan is cost feasible (e.g., community services cost less than placement in a medical institution).

- Follow through with the school system, healthcare providers, and other agencies to assure that the community services are implemented and consistently remain cost-effective.
- Develop the Program Plan: The program plan must be developed by an interdisciplinary team (IDT) consisting of the child, family or legal representative, service providers, advocates, professionals, paraprofessionals, and other stakeholders needed to ensure the delivery of the necessary level of services. This contains the same elements of the State DD-5 form.
- Provide additional evaluations: Additional evaluations, as appropriate, to determine medical eligibility and services for the specific disability group, such as psychological or psychiatric reports, social assessments, discharge plan, etc.

When an applicant's medical eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply for any or all Division of Family Assistance (DFA) programs.

24.50.1.B COMPLETE APPLICATION

The application is complete when the parent(s) or legal guardian signs the DFA- 2, DFA-MA-1, or DFA-SLA-1 with the DFA-SLA-S1 application that contains, at a minimum, the client's name and address. When the applicant submits his application by WV PATH, the application is considered complete when the application is signed electronically.

24.50.1.C DATE OF APPLICATION

The date of application is the date the parent(s) or legal guardian submits the DFA-2, DFA-MA-1, or DFA-SLA-1 with the DFA-SLA-S1 application, in person, by fax, or by other electronic transmission or by mail, that contains—at a minimum—his name, address, and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address, and signature is received in the local office. Applications can also be submitted by other

NOTE: When a faxed copy or other electronic transmission of an application is received that contains a minimum of the applicant's name, address, and signature, it is considered an original application, and no additional signature is required.

electronic transmission. When the application is submitted using WV PATH, the date of application is the date the application is submitted.

NOTE: If the applicant completed the interactive interview and there is a technical failure that prevents the printing of the DFA-2, Form DFA-5 must be signed by the applicant and attached and filed in the case record with the subsequently printed DFA-2. Form DFA-RR-1 must also be completed and signed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

24.50.1.D INTERVIEW

No interview is required.

24.50.1.E WHO MUST SIGN

The parent(s) or legal guardian of the child must sign the application. When a complete faxed or scanned application is received, no additional signature is required.

24.50.1.F AGENCY TIME LIMITS

The agency must take action to approve, deny, or withdraw the application within 30 days of the date of application.

The Worker must give the parent(s) or legal guardian at least 10 days for the information to be returned.

24.50.1.G AGENCY DELAYS

When the Department of Human Services (DOHS) fails to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received,

and the client is eligible, medical coverage is retroactive to the time eligibility would have been established had the DOHS acted in a timely manner.

Reimbursement for out-of-pocket expenses may apply. See Chapter 10.

24.50.1.H PAYEE

The CDCSP child is the payee.

24.50.1.I EFFECTIVE DATES OF ELIGIBILITY

Eligibility is retroactive to the later of these two dates:

- The date of medical need, established by the BMS, and conveyed by memorandum to the CSM; or
- The date all eligibility requirements were met, up to three months prior to the application date.

Eligibility ends the last day of the effective calendar month of closure.

24.50.1.J THE BENEFIT

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

24.50.2 REDETERMINATION

A redetermination of financial eligibility is completed annually. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If the automatic redetermination process is successful, the worker will receive a System Generated Alert to confirm continued medical eligibility and waiver enrollment.

When the redetermination process cannot be completed automatically, the eligibility system alerts the worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure.

Medical eligibility must be redetermined annually by the Bureau for Medical Services (BMS). The case does not continue to be eligible after the redetermination unless both financial and medical eligibility are redetermined.

24.50.2.A DATE OF REDETERMINATION

There is a 12-month redetermination cycle for the CDCSP assistance groups (AGs).

The eligibility system generates the redetermination form.

24.51 COMMON ELIGIBILITY REQUIREMENTS

Children with Disabilities Community Service Program (CSCSP) coverage groups use the same common eligibility requirements as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 2.

24.52 ELIGIBILITY DETERMINATION GROUPS

24.52.1 THE ASSISTANCE GROUP (AG)

Only the Children with Disabilities Community Services Program (CDCSP) child is included in the AG.

24.52.2 THE INCOME GROUP (IG)

Only the CDCSP child's income is counted. Income of the parent(s) is not deemed or counted in any way.

24.52.3 THE NEEDS GROUP (NG)

Only the CDCSP child's needs are considered.

24.53 INCOME

The determination of which income sources to count is the same as Supplemental Security Income (SSI)-Related Medicaid. See Chapter 4. No income is deemed to the Children with Disabilities Community Service Program (CDCSP) client. The client's monthly gross countable income must be equal to or less than 300% of the maximum (SSI) payment for a single individual to be Medicaid-eligible. There is no post-eligibility process for this coverage group.

NOTE: The spenddown provision does not apply.

24.53.1 INCOME DISREGARDS AND DEDUCTIONS

No income disregards or deductions are applied to the child's countable income.

24.53.2 DETERMINING FINANCIAL ELIGIBILITY

The Worker determines the child's own total countable income from all sources and compares it to 300% of the SSI payment level. If the income is equal to or less than 300% of the SSI payment level, the child is financially eligible.

24.54 ASSETS

The determination of countable assets is the same as for Supplemental Security Income (SSI)-Related Medicaid. See Chapter 5.

Assets are not deemed for this group.

Only the child's assets are counted.

The asset limit for one person is used.

The asset limit for Children with Disabilities Community Services Program (CDCSP) is $2,000.

24.55 NOTIFICATION

Notification procedure in Chapter 9 are applicable.

24.56 CASE MAINTENANCE

24.56.1 COUNTY TRANSFER

When a Children with Disabilities Community Service Program (CDCSP) client moves from one county to another, the case record must be transferred to the new county of residence.

24.56.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for CDCSP. The Worker must:

- Notify the case management agency;
- Notify the client or his authorized representative by providing 13 days' advance notice;
- Update the eligibility system; and,
- Evaluate the client for all other Medicaid coverage groups.

24.56.3 CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that institutional-level services are no longer required, he is ineligible for the CDCSP. He must be evaluated for all other Medicaid coverage groups.

24.56.4 CHILD REACHING AGE 18

At age 18, individuals must apply for SSI. If SSI-eligible, they receive SSI Medicaid and no longer receive coverage as a CDCSP client.

Individuals who reach age 18 continue to receive the services until approved for SSI or reach age 19, whichever occurs first.

No individual who has attained age 18 is approved for CDCSP at application.

24.57 ESTABLISHING MEDICAL NECESSITY AND COST EFFECTIVENESS

Information establishing medical necessity and cost effectiveness of services is sent directly to the Bureau for Medical Services (BMS) by the case management agency.

When medical eligibility for the Children with Disabilities Community Service Program (CDCSP) is established by the BMS, a memorandum is sent to the Community Services Manager (CSM).

24.58 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payments to case management agencies are handled by the Department of Human Services' (DOHS') contract agency that handles provider services. All inquiries from case management agencies, service providers, or vendors about billing must be referred to Provider Services. See Appendix E.

CHILDREN WITH SERIOUS EMOTIONAL DISORDER (CSED) WAIVER

The Children with Serious Emotional Disorder (CSED) Waiver is a Medicaid Home and Community-Based (HCBS) waiver program authorized under §1915(c) of the Social Security Act. The CSED provides services that are additions to Medicaid State Plan coverage for members ages three (3) to 21 who are enrolled in the CSED program. The CSED permits West Virginia to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities.

This waiver prioritizes children/youth with serious emotional disorder (SED) who are:

1. In Psychiatric Residential Treatment Facilities (PRTFs) or other residential treatment providers either out-of-state or in-state; and

2. Other Medicaid-eligible children with SED who are at risk of institutionalization.

Specific program requirements and details may be found in Chapter 502 of the Bureau for Medical Services Policy Manual.

24.59 GENERAL APPLICATION PROCEDURES

24.59.1 Application Forms

Current clients of Supplemental Security Income (SSI), Deemed SSI, Parent/Caretaker Relatives, Children under Age 19, and Pregnant Women must complete only the DFA-LTC-5 to evaluate for annuities, trusts, and/or other potential resources or transfers when determined medically-eligible for CSED.

All other new applicants must apply for CSED waiver Medicaid using the DFA-MA-1, DFA-2, or DFA-SLA-1 and DFA-SLA-S1.

24.59.2 Complete Application

The application is complete when the client or his representative signs the appropriate application form which contains, at a minimum, the client's name, address, and signature. An interview is not required.

24.59.3 Date of Application

The date of application is the date the applicant submits an appropriate application form in person, by electronic transmission or by mail, which contains, at a minimum, his name, address, and signature. When the application is submitted by mail or electronically, the date of application is the date that the form with the name, address, and signature is received in the local office.

24.59.4 Who Must Sign

The application must be signed by the applicant, the spouse, or the authorized representative. See Section 24.4 for more information on authorized representatives.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

24.59.5 Due Date of Additional Information

Additional information is due 30 days from the date of application.

24.59.6 Application Processing Limits

Data system action to approve, deny, or withdraw the application must be taken within 30 days of the date of application.

24.59.7 Beginning Date of Eligibility

The beginning date of Medicaid eligibility is the later of the following:

• The date of initial medical eligibility which is established by the BMS contract agency; or

• The date on which the applicant was approved for financial eligibility.

24.59.8 The Benefit

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

CSED waiver services will only be paid on or after the CSED waiver approval date.

24.59.9 REDETERMINATION PROCESS

CSED cases are redetermined financially once a year. An interview is not required. The same financial criteria used at application applies at each annual redetermination. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the Federal Data Services HUB and the Asset Verification System (AVS). If determined eligible after completing the redetermination process, the DoHS will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances. These changes will be treated as a change in circumstance during the certification period.

If the automatic redetermination process is successful, the worker will receive a System Generated Alert to confirm continued medical eligibility and waiver enrollment.

When the redetermination process cannot be completed automatically, the eligibility system alerts the worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination form is due by the first day of the 12th month of the certification period. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure. The Worker must manually schedule the redetermination for SSI and Deemed SSI CSED waiver clients. SSI and Deemed SSI clients must complete the DFA-LTC-5 to complete an CSED waiver redetermination.

Medical necessity must be verified annually at redetermination with a letter from the Utilization Management Contractor (UMC) stating the client continues to be eligible. If the client continues to meet financial and medical requirements, Medicaid eligibility for waiver services is established. Continued medical eligibility for services is monitored by the BMS.

Information about CSED Waiver Services is found on the BMS website on the Office of Home and Community-Based Services page. The CSED Waiver application (WV-BMS-CSED-01) needed to determine medical eligibility can be found on the BMS website and on the DFA intranet forms page.

24.60 NOTIFICATION

24.60.1 CLIENT

Notification procedures in Chapter 9 are applicable.

24.60.2 CASE MANAGEMENT AGENCY (CMA)

The Worker notifies the CMA when:

- The client's financial determination is made or the client's receipt of Supplemental Security Income (SSI);
- The Children with Serious Emotional Disorders (CSED) Waiver case is approved and the date the client is eligible for services;
- The CSED client becomes ineligible for any reason.

The case manager notifies the Worker when:

- An application is required;
- The client no longer requires CSED waiver services.

24.60.3 OTHER

The Bureau for Medical Services (BMS) contract agency notifies the Community Services Manager (CSM) when the client's medical necessity for CSED waiver services is established.

24.61 CASE MAINTENANCE

24.61.1 COUNTY TRANSFER

When a CSED waiver client moves from one county to another, the case record must be transferred to the new county of residence.

24.61.2 CHANGES IN INCOME

When the client's income increases to above 300% of the Supplemental Security Income (SSI) payment level, he is no longer eligible for CSED waiver services; however, the child under age 19 is eligible for 12 months continuous eligibility of full coverage Medicaid per IMM 10.6. The Medicaid benefit will remain open in the current certification period.

The Worker must:

• Notify the Bureau for Medical Services (BMS) for the ending date of eligibility for CSED waiver services;

• Notify the client or his authorized representative regarding ineligibility of waiver services by providing 13 days' advance notice;

• Notify the case management agency of ineligibility of waiver services; and,

• Keep CSED (MALM) open in the eligibility system with the current certification for continuous eligibility per IMM 10.6.

24.61.3 CLOSURE / DENIAL

When a CSED case is closed or denied and an application is taken for nursing facility services, no waiver services are covered under Medicaid.

24.62 ESTABLISHING MEDICAL NECESSITY

The Bureau for Medical Services (BMS) contract agency determines medical necessity for Children with Serious Emotional Disorder (CSED) waiver services.

The BMS contract agency notifies the Community Services Manager (CSM) by memorandum of the Notice of Decision, client's name, and the date that medical necessity for CSED waiver services was established.

Medicaid is continued when the case is in hearing status or an extension has been granted by the Office of HCBS waiver services in the BMS due to circumstances beyond the client’s control.

APPENDIX A: REMAINDER INTEREST TABLES

Age	Remainder
0	.02812
1	.01012
2	.00983
3	.00992
4	.01019
5	.01062
6	.01116
7	.01178
8	.01252
9	.01337
10	.01435
11	.01547
12	.01671
13	.01802
14	.01934
15	.02063
16	.02185
17	.02300
18	.02410
19	.02520
20	.02635
21	.02755
22	.02880
23	.03014
24	.03159
25	.03322
26	.03505
27	.03710

Age	Remainder
30	.04457
31	.04746
32	.05058
33	.05392
34	.05750
35	.06132
36	.06540
37	.06974
38	.07433
39	.07917
40	.08429
41	.08970
42	.09543
43	.10145
44	.10779
45	.11442
46	.12137
47	.12863
48	.13626
49	.14422
50	.15257
51	.16126
52	.17031
53	.17972
54	.18946
55	.19954
56	.20994
57	.22069

Age	Remainder
60	.25509
61	.26733
62	.27998
63	.29304
64	.30648
65	.32030
66	.33449
67	.34902
68	.36390
69	.37914
70	.39478
71	.41086
72	.42739
73	.44429
74	.46138
75	.47851
76	.49559
77	.51258
78	.52951
79	.54643
80	.56341
81	.58033
82	.59705
83	.61358
84	.63002
85	.64641
86	.66236
87	.67738

Age	Remainder
90	.71779
91	.73045
92	.74229
93	.75308
94	.76272
95	.77113
96	.77819
97	.78459
98	.79000
99	.79514
100	.80025
101	.80468
102	.80946
103	.81563
104	.82144
105	.83038
106	.84512
107	.86591
108	.89932
109	.95455

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
28	.03938	58	.23178	88	.69141		
29	.04187	59	.24325	89	.70474		

APPENDIX B: PATIENTS' RIGHTS

A policy statement setting forth the rights of patients and prohibiting their mistreatment or abuse is established and made available to staff, patients' families, or legal representatives. Written policies and procedures ensure that each patient admitted to the facility is fully informed of his/her rights and responsibilities as a patient in the facility.

A. NOTICE OF RIGHTS

1. Inform each patient of all rules and regulations governing patient conduct and responsibilities. Such information must be provided prior to or at the time of admission or, in the case of patients already in the facility, upon the facility's adoption or amendment of resident right's policies, and its receipt must be acknowledged by the patient in writing. In the case of a mentally retarded individual or of a patient adjudged to be incompetent, the rights described in this provision shall be exercised by the individual's guardian or committee, as applicable under State Law, to act on the patient's behalf.
2. Encourage and assist the patient throughout the period of stay to exercise rights as a patient and a citizen and, to this end, to meet and organize with resident groups, voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of choice free from restraint, interference, coercion, discrimination, or reprisal.
3. Assist each patient to retain and use his/her personal clothing and possessions as space permits.
4. May not require the patient to perform services for the facility.
5. Assure participation in activities of social, religious and community groups at the patient's discretion unless contraindicated for reasons documented by a Qualified Mental Retardation Professional as appropriate in the patient record.

B. NOTICE OF CHARGES FOR SERVICES

1. Inform each patient in writing who is entitled to Medicaid, prior to or at the time of admission and periodically during the patient's stay, of services available in the facility and of related charges, including any charges for services not covered under the Medicaid Program, or not covered by the facility's basic per diem rate. Only charges by the facility for items or services that are allowable and consistent with the Medicaid Program regulations may be imposed.

2. Maintain admission policies and procedures which do not require patients to waive their rights to apply for Medicaid benefits and do not require third party guarantee of payment to the facility as a condition of admission to, or continued stay in the facility.
3. Provide information to each patient, patient's family, and/or patient's representative concerning the availability of assets assessments. Advise them that these assets assessments are available upon request at the county Department of Human Services (DOHS) office whether or not they are applying for Medicaid.

C. FREE CHOICE

Inform each patient of the right to choose a personal attending physician; to be fully informed by the physician of his/her health and medical condition unless medically contraindicated (as documented by a physician in the patient medical record) and of changes in care and treatment. The patient must be offered the opportunity to participate in the planning of his/her total care and medical treatment and participates in experimental research only upon his/her informed written consent.

D. TRANSFER AND DISCHARGE RIGHTS

Transfers and discharges are made only for medical reasons or for the patient's welfare or that of other patients or for nonpayment for stay in the facility, except as prohibited by the Medicaid Program. In a case where the patient's health improves sufficiently so that services provided by the facility are no longer needed, sufficient notice must be provided to the patient and/or family and for adequate discharge planning.

E. PROTECTION OF PATIENT FUNDS

Assure the patient's right to manage his/her personal financial affairs; except, upon written authorization by the patient, the facility will accept responsibility for managing and accounting for the patient's personal funds and records of such funds. A full and complete accounting must be made available to patients and their families, and is maintained on a current basis for each patient with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the patient.

F. FREEDOM FROM RESTRAINTS

1. Assurance of freedom from mental and physical abuse, corporal punishment, involuntary seclusion and freedom from chemical and physical restraints for the purpose of discipline or convenience. Restraints may only be imposed when authorized in writing by a physician for a specific period of time; or, when necessary in an emergency to protect the patient from injury to himself or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician or qualified mental retardation professional for use during behavior modification sessions.

2. A mentally retarded individual participates in a behavior modification program involving use of restraints or aversive stimuli only with the informed consent of his parent or guardian.

G. CONFIDENTIALITY

1. Ensure confidential treatment of all information contained in patient records including information contained in an automatic data bank; and obtain the patient's written consent for the release of information to persons not otherwise authorized under law to receive it.
2. Permit the patient access to his medical records in accord with State law.

H. PRIVACY

1. Assure each patient is treated with consideration, respect, and full recognition of his/her dignity and individuality including privacy in treatment and in care for his personal needs.
2. Ensure the patient's right to communicate, associate, and meet privately with persons of choice unless to do so would infringe upon the rights of other patients, and to send and receive personal mail unopened or censored.
3. Permit access to any patient representatives of the Secretary, DOHS, or the State, officially designated Ombudsman, and the patient's attending physician, consistent with State and federal law; and permit access to any patient by the immediate family, or other relatives, subject to the patient's right to deny or withdraw consent at any time; and permit reasonable access to a patient by any entity or individual that provides social or legal services to the patient, subject to the patient's right to deny or withdraw consent at any time.
4. Ensure privacy for spousal visits, and if both are residents in the facility, they are permitted to share a room.

I. RIGHTS OF INCOMPETENT PATIENTS

Written policies provide that all rights and responsibilities of the patient devolve to the patient's guardian, next of kin, or sponsoring agency, where:

1. A patient is adjudicated incompetent in accordance with State law; and
2. His physician or, in the case of a mentally retarded individual, a qualified mental retardation professional has documented in the patient's record the specific impairment that has rendered the patient incapable of understanding these rights.

APPENDIX C: PERIOD LIFE TABLES (HISTORICAL)

Historical – For use for annuities purchased prior to February 8, 2006 only.

MALES

Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy
0	73.54	27	48.01	54	24.91	81	7.43	108	1.32
1	72.97	28	47.12	55	24.14	82	6.96	109	1.24
2	72.00	29	46.23	56	23.37	83	6.50	110	1.16
3	71.02	30	45.34	57	22.61	84	6.07	111	1.09
4	70.04	31	44.46	58	21.87	85	5.65	112	1.01
5	69.05	32	43.57	59	21.13	86	5.26	113	0.95
6	68.06	33	42.69	60	20.41	87	4.88	114	0.88
7	67.07	34	41.82	61	19.70	88	4.53	115	0.82
8	66.08	35	40.94	62	19.00	89	4.21	116	0.76
9	65.09	36	40.06	63	18.31	90	3.90	117	0.70
10	64.10	37	39.19	64	17.63	91	3.62	118	0.65
11	63.10	38	38.32	65	16.95	92	3.36	119	0.60
12	62.11	39	37.45	66	16.29	93	3.14		
13	61.12	40	36.58	67	15.63	94	2.94		
14	60.14	41	35.72	68	14.98	95	2.76		
15	59.16	42	34.86	69	14.33	96	2.60		
16	58.18	43	34.00	70	13.69	97	2.45		
17	57.22	44	33.15	71	13.06	98	2.32		
18	56.27	45	32.30	72	12.43	99	2.20		
19	55.33	46	31.45	73	11.82	100	2.09		
20	54.40	47	30.61	74	11.21	101	1.98		
21	53.47	48	29.77	75	10.62	102	1.87		
22	52.55	49	28.94	76	10.05	103	1.77		
23	51.64	50	28.12	77	9.49	104	1.67		
24	50.72	51	27.30	78	8.95	105	1.58		
25	49.82	52	26.50	79	8.42	106	1.49		
26	48.91	53	25.70	80	7.92	107	1.40		

Historical – For use for annuities purchased prior to February 8, 2006 only.

FEMALES

Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy
0	79.30	27	53.23	54	28.62	81	8.81	108	1.39
1	78.70	28	52.28	55	27.77	82	8.26	109	1.29
2	77.74	29	51.33	56	26.93	83	7.73	110	1.20
3	76.75	30	50.38	57	26.10	84	7.21	111	1.11
4	75.77	31	49.44	58	25.27	85	6.72	112	1.03
5	74.78	32	48.50	59	24.46	86	6.26	113	0.95
6	73.79	33	47.56	60	23.65	87	5.82	114	0.88
7	72.79	34	46.62	61	22.86	88	5.41	115	0.82
8	71.80	35	45.69	62	22.07	89	5.02	116	0.76
9	70.81	36	44.76	63	21.29	90	4.65	117	0.70
10	69.82	37	43.83	64	20.52	91	4.31	118	0.65
11	68.82	38	42.91	65	19.75	92	3.99	119	0.60
12	67.83	39	41.98	66	18.99	93	3.71		
13	66.84	40	41.07	67	18.23	94	3.45		
14	65.85	41	40.15	68	17.48	95	3.22		
15	64.86	42	39.24	69	16.74	96	3.01		
16	63.88	43	38.33	70	16.00	97	2.82		
17	62.90	44	37.42	71	15.27	98	2.66		
18	61.92	45	36.52	72	14.56	99	2.50		
19	60.94	46	35.62	73	13.85	100	2.35		
20	59.97	47	34.73	74	13.16	101	2.21		
21	59.00	48	33.84	75	12.49	102	2.08		
22	58.03	49	32.95	76	11.83	103	1.95		
23	57.07	50	32.07	77	11.19	104	1.82		
24	56.11	51	31.20	78	10.57	105	1.71		
25	55.15	52	30.33	79	9.96	106	1.59		
26	54.19	53	29.47	80	9.38	107	1.49		

APPENDIX D: PERIOD LIFE TABLES

For use with annuity-related transfers after February 8, 2006. See Section 24.6.

Period Life Table, 2024

(As determined in accordance with actuarial publications of the Office of Chief Actuary of the Social Security Administration)

MALES

Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy
0	73.54	24	50.72	48	29.77	72	12.43	96	2.60
1	72.97	25	49.82	49	28.94	73	11.82	97	2.45
2	72.00	26	48.91	50	28.12	74	11.21	98	2.32
3	71.02	27	48.01	51	27.30	75	10.62	99	2.20
4	71.04	28	47.12	52	26.50	76	10.05	100	2.09
5	69.05	29	46.23	53	25.70	77	9.49	101	1.98
6	68.06	30	45.34	54	24.91	78	8.95	102	1.87
7	67.07	31	44.46	55	24.14	79	8.42	103	1.77
8	66.08	32	43.57	56	23.37	80	7.92	104	1.67
9	65.09	33	42.69	57	22.61	81	7.43	105	1.58
10	64.10	34	41.82	58	21.87	82	6.96	106	1.49
11	63.10	35	40.94	59	21.13	83	6.50	107	1.40
12	62.11	36	40.06	60	20.41	84	6.07	108	1.32
13	61.12	37	39.19	61	19.70	85	5.65	109	1.24
14	60.14	38	38.32	62	19.00	86	5.26	110	1.16
15	59.16	39	37.45	63	18.31	87	4.88	111	1.09
16	58.18	40	36.58	64	17.63	88	4.53	112	1.01
17	57.22	41	35.72	65	16.95	89	4.21	113	0.95
18	56.27	42	34.86	66	16.29	90	3.90	114	0.88
19	55.33	43	34.00	67	15.63	91	3.62	115	0.82
20	54.40	44	33.15	68	14.98	92	3.36	116	0.76
21	53.47	45	32.30	69	14.33	93	3.14	117	0.70
22	52.55	46	31.45	70	13.69	94	2.94	118	0.65
23	51.64	47	30.61	71	13.06	95	2.76	119	0.60

FEMALES

Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy	Age	Expectancy
0	79.30	27	53.23	54	28.62	81	8.81	108	1.39
1	78.70	28	52.28	55	27.77	82	8.26	109	1.29
2	77.74	29	51.33	56	26.93	83	7.73	110	1.20
3	76.75	30	50.38	57	26.10	84	7.21	111	1.11
4	75.77	31	49.44	58	25.27	85	6.72	112	1.03
5	74.78	32	48.50	59	24.46	86	6.26	113	0.95
6	73.79	33	47.56	60	23.65	87	5.82	114	0.88
7	72.79	34	46.62	61	22.86	88	5.41	115	0.82
8	71.80	35	45.69	62	22.07	89	5.02	116	0.76
9	70.81	36	44.76	63	21.29	90	4.65	117	0.70
10	69.82	37	43.83	64	20.52	91	4.31	118	0.65
11	68.82	38	42.91	65	19.75	92	3.99	119	0.60
12	67.83	39	41.98	66	18.99	93	3.71		
13	66.84	40	41.07	67	18.23	94	3.45		
14	65.85	41	40.15	68	17.48	95	3.22		
15	64.86	42	39.24	69	16.74	96	3.01		
16	63.88	43	38.33	70	16.00	97	2.82		
17	62.90	44	37.42	71	15.27	98	2.66		
18	61.92	45	36.52	72	14.56	99	2.50		
19	60.94	46	35.62	73	13.85	100	2.35		
20	59.97	47	34.73	74	13.16	101	2.21		
21	59.00	48	33.84	75	12.49	102	2.08		
22	58.03	49	32.95	76	11.83	103	1.95		
23	57.07	50	32.07	77	11.19	104	1.82		
24	56.11	51	31.20	78	10.57	105	1.71		
25	55.15	52	30.33	79	9.96	106	1.59		
26	54.19	53	29.47	80	9.38	107	1.49		

APPENDIX E: CONTRACT AGENCY LISTING

The following contains contact information for the current contract agencies for LTC coverage groups and Medical necessity questions, Estate Recovery, Annuity and Trusts reporting, and Payment and Billing issues.

Estate Recovery and Annuities and Trusts	Health Management Services (HMS) Phone: (304) 342-1604 Fax: (304) 342-1605	
Payment and Billing Issues	Gainwell Technologies	
	Gainwell Provider Services (888) 483-0793	Gainwell Member Services (888) 483-0797

Contract Agency Listings		
	Utilization Management Contract Agency	Medical Necessity Determination
TBI Waiver	Acentra Health 100 Capitol Street, Suite 600 Charleston, WV 25301 800.346.8272 Phone: (866) 385-8920 Fax: (866) 607-9903 General Email: WVTBIWaiver@acentra.com	Acentra Health Phone: (866) 385-8920 Fax: (866) 607-9903 General Email: WVTBIWaiver@acentra.com
I/DD Waiver	Acentra Health Toll-Free: (866) 385-8920 Phone: (304) 380-0617 Fax: (866) 521-6882 General Email: WVIDDWaiver@acentra.com	Psychological Consultation and Assessment, Inc. (PC&A) Phone: (304) 776-7230 Fax: (304) 776-7247 There is no general email box for PC&A for I/DD services.
AD Waiver	Acentra Health Phone: (844) 723-7811 Fax: (866) 212-5053 Email: WVADWaiver@acentra.com	Acentra Health Phone: (844) 723-7811 Fax: (866) 212-5053 Additional Information for PAS: ADWDocumentation@acentra.com

Contract Agency Listings		
Utilization Management Contract Agency		Medical Necessity Determination
Nursing Facility		Acentra Health Phone: (844) 723-7811 Fax: (844) 633-8425 General Email: WVPAS@acentra.com
ICF/IID	Psychological Consultation and Assessment, Inc. (PC&A) 202 Glass Drive Cross Lanes, WV 25313	Psychological Consultation and Assessment, Inc. (PC&A) Phone: (304) 776-7230 Fax: (304) 776-7247 Email: rworkman@pcasolutions.com or shudson@pcasolutions.com
Personal Care	Acentra Health Phone: (844) 723-7811 Fax: (866) 212-5053 General Email: WVPersonalCare@acentra.com	
BoSS	Bureau of Senior Services (BoSS) 1900 Kanawha Boulevard, East Charleston, WV 25305 Phone: (304) 558-3317	

APPENDIX F: LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP) STATES' IMPLEMENTATION DATES

EFFECTIVE DATE

The date that the U.S. Department of Health & Human Services approves the State Plan Amendment. Original Partnership indicates one of the four original Partnership States.

RECIPROCITY

Whether or not the State will honor partnership policies from other DRA partnership states when it comes to allowing asset disregard when filing for Medicaid. All DRA states plus New York, Indiana and Connecticut have reciprocity. California does not.

State	Effective Date	Policy Reciprocity
Alabama	03/01/2009	Yes
Alaska	Not Filed	---
Arizona	07/01/2008	Yes
Arkansas	07/01/2008	Yes
California	Original Partnership	No
Colorado	01/01/2008	Yes
Connecticut	Original Partnership	Yes
Delaware	11/01/2011	Yes
District of Columbia	Not Filed	---
Florida	01/01/2007	Yes
Georgia	01/01/2007	Yes
Hawaii	Pending	---
Idaho	11/01/2006	Yes
Illinois	Pending	---
Indiana	Original Partnership	Yes
Iowa	01/01/2010	Yes
Kansas	04/01/2007	Yes
Kentucky	06/16/2008	Yes

State	Effective Date	Policy Reciprocity
Louisiana	10/01/2009	Yes
Maine	07/01/2009	Yes
Maryland	01/01/2009	Yes
Massachusetts	Proposed	---
Michigan	10/01/2013	Yes
Minnesota	07/01/2006	Yes
Mississippi	Not Filed	---
Missouri	08/01/2008	Yes
Montana	07/01/2009	Yes
Nebraska	07/01/2006	Yes
Nevada	01/01/2007	Yes
New Hampshire	02/16/2010	Yes
New Jersey	07/01/2008	Yes
New Mexico	Not Filed	---
New York	Original Partnership	Yes
North Carolina	03/07/2011	Yes
North Dakota	01/01/2007	Yes
Ohio	09/10/2007	Yes
Oklahoma	07/01/2008	Yes
Oregon	01/01/2008	Yes
Pennsylvania	09/15/2007	Yes
Rhode Island	07/01/2008	Yes
South Carolina	01/01/2009	Yes
South Dakota	07/01/2007	Yes
Tennessee	10/01/2008	Yes
Texas	03/01/2008	Yes
Utah	Not Filed	---
Vermont	Not Filed	---
Virginia	09/01/2007	Yes

State	Effective Date	Policy Reciprocity
Washington	01/01/2012	Yes
West Virginia	07/01/2010	Yes
Wisconsin	01/01/2009	Yes
Wyoming	06/29/2009	Yes

Chapter 25

Medicaid Buy-In Procedures

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
25.1				
25.2	10/1/24	857	25.2	Added language that an individual entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B is eligible for Buy-In.
25.3	5/1/25	865	25.3.2	Added language that a worker should approved deemed QMB for any individual discovered eligible for SSI.

25.1 INTRODUCTION

25.1.1 DEFINITION OF BUY-IN

The Department of Human Services (DOHS) “buys in,” or pays, the Medicare Part A and/or Part B premium for certain Medicaid clients who are also eligible for Medicare. This procedure is referred to as the buy-in process.

25.1.2 MEDICARE BUY-IN UNIT

The Bureau for Medical Services (BMS) Medicare Buy-In Unit is responsible for the buy-in process. This process is a joint effort of the Social Security Administration (SSA) and BMS. SSA initiates the process for Supplemental Security Income (SSI) eligibles by identifying those who qualify, and bills the DOHS monthly for the total premium. The DOHS initiates the process for individuals in all other Medicaid coverage groups who are eligible for Medicare.

The Buy-In Unit ensures buy-in for all clients who qualify, and that the DOHS is not being charged for premiums for those who are not eligible, or those who are not residents of the State.

25.1.3 MEDICARE PROGRAM

25.1.3.A Definition

Medicare is a federal insurance program that helps pay health care costs for people age 65 or older, regardless of income, and certain individuals receiving Retirement, Survivors, and Disability Insurance (RSDI) benefits based on disability.

Medicare is the same in all states and is administered by the SSA. SSA makes all decisions regarding eligibility for Medicare.

25.1.3.B Medicare Parts A, B, and D

The following benefits are available to Medicare enrollees:

- Medicare Part A – Hospitalization Insurance Benefits (HIB)

The Buy-In Unit controls the purchasing and payment of Part A premiums for all uninsured eligibles. The State is billed for the Part A premiums for all Medicare eligibles who are not eligible for premium-free Medicare Part A because they lack the necessary quarters of coverage, have enrolled voluntarily, and pay a premium.

- Medicare Part B – Supplementary Medical Insurance Benefits (SMIB)

An individual enrolled in Part B pays a monthly premium. If he is receiving RSDI or Railroad Retirement Board (RRB) Benefits, the premium is deducted from his benefit; otherwise, he must pay the premium from his income.

See Chapter 25.2 below for a list of those for whom the DOHS buys in.

- Medicare Part D – Medicare Prescription Drug Benefit

An individual who is already enrolled in Medicare Part A or Part B may receive the Medicare Prescription Drug Benefit. The Part D Prescription Drug Benefit is not administered by the SSA. The benefit is obtained by enrolling in a Prescription Drug Plan (PDP). Enrollees must pay a monthly premium, unless financially qualified for extra help, also known as the Low Income Subsidy (LIS). The LIS pays all or part of the drug benefit premium, co-pays, and deductibles that may be required. Workers must assist individuals who request it to complete an application for the LIS. The application must be submitted on an original Social Security form (SSA-1020-OCR-SM) or submitted on the internet using the SSA website.

Medicaid clients enrolled in Medicare automatically qualify for LIS and are automatically enrolled in a PDP. With a few exceptions, Medicaid will not pay for prescription drugs for individuals age 65 or over who are eligible for, and do not enroll in, a PDP. This also applies to Medicare enrolled individuals under age 65 who are identified by DOHS.

Additional information about the PDP and LIS are available at the SSA and Medicare websites.

25.2 ELIGIBLE INDIVIDUALS

The Department of Human Services (DOHS) buys in for clients in the following Medicaid categories when they are eligible for Medicare. See Chapter 23 for more detail on Medicaid eligibility categories.

- Supplemental Security Income (SSI) Recipients
    - SSI recipients who are age 65 or older and who are entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B
    - SSI recipients who are under age 65 and who have been receiving monthly Social Security Administration (SSA) Disability or Railroad Retirement Board (RRB) Benefits under Title II of the Social Security Act for 24 months
- Deemed SSI Recipients
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary program (SLIMB)
- Qualified Individual-1 (QI-1)
- Qualified Disabled Working Individuals (QDWI)

25.3 SPECIAL PROCEDURES

25.3.1 NECESSARY CONDITIONS FOR BUY-IN

In order for the Department of Human Services (DOHS) to buy-in for a client, the following conditions must be met:

- He must be eligible for, and enrolled in, Medicare.
- He must have an active case in the eligibility system.
- His full name, birthdate, sex, and Social Security claim number (CAN) must match those shown on the Master Beneficiary Records, received by the Buy-In Unit.

25.3.2 BUY-IN PROCESS FOR SSI RECIPIENTS

The Worker has no responsibility other than acting as requested by the Medicare Buy-In Unit.

Note: If a worker identifies an SSI recipient who is entitled to premium-free Medicare Part A and/or enrolled in Medicare Part B, and not receiving QMB, they must open the QMB coverage. An SSI recipient is deemed eligible for QMB coverage the first day of the month following the month they are determined eligible for QMB.

25.3.2.A SSA Responsibilities

The Social Security Administration (SSA) is responsible for enrolling Supplemental Security Income (SSI) recipients who qualify for Medicare.

The Centers for Medicare and Medicaid Services (CMS) provides information about these SSI recipients to the DOHS on a monthly Master Buy-In file.

25.3.2.B Termination of Buy-In

Buy-in for an individual is terminated under any of the following circumstances:

- Death
- Upon becoming ineligible for SSI and not qualifying for a Deemed SSI group
- Upon losing entitlement to Medicare due to the loss of disability
- Upon becoming a resident of another state

NOTE: When the individual who loses SSI Medicaid qualifies for a Deemed SSI group, or for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), or Qualified Individual-1 (QI-1) coverage, the Worker must notify the Medicare Buy-In Unit so that buy-in will continue without interruption.

The Worker must close the SSI Medicaid case when the buy-in is terminated. If an individual is deleted from buy-in, and the Worker has not taken the appropriate action, the Worker will receive a system alert.

25.3.3 BUY-IN PROCESS FOR ALL OTHER ELIGIBLE MEDICAID GROUPS

The DOHS pays the Medicare premiums for those persons specified in Chapter 25.2.

25.3.3.A Buy-In Unit's Responsibilities

The Buy-In Unit must:

- Add eligible individuals to the Buy-In Master List Tape.
- Delete ineligible individuals.

25.3.3.B Worker's Responsibilities

The Worker must:

- Identify individuals eligible for Medicare and verify enrollment.
- Correctly code the Medicare Claim Number in the eligibility system.
- Update the client case when changes occur. This results in notification to the Buy-In Unit of any change that affects a client's buy-in status.

Chapter 26

Medicaid Work Incentive (M-WIN)

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
26.1				
26.2	5/1/20	786	786	Waiving enrollment fees and premium payments for MWIN for March, April, and May 2020
	4/1/23	835	26.2.5	Changed the Note to reflect beginning April 1, 2023, the Enrollment fees will resume at application. Premium payments will resume after a full redetermination is completed on the case.
	11/1/24	856	26.2.5	Removed note related to PHE only.
	2/1/26	873	26.2	Updated to new eligibility codes for M-WIN to MWIN and MWII.
			26.2.5.A.1	Updating M-WIN policy to language indicating notification is moving to an automatic system process.
			26.2.5.A.2	
			26.2.5.A.3	Updated example to match new M-WIN policy.
			26.2.5.B.2	Updated example from six-month certification to twelve month.
			26.2.5.B.4	Updating M-WIN policy to language indicating notification is moving to an automatic system process. Updated example to match new M-WIN policy.
26.3	4/1/18	755	26.3.12 26.3.12.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20		26.3.1	Changed inROADS to WV Path
	2/1/26	873	26.3.10	Updated from a worker generated redetermination policy to system generated redetermination policy.
26.4				
26.5				
26.6	1/1/18		26.6.4.B	New SSI amounts
	1/1/19		26.6.4.B	New SSI amounts
	1/1/20		26.6.4.B	New SSI amounts
	1/1/21	799	26.6	New SSI amounts

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
	1/1/22 1/1/23 1/1/24 1/1/25 1/1/26 2/1/26	815 830 845 859 872 873	26.6.4.B 26.6.4.B 26.6.4.B 26.6.4.B 26.6.4.B 26.6.4.A 26.6.4.B 26.6.6.B 26.6.7.G	New SSI amounts New SSI amounts New SSI amounts New SSI amounts New SSI amounts Removed language regarding funds diverted to a PASS account Updated language of how funds diverted to a PASS account are not considered for M-WIN.
26.7				
26.8	2/1/26	873	26.8	Added policy regarding the daily batch file transmissions between the Department to HMS.
26.9				
26.10				
26.11	4/1/25 2/1/26	862 873	26.11 26.11.1 26.11.3 26.11.4 26.11.6	Added reference to 9.3.1.B for when advance notice requirements are waived. Changed policy from six months to twelve months for allowable m-WIN closures. Changed the policy from six months to twelve months for M-WIN certification. Changed policy for involuntary Loss of Employment for M-WIN to reflect 12-month certification. Updated language to reflect changes of address for M-WIN are reported automatically from the eligibility system.
26.12				
App A				
App B	11/1/23	842	Appx B	Updated Address

26.1 INTRODUCTION

The Medicaid Work Incentive (M-WIN) is a full coverage Medicaid group was established by West Virginia Senate Bill 388. M-WIN assists individuals with disabilities in becoming independent of public assistance by enabling them to enter the workforce without losing essential medical care. Being eligible for, or enrolled in other health insurance coverage, including Medicare, does not prevent eligibility for M-WIN.

The M-WIN coverage group operates similarly to health insurance by offering coverage upon receipt of an initial enrollment fee and payment of monthly premiums for ongoing enrollment.

This chapter outlines the specific guidelines for determining eligibility for this group.

26.2 SPECIFIC M-WIN REQUIREMENTS (Code: MWIN or MWII)

26.2.1 FINANCIAL

Income: 250% of the Federal Poverty Level (FPL) – When Unearned Income is at or below the Supplemental Security Income (SSI) Payment Level.

No spenddown provision.

Assets: $2,000 – Individual; $3,000 – Individual with Spouse.

26.2.2 AGE

The applicant must be at least age 16, but not yet age 65.

26.2.3 DISABILITY

The applicant must be disabled as defined by the Social Security Administration (SSA). The SSA or the State Medical Review Team (MRT) may determine the disability. Disability, for this coverage group, is defined as a medically determined physical or mental condition that has lasted, or is expected to last, a year or more, or is expected to result in death. The disability definition for individuals under age 18 is found in Section 13.2.1.B.

26.2.4 EMPLOYMENT

The applicant must be engaged in competitive employment. There is no minimum number of hours a client must be employed for M-WIN eligibility. Competitive employment includes self-employment and non-traditional work which is compensated at or above the federal minimum hourly wage in a setting that also includes, or could include, non-disabled individuals.

This does not include settings such as sheltered workshops if less than minimum wage is paid. However, certain sheltered workshops have contracts offering employment both inside and

outside the sheltered workshop setting. Individuals employed through a sheltered workshop contract working on an outside contract are paid at or above the federal minimum wage and are engaged in competitive employment alongside others without disabilities.

26.2.5 ENROLLMENT FEE AND PREMIUM PAYMENT

Each eligible applicant must pay a $50 enrollment fee. Once the assistance group (AG) is approved, an ongoing monthly premium payment will be required. Upon payment of the enrollment fee, the first month's premium is waived. In the following months, the client must make the premium payment by the premium due date for continued enrollment.

Except in the case of agency error, the enrollment fee must be paid each time the client loses coverage under this program for any reason. This includes, but is not limited to, non-payment of the monthly premium, failure to complete a redetermination of eligibility, or voluntary disenrollment. When an enrollment fee payment is returned for insufficient funds, this is considered as non-payment.

26.2.5.A Enrollment Fee

26.2.5.A.1 Notification

After eligibility is established, the applicant is notified that he meets all program requirements, except payment of the enrollment fee.

The notice includes the following information:

- The amount of the enrollment fee
- The requirement that the enrollment fee must be received within 60 days of the date of the notice or the application will be denied
- The amount of the ongoing monthly premium
- Instructions to mail a check or money order for the enrollment fee made payable to the State of West Virginia with the enclosed enrollment fee payment stub to:

  West Virginia Department of Human Services (DOHS)

P. O. Box 40288
Charleston, WV 25364

- The Worker's name
- Notice that the first month of coverage will be the month following the month the enrollment fee is received

NOTE: Enrollment fees and premium payments are not accepted by local or state offices.

- The applicant's personal identification number (PIN). This appears on the enrollment fee payment stub, which is attached to the applicant's method of payment and returned to the DOHS address above for proper credit of payment.

The contract agency is notified the same day it is issued to the applicant. See Appendix B of this chapter for the contact information of the contract agency.

26.2.5.A.2 Payment

It is the responsibility of the contract agency to notify the Department when the enrollment fee is paid, not paid, or returned for insufficient funds.

If the Department does not receive notice of the enrollment fee payment within 60 days of the date of the eligibility notice, the AG is automatically denied and the appropriate notice is generated by the system.

If the Department receives notice of the enrollment fee payment within 60 days of the date of the eligibility notice, the AG is automatically approved and the appropriate notice is generated by the system.

The contract agency does not accept advance payments for anticipated enrollment fees. The contract agency must return any advance payments received to the applicant.

26.2.5.A.3 Refund

Once an enrollment fee is paid and the M-WIN benefit received, the contract agency cannot refund the enrollment fee payment. See EXCEPTION below.

> **Anticipated Enrollment Payment Example 1:** Ms. Pine pays her $50 enrollment fee. The contract agency notifies the Department of her payment. Before the AG is confirmed, Ms. Pine contacts the Worker, explaining she found enough old medical bills to meet a spenddown. She requests SSI-Related

Medicaid rather than M-WIN. Because she has no other medical bills remaining, she requests the contract agency retain her enrollment fee to apply against a future M-WIN period of eligibility. Ms. Pine does not know if she will incur additional medical bills in the next six months or if she will be working. The contract agency refunds her enrollment fee.

Anticipated Enrollment Payment Example 2: Same situation as above, except Ms. Pine contacts her Worker after the AG is confirmed and the M-WIN benefit issued. Because the Worker explained the advantages of both M-WIN and SSI-Related Medicaid, documented Ms. Pine's choice of M-WIN, and she received the M-WIN benefit, no refund is given.

EXCEPTION: The contract agency can reimburse the client only when he pays the enrollment fee solely due to an agency error. The BMS Policy Unit must request and approve the refund.

Agency Error Example: Same situation as in the example above. The Worker failed to explain that Ms. Pine was potentially eligible for both M-WIN and SSI-Related Medicaid. Ms. Pine learns she would not have a monthly premium if she had chosen SSI-Related Medicaid. She had old medical bills that had never been used to meet a spenddown. Because the Worker failed to follow the policy requirement regarding explanation of eligible coverage groups, the enrollment fee was paid as a result of DOHS error. The Bureau for Medical Services (BMS) Policy Unit contacts the contract agency and requests reimbursement.

26.2.5.B Monthly Premium Payments

When the enrollment fee is paid, the first month's premium is waived. The following and subsequent months require a premium payment for enrollment to continue.

26.2.5.B.1 Notification

The contract agency sends premium due letters and payment stubs to M-WIN clients on approximately the second day of the month in which the premium is due. To ensure proper credit of payment, the client must mail the stub and payment in the window envelope provided addressed to:

DOHS-Medicaid
P. O. Box 40288
Charleston, WV 25364

26.2.5.B.2 Payment

Premium payments are due the 16th of the coverage month and are considered overdue if not received by the 26th of the coverage month.

Local and State offices do not accept Premium payments.

The contract agency does not accept advance payments for future anticipated premium payments. They are returned.

> **Anticipated Premium Payment Example:** Mr. Rosemary receives his federal income tax refund. He sends the remainder of his premiums for his current period of eligibility and the next twelve month's premiums to the contract agency. These are returned because the Worker cannot assume Mr. Rosemary's premiums will remain the same or that he will be eligible for M-WIN beyond his current twelve-month period of eligibility.

NOTE: Except in the case of agency error, the enrollment fee must be paid each time the client loses coverage under this program for any reason. This includes, but is not limited to, non-payment of the monthly premium, failure to complete a redetermination of eligibility, or voluntary disenrollment.

If the client reapplies after closure due to non-payment of a premium(s), he must pay the enrollment fee again, but is not required to pay the missed premium(s).

When M-WIN Medicaid benefits are continued due to a Fair Hearing request, the premium(s) must be paid for any continued month at the last established amount.

26.2.5.B.3 Refund of Payment

Once a monthly premium payment is paid and the M-WIN benefit is received, premium payments are not refunded by the contract agency. The M-WIN coverage group operates similarly to a health insurance plan with premiums not refunded when the benefit was received.

EXCEPTION: The contract agency can only reimburse the client for a monthly premium payment when payment occurs due to an agency error. The BMS Policy Unit must request and approve the refund.

26.2.5.B.4 Non-Payment of Premium/Insufficient Funds

When the premium payment is not received by the contract agency by the 26th of the coverage month, the contract agency staff notifies the Department by the 10th of the following month. The eligibility system will be updated and the AG will automatically close on adverse action date and the client is sent advance notice of M-WIN closure for premium non-payment.

The contract agency also notifies the Department when premium payments are returned for insufficient funds. This is considered as non-payment. The AG is closed using the same procedures as for non-payment after advance notice.

The contract agency is notified of any subsequent AG closures.

> **Overdue Premium Example:** Mr. Chive received M-WIN in March. He is mailed his premium due letter April 2 for the month of April. Payment is due April 16 and overdue April 26. If not received, the contract agency notifies the Department by May 10. The client is sent advance notice that his last month of M-WIN is May. A new enrollment fee is necessary to reestablish coverage for June.

26.3 APPLICATION/REDETERMINATION PROCESS

26.3.1 APPLICATION FORMS

A DFA-2, the DFA-SLA-1 with supplement, DFA-SLA-2 with supplement, or WV PATH.

The application is complete when the client or his representative submits an application that contains, at a minimum, the client's name and address, and signature.

26.3.2 DATE OF APPLICATION

The date of application is the date the applicant submits an application—in person, by fax or other electronic transmission, or by mail—that contains, at a minimum, his name, address, and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address, and signature is received in the local office.

26.3.3 WHO MUST SIGN

The application must be signed by the applicant or his authorized representative.

26.3.4 DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

26.3.5 AGENCY TIME LIMITS

26.3.5.A Application Processing Limits

The Worker must process an M-WIN applicant's Medicaid application as soon as possible rather than within the maximum allowable time because the benefit is delayed until the month after the enrollment fee is received.

Agency time limits for this AG differ depending on how the disability was determined: by the Social Security Administration (SSA) prior to application or by the Medicaid Review Team (MRT).

Required Action	Time Limit	
	Disability Established by SSA	Disability Determined by MRT
When the client meets all requirements except payment of the enrollment fee, the Worker must process the application in the eligibility system:	Within 30 days of the date of application	Within 90 days of the date of application
When the client withdraws or is denied for a reason other than non-payment of the enrollment fee, the Worker must take eligibility system action:	Within 30 days of the date of application	Within 90 days of the date of application
The Worker must deny the application If the applicant failed to submit the enrollment fee:	Within 60 days of the date of the initial eligibility and notification sent	Within 60 days of the date of the initial eligibility and notification sent
The Worker must approve the eligibility the day he is notified that the client has paid the enrollment fee, if the enrollment fee is paid:	Within 60 days	Within 60 days

26.3.5.B MRT Processing Time Limits

To ensure the 90-day limit is met for MRT cases, the following time limits apply to the MRT process:

Required Action	Time Limit
Request medical records and reports	By the 7th calendar day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request, and each 30 days thereafter
Submission to the MRT	By 7 days after initial request, and each 30 days thereafter
Receipt of file and logged in by the MRT	By 2 days after receipt by the MRT
Initial review by the MRT staff	By 7th day after receipt
Physician's initial review	By 14th day after receipt
Additional medical information requested, if required, by physician	By 7th day after initial physician review
Physician's final review	By 7th day after receipt of additional medical information
Final decision and completion of ES-RT-3	By 7th day after final physicians review
File returned to county office	By 3rd day after final review decision
Notice to the client	By 7th day after receipt of final decision at county office

NOTE: The 90-day processing time limit concludes with the date client notification is mailed, not the date of the eligibility system action.

26.3.6 AGENCY DELAYS

If the Department of Human Services (DOHS) failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 to the applicant and note that the application is pending.

If the Department delayed requesting necessary verification or acting on the information already received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.

If an application has not been acted on within a reasonable period of time, unless the delay is due to factors beyond the control of the DOHS, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Section 10.6.6.

> **Agency Delay Example:** Poppy Elm applies for M-WIN on December 5 and explains she is scheduled for surgery on January 2. The Worker explains the importance of paying the enrollment fee in December to provide Medicaid coverage for January. Poppy pays her enrollment fee December 28. The Worker returns January 5 and approves M-WIN effective February without backdating M-WIN eligibility to include January. The Worker corrects the case; however, Ms. Elm filled prescriptions January 1 totaling $121. The pharmacy refuses to bill Medicaid. The delay was within the control of the DOHS; therefore, Ms. Elm is eligible for direct reimbursement for out-of-pocket medical expenses.

26.3.7 PAYEE

The client is the payee.

26.3.8 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month following the date the enrollment fee is received.

26.3.9 CLIENT NOTIFICATION

- The first letter notifies the client whether or not he meets all requirements, except payment of the enrollment fee. This notice contains an enrollment fee payment stub that is returned with the client's payment. See Section 26.2.5.
- If the client meets all requirements, the second letter is an approval if the enrollment fee is received or a denial if the enrollment fee is not received.

For all other notice requirements see Chapter 9.

26.3.10 REDETERMINATION

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

The eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the information must be submitted;
- Specific information necessary to complete the redetermination;
- The opportunity to report changes;
- A statement that the AG(s) my receive a verification checklist for completion and return, if reported changes require follow-up;
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed; and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call is included if the individual has questions about submitting the pre-populated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefits.

26.3.11 THE BENEFIT

A Medical ID card is issued for each eligible individual.

26.3.11.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

26.3.11.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

26.4 COMMON ELIGIBILITY REQUIREMENTS

26.4.1 RESIDENCE

The client must be a West Virginia resident.

26.4.2 CITIZENSHIP STATUS

The Medicaid policy/procedures in Section 15.7.5 apply to Medicaid Work Incentive (M-WIN).

26.4.3 COOPERATION WITH QUALITY CONTROL

The client must cooperate with any Quality Control review. Failure to comply results in assistance group (AG) closure. See Section 2.4 for requirements to cooperate with Quality Control.

26.4.4 LIMITATIONS ON RECEIPT OF OTHER BENEFITS

The client may receive other Department of Human Services (DOHS) benefits for which he qualifies. See Non-Duplication of Benefits below.

26.4.5 NON-DUPLICATION OF BENEFITS

The client cannot be enrolled in any other full coverage Medicaid group.

26.4.6 ENUMERATION

The enumeration requirements in Section 2.7 for Medicaid apply.

26.5 ELIGIBILITY DETERMINATION GROUPS

26.5.1 THE ASSISTANCE GROUP (AG)

Only the disabled individual must be included.

26.5.2 THE INCOME GROUP (IG)

Count only the client's income.

26.5.3 THE NEEDS GROUP (NG)

The income limit for an individual is used.

26.6 INCOME

26.6.1 INCOME LIMIT

The income limit is 250% of the Federal Poverty Level (FPL) when unearned income is at or below the Supplemental Security Income (SSI) payment level.

26.6.2 INCOME SOURCES

The income sources in Section 4.3 are treated the same as for Supplemental Security Income (SSI)-Related Medicaid.

26.6.3 BUDGETING METHOD

The method used to anticipate monthly countable income is the same as in Section 4.6.

26.6.4 INCOME DISREGARDS AND DEDUCTIONS

NOTE: Retirement, Survivors, and Disability Insurance (RSDI) cost of living adjustments (COLA) are disregarded in determining income eligibility until the new Federal Poverty Level (FPL) limits become effective.

The following disregards and deductions are applied, if applicable.

26.6.4.A Unearned Income

- SSI $20 Disregard: A $20 disregard is applied to the total gross unearned income. If unearned income is less than $20, the remainder is subtracted from earned income, prior to the application of any other earned income disregards and deductions.

NOTE: The SSI $20 disregard is not applied to any unearned income received that is based on need. This includes, but is not limited to, Veterans Administration (VA) benefits based on need.

- For SSI-Related Children Only: One-third of the child support intended for the SSI-Related child is disregarded.
- Death Benefits: The portion of a lump sum payment received as a result of the death of a client, which is used to pay the expenses of the last illness and burial of that client, is deducted.

26.6.4.B Earned Income

- SSI $20 Disregard: the remainder of the $20 income disregard. See Unearned Income above.
- SSI Earned Income Disregard: $65 and half (1/2) of the remainder are subtracted from earned income and from gross profit from self-employment earnings. See Determining Countable Income below.

NOTE: These disregards and deductions apply only to earned income. Any unused portion of the disregards or deductions is not applied to unearned income.

- Impairment-Related Work Expenses: Expenses for items or services that are directly related to enabling a person with a disability to work and that are necessarily incurred by the client due to a physical or mental impairment. The client must be:
    - Disabled, but not blind; and
    - Under age 65

In addition, the severity of the impairment must require the client to purchase or rent items and services in order to work, and the expense must be reasonable and not reimbursable from another source, such as, but not limited to, Medicare or private insurance. The payment must be made with income received for a month in which the person both worked and received the services or used the item, or the payment may be made before the earned income is received when the person is working.

Examples of impairment-related work expenses include, but are not limited to, attendant care services, both at home and at work; drugs and medical supplies and devices; federal, state, and local income taxes and Federal Insurance Contributions Act (FICA); service animals; fees such as union dues; mandatory contributions such as pensions; meals consumed during work hours; work-related equipment or services; physical therapy; prosthesis; structural modifications to the person's home; transportation to and from work; and vehicle modification.

- SSI Work-Related Expenses (Blind Persons Only): A deduction for impairment-related expenses necessary for employment is allowed, such as a guide dog, cane training, purchase of special equipment needed to perform or advance on the job, etc.
- SSI Student Child Earned Income Disregard: $2,410 per month, but no more than $9,730 in a calendar year, is disregarded when the child meets the following criteria:0
    - Is under age 22, unmarried and not head of a household; and
    - Takes one or more courses of study and attends classes as follows:
        - In a college or university at least eight hours a week; or
        - In grades 7 – 12 at least 12 hours a week; or
        - In a course of training to prepare for a paying job for at least 15 hours a week, if shop practice is involved, or 12 hours a week, if shop practice is not involved; or
        - For less than the amount of time indicated above for reasons beyond the student's control, such as illness, if circumstances justify a reduced load or attendance.
    - This applies to homebound students when a disability requires home school and a home visitor or tutor from school directs the study.

26.6.5 TRANSFERS OF INCOME

The transfer of resources policy does not apply to Medicaid Work Incentive (M-WIN).

26.6.6 DETERMINING ELIGIBILITY

Determination of financial eligibility has two parts: the unearned income test and determining countable income.

26.6.6.A Unearned Income Test

The first part is the unearned income test. If the client fails this test, he is ineligible.

- Step 1: Determine the amount of countable unearned income.
- Step 2: Subtract the $20 SSI Disregard.
- Step 3: Compare the remainder to the current SSI payment for one person.

If the remainder exceeds the SSI payment, the client is ineligible and no additional calculations are required.

If the remainder is equal to or less than the SSI payment, the Worker must determine countable income.

26.6.6.B Determining Countable Income

The second part is determining countable income. Countable income is determined by subtracting any allowable disregards and deductions from the total countable gross income. Countable income is determined as follows:

Step 1: Determine the total countable gross unearned income and subtract the $20 Disregard, if applicable.

Step 2: Determine the total countable gross earned income. Subtract the following in order:

- Remainder of SSI $20 Disregard
- SSI $65 Earned Income Disregard
- SSI Impairment-Related Expenses
- One-half (1/2) of Remaining Earned Income
- SSI Work-Related Expense Deductions (blind persons only)

Step 3: Add unearned income from Step 1.

Step 4: Subtract the Death Benefits deduction and, for children, the child support disregard.

- The result is the total monthly countable income.

Step 5: Compare the amount in Step 4 to 250% of the FPL for one person.

If the net countable monthly income is equal to or less than 250% of the FPL, the client is financially eligible.

NOTE: Once the client has been determined eligible, premium fees are based on gross countable income before these disregards and deductions.

26.6.7 SPECIAL SITUATIONS

26.6.7.A Self-Employment

Gross profit is determined the same way it is for AFDC-Related Medicaid. The gross profit may be earned or unearned income. See Section 4.16.

26.6.7.B Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC-Related Medicaid. See Section 4.16.

26.6.7.C Educational Income

Educational Income is counted the same way it is for AFDC-Related Medicaid. See Section 4.16.

26.6.7.D Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

26.6.7.E Lump Sum Payments

Lump sum payments are treated as unearned income in the month received.

26.6.7.F Withheld Income

26.6.7.F.1 From Earned Income

Earnings withheld to repay an advance payment are disregarded if they were counted in the month received. If not counted in the month received, the withheld earnings are considered income. No other earned income is excluded just because it is withheld by the employer.

26.6.7.F.2 From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine Medicaid eligibility.

26.6.7.G Funds Diverted to a PASS

Funds diverted to a PASS are not considered.

26.6.7.H Unstated Income

Unstated income is income that has not been reported by the household, and is not otherwise known to the agency, but is determined to exist because the client's paid living expenses exceed income from known sources.

The amount of unstated income is the difference between the known monthly income and the monthly paid living expenses.

When the information in the client's record, including statements of the client or third parties, indicates that paid expenses exceed the stated income, the existence of unstated income must be explored.

If insufficient or conflicting evidence exists, the Worker must question the client about the possibility of unstated income and allow him the opportunity to explain how his expenses are met. If the client provides a satisfactory explanation, the Worker records the explanation.

If the client's explanation of how the expenses are met is inadequate, the Worker makes a recording of the explanation and then determines the amount of unstated income to count. To determine the amount of unstated income to count, the Worker compares the usual amount of monthly living expenses with the client's reported income, taking into consideration any other reasonable explanations the client provides. The difference is unstated income and is counted as unearned income.

26.6.7.I Unavailable Income

Income intended for the client, but received by another person with whom he does not live, when the individual receiving this income refuses to make it available, is excluded.

26.6.7.J Income Received for a Non-Income Group Member

Income received by a member of the Income Group (IG), which is intended and used for the care and maintenance of an individual whose income is not used in determining the eligibility AG, is excluded as income.

26.7 ASSETS

26.7.1 ASSET LIMIT

The asset limit for Medicaid Work Incentive (M-WIN) is:

- $2,000 for a single individual.
- $3,000 for an individual who lives with his legal spouse. Total countable assets of the couple are combined to determine asset eligibility.

26.7.2 LIST OF ASSETS

Assets are treated according to the policy in Chapter 5 for Supplemental Security Income (SSI)-Related Medicaid with the following exceptions.

26.7.3 SPECIAL ASSET EXCLUSIONS

26.7.3.A Retirement Accounts

Retirement accounts or funds invested in an approved retirement account are not counted as assets. This includes, but is not limited to, Individual Retirement Accounts (IRAs), Keoghs, 401(k)s, or employer pension plans.

26.7.3.B Liquid Asset Exclusion

Liquid assets in the amount of $5,000 for an individual or $10,000 for a legally married couple are excluded when determining total countable assets. Liquid assets are cash or those payable in cash on demand. This includes checking or savings accounts and financial instruments such as, but not limited to, Certificates of Deposit (CD) or stocks and bonds that can be converted to cash within 20 work days. Federal, state, and local holidays are not work days.

26.7.3.C Independence Accounts

Independence accounts are Department of Human Services (DOHS)-approved separate accounts established with the earned income of an M-WIN client. The funds in the account are used to pay necessary expenses or to enhance or maintain the client's independence or increase his employment opportunities. Approved expenditures from the funds include, but are not limited to, the following:

- Educational expenses.
- Home purchase or modification.
- Transportation.
- Medical expenses.
- Assistive technology and related services.
- Short-term living expenses during a qualified emergency such as, but not limited to, an illness of the client, spouse, child, or parent that results in a loss of wages and/or causes extra expenses not reimbursable by a third party, or an involuntary loss of employment. The DOHS may approve other expenditures upon request.

So long as the account is maintained and used according to the guidelines, and the establishment and expenditures of the account are reviewed and approved by the Worker and/or Supervisor, the funds are excluded.

As fund must be reviewed during the six-month financial redetermination.

26.7.4 TRANSFER OF RESOURCES

The transfer of resources policy does not apply to M-WIN Medicaid.

26.8 DATA EXCHANGE

The data exchange and matches described in Chapter 6 are applicable to Medicaid Work Incentive (M-WIN). Changes in income do not affect eligibility during the certification period, but may affect the premium amount.

A daily batch file will be sent from the eligibility system to the contracted agency who tracks and manages the MWIN enrollment fees and premiums, See Appendix B for current information. The following information is sent for new and/or existing AGs:

- Demographics (name, PIN, DOB, address, county)
- Status (new enrollee, redetermination, termination, active)
- Enrollment data (category, eligibility dates)
- Monthly Premium Acount (initial, decreases and increases at redetermination, including date of change)
- Redetermination (date, eligibility dates)
- Closures (date, eligibility dates)

A daily batch file will be received by the eligibility system from the contracted agency with the following information:

- Demographics (name PIN, DOB, gender, address, county)
- Enrollment Fee not paid
- Enrollment Fee paid and date paid
- Monthly Premium not paid
- Monthly Premium paid and date paid

26.9 VERIFICATION

The policy and procedures described in Chapter 7 apply to Medicaid Work Incentive (M-WIN).

26.10 RESOURCE DEVELOPMENT

The resource development policies in Chapter 8 do not apply to Medicaid Work Incentive (M-WIN). The client may be encouraged to apply for other benefits, such as, but not limited to, Workers' Compensation or Unemployment Compensation, if he loses employment, but there is no requirement to seek other benefits.

26.11 CASE MAINTENANCE

26.11.1 CLOSURES

A Medicaid Work Incentive (M-WIN) client may be determined ineligible prior to the end of the twelve-month eligibility period if he:

- Moves out of state
- Dies
- Reaches age 65
- Becomes eligible for Supplemental Security Income (SSI)
- Was approved for M-WIN in error and is not currently eligible
- Is determined no longer disabled by the Social Security Administration (SSA) or the Medical Review Team (MRT)
- Acquires assets over the allowable limit
- Terminates employment voluntarily or employment is no longer competitive; see Section 26.11.4.
- Fails to meet the requirements in Section 26.11.4 when determined unable to maintain employment – involuntary
- Fails to pay a required enrollment fee or premium payment(s)
- Voluntarily disenrolls

NOTE: The enrollment fee must be paid each time the client loses coverage under this program for any reason. This includes but is not limited to: non-payment of the monthly premium, failure to complete the redetermination of eligibility or voluntary disenrollment.

When the assistance group (AG) is closed for any reason, including voluntary disenrollment, advance notice is required. See Section 9.3.1.B for when advance notice requirements are waived. Any notice must inform the client of the last month for which a premium is due. The contract agency is notified of the termination and the effective date of closure, i.e., the last day of the last month for which the premium is due.

26.11.2 CHANGE IN INCOME AND DEDUCTIONS

A change in income and/or deductions between redeterminations does not result in ineligibility for the coverage group.

An income change is not used to increase the premium amount. However, the premium amount may be decreased based upon a reported income change.

NOTE: Retirement, Survivors and Disability Insurance (RSDI) cost-of-living adjustments (COLA) are disregarded in determining income eligibility until the new Federal Poverty Level (FPL) limits become effective.

26.11.3 REDETERMINATION OF DISABILITY

The Department of Human Services (DOHS) cannot determine that a client who participates in the program is no longer disabled solely due to his employment or earned income, including self-employment income. At the time of the twelve-month redetermination, the Worker must ensure that the client continues to meet the disability requirement for the new period of eligibility. The client must be a current RSDI recipient or there must be a valid MRT decision that extends into the new eligibility period. MRT reevaluations will be completed at the time specified by the MRT.

MRT Evaluation Period Example: At redetermination in January 2016 for a new eligibility period to begin February 2016, the Worker discovers that the last MRT evaluation covers the period from April 2015 through March 2016. Because part of the new eligibility period through March 2016 is covered by an MRT evaluation, the disability requirement is met.

RSDI Stopped Example: At redetermination, the Worker discovers that the client's RSDI was stopped. The Worker must

NOTE: When the information is submitted to MRT for the reevaluation of disability, an evaluation for Medically-Improved eligibility must be requested at the same time. If the individual is determined no longer disabled, he is evaluated automatically as Medically-Improved.

refer the case to the MRT to establish disability, but completion of the redetermination is not delayed.

26.11.4 UNABLE TO MAINTAIN EMPLOYMENT – INVOLUNTARY

Only clients who originally received benefits under the M-WIN coverage group may remain eligible for M-WIN during periods of involuntary loss of employment. Involuntary loss of employment includes, but is not limited to, a layoff or a temporary leave due to health problems. Coverage under this provision may continue from the date of the loss of employment through the duration of the current M-WIN coverage period of eligibility, up to twelve months.

At redetermination, the client must meet competitive employment requirements or be evaluated for any other coverage group for which he may qualify.

To continue M-WIN when the client does not meet competitive employment requirements, the client must meet the specific criteria below. The client must:

- Submit a written request for continued coverage to the local DOHS office within 30 days of the date he becomes unemployed. An authorized representative may submit the request.
- Maintain a connection to the workforce during his continued Medicaid eligibility period. He meets this requirement by:
    - Enrolling in a state or federal vocational rehabilitation program;
    - Enrolling in or registering with WorkForce West Virginia;
    - Participating in a transition from school-to-work program;
    - Participating with an approved provider of employment services. The approved Employment Network (EN) providers are found at the WorkForce West Virginia website; or
    - Providing documentation from his employer that he is on a temporary involuntary leave.
- Continue to be otherwise eligible for M-WIN and does not meet a closure reason in Section 26.11.1

Involuntary Loss of Employment Example: Iris Aster is approved for M-WIN for August 1 through July 31. In October, she loses her job because her employer cannot hold her position open while she is off due to surgery. She notifies her Worker within 30 days of the loss of her employment, verifies enrollment at Division of Rehabilitation Services (DRS), and requests continued coverage. The Worker leaves her M-WIN enrollment open and documents nine

> months continued coverage under the Unable to Maintain Employment – Involuntary provision.

If the client loses employment and does not meet the requirements above, he must be evaluated for any other coverage groups for which he may qualify. Coverage under this group is stopped.

26.11.5 IMPROVEMENT IN MEDICAL CONDITION – MEDICALLY-IMPROVED COVERAGE GROUP

Only clients who originally received benefits under the M-WIN coverage group may receive this coverage as Medically-Improved. The medical determination is made by MRT.

An M-WIN client whose medical condition improves remains eligible if he meets all other program eligibility requirements.

26.11.6 CHANGE OF ADDRESS

The contract agency is notified of all address changes.

26.12 DETERMINING DISABILITY, INCAPACITY AND BLINDNESS

26.12.1 DETERMINING DISABILITY

The Medicaid Work Incentive (M-WIN) client must meet the disability criteria established by the Social Security Administration (SSA). If the client does not receive Retirement, Survivors and Disability Insurance (RSDI) based on disability, disability must be established by the Medical Review Team (MRT). See Chapter 13 for the MRT procedures and requirements for both adults and children.

26.12.2 DETERMINING ELIGIBILITY FOR A MEDICALLY-IMPROVED DISABILITY

Eligibility for this group is determined by the MRT. These are clients who no longer meet the RSDI or SSI-Related disability definition due to a medical improvement brought about by treatments such as therapy or medication. Examples of potentially eligible clients are those with severe mental illness, HIV/AIDS, and epilepsy. See Section 26.11.5 for other specific requirements.

NOTE: When the Worker submits information to the MRT for the reevaluation of disability, an evaluation for Medically-Improved eligibility must be requested at the same time. If the individual is determined no longer disabled, he is evaluated automatically for Medically-Improved eligibility.

APPENDIX A: M-WIN PROGRAM PREMIUM AMOUNTS

Monthly Gross Income	Premium Amount
$500 or Less	$15.00
$501 – 700	$17.50
$701 – 900	$24.50
$901 – 1100	$31.50
$1101 – 1300	$38.50
$1301 – 1500	$45.50
$1501 – 1700	$52.50
$1701 – 1900	$59.50
$1901 – 2100	$66.50
$2101 – 2300	$73.50
$2301 – 2500	$80.50
$2501 – 2700	$87.50
$2701 – 2900	$94.50
$2901 – 3100	$101.50
$3101 – 3300	$108.50
$3301 – 3500	$115.50
$3501 – 3700	$122.50
$3701 – 3826*	$129.50

*Individuals whose monthly gross income exceeds $3,826 pay the maximum premium amount of $129.50.

APPENDIX B: M-WIN CONTRACT AGENCY CONTACT INFORMATION

The current contract agency that tracks and manages M-WIN enrollment fee and monthly premium payments is Health Management Systems (HMS). Contact information is listed below:

Health Management Systems (HMS)
1201 B Greenbrier St.
Charleston, West Virginia 25311
Phone: 1-877-735-7430
Fax: (304) 342-1605
Email: MWINcustomerservice@gainwelltechnologies.com

Any requests for refunds of M-WIN enrollment fees or monthly premium payments must first be requested of, and reviewed by, the Bureau for Medical Services (BMS) Medicaid Policy Unit staff. This staff forwards appropriate requests for refunds to HMS.

Chapter 27

Non-Emergency Medical Transportation (NEMT)

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Change History Log

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27.1				
27.2				
27.3				
27.4				
27.5	9/1/23 12/1/24	840 858	27.5.1 27.5.2	WV CHIP recipients became eligible for Non-Emergency Medical Transportation (NEMT) Updated language to Bureau for Medical Services.
27.6				

27.1 INTRODUCTION

Non-emergency medical transportation (NEMT) is a reimbursement program for clients of Medicaid and Children with Special Health Care Needs (CSHCN) for the cost of transportation and other expenses associated with receiving medical services. Because the program is intended for reimbursement only, payment in advance of a scheduled appointment is not appropriate and cannot be issued from the eligibility system.

Beginning October 1, 2014, NEMT administration is the responsibility of the contracted NEMT broker. The broker is responsible for full administration of the program, including customer services, provider enrollment, benefit replacement, safety requirements, and monitoring for fraud, waste, and abuse.

The NEMT provider policy can be found in Chapter 524 of the Bureau for Medical Services (BMS) Provider Manual.

27.2 NEMT REQUEST PROCESS

27.2.1 BEGINNING DATE OF ELIGIBILITY

Medicaid clients are eligible for non-emergency medical transportation (NEMT) beginning the first day of the month in which Medicaid is approved.

Clients of Children with Special Health Care Needs (CSHCN) and others who qualify for reimbursement of transportation expenses are eligible for NEMT beginning the month of approval, as determined by the program that provides the medical services.

27.2.2 THE BENEFIT

Services provided under this program include reimbursement for transportation and certain related expenses necessary to secure medical services normally covered by Medicaid. Funding for this program is provided by three different sources:

- Title XIX funds for all Medicaid clients, including foster children
- Title V funds for non-Medicaid eligible clients of CSHCN
- Agency administrative funds (cash assistance or Medicaid) for applicants who need a physical examination in order to complete the eligibility process

Reimbursement for transportation and related expenses is available to Medicaid clients who:

- Require transportation to keep an appointment for medical services covered under the approved Medicaid group;
- Receive scheduled Medicaid-covered services at a clinic, hospital, or doctor's office; or
- Receive pre-authorization as necessary.

27.2.3 THE NEMT REQUEST FORM

The medical service provider, or his designee, is required to sign the section verifying that the individual had an appointment and was seen for Medicaid-covered treatment or services. Medical service providers include doctors, nurses, nurse practitioners, physicians' assistants,

lab technicians, and others who perform a Medicaid-covered service.

When prior authorization is required for out-of-state services, coordination of the process may be facilitated by telephone and/or fax with the Utilization Management Contractor and the physician, as necessary. Members should contact the broker to arrange transportation for all medical appointments.

Altered forms that include questionable entries will result in denial of the request, unless the broker is able to resolve the discrepancies. Items which have been corrected must be initialed by the applicant or other person providing the information.

27.2.4 PROCESSING DELAYS

The broker must process requests received for travel upon receipt, provided the date for which reimbursement is being requested occurred no earlier than 365 days prior to the date of the request. Delay caused by failure on the part of the broker to process a request in a timely manner is not a reason to deny payment.

27.3 VERIFICATION

Specific requirements for verification of travel expenses are determined by the broker.

27.4 CLIENT NOTIFICATION OF DENIAL

The client must be notified in writing within 30 days of his non-emergency medical transportation (NEMT) payment denial.

27.5 SPECIFIC ELIGIBILITY REQUIREMENTS

27.5.1 EXCEPTIONS TO ELIGIBILITY

The following individuals are not eligible for non-emergency medical transportation (NEMT):

- Individuals designated only as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLIMB), Qualified Individuals (QI-1), or Qualified Disabled Working Individuals (QDWI) and who are not dually eligible for any full-coverage Medicaid group
- Medicaid public school patients being transported to schools for the primary purpose of obtaining an education, even though Medicaid-reimbursable school-based health services are received during normal school hours, except for children receiving services under the Individuals with Disabilities Education Act (IDEA) when the child receives transportation for a Medicaid-covered service, and both the transportation and service are included in the child's Individualized Education Plan (IEP)

Reimbursement is allowed in certain circumstances for trips to pick up medicine, eyeglasses, dentures, or medical supplies, or for repairs or adjustments to medical equipment.

When services are paid for by any other program, or otherwise not charged to Medicaid, NEMT is not approved.

When other reimbursement is available, Medicaid is always the last payer.

Reimbursement is not approved for services normally provided free to other individuals.

27.5.2 PRIOR AUTHORIZATION

The following situations require prior authorization from the broker.

- All requests for out-of-state transportation and certain related expenses, except for travel to those facilities which have been granted in-network status. Facilities granted in-

NOTE: Individuals who receive both Medicare and Medicaid do not require prior approval for out-of-state transportation.

network status are considered in-state providers.

  - Members are required to contact the broker to schedule the travel for all medical appointments or visits, regardless of the in-network or out-of-network status.

- Transportation of an immediate family member (parent, spouse, or child of the patient) to accompany and/or stay with the patient at a medical facility when the need to stay is based on medical necessity and documented by the physician. Exceptions require Bureau for Medical Services (BMS) approval.
- Two round trips per scheduled hospitalization (one for admittance and one for discharge) when the parent or family member chooses not to stay with the patient.
- Lodging.
- Meals, only when lodging is approved.
- Transportation via common carrier judged to be the most economical. If the member insists on incurring expenses beyond those approved by the broker, such costs will not be reimbursed.

Travel for parents/children to visit or participate in a treatment plan for hospitalized individuals is not authorized when it does not coincide with the patient's travel. Exceptions require BMS approval.

27.5.3 ROUTINE AUTOMOBILE TRANSPORTATION REQUESTS

Members may request reimbursement for costs related to automobile travel, such as mileage, tolls, and parking fees when free parking is not available. The travel must be for scheduled appointments and treatment. Mileage is paid from the patient's home to the facility and back to the home. When comparable treatment may be obtained at a facility closer to the patient's home than the one he chooses, mileage reimbursed is limited to the distance to the nearest facility. The client's statement about the availability of a closer facility is accepted unless the information is questionable. See Determining the Amount of Payment below.

Meals are not reimbursed for any travel that does not include an overnight stay.

When travel by private automobile is an option, but the member chooses more costly transportation, the rate of reimbursement is limited to the private auto mileage rate.

When the member chooses to rent an automobile and submits the costs of the rental and connected fees, and the total is less than the private mileage rate, the lower cost is paid.

Members must car-pool when others in the household have appointments the same day at the

same facility.

Round trips are limited to one per household per day. Parents must make an effort to schedule appointments for children at the same time or on the same day whenever possible.

27.5.4 REQUESTS FOR TRANSPORTATION FOR EMERGENCY ROOM SERVICES

Members who use emergency rooms for routine medical care are not reimbursed for transportation. When the broker documents that emergency room treatment was necessary, the broker may approve the transport for the member to return home from the emergency room.

27.5.5 APPROVED TRANSPORTATION PROVIDERS

The least expensive method of transportation must always be considered first and used, if available.

Providers are listed below. Members who choose a more expensive method than the one available are reimbursed at the least expensive rate.

- The patient or a member of his family; friends; neighbors; interested individuals; foster parents; adult family care providers; or volunteers
- Volunteers or paid employees of community-based service agencies, such as Community Action and Senior Services
- Common carriers (e.g., bus, train, taxi, or airplane)

27.5.6 DETERMINING THE AMOUNT OF PAYMENT

The amount of reimbursement for transportation expenses depends on the method of transportation, the round-trip mileage, and/or whether lodging was required.

Payment may be authorized for one round trip per patient per day, with a maximum of two round trips per hospital admission. Exceptions require documentation of medical necessity and BMS approval.

27.5.6.A Mileage

Round-trip mileage from the patient's home to the medical facility is paid. The round trip must be made over the shortest route, as determined by the broker.

As stated above, mileage is limited to the nearest comparable facility for routine services (e.g., allergy shots, blood pressure readings) when the physician has not specified that a specific facility must be paid.

27.5.6.B Common Carrier

The cost of waiting time is paid only when travel between cities is required. This waiting time is permitted only for obtaining medical services. When waiting time is claimed, the broker must obtain a dated and signed statement from the taxi company indicating the rate, elapsed time, and total charges for the waiting time.

27.5.6.C Lodging

When an overnight or longer stay is required, lodging may be paid for the patient and one additional person if the patient is not the driver. Accommodations must be obtained at the most economical facility available. Resources such as Ronald McDonald Houses, or facilities operated by the hospital, must be used whenever possible.

West Virginia currently has three Ronald McDonald Houses that may invoice the broker directly for payment. The client must not be reimbursed unless he provides a receipt to verify he made the payment. Their addresses, telephone numbers, and the medical facilities with which they are affiliated are as follows:

- Ronald McDonald House of Southern WV, Inc.
  910 Pennsylvania Avenue
  Charleston, WV 25302
  Telephone Number: (304) 346-0279
  Hospital affiliate: Charleston Area Medical Center (CAMC)
- Ronald McDonald House Charities of the Tri-State, Inc.
  1500 17th Street
  Huntington, WV 25701

Telephone Number: (304) 529-2970
Hospital affiliates: Cabell-Huntington Hospital and St. Mary's Hospital

- Ronald McDonald House of Morgantown
  841 Country Club Drive
  Morgantown, WV 26505
  Telephone Number: (304) 598-0050
  Hospital affiliates: Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital, and Mountaineer Rehabilitation Center

Lodging prior to the day of the appointment is determined necessary when the appointment is scheduled for 8:00 a.m. or earlier and travel time to the facility is two hours or more from the patient's home. It may also be determined necessary when the patient is required to stay overnight to receive additional treatment. Exceptions require BMS approval.

27.5.6.D Meals

Reimbursement for meals is available only in conjunction with lodging and only for meals that occur during the time of the travel or the stay. Meals are permitted for the patient and/or the person approved to stay with the patient. The rate is $5 per meal per person, regardless of which meals the reimbursement covers. Determination of which meals to include is based upon the time the trip started and when the patient returned home.

27.5.6.E Related Expenses

Reimbursement may be made for other travel-related expenses, such as turnpike tolls and parking fees. Parking is limited to $3 per day when free parking is not available within reasonable walking distance of the facility. A receipt is required. Metered parking is limited to $2 per day with no receipt required.

27.5.6.F Limitations and Restrictions

Anyone may volunteer to provide transportation for Medicaid clients for reimbursement of expenses only. However, the broker does not reimburse any volunteer for more than 6,000 miles in any calendar year except as follows:

NOTE: A volunteer is a person, other than the client, his family, or friends, who provides transportation to medical appointments for Medicaid clients. The 6,000-mile limit does not apply to family or friends who have been selected by the Medicaid client to provide the transportation. The limit does not apply to common carriers.

- No public transportation is available, and the client does not drive and has no one else who can provide transportation.
- The patient requires frequent medical treatment (e.g., dialysis, chemotherapy) and local staff have approved the continued use of the same provider.

Employees of entities that provide Medicaid services (e.g., personal attendant, behavioral health rehabilitation providers, Aged and Disabled [ADW] providers, Traumatic Brain Injury [TBI] providers, Intellectual/Developmental Disability Waiver [I/DD] providers) cannot be reimbursed as an NEMT provider when transporting individuals while being paid by that Medicaid provider (e.g., being on the clock and being paid for NEMT at the same time).

I/DD Waiver providers must bill NEMT for Medicaid-approved services unless training is occurring during the transportation time. If a provider is billing another State Plan (non-waiver) Medicaid service, then the provider must utilize NEMT for transportation costs.

27.6 BENEFIT REPAYMENT

Members must be informed that fraudulent claims will result in denial of subsequent requests up to the amount of the claim, and could result in permanent ineligibility for non-emergency medical transportation (NEMT).

When the broker is aware that a client may be obtaining NEMT reimbursements to which he is not entitled, the broker must monitor all requests from the client to determine if misuse or abuse of the program is actually taking place. Any information deemed questionable must be verified, even if not routinely required.

If the broker has reason to suspect that reimbursement is being requested for trips that were not taken, he must contact the medical provider(s) listed and verify appointment dates and whether or not the appointments were kept.

A referral must be made to Bureau for Medical Services (BMS) and Office of the Inspector General (OIG) to notify the agencies of potential fraud, waste, and abuse.

Chapter 28

Special Pharmacy

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
28.1				
28.2				
28.3	4/1/18	755	28.3.14	Reflect the December 2017 change in the way Medical ID cards are issued.
28.4				
28.5				
28.6				
28.7				
28.8				
28.9				
28.10				
28.11				
28.12				
28.13				
28.14	4/1/18	755	28.14	Reflect the December 2017 change in the way Medical ID cards are issued.

28.1 INTRODUCTION

The Special Pharmacy Program was established to help pay for certain necessary drugs for individuals not eligible for Medicaid. These costs are paid from State funds and cover only the costs of immunosuppressant (anti-rejection) drugs after a patient has received a transplant and Antipsychotic (atypical) Drug Management.

28.2 SPECIFIC ELIGIBILITY REQUIREMENTS

The applicant must have been denied Medicaid due solely to failure to meet a spenddown within six months of the date of the client's request for payment. If he is unable to meet a spenddown, special approval is considered. To qualify for Special Pharmacy, it must be established that the cost of the anti-rejection or antipsychotic medication paid by the client reduces the family's gross income to below 100% of the Federal Poverty Level (FPL) for a family of the same size.

NOTE: Individuals eligible for or receiving Qualified Medicare Beneficiary (QMB) coverage are not eligible for Special Pharmacy coverage.

28.3 APPLICATION/REDETERMINATION PROCESS

The individual may apply at any time after receiving the transplanted organ.

28.3.1 APPLICATION FORM

The Application for Special Pharmacy (DFA-SP-1) is completed by the Worker and forwarded to the Bureau for Medical Services (BMS) Medicaid Policy Unit for consideration. This is an interdepartmental form and is not given to (or completed by) the applicant. The form must contain the following information:

- Applicant's name, address, date of birth, Social Security number (SSN), sex, county of residence, case number, and race;
- Individuals in the applicant's home and the relationship of each to the applicant;
- Gross income of the applicant, applicant's spouse, and all dependent children living in the home;
- Applicant's Medicare eligibility status and participation in payment for drug costs. If eligible, provide the Medicare claim number and the beginning dates of Part A and Part B;
- Applicant's Qualified Medicare Beneficiary (QMB) eligibility status;
- List of prescribed immunosuppressant/anti-rejection or antipsychotic drugs;

NOTE: Medicare pays 80% of the cost of anti-rejection drugs indefinitely, if all Medicare requirements are met. Medicare pays 80% of the cost of anti-rejection drugs for transplant recipients with End Stage Renal Disease (ESRD). When Medicare participates in the payment of the drugs, the Worker must deduct any amount Medicare pays and indicate only the amount for which the client is responsible. Only the remaining amount is used to determine eligibility and subsequent payment by the Department.

- Average monthly cost to the applicant of the prescribed anti-rejection or antipsychotic drugs;
- Name, address, and telephone number of the pharmacy;
- Physician's name;
- Date of the transplant;
- Date of the most recent Medicaid application and reason for denial; and,

- Cost of lab tests and testing facility for antipsychotic drugs.

Certain recipients of benefits from the Office of Children and Adult Services (CAS) are eligible to receive coverage for immunosuppressant drugs through the child welfare information system. During the application or renewal process, the Worker must inquire if the Special Pharmacy applicant is receiving medical coverage through CAS. If the Worker believes the applicant may be receiving duplicate coverage or services through both the child welfare information system and the eligibility system, the Worker must electronically notify the BMS Medicaid Policy Unit with the following information:

- Applicant/Recipient's Name
- Date of Birth
- Social Security Number
- Client's child welfare information system ID (if known)

28.3.2 COMPLETE APPLICATION

The application for Special Pharmacy is complete when the Worker submits the completed DFA-SP-1 to the BMS Medicaid Policy Unit.

28.3.3 DATE OF APPLICATION

The date of application is the date the DFA-SP-1 is completed.

28.3.4 INTERVIEW REQUIRED

An interview is not required for completion of the DFA-SP-1, however it may be necessary to complete the application or redetermination.

28.3.5 WHO MUST SIGN

A client signature is not required on the DFA-SP-1.

28.3.6 DUE DATE OF ADDITIONAL INFORMATION

The client must be given at least ten days to return additional information. All information must be submitted with the DFA-SP-1. The worker will not submit the application if the client fails to provide the required information.

28.3.7 AGENCY TIME LIMITS

The Worker must submit the DFA-SP-1 to the BMS Medicaid Policy Unit within 10 days of completion. The BMS Medicaid Policy Unit must make a decision and notify the Worker of that decision within 30 days from the date the completed DFA-SP-1 is received.

28.3.8 REPAYMENT AND PENALTIES

This does not apply to the Special Pharmacy Program.

28.3.9 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility for Special Pharmacy is the first day of the month of the DFA-SP-1 application, if eligible. Special Pharmacy may be backdated up to three months prior to the month of application.

28.3.10 REDETERMINATION SCHEDULE

All assistance groups (AG) are reevaluated in the sixth month of certification. The BMS Medicaid Policy Unit sends notification to the local office in the fifth month of eligibility.

28.3.11 EXPEDITED PROCESSING

Applications must be processed as soon as possible after the Worker becomes aware of the need for immunosuppressant/anti-rejection/antipsychotic drugs.

28.3.12 CLIENT NOTIFICATION

Once the eligibility decision is made, the local office is notified by the BMS Medicaid Policy Unit. The local office must notify the client of the decision in writing. BMS notifies the service provider of the approval and appropriate billing procedures. The service provider notifies the client of the following:

- Covered medications;
- How to obtain payment for drugs and services;
- The Special Pharmacy ID number; and
- Dates of coverage.

28.3.13 REDETERMINATION VARATIONS

The redetermination process is as follows.

28.3.13.A Redetermination List

Special Pharmacy is reevaluated in the sixth month of eligibility. The Supervisor is notified by the BMS Medicaid Policy Unit of the upcoming review in the fifth month of eligibility.

28.3.13.B Date of Redetermination

The Worker is responsible for scheduling the redetermination so that it is completed prior to or during the sixth month of eligibility.

28.3.13.C Scheduling Redetermination

A system generated appointment letter must be requested by the Worker to notify the client of the redetermination and the date the interview is scheduled.

28.3.13.D Completion of the Redetermination

When the redetermination is completed and the AG remains eligible, the new eligibility period begins the month immediately following the month of redetermination with no break in coverage. The Worker is notified by the BMS Medicaid Policy Unit when the redetermination is due.

28.3.14 THE BENEFIT

There is no Medical ID card issued for Special Pharmacy. BMS notifies the service provider of the approval and appropriate billing procedures. The service provider notifies the client of the following:

- Covered medications;
- How to obtain payment for drugs and services;
- The Special Pharmacy ID number; and
- Dates of coverage.

28.4 COMMON ELIGIBILITY REQUIREMENTS

28.4.1 RESIDENCE

The applicant must be a West Virginia resident.

28.4.2 CITIZENSHIP STATUS

The Medicaid policy/procedures in Section 15.7.5 apply to Special Pharmacy.

28.4.3 COOPERATION WITH QUALITY CONTROLS

Cooperation with Quality Control does not apply to Special Pharmacy.

28.4.4 LIMITATIONS ON RECEIPT OF OTHER BENEFITS

The applicant may receive other Department of Human Services (DOHS) benefits for which he qualifies, with the exception of Qualified Medicare Beneficiary (QMB) or full coverage Medicaid.

28.4.5 NON-DUPLICATION OF BENEFITS

The individual cannot be a recipient of QMB, a recipient of any other full coverage Medicaid group, or receive Special Pharmacy in more than one county concurrently.

28.4.6 ENUMERATION

The enumeration requirements in Section 2.7 for Medicaid apply.

28.5 ELIGIBILITY DETERMINATION GROUPS

28.5.1 THE ASSISTANCE GROUP (AG)

28.5.1.A Who Must Be Included

The individual who qualifies for Special Pharmacy services is the only person in the AG.

28.5.1.B Who Cannot Be Included

The following individuals cannot be included:

- Recipients of any full coverage Medicaid group or Qualified Medicare Beneficiary (QMB) coverage group
- Any other person except the person who qualifies for anti-rejection/antipsychotic drugs

28.5.2 THE INCOME GROUP (IG)

The IG includes:

- The legal spouse of the Special Pharmacy applicant, if living in the home.
- All dependent children of the Special Pharmacy applicant who lives in the home. See Chapter 3.3 for the definition of a dependent child.

28.5.3 THE NEEDS GROUP (NG)

The income limit for the number of persons in the IG is used.

28.6 INCOME

28.6.1 TRANSFERS OF INCOME

The transfer of resources policy does not apply to Special Pharmacy.

28.6.2 INCOME SOURCES

The income sources in Section 4.3 are treated the same as for Supplemental Security Income (SSI)-Related Medicaid.

28.6.3 BUDGETING METHOD

The method used to anticipate monthly countable income is the same as the method outlined in Section 4.6.

28.6.4 INCOME DISREGARDS AND DEDUCTIONS

The only deduction is the monthly cost of anti-rejection/antipsychotic medication for the applicant.

28.6.5 DETERMINING ELIGIBILITY

Eligibility is determined as follows:

- Step 1: Determine the total gross income for the Income Group. See Section 28.6.
- Step 2: Subtract the costs for the anti-rejection/antipsychotic drugs the applicant would actually pay if not eligible for Special Pharmacy. Do not include any amount covered by Medicare or any other third party payer.

- Step 3: Compare the remainder to 100% of the Federal Poverty Level (FPL) for the Needs Group. If the amount in Step 3 equals or exceeds 100% of the FPL, the client is ineligible. If the amount in Step 3 is less than 100% of the FPL, the client is eligible.

> **Determining Eligibility Example:**
>
> | | |
> |---|---|
> | Needs Group Size | = 1 |
> | 100% FPL for 1 | = $903 |
> | STEP 1: Income for Income Group (IG) | = $1,001 |
> | Clients Monthly Cost of Anti-rejection Drugs | = $350 |
> | STEP 2: Remainder | = $651 |
>
> STEP 3: The remaining amount is less than 100% FPL for one, therefore, the applicant is eligible for Special Pharmacy.

28.7 ASSETS

There is no asset test for Special Pharmacy.

28.8 DATA EXCHANGE

The data exchange and matches described in Chapter 6 are not applicable to Special Pharmacy.

28.9 VERIFICATION

The client's cost of the immunosuppressant/anti-rejection/antipsychotic drugs must be verified by the Worker. Gross monthly income for the applicant, applicant's spouse and all dependent children living in the home must be verified.

28.10 RESOURCE DEVELOPMENT

The resource development policies do not apply to Special Pharmacy.

28.11 CASE MAINTENANCE

28.11.1 CHANGE IN INCOME AND DEDUCTIONS

A change in income and/or deductions between redeterminations does not result in ineligibility for the client, unless the changes result in eligibility for a full coverage Medicaid group.

The client must report a change of address, change in pharmacy, and any additions to or deletions from the household to the Worker. The Worker must forward all reported changes to the Bureau for Medical Services (BMS) Policy Unit.

28.11.2 AG CLOSURE

If the Special Pharmacy Program client becomes eligible for full coverage Medicaid, notification must be sent to the BMS Policy Unit immediately. The Special Pharmacy is closed after the Policy Unit notifies the Worker and advance notice is issued to the client. The Policy Unit notifies the services provider to close the Special Pharmacy case.

28.12 BENEFIT REPAYMENT

Benefit repayment does not apply for Special Pharmacy.

28.13 BENEFIT REPLACEMENT

If the client is unable to obtain his medication, the Worker must contact the Bureau for Medical Services (BMS) Policy Unit. The Policy Unit will contact the BMS to send another notification to the client.

28.14 ANTIPSYCHOTIC (ATYPICAL) DRUG MANAGEMENT AND TESTING

Individuals for whom antipsychotic (atypical) drugs have been prescribed, and who are not eligible for Medicaid due solely to failure to meet a spenddown, may have the cost of the medication paid by the Department of Human Services (DOHS). To qualify, it must be established that the cost of the antipsychotic drugs, if paid by the client, would reduce the family's income to below 100% of the Federal Poverty Level (FPL) for a family of the same size. The individual must have been denied Medicaid for the above reason within six months of the date of the client's request for payment. In addition, the Worker must review the case every six months to determine if the client remains ineligible for failure to meet a spenddown. If he continues to be ineligible for Medicaid due solely to failure to meet a spenddown at the time he requests payment of the antipsychotic (atypical) drugs, special approval is considered.

The Worker must submit a completed DFA-SP-1 to the Bureau for Medical Services (BMS) Medicaid Policy Unit to have the client considered for this special approval. The form must contain all of the information specified in Section 28.3.1, with the following additions:

- The average monthly out-of-pocket cost of antipsychotic drugs;
- The average monthly cost of lab tests; and
- The name of the facility that will perform the lab tests. No verification of the information submitted is required, unless the client does not know the information, or the Worker has reason to doubt the client's statement.

Certain recipients of benefits from the Office of Children and Adult Services (CAS) are eligible to receive coverage for immunosuppressant drugs through the child welfare information system. During the application or renewal process, the Worker must inquire if the Special Pharmacy applicant is receiving medical coverage through CAS. If the Worker believes the individual may be receiving duplicate coverage or services through both the child welfare information system and the eligibility system, the Worker must electronically notify the BMS Medicaid Policy Unit with the following information:

- Applicant/Recipient's Name
- Date of Birth
- Social Security Number (SSN)
- Client's child welfare information system ID (if known)

Once the eligibility decision is made, the local office is notified by BMS Medicaid Policy Unit. The local office must notify the client of the decision in writing. BMS will notify the service provider and the service provider will notify the client how to obtain payment for

medication/treatment and provide a list of medications covered, Medicaid ID number and dates of coverage. No Medical ID card is issued.

A list of all antipsychotic (atypical) drugs may be found on the BMS website by clicking on Preferred Drug List.

Chapter 29

COVID-19 Testing Group Medicaid

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Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
29.1	6/5/20 5/1/23	788 837		Chapter Created Added a note that all applications for COVID-19 testing group Medicaid must have a (service date) on or before May 11, 2023.
29.2	1/1/21	799	29.2	Deleted wording
29.3				
29.4				
29.5				
29.6				

29.1 INTRODUCTION

The COVID-19 Testing Group Medicaid coverage was established by section 6004(a)(3) of the Families First Coronavirus Response Act to provide coverage for uninsured individuals otherwise ineligible for coverage for the purposes of receiving testing for coronavirus (COVID-19). Coverage under the COVID-19 Testing Group may be effective no earlier than March 18, 2020.

NOTE: Effective May 11, 2023, the COVID-19 Public Health Emergency declaration expires. All applications for COVID-19 Testing Group Medicaid must be dated (service date) prior to this effective date to be eligible for the benefit. Applications must be submitted before August 11, 2023 to be covered under this coverage group.

29.2 APPLICATION PROCESS

29.2.1 APPLICATION FORM

The application for COVID-19 Testing Group Medicaid is completed by the applicant, or authorized representative, preferably at the time of testing. The application is submitted by the Medicaid provider along with the claims submission. The form must include:

- Applicant's name;
- Applicant's address;
- Applicant's date of birth;
- Applicant's social security number; and,
- Applicant's signature, or signature of authorized representative.

29.2.2 COMPLETED APPLICATION

The application is considered complete when all relevant sections have been completed on the form and is signed by the applicant or authorized representative.

29.2.3 DATE OF APPLICATION

The date of application is the date the applicant submits a completed application to the department.

29.2.4 DATES OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

Eligibility will end the last day of the 12th month of eligibility, or the last day of the month of the end of the COVID-19 Public Health Emergency, whichever comes first. Advance notice

requirements apply. A redetermination is not required.

29.2.5 INTERVIEW REQUIRED

No interview is required for the COVID-19 Testing Group Medicaid Group.

29.2.6 WHO MUST SIGN

The applicant, or authorized representative, must sign the application form.

29.2.7 THE BENEFIT

Effective no earlier than March 18, 2020, covered services for beneficiaries under the COVID-19 testing eligibility group are limited to medical assistance for:

- in vitro diagnostic testing (and administration of that testing) described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act, and

- COVID-19 testing-related services described in 1916(a)(2)(G) of the Act, added by section 6004(a)(2)(A) of the FFCRA, furnished during a provider visit related to such testing during the public health emergency period. The limitation on the benefits available to beneficiaries under this group is found in clause (XVIII) in the matter following section 1902(a)(10)(G) of the Act, as added by section 6004(a)(3)(A)(ii) of the FFCRA. See Question C.14 for information on the requirement to cover COVID-19-related testing and diagnostic services for all Medicaid beneficiaries.

29.3 COMMON ELIGIBILITY REQUIREMENTS

29.3.1 RESIDENCE

To be eligible to receive benefits, the client must be a resident of West Virginia. The client must live within the borders of West Virginia for purposes other than vacation. There is no minimum time requirement for how long the client must live or intends to live in West Virginia. The client is not required to maintain a permanent or fixed dwelling. An individual remains a resident of the former state until he arrives in West Virginia with the intention of remaining indefinitely. Therefore, intent to establish or abandon residency must be known before the state of residence is determined.

29.3.2 CITIZENSHIP STATUS

The Medicaid policy/procedures in Section 15.7.5 apply to the COVID-19 Testing Group Medicaid. See Section 7.4 for citizenship verification requirements for COVID-19 Testing Group Medicaid.

29.3.3 ENUMERATION

The Medicaid policy in Section 2.7.1 applies to the COVID-19 Testing Group.

29.3.4 OTHER ELIGIBILITY REQUIREMENTS

Applicants must meet the following requirements:

- They must meet the definition of “uninsured individual”;
    - Uninsured individual is defined as any individual that does not have minimum essential coverage under Section 5000A(f)(1) of the Internal Revenue Code of 1986.
        - Government Sponsored programs:

- Medicare Part A;
- Medicaid;
- CHIP;
- Medical coverage received from an employer, including TRICARE;
- Medical coverage received by Secretary of Veterans Affairs;
- Health plan received from Peace Corps Volunteers;
- Nonappropriated Fund Health Benefits Program of the Department of Defense;

▪ Employer-Sponsored Plan
- Coverage under an eligible employer-sponsored plan

▪ Plans in the individual market
- Coverage under a health plan offered in the individual market within a State

▪ Grandfathered health plan
- Coverage under a grandfathered health plan

▪ Other coverage
- Such other health benefits coverage such as a State health benefits risk pool

- They must not be actively enrolled in any Medicaid coverage groups;
- They must not be required to be assessed for other Medicaid coverage;
- They must be allowed to self-attest to income and insurance status;
- The must assign rights to medical support and payments for medical care from any third party, see Section 23.2.

29.4 ELIGIBILITY DETERMINATION GROUPS

29.4.1 THE ASSISTANCE GROUP (AG)

The Assistance Group (AG) for the COVID-19 Testing Group is only the individual applicant.

29.4.2 THE INCOME GROUP (IG)

There is no Income Test for this program.

29.5 INCOME

There is no Income Test for this Group.

29.6 ASSETS

There is no Asset Test for this Group.

29.7 Case Maintenance

Clients must report changes in circumstances during the period of COVID-19 Testing Group eligibility. Case maintenance policies in Section 10.6 apply.

29.7.1 AG Closures

The AG must be closed when:

- The client is determined eligible for another full coverage Medicaid group.
- The client is no longer a West Virginia resident.
- The client is deceased.
- The client voluntarily requests closure.

29.8 CLIENT NOTIFICATION

The applicant must be notified in writing of the action taken on his application for the COVID-19 Testing Group.

Fair Hearing requirements at Section 9.3.1.D.3 apply to COVID-19 Testing Group application denials. Denial notices must include form DFA-FH-1.

Fair Hearing requirements do not apply at case closure at the end of eligibility period, however advance notice is required.

Acronyms, Forms, and Glossary

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Change History Log

Section	Date of Change	Change Number	Description of Change
Started July 1, 2021			
Acronyms And Abbreviations	7/1/21	806	Replaced OMRS with RRIS
	3/1/22	818	Removed NILC-Non-issuance Limited County
	5/1/22	821	Removed Test Assessing Secondary Completion (TASC)
	6/1/22	822	Changed Domestic Violence to sexual harassment & domestic violence, sexual assault, and stalking.
	9/1/22	827	Added Children with Serious Emotional Disorder Waiver
	5/1/24	850	Added SEBT acronym for Summer EBT Program.
	1/1/26	872	Added NCHZ Notice of Match Results
	2/1/26	873	Added Catholic Charities of West Virginia. Removed Refugee Resettlement and Immigration Services
Forms	7/1/21	806	Added DFA-ADARA-1
	5/1/22	821	Added DFA-PVM-1
	7/1/22	824	Changed form to IG-IFM-BENPAY-1
	9/1/22	826	Replaced ES14 with DF-68
	2/1/24	846	Added DFA-36-B, DFA-PSSE, DFA-WVW-CCG-2
			Removed DFA-WVW-ADA-1, DFA-WVW-ADA-1A, DFA-WVW-CCG-1
	5/1/24	850	Updated Forms DFA-BU-1, DFA-BU-2, DFA-BU-3, DFA-BU-3, DFA-BU-4, DFA-67-A, DFA-WVW-70
			Added DFA-SEBT-1

Section	Date of Change	Change Number	Description of Change
	4/1/24	862	Updated Form DFA-HV-1
	7/1/25	866	Updated DFA-PRC-2
	2/1/26	873	Added DFA-REF-1 and DFA-REF-2
Glossary	7/1/21	806	Added COFA migrants
	3/1/22	817	Removed NILC; removed Dormant Card; updated Expungement.
	3/1/22	817	Shortened Administrative Terminal
	7/1/22	824	Updated expungement
	9/1/23	840	Updated ages impacted by ABAWD Policy.
	5/1/24	850	Updated definition for Expungement to include Summer EBT.
	10/1/24	855	Updated age for ABAWD to 55, updated 53rd birthday to 55th birthday.
	2/1/25	860	Updated the definition of a countable ABAWD month.
	11/1/25	870	Updated the definition for ABAWD and Dependent (for ABAWD policy).
	2/1/26	873	Removed RRIS.

ACRONYMS A/ND ABBREVIATIONS

The following is a list of acronyms, eligibility system codes, and abbreviations commonly found throughout the West Virginia Income Maintenance Manual (IMM). Additionally, the chapter(s) in which the acronyms and abbreviations are found are included.

Acronym/ Abbreviation	Phrase/Word	Chapter
AAA	Area Agency on Aging	21
AB	Aid to the Blind	23
AB (Component)	Secondary School	14
ABAWD	Able Bodied Adults without Dependents	1, 3, 4, 7, 10, 13, 14, 17
ABE	Adult Basic Education	1, 17, 18
ABLE	Achieving a Better Life Experience	4, 5, 7, 10, 24

Acronym/ Abbreviation	Phrase/Word	Chapter
AC	Authorized Cardholder	12
ACA	Affordable Care Act	1, 3, 4, 6, 22, 23, 24
ACE	AmeriCorps Community Enrichment Programs	4, 20
ACF	Administration for Children and Families	18
AD	Aid to the Disabled	18, 23
AD (Component)	Participant with a Documented Disability	18
ADA	American with Disabilities Act	1
ADAP	AIDS Drug Assistance Program	1, 2, 3, 4, 10, 13, 23
ADH	Administrative Disqualification Hearing	2, 3, 10, 11
ADW	Aged and Disabled Waiver	1, 4, 10, 13, 14, 18, 22, 24
AFDC	Aid to Families with Dependent Children	2, 3, 4, 5, 7, 8, 14, 18, 22, 23
AFDC/U	Aid to Families with Dependent Children, Unemployed Parents	11, 18
AFIA	Assets for Independence Act	4
AG	Assistance Group	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 26, 28
AI/AN	American Indian/Alaskan Native	22
AIDS	Acquired Immune Deficiency Syndrome	1, 2, 5, 13
ALJ	Administrative Law Judge	10
ALS	Amyotrophic Lateral Sclerosis	8
ANCSA	Alaska Native Claims Settlement Act	5
ANG	Air National Guard	4
Ap	Additional parent	14
APHSA	American Public Human Service Association	1
APTC	Advance Premium Tax Credits	1, 4, 22, 23

Acronym/ Abbreviation	Phrase/Word	Chapter
AR	Authorized Representative	1
ARU	Automated Response Unit	11
ASVI	Alien Status Verification Index	15
ATM	Automated Teller Machine	1
AVS	Asset Verification System	6
BAH	Basic Allowance for Housing	4
BCC	Breast or Cervical Cancer	1, 10, 23
BCCSP	Breast and Cervical Cancer Screening Program	1, 10
BCF	Bureau for Children and Families	1, 4, 18, 19, 20
BCSE	Bureau for Child Support Enforcement	1, 3, 4, 6, 7, 8, 9, 10, 11, 14, 18, 19, 22, 23
BEERS	Beneficiary Earnings and Exchange Record System	6
BENDEX	Beneficiary and Earnings Data Exchange	6, 10
BIA	Bureau of Indian Affairs	4, 5, 15, 20
BMS	Bureau for Medical Services	1, 3, 5, 7, 8, 10, 11, 13, 15, 23, 24, 25, 26, 27, 28
BoSS	Bureau of Senior Services	24
BPH	Bureau of Public Health	1, 4
CAA	Consolidated Appropriations Act	15
CAF	Common Application Form	1
CAN	Claim Number	25
CAS	Children and Adult Services	28
CARES	Coronavirus Aid, Relief and Economic Security	4,5
CC (Component)	Child Care	1, 18
CCRC	Continuing Care Retirement Community	5
CCU	Claims and Collections Unit	11

Acronym/ Abbreviation	Phrase/Word	Chapter
CCWVA	Catholic Charities of West Virginia	15
CD	Certificate of Deposit	5, 7, 11, 20, 26
CDC	Centers for Disease Control	23
CDCSP	Children with Disabilities Community Service Program	1, 4, 5, 10, 13, 22, 23, 24
CDL	Commercial Driver's License	18
CEN	Continuously Eligible Newborn	1, 2, 3, 4, 7, 10, 23
CHAMPUS	Civilian Health and Medical Program of Uniformed Services	6, 22
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs	22
CHIP	Children's Health Insurance Program	4, 6, 7, 9, 22
CI	Criminal Investigator	11
CIB	Criminal Identification Bureau	3, 18
CIS	Central Index System	15
CIU	Criminal Investigation Unit	11
CL (Component)	College	14, 18
COFA	Compact of Free Association	15
CMA	Case Management Agency	24
CME	Continuous Medicaid Eligibility	1, 10
CMS	Center for Medicare and Medicaid Services	8, 24, 25
CMV	Current Market Value	5, 20, 24
CNA	Certified Nursing Assistant	18
CNCS	Corporation for National and Community Service	4, 5, 20, 21
COBRA	Consolidated Omnibus Budget Reconciliation Act	23

Acronym/ Abbreviation	Phrase/Word	Chapter
COLA	Cost-of-Living Allowances	4, 10, 23, 26
CPS	Child Protective Services	3, 10, 18
CS (Component)	Community Services Programs	1, 18
CSED	Children with Serious Emotional Disorder	23, 24
CSEP	Community Service Employment Program	4, 20, 21
CSHCN	Children with Special Health Care Needs	13, 22, 23, 27
CSI	Child Support Incentive	1, 4, 10, 11, 18
CSM	Community Services Manager	1, 10, 14, 16, 18, 24
CSMA	Community Spouse Maintenance Allowance	24
CSR	Cost-Sharing Reductions	1, 23
CSR	Civil Service Retirement	13, 18
CSR	Customer Service Representative	1
CSRC	Customer Service Reporting Center	1
CW (Component)	Community Work	18
CWEP	Community Work Experience Program	1, 14, 17, 18
CWN	Consolidated Work Notice	1, 9, 14
CWS	College Work Study	3, 4
DA&A	Drug Addicts and Alcoholics	4, 5, 23
DAC	Disabled Adult Children	1, 4, 23
DCA	Diversionary Cash Assistance	1, 4, 7, 10, 18, 19
DED	Deferred Enforced Departure	15
DFA	Division of Family Assistance	1, 3, 6, 8, 12, 13, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24
DOHS	Department of Human Services	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28
DHS	Department of Homeland Security	7, 15

Acronym/ Abbreviation	Phrase/Word	Chapter
DME	Durable Medical Equipment	24
DMV	Division of Motor Vehicles	5, 18
DOC	Division of Corrections	1
DOD	Department of Defense	4, 5, 6
DOE	Department of Education	18
DOL	Department of Labor	8, 18
DPQI	Division of Planning Quality Improvement	1, 2, 18
DRA	Deficit Reduction Act	7, 18, 24
DRS	Division of Rehabilitation Services	1, 4, 13, 17, 18, 26
D-SNAP	Disaster Supplemental Nutrition Assistance Program	16
DUI	Driving Under the Influence	18
EA	Emergency Assistance	1, 11, 14, 15, 20, 21
EAB	Enumeration at Birth	2
EAD	Employment Authorization Document	15
EAP (Component)	Employment Assistance Program	1, 18, 19
EBT	Electronic Benefits Transfer	1, 4, 5, 10, 12, 11, 16
EEG	Electroencephalogram	13
EEO	Equal Employment Opportunity	1
EEOC	Equal Employment Opportunity Commission	1
EHI	Emotional Health Inventory	18
EIP	Employer Incentive Program	18
EITC	Earned Income Tax Credit	1, 4, 5
EKG	Electrocardiogram	13
ELA	Eligible Legalized Alien	15

Acronym/ Abbreviation	Phrase/Word	Chapter
EN	Employment Network	26
EOB	Explanation of Benefits	7, 22, 24
EOIR	Executive Office for Immigration Review	15
ESABPS	Unemployment Compensation Benefit System	10
ESL	English as a Second Language	15, 18
ESOL	English for Speakers of Other Languages	15
ESP	Employment Subsidy Program	18
ESRD	End Stage Renal Disease	8, 28
FAFSA	Free Application for Federal Student Aid	18
FB (Component)	Full-Time Subsidized Public Sector Employment	18
FDH	Federal Data Hub	1, 2, 4, 6, 7
FECA	Federal Employment Compensation Act	13, 14, 18
FEFU	Front-End Fraud Unit	11
FEIN	Federal Employer Identification Number	20
FEMA	Federal Emergency Management Agency	20
FERPA	Family Educational Rights and Privacy Act	18
FEVS	Front-End Verification Specialist	11
FFCRA	Families First Coronavirus Response Act	4, 10, 26
FFEL	Federal Family Education Loan	4
FFM	Federally Facilitated Marketplace	1, 4, 6, 9, 13, 22
FHA	Federal Housing Administration	4
FICA	Federal Insurance Contribution Act	4, 26
FL (Component)	FLSA Component	18
FLSA	Fair Labor Standards Act	17, 18
FMA	Family Maintenance Allowance	24
FMLA	Family and Medical Leave Act	14

Acronym/ Abbreviation	Phrase/Word	Chapter
FNS	Food and Nutrition Service of the United States Department of Agriculture	1, 4, 16
FOEFRPAA	Financing and Related Programs Appropriations Act	15
FOIA	Freedom of Information Act	15
FPHA	Federal Public Housing Assistance	20
FPL	Federal Poverty Level	1, 3, 4, 5, 6, 10, 15, 18, 19, 21, 22, 23, 26, 28
FSEOG	Federal Supplementary Educational Opportunity Grants	4
FSS	Family Self-Sufficiency	5
FTI	Federal Tax Information	6
FV (Component)	Full-Time Subsidized Private Sector Employment	18
GED	General Educational Development (High School Equivalency test)	1, 18
GLF	Group Living Facility	1, 2, 3, 4, 7, 13, 16
GSYP	Governor's Summer Youth Program	1, 4
HCBS	Home and Community-Based Services	24
HCS	Heating/Cooling Standard	4, 24
HIB	Hospital Insurance Benefit	8, 25
HIPP	Health Insurance Premium Payment	23
HIV	Human Immunodeficiency Virus	13, 24
HMO	Health Maintenance Organization	22
HMS	Health Management Systems	24, 26
HRDF	Human Resource Development Foundation	4
HUD	(U.S. Department of) Housing and Urban Development	4, 5, 10, 23, 21

Acronym/ Abbreviation	Phrase/Word	Chapter
I/DD	Intellectual/Developmental Disabilities Waiver	1, 4, 10, 13, 14, 18, 22, 23, 24
IAP	Insurance Affordability Program	4, 22
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	1, 3, 4, 10, 11, 22, 23, 24
IDA	Individual Development Account	4, 5
IDEA	Individuals with Disabilities Education Act	27
IDT	Interdisciplinary Team	24
IEP	Individualized Education Plan	27
IEVS	Income and Eligibility Verification System	6
IFM	Investigations and Fraud Management	1, 10, 11, 12, 18, 20, 23
IG	Income Group	3, 4, 7, 10, 15, 22, 24, 26, 28
ILC	Issuance Limited County	3, 10
IMM	Income Maintenance Manual	1, 9, 22
INA	Immigration Nationality Act	15
INS	Immigration and Naturalization Service Effective June 14, 2019, changed to United States Citizenship and Immigration Services	7, 10, 15
IPV	Intentional Program Violation	1, 3, 4, 10, 11
IRA	Individual Retirement Account	5, 24, 26
IRC	Internal Revenue Code	6, 9, 16, 24
IRCA	Immigration Reform and Control Act	15
IRS	Internal Revenue Service	3, 4, 6, 9, 15, 22, 24
ISV	Immigration Status Verifier	15
IVRU	Interactive Voice Response Unit	1
JN/JOIN	Joint Opportunities for Independence Program	1, 18
JR (Component)	Job Search and Job Readiness Assistance	18

Acronym/ Abbreviation	Phrase/Word	Chapter
LAWV	Legal Aid of WV	18
LEAP	Leveraging Educational Assistance Partnership	4
LEP	Limited English Proficiency	1
LES	Leave and Earnings Statement	4, 7
LG	Legal Guardian	10
LIEAP	Low-Income Energy Assistance Program	1, 4, 5, 15, 20, 21
LIAWAP	Low-Income Household Water Assistance Program	
LIS	Low Income Subsidy	1, 8, 24, 25
LP	Liquefied Petroleum Gas (or LPG)	4
LPG	Liquefied Petroleum Gas	20
LPN	Licensed Practical Nurse	18
LPRA	Lawful Permanent Resident Alien	15
LTC	Long Term Care	1, 3, 5, 24
LTCIP	Long Term Care Insurance Partnership	7, 24
LP or LPG	Liquid Petroleum Gas	4, 20
MAGI	Modified Adjusted Gross Income	1, 2, 3, 4, 6, 7, 9, 10, 15, 22, 23, 24
MAID	Medicaid Identification	13
MDT	Multi-Disciplinary Treatment	18
MEC	Minimum Essential Coverage	3, 4, 9, 23
MICS	Maine Indians Claims Settlement Act	5
MMIS	Medicaid Management Information System	1, 2
MNIL	Medically Needy Income Level	4, 9, 23, 24
MP	Major Parent	3, 4, 18
mp	Minor Parent	3, 4, 18

Acronym/ Abbreviation	Phrase/Word	Chapter
MPA	Medicare Premium Insurance	1
MRT	Medical Review Team	1, 5, 7, 10, 13, 14, 18, 24, 26
M-WIN	Medicaid Work Incentive	1, 4, 5, 13, 23, 26
NADA	National Automobile Dealers Association	7
NAIC	National Association of Insurance Commissioners	24
NCCC	AmeriCorps National Civilian Community Corps	4
NCHZ	Notice of Match Results	6, 7, 9, 10
NEMT	Non-Emergency Medical Transportation	4, 22, 27
NF	Nursing Facility	23, 24
NG	Needs Group	3, 10, 15, 22, 24, 26, 28
NHCS	Non-Heating/Cooling Standard	4
NMI	Northern Mariana Islands	7
NOPP	Notice of Privacy Practices	1
NPA	Non-public Assistance	23
NRME	Non-Reimbursable Medical Expenses	24
NVRA	National Voter Registration Act of 1993	1
OAA	Old Age Assistance	23
OIG	Office of Inspector General	2, 6, 27
OJ (Component)	Other Agency OJT Programs	18
OJT	On-The-Job Training	18
OLE	Outside Living Expense	24
OMCFH	Office of Maternal, Child, and Family Health	1, 18, 22, 23
OPM	Office of Personnel Management	6
ORR	Office of Refugee Resettlement	15
OSC	Order to Show Cause	15

Acronym/ Abbreviation	Phrase/Word	Chapter
OUS	One Utility Standard	4
OW (Component)	Other Work Activities	14, 18
PA	Program Assistance	11
PAC	Pickle Amendment Coverage	1, 3, 4, 5, 7, 10, 23
PARIS	Public Assistance Reporting Information System	6
PAS	Pre-Admission Screening	24
PASARR	Pre-Admission Screening and Annual Resident Review	24
PASS	Plan to Achieve Self-Support	4, 5, 7, 26
PB (Component)	Part-Time Subsidized Public Sector Employment	18
PCC	Personal Care Contract	24
PDP	Prescription Drug Plan	8, 25
PE	Presumptive Eligibility	1
PERM	Payment Error Rate Measurement	22
PIN	Personal Identification Number	1, 12, 18, 22, 26
PL	Poverty Level	18
PNA	Personal Needs Allowance	24
POA	Power-of-Attorney	10, 24
POC	Period of Certification	9
POC	Period of Consideration	1, 4, 10, 24
POE	Period of Eligibility	1, 4, 10, 24
POS	Point of Sale	1, 16
PP	Primary Person	10
PR	Periodic Review	10
PRC	Personal Responsibility Contract	1, 2, 3, 4, 7, 8, 9, 10, 14, 18

Acronym/ Abbreviation	Phrase/Word	Chapter
PRL	Periodic Review Letters	23
PRP	Personal Responsibility Plan	17
PRUCOL	Permanent Residence Under Color of Law	15
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 2099	1, 4, 15, 18
PSC	Public Service Commission	20, 21
PSSE	Periodic Self-Sufficiency Evaluation	18
PV (Component)	Part-Time Subsidized Private Sector Employment	18
QC	Quality Control	1, 2, 4, 10, 11, 23
QDWI	Qualified Disabled Working Individual	1, 3, 4, 5, 7, 10, 13, 23, 25, 27
QHP	Qualified Health Plan	4
QI-1	Qualified Individual	1, 4, 5, 7, 8, 9, 10, 23, 24, 25, 27
QIDP	Qualified Intellectual Disabilities Professional	24
QMB	Qualified Medicare Beneficiary	1, 4, 5, 7, 8, 9, 10, 15, 23, 24, 25, 27, 28
RAW	Replenishment Agricultural Worker	15
RCA	Refugee Cash Assistance	15
RD	Regional Director	1
RFA	Request for Assistance	2
RHS	Rural Housing Service	4
RI	Repayment Investigator	10, 11, 18
RJA	Regional Jail Authority	1
RMA	Refugee Medical Assistance	15
RN	Registered Nurse	18
RRB	Railroad Retirement Board	25

Acronym/ Abbreviation	Phrase/Word	Chapter
RSDI	Retirement, Survivors, and Disability Insurance	1, 4, 5, 6, 7, 8, 9, 10, 13, 14, 18, 20, 23, 24, 25, 26
RSVP	Retired Senior Volunteer Program	4, 20
SAVE	Systematic Alien Verification for Entitlements	6, 7, 10, 15
SAW	Special Agricultural Worker	15
SCA	School Clothing Allowance	1, 11, 19, 20
SDX	State Data Exchange	1, 6, 10, 24
SEBT	Summer EBT	1,10,20
SEP	Simplified Employee Pension	4, 5
SGA	Substantial Gainful Activity	1, 4, 5, 23
SIMPLE	Savings Incentive Match Plan for Employees	4
SLA	Single Streamlined Application	1, 24
SLEAP	Special Leveraging Educational Assistance Partnership	4
SLIMB	Specified Low-Income Medicare Beneficiary Program	1, 4, 5, 7, 8, 9, 10, 23, 24, 25, 27
SMI	State Median Income (LIEAP)	21
SMI	Supplementary Medical Insurance	8
SMIB	Supplementary Medical Insurance Benefits	25
SMS	Spousal Maintenance Standard	24
SNAP	Supplemental Nutrition Assistance Program	1, 2, 3, 4, 5, 6, 7, 9, 10, 11,12, 13, 14, 15, 16, 17, 18, 20, 21, 22
SNAP E&T	Supplemental Nutrition Assistance Program Employment and Training Program	1, 3, 9, 10, 14, 17
SOLQ	State On-Line Query	6, 10
SON	Standard of Need	1, 4

Acronym/ Abbreviation	Phrase/Word	Chapter
SPA	State Plan Amendment	24
SPOKES	Strategic Planning in Occupational Knowledge for Employment and Success	18
SSA	Social Security Administration	1, 2, 3, 4, 5, 7, 6, 8, 9, 10, 13, 14, 15, 18, 21, 23, 24, 25, 26
SSF	Solely State Funded	18
SSI	Supplemental Security Income	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 18, 20, 21, 22, 23, 24, 25, 26, 28
SSN	Social Security Number	1, 2, 6, 7, 8, 10, 15, 18, 21, 22, 28
SSP	Self-Sufficiency Plan	1, 2, 3, 7, 8, 9, 10, 13, 14, 17, 18
SUA	Standard Utility Analysis	1, 4, 7, 24
SVES	State Verification Exchange System	6, 7
TABE	Test of Adult Basic Education	18
TANF	Temporary Assistance for Needy Families	1, 2, 4, 5, 6, 11, 14, 15, 18, 20
TBI	Traumatic Brain Injury	1, 4, 13, 14, 18, 23, 24
TBIW	Traumatic Brain Injury Waiver	10, 11
Td (Component)	Child Under Six / Unavailable Child Care	14
Tf (Component)	Age of Child	14
Ti (Component)	Physical Incapacity	14
TM	Transitional Medicaid	1, 3, 4, 10, 23
Tm (Component)	Mental Incapacity	14
TOP	Treasury Offset Program	11
TPI	Trust Property Income	5
TPL	Third-Party Liability	4, 23
TPS	Temporary Protected Status	15

Acronym/ Abbreviation	Phrase/Word	Chapter
TRA	Trade Readjustment Allotment	3, 14
TV (Component)	Sexual harassment and domestic violence, sexual assault, and stalking	14, 18
TVPA	Trafficking Victims Protection Act	15
TW (Component)	Care for a Disabled Family Member	14
UC	Unemployment Compensation	10
UCI	Unemployment Compensation Income	6
UCI	Unemployment Compensation Insurance	3, 4, 8, 11, 14
UGMA	Uniform Gifts to Minors Act	5
UMC	Utilization Management Contractor	24
UMWA	United Mine Workers of America	8
UPV	Unintentional Program Violation	11
USC	United States Code	13, 14
USCIS/A-Number	United States Citizenship and Immigration Services Number	15
USDA	U.S. Department of Agriculture	1, 11, 16
USPS	United States Postal Service	10, 19, 21
UTMA	Uniforms Transfer to Minors Act	5
VA	Veterans Affairs	4, 6, 8, 10, 13, 17, 18, 20, 21, 24, 26
VFW	Veterans of Foreign Wars	8
VISTA	AmeriCorps Volunteers in Service to America	4, 20, 21
VOLAG	Voluntary Placement Agency	15
VT (Component)	Vocational Educational Training	14, 18
WDB	Workforce Development Board	17
WE (Component)	Work Experience Programs	1, 18
WIC	Women, Infants, and Children	4, 20, 21

Acronym/ Abbreviation	Phrase/Word	Chapter
WIOA	Workforce Innovation and Opportunity Act	3, 18, 20, 21
WOTC	Work Opportunity Tax Credit	17
WP (Component)	Work Programs	1, 17, 18
WVAW	West Virginia American Water	20
WVCHIP	West Virginia Children's Health Insurance Program	1, 2, 3, 4, 5, 6, 9, 10, 15, 20, 22, 27
WVCTC	West Virginia Community and Technical College	18
WVOEO	West Virginia Office of Economic Opportunity	21
WVOT	West Virginia Office of Technology	22
WV PATH	West Virginia People’s Access to Help	1, 9, 19, 20, 21, 24, 26
WVSCA	West Virginia School Clothing Allowance	1, 11, 19

FORMS

The following is a list of forms commonly found throughout the West Virginia Income Maintenance Manual (IMM). Additionally, the chapter(s) in which the forms are referenced are identified. The form names reflect the names used in the IMM.

Form Abbreviation/Code	Form Name	Chapter (s)
BA-67	WVTS Voucher	5, 12, 18
CSHCN-1	Children with Special Healthcare Needs Application	1, 23
CSLE	SNAP Review Form - CSLE	1
CSLR	SNAP and Medicaid Review Form	1
CWN-1	Consolidated Work Notice	1, 9, 14
DF-25	Financial Document	11
DF-36	Lost Check Affidavit	12, 21
DF-68	Remittance Form	18, 20
DF-622	Authorization for Payment	21
DFA-2	Application for Benefits	1, 9, 10, 19, 20, 21, 23, 24
DFA-4	Appointment Letter	9
DFA-5	Document for Protection of Application Date	1, 9, 19, 20, 24
DFA-6	Request for Additional Information	1, 2, 4, 6, 7, 9, 10, 18, 20, 24
DFA-6A	Spenddown Explanation	4, 9, 24
DFA-10	Appointment Letter for Office, Home, Phone	9, 24
DFA-17	Work Record Sheet	7
DFA-20	Application Not Acted On Letter	1, 9, 13
DFA-22	Agreement to Sell Property	5, 7
DFA-36B	Request for Replacement of Stolen SNAP & WV WORKS Benefits	12
DFA-67	Authorization for Payment	20, 21
DFA-67-A	Burial Billing Form	20

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-ADA-1	Referral Form for Accommodations for the Disabled	1
DFA-ADA-1A	Follow-Up to DFA-ADA-1	1
DFA-ADARA-1	ADA Reasonable Accommodation Request Form	1, 18
DFA-AP-1	Acknowledgement of Automatic Assignment of Support Rights and of Cooperation Requirements	1, 18
DFA-AP-1A	Notice to Individual Who Has Claimed Good Cause for Refusal to Cooperate in Child Support Activities	1, 18
DFA-B-13	Eye Exam - Physician Report	13
DFA-B-13a	Report on Eye Examination	13
DFA-BCC-1	BCC Application	1
DFA-BU-1	Application for Burial Benefits	1, 20
DFA-BU-2	Affidavit of Responsible Relative	1, 20
DFA-BU-3	Affidavit of Burial Costs and Supporting Documentation	20
DFA-BU-4	Indigent Burial Application	20
DFA-CARS-1	Donated Vehicle Program Referral	18
DFA-CI-1	Release of Confidential Information	1
DFA-CWEP-1	CWEP/JOIN Individual Participation Agreement	18
DFA-CWEP-3	CWEP/JOIN Contract with Attachments	18
DFA-CWEP-3A	CWEP/JOIN Addendum/Renewal	18
DFA-DIMA-1	Disability/Incapacity Med. Assessment	7, 13, 14
DFA-EA-1	Application for Emergency Assistance	1, 20
DFA-EIP-1	Employer Incentive Program Agreement	18
DFA-ESP-1	ESP Agreement	18
DFA-ESP-1a	Employment Subsidy Program Agreement	18
DFA-ESP-2	Employer Reimbursement Request	18
DFA-EX-1	Extension Request Form	18
DFA-FH-1	Pre-Hearing Conference and/or Fair Hearing Request	9, 20, 24
DFA-FS-19	Notification of Denial of Expedited Service (SNAP Only)	9

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-FTI-1	Disclosure of Federal Tax Information	6
DFA-HIP-1	Certificate of Medical Coverage	10, 22, 23
DFA-HS-3	Referral to Social Security Administration	2, 24
DFA-HV-1	Missed Home Visit	1
DFA-ICF/MR-1	Pre-Admission for ICF/MR	24
DFA-ID-1	Identity Declaration	7
DFA-IE-01	IRS Disclosure Notice Log	6
DFA-IE-02	IRS Safeguard Log	6
DFA-J-1	JOIN Individual Participation Agreement	18
DFA-J-3	JOIN Contract	18
DFA-J-3A	JOIN Addendum/Renewal	18
DFA-JD-1	Job Experience Description	18
DFA-LIEAP-1	LIEAP Application	1, 21
DFA-LIEAP-1a	Instructions for Completing the Application Form	21
DFA-LIEAP-1b	Supplement to LIEAP Application	1, 21
DFA-LIEAP-3	Repayment Agreement	21
DFA-LIEAP-4	Zero Income/Home Heating Cost	21
DFA-LIEAP-5	Authorization for Delivery and Payment of Emergency/ Regular LIEAP	21
DFA-LIEAP-6	LIEAP Application Log	21
DFA-LIEAP-8	LIEAP Repayment Tracking Form	21
DFA-LIEAP-ERR-1	Application for Emergency Repair and Replacement	1
DFA-LIHWAP-3	Repayment Agreement	
DFA-LIHWAP-8	Repayment Tracking Form	
DFA-LTC-5	Application for Long Term Care Services for Current Medicaid Recipients	24
DFA-LTCIP-1	Long-Term Care Insurance Partnership Policy Verification	7, 24
DFA-MA-1	Medical Assistance Application	1, 24

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-NH-3 (NMNH)	Contribution to the Cost of Care Notice	24
DFA-NL-5	Waiver of 13-Days Advance Notice	9
DFA-NL-6	Notice of Withdrawal of Application	9
DFA-NL-A	Notification Letter: Action Taken On Your Application	9, 16, 24
DFA-NL-B	Notice of Decision - Redetermination	9, 24
DFA-NL-C	Notice of Decision - Change	9, 13, 18, 24
DFA-NL-D	Asset Assessment - Notice of Decision	24
DFA-NL-MN-1	AFDC-Related Medicaid Computations	9
DFA-NL-SNAP-1	SNAP Computations	9
DFA-NL-UH-1	Right to Request Undue Hardship Waiver	24
DFA-NL-UH-2	Notice of Decision - Request for Undue Hardship	24
DFA-PAC-4	Pickle Medicaid Review	1
DFA-PHI-1	Authorization for Information	13
DFA-PRC-1	WV WORKS Personal Responsibility Contract	1, 18
DFA-PRC-2	Interim Contact Form	1, 10
DFA-PSSE	Periodic Self Sufficiency Evaluation	18
DFA-PVM-1	Prisoner Verification Match	
DFA-QSQ-1	QMB/SLIMB/QI Application	1
DFA-R-1	Pre-Employment Services Project Referral - Vision/Dental Services	18
DFA-REF-1	Referral & Information Form	15
DFA-REF-2	Reverse-Referral & Information Form	15
DFA-RFA-1	Request for Assistance	1
DFA-RR-1	Rights and Responsibilities	1, 4, 6, 20, 24
DFA-RT-1	Social Summary	13
DFA-RT-2	MRT Transmittal Form	13
DFA-RT-3M	Mental Disability/Incapacity Evaluation Form	1, 13
DFA-RT-5	Adult - General Physical	13

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-RT-5a	Child - General Physical	13
DFA-RT-6	Medical Information/Diagnostic Request Letter	13
DFA-RT-7	Specialist Consultation	13
DFA-RT-8	Request from Physician's Record	13
DFA-RT-8a	Physician's Summary	13
DFA-RT-9	Report from Hospital Records	13
DFA-RT-10	Inpatient Diagnostic Services	13
DFA-RT-11	Physician's Hospital Services	13
DFA-RT-15	Psychiatrist's Billing Form	13
DFA-RT-15a	Psychiatrist’s Summary	13
DFA-RV-1	Recreational Vehicle Estimate	7
DFA-SEBT-1	Summer EBT application	20
DFA-SLA-1	Single Streamlined Application for Healthcare Coverage	1, 24, 26
DFA-SLA-2	Single Streamlined Application for Healthcare Coverage-Short Form	1, 24, 26
DFA-SLA-S1	Application for Health Care Coverage	1, 22, 24
DFA-SNAP-1	Supplemental Nutrition Assistance Program Application	1
DFA-SNAP-2	SNAP Change Reporting Form	10
DFA-SNAP-36	SNAP Benefits Replacement	12
DFA-SNAP-E&T-1	SNAP E&T Personal Responsibility Plan	17
DFA-SNAP-E&T-2	SNAP E&T Notification Form	17
DFA-SNAP-E&T-4	SNAP E&T Self-Sufficiency Appraisal	17
DFA-SNAP-E&T-PD	SNAP Provider Determination	3, 17
DFA-SNAP-E&T-TA	SNAP E&T Training Agreement	17
DFA-SNAP-I&R1	Information and Referral Guide	1
DFA-SP-1	Application for Special Pharmacy	1, 28
DFA-SS-2	Continued Sup. Serv. Application	18
DFA-SSP-1	WV WORKS Self-Sufficiency Plan	18

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-SSP-1a	WV WORKS Goal Action Plan	1, 18
DFA-TA-2	Tel-Assistance/Lifeline Application	20
DFA-TA-3	Tel-Assistance/Lifeline Fact Sheet	20
DFA-TA-34	WV WORKS Training Agreement	17, 18
DFA-TS-12	Participant Time Sheet	17, 18
DFA-UH-5 (NMUS)	Application for Undue Hardship Waiver	24
DFA-V-1	Vehicle Estimate Form	5, 7
DFA-WVSC-1	West Virginia School Clothing Allowance Form	1, 19
DFA-WVW-1	Eligibility Determination Computation Sheet	9
DFA-WVW-3	DCA Agreement	1
DFA-WVW-3a	WV WORKS Initial Self-Sufficiency Appraisal Form	1, 18
DFA-WVW-3b	Caretaker Relative Assessment	18
DFA-WVW-3c	Pandemic Diversionary Cash Assistance Agreement	
DFA-WVW-4	Orientation to WV WORKS	1
DFA-WVW-5	Notice of Pending Closure of Benefits	14
DFA-WVW-6	Case Staffing Information	14
DFA-WVW-10	WV WORKS Caretaker Relative Option	1, 3
DFA-WVW-15	WV WORKS Transitional Benefit Option	18
DFA-WVW-25	Employer Contact Form	18
DFA-WVW-40	EHI and Learning Needs Screening Declination Form	18
DFA-WVW-70	Referral for Training/Services	18
DFA-WVW-75	WV WORKS 4th Sanction and Subsequent Sanctions	14
DFA-WVW-100-A	55 Month Letter	18
DFA-WVW-100-B	Request for Extension	18
DFA-WVW-Bridge-1		
DFA-WVW-CCG-2	Self Sufficiency Appraisal Addendum and Coaching Guide	1, 18
DFA-WVW-DAST-1	Drug Use Questionnaire	1, 3, 10, 14, 18
DFA-WVW-FLSA-1	Fair Labor Standards Act Computation Sheet	18

Form Abbreviation/Code	Form Name	Chapter (s)
DFA-WVW-JR-1	Job Retention 30-90 day Follow-up Checklist	18
DFA-WVW-NL-1	WV WORKS Pending Change of Benefit Notice	9, 14
DFA-WVW-NL-2	WV WORKS Sup. Serv. Reg. Denied Memo	18
DFA-WVW-NL-3	WV WORKS Continued Sup. Serv. Req. Denied	18
DFA-WVW-VERIF-1	TANF Verification - Months Used	7, 18
DFA-WVW-VERIF-2	Protective Payee Verification	10, 18
DHS-1	Deferral and Communication Form	1, 10, 11, 18, 23, 24
DHS-3	Written Statement from SSA	7, 24
DS-1350	Certification of Report of Birth	7
EOIR-26	Notice of appeal; date stamped by the Office of the Immigration Judge	15
ES-AP-225	Verification of Loan Conditions	4
ES-IN-1	Statement of Monthly Living Expenses	4
ES-NH-3	Notice of Client's Contribution Toward His Cost of Care	24
ES-NL-D	Notification Letter: Action Taken on Your Request for an Assessment of the Assets Belonging to Both You and Your Community Spouse	24
ES-REPAY-1	Repayment Agreement	11
ES-RT-3	Disability/Incapacity Evaluation Form	1, 13, 26
FS-240	Consular Report of Birth Abroad of a Citizen of the United States of America	7
FS-240	Report of Birth Abroad of a Citizen of the U.S.	15
FS-545	Certification of Birth Abroad	7
FS-545	Certificate of Birth	15
FS-D-2		16
FSPU-9	SNAP FLSA Work Hours Calculation	18
G-845	Document Verification Form	15
HS-3	Referral to Outside Agencies	8, 13

Form Abbreviation/Code	Form Name	Chapter (s)
I-151	Green Card (USCIS Form)	15
I-197	U.S. Passport	15
I-220A	DHS order of Release of Recognizance	15
I-221	DHS order to show cause and notice of hearing	15
I-221S	DHS order to show cause, notice of hearing, and warrant for arrest	15
I-222	DHS notice of applicant detained for a hearing before an immigration judge	15
I-485	DHS application to register permanent residence or to adjust status; individual is subject of removal, exclusion, or deportation proceedings	15
I-551	Green Card (USCIS Form)	15
I-589	DHS application for asylum and withholding of removal; individual is subject of removal, deportation, or exclusion proceedings.	15
I-688B	Employment Authorization Document with the provision of law 274a.12(c)(10)	15
I-766	Employment Authorization Document with the code C10. Notice of appeal; date stamped by the Office of the Immigration Judge	15
I-862	DHS notice to appear	15
I-94	Arrival-Departure Form	15
IFM-1	Fraud Referral Form	11
IG-BR-44	Waiver of Rights	11
IG-CR-3	Civil Rights Discrimination Complaint Form	1
IG-IFM-BENPAY-1	Request/Receipt for EBT Account Deduction	10, 19
IM-NL-AC-1	Assets Computation and Asset Assessment	24
IM-NL-LTC-1	Calculation Form	24
IM-NL-LTC-2	Calculation Form	24
MAGI	Request for Information	24
N-0570	Naturalization Certificate	15

Form Abbreviation/Code	Form Name	Chapter (s)
N-550	Naturalization Certificate	15
N-560	Certificate of Citizenship	15
N-561	Certificate of Citizenship	15
NMRL	Eligibility System Notice	1
OFS-JO-1		18
OFS-Release 1	Release of Confidential Applicant/Recipient Information	17
OFS-Release 1 (NMR4)	Release of Confidential Applicant/Recipient Information	18
PAS-2005	Patient Medical Evaluation	13
SSA-1020-OCR-SM	Original Social Security Form	25
SSA-2253	Enumeration at Birth (EAB) Receipt	2
SSA-234	Public Assistance Agency Information Request and Report	23
SSA-420-OCR-SM	Original Social Security Form	8
V-92	Visa 92	15
W-2	Wage and Tax Statement	15
W-2c	Statement of Corrected Income and Tax Amount	15
WV-BMS-IDD-1	WV I/DD Waiver Application	24

GLOSSARY

The following is a list of terms commonly found throughout the West Virginia Income Maintenance Manual (IMM), and their definitions. Additionally, the chapter(s) in which the terms are found are included.

Term	Definition	Chapter (s)
36-Month Period (ABAWD Only)	A fixed period for all individuals regardless of client's status or the county or state of residence.	3
ABAWD	ABAWD (Able Bodied Adults Without Dependents) is a population of individuals who are age 18 or older but not yet age 65. An individual who turns 18 becomes an ABAWD in the month following their birthday. An individual is no longer an ABAWD in the month of their 65th birthday.	1, 3, 4, 7, 10, 13, 14, 17
ABLE Account	A tax-free saving account set-up for individuals with disabilities to be used for qualified disability expenses such as, but not limited to, education, transportation, housing, medical, dental care, community-based supports services, employment training and assistive technology.	4, 5, 7, 10, 24
Accessibility of Assets	A client may not have access to certain assets. In order to be considered an asset, the asset must be owned by, or available to, the client. If the client cannot legally dispose of the asset, it is not treated as an asset.	5
Additional Three-Month Period (ABAWD Only)	Three consecutive months of SNAP benefits after regaining eligibility by fulfilling the ABAWD work requirement.	3
Adjusted Gross Income	The amount of taxable income of a household minus specific deductions allowed under federal law. See Section 4.7 for instructions on calculating adjusted gross income.	4
Administrative Redetermination	A redetermination process occurring without active participation by the client for Medicaid Groups and the West Virginia Children's Health Insurance Program (WVCHIP). This process is designed to occur electronically or by a pre-populated form, rather than requiring the completion of a blank application.	4
Administrative Terminal	EBT vendor system used to inquire into EBT account information.	1

Term	Definition	Chapter (s)
Admission Number	An 11-digit number assigned to a noncitizen when he enters the United States (U.S.). This number is frequently found on the Arrival-Departure Record (Form I-94) and should not be confused with the Noncitizen Registration Number (A-Number) defined below.	15
Available Resources (Emergency and Special Assistance Only)	Cash-on-hand, checking or savings account balances or other readily accessible funds not already obligated for food, shelter, or home heating.	20
Advance Premium Tax Credit (APTC)	A federal tax credit through Federally Facilitated Marketplace (FFM) that will help make a Qualified Health Plan (QHP) affordable by reducing a taxpayer's out-of-pocket premium when enrolled through the Marketplace.	1, 4, 22, 23
Affordable Care Act	The Patient Protection and Affordable Care Act enacted March 23, 2010, and the Health Care and Education Reconciliation Act enacted March 30, 2010, are collectively referred to as the Affordable Care Act.	1, 3, 4, 6, 22, 23, 24
Aged	This is also referred to as ELDERLY. Medicaid: An individual who is at least age 65. Supplemental Nutrition Assistance Program (SNAP) and WV WORKS: An individual who is at least age 60.	4
Alien	Any person who is not a citizen or national of the U.S.; also referred to as a noncitizen.	15
Alien Registration Number or United States Citizenship and Immigration Services Number (USCIS/A-Number)	A seven or eight-digit number assigned to a noncitizen at the time his Alien File is created.	15
Alien Registration Receipt Card	A United State Citizenship and Immigration Services (USCIS) document that certifies lawful permanent resident status, commonly called a Green Card; older versions may be green, blue/white, salmon, or pink. It carries the USCIS form number I-151 or I-551.	15

Term	Definition	Chapter (s)
Alien Status Verification Index	A database designed for the use of entitlement benefit agencies in verifying noncitizen immigration status in accordance with the Immigration Reform and Control Act of 1986 (IRCA).	15

All Family Household (WV WORKS)	Families that do not meet the definition of a two-parent family are considered “All Family” Households regardless of the number of parents or other adults included in the household.
	All Family Households include, but are not limited to, the following situations:
	• Families with only one parent living in the home, whether he is included in the AG or is a non-recipient Work-Eligible Individual.
	• Families with two parents with a common child living together and one is excluded from the WV WORKS payment due to one of the following reasons:
	  ○ Minor parent who is not the head-of-household;
	  ○ Ineligible noncitizen due to immigration status; or
	  ○ SSI recipient.
	• Families with one parent and one stepparent included in the benefit when they have no common child.
	• Families with one or two non-parent caretaker relatives included in the WV WORKS payment.
		18

Allocation Standard	The difference between the maximum Supplemental Security Income (SSI) payment for one and two persons.	4
Allotment	An appropriation of one individual’s income diverted to another, such as a military allotment.	4
SNAP Benefit Allotment	The approved monthly benefit that is deposited into an electronic benefits transfer (EBT) account for the client to purchase food for home preparation or seeds and plants that produce food for home consumption.	4
Amerasian (Vietnam)	Children born in Vietnam to Vietnamese mothers and American fathers and are admitted to the U.S. under P.L. 100-202 as immigrants but are entitled to the same social services and assistance benefits as refugees. Spouses, children, and parents or guardians may accompany the noncitizen to the U.S.	15

Term	Definition	Chapter (s)
AmeriCorps	A national service program administered by the Corporation for National and Community Service (CNCS). Included in the AmeriCorps Network of programs are AmeriCorps USA, AmeriCorps Volunteers in Service to America (VISTA), and AmeriCorps National Civilian Community Corps (NCCC). Closely associated with the AmeriCorps Programs are: the Senior Corps, the Youth Corps, and Learn and Serve, which are also administered by CNCS.	4
Amortization Schedule	The schedule of payments for paying off a loan.	5
Annuitant	An annuitant is defined as a person who receives an annuity.	24
Annuity	An investment contract or agreement, which gives the right to receive fixed, periodic payments, either for life or a specific term of years	4, 5, 24
Assets	Total real and personal property the client has available to meet financial needs, including the value of assets assigned from certain individuals. Assets may be liquid or non-liquid.	5
Assistance Group (AG)	A group of people who apply for or receive assistance together for a program.	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 26, 28
Asylee	A noncitizen already in the U.S. or at a port of entry who is granted asylum in the U.S. Asylum may be granted to those persons who are unable or unwilling to return to their countries of nationality, or to seek the protection of those countries, because of persecution or a well-founded fear of persecution. This status is covered by Section 208 of the Immigration and Nationality Act of 1952 (INA). See REFUGEE, which explains the difference between asylum and refuge in the U.S.	15
Authorized Cardholder	An individual, who, in addition to the payee, may be issued an EBT card and access to the EBT account.	1
Authorized Representative	An individual designated by an applicant or client to act on his or her behalf.	1, 2, 3, 7, 10, 11, 15, 16, 24, 26

Term	Definition	Chapter (s)
Authorized Representative (Employer's)	An individual designated by an employer or training facility to act on its behalf.	18
Available Resources	Cash-on-hand, checking or savings account balances or other readily accessible funds not already obligated for food, shelter, or home heating.	20
Asset Verification System (AVS)	An electronic system to gather reported and unreported asset matches to assist in the eligibility determination for appropriate programs.	6
Basic Needs	The primary needs of individuals or families, such as food, clothing, shelter, and incidentals	4
Bed-hold Days	A reservation that allows one to stay in, or return to, a care facility. The reservation is usually made just before relocation to the facility or during furloughs away from it (e.g., in hospital or on family visits).	24
Beneficiary	A person to whom benefits are payable.	5
Blindness	To meet the definition of blindness, the individual must have: • Central visual acuity that cannot be corrected to better than 20/200 in the better eye; or • A limitation of the field of vision in the better eye so that the widest diameter of the visual field subtends an angle of 20 degrees or less.	1, 13
Bona Fide Loan	Aid to Families with Dependent Children (AFDC)-Related Medicaid Only: A loan that meets one of the following conditions: The client has proof that the loan was obtained from an individual or establishment engaged in the business of making loans; or The client and the lender have completed and signed form ES-AP-75 (Verification of Loan Conditions) to acknowledge the obligation to repay the loan, with or without interest.	4
Bonds	U.S. Government, municipal or corporate.	5
Bulk Fuel	Home heating or cooking fuel such as coal, fuel oil, liquefied petroleum gas (LPG), or kerosene which must be purchased in certain quantities and stored on site.	20

Term	Definition	Chapter (s)
Burial Contract	An agreement in which a provider of funeral services and burial items agrees to provide burial services or other final arrangements.	5
Burial Funds	Burial funds include revocable burial contracts, revocable and irrevocable burial trusts, cash, savings bonds, and any other separately identifiable assets which an individual state are intended for expenses connected with burial, cremation, or other funeral arrangements.	5
Burial Insurance	Insurance with terms specifically providing that the proceeds can be used only to pay burial expenses of the insured individual.	5
Burial Rate	The maximum allowable payment that the Department of Human Services (DOHS) will make toward the cost of a funeral.	20
Burial Spaces	Conventional grave sites, crypts, mausoleums, urns, vaults or other repositories which are customarily and traditionally used for the remains of deceased persons. Burial spaces include the following: • Headstones, markers or plaques • Burial containers for caskets • Arrangements for opening and closing the gravesite • Reasonable maintenance of such spaces.	5
Burial Trust Funds	Assets placed in a trust fund for burial expenses.	5
Buy-In	The Department of Human Services (DOHS) “buys in,” or pays, the Medicare Part A and/or Part B premium for certain Medicaid clients who are also eligible for Medicare. This procedure is referred to as the buy-in process.	25
Case Composition	The case is composed of the institutionalized individual, a spouse living in the community, and any of the individual’s dependents. A Medicaid-eligible spouse receives benefits in his own case, whether he is also institutionalized or not.	24
Cash	For the purposes of Chapter 20 (Emergency Assistance), funds or money in the form of currency or any negotiable instrument that is in the possession of the applicant or any	20

Term	Definition	Chapter (s)
	member of the assistance group (AG) at the time of application.	
Cash Savings	The amount of savings or cash-on-hand held by the client or for him by another person.	5
Cash Surrender or Cash-in Value (life insurance)	The amount of cash received by the owner of the policy, if redeemed before death of the insured.	5
Categorically Eligible SNAP AG	An AG which is automatically eligible for the SNAP program without application of the usual eligibility tests.	5
Central Index System (CIS)	An automated system containing information on noncitizens. The CIS, from which ASVI is extracted, is the USCIS' most complete database of information on noncitizens in the U.S.	15
Certificate of Citizenship	An identity document proving U.S. citizenship.	15
Certificate of Deposit (CD)	Funds held in an account that specifies a maturity date.	5, 7, 11, 20, 26
Certificate of Naturalization	An identity document proving U.S. citizenship.	15
Change of Nonimmigrant Status	The action of changing a nonimmigrant's classification (e.g., from visitor to student).	15
Child	SNAP Only: An individual who is not yet 18, nor the head of a household. AFDC-Related Medicaid and WV WORKS Only: See Section 3.3 for definition of a dependent child for these programs. SSI-Related Medicaid, CDCSP, PAC, QDWI, QMB, SLIMB and QI-1 Only: When an individual meets the SSI definition of a child, he may be entitled to additional income disregards or deductions, have income deemed to him or have his needs considered when income is deemed from an ineligible individual to an eligible one. A Child is: • A natural or adopted child who lives in a household with one or both parents; and • Under age 18; or • Under age 22 and a student; and	4

Term	Definition	Chapter (s)
	• Not married nor head of household Deeming (defined below) to an eligible child no longer applies beginning the month following the month the child attains age 18 or is over 18 and is no longer a student. Modified Adjusted Gross Income (MAGI) Coverage Groups: For MAGI Medicaid coverage groups where eligibility is determined based on MAGI methodology, a child is defined an individual under the age of 19.	
Chronic Homelessness	The lack of consistent living arrangements, including homeless shelters, for a period of 90 days prior to the date of the determination or the client has an extended history that demonstrates a pattern suggesting the inability to find suitable, long-term housing.	13
Citizen	A person born in a country or who has become a naturalized citizen of that country.	15
COFA Migrants	COFA Migrants - as a person born in the Republic of the Marshall Islands or the Federated States of Micronesia, and who entered American Samoa, CNMI (Commonwealth of the Northern Mariana Islands), Guam, or Hawaii in 1986 or later or born in the Republic of Palau, and who entered American Samoa, CNMI, Guam, or Hawaii in 1994 or later.	15
Community Spouse	A spouse living in the community whose spouse is an institutionalized individual. This definition is used when one spouse is applying for long term care (LTC) benefits and the other spouse is not and is used in conjunction with the definition of institutionalized spouse.	5, 24
Competitive Employment	Competitive employment includes self-employment and non-traditional work which is compensated at or above the federal minimum hourly wage in a setting that also includes, or could include, non-disabled individuals. This does not include settings such as sheltered workshops if less than minimum wage is paid.	23, 26
Conditional Eligibility	WV WORKS Only: The period of time during which eligibility is allowed, even though assets exceed the maximum allowable asset limit.	5
Conditional Entrant	A refugee.	15

Term	Definition	Chapter (s)
Conditional Permanent Resident	A conditional permanent resident receives a Permanent Resident Card valid for two years. In order to remain a permanent resident, a conditional permanent resident must file a petition to remove the condition during the 90 days before the card expires. The conditional card cannot be renewed. The conditions must be removed, or permanent resident status will be lost.	15
Conditional Resident Noncitizen	A noncitizen granted conditional resident status based on marriage to a U.S. citizen or national, or a permanent resident noncitizen; conditional status is removed after two years if USCIS rules favorably on a petition by the noncitizen for retention of lawful permanent residence. (The noncitizen's children, under the age of 18, can also be granted this status.) During the pendency of any such petition not adjudicated by the end of the two years, the noncitizen can present his I-551 and an USCIS receipt for the filed petition as proof of work authorization.	15
Continuing Care Retirement Community (CCRC)	A residential community, also known as a life care community, which offers services for the remainder of an individual's life, with a choice of services and living situations, based on changing needs at each point in time. Individuals that enter these communities sign a long-term contract that includes housing, services, and nursing care, usually provided in one location, enabling seniors to remain in a familiar setting as they age. These service and housing packages parallel independent living, assisted living, and skilled nursing facilities. Seniors who are independent may live in a single-family home, apartment, or condominium within the continuing care retirement complex. If they begin to need assistance with activities of daily living, (i.e., mobility, eating, bathing, dressing, etc.), they may be transferred to an assisted living or skilled nursing facility on the same site.	5
Contract Beneficiary	Any entity that is named in a contract as the beneficiary.	5
Contract Buyer	A person who purchases goods or services as specified in a contract.	5
Contract Seller	A person, his agent or his employee who sells, makes available or provides contracts.	5

Term	Definition	Chapter (s)
Converting Income and Deductions	The method used to change income and deductions paid less often than monthly to a monthly amount.	4
Conversion or Sale of an Asset	The sale or exchange of an asset from liquid to non-liquid or non-liquid to liquid.	5
Cost-of-living Adjustments (COLA)	Adjustments to entitlement benefits, pensions or other retirement income such as Retirement, Survivors, and Disability Insurance (RSDI), Black Lung and Railroad Retirement.	4
Corporation for National Service (CNCS)	The federal government administers a number of national and community service programs such as, but not limited to, AmeriCorps and the NCCC. In addition, it administers the former ACTION Agency programs created by the Domestic Volunteer Act of 1973. Former ACTION programs include, but are not limited to, AmeriCorps VISTA, University Year of Action, Urban Crime Prevention Program, Retired Senior Volunteer Program (RSVP) and Foster Grandparents.	4
Countable Income	The amount of income after all allowable exclusions, disregards and deductions have been applied. The eligibility and level of benefit are based on this amount. MAGI Medicaid Coverage Groups Only: For these groups, eligibility is not based on countable income, it is based on the MAGI calculated as outlined in Section 4.7.	4
Countable Months (ABAWD Only)	Screened and assigned months in which the client receives a full monthly benefit while not exempt or meeting the ABAWD work requirement.	3
Creditable (Non-excepted) Insurance Benefits	Benefits that affect WVCHIP eligibility.	22
Creditor	The owner of an agreement such as a promissory note or a property agreement such as a land sale contract. A creditor or lender is the seller of the property or holder of a promissory note.	5
Cuban/Haitian Entrant	The status afforded to (a) Cubans who entered the U.S. illegally between April 15, 1980, and October 10, 1980, and to (b) Haitians who entered the country illegally before	15

Term	Definition	Chapter (s)
	January 1, 1981. This status is covered by Section 520(e) of Public Law 96-422.	
Current Market Value (CMV)	Also called FAIR MARKET VALUE for Chapter 5 references. The amount an asset can be expected to sell for on the open market, in the particular geographic area. Market conditions are reflected in an asset's CMV.	5
Customer Service Representative (CSR)	The CSR for the EBT vendor who is reached through the IVRU toll-free number also referred to as the EBT Helpline. This person has the ability to replace or deactivate lost, stolen or damaged cards and to file a claim on behalf of a client regarding transactions.	1
Debt	Any form of legal indebtedness against an asset, such as mortgages, liens, loans, purchase contracts and security interests. For purposes of establishing equity value, a debt must be legally recognized as binding on the individual who holds the asset.	5
Dedicated Account	An SSI recipient, who is under age 18 and who has a representative payee, may have a dedicated account, so that back SSI payments can be deposited directly into the account. SSA regulations require that certain such payments be directly deposited. Other payments of the same type are not required to be deposited directly into the account but may be deposited in the dedicated account at the discretion of the representative payee. SSA places certain restrictions on the use of the funds deposited into these accounts. SSI representative payees receive notification from SSA that a dedicated account must be established and also receive notification when an SSI back payment amount is directly deposited.	5
Deduction	A specific amount subtracted from income. Allowable deductions are different, depending upon the program involved.	4
Deeming	The process by which the treatment of income of individuals, not included in the assistance group (AG), but living in the home, is counted for the AG, whether or not the income is actually made available. There are two methods by which this may be accomplished: by treating the deemor's income as if he were included in the AG or by allowing for the needs of the deemor, as well as the needs of others for whom he is	4

Term	Definition	Chapter (s)
	financially responsible to be subtracted from the income, and counting the remaining income for the AG. The appropriate method depends on the relationship between the individuals and the program or coverage group involved.	
Demographic Information	Identifying information about the AG's primary person which is sent to the EBT vendor in order to set up an EBT account and mail the EBT card. This includes the name, SSN and date of birth of the AG's primary person and the payee's address.	1
Dependents (ABAWD Only)	For ABAWD purposes only, any member of the SNAP AG under the age of 14.	3
Disabled (SNAP Only)	Disabled means the individual is unfit to engage in full-time employment due to a physical and/or mental disability.	13
Disability: Individuals Age 18 or Over (Medicaid and WV WORKS Only)	An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment that has lasted, or is expected to last, for a continuous period of at least 12 months, or is expected to result in death.	1, 13
Disability: Individuals Under Age 18 (Medicaid and WV WORKS Only)	The child who is under age 18 is considered to be disabled if he has a medically determinable physical or mental impairment (or combination of impairments), the impairment(s) results in marked and severe functional limitations, and the impairment(s) has lasted (or is expected to last) for at least one year or to result in death. An individual under age 18 is not considered a child if he: • Is legally married; • Is divorced; or • Is over age 16 and has been emancipated by a court of law.	1, 13
Disqualified Individual	A person who must normally be included in an AG, but who has been excluded due to his failure to comply with a specific program requirement. This person may also be referred to as a SANCTIONED INDIVIDUAL.	4
Disregard	A portion of income that is not counted when determining countable income. Allowable disregards are different, depending upon the program involved.	4
Dividend	A share of profits received by a stockholder, stakeholder, or a policy holder.	4

Term	Definition	Chapter (s)
Document Noncitizen	A noncitizen in the U.S. who is in possession of valid documents. See Section 15.2.3 for examples of valid documents.	15
Document Verification Request (Form G-845)	A form designed for use by entitlement benefit agencies to request secondary verification of noncitizen status from USCIS under the Immigration Reform and Control Act of 1986. This is used by the Systematic Alien Verification for Entitlement (SAVE) Coordinator for such requests to USCIS.	15
Earned Income	Income of an individual which is derived, at least in part, from compensation for physical or mental activity as part of a trade or business. Earnings include gross income from employment and gross profit from self-employment.	4
Earned Income Tax Credit (EITC)	An amount by which an individual's federal income tax obligation is reduced or eliminated. When eligible for the EITC, an individual may receive a federal tax refund which exceeds the original amount withheld or he may receive monthly advance payments.	4
EBT (Electronic Benefits Transfer)	EBT or the use of a card to access WV WORKS, CSI and DCA cash benefits, and SNAP benefits.	1, 4, 5, 10, 12, 11, 16
EBT Helpline	The toll-free number through which the client may access the Interactive Voice Response Unit (IVRU) or CSR.	1
Elderly (SNAP and WV WORKS)	Age 60 and over, for SNAP benefits and WV WORKS.	5
Elderly (Medicaid)	Age 65 and over, for Medicaid.	5
Eligible Legalized Alien (ELA)	A noncitizen who has been granted lawful temporary resident status under Section 245A or Section 210 of the Immigration Reform and Control Act (IRCA) of 1986 and who may apply for permanent resident noncitizen status.	15
Eliminate the Emergency	Delaying or preventing the emergency from occurring for a period of not less than 30 days from the date the vendor is made aware of and accepts the DOHS's offer.	20
Emancipation	Under West Virginia State law, emancipation occurs when: • A child has been declared emancipated by a court; or • A child marries.	3

Term	Definition	Chapter (s)
Emergency	Being without or in immediate danger of being without a basic necessity, such as food, shelter, heat, etc., and having no available resources with which to obtain it.	20
Employment	A situation in which a wage, salary or commission is paid to an individual for services rendered. The employer usually takes the responsibility for withholding income taxes and FICA taxes from the wages. However, if this is not done, the employee may pay these taxes himself without affecting his status as an employee. The employer controls such things as hours worked, what is done and where the work is located.	4
Endowment for Perpetual Care	A contract for care and maintenance of a grave site.	5
English as a Second Language (ESL) or English for Speakers of Other Languages (ESOL)	The use or study of English by speakers with different native languages.	15, 18
Equity Value	The CMV, less any legal debts, such as mortgages, liens, etc. This is determined by multiplying the amount of the installment payment by the number of payments left and subtracting this amount from the CMV.	5
Excepted Insurance Benefits	Benefits that do not affect WVCHIP eligibility.	22
Excessive Home Equity	This definition is used in the determination of eligibility for LTC for Medicaid. Excessive home equity can result in a denial of payment for LTC or waiver services when the equity in the homestead exceeds the current allowable maximum. This amount changes every year. A denial for excessive home equity is subject to the Undue Hardship Provision.	5
Excluded	Assets which are not considered when determining asset eligibility.	5
Excluded by Law	An individual specifically excluded from the AG by Federal or State law.	4
Exclusion	Income or assets that are treated as if they do not exist.	4

Term	Definition	Chapter (s)
Expungement	122 days from the date of issuance for Summer EBT. 274 days from the date of issuance for SNAP. 365 day from the date of last use for WV WORKS. Expungement of EBT benefits must occur immediately for SNAP when it has been determined all members of the assistance group are deceased, and independent verification of the death(s) have been obtained by the worker.	1, 10, 11, 18, 19, 20
Face Value (life insurance)	The specified amount payable on death of the insured, usually listed on the front of the policy, is the amount guaranteed and premium terms agreed upon via contract at the time of purchase. When the premium payment specified in the contract has been fulfilled and premium payments continued to be made resulting in additional paid-up insurance, the policy's death benefit, i.e., face value, has increased and the current amount counted.	5
Fair Market Value (FMV)	The FMV is an estimate of the value of a resource, if sold at the prevailing price at the time it was actually transferred.	24
Family	For the benefits covered in Chapter 20 (Emergency Assistance), a group of two or more persons related by birth, marriage, or adoption who live together.	20
Family Unit	Provides protection from deportation and eligibility for employment authorization to the spouses and children of noncitizens who were legalized under the IRCA.	15
Federal Data Hub (FDH)	An electronic Federal data service through which the Department of Human Services (DOHS) will obtain information from federal agencies or other data sources such as the Social Security Administration (SSA), the Department of Treasury and Homeland Security.	1, 2, 4, 6, 7
Federally-Facilitated Marketplace (FFM)	This term refers to a State or Federally-Facilitated Health Insurance Marketplace and is also referred to as The Marketplace. It is a governmental agency or non-profit entity that makes Qualified Health Plans (QHP) available to qualified individuals. The Marketplace will allow individuals to: compare private health plans; obtain answers to questions about health coverage options; determine if they are eligible for tax credits for private insurance or health programs like Medicaid and WVCHIP; and enroll in a health plan that meets their needs. The Marketplace must have a consumer	1, 4, 6, 13, 22

Term	Definition	Chapter (s)
	assistance function, including the navigator program. The Marketplace must provide for operation of a toll-free call center and must maintain an up-to-date Internet website. States must coordinate with the State or Federal Exchange to share eligibility date and eligibility determinations for applicants for Medicaid, WVCHIP or the Marketplace.	
For the Sole Benefit of	For a transfer or trust to be considered for the sole benefit of a spouse, disabled child, or a disabled individual under age 65, the transfer or trust cannot benefit any other in any way, either at the time of the action, or at any time in the future, except as provided below. The agreement must be in writing.	24
Fulfilling the ABAWD Work Requirement (ABWAD Only)	Working and/or participating in an allowable ABAWD work activity for 20 hours per week or 80 hours per month.	3
Full-time Employment (WV WORKS)	Working an average of at least 30 hours per week.	18
Gift Card/ Certificate	Representation in paper form as a certificate or other device such as an electronic card that has a dollar value, a merchandise credit, or verification of value where the issuer has received payment for the full face value with the agreement that the card will be redeemed in the future for food, goods, services, credit, or money of at least an equal value. A gift card/certificate must be evaluated to determine if it can be used to purchase food or shelter and if there are any restrictions related to its use.	4
Green Card	A slang term describing the Permanent Resident Card (Form I-151 or Form I-551). Many versions of these forms are not green in color.	15
Gross Income	The amount of monthly income received before any deductions.	4
Gross Profit	The total gross income from self-employment, less the cost of producing the income.	4
Group Health Insurance Coverage	Health insurance coverage offered in connection with a group health plan.	22

Term	Definition	Chapter (s)
Group Health Plan	An employee welfare benefit plan that provides medical care and services to employees or their dependents, as defined under the plan, directly or through insurance, reimbursement, or otherwise. Can be public or private.	22
Group Living Facility (GLF)	For its residents to qualify for Supplemental Nutrition Assistance Program (SNAP), the GLF must: • House no more than 16 residents; • Be a public or private non-profit group home; and, • Be certified by the State under Chapter 1616e of the Social Security Act or be certified under standards comparable to Chapter 1616e as implemented by the appropriate West Virginia State agency and approved by the Secretary of the U.S. Department of Agriculture (USDA).	3, 16
Health Insurance Coverage	Benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization (HMO) contract, offered by a health insurance issuer.	22
Homeless (EA eligible)	Homeless transients for which transportation arrangements to their communities are incomplete; or applicants rendered homeless because their living quarters have been destroyed.	20
Homeless Individual	A homeless individual is an adult or child who lacks a fixed or regular nighttime residence, or a person whose primary nighttime residence is one of the following: • A supervised shelter designed to provide temporary accommodations, such as a congregate shelter; • A halfway house or similar institution that provides temporary residence for persons who might otherwise be institutionalized; • A temporary accommodation in the residence of another individual. Homeless is defined in this manner for up to a 90-day period. When the homeless individual(s) moves from one residence to another, a new 90- day period begins. A 90-day period in one residence continues when there is a break in participation; or • A place not designed for, or ordinarily used, as a regular	3, 16

Term	Definition	Chapter (s)
	sleeping accommodation for human beings, such as a vehicle, a hallway, a bus station, a lobby or similar places.	
Homeless Meal Provider	A homeless meal provider is a public or private non-profit establishment, such as, but not limited to, a soup kitchen or temporary shelter which is approved by the State and feeds homeless persons.	16
Homestead Property	The dwelling and land on which the dwelling rests, which is not separated by intervening property owned by others. This property does not have to be part of the original purchase. This includes the life estate interest, when it is the life estate holder's home.	5
Illegal Noncitizen	A foreign national who either entered the U.S. without inspection, entered with fraudulent documentation, or who, after entering legally as a nonimmigrant, violated status and remained in the U.S. without authorization. See the definition for undocumented noncitizen, which is one type of illegal noncitizen.	5
Immediate Family	The SSI-Related Medicaid individual's immediate family includes: parents, or adoptive parents; minor or adult children, including minor or adoptive- and step- children; siblings, including adoptive- and step-siblings. Immediate family also includes the spouse of the above relatives.	5
Immigrant	A noncitizen who has been lawfully afforded the privilege of residing permanently in the U.S. with the right to eventually obtain citizenship. This status allows authorization for work and entitlement benefits. See the definitions for lawful permanent resident noncitizen and permanent resident noncitizen, which are terms used interchangeably with immigrant.	15
Immigration Status	The legal status conferred on a noncitizen by immigration laws.	15
Immigration Status Verifier (ISV)	A USCIS employee who performs secondary verification duties at the local File Control Offices.	15
Incentive Payment	An allowance paid for participation in or successful completion of a training program, or an additional benefit paid.	4

Term	Definition	Chapter (s)
Income Group	Whose income and assets are counted for eligibility purposes.	3
Incurred Expenses	Monetary liabilities of the client.	4
Income-producing Property	Property that is annually producing income which is consistent with its current or fair market value.	5
Individual Development Account (IDA)	An IDA is a special bank account that helps an individual save for his education or the purchase of a first home or to start a business. The funds are matched by a government or non-profit agency.	5
Individual Health Insurance Coverage	Health insurance coverage offered to individuals. It does not include short-term, limited-duration insurance.	22
Ineligible Noncitizen	See nonimmigrant. Exceptions are made for pregnant women and children 18 and under for Medicaid and the West Virginia Children's Health Insurance Program (WVCHIP).	15
In-kind Income/payment	Goods or services received or provided by the AG in lieu of a cash payment.	4
In-kind Services (ABWAD Only)	In-kind services are defined as any labor that results in an individual receiving an in-kind income/payment as defined in Section 4.2.	3
Institution of Higher Education	An institution of higher education is defined as a business, technical, trade, or vocational school that normally requires a high school diploma or its equivalent for enrollment in the curriculum, or a college or university that offers degree programs whether or not a high school diploma is required for a particular curriculum. For this definition, a college includes a junior, community, two-year, or four-year college.	3
Institutionalized Individual	An institutionalized individual is: • An individual who is an inpatient in a nursing facility, or who is an inpatient in a medical institution, and for whom payment is made for a level of care provided in a nursing facility; or, • An individual who is a Home and Community Based Services (HCBS) waiver participant.	23, 24

Term	Definition	Chapter (s)
	For purposes of this section, a medical institution includes intermediate care facilities for individuals with intellectual disabilities (ICF/IID).	
Institutionalized Spouse	A spouse who is an institutionalized individual. This individual has a spouse living in the community who is not receiving long-term- care benefits. This definition is used when one spouse is applying for long term care benefits and the other spouse is not and is used in conjunction with the definition of community spouse.	5, 24
Insurance Affordability Program	The IAP includes Medicaid, WVCHIP, and coverage in a QHP offered through the Marketplace using advanced payments of premium tax credit or cost-sharing reductions.	4
Interactive Voice Response Unit (IVRU)	The IVRU is also referred to as EBT Helpline. The EBT vendor operates the IVRU seven days a week, 24 hours a day. Functions of the IVRU include, but are not limited to, account balance inquiries, card activation and PIN changes.	1
Invulnerability, Invulnerable AGs	Invulnerability means the AG has no home heating costs or is not responsible for payment of the heating cost. Clients who live in state institutions, hospitals and certain group living facilities, such as halfway houses and domestic violence centers, and those whose home heating costs are paid by a third-party, are considered invulnerable.	20
Irrevocable	Impossible to retract, revoke or annul.	5
Irrevocable Arrangements	Assets which are available for burial and held in an irrevocable burial contract or irrevocable burial trust. Irrevocable contracts and trusts are those which cannot be changed, and which do not allow the client access to the assets.	5
Issuance Limited County (ILC)	An issuance limited county is a county with enforced specified time limits for the ABAWD population to be eligible for SNAP benefits.	3
Jointly Owned Property	An asset owned by two (2) or more individuals.	5
Land Sale contract	A contract whereby a landowner enters into a legal agreement to sell property to another person by installment payments. The buyer is entitled to possession and equitable title to the property. The seller or creditor holds legal title until	5

Term	Definition	Chapter (s)
	the buyer completes the required payments to fulfill the contract.	
Lawful Permanent Resident Alien (LPRA)	A noncitizen who has been lawfully afforded the privilege of residing permanently in the U.S. See the definitions for IMMIGRANT and PERMANENT RESIDENT NONCITIZEN, which are terms used interchangeably with this term.	15
Lawfully Present	For Medicaid and WVCHIP, a noncitizen who has been legally permitted to enter the U.S. and meets the state residency requirements in Section 2.2. See Section 15.7.5 for an inclusive list of lawfully present individuals.	15
Life Estate	Under a life estate, an individual who owns property and transfers ownership of the property to another individual, while retaining certain rights to it for the rest of his life, or the life of another person. Generally, a life estate entitles the owner of the life estate to possess, use, and obtain profits from the property for as long as he lives. However, actual ownership of the property has been transferred.	5
Life Estate Holder	The person who benefits from the life estate.	5
Life Insurance	A contract whereby one party insures his own life or the life of another party for a specified amount of money.	5
Liquid Assets	Those which are cash or payable in cash on demand, including financial instruments that can be converted to cash. For SSI-Related Medicaid: Liquid assets are those which are cash, or which can be converted into cash within 20 working days. National, state and local holidays are not working days.	5
Long Term Care Insurance Partnership (LTCIP) Asset Disregard	An asset disregard available to certain institutionalized aged, blind, or disabled individuals with income equal to or less than 300% of the SSI payment for one but whose resources exceed the allowable asset limit. Eligible individuals must have a Qualified LTCIP Policy issued by a Partnership State while residing in a Partnership State with insurance payments made as of the date of the State's State Plan Amendment (SPA) that implemented the LTCIP. Assets are disregarded dollar-for-dollar in the amount of insurance payments made. Assets are protected at Estate Recovery in this same amount.	24
Look-back Period	The look-back period is the length of time for which the Worker looks back for any resource transfers. The look-back	24

Term	Definition	Chapter (s)
	period is 60 months, whether or not a trust fund was involved. The look-back time period begins the month the client is both institutionalized and has applied for Medicaid.	
LTCIP Policy Verification (DFA-LTCIP-1)	This form is given to the applicant for completion by the individual's insurance carrier or other individual who can attest to the policy's details and benefits paid. Other sources of verification are the Qualified LTCIP Policy, letter from the issuing state's governmental agency that regulates insurance, or verification from the issuing insurance agency indicating compliance of the Policy with Section 1817(b)(5)(A) of the Social Security Act.	24
Lump-sum Payments	Non-recurring, recurring, or advance payments. This may include, but is not limited to, RSDI, stock dividends paid quarterly, or payments from an income disability insurance plan that cover a previous period, but are delayed for medical reports, etc.	4
MAGI Disregard	An income disregard that equals 5% of the Federal Poverty Level (FPL) for the family size, applicable only to Medicaid Groups and WVCHIP that use MAGI income-based methodologies. See Section 4.7 for further details.	4
MAGI Screening	All applicants will go through a "MAGI Screen" and will have MAGI Medicaid eligibility determined first. If eligible for a MAGI Medicaid coverage group, the applicant should promptly be enrolled into the MAGI coverage group. The applicant may also pursue eligibility for coverage in non-MAGI groups.	4
Major Life Activities	Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working. In addition, a major life activity includes the operation of a major bodily function, including, but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions.	

Term	Definition	Chapter (s)
	NOTE: The determination of whether an impairment substantially limits a major life activity shall be made without regard to the helpful effects of mitigating measures such as: • medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary glasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices or oxygen therapy equipment and supplies; • use of assistive technology; • reasonable accommodations or auxiliary aids or services; or • learned behavioral or adaptive neurological modifications	
Mandatory Payroll Deductions	Income withholdings common to all employees of the same employer.	4
Means Tested Program	A program for which the client's financial circumstances are considered in determining eligibility and/or benefit level. Also known as NEEDS-BASED PROGRAM.	4
Medical Care	Amounts paid for any of the following: • The diagnosis, cure, mitigation, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body • Transportation primarily for and essential to medical care • Insurance covering medical care as defined above.	22
Medicare	Medicare is a federal insurance program that helps pay health care costs for people age 65 or older, regardless of income, and certain individuals receiving Retirement, Survivors, and Disability Insurance (RSDI) benefits based on disability. Medicare is the same in all states and is administered by the SSA. SSA makes all decisions regarding eligibility for Medicare.	25
Medicare Part A	Hospitalization Insurance Benefits (HIB).	25
Medicare Part B	Supplementary Medical Insurance Benefits (SMIB).	25

Term	Definition	Chapter (s)
Medicare Part D	Medicare Prescription Drug Benefit: An individual who is already enrolled in Medicare Part A or Part B may receive the Medicare Prescription Drug Benefit. The Part D Prescription Drug Benefit is not administered by the SSA. The benefit is obtained by enrolling in a Prescription Drug Plan (PDP). Enrollees must pay a monthly premium, unless financially qualified for extra help, also known as the Low-Income Subsidy (LIS).	25
Minimum Essential Coverage (MEC)	Coverage as defined in Section 5000 (f) of Subtitle D of the Internal Revenue Code. MEC includes, but is not limited to, Medicaid, the Children's Health Insurance Program (CHIP), Medicare, TRICARE, Veteran's Affairs (VA) benefits, Peace Corps, Employee Sponsored Plans and Plans in the individual market.	4
Modified Adjusted Gross Income (MAGI)	Income figure used to determine eligibility for specific Medicaid eligibility groups and WVCHIP. The MAGI is calculated by making adjustments to the adjusted gross income. See Section 4.7.	4
Mountain State Card	The West Virginia EBT card.	1
Mutual funds	A pool of assets managed by an investment company that buys and sells securities and other investments.	5
National of the U.S.	A citizen of the U.S. or an individual who, though not a citizen of the U.S., owes permanent allegiance to the U.S.	15
Nationality	The state or country to which a person has legal allegiance. Note that the country of birth does not necessarily correspond to the nationality.	15
Naturalization	The legal act of becoming a citizen, other than birth. A resident noncitizen married to a U.S.-born citizen must hold permanent resident noncitizen status for three years before petitioning for naturalization. Also, others must hold permanent resident status for five years before petitioning for naturalization.	15
Needs Groups	Whose needs are considered in determining eligibility.	3
Negotiable Agreement	An agreement whereby the ownership of the instrument itself and its face value can be transferred, e.g., sold, from one person to another.	5

Term	Definition	Chapter (s)
Non-AG Member	An individual whose income, resources, needs and/or expenses are not included in the AG of the individual or group of individuals with whom he lives, but who has not been disqualified, sanctioned or excluded by law.	4
Noncitizen	Any person who is not a citizen or national of the U.S.; also referred to as an alien.	15
Non-excluded	Assets that are considered when determining asset eligibility.	5
Non-homestead Property	Real property, other than the homestead, that the client owns or is purchasing.	5
Nonimmigrant	A noncitizen who is permitted to enter the U.S. for a specific purpose and for a limited period of time. Examples include tourists, students, and business visitors.	15
Non-liquid Assets	Those which can be converted or sold for cash. For SSI-Related Medicaid: Non-liquid assets are those which cannot be converted to cash within 20 working days.	5
Non-means Tested Program	A program that does not take into account income, or an individual's means, without the assistance. However, the benefit has its own rules for eligibility.	4
Non-Recipient Work Eligible Individual	A non-recipient Work-Eligible Individual is not included in the WV WORKS benefit. He must still complete Orientation, a Personal Responsibility Contract (PRC)/Self-Sufficiency Plan (SSP) and be participating in a work activity; therefore, is work-eligible. Non-recipient Work-Eligible individuals include: • Individuals convicted in federal or state court of having made a fraudulent statement or representation about residence to receive Temporary Assistance for Needy Families (TANF), WV WORKS, Medicaid, SNAP benefits or SSI are ineligible for 10 years from the date of the conviction. The conviction must have occurred on or after August 23, 1996. • Individuals who are fleeing to avoid prosecution, custody or confinement after conviction, for a felony or an attempt to commit a felony. • An individual convicted of a felony under federal or state law when the offense involves the possession, use or distribution of a controlled substance, as defined in Section 102(6) of the	1

Term	Definition	Chapter (s)
	Controlled Substance Act and when the offense occurred on or after August 23, 1996; or • Individuals who are violating a condition of probation or parole which was imposed under federal or state law. • A parent or other caretaker who has not reported that their child will be or has been out of the home for at least 30 days.	
Odd Jobs	Small jobs of various types such as, cutting lawns, babysitting or other small jobs for a cash fee. Is not normally listed as a business and has little or no expenses.	4
Parental Living Allowance	The SSI payment amount for one or two persons, depending on the number of parents in the home.	4
Parolee	A noncitizen who appears to be inadmissible to the inspecting officer, but who is permitted to enter the U.S. under emergency conditions or because that noncitizen's entry is determined to be in the public interest. Although parolees are required to leave when the conditions supporting their parole cease to exist, they may sometimes adjust immigration status.	15
Partially Vulnerable AG	The AG is partially vulnerable when a surcharge for excessive usage is already added or can reasonably be anticipated to be added to the rent amount.	20
Partnership (Qualified States)	States that are participating in the LTCIP. Each Partnership State has an approved State Plan Amendment (SPA) that indicates the date the State implemented the LTCIP. West Virginia's SPA implemented the LTCIP as of July 1, 2010.	24
Part-time Employment (WV WORKS)	Working an average of under 30 hours per week.	18
Passport	Any travel document issued by a competent authority showing the bearer's origin, identity, and nationality, if any, which is valid for the entry of the bearer into a foreign country.	15
Pay card/Payroll Card/Payroll Debit Card	A plastic debit card on which the employer or agency directly deposits the employee or clients earned or unearned income for his use. This card is used in lieu of a paper check or other paper document that indicates payments. An example would be a Direct Express Card.	4

Term	Definition	Chapter (s)
Payee	The term payee identifies the person to whom benefits are issued.	1
Permanent Resident Noncitizen	A person who enters the country with an immigrant visa or adjusts his status after entering as a nonimmigrant, refugee, or asylee. Persons with this status are entitled to live and work in the U.S. and collect entitlement benefits, if qualified. See the definitions for immigrant and lawful permanent resident noncitizen, which are terms used interchangeably with this term.	15
Personal Care Contract (PCC)	A legal, written contract, also referred to as a personal care agreement or personal service contract, executed between an individual or his authorized representative and the caregiver, often an adult child, relative or friend, in which the caregiver agrees to render services at fair market value (FMV) in exchange for reasonable payment. See Fair Market Value.	24
Personal Identification Number (PIN)	This number must be used to access EBT benefits with the EBT card. This is not the eligibility system PIN number.	1
Personal Income-producing Property	Movable belongings, exclusive of land and buildings that are annually producing income consistent with their CURRENT MARKET VALUE.	5
Personal Responsibility Contract (PRC)	The PRC (form DFA-PRC-1) is a contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Case Manager, as the representative of the DOHS. Completion and signature of the PRC form is required prior to approving the WV WORKS AG. A separate PRC is completed and signed by each adult and emancipated minor in a WV WORKS AG, and any non-recipient Work-Eligible Individuals in the household. The participant's signature indicates that he understands and accepts the responsibility inherent in the program. The PRC is the same for all WV WORKS participants. It states the purpose of the WV WORKS Program and lists the participant's rights and responsibilities.	2, 4, 8, 9, 14, 18

Term	Definition	Chapter (s)
Physician's Statement	The term physician's statement means a medical report from a licensed medical professional, including physicians, surgeons, doctors of osteopathy, chiropractors, etc.	13, 14, 18
Plan to Achieve Self-Support (PASS)	A plan developed by the SSA or the DOHS for a blind or disabled individual to achieve self-support.	4
Point of Sale (POS) Equipment	This is used to spend SNAP benefits at a store. Account balance inquiries may be made using a store's POS machine located at the Service Desk. Account balances also appear on all receipts printed by a POS machine.	1
Primary Verification	A query to validate noncitizen documentation using the ASVI system.	15
Principal Place of Residence	The dwelling the client considers his fixed, established home. The principal place of residence must be a home in which the individual has lived.	5
Private Institution	Institution that provides shelter, custody, and care, and for which a governmental unit has responsibility or exercises administrative control.	2
Proceeds from Sale of Home	Net amount received by the seller, after satisfaction of all encumbrances and sale expenses.	5
Promissory Note	A written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time or on demand to another party. It may be given in return for goods, money loaned or services rendered. See BONA FIDE LOAN in Section 4.2.	5
Proration	The process of distributing income received as a single payment, or an expense met by a single payment, equally over the time period it is intended to cover.	4
Protective Payee	A protective payee is a person, or an organization appointed to receive the benefits for anyone who cannot manage or direct the management of his or her own basic needs.	1
Public Institution	Non-governmental institution that provides shelter, custody, and care, and that is required by State law to have a license to operate.	2
Pure SNAP AGs	Every person included in the SNAP AG receives TANF-funded benefits or SSI or is authorized to receive information	5

Term	Definition	Chapter (s)
	and referral services. Pure SNAP AGs are categorically eligible for SNAP benefits.	
Qualified Disability Expense	Any expenses related to the eligible individual's blindness or disability which may include, but are not limited to, expenses incurred for education, housing, transportation, employment training and support, and assistive technologies.	4, 5
Qualified Health Plan (QHP)	Under the ACA, an insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements. A QHP will have a certification by each Marketplace in which it is sold.	4
Qualified Lottery and Gambling Winnings	Winnings from a sweepstakes, lottery or pool received as a single lump sum payout. Generally conducted by a state, multistate or multijurisdictional association.	
Qualified LTCIP Policy	An LTC Policy that meets certain requirements of federal and state law. These policies are issued by Partnership (Qualified) States as of the date the State implemented the LTCIP.	24
Real Income-producing Property	Fixed property, including land and buildings, that is annually producing income consistent with its CURRENT MARKET VALUE.	5
Reasonable Accommodations	The term may include making existing facilities used by employees readily accessible to and usable by individuals with disabilities, the acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials, policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities	1
Reasonable Compatibility	Reasonable compatibility means that information provided by an applicant through self-attestation does not vary significantly, or in a way that is meaningful for eligibility when compared to information obtained through electronic data sources. Under reasonable compatibility, the Worker can require verification documentation only when the difference between the attestation and data source affects eligibility.	7

Term	Definition	Chapter (s)
Reasonable Compatibility Standard	The Reasonable Compatibility Standard is an acceptable level of variance between self-attested income and income information obtained through electronic data sources. West Virginia's Reasonable Compatibility Standard is 10%.	7
Reasonable Compatibility Test	When the difference between the self-attestation and data source incomes affects eligibility, the Reasonable Compatibility Test must be applied to determine whether or not additional verification is needed.	7
Reasonable Explanation	The applicant must be given an opportunity to provide an explanation for discrepancies between self-attested information, and information reported by an electronic data source. The Worker must determine if the client's explanation is reasonable.	7
Rebuttal	The process whereby the client refutes the Department's presumption of unrestricted access to resources.	5
Recreational Vehicles and Equipment	May include, but is not limited to, boats, snowmobiles, campers, camper-trailers, airplanes, and similar equipment that do not meet the definition of a vehicle and ATVs and similar vehicles that do not require licensing, even though they may be licensed. This does not include sporting equipment or toys. Also see VEHICLE.	5
Refugee	Any person who is outside his country of nationality and who is unable or unwilling to return to that country because of persecution or a well-founded fear of persecution. Unlike asylees, refugees apply for and receive this status prior to entry into the U.S.	15
Regaining Eligibility (ABAWD Only)	Clients regain eligibility by meeting the ABAWD work requirement for a 30-day period prior to application or meet an exemption.	3
Reimbursement	Compensation for past or future expenses.	4
Relocation Payments	Money received from federal, state or local agencies to cover moving costs, cost of purchasing a home in a new location, or as a rent supplement, when a person or family is displaced by such an agency. Examples of these payments include, but are not limited to, Highway Relocation, Urban Renewal and the Army Corps of Engineers.	4

Term	Definition	Chapter (s)
Replenishment Agricultural Worker (RAW)	Any noncitizen who is granted temporary or permanent resident status under Section 210A(c) of the Immigration and Nationality Act, as amended by IRCA, based on prior agricultural employment within the U.S. The RAW program was implemented during a fiscal year from 1990 – 1993 only upon announcement by the Secretaries of Agriculture and Labor of a shortage of agricultural workers in the U.S. for that fiscal year.	15
Resources	Income and assets.	5
Retirement Funds	Funds in an individual account, pension fund or retirement plan, such as IRAs, KEOGH Plans, 401ks, SEPs and employer plans.	5
Revocable	Capable of being revoked, retracted or annulled.	5
Royalty	A share of the profit from the product of an oil or mineral lease. Also, a payment made to an author or composer for each copy of work sold or to an inventor for each article sold under a patent.	4
Sanction	A sanction is incurred when a member of the assistance group (AG) or non-recipient Work-Eligible Individual does not comply with requirements found on his Personal Responsibility Contract (PRC) or Self-Sufficiency Plan (SSP), a sanction must be imposed unless the Case Manager determines that good cause exists. Sanctions are applied in the form of termination of WV WORKS benefits. The duration of the sanction period is determined as follows: • First Offense = Ineligibility for cash benefits for one month; • Second Offense = Ineligibility for cash benefits for six months; • Third and All Subsequent Offenses = Ineligibility for cash benefits for 12 months. WV WORKS sanctions are applied to all Work-Eligible members of a WV WORKS case, not only to the member who causes the sanction.	14
Sanctioned Individual	A person who must normally be included in an AG, but who has been excluded due to his failure to comply with a specific program requirement. This person may also be referred to as a DISQUALIFIED INDIVIDUAL.	4

Term	Definition	Chapter (s)
Secondary Verification	A request to validate noncitizen documentation, after or in lieu of primary verification, using Form G-845. Secondary verification is performed by the ISV using various automated or manual sources. This is completed by the Division of Family Assistance (DFA) Systematic Alien Verification for Entitlement (SAVE) Coordinator.	15
Self-Attestation	Information reported by an individual about financial and non-financial information.	4
Self-Employment	A situation in which an individual has an investment in a business, has costs involved in producing income from this business, and could suffer a loss. He is usually responsible for his own income taxes and Federal Insurance Contribution Act (FICA) taxes. A self-employed individual usually has to provide his own equipment, supplies and materials needed to do a job or produce the income. He controls to some extent his hours of work and where the work is done.	4
Self-Sufficiency Plan (SSP)	The SSP (form DFA-SSP-1) is a negotiated contract between each of the adult or emancipated minor members of the WV WORKS AG, or non-recipient Work-Eligible Individual(s), and the Case Manager, as the representative of the DOHS. The SSP is specific to each participant. It lists the goals, as well as the tasks necessary to accomplish the goals, including specific appointments, assignments and activities for the adult/emancipated minor. In addition, the SSP identifies the circumstances which impede attainment of the established goals and specifies the services needed to overcome the impediments.	18
Severe Victim of Trafficking and Violence	An individual who has been used in severe forms of trafficking in persons. For example, sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provisions, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.	15
SNAP Employment and	The SNAP E&T program is to provide SNAP participants with opportunities to gain skills, training, or experience that will	3

Term	Definition	Chapter (s)
Training (SNAP E&T)	improve their employment prospects and reduce reliance on SNAP benefits.	
Special Needs	Needs other than food, shelter, utilities, clothing and incidentals which are not uniformly shared by all members of the AG.	4
Spenddown	The amount by which income exceeds the Medically Needy Income Level (MNIL) for the Period of Consideration (POC).	4
Spouses	Persons legally married to each other, under the provisions of State law, or those moving to West Virginia from states that recognize their relationship as a legal marriage. West Virginia does not have a provision in State law regarding common-law marriage. Any individual that establishes this type of relationship in a state that recognizes common-law marriages is considered married for the Department purposes.	5
Status the EBT Card	Deactivate the card so that it cannot be used. This occurs when a replacement card is requested, a payee is changed, or an authorized cardholder is removed or changed.	1
Stocks	A security representing a share of ownership in a business or corporation.	5
Subsidized Employment (WV WORKS)	Work with earnings provided by an employer who receives a subsidy for the creation and maintenance of the employment position.	18
Systematic Alien Verification for Entitlement (SAVE)	An automated or manual information-sharing program whereby state agencies may verify the immigration status of noncitizen applicants for entitlement benefits. This verification is completed by the SAVE Coordinator upon request from the Worker.	15
Temporary Lawful Resident Noncitizen	A noncitizen granted a one-year period of lawful resident status based on his qualifications under the legalization or Special Agricultural Worker (SAW) programs. The temporary status may be removed after one year, when USCIS rules favorably or unfavorably on granting permanent lawful resident status to the noncitizen.	15
Term Insurance (Life Insurance)	Policies which do not have a cash surrender value.	5

Term	Definition	Chapter (s)
Third-Party Liability (TPL)	TPL refers to the legal obligation of third parties, such as any individual, entity, or other program, to pay part or all of the expenditures for medical assistance; therefore, TPL is the means by which Medicaid payments are reduced or reimbursed by the amount paid by any individual, entity or other program.	4
Third-party Payments	Payments made on behalf of the AG by an individual who is not a member of the AG. To qualify as a third-party payment, there must be an identifiable payment on behalf of the AG, rather than on behalf of the payer. Third-party payments are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).	4
Three-Month Limit (ABAWD Only)	First full three months of SNAP benefits received without meeting the ABAWD work requirements or being exempt.	3
Time Deposit	Any type of account that has a maturity date.	11
Time Limitation	The federally-mandated requirement that Emergency Assistance (EA) can be authorized just once to an eligible client for emergency situations during one 30-consecutive day period in any 12 consecutive months.	20
Title I	Grants to States for Old-Age Assistance for the Aged	4
Title II	Federal Old-Age, Survivors, and Disability Insurance Benefits	4, 6, 20, 25
Title III	Grants to States for Unemployment Compensation Administration	4, 20
Title IV-A	Block Grants to States for Temporary Assistance for Needy Families	20
Title IV-B	Child and Family Services	7
Title IV-D	Child Support and Establishment of Paternity	4
Title IV-E	Federal Payments for Foster Care and Adoption Assistance	4, 7, 23
Title V	Maternal and Child Health Services Block Grant	27
Title XVI	Grants to States for Aid to the Aged, Blind, or Disabled	13, 18
Title XIX	Grants to States for Medical Assistance Programs (AKA Medicaid)	4, 16, 27

Term	Definition	Chapter (s)
Title XX	Block Grants to States for Social Services	20
Training Allowance	An allowance paid for participation in a training program. See INCENTIVE PAYMENTS.	4
Transfer for Fair Market Value (FMV) or Valuable Consideration	For a resource to be considered transferred for FMV, or to be considered transferred for valuable consideration, the compensation received for the resource must be in a tangible form, with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for FMV.	24
Transient	An individual who is traveling or passing through a locality and experiences an emergency that makes it necessary to return to his home community. The home community does not need to be in West Virginia. The definition of transient does not include individuals who are visiting within the locality or who arrived with the intent to obtain temporary to permanent employment or otherwise remain within the locality on a temporary or permanent basis. In addition, an individual who finds temporary or permanent employment within a locality, but later decides to return to his home community does not meet the definition of a transient.	20
Trust	Any arrangement in which a grantor transfers property to a trustee(s) with the intention that it be held, managed or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries. For Medicaid, the term trust also includes any legal instrument or device that is similar to a trust. Legal Instrument Or Device Similar To A Trust: Any legal instrument, device or arrangement which may not be called a trust under State law, but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with the intention that it be held, managed or administered by the individual or entity for the benefit of the grantor or others. This may include, but is not limited to, escrow accounts, investment accounts, pension funds, and	5

Term	Definition	Chapter (s)
	other similar entities managed by an individual or entity with fiduciary obligations.	
Trust Fund	A legal vehicle which allows money to be held by one individual (the trustee) for the benefit of another (the beneficiary).	4
Trustee	Person or institution which holds legal title to property for the benefit or use of another.	5
Two-Parent Family (WV WORKS)	In a two-parent family, for these purposes only, neither parent is incapacitated or disabled according to the Social Security Administration (SSA) definition, and the family meets one of the following criteria: • There are two natural or adoptive parents, who are Work-Eligible Individuals, of the same minor child living in the home and included in the same WV WORKS payment. • There are two parents with a common child living together and one or both is excluded from the WV WORKS payment unless the exclusion is due to one of the following reasons: o Minor parent who is not the head-of-household; o Ineligible noncitizen due to immigration status; or o SSI recipient.	18
Uncompensated Value	For Chapter 5, uncompensated value is the CMV, less any outstanding loans, mortgages or other encumbrances on the asset, minus the amount of compensation received by the AG.	5
Uncompensated Value	For long term care, the uncompensated value is the difference between the FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the resource) and the amount received for the resource.	24
Undocumented Noncitizen	A noncitizen in the U.S. without proper documentation. He is in violation of U.S. immigration law. (See also the definition for illegal noncitizen for a broader explanation of unauthorized noncitizens in the U.S.).	15
Undue Hardship	Applies to Medicaid LTC groups only. This condition exists with the application of one or more of the following asset policies: • Excessive home equity;	5

Term	Definition	Chapter (s)
	• Transfer to a non-permissible trust; and/or • A transfer of assets penalty results in the denial of payment of LTC services, and causes the individual to be deprived of medical care to the extent that the individual's health or life would be endangered or his food, clothing, shelter, or other necessities of life are at severe risk. When there has been a transferred asset, in order to meet Undue Hardship requirements, the individual must have exhausted all means, legal and otherwise, to receive CMV for and/or to regain the transferred asset. All means, legal or otherwise, refers to action through the court system and/or the voluntary return or recovery of the asset or item. Undue Hardship does not exist when the denial causes the individual inconvenience or might restrict his lifestyle but would not put him at risk of serious deprivation.	
Undue Hardship Committee	A standing committee comprised of representatives from BMS and DFA, that determines if an individual's denial for Medicaid LTC Services should be waived due to the individual's undue hardship condition as defined above.	5
Undue Hardship Provision	This provision only applies to individuals who are denied Medicaid LTC Services due to the application of the excessive home equity, transfer of asset to a non-permissible trust, and/or a transfer of assets penalty. The individual must be otherwise eligible for LTC Services.	5
Unearned income	Income which is not related, or only indirectly related, to the efforts or activities of the individual. Examples of unearned income are RSDI, SSI, VA benefits, pensions, compensation benefits, interest, royalties, allotments, contributions, and WV WORKS payments.	4
Uniform Gifts to Minors Act (UGMA)	The State law which allows an irrevocable gift of money or property, made to a minor, to be tax-free. This may also be referred to as Uniform Transfer to Minors Act (UTMA).	5
United States	Defined in a geographical sense as the continental U.S., Alaska, Hawaii, Puerto Rico, Guam, U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands.	15
United States Citizenship and Immigration Services (USCIS)	The federal agency under the Department of Homeland Security that administers immigration law.	15

Term	Definition	Chapter (s)
Unpaid Work (ABAWD Only)	Labor for an individual outside the AG or organization in which a person would traditionally be paid, but the client has chosen not to seek payment.	3
Unstated income	SSI-Related Medicaid and WV WORKS Only: Money that has not been reported, and that is not otherwise known to the DOHS, but is determined to exist because the client's paid living expenses exceed income from known sources.	4
Unsubsidized Employment (WV WORKS)	Work with earnings provided by an employer who does not receive a subsidy for the creation and maintenance of the employment position, or through self-employment.	18
Valuable Consideration	Valuable consideration means that an individual receives in exchange for his or her right or interest in a resource some act, object, service, or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred resource.	24
Vehicle	A car, truck, motorcycle, motor scooter, or a camper when the living section of the camper is a permanent part of the motorized section. To be considered a vehicle, it must require licensing to operate on public roadways, not necessarily be licensed. ATV's are treated as recreational vehicles, not as vehicles. See Section 5.1, QQ, 3 for SSI-Related vehicles. Also see RECREATIONAL VEHICLES AND EQUIPMENT.	5
Vulnerability, Vulnerable AGs	Vulnerable AGs are those which must pay the primary heating cost for the home in which they reside. AGs may also be considered vulnerable if there has been a documented increase in a rent or mortgage payment due to increased fuel costs. Clients who are temporarily away from home for medical, educational, or employment purposes, and who still must pay a heating cost for the dwelling, are considered vulnerable. This includes nursing home residents who are still maintaining a home and have a heating cost. Vulnerability also exists when the AG must pay at least a part of the cost of home heating, whether they pay just part of the cost each month or alternate payments with a third-party.	20
Welfare Fraud	Any person who obtains or attempts to obtain, or aids or abets an applicant or recipient in obtaining or attempting to	11

Term	Definition	Chapter (s)
	obtain, by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device: • Any class of welfare assistance to which the applicant or recipient is not entitled; or • Any class of welfare assistance in excess of that to which the applicant or recipient is justly entitled.	
Whole Life Insurance	Insurance policies which have a cash surrender value.	5
Work (ABAWD Only)	For ABAWD purposes only, work is defined as any activity performed for monetary compensation, for in-kind services, or unpaid work.	3
Work-Eligible Individuals	A Work-Eligible individual is a parent, a caretaker included in the WV WORKS AG, or a minor child head-of-household receiving WV WORKS assistance unless the individual is: • A minor parent and not the head-of-household or spouse of the head-of-household; or • A noncitizen who is ineligible to receive assistance due to his or her immigration status; or • A recipient of Supplemental Security Income (SSI) benefits.	18