

WORKER GUIDE

Case Management Examples

1. Generic Case Management

Case management consists of these elements. (*Eligibility items are italicized.*)

Screening and Assessment to obtain basic information for case management and eligibility purposes.

This includes the following steps:

- Reviewing the application.
- Reviewing the *My Self Assessment* (DHS 7823) form with the client.
- Reviewing prior case history (case file, TRACS).
- Reviewing the testing screen on TRACS for results of any screenings or assessments the client has completed.
- Checking the appropriate screens.

Possible Questions or Statements to gather information about client circumstances.

- Tell me about any recent job losses you may have experienced.
- Tell me about your work history and educational background.
- Who lives in the home; who is working; who is in school; who is a citizen? How would these individuals support you or be a barrier to your participation in activities?
- How old are the individuals in your home, and what is your relationship with them?
- Who is not in the home, but who is involved with the family, and what resources do they offer?
- What income is available to you?
- Are there personal resources such as transportation, child care that you can use?
- Tell me about any health problems you or members of your family may be experiencing. Are they affecting the family functioning (physical, mental, intellectual functioning)?
- Are alcohol & drug (A&D) issues affecting the family? If yes, how are they affecting the family?

- Are there concerns about safety for any member of the family? Tell me about that.
- ☞ SEE FOCAL POINT 9. BELOW IN THIS CHAPTER FOR MORE INFORMATION ON DOMESTIC VIOLENCE QUESTIONS.
- Are there other organizations with which you are involved? If so, what are these organizations requiring you to do? How will these plans impact your goals?

Remember: the decision maker is the client.

This may be a good opportunity to discuss release of information issues with the client and have them sign the *Authorization for Use and Disclosure of Information (DHS 2099)* if they agree.

Staffing is consulting or meeting with partners regarding clients' service needs to assist in making joint plans. Before inviting partners or sharing information, obtain the clients consent. Staffing could mean:

- Contacting community partners with whom the client is involved, or may be involved with in the future, by phone to advise them of DHS/JOBS activities and to determine the need for joint planning;
- Arranging a formal meeting of all partners to staff the client and develop a joint family plan (the client might be invited to participate);
- Having an in-branch staffing on a family to problem solve and develop strategies;
- Consider staffing the family with any branch or local staffing teams to access a wide range of services;
- Evaluating the client's progress toward achieving the case plan goals.

Brokering is guiding clients to appropriate community resources and doing followup to determine effectiveness.

This includes:

- Identifying and coordinating with partners the client is currently working with;
- Coaching clients in determining what community resources are appropriate to meet their needs;
- Coaching clients in how to effectively access resources;
- Offering referral information;
- Doing followup to ensure that the client has connected with the agency/resource s/he has been referred to;
- Assisting client in contacting resources and obtaining help from them, if needed;

- Getting feedback from clients on effectiveness of brokered resource;
- Advocating with partners in behalf of the client.

Resources are used or developed to meet client needs.

This means:

- Being aware of all community resources that clients commonly use;
- Knowing where to obtain information on resources for clients with specialized needs;
- Being aware of and using Central Office resources as needed;
- Alerting others in the branch/district of the need for new resources to meet newly discovered needs of clients.

Development of Plan

- Mutually develop the plan with the client for the family and individuals within the family based on the Assessment, Staffing, Brokering and Resources.
- Determine the long-term (usually employment) and short-term goals (intermediate steps for achieving the long-term goal).
- The employment goal is based on the client's skills, job history and abilities.
- Identify activities to address the short-term goals.
- Prioritize the accomplishment of activities, if needed.
- Selected activities will include JOBS components and community resources.
- Establish time frames for beginning and completing the activity.
- Determine what resources the client, agency and partners can use to support the activity.
- Outline how the plan will be coordinated with partner agencies.
- Be clear about the case manager's role in the plan.
- Establish dates for reviewing progress and the method of contact between the case manager and client.
- Update the plan as needed.

2. **Determining the Appropriate Focal Point of Case Management**

Keep in mind that family members may need more than one focal point of case management.

WORK STATUS

Ready to work

Identifiers: Good recent work history. Job losses are not client caused. There are no family or medical problems needing resolution. There are no issues that would interfere with employment. Any issues that need to be resolved can be done in off work hours.

Almost ready to work

Identifiers: No recent job history or job losses that may be client caused. Medical problems exist that need to be dealt with prior to employment. There are family problems that cannot be dealt with in off-work hours.

Working: Retention/Wage Enhancement

Identifiers: Client begins job, but has issues they are still working on. Includes clients moving to employment after TANF, clients in the Post-TANF Program, Refugee benefits or Pre-TANF Program ends. Client is working part time, and needs help finding full-time employment. Client wants to get a better paying job. Client needs skill building training or education to promote at current job or get a better job.

Child Care

Identifiers: Clients who are working or in JOBS activities, who need care for children under 13 or children under age 18 with special needs.

TEENS

Teen Parent

Identifiers: Parents who are age 19 or younger.

Teens (nonpregnant) on OHP or OHP/FS not living with parents/relatives

Identifiers: Teen lives with friends, is homeless or is living on their own.

FAMILY ISSUES

Domestic violence issue

Identifiers: A response to the application item #5 or #6 indicating domestic violence. This could also be indicated on the *Cooperating with Child Support Enforcement and Pursuing Third Party Resources* (DHS 428A), DCS good cause form and DHS 7823. Client may self-identify as a victim of domestic violence. The case manager observes or becomes aware of hypervigilance; explanation of injuries inconsistent with type/location of injury; substance abuse; frequent headaches; multiple injuries; gastrointestinal problems; eating and sleeping disorders; depression/suicidal ideation/high anxiety; sexual assault/rape.

Client comes to appointments with injuries. Comes to appointments late, needs to leave early, is secretive about home life. There is frequent absenteeism due to medical problems or concerns about children. Client is excessively emotional, tearful, angry, depressed, nervous or confused. Client has low energy, fatigue and has trouble making decisions. Does not feel confident making any big decisions without partner, and will not make appointments without partner. Partner shows up frequently at client's JOBS activity site.

A&D issues

Identifiers: Client always blames others for the problems in his/her life. Questionable job losses. Others in family are alcoholics or drug abusers. Job losses have occurred due to excessive absence. There is pattern of accidents on the job. Client has had DUIs. There are observable mood swings, dilated pupils, needle marks, the smell of alcohol, hyperactivity, difficulty staying on track or dramatic attention getting. The client has short-term memory loss and/or blackouts. The client may have an infectious disease such as TB, HIV, STDs, urinary tract infections, pneumococcal and other pneumonias, hepatitis B and C and other vaccine-preventable diseases.

Housing issues

Identifiers: A response on the application in the Emergent Need section regarding needing a place to live, monthly rent and utility payments being more than monthly income or responses that indicate a pending eviction or utility shut-off notice may indicate a need for support around housing issues. Housing issues may also come up during other client contacts, including the screening process using the DHS 7823; case management/JOBS interviews; conciliation appointments; as well as appointments with contractors or other community partners.

Health issues (Physical Disabilities, Mental Health, Intellectual Functioning)

Physical Health Identifiers: Clients who state they cannot work and/or offer a doctor's statement to that effect. Clients with observable medical problems.

Mental Health Identifiers: Client's affect is inconsistent with the situation. Frequent visits to hospital emergency rooms. Appearance, attire and hygiene are less than socially acceptable. Client seems disorganized, confused or sleeps excessively. Chronic lack of follow-through and inability to get along with others. Pattern of noncompliance with case plan activities.

Intellectual Functioning Disabilities Identifiers:

Learning disability: Client has been in special classes. Reverses letters/figures when filling out agency forms. Low level of literacy as observed on application.

Marginal intelligence: Client has been in special classes. Client has frequent job losses which may be due to being too slow. Client has difficulty with abstract thinking.

Pregnant women/women with infants

Identifiers: Self identification.

Youth/child issues (juvenile justice, education, abuse/neglect)

Identifiers: The family is involved with Child Welfare and/or the juvenile court. The child(ren) has poor grades, behavior problems at school, is in special classes or is suspended from school. The parents are called to the school frequently to deal with the child's problems. Observable abuse or neglect. The family is receiving treatment/counseling from a community mental health or child welfare agency.

Children Living with Adults Who Are Not Receiving Cash Benefits

Identifiers: Relatives (non-needy caretaker relatives) raising their grandchildren, nieces and nephews or cousins. Families in which one or more of the adults are noncitizens.

Noncustodial Parent

Identifiers: As identified by DCS, custodial parent or relatives of children. Teen girl living with a male.

3. Work Status Focal Point; Ready to Work

Principle-Based Decision

Work is better than welfare.

- ☞ SEE WORK STATUS FOCUS POINT; CHILD CARE, IN THIS WORKER GUIDE (CM WG1.6).

Assessment

- Review the *Application for Services* (DHS 415F).
- Review the *My Self Assessment* (DHS 7823) form.
- Identify what support services the client needs to do job search and become employed.
- Explain tax credits (EIC, and others).
- Evaluate (and reevaluate) suitability of client's job search choices given the job market and the client's skills.
- Explore transportation options including carpooling.
- Explore child care options.
- Explain transitional benefits to support continued employment.

Possible Questions

- What type of work are you interested in seeking?
- Is it possible to obtain that type of job within commuting distance?
- What are your skills?
- What support do you need to become employed?
- Do you feel ready to work?
- Are there any family problems? If so, can they be resolved outside of work or job search hours?
- Is there anything that would interfere with your going to work, or make it difficult to work?
- Do you need clothing for job interviews?

Staffing

- Consult with staff in JOBS program.
- Possibly contact employers to follow up on client interviews.

Brokering

- Other partners may include the Employment Department, WIA, temporary agencies, Dislocated Worker programs.

Resources

- Local: branch resource room.
- District: CRC.
- Central Office: information resource person.

Development of Plan

- Determine the employment goal.
- Job search will be the primary activity.
- Other JOBS activities such as Life Skills may be useful.
- Identify steps to secure adequate transportation, child care, and back-up arrangements. Explore carpooling.
- Identify what support payments will be needed: transportation, child care, etc.
- Establish time frames for review of job search.
- Identify steps to resolve issues that might hinder employment.

Tools

- *Job Search Verification* (DHS 475), *Employment Development Plan (EDP)* (DHS 7831), *Personal Development Plan (PDP)* (DHS 7832), or TRACS Personal Development Plan.
- EIC brochures.

Legal Considerations

If the client does not have a driver's license, but does drive for doing job search, explore ways of helping the client get a driver's license or explore alternative means of transportation.

If the client has legal problems such as the need to do community service, fines, or is on probation, these will need to be taken into consideration in planning the job search.

Ethical boundaries/cautions

Clients who have recovered from A&D problems must not be referred to jobs providing access to alcohol or drugs.

Narrative/Data Entry

Coding for CMS: Work status.

Coding for TRACS: Enter PE, other activity codes and attendance on TRACS.

Coding for FSMIS: Work status.

Narrate: Employment goal, date of case plan, review dates, arrangements for transportation and child care, support service payments, progress towards goals.

Eligibility

Support services payments may be issued during the Pre-TANF Program prior to final determination of eligibility.

Principle-Based Outcome

Clients become employed as quickly as possible.

4. Work Status Focal Point; Almost Ready to Work

Principle-Based Decision

Work is better than welfare. Some clients need employment preparation activities and/or resolution of personal/family issues in addition to, or before seeking employment.

Assessment

- Review the *My Self Assessment* (DHS 7823).
- Identify what support services the client needs to do job search and become employed.
- Consider contacting previous employers to determine basis for the client's job losses.
- Explain tax credits (EIC and others).
- Explore transportation and child care options.

Possible questions

- What type of work are you looking for?
- What are your skills?
- What caused past job losses?
- What do you think you could do to solve the problems that caused the job losses?
- What support do you need to become employed?
- Are there family issues that need attention so that you can keep your job?
- How do you plan to get to work?

Staffing

- It is important to coordinate planning closely with staff in JOBS program.

Brokering

- Partners may include a variety of community resources/partners.

Resources

- Local: branch resource room.
- Central Office: information resource person.

Development of Plan

- Determine the employment goal.
- Job search will be an activity, if appropriate, based on the results of a labor market test.
- Determine what other goals need to be established to remove barriers to employment.
- Select activities to deal with these barriers from JOBS components and community resources. (GED class, work experience, JOBS Plus, vocational training, Life Skills, etc.)
- Identify what support payments will be needed: transportation, child care, etc.
- Establish time frames for review of quality of job search and progress towards resolution of other issues.

Tools

- *Job Search Verification (DHS 475), Employment Development Plan (EDP) (DHS 7831), Personal Development Plan (PDP) (DHS 7832), or TRACS Personal Development Plan.*
- EIC brochures.

Legal Considerations

Same as for Ready-to-Work.

Ethical boundaries/cautions

Same as for Ready-to-Work.

Narrative/Data Entry

Coding on CMS: Work status.

Coding on TRACS: Enter activities on TRACS, update attendance.

Coding on FSMIS: Work status.

Narrate: Arrangements for transportation and child care, support service payments, progress towards goals.

Principle-Based Outcome

Clients, who have received job preparation services and who have resolved personal/family issues become employed as quickly as possible.

5. Work Status Focal Point; Retention and Wage Enhancement

Principle-Based Decision

Working clients will remain employed at the same job or will obtain a better paying job.

Assessment

- Determine if the client has any issues that need to be resolved in order to keep the job.
- Determine if the employer has classes/training available for skill building.
- Determine what type of skill enhancement might lead to a better paying job.

- If the client has domestic violence issues, determine if the client would like to make a safety plan regarding employment.
- Explain transition services and available retention activities.

Possible questions

- How are your child care arrangements working out now that you are employed?
- Are you able to get to work okay?
- How are you getting along on the job?
- What has your employer said to you about how you are doing on the job?
- How are your children reacting to your working?
- What skills did your employer say you would have to have to promote?
- Would you be willing to take classes at night to gain skills?

Staffing

- Could include the current employer.
- May include community partner staff.

Brokering

- The community college's financial aid office may be able to help the client obtain funds for classes.

Resources

- Local: Community college.
- Central Office: Information resource person.
- If the client participated in JOBS Plus, the client will have an educational account that can be used to fund further skill training.

Development of Plan

- Identify new employment goal.
- Identify skill and include skill enhancing activities.

Narrative/data entry

Coding on TRACS:

- For clients who become employed while in the JOBS Program:
 - TRA.
 - Use one or more retention codes: RT, BR.
- For any employed client:
 - Use the appropriate specific TRACS activity code when one exists. For example: JS, SL, MH, PT, DA, etc.

Eligibility

- Clients are eligible for JOBS services for retention and wage enhancement after their TANF or Pre-TANF Program benefits close due to employment.
- Employed FS, ERDC, and OHP clients can receive retention and wage enhancement services even if they did not become employed while in the JOBS program.

☞ FOR MORE INFORMATION, SEE RULE 461-190-0211.

Principle-Based Outcome

Employed clients who receive services to help them retain their first job increase their income through working more hours, promoting, or getting a better job.

6. Work Status Focal Point; Child Care

Principle-Based Decision

When clients are working or participating in the JOBS program, their children are in safe, stable, and dependable child care that supports the child's development. Clients and child care providers understand the payment system. Clients understand the need to pay the provider the copay, and providers are paid promptly.

Assessment

- View the development of the child care plan as an integral part of the client's self-sufficiency plan for which the client and the case manager share responsibility.
- Coach the client on how to locate and select a quality child care provider using the "Four Steps to Select Your Child Care Provider" in the *Parent Guide to Child Care* (DHS 7478). Offer the client the local Child Care Resource and Referral phone number, and review the Provider Guide.

- Assist the client in determining if the child care situation does, or will, meet the children's needs.
- Explain the payment system including the need to pay the copay.
- Inform client about the agency requirements for child care providers, including completion of the listing form and the criminal background check.
- Explain the relationship between DHS and the child care provider (the client is the employer of the provider even though the agency makes payment), including what the case manager may discuss with the provider.
- Determine if the child needs a special payment rate due to a physical, behavioral or medical disability.
- Determine if the children's immunizations are up to date.
- On an ongoing basis, evaluate whether the work hours or JOBS activity hours correspond with the provider billed hours.
- Obtain the name, address and phone number of the child care provider.
- Determine whether the provider is a family provider or center.
- Discuss the implications for child care of odd work hours.
- Assist the client in problem solving on obtaining and retaining child care.
- Coach the client about the need to obtain a provider who can accommodate such things as overtime, alternatives for sick kids or sick providers, etc.

Possible questions

- Do your children have any special needs that a child care provider would need to deal with?
- Are the children's immunizations current?
- How is the day care arrangement working out for you and your children?
- What is the name, address and phone number of your child care provider?
- Do you have any concerns about the type of care your children are receiving?
- What would you do if your children become sick? ...you have to work overtime? ...your provider gets sick? ...your work schedule changes?
- Are the school holidays or summer vacation going to affect your child care arrangements?
- Who is your backup provider?

Staffing

- Could involve the child care provider and the client.
- May include the local Child Care Resource & Referral agency.
- May involve staff from other agencies client has contact with.

Brokering

- Advising client that providers may receive information about services for child care providers from the local Child Care Resource & Referral agency (information on the USDA Child Care Food Program, training on CPR and First Aid, support groups, help with billing DHS, help with collecting the copay from clients).
- Exploring with the local Child Care Resource & Referral agency what services may be available to the client and child care provider.
- Provide information on DHS payment systems and policies to child care providers. Address concerns of provider.

Resources

- Local: Child Care Resource & Referral agencies.
- Central Office: Direct Pay Unit, information resource person.
- For obtaining immunizations: OHP, county health department, 1-800-SAFENET for those with no medical coverage, also for county health clinic locations. The statewide Oregon Child Care Resource & Referral Network is available at 1-800-342-6712. For information on required immunizations, call Health Services at 503-731-4020.

Development of Plan

- Include updating immunizations (DTP, Hepatitis B, Polio, Measles/Mumps/Rubella, Hib Influenzae Type B, Varicella chickenpox).
- Direct the client to give the *Child Care Provider Listing* (DHS 7494) and the *Child Care Provider Guide* (DHS 7492) to the provider. The provider should refer to “How to Become a Listed Provider for the DHS Child Care Program” in the DHS 7492.
- Have the client use the “Finding and Keeping Good Child Care” section of the DHS 7478 as a guide to interview prospective providers.
- Have the client report to you the name, address and phone numbers of the child care providers.
- Set appropriate time frames for obtaining a child care provider.

Tools

- DHS: *Child Care Need Statement for Older Children* (DHS 7484),
DHS 7478, Special Need Child Care Rate Request (DHS 7486),
DHS 7492, DHS 7494 and Child Care Provider Letter (DHS 7494E).
- Certificate of Immunization Status: Available from the county health department for use by providers to record children's immunizations.
- Managing the Cost of Quality Child Care and Making Good Child Care Choices (brochures of the Child Care Division, Employment Dept.)

Legal Considerations

Child care providers must report child abuse to DHS. Providers must keep immunization records for children in care.

State law requires children in child care facilities to be immunized or in the process of completing their immunizations.

Confidentiality rules allow DHS staff to give information to child care providers limited to these items: case number and program of client, amount agency will pay, copay amount and reason for delay in agency's paying bill.

Child care providers, unless they are exempt, must be registered with or licensed by the Child Care Division.

The client, not DHS, is the employer of the child care provider. However, DHS is required to report payments of more than \$600 in one year to the IRS.

Narrative/data entry

Coding on CMS: For ERDC, enter work hours in CC Wrk Hrs and the number in the ERDC household in # ERDC. Entry in these fields generates the CCB if the listing information is on the system.

Coding on FSMIS: Use code CC for dependent care for working clients and enter the ERDC copay and child care cost above the DHS rate.

Coding on WSIT: Enter data in the WSIT screen to generate a JCCB.

Narrate: Narrate name, address, phone number of child care providers and which one is the primary provider. If a special rate is being paid, narrate the basis for the rate.

Eligibility

Use prospective budgeting to determine income amount for ERDC. Use the JCCB for JOBS participants when the provider is listed.

The agency will not continue to pay for child care if the client fails to pay the copay to the provider.

The child care provider cannot be under age 18; on the same TANF grant as the child in care; a sibling under age 18 who lives with the child; a parent/step-parent of the child; or a parent of the child's siblings, if all are living in the same household.

Dependent Care Costs; Deduction and Coverage: 461-160-0040

Providers must agree to these things:

- Not charge more for DHS-subsidized care than they normally charge other families;
- Keep daily attendance records for at least six months;
- Bill an hourly rate for children usually in care less than 158 hours per month;
- Allow DHS to review their records upon request;
- Cooperate with any investigation of a complaint, including a visit to the child care provider site, during hours when care is provided;
- Inform DPU of any arrests, convictions, or involvement with child welfare of themselves or persons living with them;
- Inform DPU of changes of name, address or of persons who live with them.

Principle-Based Outcome

Children of employed clients and clients in the JOBS program are cared for in safe, stable, and dependable child care that supports the child's development. Clients and child care providers understand the payment system, which results in clients paying the provider the copay, and providers receiving agency payment promptly.

7. Teen Focal Point; Teen Parents

Principle-Based Decision

Teen parents complete high school or obtain their GED, and then become employed as soon as possible.

- Teen parents do not have a subsequent pregnancy.
- Teen parents live in a safe environment.
- Teens have healthy infants.

☞ SEE FAMILY ISSUES FOCAL POINT; PREGNANT WOMEN AND WOMEN WITH INFANTS, IN THIS WORKER GUIDE (CM WG1.12).

Assessment

- Evaluate living situation. Is it safe? If not, explore safe alternatives. Is the teen living with his/her parents? If not, why? This may include consideration of whether the teen can return to the family's home.
- Determine if there are domestic violence issues regarding the teen's partner, father of the child or parents.
- Determine if infant/child is being adequately cared for. Assess parenting skills.
- Determine if the teen is able to select appropriate child care.
- Obtain information on the client's educational background/school attendance.
- Determine if the teen parent has a history of child welfare involvement.
- Determine if the infant/child is developmentally on target.
- Evaluate potential for early attachment to work.
- Identify possible A&D issues.

Possible questions

- How would you describe your living situation?
- How were your experiences in school? What grade have you completed?
- How is your baby/child doing?
- How do you feel about being a parent?
- How is your health? What are you doing to prevent additional pregnancies?

- Is there anything that would interfere with you attending school?
- How is the baby/child's father involved in your situation?
- How do you get along with your parents?

Staffing

- Include JOBS Teen component staff.
- Could include teachers.
- Could include staff at these agencies if the client is participating in the programs: WIC, Head Start, Healthy Start, Community Health Nursing, etc., and teen employment programs such as Project YESS.
- May include Child Welfare, A&D treatment provider if appropriate, juvenile authorities.

Brokering

- May include negotiating with parents and relatives for assistance for teen parent, absent safety concerns.
- May include linking teen parent to parenting classes and other services not provided as part of the local JOBS program component for teen parents.

Resources

- Local: Local teen parent groups, teen pregnancy prevention group, RAPP group or coalition.
- Central Office: Information resource person.
- Transportation could include a bicycle.
- There may be a need to work with other agencies in the community to develop resources.

Development of Plan

- Select an activity to reach the educational goal of high school completion or GED certificate (GED class, return to high school, alternative high school).
- After educational goal is met, include job preparation and job search activities.
- If living situation is not safe, establish activities to lead to a safer situation.
- Address health issues.

- Consider including a developmental assessment of the child through a Medichcek screening.
- Include expectation on attendance at school and time frames for evaluation of progress.
- Include participation in District Teen Parent program.
- Include Life Skills training.

Tools

- *Employment Development Plan (EDP)* (DHS 7831), *Personal Development Plan (PDP)* (DHS 7832) or TRACS Personal Development Plan.

Legal Considerations

Child abuse must be reported to Child Welfare.

If the pregnancy is a result of criminal acts including rape, incest, abuse and exploitation, report to law enforcement and work towards prosecution of predators. It is illegal for a person of any age to have sexual intercourse with a person under age 16, and those who are mentally defective, mentally incapacitated or physically helpless. It is illegal for a person over 18 to have sexual intercourse with a person under age 18. Nonconsensual sexual intercourse is illegal.

Ethical boundaries/cautions

DHS participates in the Governor's Teen Pregnancy Prevention, Oregon Action Agenda~1997.

Narrative/data entry

Narrate: Living situation.

Eligibility

Teen parents must live with their parents, legal guardian or adult relative unless it is a case management decision that this is unsafe or impractical.

If a teen parent returns to live with their parents and the parents' deemed income is over the income standard, the teen may continue to be eligible for medical coverage and JOBS support service payments. For this to happen, the teen must either be in high-school-level classes full time or participate with JOBS, or other program to develop employment or self-sufficiency skills.

☞ SEE TANF SECTION J FOR MORE INFORMATION ABOUT TANF ELIGIBILITY FOR MINOR PARENTS.

Principle-Based Outcome

Teen parents:

- Have healthy infants.
- Reside in safe living situations.
- Have no subsequent pregnancy.
- Become employed as soon as possible after completing their high-school-level education.
- Know the importance of assuming responsibility for personal choices.
- Understand short- and long-term consequences of safe, risky and harmful behaviors.
- Know communication strategies for avoiding potentially harmful situations; i.e., refusal skills and resistance to peer pressure.
- Know how to access community agencies that advocate for healthy individuals and families.

8. Teen Focal Point; Nonparent Teens on OHP/FS Not Living With Their Parents

Principle-Based Decision

Teens receive services to stabilize their living situation, enable them to complete their education and become employed.

Assessment

- Determine the nature of the living situation. Is it safe?
- Determine if there are health issues that need attention.
- Address family planning issues.
- Determine educational status/school attendance.

Possible questions

- How is your living situation?
- How are you getting along in school?
- What are your plans for the future?

- How is your health?
- What agencies are you working with?

Staffing

- School staff and health professionals may need to be involved.
- Include other agencies that are working with the teen.

Brokering

- Assist client in accessing services of other agencies.

Resources

- Local: Local services to homeless youth, homeless youth shelters, WIA.
- Central Office: Information resource person.

Development of Plan

- Include high school completion.
- Include attending to health issues/referral to Health Services for health care services, including family planning.
- Identify steps for securing a safe, stable living situation.
- Identification of future goals including additional education and employment.
- Include Life Skills training.

Legal Considerations

Youth can be emancipated from their parents at age 16. Consider whether this might be appropriate.

Narrative/data entry

Coding on CMS: Work status codes.

Coding on FSMIS: Work status codes.

Principle-Based Outcome

Teens:

- Become employed as soon as possible after completing their high-school-level education.

- Know the importance of assuming responsibility for personal choices.
- Understand short- and long-term consequences of safe, risky, and harmful behaviors.
- Know communication strategies for avoiding potentially harmful situations; i.e., refusal skills and resistance to peer pressure.
- Know how to access community agencies that advocate for healthy individuals and families.

9. Family Issue Focal Points; Domestic Violence

Principle-Based Decision

Clients with domestic violence issues become employed without jeopardizing their safety or the safety of their children.

Assessment

- Follow the process in the branch plan for identifying domestic violence.
- Check the application (items #5 and #6) to see if the response indicates domestic violence. Also, check forms *My Self Assessment* (DHS 7823), *Cooperating with Child Support Enforcement and Pursuing Third-Party Resources* (DHS 428A) and the DCS good cause form.
- May offer educational materials to clients about domestic violence.
- May include using the *Safety Assessment* (DHS 7802), and *Safety Plan - "Are you being hurt by someone you love?"* (DHS 7808).

Possible questions

- What about your living situation is unsafe?
- Tell me about what you think will keep you safe.
- What have you tried?
- What worked? What did not work?
- Have you worked with, or considered working with, a domestic violence resource advocate on safety planning?
 - If no, would you be interested in working with one?
- Have you considered getting a restraining order?

- What do you need to protect yourself and your family?
- Would you like help in developing a safety plan for you and your children?
- Is there someone in your life with whom you have had a relationship in which there has been physical, sexual, or emotional abuse?

(Read the following.)

- Pushing, grabbing, shoving, slapping, hitting, restraining?
- Being kept away from family and friends, prevented from leaving your home or going where you wanted to go?
- Being constantly put down, or told you are worthless?
- Receiving threats to hurt you, your children, your pets, or other family or friends?
- Being stalked, monitored, or followed?
- Has anything like this happened in the past?
- Are you afraid of your partner or ex-partner?
- Is the abusive person the parent of any of your children?

Staffing

- Staffings should be done early on, and include the domestic violence service provider and others assisting the client in leaving and staying away from the violence.
- Obtain the client's permission before discussing the case with other agencies.
- Domestic violence service providers may accompany clients to DHS interviews.
- Domestic violence service providers may be willing to accompany staff on home visits.

Brokering

- Partners may include police, the domestic violence service provider, district attorney, legal aid services, counseling providers, medical providers, Child Welfare and the CAP agency.
- County health departments are a source of specialized services to victims of domestic violence.

Resources

- Local: District point person for domestic violence, support groups and other services offered by local domestic violence service provider.
- Central Office: For calls on second or subsequent requests for TA-DVS within 12 months.
- Survivors may be eligible for unemployment if job loss was a result of domestic violence.

Development of Plan

- The *Domestic Violence Assistance Agreement* (DHS 1543) should be used when developing plans with survivors of domestic violence.
- Developing a plan should be as empowering as possible for the client.
- Safety issues must be considered regarding all activities and expectations.
- More short-term goals may be necessary.
- For counseling/therapy related to the effects of domestic violence, refer the client to the domestic violence service provider or other service provider that offers specialized counseling.
- Determine what agency resources will be used to support the activities.
- Domestic violence service providers should be involved in the development of the plan.

Tools

- Local assessment/identification tools; domestic violence crisis cards; domestic violence reference card for staff use; domestic violence library materials for staff use (books and videos), contact Central Office.
- Domestic Violence Staff Tools web page link:
www.dhs.state.or.us/training/dv/index.htm
- Other:
 - Restraining order information and other legal resources at www.oregonlawhelp.org
 - Face to Face Surgery Program, 1-800-842-4546 (program offers no-cost facial reconstructive plastic surgery to victims of domestic violence).

Legal Considerations

State law requires DHS to screen clients for domestic violence, and do community staffings and individualized family plans.

Ethical boundaries/cautions

Believe her; listen; do not minimize the violence; validate her feelings.

Clients are not responsible for the abuse they receive, but they are accountable for engaging in activities to move themselves toward self-sufficiency within the parameters of agency policy, taking safety concerns into consideration.

If the abuser is present, do not discuss or offer the items listed under **Tools**. The abuser may renew the violent behavior when the women does job search or becomes employed. Anger management classes and family counseling are not considered appropriate treatment for abusers.

Narrative/data entry

Coding on CMS: Program code "E2" on a new case. Use "DVS" Need/Resource code on new and currently open program 2, 82, P2 and M5 cases with the first month of eligibility. Use Special Pay reason 22 on 437 issuances.

Coding on TRACS: Code waivers related to domestic violence on TRACS. Refer to TANF Section K for detailed information.

Use "DV" activity code when clients participate in activities directly related to Domestic Violence Intervention.

Narrate: If there are safety concerns about the narration on domestic violence, you may put the narration on a separate sheet of paper which can be easily removed if it is appropriate for non-DHS staff individuals review of case file.

Eligibility

No verification of domestic violence is required. Accept the client's statement.

Eligibility requirements may be waived temporarily for TANF if those requirements make it more difficult for individuals to escape domestic violence or place them at risk of further, future violence. See policy for exceptions to the waiver regarding citizenship, income and resources.

Principle-Based Outcome

Clients who have domestic violence issues are employed and are at minimal risk of future abuse.

10. Family Issues Focal Point; Alcohol and Drugs

Principle -Based Decision

Clients with alcohol and drug problems will have their chemical dependency identified, receive appropriate treatment and become employed as soon as possible.

☞ SEE THE FAMILY ISSUES FOCAL POINT; HEALTH ISSUES (PHYSICAL, MENTAL, INTELLECTUAL) IN THIS WORKER GUIDE (CM WG1.11).

Assessment

- Look for patterns of behavior that indicate A&D issues.
- Use A&D screening and assessment providers to identify these issues as early as possible.
- Be alert to behavior that indicates relapse.
- Be alert to the possibility of other health issues, caused by, or related to, the A&D problems.

Possible questions

- Have you lost a job for excessive absence?
- Have you lost a job due to accidents on the job?
- How do you think drinking/drug use has affected your family?
- Have you ever been arrested for DUI? How many have you had?
- Are you struggling with a spouse, partner, friend, parent, child or sibling who you feel is abusing drugs or alcohol?
- Are you currently using alcohol or drugs? If not, when was the last time? What were you using and how often?

Staffing

- Include treatment providers.

- May include the DHS Disability Liaison.

Brokering

- Evaluate whether the treatment and other services the client receives is moving the client closer to becoming employable.

Resources

- Local: Client's health plan, chemical dependency treatment programs, AA, Alateen, Al-Anon, NA.
- Central Office: Disability Liaisons, information resource person.

Development of Plan

- Set time frames for client making appointments for treatment.
- Include the treatment plan.
- Include dates for evaluation of progress.
- Identify the type of support group the client will participate in on a long-term basis following treatment.
- Determine if other family members have A&D issues that need resolution and identify actions client could take regarding them.

Tools

Documentation: *Administrative Medical Examination/Report Authorization (DMAP 729); Comprehensive Psychiatric or Psychological Evaluation (DMAP 729A); Report on Eye Examination (DMAP 729C); Medical Record Checklist (DMAP 729D); Physical Residual Function Capacity Report (DMAP 729E); Mental Residual Function Capacity Report (DMAP 729F).*

Releases: *Authorization for Use and Disclosure of Information (DHS 2099), 419M, 532.*

Legal Considerations

A&D providers may have their own release of information forms.

Some medical documents may have "Not for further release" stamped on them. If so, this means you cannot give copies of these documents to any other agency or person. Other agencies or persons will need to obtain the documents directly from the original source.

Ethical boundaries/cautions

It is not acceptable to pay fines for traffic tickets, directly or indirectly. It is acceptable to advise the client about contacting the probation officer and judge about alternatives to paying the fines.

Narrative/data entry

Coding on CMS: Medical review date, work status codes.

Coding on TRACS: Record DA on TRACS, update attendance.

Coding on FSMIS: Work status codes.

Narrate: Results of evaluations, who did it, the date done; do tickler for dates progress is to be evaluated, dates for expiration of doctor's notes, date treatment will be completed, expiration dates for release of information forms.

Eligibility

Recipients of TANF must participate in substance abuse diagnostic, counseling and treatment programs if this is necessary for the individual to be able to work. Failure to cooperate with this requirement can result in the individuals' disqualification for JOBS mandatory clients. For JOBS exempt clients, cooperation with the requirement is an eligibility requirement for TANF.

☞ SEE SECTION D.7. OF THE TANF CHAPTER FOR MORE INFORMATION

Principle-Based Outcome

Employed clients with resolved chemical dependency problems, who are able to maintain long-term employment.

11. Family Issues Focal Point; Health Issues (Physical, Mental, Intellectual)

Principle-Based Decision

Clients who are able to work, even though they have health problems, seek employment. Whenever possible, clients participate in employment preparation activities concurrently with taking steps to resolve their health problems.

- Clients whose health problems preclude immediate employment, seek medical and rehabilitative services to help them become employable.
- Clients who have been medically determined to be unable to work may apply for SSI/SSD.

- Clients who are needed in the home to care for dependents with disabilities receive support services to enable them to prepare for employment, unless this puts an undue hardship on the family.

Assessment

- Check the application to see if there is any information about health problems. Also, check the *My Self Assessment* (DHS 7823) form.
- Look for patterns of behavior that indicate mental health issues.
- Use mental health screening and assessment providers to identify these issues as early as possible. Also consult with the Disability Liaisons.
- Obtain any documentation that the client has regarding the health issue.
- Authorize administrative exams to obtain current information from medical providers on the health problem using the DMAP 729 series of forms.
- Explore OVRs for those needing rehabilitative services.
- Explore SSI /SSD for those unable to perform any work.
- Explore the DHS Spousal Pay Program for two-parent families where one parent is on SSI or SSD and is dependent on the other parent for care with four of the six activities of daily living.
- Be alert to behavior that indicates relapse.

Possible questions

General (and physical)

- How does your health problem affect your activities of daily living (housework, shopping, cooking, care of children, etc.)? How does it affect your ability to work?
- Could you work if you had some accommodation made for you on the job?
- When was the last time you saw the doctor? What did the doctor say? Did the doctor restrict your activities? If so, how?
- What medications are you now taking, and for what condition? Does your doctor have you in a treatment plan? If so, what treatment are you receiving now?
- Are you receiving Workers' Compensation? Are you receiving services through SAIF?

Intellectual Functioning

- Were you in special education classes in grade school or high school? What were you told about why you were in special classes? Do you have your IEP from school?
- Have you lost jobs because you were too slow?
- How well do you think you understand written information?
- How easy is it for you to follow written instructions?
- Do you need help with following recipes, going shopping, keeping a checkbook, using a stove or washing machine, etc.?

Mental Health

- How hopeful do you feel right now about the future for you and your family?
- How would you describe your appetite and sleeping patterns?
- What have you done in the past when you have needed help with a personal problem?
- Have you had many trips to the emergency room? If so, for what problem?
- Have mental/emotional problems affected your ability to seek or maintain employment in the past? If so, how?

Needed in home to care for child/spouse with disabilities

- What has the doctor said about why you are needed in the home to care for your child/spouse with disabilities?
- Is there anyone who can care for your child/spouse with disabilities while you work?
- What kinds of things do you need to do for your child/spouse with disabilities that they cannot do for themselves?
- Is the child/spouse's disability progressive or chronic? Will the condition improve to the point where the child/spouse with disabilities will not need a high level of care?

Staffing

- May include the DHS Disability Liaison, treatment providers, medical providers, OVRs staff, community health nurses, Goodwill, etc.

- If the client has multiple health problems, coordination of treatment among all health care providers involved will be necessary.
- Documentation should be submitted to the Disability Liaison prior to staffing with them. (Disability Liaisons are always available for informal discussion of what type of medical evaluation is appropriate to request for a particular client.)
- Staffings should be done early on if the client is already involved with other agencies such as OVRs, SAIF.

Brokering

- Evaluate whether the treatment and other services the client receives is moving the client closer to becoming employable.
- Negotiate with OVRs regarding how much it and DHS will mutually spend on support services for clients going through rehabilitation.
- Explore whether the client can be certified as a care provider for the dependent with disabilities.
- Explore whether a special child care rate can be authorized for the child with disabilities, if under age 18.
- Explore whether respite care is available for the dependent with disabilities.
- To explore eligibility for the Spousal Pay Program, make a referral to the local SPD office.

Resources

- Local: Client's health plan, county health clinic, chemical dependency treatment programs, psychologists, psychiatrists. For employment opportunities for clients with limited intellectual functioning, contact OVRs, sheltered workshops, Goodwill.
- Central Office: Disability Liaisons, information resource person.
- Possible referral to SFPSS.
- Other: Prepaid Health Plan Coordinators (DMAP) and Exceptional Needs Care Coordinators (Managed Care Plans).
- This may include identifying services such as psychological testing that are an unmet need and seeking access to or creation of a resource.

Development of Plan

- Consider consulting the Disability Liaison for help with developing an appropriate case plan for clients applying for SSI/SSD and clients with severe medical problems who do not meet the SSI/SSD criteria.
- Encourage SSI/SSD applicants to seek legal representation to help pursue these benefits.
- Set time frames for client making appointments for further evaluation of condition.
- Determine self-sufficiency activities that the client can participate in while evaluation of condition takes place (GED class, work experience, ESL class, solving family problems, getting drivers license, stabilizing living situation, etc.).
- Consider consulting with Disability Liaison for appropriateness of activities given the client's medical condition.
- If treatment is appropriate, include the treatment plan and time frames.
- Include expectations for other agencies (OVRs, SSA) and resources the client will contact.
- Include dates for evaluation of progress.

Tools

Documentation: *Administrative Medical Examination/Report Authorization (DMAP 729); Comprehensive Psychiatric or Psychological Evaluation (DMAP 729A); Report on Eye Examination (DMAP 729C); Medical Record Checklist (DMAP 729D); Physical Residual Function Capacity Report (DMAP 729E); Mental Residual Function Capacity Report (DMAP 729F).*

Computer screens: BEIN (information on SSI, SSD, SSB, & Medicare, and appeal of SSA denial of benefits)
WQTR (# of quarters paid into SSA system; also see TPQY, F23 from BEIN)
VCLQ (identifies OVRs clients, their OVRs counselor, disability diagnosis, OVRs plan status, & employment information)

Referrals: *Interagency Referral (DHS 224), JOBS Referral for Services (DHS 7841), Disability Referral (SDS 708), Referral to VRD (SDS 927)*

Releases: *Authorization for Use and Disclosure of Information (DHS 2099), 419M, 532.*

Legal Considerations

For most medical providers, a release of information form will need to be signed by the client for the case manager or Disability Liaison to receive medical documents.

Be cognizant about the confidentiality rules pertaining to HIV and AIDS.

Some medical documents may have “Not for further release” stamped on them. If so, this means you cannot give copies of these documents to any other agency or person. Other agencies or persons will need to obtain the documents directly from the original source.

Ethical boundaries/cautions

It is important not to assume that a client who has health problems cannot work.

Medical documentation must include the following items to be useful for case management planning or eligibility determination:

- Description of the health problem (diagnosis).
- Testing and evaluation results, why the doctor thinks the client has a health problem (clinical findings, psychological or psychiatric evaluations or testing x-ray reports).
- What treatment or other things the doctor thinks will improve the health condition (treatment plan).
- What the time frames are for the treatment to be effective or the condition to be fixed.
- What the doctor thinks the prospects are for improvement (prognosis).
- How the condition affects the client’s ability to work.
- What limitations has the doctor placed on the client regarding lifting, walking, sitting, etc.

Medical documentation is acceptable only from medical and osteopathic doctors, optometrists, and licensed psychologists and psychiatrists. For casework planning purposes only, documentation is acceptable from licensed social workers, licensed physical therapists and licensed occupational therapists.

For ABAWDs only, documentation from any medical practitioner is acceptable, and need not contain the depth of information required by other programs.

Clients with back problems need to be evaluated by an orthopedist. Clients with mental health problems need to be evaluated by a psychologist or psychiatrist, not a general practitioner.

A good resource for interpretation of medical reports is your Disabilities Liaison.

For the Spousal Pay Program, the care giver is paid to care for the dependent spouse with disabilities if the spouse with disabilities needs help with four out of six activities of daily living: eating, dressing/grooming, bathing/personal hygiene, mobility, bowel/bladder management, and cognition (and behavior). An assessment of the level of care is determined, and a service plan is created. The amount of pay is based on the level of care needed by the spouse with disabilities. Examples of disabilities requiring spousal care are: cancer, Lou Gehrig's disease, MS, CP.

Narrative/data entry

Coding on CMS: SSI and Incap case descriptors, medical review date, work status codes.

Coding on TRACS: Record health related activities (MH, ME, SS) on TRACS.

Coding on FSMIS: Work status codes.

Narrate: Results of medical evaluations, who did it, the date done; do tickler for dates progress is to be evaluated, dates for expiration of doctor's notes, treatment will be completed, expiration dates for release of information forms.

***Note:** Managed Care Health Plans will continue to remail the member handbook to the client as long as the post office puts a forwarding address on the envelope. Absent a forwarding address, the health care plan will send the item to the branch.*

Eligibility

Recipients of TANF must participate in mental health and/or substance abuse diagnostic, counseling and treatment programs if this is necessary for the individual to be able to work. Failure to cooperate with this requirement can result in the individual's disqualification for JOBS mandatory clients. For JOBS exempt clients, cooperation with the requirement is an eligibility requirement for TANF.

To meet the incapacity deprivation requirement for TANF, one parent must have a medical condition that is expected to last 30 days from the date of request for TANF. The condition must substantially reduce or eliminate the parent's ability to support or care for their children.

☞ FOR MORE INFORMATION ABOUT DEPRIVATION BASED ON INCAPACITY, SEE TANF E.5 AND E.6.

Principle-Based Outcome

Clients with health problems go to work as soon as is practical.

- For some, this means rehabilitation occurs first.
- For others, it means pursuing SSI/SSD if they appear likely to meet the program's criteria.
- For clients caring for dependents with disabilities, it means receiving agency help in exploring alternative care and resources and engaging in employment preparation activities unless this creates a hardship for the family.

12. Family Issues Focal Point; Pregnant Women and Women with Infants

Principle-Based Decision

Pregnant women and women with infants become employed as soon as possible.

- Pregnant women give birth to healthy infants.
- Pregnant women and women with infants prepare for employment by making satisfactory child care arrangements and taking care of the children's basic health needs.
- Women are encouraged and supported in their efforts to breast-feed their infants, including after they become employed. Infants who are breast-fed for the first year of life will experience health, nutritional and developmental benefits. An employed mother of a breast-fed infant will miss fewer days of work because her infant will be healthier.

Assessment

- Determine if the client is receiving prenatal care/vitamins.
- Determine if immunizations for infants/toddlers and mothers are up to date.
- Determine if the client is prepared for the arrival of the baby, i.e., clothes, diapers, equipment such as car seat, crib.
- Determine if paternity has been established.
- Determine if the client needs support in breast-feeding her infant, especially if she plans to work.
- Identify possible A&D issues.

Possible questions

- How do you feel about becoming a parent?
- Do you have any concerns about your baby?

- How is your prenatal care going?
- Are you prepared at home for the baby's birth? (Crib, car seat, clothing, etc.)
- Do you have family or friends you can talk to and count on to provide emotional support for you and the baby?
- Is your baby on schedule for immunizations?
- Do you need support to continue breast-feeding your infant?
- What do you think you need to do to continue breast-feeding your infant after you become employed or you return to work?
- What do you think you need to do to prepare to work after the baby's birth?
- What do you think you could do while you are pregnant to prepare to work?
- What can you count on the father of the baby for regarding acknowledging paternity, supporting the baby financially, medical insurance coverage, participating in child rearing, etc.?

Staffing

- Staffing with the Department of Child Support (DCS) or the district attorney may need to occur regarding paternity and child support issues.
- Staffings may include WIC and community health nurses regarding health issues, developmental issues, and breast-feeding issues.
- Staffings may need to occur often for clients who have a high-risk pregnancy, a failure-to-thrive infant, or an infant with other medical problems.

Brokering

- Support services may be available from WIC (nutrition classes, etc.), community health nurses, medical providers, and early intervention programs such as Healthy Start.

Resources

- Central Office: WIC brochures can be ordered through Distribution Services.
- For locations of WIC program, call 1-800-723-3638. For La Leche League breast-feeding support services, call 1-800-525-3243. For information on required immunizations, call Health Services at 503-731-4020.

Development of Plan

- Consider including activities such as attendance at WIC classes, obtaining immunizations for self and baby, obtaining prenatal care, birth preparatory classes, obtaining equipment needed for baby, obtaining a breast pump, and attending parenting classes.
- If immediate employment is not an option, activities could include GED classes, skill building training, work experience, or volunteer work.
- Evaluating the progress could be timed to coincide with the developmental time table for children or immunization schedule.
- If homelessness or risk of homelessness is an issue, stabilizing housing could be a goal.
- If paternity and child support have not been established, accomplishing this would be a priority.

Legal Considerations

Report child abuse to Child Welfare.

It is illegal to discriminate against pregnant women in hiring practices.

All state agencies are directed to institute practices supporting breast-feeding mothers. (Executive order EO-99-10, signed by Governor John Kitzhaber on June 24, 1999.)

A woman may breast-feed her infant in public. (Senate Bill 744, signed into law on June 24, 1999.)

Ethical boundaries/cautions

Even though women in their ninth month of pregnancy and those within six months after the baby's birth cannot be disqualified, they can be encouraged to use this time to take advantage of appropriate activities to prepare for employment, parenting or other family stability activities.

Narrative/data entry

Coding on CMS: JOBS exempt status for the ninth month of pregnancy and the first six months of the baby's life if the client elects to take the exemption for clients 20 and over, and 16 weeks for clients 19 and under.

Coding on TRACS: Put PT if appropriate on TRACS.

Coding on FSMIS: Work status.

Eligibility

There are limitations on the amount of JOBS activities that can be required of pregnant clients in the seventh and eighth month of pregnancy if they are age 20 or older.

The following groups are exempt from disqualification for noncooperation with JOBS: pregnant women age 20 and older, who are in their ninth month; and clients 20 and older during the six months after giving birth. Clients under age 20 for 16 weeks after the birth of their child.

☞ SEE SECTION F.3. AND 4. OF THE TANF CHAPTER

Principle-Based Outcome

Pregnant women and women with healthy infants, who have resolved their child care and health issues, become employed as soon as possible.

13. Family Issues Focal Point; Youth/Child Issues

Principle-Based Decision

Youth/child issues (education, juvenile justice, Child Welfare) are effectively resolved so that clients will be able to become employed and retain employment.

☞ SEE “CHILDREN LIVING WITH ADULTS WHO ARE NOT RECEIVING CASH BENEFITS” IN DETERMINING THE APPROPRIATE FOCAL POINT OF CASE MANAGEMENT, IN THIS WORKER GUIDE (CM WG1.2).

Assessment

- Determine if the children are attending school regularly.
- Determine if there are any children’s issues that need attention to avoid interfering with the parent’s employment.
- Determine if the client is involved with partner/other agencies regarding their children.
- Determine if Head Start would be an appropriate option for the child.

Possible questions

- Are there any issues regarding the children that concern you?
- Have any issues regarding your children caused you to lose a job?
- How are your children doing in school?

- What sort of grades are they getting?
- Are they participating in any school activities?
- How is your children's health?
- Are other agencies helping your children? If so, how?

Staffing

- May involve school personnel such as teachers, social worker, or counselor.
- May involve juvenile authorities.
- May need coordinating with parent-teacher conferences.
- Child Welfare staff may need to be involved.
- Coordination among agencies serving the family may be needed.

Brokering

- Assist client with accessing other agency services.
- For youth not in school, consider helping the individual access the Job Corps, YESS program, GED classes and other educational/employment-related programs.

Resources

- Local: Child Welfare, School District, Park Department for recreation programs.
- Central Office: Information resource person.

Development of Plan

- Identify what needs to be done to help the children be successful in school.
- Identify any health needs and assign activities to resolve them.
- Determine steps needed to coordinate services among agencies helping family.
- May include requiring the client to meet partner agencies' expectations.

Eligibility

Youth who are not attending school regularly must participate in JOBS.

Children who are 18 years old are not eligible for cash assistance unless they are attending high school full time.

Principle-Based Outcome

Employed clients have their children's issues regarding education, juvenile justice and Child Welfare resolved to the point that these issues do not interfere with employment.

Women who are breast-feeding their infants are encouraged and supported in their efforts and become employed as soon as possible.

14. Family Issues Focal Point; Noncustodial Parents

Principle-Based Decision

Noncustodial parents become employed in order to pay child support.

Noncustodial parents become a meaningful contributor to their child's upbringing, absent safety issues.

☞ SEE THE WORK STATUS FOCAL POINTS EARLIER IN THIS SECTION, (CM WG1.3), (CM WG1.4), (CM WG1.5) AND (CM WG1.6).

Assessment

- Determine if parent needs help in obtaining employment.
- Determine if parent has any issues that need to be addressed before job search can begin.
- Determine if parent needs help resolving family issues such as visitation.
- Determine if parent has A&D or other health issues.
- Determine if parent needs assistance in stabilizing their living situation.
- Determine if parent needs help with parenting issues.
- Determine if a modification of the support order is needed.

Possible questions

- What do you need in order to become employed?
- Do you have concerns about your children?
- Do you have any health issues that need attention?
- Do you have concerns about your relationship with your children's mother?
- How do you feel about paying child support?

- Have alcohol or drug use led to problems for you?

Staffing

- Consider including the noncustodial parent's case manager in staffings, if the parent has an open case with DHS or another case management agency.
- Consider including staff from DCS and the JOBS program.
- May include other community agencies such as those providing mediation services.
- Obtain custodial parent's consent before sharing information about their case with others involved with the noncustodial parent.

Brokering

- Coach parent on how to access community services for housing, help with visitation, etc.
- Coach parent in how to work with DCS.

Resources

- Local: Mediation services, local DCS office.
- Central Office: Information resource person.

Development of Plan

- Identify activities that will lead to employment.
- Identify steps toward resolving family-related issues.
- Include any other child support related activities.

Tools

Brochure: District 6 has a brochure inviting noncustodial parents to participate in their program. This could be customized for other districts.

Legal Considerations

Check with DCS regarding child support requirements.

Be aware of confidentiality issues regarding the release of information on child support and paternity.

Ethical boundaries/cautions

Be alert to safety concerns on behalf of the noncustodial parent's family (domestic violence issues).

Narrative/data entry

Coding on CMS: Put E in the JOBS status field; use the WTW case descriptor if the parent meets the welfare to work criteria or is a participant in the District 5 and 6 obligor JOBS program.

Coding on TRACS: Put Y in the Obligor field on TRACS.

Coding on FSMIS: Appropriate ABAWD/OFFSET coding.

Narrate: Noncustodial parent's needs, visitation issues, child support issues including when payment began, modification of support order.

Eligibility

OHP should be explored for A&D and mental health services. If eligible for food stamps, explore ABAWD/OFFSET for support service payments. Noncustodial parents are eligible for JOBS support service payments. (Use OFFSET payments only if JOBS cannot be used.)

Principle-Based Outcome

Noncustodial parents become employed and pay child support as soon as possible. Noncustodial parents are a positive factor in their children's lives.

15. Family Issues Focal Point; Housing

Principle-Based Decision

Clients with stable housing are more likely to find and maintain employment.

Assessment

- Use the *Application for Services (Food Stamps, Cash, Child Care, Medical, Domestic Violence)* (DHS 415F) and *My Self Assessment* (DHS 7823) to identify possible housing issues.
- Determine the nature of any housing issues. Are they related to high cost of housing, no credit history, poor rental history, history of evictions, poor credit history, domestic violence or need for drug/alcohol-free housing.

- Assess whether or not housing is a factor that is impacting the client's ability to follow through with JOBS activities or as a reason they have lost jobs.

Possible Questions

- How long have you lived at your present address? How is that working for you?
- Tell me about any problems you are having related to housing. How are you handling those?
- What help (if any) have you accessed related to housing? How did that work for you?
- What are your plans related to housing?

Staffing

- Joint case planning with the client and Community Action agencies or other housing programs that address housing stabilization or self sufficiency may reduce the likelihood of long-term housing issues.
- Obtain the client's permission before discussing their case with other agencies.

Brokering

- Assist the client in locating appropriate housing resources. Appropriate housing type may depend on other challenges that the client may be experiencing. Examples might include temporary housing needs, including family shelters (for homeless clients), domestic violence shelters or other safe housing (for clients experiencing domestic violence), drug-or-alcohol-free housing (for clients in recovery), transitional housing (for families who need case-management services while looking for permanent housing), low-income housing (for families with limited income or resources).
- When other challenges (not directly relating to housing) are contributing to the client's inability to find housing, such as poor rental history or poor credit, refer to local services that might help with these issues.

Resources

- Community Action Agencies (CAA) for Housing Stabilization Program, utility assistance and other emergency housing assistance. You can find your local CAA at: <http://cado-oregon.org/members.htm>
- Housing and Urban Development (HUD) and Housing Authority Programs (HAP) for public and subsidized housing or purchasing options for low income families. You can access information about local resources at: <http://www.affordablehousingonline.com/housingauthority.asp?State=OR>

- Domestic violence service providers for emergency shelter and possibly transitional housing. Information about local providers is available at: <http://www.dhs.state.or.us/abuse/domestic/gethelp.htm>
- A&D and MH service providers for referral to drug/alcohol-free housing.

Resources for associated issues

- Legal aid web page: www.oregonlawhelp.org for landlord tenant information and resources.
- Credit counseling agencies.
- “Good renter” programs.
- Oregon Telephone Assistance Program (OTAP) at 1-800-848-4442, or TTY users at 1-800-648-3458.
- Local utility companies.

Development of Plan

- Plans related to addressing housing issues should be specific. Getting a roommate or finding a job are great goals, but the plan should include the steps the client is planning to take to reach these goals.
- In the planning process determine what agency resources will be used to support the client in finding and securing housing.

Principle-Based Outcome

- Housing issues are no longer a barrier to the client accessing or maintaining employment.

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E. Eligibility Requirements

Refer to TANF nonfinancial eligibility requirements except as follows:

- TA-DVS eligibility is based on a client's current or future risk of domestic violence.
- Citizenship/alien requirements may be waived if the client is fleeing or at risk of domestic violence (refer to TANF section K).
- Do not waive the requirement to be a parent, caretaker relative or dependent child, or to live with a caretaker relative, but do give the caretaker a reasonable period of time to regain physical custody of the children if they are not currently with the caretaker due to the domestic violence situation (refer to TANF section C.3).

Note: If the child is expected to be out of the home for more than 90 days, staff the case with a lead worker or Operations Manager to determine what is reasonable.

Note: If the only child is in Child Welfare custody and the parent does not have care, control and supervision of the child, check with the Child Welfare worker to determine when the child will likely be returned to the client. If Child Welfare is unable to say it is likely to be within 90 days, deny TA-DVS, but let the client know she can reapply when the child is returned. Refer to other appropriate resources.

- TANF eligibility requirements may be waived if they make it more difficult for a client to escape domestic violence or if they put a person at risk of harm by domestic violence. (Refer to TANF section K.)
- No periodic redetermination is required.
- Child support should only be pursued if client requests as part of case plan.
- No penalty should be assessed for failure to cooperate with the Child Support Program.
- Waive the requirement for a pregnant woman to be in the calendar month before the month in which the due date falls when the client has a current safety concern or is at risk due to domestic violence.

Note: Federal law requires tracking of all TANF/TA-DVS requirements waived due to domestic violence. If a requirement is waived, record it in TRACS.

- The client must be a resident of Oregon at the time of application, but does not have to have an intent to remain in Oregon.
- Waive the TANF requirement (OAR 451-135-0070) for a caretaker relative in the need group to not have separated from their most recent employment for a reason that would or did result in disqualification from unemployment when there is current domestic violence or a risk of future domestic violence.

☞ SEE TANF SECTION K.3 FOR MORE INFORMATION ON CODING WAIVERS.

No redetermination: 461-115-0430
TANF DV policy: 461-135-1200
Child Support and Eligibility: 461-135-1225

K. Issuing Payments and Notification

1. Deciding When To Make A Payment and Appropriate Notices

TA-DVS payments can be made for items listed under program benefits. Payments totaling up to \$1,200 can be issued as necessary over the 90-day eligibility period. TA-DVS is not intended to meet ongoing or recurrent needs. Benefits of the program are listed in TA-DVS H. Items that are not listed as program benefits but that address safety concerns can also be purchased.

Payment decisions should be made as quickly as possible to avoid putting the client at further risk of domestic violence.

Denial of payments which do not meet program guidelines does not mean the client is ineligible for other qualifying payments.

On occasion DHS will issue a payment to a landlord, and then for some reason the client will not want to move into the new residence or something happens that the landlord does not make the residence available as agreed. DHS would only reissue the payment if the landlord agrees to return the check or the landlord does not make the residence available in a timely manner and the client's safety remains at risk (contact Central Office so a bill can be issued to the landlord). If the client changes their mind about the location for reasons unrelated to safety, then DHS would not reissue the funds. A decision notice denying the payment would be issued and should note the funds requested are not needed to address a safety issue.

If all TA-DVS funds have been issued and later the abuser finds the client at their new residence, consider the use of support services to help the client to relocate.

Benefits; TA-DVS: 461-135-1230
Standards for Support Services: 461-190-0211

Notices:

No notice is required if a payment is approved.

If a payment is denied or a modified payment is made under the TA-DVS program, provide the client with a *Notice of Decision and Action Taken* (DHS 456) which states the reason for denial or the modification.

Hearings:

Sometimes clients will request TA-DVS payments for items that are not listed under benefits of the program (see TA-DVS-H – Program Benefits), or they may ask for payments that are above the TA-DVS payment standards. As in TA-DVS program denials, when payments are denied (fully or partially), clients are eligible for expedited hearings.

☞ SEE SECTION L OF THE TA-DVS – HEARINGS; OVERPAYMENTS; INTENTIONAL PROGRAM VIOLATIONS (DV L.) SUBCHAPTER.

Expedited Hearings: 461-025-0315
TA-DVS; Benefits of the Program: 461-135-1230

2. Housing-Related Payments

When issuing shelter-related payments, the client's immediate safety needs must be addressed. Make all attempts to help the client access affordable housing. If the client's future housing and utility costs exceed the client's future income, the *DV Assistance Agreement* (DHS 1543) should address how the client will pay subsequent shelter costs.

It is often appropriate to verify landlord information in TA-DVS cases for the purpose of issuing a dual payee or vender payment. If TA-DVS housing payments are questionable and cannot be verified in a timely manner, then housing payments should be limited to motels or shelters. As with other eligibility factors, document the information as quickly as possible to avoid delays that may lead to increased risk of domestic violence.

Regarding hotels and motels. *When using motels or hotels, the use should be limited to addressing immediate safety issues. The intent, when safe housing is an issue, is to help the client find safe, stable housing, not to pay ongoing costs to stay in a hotel or motel.*

Limitation on payments: *It is inappropriate for landlords to ask for more money from our clients than other potential renters. In this type of situation, you would inform the landlord that you are only able to pay the same amount they would ask of other prospective renters. If the landlord continues to ask for more money, notify the client of the maximum we can pay (what the landlord asks from other prospective renters) and that the landlord is requesting them to pay more. The client has the option of paying any additional amount requested. The client may want to contact a legal aid organization to see what rights they may have in this situation.*

Regarding evictions and inability to pay current rent: *Receiving an eviction notice or being unable to pay rent does not automatically make a client eligible for TA-DVS rental payments. Assess the cause of the eviction or inability to pay rent. Issue payments if the eviction or inability to pay was related to domestic violence and the client intends to stay in their home. Examples of evictions or inability to pay that are domestic violence related:*

- Nonpayment of rent by the abuser;
- Evicted because of damage done by the abuser;
- Evicted because of the domestic violence (refer the client to the legal aid organization in your area to see if the landlord can legally evict under these circumstances);

- The client was unable to pay rent because of missed work related to the domestic violence; and
- The client used the rent money to keep herself and/or her children safe (i.e., used the money for motels or other temporary housing).

If an eviction is for a nondomestic-violence-related reason, you can refer the client to your local legal aid office to learn more about their rights, or they can access information online at www.oregonlawhelp.org.

A referral to your local housing resources including to the Community Action Agency for the housing Stabilization Program may also be appropriate.

Regarding homelessness: *The number one reason that women and children are homeless in the United States is domestic violence. If a person's safety is at risk due to domestic violence, then TA-DVS funds may be issued whether or not the client is homeless. If the homelessness is not related to domestic violence and the client's safety is not currently at risk due to domestic violence, refer the client to other housing resources in your community.*

TA-DVS; Who is Eligible for the Program: 461-135-1215

3. Roommates

1. Payments should only be made to roommates if the person is a property owner or has permission from the property owner to sublet.
2. When a client and people not in the filing group are moving into a new home together, the people moving with the client are expected to pay a portion of the move-in costs.

Sharing Assistance Prohibited; exception: ORS 412.099

4. TA-DVS Payment Considerations

Consider the following before making a TA-DVS payment:

- Are there lower cost alternatives available?
- Can the item requested be accessed through a community resource (i.e., used furniture versus purchasing new furniture)?
- Does the client have income available to meet the need (in this type of case negotiate with the client about what they can pay and what we can help with)?
- Is the item nonessential (e.g., television, cable, Internet, etc.)?

- Does the item address a domestic-violence-related safety concern or is the request for something self-sufficiency related (i.e., payment for car insurance)?

Note: Do not delay a payment to pursue alternative resources if doing so increases the risk of further domestic violence.

5. Issuing the Payment

Payments should be used as vendor or dual-payee checks (both the client's name and vendor's name will be on the check and both will have to sign off). Payments should only be made directly to the client when it is unsafe to use the dual-payee or vendor-pay process.

Examples of common TA-DVS payment options used in the field:

- Pay landlord/property management companies directly (the client's name should be on the rental agreement/lease).
- Pay utility companies directly (the utilities should be in the client's name).
- Ask the client to get estimates for other items and then pay the vendor directly.

When moving out of state:

- Pay bus companies, train companies or airlines directly.
 - Though we look for lowest cost alternatives we can consider factors such as the age of the child(ren) and length of travel time in determining appropriate method of travel.
- Purchase a pre-paid gas card to cover gas when the client is moving out of state (if making a gas payment for a person vehicle, the client or driver needs to have a valid driver's license).
- Pay for car repairs when lower-cost transportation is not available. (Car repairs can only be made on vehicles owned by the client).
- Arrange motels in advance and have the vendor bill us or issue payments directly to the motel.
- Purchase gift cards from restaurants (such as fast food restaurants or restaurants such as Denny's, IHOP, etc.) that can be accessed during the trip.

Examples of options used by workers when vendor/dual-payee payments are not an option:

- If the vendor will not accept a state check, then use another vendor.

- Use a local travel agent to arrange for transportation (bus; plane; train) and/or schedule motels and pay the cost through the travel agent.
- Issue a check to the DV service provider (if they agree) and have them pay up front for items.
- If making a payment directly to the client, ask the client to turn in receipts.

The Process:

Prior to issuing a TA-DVS payment, code CMS with a DVS Needs/Resource code. You only need to add the code to the adult in the household. Use the first month of eligibility for the need/resource date.

Issue TA-DVS payments through the Special Pay system. It is appropriate to verify vendor information, if questionable, before making such payments. Use the domestic violence pay reason code of 22 for TA-DVS issuance except in cases where payments are made for medical-related issues (such as prescription, doctor visits, etc.), then use 2M and payments to non-TANF eligible noncitizens, then use 2N.

Support service payments to support successful completion of the case plan should be made through JASR.

TA-DVS; Benefits of the Program: 461-135-1230
Standards for Support Service Payments: 461-190-0211

6. Notices

Using a *basic decision notice* (see 461-001-0000) is appropriate in TA-DVS cases. Notices should be sent to a safe mailing address or hand delivered.

To approve program eligibility for TA-DVS, use the *Notice of Decision and Action Taken* (DHS 456DV). This notice includes the dates of eligibility as well as information on how the program operates. The notice also explains clients' hearing rights.

Note: *If the program remains open for the entire 90 days, there is no reason to send another decision notice at the end of the 90-day eligibility to close or end TA-DVS, as the DHS 456DV includes the program eligibility dates and, as such, meets the requirements of both an approval and closure notice.*

To end or close the TA-DVS program prior to the end of the 90-day period, use the *Notice of Decision and Action Taken* (DHS 456). Document the reason the program is ending early (i.e., no eligible child; moved out of state; reconciled with the abuser; etc.)

To deny the application or a payment for TA-DVS, use the DHS 456 form. Document the reason for the denial.

Use TANF denial or closure codes when appropriate. For specific TA-DVS-related denials or closures, use the following codes:

VE – no emergent need (i.e., no safety concern related to domestic violence)

VM – closed due to reconciliation with abuser

VS – does not meet definition of domestic violence in OAR 461-001-0000

VW – Waiver Removed (when eligibility is based on waiving a TANF requirement such as citizenship)

VN – 90-day eligibility has expired (only needed if the client did not receive the DHS 456DV with the eligibility dates included)

Note: Exercise caution when issuing notices to DV households.

- *When possible, hand deliver in the office or at the domestic violence shelter.*
- *Verify with the client that using the mailing address is safe.*

Notice Situation, General Information: 461-175-0200

B. Application, Verification, Eligibility, and Participation

1. Application Process

The *Application for Services (Food Stamps, Cash, Child Care, Medical, Domestic Violence)* (DHS 415F) used to apply for TANF benefits is the form used to determine eligibility for the Pre-TANF Program. Families must meet basic TANF eligibility requirements (including the \$2,500 TANF resource limit for applicants) to be eligible for the program. For the Pre-TANF Program, verification of eligibility factors is based on the client's declaration and not on written verification. It is especially important to accept the client's statement of a domestic violence situation; no additional verification is required.

Pre-TANF Program services must be offered to all TANF applicants as soon as possible upon submittal of their application but no later than 15 days from the date of request. The date of request for the Pre-TANF Program is the date of request for TANF cash assistance. Do the following as soon as possible when a TANF application is received:

- Gather information about the family to identify emergent needs and determine eligibility for emergency benefits.
- Make referrals to other community-based resources when they are best suited to deal with the family's issues.
- Screen for TANF eligibility.
- Determine medical eligibility, beginning with MAA.
- Determine eligibility for expedited and regular FS, and issue FS and emergency benefits, using the eligibility and application processing time frame requirements of those programs.

☞ SEE #6 (PRT B.6) BELOW FOR MEDICAL ASSISTANCE ELIGIBILITY.

If clients are ineligible for TANF, do the following within 45 days of the date of request for TANF:

- If the family is ineligible for MAA, determine eligibility for MAF. See the Medical Program chapter for more information on MAF.

The Pre-TANF Program begins on the date that clients begin the initial assessment process. Once clients are presumed eligible for the Pre-TANF Program, changes in circumstances such as lack of participation may not necessarily make them ineligible for other services. A lack of participation without good cause could result in TANF opening with a JOBS disqualification, provided the re-engagement process has been completed. A JOBS disqualification does not affect clients' eligibility for MAA medical.

2. Who Must Participate in the Pre-TANF Program Initial Assessment Process

The Pre-TANF Program begins with the initial assessment process, which includes orientation, intake screening (using the *Application for Services (Food Stamps, Cash, Child Care, Medical, Domestic Violence)* (DHS 415F) form), and intake. All clients applying for TANF must participate in the initial assessment process to determine which benefits and self-sufficiency services the family needs right now. **All** clients means not only adults applying for benefits for themselves, but also non-needy caretaker relatives, those on SSI or who have disabilities, ineligible noncitizens, and children in no-adult households. Based on the results of the initial screening, further participation in the Pre-TANF Program employment and self sufficiency services will be required of some applicants. See Section C (Pre-TANF Program Case Management) and the client assessment process section of the Case Management chapter for what should be included in an initial screening.

☞ SEE SECTION C (PRT C.), OF THIS CHAPTER AND SECTION B (CM B.), OF THE CASE MANAGEMENT CHAPTER FOR MORE INFORMATION ON THE INITIAL ASSESSMENT.

3. Who Must Participate in Pre-TANF Program Employment and Self-Sufficiency Services

After the initial assessment process, engage all applicants presumed to meet TANF eligibility requirements and able to benefit from the program in the Pre-TANF Program services. Use TANF policy to determine eligibility, unless indicated otherwise in specific rules. Base eligibility determination for the Pre-TANF Program on the client's declaration.

TANF applicant families with no JOBS mandatory adults in the benefit group are not required to participate in the Pre-TANF Program.

☞ SEE SECTION F (TF F.), OF THE TANF CHAPTER FOR MORE INFORMATION ON WHO IS REQUIRED TO PARTICIPATE IN EMPLOYMENT PROGRAMS.

End Pre-TANF Program services early when new information shows the client is unable to benefit from the program within the “up-to” 45-day time period. Domestic violence may be a reason to end the Pre-TANF Program early.

4. Who Is Likely To Benefit From Continued Participation in Pre-TANF Program Services

Use the initial assessment process to identify the following types of applicants who could benefit from participation in Pre-TANF Program employment and self-sufficiency services:

- TANF-eligible adults who are employable or who could benefit from the labor market test to assess their employability.
- TANF-eligible adults who seem employable or who could benefit from the labor market test to identify factors affecting employability.
- TANF-eligible adults who seem currently unable to perform work search, but where participation in self-sufficiency activities during the Pre-TANF Program would prepare and motivate the applicant for the JOBS participation requirements of ongoing TANF (example: need to complete mental health (MH) or alcohol & drug (A&D) assessment, enroll children in school, participate in Child Welfare services, etc.).

End Pre-TANF Program services early for clients who seemed able to benefit and who started services, but then were determined not to be likely to benefit based on new information (example: domestic violence, MH or A&D, or learning disabilities issues surface that prevent employment now).

Pre-TANF Program Requirements: 461-135-0475

5. Pre-TANF Program Duration

For applicants who are eligible based on their declaration and who are likely to benefit from employment and self-sufficiency activities within the 45-day Pre-TANF program, develop the initial case plan. The Pre-TANF program begins on the date of request. The dates of case plan activities should not exceed the 45-day Pre-TANF program.

End the Pre-TANF Program when one of the following occurs:

- The client becomes employed, enters the Post-TANF program, or begins a JOBS Plus assignment;
- The client is determined unlikely to benefit from continued participation;
- The client stops cooperating with the Pre-TANF Program case plan and the re-engagement process has ended with a determination that the client is willfully noncompliant;
- The client withdraws their TANF application or is denied; or
- 45 calendar days have elapsed from the date of request for TANF benefits.

Open TANF the day the Pre-TANF Program ends, for those who are eligible for TANF. For those not cooperating, open TANF with the disqualified person's needs removed.

☞ SEE SECTION F, *ENDING THE PRE-TANF PROGRAM*, (PRT F.) IN THIS CHAPTER FOR MORE INFORMATION.

Pre-TANF Program Requirements: 461-135-0475

6. Medical Assistance Eligibility

Clients in the Pre-TANF Program are not assumed eligible for MAA. Treat MAA as a separate eligibility program. Screen all clients for retroactive medical eligibility. For Pre-TANF Program clients who are eligible for medical, code the case on CMS as a program P2 with MAA and PRE case descriptors.

For all applicants who end the Pre-TANF Program, follow the medical due process redetermination requirements.

☞ SEE SECTION B, (MA B.5), OF THE MEDICAL CHAPTER FOR INFORMATION ON THE MEDICAL REDETERMINATION PROCESS.

☞ SEE SECTION F, *ENDING THE PRE-TANF PROGRAM*, (PRT F.) FOR MORE INFORMATION.

Assumed eligibility for Medicaid: 461-135-0010

Specific requirements: 461-135-0070, 461-135-0095, 461-135-1100

Pre-TANF Program Requirements: 461-135-0475

7. Pre-TANF Program Clients Who Locate Employment

Clients who find employment during the Pre-TANF program will be enrolled in the Post-TANF Program.

- The client must maintain nonfinancial TANF eligibility requirements (unless otherwise indicated in rule) during Post-TANF; and
- Must work enough hours to meet the federal participation rate or supplement work hours with other federally approved JOBS activities.

Post-TANF: 461-135-1250

8. Verification for TANF Eligibility

TANF eligibility is presumed for the Pre-TANF Program. However, to open a TANF grant, verify all eligibility factors within the application processing time frame. To initiate the verification process, list all the factors that need to be verified on the *Notice of Pending Status* (DHS 210) form.

For applicants who are victims of domestic violence, waive or modify verification requirements if needed to prevent risk of harm to the client. For example, no documentation of domestic violence is required to open TANF. See Section K of the TANF chapter for more information about domestic violence guidelines.

Date of request: 461-115-0030
Domestic violence: 461-135-1200

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F. Ending the Pre-TANF Program

1. Ending the Pre-TANF Program

The Pre-TANF Program ends no later than 45 consecutive days from the client's date of request for TANF. It can end in less than 45 days under the following circumstances:

- The client begins full or part-time employment that is expected to result in, or lead to, self-sufficiency. (The client will automatically be enrolled in Post-TANF.)
- The client is placed in a JOBS Plus assignment.
- The Department of Human Services (DHS) determines that the client is unlikely to benefit from continued Pre-TANF Program participation due to their circumstances, such as situations of domestic violence.
- The TANF application is withdrawn or denied.

For clients who have not become self-sufficient at the end of the Pre-TANF Program period or who leave the Pre-TANF Program early, open their TANF ongoing grant no earlier than the day the Pre-TANF Program ends. Open the TANF grant using the application processing time frame requirement for that program.

For clients who are determined to be willfully noncompliant during the Pre-TANF Program but remain otherwise eligible for TANF, the effective date to open their TANF grant is no earlier than the day the Pre-TANF Program ends. If they are mandatory for JOBS participation or substance abuse/mental health treatment, their TANF grant will be opened with a disqualification and without the special need for Cooperation Incentive payments. For non-mandatory clients, their TANF grant will be opened without the Cooperation Incentive payments added to their grant.

☞ SEE SECTION E OF THIS CHAPTER (PRT E.), NONCOOPERATION AND DISQUALIFICATION, FOR MORE INFORMATION.

Penalties: 461-130-0330; 461-135-0085
Post-TANF: 461-135-1250
Pre-TANF Program: 461-135-0475
Effective date: 461-180-0070

2. Medical Assistance Eligibility

Eligibility for medical assistance must be reviewed when Pre-TANF Program eligibility ends.

- If the client is ending the Pre-TANF Program due to employment or increased child support, review for other medical program eligibility, including EXT. A new application is not needed.

- Clients who had an open OHP case when they entered the Pre-TANF Program cannot be placed back on their original OHP certification.

☞ SEE SECTION B, (MA B.), OF THE MEDICAL ASSISTANCE CHAPTER FOR MORE INFORMATION ON MEDICAL ELIGIBILITY.

Effective Dates; Initial Month Cash Benefits: 461-115-0190
Assumed eligibility for Medicaid: 461-135-0010
Specific requirements: 461-135-0095, 461-135-1100
Application Processing Time Frames; Not Assessment or FS: 461-180-0070

3. Denying the TANF Application

When a TANF applicant does not verify TANF eligibility factors by the forty-fifth day after the application date, the application is denied. This includes applicants who:

- Did not complete the TANF application process; **or**
- Whereabouts are unknown; **or**
- Did not return required verifications listed on a pending notice or case plan.

☞ FOR MORE INFORMATION ABOUT DENYING THE TANF APPLICATION, SEE TANF-B (TF B.).

4. Transition/Retention Services

Clients who become employed while on the Pre-TANF Program are eligible to receive transition services. Code TRACS with participation status code TRA. Make payments using JASR if necessary to help them retain employment.

Transition Services: 461-190-0241

K. Domestic Violence and TANF Eligibility

Intent:

- To keep the domestic violence survivors safe from domestic violence or the threat of domestic violence.
- To remove domestic violence as a welfare-to-work barrier as early as possible.
- To identify client situations of potential or actual domestic violence early in the application/assessment process.
- To use this information when designing the DV Assistance Agreement to ensure the safety of the applicant/client and his/her children.
- To determine whether the client should be excused from certain program requirements as long as danger exists (e.g., pursuit of child support or specific JOBS activities).
- To help persons fleeing domestic violence.

Expectations:

- Clients have the right to be informed of the options for protection from domestic violence.
- All clients have the right to apply for aid from DHS and participate in self-sufficiency activities without fear of actual or threatened violence from a domestic partner.
- Clients are capable and should be allowed to make their own choices. They are not responsible for creating the abusive situation or abuser behavior.
- DHS will support the opportunity for clients to achieve a life without domestic violence by using methods of identification, education, protection and prevention.
- A DV Assistance Agreement (DVAA) will be completed in TANF cases in lieu of an Employment Development Plan (EDP) or Personal Development Plan (PD) where there is a risk due to domestic violence. The DVAA will include:
 - Activities the client feels will address safety and stabilization from domestic violence.
 - Referrals or coordination with community partners.
 - Agreed upon support services (e.g., child care, transportation, etc., to complete activities).
 - Any follow-up meetings or appointments to review the agreement.

- Whenever possible and the client agrees, involve the DV service provider in developing the DVAA.
- In cases where there has been past domestic violence or the domestic violence is not currently affecting the client's ability to participate in a regular JOBS plan, a DVAA is not required.

Note: A referral to the DV service provider may still be appropriate in these cases to address post-traumatic stress issues or to attend support groups.
- Staff waiving TANF/TA-DVS requirements and developing DVAA or case plans for clients affected by domestic violence must have domestic violence and domestic violence policy training.
- Domestic violence education is available to all DHS staff.
- TANF eligibility requirements should not prevent individuals from escaping, or put them at further risk of domestic violence.
- Domestic violence service providers will be involved, with the client's permission, in assessing needs and resources necessary to intervene in domestic violence situations.

1. Definition

- (A) Domestic violence is the occurrence of one or more of the following acts between family members, intimate partners or household members:
- Attempting to cause, or intentionally, knowingly, or recklessly causing physical injury or emotional, mental or verbal abuse.
 - Intentionally, knowingly or recklessly placing another in fear of imminent serious physical injury.
 - Committing sexual abuse in any degree as defined in Chapter 163 of the Oregon Revised Statutes.
 - Using coercive or controlling behavior.

Domestic violence: 461-135-1200

- (B) Domestic violence for the purpose of the TANF and TA-DVS program does not include other criminal acts such as violence perpetrated by a stranger, neighbor, acquaintance or friend unless those persons meet the relationships defined in (A) above.

- When a client is a victim of a crime that is not listed under the above definition offer them a referral to law enforcement, the local district attorney, victim's assistance, etc.
- When a client is a victim of sexual assault or rape whose perpetrator is not listed in the above definition (i.e., a stranger), offer the client a referral to the local sexual assault or domestic violence service provider and/or law enforcement.
- When a child is abused or neglected or is at substantial risk of abuse by the domestic violence perpetrator, report to Child Welfare. (See "Mandatory Reporting of Child Abuse in domestic violence cases" below.)
- Elder abuse or abuse of people with disabilities by nonrelative caretakers should be referred to Adult Protective Services.

2. Guidelines

- Identify as early as possible the occurrence (past or present) or threat of domestic violence by asking nonvictim-blaming questions about the abuse and/or history of abuse.
- Develop Domestic Violence Assistance Agreements (DVAAAs) reflecting that the client is a survivor of domestic violence.
- Refer clients to the appropriate counseling resources.
- Provide education resources to clients about domestic violence.
- Accept the client's statement of domestic violence, without requiring verification of the domestic violence. Other TANF eligibility requirements can be verified if questionable.
- Ensure clients of their right to confidentiality, particularly in cases when disclosure of information could raise the risk of harm.
- Provide referrals to community resources for prevention and protection.
- Collaborate and consult with community partners in assessing, developing and monitoring the DVAA.
- The branch should:
 - Provide case management.
 - Develop a DVAA, with client and community-partner involvement, that addresses the safety of the client and other family members. This may include home visits, protective service referrals or other community

resource involvement including counseling, support groups, or other DV-related interventions.

- Consult with a local domestic violence service provider, the central office domestic violence program analyst, or the local domestic violence point person if it is unclear whether the situation meets the definition of domestic violence or if help is needed in developing the DVAA.

Clients Excused for *Good Cause* from Compliance with OAR 461-120-0340 and -0345: 461-120-0350
Eligibility for and Needs Covered by EA: 461-135-0300
Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060

Note: *It is important to include domestic violence service providers in the re-engagement process to resolve problems that could lead to disqualification. It is especially critical to use the existing staffing process before imposing third-level JOBS penalties on these cases.*

3. Waiver of Support and Other TANF Requirements

(A) The following requirements cannot be waived:

- The requirement to be a dependent child, caretaker relative or parent;
- The requirement that a dependent child live with a caretaker relative;
- The requirement to be an Oregon resident;
- TANF income or resource limits.

(B) When waiving requirements:

Waiver or modification of TANF requirements is not intended to be automatically granted to every identified survivor of domestic violence. The intent of the policy is to give case managers more latitude in helping people escape domestic violence, to move toward safety and self-sufficiency.

The case manager may decide, on an individual basis, to waive or modify TANF eligibility requirements that put a person at risk of harm by domestic violence or which would make it more difficult for the person to escape domestic violence. The decision to waive any requirement does not mean automatically waiving all of them. The waiver or modification of program requirements is intended to be temporary, to help survivors of domestic violence to move forward with their self-sufficiency plan and to meet program requirements when safe. The decision to waive or modify eligibility requirements should be re-evaluated at least every six months.

Example 1: A woman who has just left an abusive situation may need cash to help establish a new home before she can regain

physical custody of her children from child welfare. The case manager may decide to waive the requirement for a dependent child to live with her, if it is reasonable to assume that her children will move into her new home once she has secured it through a down payment or deposit. Such decisions should be based on intensive case management and be well documented in the case file.

Example 2: A pregnant woman in her fifth month of pregnancy applies for cash assistance. She is unable to work due to complications from the pregnancy and is fleeing domestic violence. She has no resources and is likely to return to her abuser, which will put her at greater risk of domestic violence if she is unable to secure a safe place to live. Since there is risk of further domestic violence, the case manager may waive the requirement for the woman to be in her last month of pregnancy and may open a TANF case. TA-DVS may also be a resource.

Federal law requires that we track TANF requirements that are waived due to domestic violence. On TRACS there is a DV flag that should be used whenever you waive a TANF requirement related to domestic violence. If no requirements are waived, then “no” should be entered in the ***Dom Viol*** field.

- (C) Examples of things that can be waived and how you would track them on TRACS:

Use “No” under the waiver flag:

- When there are no TANF requirements being waived due to domestic violence.
- In cases where domestic violence is not a factor.

Use the Work and JOBS waiver reason code:

- When required hours of participation are reduced due to domestic violence.
- When participating in specific activities would put a client at risk.
- When a job quit is due to domestic violence.
- When other JOBS or work requirements are waived due to an increased risk of domestic violence.

Use the Penalties waiver reason code:

- When noncooperation with child support is due to domestic violence concerns (i.e., Good Cause given for noncooperation).
- When noncooperation with JOBS is due to domestic violence concerns (e.g., Good Cause was granted for noncooperation due to the affect of domestic violence or disqualifications removed due to domestic violence).
- When overpayments or fraud are a result of actions by the abuser or the abuser's control over the domestic violence survivor.
- When other penalties would have been assessed as a result of domestic violence and/or if the penalty would put the client at risk of further domestic violence (i.e., pursuing an overpayment, IPV or other penalty that names both the abuser and the domestic violence survivor, and pursuit would potentially give the abuser knowledge of the survivor's address or other information).
- When waiving penalties for failure to comply with a program requirement.

Use the Nonfinancial waiver reason code:

- When waiving the requirement for the client to be in her last month of pregnancy.
- When waiving citizenship requirements for TANF due to domestic violence (add WDV as case descriptor on UCMS).
- When waiving the requirement or expectation that children will be in the home within 30 days.
- When waiving residency due to risk of or flight from domestic violence.
- Family caps if or when such provisions are placed in policy.
- When a client quit or lost a job that would or did result in an unemployment disqualification (not related to domestic violence) and the client is currently at risk of domestic violence, you can waive the UI disqualification rule and allow eligibility for TANF.

Note: If a client quit or lost a job due to domestic violence, it is good cause under state law and unemployment rules.

- When other nonfinancial requirements would put the client at risk of further/future domestic violence.

Use the Financial waiver reason code:

- When you are waiving income controlled by the abuser.

- When you are waiving income used to flee the violence.
- When you are waiving other financial requirements that pursuit of which may put the client at risk of domestic violence.

Use the Time-limits waiver reason code:

- When the federal five-year time limit puts the client at greater risk of domestic violence.

Note: Use the time-limit code of TLD on UCMS if the client is unable to obtain or maintain employment due to domestic violence.

4. Cooperation With JOBS or Child Support

Victims of domestic violence are not exempt from the federal work participation rate; however, both state and federal law allow us to waive JOBS participation (for as long as necessary) when such participation would put a client at risk of further domestic violence. This ability is not intended to exclude the client from activities that would not endanger their safety.

Note: These waivers are tracked by the DV waiver code on TRACS: clients who have an active DV intervention activity with attendance coded for JOBS; clients who are within the 90-day eligibility period for TA-DVS. These waivers are reported to federal agencies on an annual basis. If the state is unable to meet the required federal work participation rate, the number of domestic violence waivers will be considered in determining reasonable cause for failing to meet that rate.

Example: The abuser and the domestic violence survivor received TANF together in the past. The survivor, who is no longer with the abuser, does not want to attend classes at the local community college because she believes he is likely to stalk her or cause her harm in some other way if she goes to the college. We should develop an alternative JOBS plan that includes activities that would not put her at further risk of domestic violence.

Child Support:

Explore with the client how child support could be safely pursued. Use the *Client Safety Packet on Good Cause* (DHS 8660) to inform the client of child support safety options, including good cause and nondisclosure based on claim of risk. If the client requests a good cause exemption against pursuing child support, review the situation periodically and at each eligibility redetermination to determine whether the client can now safely pursue child support.

5. **Noncooperation with JOBS**

If a client fails to cooperate with JOBS activities, offer the opportunity for re-engagement. At the re-engagement appointment, determine whether the noncooperation was a result of domestic violence. If the domestic violence affected the client in a way that made it unsafe for her to participate or if she was otherwise affected by the domestic violence (e.g., court appointments, did not receive notices, abuser sabotaged the client's participation, etc.), give the client good cause for noncooperation. If the client failed to cooperate and it was not a result of domestic violence, follow the normal JOBS disqualification process. Involve the local DV service provider in the re-engagement process or joint staffings with domestic violence survivors whenever possible.

When domestic violence survivors do not cooperate with assigned JOBS activities that are safe for them to perform, they are not eligible for the TANF cooperation incentive. In addition, if the caretaker relative meets the citizen/alien status requirement, the JOBS progressive disqualifications will be applied.

6. **Confidentiality and Narration in Cases Where Domestic Violence is Present**

Confidentiality is crucial in domestic violence cases. In some cases, how we narrate and how we track information can impact a client's safety. Be cautious sharing any information on DV cases, even within the branch. You may not be aware of family or community connections that the abuser has. Abusers often try to use the system to manipulate or control the victim.

Forms, notices or other information should be sent only when we know there is a safe address.

ORS: 411-117

Narration:

Narrate information about the domestic violence if it is safe to do so. Examples of when it might not be safe: The abuser is in the home; the abuser or his family member works for DHS or a partner agency; the abuser or his family member works for law enforcement; the domestic violence survivor is concerned that the narration will affect their safety (i.e., the abuser is a computer hacker and the survivor is fearful that he may access our systems).

When it is safe, narrate information about the client's safety concerns, history of abuse, planned activities, waived requirements, referrals, eligibility dates for TA-DVS, TA-DVS payments, support service payments, follow-up appointments, etc.

Alternative Identity:

In some cases you may have a client request use of an alternative identity or they may be going through a name change. We can use an alternative identity on the system. If this is the case, you must have permission from your manager, and the manager or his/her

designee needs to contact central office to authorize release of the procedure to code alternative identities.

Use of an alternative identity does not mean that we do not determine eligibility or ask for verification of eligibility information (e.g. citizenship, relationship, social security numbers, Oregon residency, etc.). The information should be kept secure. Sometimes the file is held in the manager's office; sometimes confidential information is put in a folder marked confidential; sometimes a separate file is kept. Check with your manager or DV point person to determine the process used in your branch.

It is important to remember that an alternative identity in itself does not make a person safe. The abuser may very well continue to pursue the victim. In addition, use of an alternative identity may cause problems for the client when trying to access medical records, employment records, use an EBT card, or cash a check.

If the client is requesting use of an alternative identify, we should help the client make an informed decision by discussing the potential issues related to alternative identity.

7. Mandatory Reporting of Child Abuse in Domestic Violence Cases

"The presence of domestic violence is a risk for children. However, not all situations of domestic violence require a report to DHS or law enforcement. DHS's authority to intervene with families is based on whether a child is being physically abused, sexually abused, neglected, suffering mental injury or is being subjected to an activity or condition likely to result in substantial harm.

A report to DHS or law enforcement is necessary when there is a reasonable cause to believe:

1. *There is current domestic violence or the alleged abuser has a history of domestic violence; AND*
2. *One of the following:*
 - *There is a reason to believe the child will or is intervening in a violent situation, placing him at risk of "substantial harm."*
 - *The child is likely to be "harmed" during the violence (being held during the violence, physically restrained from leaving, etc.).*
 - *The alleged abuser is not allowing the adult care giver and child access to basic needs, impacting their health or safety.*
 - *The alleged abuser has killed, committed "substantial harm," or is making a believable threat to do so to anyone in the family, including extended family members and pets.*

- *The child's ability to function on a daily basis is substantially impaired by being in a constant state of fear.*

If you know a child is witnessing repeated or serious domestic violence and you are unsure of the impact on the child, call and consult a CPS screener.” – Excerpt from PAM 9061 – What You Can Do About Child Abuse.

8. Use of the Safety Assessment (DHS 7802) Form

- Completion of this form is optional. Suspected domestic violence survivors should be supported, but not forced to disclose abuse.
- This form should not be included in any packets of information that would be taken home, due to increased risk of abuse.
- This form should not be given to a suspected domestic violence survivor in the presence of someone who might be an abuser.

9. Coding, Issuing and Tracking Payments in Waiver Situations

Open cash benefits as if clients have met all TANF eligibility requirements. Enter clients in the Domestic Violence Step on TRACS for activities pertaining to safety issues such as counseling. If the client does not have a Social Security Number (i.e., nonqualified noncitizen cases), JAS will assign a temporary “J number” to the TRACS Plan and JAS screens. The J number will display on the TRACS plan and the JAS screens in place of the Social Security Number.

Issue support services for the Domestic Violence Step on JASR using the appropriate support service pay reason code.

For TA-DVS payments, in most cases use pay reason code 22 in the Special Cash Pay system.

Exceptions: Payments for medical under TA-DVS and payments for noncitizens who do not qualify for TANF must be tracked separately for accounting purposes.

- Code TA-DVS payments related to medical (i.e., doctors, medication, etc.) as 2M (not 22); and
- For noncitizens (even if their children receive TANF) who themselves do not qualify for TANF as 2N (not 22).

Issue up to \$1,200 for services needed to enhance the safety of or stabilize their living situation. Consult with central office if the client has received TA-DVS within the last 12 months. The amount may include payments to shelters that

provide transitional housing to the families who are fleeing from domestic violence.

Benefits; TA-DVS: 461-135-1230

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O. Decision Notices

1. Types of Decision Notices

A decision notice is a written notice sent to the benefit group describing the action taken on an application or the benefits. There are three types of decision notices that can be given to clients. They are:

- A Basic Decision Notice. This notice is mailed no later than the planned date of action on the case, and does not give the client the right to continuation of benefits pending a hearing.
- A Continuing Benefit Decision Notice. This notice is mailed in time to be received by the date that benefits are, or would be received, and gives information on the benefit group's right to continuing benefits.
- A Timely Continuing Benefit Decision Notice. This notice must be mailed no later than 10 calendar days before the effective date of the action. Count the day after the notice is mailed as the first calendar day. The effective date is the 11th calendar day or later. If the 10th calendar day falls on a weekend or a holiday, extend the date to the first working day after the end of the 10-day period. This notice also contains information on the benefit group's right to continuing benefits.

461-001-0000

The notice period is used to determine the effective date for taking action when a decision notice is sent to the filing group. For a Basic Decision notice, the notice period is the month in which the notice is mailed. For a Continuing Benefit Decision notice, the notice period is the budget month from which information is used to initiate the decision notice. For a Timely Continuing Benefit Decision notice, the notice period is the month in which the 10-calendar-day mailing requirement ends.

461-175-0050

2. What a Decision Notice Must Contain

A decision notice must do all of the following:

- Except for mass changes, specify the action that the Department of Human Services (DHS) intends to take, the effective date of the action, the date the notice is mailed, and the reason for the action.
- Provide the name and phone number of the agency staff person or department to contact for additional information.

- Inform the client of their right to a hearing before an impartial person. This includes the following: specifying the method and time frame for requesting a hearing; informing the client of their right to a pre-hearing conference with staff representing the agency; informing the client of their right to representation (including legal counsel); informing the client about availability of free legal help; and informing the client of their right to have witnesses testify on their behalf.
- Cite the administrative rule that supports the action being taken on the case.

Continuing Benefit Decision Notices and Timely Continuing Benefit Decision Notices must also inform clients of their right to continuing benefits. Clients are entitled to a continuation of benefits if they request a hearing by the later of the following:

- Within 10 days of the mailing of the notice; OR
- On or before the effective date of the action.

☞ FOR MORE INFORMATION ABOUT WHEN (WHICH DATE) TO SEND A TIMELY NOTICE, PLEASE SEE MULTIPLE PROGRAM WORKER GUIDE #18 (MP WG#18).

What a Decision Notice Must Include: 461-175-0010
Notice Situation; Mass Changes: 461-175-0250

***Note:** Some notice situations may require that more information be included than has been described here. Please see item 3 below for more information on specific notice situations.*

3. TANF Notice Situations

Send a Basic Decision notice if:

- An application for TANF is denied.
- Ongoing TANF benefits are approved.
- A JOBS support service payment, or a request for a payment for a basic living expense for an Pre-TANF Program or “at-risk” applicant, is denied. This includes instances where the branch provides a payment that is different in type or amount from the one the client requested.
- Benefits are opened without a disqualified individual on the case.
- A benefit group member has received an Intentional Program Violation (IPV) disqualification.
- A child is removed from the benefit group as a result of a court decision or voluntary placement in foster care by their caretaker relative.

- New TANF applicants are ineligible because of a disqualifying transfer of resources.
- The client has been placed in skilled nursing care, intermediate, or long-term care.
- A client (or another adult filing group member or their representative) signs a written request to withdraw their application or end their benefits. This is normally done on a *Voluntary Agreement to Reduce, Close, or Deny Benefits and Notice of Decision & Action Taken* (DHS 457D) form.
- The client is placed in official custody or a correctional facility.
- The client has been admitted or committed to an institution.
- The client's mail has been returned and their whereabouts are unknown.
- A client receives benefits for less than 30 days.
- A client has moved out of state and becomes eligible in another state.

Notice Situations; General Information: 461-175-0200

Notice Situation; Benefits for Less Than 30 Days: 461-175-0205

Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210

Notice Situation; Disqualification: 461-175-0220

Notice Situation; Nonstandard Living Situations: 461-175-0230

Notice Situation; Removing a Person From a Benefit Group or Need Group: 461-175-0305

Notice Situation; Asset Transfer Disqualification: 461-175-0310

Notice Situation; Voluntary Action: 461-175-0340

Send a Continuing Benefit Decision notice if:

- The clients have moved out of state and the information was reported to DHS through the Monthly Reporting System (MRS).
- The branch implements a sanction or disqualification (that results in a grant reduction or closure or change of payment method) on a client's case due to failure to: participate in JOBS or Alcohol and Drug/Mental Health programs, pursue assets, cooperate with child support enforcement, or pursue a Social Security number *so long as the information came to the branch's attention through the MRS*. The notice must include information about the action that caused the disqualification, the minimum length of the disqualification period, and the amount of the benefit reduction.
- A client enters or re-enters the MRS.
- An action is taken on the TANF case due to information reported through the MRS.

- The branch is closing or reducing an ongoing JOBS support service payment as a result of information received through the MRS.

Notice Situations; General Information: 461-175-0200

Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210

Notice Situation; Disqualification: 461-175-0220

Notice Situation; APR, MRS, SRS or TBA: 461-175-0270

Note: *The computer automatically sends a notice to the client if the Monthly Change Report (Bond and Variable Data) form (DHS 859A) is not received by the 10th calendar day of the payment month.*

Send a Timely Continuing Benefit Decision notice if:

- Benefits are reduced or closed (if information was not reported through the MRS).
- The method of TANF payment changes to protective, vendor, or two-party.
- The client has moved out of state and the information was not reported through the MRS.
- The branch implements a sanction or disqualification (that results in a grant reduction, or closure, or change of payment method) on a client's case due to failure to: participate in JOBS or Alcohol and Drug/Mental Health programs, pursue assets, cooperate with child support enforcement, or pursue a Social Security number *if the information did not come to the branch's attention through the MRS*. The notice must include information about the action that caused the disqualification, the minimum length of the disqualification period, and the amount of the benefit reduction.
- TANF benefits are reduced to recover an overpayment. Send a copy of the *Notice of Overpayment and Planned Action* (DHS 284B) and *Monthly Overpayment Worksheet for TANF* (AFS 284G) forms to each liable adult in the household.
- When giving closure notice for change in deprivation.

☞ SEE TANF SECTION E, DEPRIVATION, (TF E.8) OR RULE 461-125-0255 FOR MORE INFORMATION.

- An ongoing TANF household is being found ineligible because of a disqualifying transfer of resources.
- The client makes a verbal request (in person or by phone) to reduce or close their TANF benefits.

- An ongoing JOBS support service payment is reduced or closed because of information not received through the MRS.

Notice Situations; General Information: 461-175-0200

Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210

Notice Situation; Disqualification: 461-175-0220

Notice Situation; Overpayment Repayment: 461-175-0290

Notice Situation; Asset Transfer Disqualification: 461-175-0310

Notice Situation; Voluntary Action: 461-175-0340

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B. Applications

1. Overview

Branch offices must ensure the application process is not a barrier to the people accessing benefits. It should be simple, efficient, and responsive to the needs of persons seeking help. It should also consider the privacy and confidentiality of each applicant. Whenever possible, use one application to determine eligibility under multiple programs.

To complete the application process, individuals or their authorized representative (FS B.14) must complete the application, have an interview (FS B.8), and provide the necessary information and verification (FS B.11) within given time frames (FS B.9).

The information necessary to determine eligibility and benefit amount for all people in the filing group (FS C.2) must be gathered during the application process.

Food Stamp (FS) households must file an initial application. Once approved, they can get FS for a set number of months called a certification period. At the end of that time frame they are required to reapply for FS if they want to continue getting benefits. This is called recertification (recert).

Application Process; General: 461-115-0010
Application Requirements: 461-115-0020

2. Where Clients Apply

Applicants may apply at the branch office serving the area where they live or work. This may be any DHS or AAA office that administers the FS program. Persons temporarily in another part of the state may apply at the office serving that area.

When applicants contact any DHS or AAA office that does FS eligibility, their application for FS must be taken. Clients may choose to complete the application process in this office or have the application forwarded to another office. If the client chooses to complete the eligibility process in another branch, record the filing date (FS B.5) and forward the form to that branch. The application processing time frames (FS B.9) begin with the filing date. If the client chooses to stay at the branch where they made the initial contact, determine eligibility and issue benefits. Transfer the case to the branch closest to the client's home or work site if the client wants their case transferred.

People may request an application in a variety of ways: they may walk into the office and ask for an application; they may call on the telephone and ask that an application be mailed to them; they may ask that an application be faxed to them.

Upon completion, an applicant may bring the application to any branch office that does FS; they may mail it in or fax it to the office.

Note: *Branch offices need to have a process in place for receipt of applications by fax or mail. These applicants must be notified that they need to have an interview (FS B.8) before the application process can be completed. Some may be eligible for expedited service (FS B.6). Determine with the applicant the date and time of this interview. This must be done as quickly as possible after receipt of the application to ensure the household will receive a timely determination of eligibility.*

When all members of the filing group (FS C.2) are applying for or receiving SSI, the group may apply at the SSA office. Filing groups applying at SSA must not have applied for or received FS in the last 30 days.

The SSA office must use the same application process as the department. The SSA office forwards the completed application and verification (FS B.11) to the department for eligibility determination and benefit issuance.

Offices Where Clients Apply: 461-115-0150

3. When to Use an Application

Use an application form approved by the department, when determining initial eligibility. The application must be complete, including a mailing address and a signature.

Use the same application to deny and approve if changes occur that make the group eligible after the initial eligibility decision and it is within the application processing time frame (30 days). Also, use the application to determine eligibility for two months if the filing group (FS C.2) provides verification 30 to 60 days (FS B.9) following the filing date (FS B.5). This may occur when they have been given extra time to do so, or the time frame is extended due to branch office delay.

A new application is not required when the client is ineligible for FS during the first 30 days from the filing date, but circumstances are changing and they will be eligible the next month or during the second 30-day period following the filing date.

In addition to initial eligibility, an application is also used to determine eligibility at recertification. The same application process (including forms and time frames) is used for recertification as for initial eligibility.

A new application is also required any time there is a break in benefits. For example, a case is certified from November 1 to December 31 and on July 31 the benefits close. The client comes to the office on August 1 and wants FS: the client must reapply.

No new application is needed if a case closes and reopens during the same calendar month, or when a case suspends for one month. An application is not required to add a person, including newborns, to a FS case. The request to add a new person must be

documented and the *Notice of Information or Verification Needed* (DHS 210A) will be used to gather all the information to establish eligibility and benefit level.

When an Application Must be Filed: 461-115-0050
Application Processing Time Frames; FS: 461-115-0210

4. Who Must Sign an Application and Complete the Application Process

Usually, a responsible adult signs the application and completes the application process. It could be the primary person (GP A.30), the spouse (GP A.37) of the primary person or another adult in the filing group (FS C.2). An authorized representative from a facility or a person named as an authorized representative by the client may also sign the application (SEE FS B.14). When there is no responsible adult, such as when a homeless (GP A.17) teen applies, the child can sign the application and complete the application process.

If an applicant is unable to write their name, they can sign with their mark. The mark must be witnessed by a department employee.

An electronic application is signed electronically by the client typing their name and clicking on the submit button.

☞ SEE FS B.14 AND WG-FS #3 FOR INFORMATION ON WHO SHOULD SIGN AN APPLICATION WHEN THE CLIENT LIVES IN AN ALCOHOL & DRUG (A&D) TREATMENT CENTER OR RESIDENTIAL CARE FACILITY (RCF).

Note: *Applicants must sign the last page of the application. If they sign the last page and do not sign the filing page of the Application for Services (DHS 415F, page 2) or of the Food Benefit Filing Form (SDS 539F), the filing date begins the date the total application is signed, unless the filing date is set via another document.*

Application Requirements: 461-115-0020
When an Application Must be Filed: 461-115-0050
Who Must Sign an Application and Complete the Application Process: 461-115-0071

5. Filing Date

The FS application process begins with the filing date. This is the date a signed request for FS – including the client’s name, address, and signature – is received by the department. It is also the date the first signed request is received by the Social Security Administration (SSA), for people allowed to apply for FS there.

The filing date starts the application processing time frames (FS B.9). For persons whose benefits are approved, it is usually the date benefits begin (FS B.16).

People who visit a branch office must be given an opportunity to establish a filing date the same day. People who contact the office by telephone, fax, or mail must have a form

mailed to them the same day. Their filing date is established when the branch receives the signed request for FS back. The filing date is also established as of the date the application is faxed (FS B.2) to the office.

The filing date for an electronic application is the date that the department receives the signed electronic application.

A new filing date is established whenever an applicant does not provide the requested verification in the 30-day application processing period unless the department extends the processing period.

Filing Date; FS: 461-115-0040
Application Processing Time Frames; FS: 461-115-0210

***Note:** The filing date is set when the office receives the name, address, and signature written on any piece of paper. This may be on the Application for Services (DHS 415F), the Re-Application for Food Stamp Benefits (AFS 415Y), the Food Benefit Filing Form (SDS 539F), or the completed reapplication forms at recertification. Ask all applicants to do this as soon as possible when they request food stamps. A completed application is not needed or required to set the filing date. To keep the filing date, the local office must keep the paper and not give it back to the client.*

6. Expedited Service

Certain applicants are entitled to expedited service, which means, if they are eligible, they must have their benefits by the seventh day following their filing date (FS B.5).

Entitlement to expedited service does not mean automatic eligibility for FS. Instead, it means that client statements and limited verification will be used to determine eligibility for FS for a short period of time. All verification except identity (FS D.1) may be postponed until later. Do not use expedited service processing time frames when clients apply for FS before the end of their current certification. Expedited processing is used any time there is a break in benefits.

To be eligible for expedited service, the filing group (FS C.2) must meet one of the following:

- Have countable income of less than \$150 a month and resources in the form of cash and bank accounts of \$100 or less.
- Have combined monthly income, cash, and bank account balances that are less than the group's total monthly housing and utility costs (use appropriate standard FUA or LUA) (GP A.7).
- Be destitute (FS I.1).

Note: For expedited service determination, use the appropriate utility allowance.

Applicants eligible for expedited service must meet all FS eligibility requirements, but because of the shorter application processing time frame, they may have some verification delayed.

Seven-Day Processing (Expedited Service): Branches must have a process in place to screen applicants for expedited service, so that benefits can be issued within the seven-day time frame for eligible clients. Use Part I of the application (pages 1 and 2 of the *Application for Services* (DHS 415F), the *Re-Application for Food Stamp Benefits* (AFS 415Y), or the *Food Benefit Filing Form* (SDS 539F) for this screening.

The seven-day processing includes the screening, the intake interview (FS B.8), ID, other verification readily available and the decision that the client meets all eligibility requirements, and the issuance of benefits for those eligible for expedited service. When applicants qualify for expedited service, they must have the benefits by the seventh calendar day following their filing date. This applies even if the in-office interview is waived for a phone interview.

Sometimes the initial screening does not identify a group that qualifies for expedited service. When this was due to a department error, benefits must still be received by the seventh day following the filing date. When this was due to the applicant withholding information or providing misinformation, benefits must be received as soon as possible, but no later than seven calendar days following the date the error was discovered or the date the information was provided.

Sometimes when the initial screening identifies a group that qualifies for expedited service, the client loses entitlement to the service. When the branch screens the application and identifies a client potentially eligible for expedited service, they must schedule an interview date and inform the client that they will lose entitlement to the seven-day processing should they miss the interview. If the client then fails to attend the interview, they lose entitlement to expedited service except when they missed the appointment for reasons beyond their control. Always narrate this loss of expedited eligibility.

When issuing expedited service benefits, use the X code. For clients who lose entitlement to expedited service, use the J code so that benefits are still issued as quickly as possible.

Application Processing Time Frames; FS: 461-115-0210

☞ SEE EXAMPLES OF EXPEDITED SERVICE SITUATIONS (FS B. EXAMPLES 6)

There is no limit to the number of times that a client may receive expedited service. However, all eligibility factors from the previous expedited service must be verified before they are entitled to seven-day processing again.

If an applicant specifically requests expedited service and is denied, they are entitled to an expedited hearing. Send a *Notice of Decision and Action Taken* (DHS 456) or *Notification of Planned Action* (SDS 540) to the client when their request is denied.

Expedited Hearings: 461-025-0315
Notice Situation; Prior Notice: 461-175-0300

Verification for seven-day application processing: The only eligibility factor absolutely required to be verified under expedited service is the identity (FS D.1) of the applicant. A reasonable effort must be made to verify all factors, but require only those that will not cause a delay in issuing benefits. The rest of the verification (FS B.11) can be postponed.

☞ SEE FS D.1 AND MP-WG #2.5 FOR MORE INFORMATION ON VERIFYING IDENTITY.

If the filing date is on or before the 15th of the month, postponed verification must be provided before the second month's benefits are issued. If the filing date is after the 15th of the month, postponed verification must be provided before the third month's benefits are issued.

At all times, give the client a list of postponed verifications when issuing expedited FS.

If the application is approved for more than one month and verification is postponed, give the applicant a *Notice of Pending Status* (DHS 210) or a *Notification of Pending Status* (SDS 539H). The notice must tell them they will not receive further benefits until they provide the postponed verification. In addition, if the verification they provide causes a change in eligibility or benefits, the change will be made without further notice.

Application filed on or before the 15th: Benefits approved using expedited service may be certified for one month only. Clearly note on the pending notice that to receive further benefits, they must provide the postponed verification in the given time frames of end of month or no later than 30 days from the filing date. The verification must be provided by the end of that month for the client to get continued benefits the next month. If the verification is provided before the end of the filing month, extend the certification period. If verification is provided within 30 days of the filing date but after the end of the one month certification period, process a recertification action using the new information.

Application filed after the 15th: Benefits approved using expedited service may be certified for two months only. The verification must be provided by the end of the 30-day processing period following the filing date so that continued eligibility can be determined. Clearly note on the pending notice that to receive further benefits, they must provide the postponed verification within 30 days. If the verification is provided by the end of the 30-day processing period, extend the certification period. Take no further action if the verification is not provided.

When issuing FS using expedited services, the worker may certify the case for any appropriate length of time. However, if the case is certified for longer than one or two months, the worker must also establish a tickler to monitor that the postponed verification

is provided on time. If the postponed verification is not provided in the required time frames, the client loses eligibility for FS until the requested proof is provided.

- ☞ SEE FS B.9 FOR MORE INFORMATION ON APPLICATION PROCESSING.
- ☞ TO ENSURE THAT CLIENTS APPLYING FOR FS WHEN MOVING INTO OREGON DID NOT RECEIVE BENEFITS FROM ANOTHER STATE IN THE SAME MONTH, CONTACT THAT STATE USING THE NUMBERS IN MP WG #4.

Verification for FS Expedited Service; Time Limits: 461-115-0690

QC Hot Tip

There are several steps to issuing benefits under expedited service. All of the steps must occur. They are:

1. At time filing date is set, determine if the case meets the criteria for expedited service.
2. Schedule the full eligibility interview to occur within seven days of the filing date.
3. Obtain the client's verification of identity. Retrieve any verification from the computer system.
4. Note any other items needing verification on the pending notice, *Notice of Pending Status*, (DHS 210 or SPD 539H).
5. Establish eligibility using the client's statements on the application and during the interview and any other verification readily available.
6. Issue the benefits in not more than seven days following the filing date.
7. Set a short certification period of one to two months if verification was requested. If no verification was requested, set a normal certification period.

7. Withdrawn Applications

Allow people to voluntarily withdraw their application any time during the application process. The application is withdrawn when the person or their authorized representative (FS B.14) does not complete the process, including signing the form, and there is no contact with the branch by the end of the application processing time frame (FS B.9). It is also withdrawn when the person takes the application from the office without completing the process.

The decision to withdraw an application for FS is totally the applicant's. The department is not allowed to suggest, encourage, nor recommend the applicant withdraw the application. This is because every person has the right to apply for benefits and the department is required by FS law to encourage people to apply. If during the interview it is determined a person is not eligible for FS, the worker must process the application. An

applicant may withdraw their application at any point in the application process, which may change the reason for a denial action to withdrawal. Even if workers decide it is beneficial to households with an OFSET mandatory person who has quit a job without good cause within the last 30 days to withdraw, workers can inform the household of the policy but only the client can make the suggestion to withdraw.

When the applicant only submits the filing page with no further action or states they want to withdraw their application, ask them to complete and sign a voluntary agreement to take action form, *Voluntary Agreement to Reduce, Close, or Deny Benefits and Notice of Decision & Action Taken* (DHS 457D) or an *Agreement to Take Action* (SDS 540A). Code FCAS with the “WI” reason code and the computer will send the withdrawal denial notice.

When the applicant completes the interview but fails to provide requested information or verification, code FCAS with the “FC” reason code and the computer will send the denial notice. Workers will need to send a *Notice of Decision and Action Taken* (DHS 456) or a *Notification of Planned Action* (SDS 540) if a different reason code is used for the withdrawal action.

Once the department has correctly denied an application or considered it withdrawn, the client must initiate the application process again if they want to get FS. No new application is required when the same application is used for both a denial in the month of application and for determining eligibility the next month. This can be done when:

- The client was given over 30 days to provide verification necessary to determine eligibility; **or**
- The same application is being used to deny one month and approve the next month’s benefits.

☞ SEE EXAMPLE FOR A SITUATION WHERE NO DENIAL NOTICE IS NEEDED FOR CONCURRENT BENEFITS (FS B. EXAMPLES 7).

Application Process; General: 461-115-0010

8. Interviews

An interview is required of all households applying for FS. This interview is required as a part of the eligibility determination process for all initial applications and recertifications.

The purpose of the interview is to gather and review eligibility information and explore and resolve unclear and incomplete information. The person interviewed may be the head of household, spouse, any other responsible member of the filing group, or an authorized representative (FS B.14).

☞ SEE FS WG #4 FOR IDEAS ON EFFECTIVE NARRATION

Initial application: This interview is generally conducted in the office. The interview must be conducted protecting the client's right to privacy and confidentiality. Interview the FS applicant the same day they request benefits or schedule an appointment for them to return. Always give the client the appointment date and time for the interview. Also note it on the application or in narration.

The in-office interview is waived only when no authorized representative (FS B.14) or adult member of the filing group (FS C.2) can come to the office for one of the following reasons:

- All adult members of the group are over age 60, or have a physical or mental disability;
- There are transportation problems; or
- Other hardships exist. For example, illness, bad weather, work hours that conflict with the office hours, safety issues due to domestic violence, caring for a disabled member of the filing group, etc.

Note: Always narrate the reason the in-office interview is waived. The applicant cannot be forced to do a phone interview. They may always request an in-office interview.

When the office interview is waived, a telephone interview, a home visit or an interview at a mutually agreed upon location must be conducted. The client may decline a phone interview and request an in-office interview. When this occurs, grant the in-office interview. The department must grant an in-office interview anytime the client requests one.

Notification of Missed Interview

The department is required to notify all FS applicants that they have missed their FS interview appointment and that they are responsible for rescheduling the appointment. This notification must take place when the applicant misses the initial interview appointment. A second notification is not necessary if they miss more than one intake appointment during the 30-day application period. This notification is required for all FS applicants at initial certification and at recertification.

The interview appointment is scheduled for a set date and time when a client is not interviewed the same day as the filing date.

The expectation is that the notice of missed appointment will be mailed within two days of the missed appointment. This is to give the applicant time to receive the notice and reschedule the appointment before the 20th day following the filing date.

A Notice of Missed Interview (NOMI) is required in the following situations:

- The client leaves a filing page at the local office and is given a scheduled appointment date and time for the intake interview.

- The client is given an application to complete along with a scheduled interview appointment. They return the completed application but do not appear for the interview.
- The client receives a scheduled appointment for recertification and will complete the application when they arrive at the local office. They do not appear for the appointment and there is no filing date.
- The client receives a scheduled appointment for recertification along with an application. They do not show for the appointment or turn in the application or set a filing date.

No NOMI is required when an application is sent without an intake appointment and the client does not return the application or appear for an appointment.

To give branches a choice that will best meet their up-front process, there are two options for the notification of missed interview. These options are:

- The *Missed Appointment Post Card* (DHS 411) is available to notify households that they have missed their appointment. To use, ask FS applicants to write their name and mailing address on the post card when they turn in the filing page. Attach this post card to the filing page and place in a folder for the interview appointment date. If the client does not return by the end of day on the appointment date, separate the post card from the filing page, add the branch phone number to side two, and mail it to the client. If the client returns for the scheduled appointment, the card should be put with other confidential shred material.
- The letter (FSMA411) is available on Notice Writer and can be used when a case (pending or closed) is on FSMIS with the most current mailing address.

The revised *Self-Sufficiency Application for Services* (DHS 415F) has a box labeled “MA notice” in the top right-hand corner of the filing page. The MA box is also located on the bottom right of the filing page *Food Benefit Filing Form* (SDS 539F) for SPD and AAA to use. Check the MA box when notification of missed appointment is made and note the date and time of the missed appointment.

Recertification application: The interview requirements for a redetermination (GP A.32) of eligibility or recertification are much like the ones for an initial application. All interviews must be conducted protecting the client’s right to privacy and confidentiality. In addition, an in-office (or face-to-face) interview is required once every 12 months. For cases with certification periods of less than 12 months, the in-between recertification interviews may be by telephone or home visit instead of in-office. Branches may conduct a face-to-face interview more than once every 12 months with filing groups whose living situation is not stable, e.g., homeless (GP A.17) households, and groups with household members who move in and out frequently or lose or change their jobs often.

Note: *As with an initial application, the face-to-face in-office interview may be waived due to client hardship. The hardship decision needs to be reviewed at each recertification. Remember to narrate the hardship situation.*

☞ SEE FS B.18 FOR THE RECERTIFICATION PROCESS.

Disclosure of Client Information: 461-105-0130
Interviews: 461-115-0230

9. Application Processing Time Frames

Seven-Day Processing. See Expedited Service (FS B.6).

Thirty-Day Processing. Determine eligibility and provide benefits as soon as possible for all FS applicants. The application processing time frame for most groups is no longer than 30 days following the filing date (FS B.5). If the 30th day falls on a holiday or weekend, determine eligibility and issue benefits the last working day before the holiday or weekend. This means an eligibility determination and benefits must be issued by the 30th day. If doing a denial action, it must be taken on the 30th day or as soon as possible following the 30th day. Only deny before the 30th day if for a reason other than denying for failure to complete the application process.

☞ SEE FS B.16 FOR AUTOMATIC DENIALS FOR FAILURE TO COMPLETE THE APPLICATION PROCESS.

The application processing time frame includes the interview (FS B.8), verification (FS B.11) and the eligibility decision. Schedule the interview as soon as possible after the filing date and no later than 20 days after the filing date to assure there is adequate time for verification and the eligibility decision.

The 30-day processing period and a new filing date begins over again if verification is received after the 30th day and the processing period has not been extended.

The 30-day time frame can be extended under certain circumstances when the delay is beyond the control of the client and the extension is granted in the 30-day processing period. Extend the time limit up to 60 days from the filing date when giving the client more time to provide requested verification or when the intake interview cannot be scheduled during the 30-day processing period. Also extend the limit when the client requests a hearing before the 30-day time frame has ended.

The decision to extend the application processing period beyond the 30 days must occur during the initial 30-day period. Narrate the extension request, the reason for the extension and the department decision.

☞ SEE EXAMPLES OF APPLICATION PROCESSING TIME FRAMES: EXTENSION OF THE APPLICATION PERIOD (FS B. EXAMPLES 9)

When clients miss their scheduled interview within the 30 days, hold the application until the end of the 30 days. If the client contacts the branch to reschedule before the 30 days expire, reschedule the interview and keep the same filing date as long as the interview and all verification is received within the 30 days. If the interview occurs after the 20th day and verification is received within 10 days but not until after the 30 days has ended, establish a new filing date as of the date the verification is received. If the client does not contact the branch within the 30 days, deny the application.

Application Processing Time Frames; FS: 461-115-0210
Interviews: 461-115-0230

10. Verification; Overview

Verification is information from a source other than the client, to lend credence to the information the client is providing. Clients must provide verification when it is requested by the department. The department decides which eligibility factors require verification and when verification provided is acceptable. When the filing group (FS C.2) does not provide acceptable verification for other eligibility factors, deny the application or end ongoing benefits.

Verification may be received in a variety of ways. It may be a document that is copied and put into the agency file. It may be received via a telephone conversation, or a document may be viewed during a home visit but no copy was made for the file. When verification is received but a copy is not placed in the file, the worker must carefully narrate the information received.

During a phone conversation obtain:

- Name of person providing the information.
- Position or title along with name of organization the information is from.
- Specific information received.

Example: Joe's employer was contacted by phone. Suzy, the payroll clerk for Green Thumb Nursery, states the client is an employee and he is scheduled to work 30 hours a week at \$7.50 an hour. The first pay check will be received October 15.

Document viewed during a home visit – narrate:

- Document(s) viewed.
- Date on document(s).
- Specific information viewed on each document.

☞ SEE FS WG # 4 FOR NARRATION EXAMPLES.

Example: Viewed weekly wage stubs at home visit. Joe is working for Green Thumb Nursery. Pay stubs showed:

<u>Pay Date</u>	<u>Pay End Date</u>	<u>Hours</u>	<u>Pay Rate</u>	<u>Gross</u>
11/04	10/29	30	\$7.50	\$225
11/11	11/05	28	\$7.50	\$210
11/18	11/12	30	\$7.50	\$225
11/25	11/19	30	\$7.50	\$225

☞ SEE FS H.6 FOR INFORMATION ON ACTING ON CHANGES DURING THE CERTIFICATION PERIOD.

All requests for verification will be made in writing and the client must be given at least 10 days to provide the requested verification. Request verification using the *Notice of Pending Status* (DHS 210) or the *Notification of Pending Status* (SDS 539H) at certification and recertification. Use the *Notification of Information or Verification Needed* (DHS 210A) form to request verification when it is needed during the middle of a certification period.

☞ SEE FS H.11 FOR MORE ON USING THE DHS 210 OR SDS 539H OR FS H.12 FOR MORE ON THE DHS 210A.

Authorized representatives (FS B.14) must provide verification showing they are authorized to act for the client. This could be a written statement from the client, the *Designation of Authorized Representative or Alternate Payee* (AFS 231), or copies of papers authorizing guardianship or power of attorney.

Home visits may be made to verify eligibility factors. However, the home visit must be scheduled in advance with the household.

For FS, eligibility factors must be verified at application and when changes in these factors are reported. In addition, for FS cases in the MRS or SRS, earned income must be verified even when it has not changed when processing the *Interim Change Report* (DHS 852) or the *Monthly Change Report (Bond & Variable Data)* (DHS 859A).

Exception: There is one exception to verifying income for FS. Some clients are paid under the table or do jobs that do not generate pay stubs (i.e., pick up cans). In this instance, carefully interview the client about the income and the amount; narrate the situation and the client’s statements regarding the income. Include in the narration the reason pay verification is not available.

☞ SEE FS B.6 FOR INFORMATION ON VERIFICATION FOR EXPEDITED SERVICE.

11. Verification for 30-Day Application Processing and Changes

The eligibility factors that must be verified are:

- Identity (FS D.1) of the applicant, the authorized representative(s) (FS B.14), and the alternate payee.
- Alien status for all adult noncitizens in the filing group (FS D.5). Verify for children only if questionable. In addition, work quarters for noncitizens whose eligibility is based on 40 qualifying work quarters.
- Social Security number (SSN) (FS D.6) or application for an SSN.
- For cases being evaluated for disqualification due to a job quit or reduced hours, the reason for the job quit or reduced hours.
- Countable income.
- The actual amounts billed for medical before allowing the costs (GP A.7) in the medical deduction (FS F.20).
- Disability: when a student (FS D.3) claims they are unable to be employed due to a physical or mental condition and the physical or mental condition is not obvious.
- The legal obligation to pay child support (FS F.21) and the amount actually paid.
- Questionable information (GP A.31).

Information is questionable when it is inconsistent with information provided in the application, received by the branch or reported on previous applications.

☞ FOR EXAMPLES OF DOCUMENTS USED FOR VERIFICATION, SEE MP WG #2.

Some items to be verified are needed to accurately determine eligibility for FS. Other items are necessary to arrive at the correct amount of benefits. Therefore, eligibility may be determined if the department has all of the information and verification needed to determine eligibility without verification of all expenses necessary to determine the correct amount of benefits.

For the initial application, proof of income from one source is required for the 30 days before the filing date. Additional verification may be needed and requested if income is variable.

When the client cannot verify medical expenses or payment of court-ordered support, do not allow the unverified expense as a deduction. If the household is certified pending the receipt of the verification of medical costs, narrate the reason actual costs are not used.

Anytime a client is asked to verify a cost (whether questionable or required), do not allow the deduction until the verification is provided. For example, if a client is eligible for FS

but has not provided the requested rent verification by the 30th day, the case may be certified for FS without allowing the rent cost as a deduction. Remember to narrate the reason the cost is not allowed.

When a change in costs is reported during a report period that will increase benefits and verification is requested, continue the former deduction amount until the verification is received.

Income Deductions; FS: 461-160-0430

☞ SEE EXAMPLES OF VERIFICATION FOR 30-DAY APPLICATION PROCESSING AND CHANGES (FS B. EXAMPLES 11)

Further verification is not required for categorically eligible groups (FS E.1) when their residency, SSNs, and resources have already been verified for the other program.

FS Verification Table

Eligibility Factors	At Certification		At Recertification **	
	Accept Client Statement	Verify	Accept Client Statement	Verify
Identity of applicant		X		Only if a new applicant
Identity of other persons in the filing group	X		X	
Age	X		X	
Residency	X		X	
Household composition	X		X	
Relationship	X		X	
SSN		X		Only if not verified before
Citizenship	X		X	
Noncitizen status For adults		X		Only if the prior INS card has expired, or the status changed
Income		X		X (see below)
Resources	X		X	
Work status	X		X	
Shelter cost	X		X	
Utility allowance	X		X	

Eligibility Factors	At Certification		At Recertification **	
	Accept Client Statement	Verify	Accept Client Statement	Verify
Medical costs		X		X (see below)
Child support deduction		X		X
Pregnancy	X		X	
Student status	X		X	

Remember, verification may be required for any information that is questionable.

Verification after initial certification: Once verified, some items do not need to be verified again (i.e., SSN). Other items must be verified at recertification or when changes are reported.

At recertification verify:

- Income from any source.
- Medical expenses when the source changed or the source is unchanged but the amount has changed by more than \$25. As always, verify when the information is incomplete, inaccurate, inconsistent, or outdated.
- Change in the legal obligation to pay child support and the amount paid must always be verified.

At Interim Report processing, verify all income received in the fifth month of the certification period.

Mid-certification for cases in CRS or MRS (other than the *Monthly Change Report* (DHS 859A)):

- Income changes.
- Medical expenses previously unreported or when the amount of reported expenses changes by more than \$25.
- Changes in the legal obligation to pay child support or in the amount the client is paying.

Mid-certification for cases in SRS (other than Interim Report processing):

- Alien status and SSN when a new member joins the benefit group.
- All changes in countable income.
- All changes in medical expenses used as a deduction.

- An order to pay child support and the amount being paid.
- ☞ SEE FS F.8 FOR THE DEFINITION OF “VERIFIED UPON RECEIPT” FOR CASES IN SRS.
- ☞ SEE CA WG #1.7 FOR VERIFICATION OF SELF-EMPLOYMENT INCOME

Required Verification and When to Verify; FS: 461-115-0651
Categorical Eligibility for FS: 461-135-0505

12. Verifying Terminated Income and Reduced Work Hours

In some cases (SUP, UC), income termination can be verified by a mainframe screen. However, if the income was from a job, it can be difficult to obtain proof. In most cases, it is acceptable merely to talk to the client and get information on why the job ended, date last worked, and the date and amount of the last paycheck. If the work was seasonal or temporary, narrate the client’s statements and you are done. If the client is OFFSET mandatory and job quit must be determined, begin by asking the client why the job ended. Was it a layoff or firing? If the client quit, what was the reason? Has the client applied for UC?

Workers may contact the employer to verify the last day of work and the date of the final paycheck. However, many employers are reluctant to state that a worker has been fired or give any reason for termination. If the client is OFFSET mandatory and did not have good cause for a job quit, advise them that a disqualification will be applied.

In most cases, a drop in employment hours must be verified before income can be reduced on the case. Although the client is responsible to obtain proof, the worker can get verification by talking to the employer. The exception is for jobs in which seasonal fluctuations or similar circumstances explain the drop in hours (e.g., for retail sales or tourist employment, a cut in hours one month due to illness). For these cases when the work situation is generally known in the community, it is acceptable to narrate the reduction in work hours without pursuing verification.

13. Length of Certification

When FS benefits are approved, assign the longest possible certification period, up to 12 months while attempting to align the end date with companion benefits. The length depends on how long the client’s circumstances can be anticipated and the report system they are in. Match the certification period with the household’s situation. These are the guidelines:

- Use a one- or two-month certification period for clients who meet expedited services criteria (FS B.6) when pending for ongoing months or when it appears that the household will not be eligible for FS longer than one or two months.

- Assign a six-month certification period when the case is in CRS, unless the case meets the requirement for a longer period.
- Assign a 12-month certification period when the countable income is from annualized self-employment, the case is in SRS or MRS, or the case is in CRS and they receive companion ERDC or every member of the filing group is elderly or disabled. In essence, except for cases with elderly or disabled, there must be a periodic reporting of the household situation at least once each six months in order to assign a 12-month certification period.

In addition, when the filing group (FS C.3) also receives cash or medical, set the certification period so that eligibility for FS and the other program will be reviewed at the same time. This allows clients to reapply for multiple program benefits on one application.

For example, TANF redetermination is due by December: set the FS certification period to end as of November 30 (i.e., TANF date 1209 and FS date 113009).

Once the certification period is established, it cannot be shortened. If the household's circumstances change, determine if the household continues to be eligible to receive FS benefits. If ineligible, send a timely continuing benefit decision notice and end the benefits.

The certification period for FS may be extended out to 12 months from the starting date of the certification period. This may be accomplished by changing the ending date (not the start date) for the certification period with an ADJ action. To extend the certification period, the action must occur before the last day of the current certification period.

Caution: If you change the starting date, or do a REC action, you are stating that you have processed a complete recertification of eligibility. This means that you have received and processed a complete application (FS B.1) and interviewed (FS B.8) the client.

FS households with a certification period of less than 12 months may have their certification period extended using the following criteria:

- FS benefits were certified as expedited (FS B.6) for one or two months and the requested verification was received. (A new application or report form is not needed.)
- The recertification packet was received and reviewed with a desk audit only in the last month of the current certification period.
- When the *ERDC Re-application and Food Stamp Application* (DHS 7476) is received and no interview is scheduled.
- When TBA begins and the certification period will expire prior to the end of the TBA period.

- When SRS begins and the certification period is less than 12 months.

Do not extend the certification period for any case where a filing group (FS C.2) member is serving an OFSET (FS D.20) or IPV (GP C.5) disqualification.

FCAS will send the household the notice (AB) to inform them that the certification period is extended to the new ending date. The new benefit amount is included in this notice.

The only time a certification period may be greater than 12 months is if a TBA period or TANF JOBS Plus worksite agreement extends beyond the end of the 12-month limit. When this happens, the length of the certification period may be extended to end the last month of the TBA or worksite period.

Periodic Redeterminations; FS: 461-115-0450

14. Authorized Representatives and Alternate Payees

There are two types of authorized representatives. There are authorized representatives that are named by the filing group to assist them with the process. There are also authorized representatives named by a facility for clients residing in that facility.

The authorized representative (AR) may help the filing group (FS C.2) by completing the application process for them and reporting changes.

The alternate payee (AP) helps the filing group by using their benefits for them. An AP is needed when members of the filing group are not able to do their own grocery shopping.

If necessary, the group can have both an AR and an AP; one to complete the application process and one to use benefits. They also can have one person who is both the AR and the AP, as long as it is clearly designated on the *Designation of Authorized Representative or Alternate Payee* (AFS 231).

Note: *The AFS 231 only needs to be completed when a nonfiling group member is named as AP or AR.*

An AR or AP is a person outside the filing group who is aware of the group's circumstances or a private nonprofit organization. Those ARs and APs outside the filing group should be persons who can be trusted to represent the client appropriately. The branch must notify the client when an AR or AP they have chosen cannot be approved as such.

An AR or AP cannot be any of the following:

- People serving a disqualification for intentional program violation (unless they are the only adult member of the case).

- Landlords and other vendors of goods or items who deal directly with the client. This especially includes retailers who accept FS benefits.
- Any DHS employee and any employee of an AAA food stamp office which is involved in the certification and issuance process for FS. An exception can be made only with the written permission of the FS Program Administrator or their designee.
- Homeless meal providers (FS I.4).

Authorized Representatives; General: 461-115-0090
Authorized Representative or Alternate Payee; FS: 461-115-0140

Authorized Representatives or Payees for Individuals: The primary person (GP A.30), their spouse (GP A.37) or another responsible member of the filing group appoints an AR or AP by naming them in writing. The AR signs the application as a filing group member or signs the AFS 231. The AP signs the AFS 231. The AFS 231 is only necessary when a person is named as AR or AP and is not a member of the filing group.

The department can assign an AP when no member of the benefit group (FS C.7) is able to use FS benefits because of illness. When an emergency AR is designated for a specific period of time, issue a new FS identification or EBT card for that person.

When overpayments result from information given or withheld by the AR, filing group members are responsible.

When ARs or APs knowingly misrepresent the filing group or misuse FS benefits, the ARs or APs are disqualified. The branch office can disqualify them for one year after sending written notification of the disqualification to the client and the AR or AP 30 days prior to the disqualification. The notice must specify the reason for the disqualification, the disqualification period, and the client's right to request a hearing.

As with each member of the filing group who will use the FS benefits at a store, the AP must be given their own FS identification or EBT card.

Note: Code the AR on page one of FSUP in the Auth-Rep-Cd field. See Computer Guide X-C-3 for information on coding APs.

Authorized Representatives; General: 461-115-0090
Authorized Representative or Alternate Payee; FS: 461-115-0140;
Alternate Payees; EBT: 461-165-0035

Authorized Representatives for Clients Residing in Facilities:

Two types of facilities qualify to be the AR or AP when their residents receive FS benefits. These are:

- Drug addiction or alcoholic treatment centers which are tax exempt, private, or nonprofit, and are:

- Certified as meeting the criteria under part B of title XIX of the Public Health Service Act by the State of Oregon Office of Alcohol and Drug Abuse Programs; or
- Drug or alcohol treatment and rehabilitation centers which are authorized as a retailer by FNS.
- Nonprofit residential care facilities (RCFs) (GP A.6) licensed by SPD and Mental Health.

Note: *A list of drug or alcohol treatment centers certified to receive Medicaid payments under part B of title XIX of the Public Health Service Act is available on the State of Oregon Office of Alcohol and Drug Abuse Programs website at www.dhs.state.or.us/addiction. Also refer to the Oregon Alcohol & Other Drug Prevention Services Directory. Certified facilities not listed on this site need to provide a letter of certification from the Oregon Office of Alcohol and Drug Abuse Programs.*

Residents of the certified drug or alcohol treatment centers are not eligible for FS on their own. However, a representative of the facility may apply for the client. In this situation, the authorized representative for the facility must sign the application.

Note: *Sometimes clients apply for FS while residing in a drug or alcohol treatment center that is not state certified. Do not follow this AR/AP policy for these clients. If eligible for FS, and they want to name an AR or AP, they do so as an individual and the representative cannot be from the noncertified facility.*

Residents of licensed residential care facilities must apply through an authorized representative who is an employee of the RCF, except when the facility determines that the resident can apply on their own. If the authorized representative applies for the client, they must sign the application. If the client applies on their own, the client must sign the application. Residents must meet the FS definition of disabled (GP A.10).

In both types of facilities, the authorized representative must complete the application process for each individual they want to receive FS. They must also complete the intake interview and provide complete information about each individual's situation and verification as requested. The AR is asked to sign the *Facility As Authorized Representative* (DHS 222) form with each application.

Note: *Ask the AR for the facility to sign the DHS 222 form at each certification and recertification.*

Facility AR/AP responsibilities: As AR or AP, the facility is responsible for reporting changes in the residents' assets or other circumstances. The facility must provide the branch with a monthly list of residents receiving benefits. The list must include a statement of validity and be signed by an official of the facility. The AFS 222A form may be used for this listing.

When residents leave the facility, the facility must inform the branch to cancel their EBT card and immediately stop using the EBT card. When the resident leaves before the 16th of the month, the facility must leave at least one-half of the client's FS allotment for that month in the EBT account. When clients leave on or after the 16th, the facility is to leave any remaining benefits for the month. Upon leaving the facility, residents should be instructed to go to the branch office to report their new situation and for a new EBT card.

Facility ARs and APs are responsible for overpayments that result from information they give or withhold on their residents' cases. If the AR or AP knowingly misrepresents the resident's circumstances or misuses FS benefits, the facility may be prosecuted under applicable federal and state statutes.

☞ SEE FS WG #3 FOR INFORMATION ON CLIENTS LIVING IN A FACILITY, A&D TREATMENT CENTERS OR RCF.

Branch responsibilities when there is a facility AR/AP: The branch office must maintain a file of the monthly AFS 222A and update the branch office records as residents change. Keep the list (completed AFS 222A) for three years.

Ask clients coming to the branch office after leaving the facility to review, update, and sign the application that was originally provided by the facility or to complete a new application. Review the "*Rights and Responsibilities*" to ensure the client knows what they need to report. Give them a new EBT card and PIN.

Note: On FSMIS, only do a recertification if the certification period is expiring. Always remove authorized representative's name.

It is a good practice to cancel the PIN on the card used by the facility when they report the client has left the facility. This preserves any remaining benefits for the client.

The Food and Nutrition Service (FNS) disqualifies a facility if the facility was authorized as a retailer and the facility misappropriated or did not use the benefits for the groups' meals. If the branch office receives word that the facility is disqualified for this reason, immediately end the FS for all residents. No decision notice is needed when benefits end due to this reason per OAR 461-175-0230.

Responsibilities of a Center or Facility Acting as Authorized Representative; FS: 461-115-0145
Residents of Institutions; FS: 461-135-0510
Residents of Drug Addiction and Alcohol Treatment Facilities; FS: 461-135-0550

15. Disposition of the Application

When eligibility cannot be determined at the intake interview (FS B.8), branches give or send a pending notice, *Notice of Pending Status* (DHS 210) or *Notification of Pending Status* (SDS 539H) to the client, which holds the case in pending status. The notice must inform the client what information is needed or requirements must be met to be eligible, and the date by which this must be done.

When an application for benefits is approved or denied (FS B.16), send a basic decision notice (FS H.9). The effective date (GP A.12) for a denial is the date the decision is made. The decision is made either on the date it is determined the group is not eligible, or at the end of the application processing time frame (FS B.9) (when clients fail to follow through with the process), whichever is earlier. Regardless of whether the application is approved or denied, code the action on FCAS.

***Note:** The FCAS computer system automatically sends the approval notice “A” when the case is certified (CRT or REC transaction codes). Some denial notices are also sent by the computer with a DEN transaction code and certain reason codes. The denial reason codes that generate a notice are: “DQ” ineligible because they are disqualified for IPV; “FC” failed to provide information; “FH” failed to cooperate with OFSET (also code the person as DH); “IT” missed the interview appointment; “JQ” applicant job quit; “NC” all household members are ineligible noncitizens; “NR” not a resident of Oregon; “OI” over the income limit; “OR” over the resource limit (don’t use for households that are categorically eligible); “SH” cannot apply as a separate filing group; “ST” ineligible student; “WI” withdrew the application; “WR” not eligible due to failure to comply with OFSET requirements. Whenever a worker is denying an application for any other reason, a basic decision notice is required. Send the Notice of Decision and Action Taken (DHS 456) or Notification of Planned Action (SDS 540) noting the reason for the denial action.*

***Note:** All decisions made on food stamp applications – whether approval or denials – must be entered into FCAS.*

16. Effective Dates on Applications

The effective date (GP A.12) for approval is the filing date (FS B.5), as long as the filing group (FS C.2) was eligible on that date. Use the filing date only if the group attended the interview and provided the necessary verification (FS B.11) within the processing time frame (FS B.9), or within the extended processing time frame.

Approval. For FS filing groups making an initial application or applying after the end of their certification period, the effective date for starting benefits is one of the following:

- If verification is provided within one of the following time frames, the effective date is the filing date, as long as all eligibility requirements are met on the filing date. If all eligibility requirements are not met on the filing date, the effective date is the date all eligibility requirements are met.
 - 30 days after the filing date.
 - 30 days after the intake interview, if the 30-day application time frame is extended because of branch office delay.

- 60 days after the filing date, if the filing group is given extra time to provide required information per rule 461-115-0210.
- If verification is not provided within the time frames listed above, the effective date for starting benefits is the date the required verification is provided, if all the following are true:
 - The verification is received between 30 and 60 calendar days after the filing date.
 - No extra time was given to provide the verification.
 - All eligibility requirements are met on the date the verification is provided.

Effective Dates; Initial Month FS Benefits: 461-180-0080

Denial. The effective date for denying benefits is the earlier of the following:

- The date the decision is made that the client is not eligible; OR
- The last day of the application processing time frame, if the application, interview, or required verification is incomplete.

Effective Dates; Denial of Benefits: 461-180-0060

Note: *All new application or recerts on expired certifications are to be entered on to the computer in Pend Status within 48 hours of the filing date. Minimum information needed for entry is case name, address, filing date, language, and alternate format (if applicable). This will allow the computer to send an auto deny on the 30th day (or first working day after the 30th day, if the 30th day is a weekend or holiday), for those cases in which the application process was not completed. If the worker is extending beyond the 30-day time period, a household type of EAT must be entered on FSMIS.*

☞ FOR MORE INFORMATION ABOUT ALLOWING EXTRA TIME FOR VERIFICATION SEE FS B.9.

☞ SEE EXAMPLES OF EFFECTIVE DATES ON APPLICATIONS: EFFECTIVE DATE IS NOT THE FILING DATE (FS B. EXAMPLES 16).

Definitions for Chapter 461: 461-001-0000
Application Process; General: 461-115-0010
Notice Situations; General Information: 461-175-0200

17. Redetermination of Eligibility; Overview

At initial application, a filing group (FS C.2) is approved for benefits for a specific certification period. So that benefits are not interrupted, clients are given the opportunity to reapply before the current certification period ends. At this time a redetermination

(GP A.32) of eligibility is made to approve or deny continuing benefits. Therefore, a redetermination of eligibility is a time initiated by the department to act on changes, rather than acting on changes initiated by the client.

In addition to the redetermination at the end of a certification period, a new redetermination of eligibility is required at any other time changes are reported or the department determines that eligibility for benefits is questionable. This redetermination of eligibility in the middle of a certification period does not require a new application. A new certification period should not be established. The reported changes and worker's subsequent action should be documented in TRACS or ACCESS in a timely manner.

☞ SEE FS H.6 FOR ACTION ON CHANGES DURING A CERTIFICATION PERIOD AND FS B.13 ON LENGTH OF CERTIFICATION PERIODS.

The certification period means the months between initial eligibility and when the certification expires, or the months between one certification and the next.

When a client is receiving PA, they do not need to complete a separate application for FS. The PA redetermination form is also used to redetermine eligibility for food stamps. This means that when a PA redetermination is received, eligibility for food stamps should also be determined. In the combined PA/FS application situation, the FS redetermination period should be matched with the PA redetermination date. For example, if the FS certification period ends on June 30, 2003, the PA redetermination date should be July 2003.

Periodic Redeterminations; FS: 461-115-0450

Clients receiving TBA will automatically be required to complete an application for redetermination at the end of the TBA period. This is true even if there are months remaining on the certification period that began before TBA.

Transitional Benefit Alternative (TBA) in the Food Stamp Program: 461-135-0506

***Note:** Once a case has closed and there has been a break in benefits of even one day, the client must reapply and establish a new filing date. The only exception is if benefits closed because mail was returned by the post office marked "moved, unable to forward" and the closing code was RM.*

☞ SEE FS H.4.

18. Notice of Redetermination

For certification periods longer than two months, the system automatically sends the *FS Redetermination Due* notice (FCAS notice "C2"), about 45 days before the end of a certification period. The notice tells the client the date their certification period ends, that they must reapply to continue getting benefits and that they have a right to a hearing.

Notice Situations - Expiration of Certification Period; FS: 461-175-0222

When a filing group (FS C.2) is certified for one or two months (and not expedited), give the client a *Continuing Your Food Stamps* notice (AFS 944) at application, since the system will not have the necessary lead time to issue a notice.

Once established, the certification period cannot be shortened. Instead, the worker must redetermine eligibility as each change is reported. When the group becomes ineligible, the FS case must be closed.

- ☞ SEE FS H.6 FOR ACTIONS ON CHANGES REPORTED DURING THE CERTIFICATION PERIOD.

Notice Situation; Benefits for Less Than 30 Days: 461-175-0205

19. Redetermination Process and Interview

The redetermination (GP A.32) process involves establishing a filing date (FS B.5), conducting an interview (FS B.8), review of the application and supporting verifications (FS B.11), and an eligibility determination the same as with an initial application. Clients must cooperate in the redetermination. Failure to do so causes ineligibility and benefits are stopped. If the filing date is before the 15th day of the last month of the prior certification period, the interview must be conducted before the end of the certification period. Clients must be given the opportunity to receive the benefits for the new certification period without a break.

- ☞ SEE FS B.20 FOR MORE ON THE RIGHT TO UNINTERRUPTED BENEFITS.
- ☞ SEE FS B.9 ON APPLICATION PROCESSING TIME FRAMES AND FS B.20 ON THE CLIENT'S RIGHTS TO UNINTERRUPTED BENEFITS AT RECERTIFICATION.
- ☞ THE NOTICE WRITER FORM GS1090A CAN BE USED TO SCHEDULE A FACE-TO-FACE INTERVIEW AT RECERT.

As a part of the redetermination process, some clients may be entitled to expedited services (FS B.6). They are only eligible for expedited services if they meet the eligibility criteria and their filing date is after the ending date of the prior certification period. In other words, there must be a break in benefits.

In addition to the possibility of expedited services, benefits must be prorated (FS F.28) at recertification if the household established the filing date after the prior certification period ended.

Similar to an initial application, an interview is required at the time eligibility is redetermined. The in-office interview may be waived (see FS B.8) but it must be replaced by a telephone or home visit interview. If the client does not attend the interview, the Notice of Missed Interview must be sent (FS B.8) and a denial action is required on the 30th day from the filing date.

- ☞ SEE FS B.8 FOR POLICY REGARDING INTERVIEWS AND REASONS FOR WAIVING THE FACE-TO-FACE IN-OFFICE INTERVIEW.

Interviews: 461-115-0230

As with the initial certification application process, clients are required to provide verification at each redetermination. Verifications that were provided with the initial application and have not changed do not need to be requested again. Generally income needs to be verified with each application and reapplication. Give applicants for recertification a written request for verification and allow them at least 10 days to provide the verification.

- ☞ SEE FS B.11 FOR MORE ABOUT VERIFICATION.

For Self-Sufficiency offices: A prior application may be used during the redetermination process. This involves reviewing the prior application with the client and having the client initial any changes and sign and date the form. This process requires sitting down face-to-face with the client. Applications may be reused in this manner as long as a new application is completed once every 12 months.

Clients receiving TANF should have their redetermination processed in time to receive their benefits on the regular issuance date if they return their application and provide the needed verifications before the end of the current certification period.

For Aging Disabled offices: There are a number of ways to process the ACCESS application at redetermination:

- During the redetermination interview, changes can be made to ACCESS and the client can sign the new application.
- If a phone interview is done, the application can be mailed to the client after the interview to be reviewed and signed (Clear defaults should be selected).
- If a home visit is done, a Redetermination Application (contains only basic demographics) can be printed from ACCESS and used during the interview in the home.
- The Redetermination Application can be mailed to the client, completed, and returned to the local office. An interview to review the application can then be completed.

Note: Remember that a phone interview or home visit *MUST* be completed if the face-to-face interview is waived.

Periodic Redetermination; FS: 461-115-0450

Once eligibility has been determined, assign the longest certification period (FS B.13) over which the group's circumstances can be anticipated, not to exceed 12 months. When the group also receives cash or medical, set the period so that eligibility for FS and the

other program will come up for review at the same time. Once a new certification period is established, the benefit group (FS C.7) continues to receive food stamps unless it becomes ineligible. Do not shorten the certification period.

☞ SEE FS B.13 FOR INFORMATION ON ALIGNING CERTIFICATION OR REDETERMINATION PERIODS.

Periodic Redeterminations; FS: 461-115-0450

20. Right to Uninterrupted Benefits

Clients establish a filing date (FS B.5) when they turn in their redetermination application. Clients not receiving TANF or GA will receive uninterrupted benefits if they file their redetermination papers and complete their interview (FS B.8) by:

- The 15th of the last month of their certification period if they were approved for two or more months, or
- Within 15 days of receipt of the Notice of Expiration, if they were approved for less than two months.

Note: This means workers need to process the recertification papers in such a manner that allows the client 10 days to provide requested verification before the end of the current certification period.

Clients receiving TANF or GA are entitled to uninterrupted benefits if they file their redetermination papers in a timely manner. Redetermination papers are considered filed in a timely manner when they are received by the department by the 15th day of the last month of a certification period. This means, rather than the normal 30-day processing, they must have their benefits for the following month issued on the regular issuance date. Clients on TANF or GA also must not have benefits interrupted while eligibility is redetermined for the cash program.

Periodic Redeterminations; FS: 461-115-0450

21. Acting on Changes from the Redetermination

At the end of the certification period, adjust or end benefits for the next certification period by sending a basic decision notice, because notice requirements are the same as for initial approval of benefits. The system sends the notice when the recertification (REC) action is coded. Should the client request a hearing and continuing benefits in the amount of their previous month's benefits, do not allow the continuing benefits. This is because benefits for the prior amount ended with the end of the certification period. A new eligibility and benefit level must be established with each certification period.

Notice Situations; General Information: 461-175-0200
Continuation of Benefits: 461-025-0311

☞ FOR ACTION ON CHANGES PRIOR TO THE END OF THE CERTIFICATION PERIOD,
SEE FS H.6.

22. Food Stamps B – Applications Examples

6. Expedited Service Examples

Example 1: A client applied for FS on June 18 and meets the expedited criteria. They come into the office for their interview on June 25. This is the seventh calendar day following the filing date. Identification is viewed. FS eligibility is determined based on the application and client statements in the interview. A pending notice (DHS 210 or SDS 539H) is given to verify income and SSN with a due date of July 17.

Example 2: A noncitizen has \$100 a month income and no resources. They also have a noncitizen status that makes them ineligible for FS. This client meets the expedited service criteria, but is denied because they do not meet all other FS eligibility requirements.

Example 3: A noncitizen has \$100 a month income and no resources. They also have a noncitizen status that appears FS eligible, but SAVE says to implement secondary verification. This client is approved for FS because they appear to meet all eligibility requirements and the eligibility decision cannot be delayed beyond the seven-day processing time frame waiting for the secondary verification from SAVE.

7. Withdrawn Applications Examples

Example 1: Meg is receiving FS benefits through March 31. In December, she applies for medical and FS benefits. The worker should clarify to Meg that she is already receiving FS and there is no need to reapply. Narrate this conversation and no denial notice is needed.

9. Application Processing Time Frames Examples

Example 1: A client completes the interview in the first 20 days from the filing date but calls their worker on day 26 of the application period to say that they are not able to get all of the verification before day 35 because the source is out of town. The worker extends the application processing period to day 35. The client provides the requested verification on day 35, eligibility is determined and benefits are opened back to the filing date.

Example 2: A client asks for a FS application, the branch is so backed up that they cannot schedule the interview before the 21st day from the filing date. The client shows for the interview, and is given a DHS 210 or SDS 539H pending notice asking for the information by the 31st day. They provide the requested verification on day 31. Eligibility is determined and benefits are issued back to the filing date.

11. Verification for 30-Day Application Processing and Changes Examples

Example 1: Adam reports his rent increased from \$250 a month to \$550. He is in HUD housing and the worker questioning the new amount requested verification on a DHS 210A. The shelter deduction of \$250 continues until the verification is received.

Example 2: Beth reports she is only paying \$200 in court-ordered child support due to a loss of income. She was paying \$300 at the start of the certification. Continue the FSMIS deduction code of COS of \$300 until the proof is received.

16. Effective Dates on Applications Examples

Example 1: A group applies for FS on May 10. They have already received benefits in another state in May. They are ineligible on the filing date. The effective date is June 1, if they have closed their other FS case.

Example 2: When the group provides verification within 30 to 60 days after their filing date and the branch did not give them extra time to do this, then, the effective date is the date they provide the verification, as long as they meet all eligibility requirements on that date.

Example 3: The effective date is the first of the month for groups including migrant (GP A.22) or seasonal (GP A.35) farm workers (FS I.1) who received FS in another state the month before applying for FS in Oregon.

C. Eligibility Determination Groups

1. Household Group

People who live in the same dwelling are in the same household. A dwelling is defined as living space, separate from other dwellings that have access to the outside that does not pass through another dwelling, and contains a sleeping area, bathroom and kitchen facility.

For example: A house is two separate dwellings when it is divided into two separate identified apartments and each contains its own entrance from outside, bedroom, kitchen and bath area.

☞ SEE HOUSEHOLD GROUP EXAMPLES (FS C. EXAMPLES 1).

Persons residing in each of these dwellings are considered their own household. If a child (under the age of 22) lives in a separate dwelling from their parents (GP A.27), they are two separate household groups. In this situation, the parents and child will not be placed in the same filing group (FS C.2) because they are not in the same household.

For homeless (GP A.17) groups, the household is the people who consider themselves living together.

☞ SEE FS I.4 FOR A LIST OF HOMELESS SHELTERS CERTIFIED TO ACCEPT FS IN PAYMENT FOR PREPARED MEALS.

When people live in more than one household during a calendar month, consider them in the household where they eat at least 51 percent of their meals.

When children live in shared custody situations, it must be determined whose household they receive the majority of their meals from. The parent whose house the child leaves to go to school that morning receives credit for breakfast and lunch.

☞ SEE HOUSEHOLD GROUP EXAMPLES (FS C. EXAMPLES 1).

Exception: Residents of domestic violence shelters (GP A.11) or safe homes (GP A.34) can be in both the household they just left and the household they are in the month they enter the shelter.

☞ SEE FS G.7 AND IB A.29 REGARDING ISSUING BENEFITS TO CLIENTS RESIDING IN DV SHELTERS OR SAFE HOMES.

In addition, people gone from the household for 30 days or more are no longer in the household.

☞ SEE FS H.5 FOR POLICY ON WHEN A PERSON IS INCARCERATED.

2. Filing Group; Overview

After determining who is in the household, determine who is in the filing group. The filing group is the people who live together whose circumstances are considered in determining eligibility.

Filing Group; Overview: 461-110-0310

3. Filing Group; Most Situations

The filing group is the people in the household who:

- Choose to apply together; **and**
- Must apply together because of relationship or other circumstances (such as purchasing and preparing their meals together) that make them ineligible to apply separately from others living there.

When all people living together purchase or prepare meals together they are all in the same filing group, unless they meet an exception in FS C.4.

☞ SEE FS I.3 FOR INFORMATION ON WHO MAY BE ELIGIBLE FOR FS WHEN MEALS ARE PROVIDED.

Additionally, some people who live together must be in the same filing group, even if they purchase and prepare their food separately. These people are:

- Spouses (GP A.37).
- Parents (GP A.27) and their children (GP A.5), unless the children are age 22 or over.
- Children under age 18 who live with an adult who is not their parent, but the adult has parental control. Parental control means the adult is responsible for the care, control and supervision of the child or the child is financially dependent on the adult.

Definitions for Chapter 461: 461-001-0000

☞ SEE FILING GROUP EXAMPLES (FS C. EXAMPLES 3).

For everyone else, the filing group is all the people in the household, except for people who purchase and prepare their food separately.

Residents of commercial boarding houses cannot be in the filing group. However, the manager/owner of a commercial boarding house and their filing group can apply separately from the resident boarders.

Higher education students that do not meet the criteria to be an eligible student (FS D.3) cannot be in the filing group. Only higher education students who meet this special criteria or who are under age 18 or age 50 or older can be included in the filing group. Higher education students residing in dorms or other group college living situations with meal plans are not eligible for FS in separate filing groups.

Eligible and Ineligible Students; FS: 461-135-0570

☞ SEE EXAMPLES OF FILING GROUPS INELIGIBLE STUDENT #7 (FS C. EXAMPLES 3).

☞ SEE FS D. 3 FOR MORE ON HIGHER EDUCATION STUDENTS.

A household member who received FS benefits in the month of application in another benefit group is excluded from the new filing group. They can be excluded for a maximum of two months, if necessary, due to notice requirements, and only if the person who already received FS was not the head of household in the other benefit group.

Note: If the person already received FS benefits this month as head of household, follow the 'add a person' policy.

☞ SEE FS F.16 FOR HOW TO TREAT PERSONS RECEIVING CALIFORNIA SSI.

Note: A person that is not included in the filing group will not have their income included in the group's countable income. If a person drops out of the filing group, they are not included in the financial, need, or benefit groups.

Filing Group; Overview : 461-110-0310
Filing Group; FS : 461-110-0370

4. Filing Group; Special Living Arrangements

☞ SEE FS I.3 FOR MORE ON SITUATIONS WHERE MEALS ARE PROVIDED.

Drug/Alcohol Treatment Centers (A & D) or Residential Care Facilities (RCF). Residents in drug/alcohol treatment centers or residential care facilities (GP A.6) are not eligible for FS when the facility provides the meals unless the facility is certified by the state.

If the facility is not state certified, the facility cannot apply for the client. In this instance, the client must have cooking facilities available for personal use and be responsible for at least 51 percent of their own meals to be eligible for FS.

Certified A & D: In order for residents of drug/alcohol treatment facilities to be eligible for FS, the facility must be certified through the State of Oregon Office of Alcohol and Drug Abuse Program. All residents must apply through an authorized representative (FS B.14) who is an employee of the facility. An employee of the facility must sign the

application. Each resident forms their own filing group unless they are parents and children under age 22. Parents with children under age 22 form one filing group.

- ☞ SEE FS-WG #3.1 FOR MORE ON CLIENTS LIVING IN AN A&D TREATMENT CENTER.
- ☞ SEE FS I.4 FOR A LIST OF A&D TREATMENT CENTERS WITH POINT-OF-SALE DEVICES.

Residents of Institutions; FS: 461-135-0510

Certified RCF: Residents of an RCF can receive benefits only if all the following are true:

- The facility is public or private nonprofit, serves no more than 16 residents, and is licensed by the State of Oregon, DHS.
- The resident applies through an authorized representative who is an employee of the facility, unless the facility determines that the resident can apply on their own.
- The person is blind or has disabilities (GP A.10).
- The person meets all other FS eligibility requirements.

The certified facility may apply for the residents as an authorized representative or the facility may decide that the resident is able to apply on their own. Each resident forms their own filing group. When the RCF residents do not have an employee of the facility as their authorized representative, form the filing groups according to the bullets in FS C.3.

Note: *If the certified RCF applies for its residents, it must apply as an authorized representative for each resident and sign the application.*

Note: *DD clients receiving brokerage services are not considered to be residing in a RCF.*

- ☞ SEE FS F.24 FOR MORE INFORMATION ON GROUP LIVING ARRANGEMENTS.
- ☞ SEE FS-WG #3.2 FOR MORE ON CLIENTS LIVING IN A RCF.
- ☞ SEE FS I.4 FOR A LIST OF NON-PROFIT MENTAL HEALTH RCFS.

Filing Group; FS : 461-110-0370
Residents of Institutions; FS : 461-135-0510
Residents of Drug Addiction and Alcohol Treatment Facilities; FS : 461-135-0550

Elderly Persons Who Have Disabilities. An elderly person (GP A.13) and their spouse (GP A.37) (if any) may apply separately from others they live with who purchase and

prepare meals for them. This is true only if the elderly person is unable to purchase and prepare their own food because of a severe and permanent disability, and the income of the other household group members managing the food does not exceed this limit:

Others Living in the Dwelling Monthly Countable Income

1	\$ 1,490
2	2,004
3	2,518
4	3,032
5	3,547
6	4,061
7	4,575
8	5,089
Each additional person	515

☞ SEE EXAMPLES OF FILING GROUP; SPECIAL LIVING ARRANGEMENTS
ELDERLY #1 AND #2 (FS C. EXAMPLES 4).

Filing Group; FS: 461-110-0370

Foster Care/Guardianship Assistance. Persons in foster care (CA B.29) or receiving Guardianship Assistance cannot form their own filing group. This is because they are having meals provided as part of their foster care/guardianship assistance, so they do not have a food need.

The familial relationship ties noted in FS C. 3 regarding spouse and child under age 22 are not broken, even when a person is in foster care. If the caregiver applies for benefits, the caregiver can choose to include or exclude the person(s) in foster care/guardianship assistance, their spouse or child under age 22 from the filing group. If the caregiver chooses to include the person(s) in foster care/guardianship assistance in the group along with other people living there, form the filing group according to the bullets in FS C.3.

For FS, treat residents of Adult Foster Care (AFC) (GP A.6) as follows:

- Residents of nonrelative AFC not licensed by the state are not eligible for FS.
- Residents of AFC and relative AFC facilities licensed by the state must apply with their caregiver to be eligible for FS per rule 461-110-0370.

☞ SEE FS-WG #3.6 FOR MORE ON CLIENTS LIVING IN AN AFC SITUATION.

Filing Group; FS: 461-110-0370
People in Adult Foster Care (AFC) and Boarding Houses; FS: 461-135-0530

☞ SEE EXAMPLES OF FILING GROUP; SPECIAL LIVING ARRANGEMENTS
FOSTER CARE, #3, #4 AND #5 (FS C. EXAMPLES 4).

Note: *Proctor care administered by or under contract to a state agency is a form of foster care. Treat these situations and income the same as foster care.*

Live-In Attendants. A live-in attendant is a person living in the household and paid to provide medical, housekeeping or similar personal services for a person with disabilities or elderly (GP A.13) person. They are not considered a member of the elderly person's or person with disabilities' household unless they are related as specified in the bullets in FS C.3. When live-in attendants are not related as specified in the bullets in FS C.3. to the person they are caring for, they may apply with their minor children (if any) separately from the people for whom they are providing services.

☞ SEE EXAMPLES OF FILING GROUP; SPECIAL LIVING ARRANGEMENTS LIVE IN ATTENDANT #6 (FS C. EXAMPLES 4).

Note: *A paid live-in attendant provides essential supportive services in the client's home; or in the home of a relative or others with whom the client lives; or the client lives with a relative or others who provide paid care services and the living situation does not meet foster care licensing requirements. The services range from assistance with household tasks to assistance with activities of daily living.*

Supportive services may be provided to those individuals who have been assessed by DHS to be in need of a service or whose physician prescribes supportive services.

Filing group; FS: 461-110-0370

Residents of Domestic Violence Shelters (GP A.11) or Safe Homes (GP A.34). These clients can be in two filing groups the month they enter the shelter, when they recently left a household containing a person who abused them. These clients may receive FS benefits twice that month if they: were not issued an Oregon Trail card; are unable to access the benefits; or the original benefits remain in control of the abuser. The two filing groups are the one they just left and the one they are in the month they enter the shelter. Once in the shelter/safe home, residents can choose to apply together or form filing groups according to the bullets in FS C.3.

☞ SEE FS G.7 AND IB A.29 REGARDING ISSUING BENEFITS TO CLIENTS RESIDING IN DV SHELTERS OR SAFE HOMES.

☞ SEE FS-WG #3.4 FOR MORE INFORMATION ON CLIENTS LIVING IN DV SHELTERS OR SAFE HOMES.

Filing Group; Overview: 461-110-0310
Filing Group; FS: 461-110-0370

☞ SEE EXAMPLES OF FILING GROUP; SPECIAL LIVING ARRANGEMENTS DV SITUATIONS #7 (FS C. EXAMPLES 4).

Institutions. People who reside in an institution that provides them with at least 50 percent of their meals may, or may not, be eligible for FS. It is important to consider the client's circumstances when making a determination.

People in a general hospital, state institution, intermediate care facility, or semi-skilled or skilled nursing facility for 30 days or more are not eligible.

The following are not considered institutions:

- Domestic violence shelters (GP A.11).
- Public or private nonprofit shelters for homeless people (GP A.17).
- Federally subsidized housing for the elderly built under section 202 of the Housing Act of 1959 or section 236 of the National Housing Act (contact your local housing authority for more information).

Residents of Institutions; FS: 461-135-0510

Lodgers. A *lodger* is someone who pays someone else in the household for their meals. Lodgers cannot form their own filing group. This is because they do not purchase and prepare their meals. However, if their meal provider applies for benefits, the meal provider can choose to include or exclude a lodger paying a reasonable amount from the filing group.

Lodgers paying less than a reasonable amount for their meals must be in the filing group with the meal provider. The amount they are paying is not reasonable when it is less than the Thrifty Food Plan for themselves and anyone else in their filing group, if they pay for more than two meals a day. It also is not reasonable when it is less than two-thirds of the Thrifty Food Plan for themselves and anyone else in their filing group, if they pay for two or less meals per day.

Residents of commercial boarding houses are not eligible. A person operating the boarding house and his or her filing group may receive benefits separate from the residents.

Filing Group; FS: 461-110-0370
People in Adult Foster Care (AFC) and Boarding Houses; FS: 461-135-0530
Work Requirements; EA: 461-145-0340

5. Financial Group

The financial group consists of all the people in the filing group (FS C.2). Everyone in this group will have their income and resources counted.

Financial Group: 461-110-0530

6. Need Group

The need group are the people whose basic and special needs are used in determining eligibility.

The need group consists of all of the financial group (FS C.5) members except any member who:

- Does not meet the nonfinancial eligibility requirements;
- Is disqualified for IPV (GP C.5);
- Is fleeing to avoid prosecution, custody or confinement after conviction for a felony or attempt to commit a felony;
 - ☞ SEE FS D.21 AND GENERIC PROGRAM L (GP L.) FOR INFORMATION ON HOW TO DETERMINE ELIGIBILITY AFTER A PERSON HAS BEEN IDENTIFIED AS NOT MEETING THE CONDITIONS OF THEIR PAROLE, PROBATION OR POST-PRISON SUPERVISION.
- Is violating a condition of parole or probation imposed under state or federal law;
or
- Is disqualified for multiple FS participation, for use or receipt of FS to purchase a controlled substance, firearms, ammunition or explosives, or trafficking benefits.
 - ☞ SEE FS F.16 FOR INFORMATION ABOUT HOW TO TREAT A PERSON WHO IS RECEIVING SSI FROM CALIFORNIA.

Note: *Examples of clients not meeting the nonfinancial requirements are ineligible noncitizens (FS D.5), clients disqualified for failure to meet work requirements (FS D.17), or clients disqualified for refusal to provide an SSN (FS D.6).*

☞ SEE NEED GROUP EXAMPLES (FS C. EXAMPLES 6).

Although people are dropped from the need group because of the bulleted reasons above, their income and resources still count. This is because they are still members of the financial group. Individuals who fail to get FS benefits for these reasons do not have their needs considered when choosing the payment standard to calculate benefits.

Need Group: 461-110-0630

7. Benefit Group

People from the need group (FS C.6) who have resources below the limit and have income below the Income Limits/Payment Standard are in the benefit group and get FS.

If the benefit group does not have at least one eligible person in the benefit group, deny the application.

Benefit Group: 461-110-0750
Filing Group; Overview: 461-110-0310

8. Food Stamps C – Eligibility Determination Groups Examples

1. Household Groups Examples

Example 1: A 20-year-old son, Art, lives in a self-contained camp trailer on his parents' property. He has a bathroom, microwave oven and a small stove in the trailer. He states that he purchases and prepares his own food, and he is applying for FS for himself only.

Forming the group: The son does not need to apply for FS with his parents because he is in a separate dwelling where he prepares his own meals. He is living in a household separate from his parents and is therefore eligible to apply for FS for himself only.

Example 2: An 18-year-old son lives in a camp trailer on his parents' property with his girlfriend. They state that they purchase and prepare their meals together. However, because the camp trailer is not equipped for cooking, they cook and eat at his parents' house.

Forming the group: The son and his girlfriend cannot form their own filing group separate from his parents because they do not have the facility or equipment to prepare their own meals.

Example 3: A client and her two children live with her husband who is a long-haul truck driver. The husband is on the road three weeks out of every month. He buys his meals on the road. The client and the children want to apply for FS separate from the husband.

Forming the group: The client and her children are separate from the husband. The husband is not included in the household because he eats over 51 percent of his meals elsewhere. However, the portion of his pay he gives to his family counts as unearned income (support).

3. Filing Group; Most Situations Examples

Example 1: A pregnant client and her boyfriend (father of her unborn) state they live together, but purchase and prepare food separately. The client wants to apply for FS separate from her boyfriend.

Forming the group: Each adult can be separate for FS. When the baby is born, however, the baby must get FS with its parents. Therefore, at that time, the three of them will become one FS group, even if they continue to purchase and prepare food separately.

Example 2: A pregnant 19-year-old lives with her parents and 13-year-old brother. She states she purchases and prepares food separately from the rest of the family and wants to apply for separate FS.

Forming the group: The 19-year-old must be part of the one FS group that lives together. She is under age 22 and lives in her parents' residence, and therefore is part of their filing group. Even when the baby is born, she and her baby cannot form a separate group from her parents until she turns 22.

Example 3: An 18-year-old lives in a camp trailer on his friend's property. He states he purchases and prepares his own meals. He cooks and eats his meals at his friend's house because the trailer is not equipped for cooking.

Forming the group: Even though 18-year-old is in his friend's household group, he does not need to apply for FS with his friend as long as he purchases and prepares his own meals. He can form his own filing group even though he cooks at his friend's house because his friend is not his parent.

Example 4: A 19-year-old, her 24-year-old friend and their common child live with her parents. She states that she and her child purchase and prepare food separately from the rest of the household and want to apply for separate FS.

Forming the group: The 19-year-old, 24-year-old and their common child must be part of the same FS filing group because the child draws in both parents. The client is under age 22 and she is living with her parents. Therefore, they must all be part of the same filing group. (If the 19-year-old, 24-year-old and child were living with the 24-year-old's parents, they could be in a separate filing group from his parents.)

Example 5: A 26-year-old woman moved in with her parents. Two of her children (ages 3 and 5) also live with her parents. The parents have guardianship over the young children.

Forming the group: The 26-year-old cannot be a separate filing group from her two children because they are under the age of 22. The children cannot be a separate filing group from the grandparents because they have parental control, care and supervision. Therefore, the filing group consists of the 26-year-old, her parents and the two children.

Example 6: Denise, age 12, is on FS with her mother. On March 16, she moves in with her father, who applies for benefits for both of them. Although her father may be eligible in March, Denise cannot receive FS benefits with him and is excluded from the filing group. Send 10-day notice to Denise's mother to remove her from that case before adding her to her father's filing group.

Example 7: A married couple purchase and prepare food together and want to apply for FS together. One of them is an ineligible student.

Forming the group: This is one household group, but the ineligible student is excluded from the filing and other groups. Therefore, only the nonstudent can get FS, and none of the ineligible student's income or resources count.

Example 8: Tammy moves in with Tommy, and they are purchasing and preparing their meals together. Tommy wants to apply for FS benefits, but Tammy received benefits with her mother this month in Washington.

Forming the group: Since Tammy was not the head of the household on her mother's case, Tommy can receive benefits this month without Tammy.

4. Filing Group; Special Living Arrangements Examples

Example 1: Elderly Person –

An elderly person and their spouse live with their daughter (age 21) and her spouse. The couple has disabilities that prevent them from purchasing and preparing their own meals. The couple may form a separate filing group from the daughter and her spouse even though the daughter is under age 22, as long as the daughter and her spouse have countable income below 165 percent FPL. (Income chart is in FS C. 4).

Example 2: Elderly Person –

A 72-year-old woman lives with her daughter. The woman has temporary disabilities due to a car accident and unable to purchase and prepare her own meals. She may not form a separate filing group from her daughter because she does not meet the criteria of a severe and permanent disability.

Example 3: Foster Care –

The household group consists of a person in AFC, his daughter (age 26), her spouse and their two children. The daughter and her husband may apply for FS with or without her father. They are all purchasing and preparing meals together but the daughter may exclude her father from the filing group simply because he is getting AFC.

Example 4: Foster Care –

Elderly parents live with their 27-year-old daughter. The daughter provides foster care for her father. The daughter purchases and prepares food for everyone in the household and wants to apply for FS for herself and her mother only.

Forming the group: The daughter can choose to exclude the person in foster care and his spouse or children under 22 from the group. She can only apply for her mother if she includes her AFC father. So, she alone can be a separate FS group. Her father and mother, however, cannot be in a separate group because he is in foster care and is ineligible if he applies for himself and spouse.

Example 5: Foster Care –

The household group consists of a teen in foster care with a newborn and the foster care provider.

Forming the group: The provider must choose to include or exclude the teen and newborn from the filing group. The newborn cannot receive food stamps without the foster care teen. The foster care teen can only receive food stamps if the provider applies and includes the teen in their filing group.

Example 6: Live-in Attendant –

The household group consists of a person with disabilities that keep them from doing housekeeping or personal services and they have hired another to live in their home to provide these services. Each may apply for FS as separate filing groups as long as they are not required to apply together due to relationship. If the person receiving care provides the majority of the attendant's meals, the attendant cannot apply for FS as a separate filing group. If the person receiving care provides the majority of the attendant's meals and the attendant is not in the filing group, the client may also get a medical deduction for the cost of the meals up to a one-person FS payment standard.

Example 7: DV –

A client and two children fled their home and went to a friend's home to be safe. This client may not get a second FS issuance in the month because she did not flee to a DV shelter and is not in a dwelling that meets the definition of a safe home.

Example 8: A 30-year-old woman lives with her husband and her 52-year-old mother. She does all the grocery shopping, using her mother's money to pay for her mother's own food. The daughter also does all the cooking, preparing separate meals each day for her mother.

Forming the group: There are two filing groups in this household - the married couple is one; the mother is separate. Even though the daughter does all the shopping and cooking, the food is purchased and prepared separately for the two groups.

6. Need Group Examples

Example 1: A married couple with 10- and 12-year-old children purchase and prepare food together and want to apply for FS together. The mother is an ineligible noncitizen.

Forming the group: This is one filing group. The mother is excluded from the need and benefit group, because she does not meet the nonfinancial requirement for citizenship. Because she is in the financial group, a prorated share of her income and deductions count.

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D. Nonfinancial Eligibility

1. Identity

The applicant and their authorized representative (FS B.14) (if any) and the alternate payee, if any, must establish and verify (FS B.11) their identity.

☞ SEE MP-WG #2.5 FOR EXAMPLES OF VERIFICATION OF IDENTITY.

Verification: 461-115-0651
Expedited: 461-115-0690

2. Residency

The group must reside in Oregon and not be simply vacationing here. There is no minimum or maximum time that they are required to be in Oregon in order to be a resident. In addition, there is no requirement that they intend to reside here permanently.

Categorically eligible (FS E.1) groups are assumed to meet residency when it has been established in the categorical program.

***Note:** Although clients are not required to have a fixed mailing address, they must provide a location to get notices from the department. This mailing address cannot be the branch address. To use the branch address means the department is sending the client notice to the department and not the client. For the homeless (GP A.17), the mailing address may be General Delivery or the address of a shelter or a friend.*

☞ SEE MP-WG #2.8 FOR EXAMPLES OF VERIFICATION OF RESIDENCY.

Residency: 461-120-0010
Categorical eligibility: 461-135-0505

3. Students

When FS clients age 18 through 49 are enrolled at least half-time in higher education, they must meet special criteria to be eligible for FS.

Use the school's definition of half-time to determine which students are in this category. In addition, consider the student continually enrolled through school vacations and breaks. Their enrollment only ends when the student graduates, drops out (by officially disenrolling), is suspended or expelled, or does not intend to register for the next school term (excluding summer term).

Note: *High school graduates who have registered for higher education but not yet started classes are not considered higher education students for FS until the higher education classes begin.*

Students are in higher education when they are enrolled in one of the following:

- All public and private universities, colleges, and community colleges including online universities, unless the student is taking high school equivalency programs such as GED, ABE, or ESL.
- All post-secondary business, trade, vocational, or technical schools that normally require a high school diploma or equivalency for enrollment into the institution or curriculum.

Caution: Determine student status and if the student meets the eligible student criteria, then look at other nonfinancial criteria (including OFSET (FS D.7)). Ineligible students are not members of the filing group (FS C.2).

QC Hot Tip

Only look at student status when:

- The student is age 18 through 49;
- The student is in higher education (beyond high school);
- The student is enrolled in a regular curriculum at a college or university; or in a trade/vocational/technical school that requires a high school diploma or equivalency before enrollment into the curriculum; and
- The student is enrolled at least half-time (per the school).

If all of these factors are true, a student status decision is required if the student is a member of the filing group.

If any one of these factors is false, include the student in the filing group and continue the FS eligibility determination.

Higher education students (age 18 through 49) meet the special criteria and may qualify for FS only when they are one of the following:

- Physically or mentally unfit for employment (FS B.11).

Note: *This includes a person receiving disability benefits or going to school through a vocational rehabilitation program or with a training plan*

supported by their vocational rehabilitation program. It also includes a person receiving SFPSS program benefits due to their own disability.

- A paid employee working an average of at least 20 hours a week. The student must be employed in an employer/employee relationship and receive a cash payment for the work. An employer/employee relationship exists when the employer controls and directs the activities in which the employee is being compensated, and could fire the employee for failure to adequately perform the activities.
- Earned in-kind payments do not count toward working 20 hours a week and are not the equivalent of 20 hours at federal minimum wage. The hours students are working in an internship, graduate assistance, or fellowship do not earn the student hours toward the 20 hours a week criteria. This is because the graduate assistance or fellowship is a form of educational income. This allows the exclusion for student costs (such as tuition, books, fees, etc.). This income cannot be both educational income and earned income counted toward the 20 hours a week. Individuals participating in AmeriCorps under the NCSTA (CA B.50) are not considered employees per 2540.320 of that act. Therefore, students cannot meet the working 20 hours a week criteria using AmeriCorps work hours

☞ SEE CA B.25 FOR INFORMATION ABOUT HOW TO COUNT EDUCATIONAL INCOME.

- Self-employed for at least 20 hours each week, and they receive countable weekly earnings of at least the federal minimum wage times 20 hours (after allowable costs (CA C.2)).

Note: The self-employment income is at least \$1,126.60 SEC or \$563.30 SEN.

- Approved for state or federally funded work-study, and expects to “actually perform” work in a work-study job during the current term or semester. “Actually perform” work study means the student has been assigned a work-study position and has been given a start date within the term or semester or is currently working in a work-study position. Eligibility for students in this category begins with the month in which school begins or the month that work study is approved, whichever is later. As long as the student does not refuse a work-study job, eligibility continues for the duration of the term or semester.

Note: Students need to pursue the work study and expect to perform the work study during the term or semester. There is no expectation to perform the work study if the school does not have the funds to hire the students. The student must meet other criteria to meet the eligible student status. Eligibility continues through breaks of less than a month. For breaks of one month or longer, e.g., summer vacation, the student maintains eligibility only if they perform work in a work-study job or is a paid employee working at least 20 hours a week during the break.

- Responsible for the care of a child in the filing group and the child is:
 - Under age six in a one- or two-parent home; or
 - Age 6-11 in a one- or two-parent home and the local office determines that adequate child care is not available for the client to both work 20 hours a week and attend school; or
 - Age 6-11 in a one-parent home, if the parent is a full-time student. This applies to any single adult with parental control.

***Note:** In a two-parent family, if both parents (GPA.27) are students, determine with the client who is responsible for care of the child or children. If the parents split the responsibilities of caring for more than one child, both parents can be eligible students. For example, Mom and Dad are both students and they have a 5-year-old and a 3-year-old. Mom takes care of the 3-year-old during the morning while the 5-year-old and Dad are at school. Dad then takes care of both the 3-year-old and the 5-year-old in the afternoon while Mom is in school. Both parents are eligible students because they each care for one child. However, if Mom takes care of both children in the morning and Dad takes care of both in the afternoon, they must state which parent has primary care of the children. Narrate their statements.*

- In a TANF benefit group.
- In a WIA training program.
- Enrolled in higher education as a result of participation in the higher education component of the JOBS program.

***Note:** Currently there is no higher education component of the JOBS program. Self-initiated training is not considered a component of the JOBS program.*

- Enrolled in higher education as a result of employer-sponsored on-the-job training.
- In a program serving displaced workers under Section 236 of the Trade Act of 1974.

How to verify the client is in a displaced worker program under the Trade Act of 1974:

- | | |
|---------------|---|
| <u>Step 1</u> | Access ECLM. If the function key “10) TRA” does not appear at the bottom of the screen, the client is not in this program. |
| <u>Step 2</u> | If the function key “10) TRA” (it will be highlighted) appears at the bottom of the screen, the client is potentially in the program. For these clients, press {F10} to access the Trade Act claim screen (ETRC). Look at the column beginning with “Prior SSN,” then go down 10 lines to the |

“Tng” field. If today’s date is within the beginning and end dates in this field, the client is currently in a program under the Trade Act.

Eligible students: 461-135-0570

Note: *Students who are covered by a meal plan are not eligible for FS.*

When dealing with students, remember that the client must meet the criteria listed above, or they are not eligible for FS. Once you have determined that they are eligible students, then they are exempt from meeting the OFSET work requirement. The student status is determined first.

Note: *If an eligible student is found to no longer meet one of the criteria during the certification period, they become ineligible. Notice Writer notice FSC00CE can be sent as the notice when the entire case is ineligible.*

Eligible students who meet at least one of the above criteria are included in the filing group. Their income and resources count; however, most student income is excluded because it is either from title IV federal funds (CA B.25) or is excluded to cover student expenses. Use the *Educational Income Calculation for ERDC and Food Stamps* worksheet (DHS 7351) to compute educational income.

☞ SEE MP-WG #14 FOR EXAMPLES OF MOST TYPES OF EDUCATIONAL INCOME.

Graduate students must meet the same student criteria as any other higher education student. The graduate assistance or fellowship income is counted the same as non-title IV educational income.

☞ SEE CA B.25 FOR HOW TO COUNT GRADUATE ASSISTANCE INCOME AFTER DETERMINING THE COUNTABLE AMOUNT ON THE DHS 7351.

Veterans may attend higher education in more than one way. Some may attend college under the Montgomery GI Bill (VA Chapter 30). Other veterans may attend school under the Chapter 31 vocational education program. The Veterans Administration provides all of the educational expenses for students attending college under Chapter 31, except travel to and from school and child care expenses. In addition, they will receive a training stipend. The stipend is not educational income. How to count this stipend income is located in Veterans’ Benefits in CA B.82.

Educational income: 461-145-0150
When to count: 461-110-0370

Remember, *an ineligible student is not a member of the filing or financial group (FS C.5). On FCAS, they are coded ST unless head of household. If head of household, code the ineligible student as DH.*

Students who are required to meet the above criteria and do not are ineligible for FS. Their income and resources do not count when there are other eligible members in the FS

group. Sometime the ineligible student is paying all of the costs (GP A.7). In this instance, the eligible household members are not given any deductions. In other instances, the ineligible student shares in the household costs with the members of the filing group. When eligible clients share housing with an ineligible student, allow a shelter deduction (FS F.22) only for amounts paid by the filing group members. For example, if the ineligible student pays the rent and the other members pay the utilities (including heat), allow zero for shelter and the FUA as deductions.

If the filing group is not able to identify what share of the costs each member pays, divide the housing amount by the number of people actually paying the costs. Subtract the share for each ineligible student and count the remainder as the deduction. For example, in a three-person group, there is one ineligible student. The rent is \$450 and the FUA is \$287. Two people (one the ineligible student) in the household are paying the costs using co-mingled funds. \$450 divided by two people = \$225 share per person. One person is the ineligible student, so subtract \$225 from the \$450. The countable housing deduction, then, is the remaining \$225. If a member of the filing group pays any part of the utilities, allow the appropriate TUA, FUA, or LUA without proration.

Shelter: 461-160-0420

Use the *Educational Income Calculation for ERDC and Food Stamps* (DHS 7351) worksheet to help determine if a child care deduction is allowable and the amount allowed. The child care deduction is the lesser of the actual cost, the unmet need in box 13, or the child care cost identified in box 11.

☞ SEE FS F.19 FOR MORE INFORMATION ABOUT THE CHILD CARE DEDUCTION.

☞ SEE EXAMPLES ABOUT STUDENT STATUS #1 THRU #4. FOR INELIGIBLE STUDENT STATUS SITUATIONS, SEE #5 THRU #10. FOR ELIGIBLE STUDENT STATUS SITUATIONS, SEE #11 THRU #16. FOR HOUSING AND UTILITY DEDUCTION WHEN THERE IS AN INELIGIBLE STUDENT, SEE #17 THRU #19 (FS D. EXAMPLES 3).

4. Declaration of Citizen/Noncitizen Status

An adult applying for FS or an authorized representative (FS B.14) must sign a statement declaring under penalty of perjury that the reported citizen/noncitizen status of each person they are requesting FS for is true.

Note: Clients accomplish this by signing the application for FS.

Declaration of Citizenship or Alien Status: 461-120-0130

5. Citizen Status

To qualify for FS, the client must be a U.S. citizen or a qualified noncitizen. Only persons who want benefits are required to disclose their citizenship. Persons who do not want benefits or who do not want to give their status and who must be included in the filing group (FS C.2) are treated as ineligible noncitizens (NC1s).

☞ SEE NC B FOR DETAILS ON DETERMINING ELIGIBILITY IF A FILING GROUP MEMBER IS NOT A CITIZEN.

A U.S. citizen includes the following people:

- A person born in the U.S.
- A naturalized citizen.
- A person born outside of the U.S. but whose parents (GP A.27) (both mother and father) are U.S. citizens.
- A person born outside of the U.S. who is over 18 years of age but who has at least one parent who is a U.S. citizen. The person must either have a certificate of U.S. citizenship or meet one of the following criteria:
 - Born on or after December 24, 1952, and prior to November 14, 1986, and their citizen parent was physically present in the U.S. or its outlying possessions for 10 years or more, at least five of which were after age 14.
 - Born on or after November 14, 1986, and their citizen parent was physically present in the U.S. or its outlying possessions five years or more, at least two of which were after age 14.
- A child born outside of the U.S. who is under 18 years of age and has at least one parent who is a U.S. citizen. The child is residing in the U.S. in the legal and physical custody of the citizen parent after having been lawfully admitted into the U.S. as an immigrant for lawful permanent residence.
- A child lawfully adopted by U.S. citizens.
- A citizen of Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands (Saipan, Tinian, Rota and Pagan), American Samoa, and the Swains Islands.

☞ SEE MP-WG #2.2 FOR EXAMPLES OF VERIFICATION OF CITIZEN/ALIEN STATUS.

Eligibility requirement: 461-120-0110
Alien Status: 461-120-0125

6. Social Security Number

All clients in the benefit group (FS C.7) must provide their Social Security number (SSN) if they have one. If they do not have an SSN, they must make a good-faith effort to apply for an SSN and provide it when it is received. Only those persons who want benefits are required to provide their SSN. Other persons living in the household are not required to provide their SSN.

☞ SEE MP-WG #2.10 FOR EXAMPLES OF VERIFICATION OF SSN.

Applicants may be required to provide documentary or collateral information that they have made every effort to supply the SSA with the necessary information to get an SSN.

Applicants eligible for FS expedited services (FS B.11) may receive their first allotment of FS benefits without meeting the SSN requirement, but they must meet the requirement before receiving a second allotment of FS benefits.

A new person (other than a newborn) must provide their SSN or provide proof they have applied for their SSN before being added to an existing FS group.

A newborn may be added to an existing FS group for six months or until the next redetermination, whichever is later, before meeting the SSN requirement.

Workers are to verify the SSN using the W204 screen. If the client is not currently receiving other program benefits, a TPQY should be processed to receive a match from the Social Security Administration (SSA).

When a match with the SSA's file indicates a discrepancy with the client's SSN, the client must provide evidence to resolve the discrepancy. If the client does not, the member of the need group (FS C.6) who fails to comply becomes ineligible if they failed without good cause. The disqualification continues until the person complies with an application for their SSN or provides the number.

Note: A person disqualified for no SSN is coded as a DP or DH; their income remains countable to the eligible benefit group members.

SSN requirement: 461-120-0210

7. FS Work Program Requirements; Overview

The intent of the FS work program is to provide resources and support that will enable families and individuals to move toward their highest possible level of self-sufficiency. Individuals are assessed for their strengths, skills, training, and support needs. The department and individual mutually develop an attainable, employment-related goal. Then, activities are assigned that will move the person toward their goal and self-sufficiency.

The FS work program in Oregon is called Oregon Food Stamp Employment and Transition (OFSET) program. Mandatory clients must participate in OFSET work components for eight weeks every 12 months.

8. Employment Program Exemptions

The following clients are exempt from FS work program (OFSET) requirements:

- Clients who are younger than 16 years of age or a client who is age 60 or older. A client who is age 16 or 17 and not the head of household or who is attending school or is enrolled in an employment training program at least half time, is also exempt.
- Clients who are employed and working a minimum of 30 hours a week or earning money equal to at least the federal minimum wage (the federal minimum wage as of July 24, 2008, is \$6.55/hr.) times 30 hours a week. Migrant (GP A.22) and seasonal (GP A.35) farm workers (FS I.1) meet this when they are under contract or agreement to work this amount and will begin work in 30 days. (Re-evaluate this exemption if the client goes on strike.) Self-employed clients are exempt only if, after allowing 50 percent of the gross as cost for doing business, income equals at least \$844.95 a month (30 hours times federal minimum wage, times 4.3).
- Clients with a mental or physical condition that prevents them from working. Verify (FS B.11) this exemption with a statement from a medical practitioner when questionable. For example, clients with diabetes have a medical condition, but the condition may not be such that it would preclude employment.

Note: Clients participating in the SFPSS program due to their own disability, or persons participating in a vocational rehabilitation program are OFSET exempt due to disability.

- Clients responsible for the care of a dependent child under age 6. In two-parent families, only one adult can claim this exemption regardless of how many children they are caring for.
- Clients required to care for a person in the filing group with a disability (FS C.2).

Note: A person caring for a spouse participating in the SFPSS program due to disability is OFSET exempt.

- Caring for a person with a disability who is not a member of the filing group (FS C.2). The client must spend at least 30 hours a week caring for the person with a disability without pay. Do not consider the client to be required to care for a disabled person when there is someone else available to provide the care. The client must verify the disability and provide medical documentation that such care is required and the number of hours needed to care for the person with a disability.

- Clients enrolled at least half-time (as defined by the school) in high school or an equivalent program, or in a training program or higher education. Clients remain exempt during normal periods of vacation and recess, including summer vacation. (Establish that the client in higher education is an eligible student (FS D.3) before determining OFSET status.)
- TANF clients who are mandatory and participating in JOBS.
- Clients who have applied for unemployment compensation (UC) and who are waiting for their claim determination, or clients who are getting UC.
- Clients attending regular participation in alcohol or drug treatment or rehabilitation programs.
- Pregnant females.
- Clients who would be mandatory except they have barriers to employment, such as lack of child care or transportation, or other issues. Other issues include, but are not limited to, being homeless (GP A.18), having a medical condition, or having family issues such as domestic violence. When evaluating these issues, decide whether the issues are truly barriers to employment. Decide when homeless clients have a barrier to employment. Some homeless clients will be exempt because they do not have a work history, a way to maintain their personal hygiene, or a way for an employer to contact them. Others will be mandatory because, despite their homelessness, they may have a recent work history or may be temporarily staying with others so that maintaining personal hygiene and being available for employer contacts are not problems.

Exemptions: 461-130-0310

9. Work Registration

Clients age 18 through 59 (also ages 16 and 17, if the client is the primary person) who are not exempt must cooperate with FS work program requirements. These clients are called mandatory for the work program.

Mandatory clients must be registered for the FS work program. Clients are registered by simply having the group's applicant sign the application. This registration is good for the statewide FS work program requirements.

Work registration: 461-130-0320

10. Employment (OFSET) Program Requirements

The department explains the client's work program status and their rights and responsibilities prior to referring them to their local service contractors for their assessment and assignment of work activities.

When a client's status changes from exempt to mandatory, the client should be notified within 10 calendar days of their new work program requirements, but must be notified of their new work requirements by at least the next redetermination.

Example: An OFSET mandatory client is participating in job search and reports he has gone to work 22 hours a week at \$11.00 an hour. He is now OFSET exempt. The case is in SRS. Narrate the report of the new job, the suspension of the OFSET assignment and the number of weeks completed. Remind the client of their income reporting requirements. The next time you process the Interim Change Report (DHS 852), at recertification, or when adding the earned income: determine if OFSET exempt and change the OFSET coding to exempt. If no earned income or not enough hours to be exempt, determine why no longer working. Look at disqualification due to job quit if they quit their job. If they are still mandatory, refer for the balance of the eight-week OFSET participation.

When the status changes from mandatory to exempt, notify the client within at least 30 calendar days from the date the change in status occurs or is reported to the branch, whichever is later. Offer the client the opportunity to continue participation as a volunteer if the district serves volunteers.

Statewide, mandatory clients and clients exempt solely due to working 30 hours a week, participating in JOBS, or getting UC must do the following, or potentially be subject to disqualification:

- Register for work.
- Cooperate in determining mandatory or exempt status.
- Cooperate with their JOBS requirements, if they would be FS mandatory in the absence of being JOBS mandatory.
- Not be disqualified from getting UC for failure to meet work search requirements.
- Accept a *bona fide* offer of employment, as long as the position is not vacant due to strike or lockout, and it pays the applicable federal or state minimum wage.
- Not quit a productive job unless they have a good reason. A productive job is one that averages at least 30 hours per week (or pays at least 30 hours per week times the federal minimum wage). Reducing hours of work to less than 30 per week or

the equivalent of 30 hours at federal minimum wage is also considered a job quit. They must not quit these jobs within 30 days before applying for FS or while receiving FS.

- Complete the work activities agreed to in the case plan.

☞ SEE ES B.20 FOR MORE ON OFFSET CASE PLANS

☞ SEE FS D.18 FOR THE QC HOT TIP ON JOB QUIT

Note: *Only the activities on the case plan and identified in FS D.12 are limited to eight weeks participation a year. All other OFFSET requirements must be met year-round for mandatory persons or persons exempt due to employment or UC or JOBS participation.*

Work registration, determine status: 461-130-0320

Accept job, Job quit, JOBS and UC: 461-130-0325

Applicant job quit: 461-135-0521

11. Mandatory FS Clients

All clients age 18 through 59, who are not exempt (FS D.8), are mandatory to participate in OFFSET. Review each client's mandatory or exempt OFFSET status at each certification and recertification or anytime a change in status becomes known to the department. Send an *OFFSET Appointment Letter* (DHS 824F) or Notice Writer notice FS0824F if a change in status becomes known during the certification period.

Mandatory clients must comply with the statewide FS work program requirements (FS D.10). Unless the client decides to conduct his or her own job search, refer all mandatory clients to the contractor(s) designated by the district via a *Personal Development Plan (PDP)* (DHS 7832R). In order to comply with the work requirements, mandatory clients must participate in an assessment of their recent work history, which the contractor will use to develop their case plan. They also must help develop, agree to, and complete the employment-related activities assigned in their plan. In addition, they must report their progress in the plan at least once in their assignment period.

Mandatory clients must participate for eight weeks every 12 months at the minimum base level. If they are involved in an activity at the end of the eight-week period, they may complete the activity. The eight-week period does not include the activities the client participated in to lift an OFFSET disqualification.

Mandatory clients must be offered an opportunity to participate in any of the work components offered in their area at initial certification when they become mandatory, and at least once every 12 months thereafter. The OFFSET plan includes the agreed-upon components or activities. Mandatory clients who fail to comply with their OFFSET plan without a good reason are subject to disqualification, as described in the *Disqualification Penalty for Failure to Cooperate in FS Work Requirements* (FS D.17).

Mandatory OFSET clients may be required to participate in any combination of work activities up to 120 hours a month.

Note: Although cooperating with work requirements is a nonfinancial eligibility requirement, do not delay issuance of benefits for completion of the OFSET plan.

OFSET participation requirements: 461-130-0320, 461-130-0325
Noncooperation and disqualification: 461-130-0330

☞ FOR A LIST OF FORMS USED IN OFSET, SEE FS WG#1.

12. Work Components

Mandatory clients are offered work components to meet their work requirement. The availability of work components may vary depending on location and the contracted service providers.

Available work components for all mandatory OFSET clients may include the following:

- Independent or Contracted Job Search. Most mandatory clients will be asked to do a minimum of 12 contacts a month for eight weeks of job search at intake and every 12 months thereafter. Clients who prefer to conduct their own job search will be allowed to do so. They must report their progress via *Job Search Verification* (DHS 475) at the end of their assignment period. However, if they need any assistance with transportation cost, they must agree to work with the contractor designated by the district. District contractor may ask client to do job search in combination with other OFSET activities.

☞ SEE ES B.21 FOR MORE ON OFSET JOB SEARCH.

- Employed 20 hours a week or more and still mandatory. Clients will be asked to maintain their employment and try to increase their work hours. Participation in another activity is not necessary.
- Contracted job preparation training. OFSET clients who need help developing the skills to obtain employment may be assigned to job preparation training (ES B.19).

☞ SEE ES B.21 FOR MORE ON JOB PREPARATION TRAINING.

- Contracted vocational or educational training. Vocational or educational training is short term and is limited to no more than three months.

☞ SEE ES B.20 FOR MORE ON OFSET VOCATIONAL OR EDUCATIONAL TRAINING.

Mandatory clients can also be referred to the following programs by the district contractor:

- Local one stop (WIA) or the Employment Department.
- A nonfunded community activity such as GED, ESL, ABE, or short-term training.

☞ SEE ES B.23 AND 24 FOR OTHER COMMUNITY SERVICES.

Note: *Community activities may also include participation in a displaced worker program, or a Vocational Rehabilitation training plan, or a work plan through HUD.*

- Displaced Worker Program. There are many types of displaced worker programs. This component is limited to the program that is approved under section 236 of the Trade Act of 1974.

☞ SEE FS D.3 FOR DISPLACED WORKER EDUCATIONAL ACTIVITIES OR ES B.22 FOR MORE ON OFFSET DISPLACED WORKER ACTIVITIES.

13. **OFFSET Volunteers**

Some districts may have funding for OFFSET volunteers. A volunteer is a client that is exempt (FS D.8) from OFFSET due to any reason except for other barriers.

Clients who are exempt due to participation in JOBS may not volunteer for OFFSET. Clients who are exempt due to pending or receipt of unemployment compensation may not volunteer for work search activities.

At district discretion and as funding allows, volunteers may participate in the same OFFSET activities (FS D.12) as a mandatory client. Volunteers may also receive OFFSET service payments (FS D.14) in the same manner as a mandatory client.

14. **OFFSET Service Payment**

OFFSET service payments may be authorized to reimburse a client for their transportation. All OFFSET service costs must be directly related to the assigned OFFSET work activity. To support OFFSET participation, up to \$60 per participant for the eight-week period may be paid to reimburse for transportation only. Where public transportation is available, bus passes or tickets may be purchased in lieu of the gas reimbursement. Contractors issue the support service payments. If the participant cannot pay for her/his child care, she/he is exempt.

Note: *Parents with school-aged children may be exempt due to lack of child care in the summer months, but become mandatory when able to do work search once the children are in school.*

Aging and disability workers should use the OFSET Program Client Agreement (DHS 7832R) to refer clients to the local OFSET contractors.

OFSET payments: 461-190-0360

☞ SEE ES A.3 FOR MORE INFORMATION ABOUT OFSET SERVICE PAYMENTS.

15. Conciliation

Conciliation is a process intended to determine good cause for failure to meet the OFSET work requirements before a disqualification is applied. This process also helps participants resolve disputes and misunderstandings concerning the FS work requirements.

Conciliation is an offered opportunity. It can be requested by the client, the department, or the contracted service provider. It is a meeting between the client, the department, and/or the contracted service provider. It can be a face-to-face meeting or over the telephone. Clients are not required to cooperate in the conciliation process.

Conciliation includes informing clients of their rights and responsibilities under the OFSET program and of potential disqualifications, establishes if good cause exists, and may result in a modification of the case plan.

Whether or not conciliation is offered, a contracted service contractor must determine good cause before deciding to apply for a disqualification.

Disqualifications: 461-130-0330

16. Good Cause for Failure to Meet Work Requirements

Mandatory clients must provide evidence to establish whether their reasons for not meeting FS work requirements are acceptable by the department. Consider clients who do not meet their work requirements to have a good reason if they:

- Have a medical authority's statement that the task has an adverse effect on their physical or mental health.
- Left a work site that violates health and safety standards.
- Have no means of transportation and would have to walk more than two miles to employment or to a pick-up point. The person must show that they have made a good-faith effort to secure the needed transportation.
- Have to commute more than two hours round trip.
- Were not being paid at least minimum wage or the acceptable piecework rate.

- Left because the work hours are 1) not customary to the occupation, 2) more than customary to the occupation, or 3) interfere with religious observances or beliefs of the client.
- Do not have child care arrangements or those arrangements have broken down. The household must attempt to get child care from another provider.
- Do not want a job that is vacant due to strike, lockout, or other labor dispute.
- Do not want to join a union due to religious objections.
- Belong to a union and a potential job goes against the conditions of that union. Good cause does not exist if the employment is not governed by the rules of the union to which the client belongs.
- Are offered a job within the first 30 days of participation and the job is not in the client's field of expertise. The department must determine that the job offered will not meet the goals of the department-approved training plan for the client.
- Have a job referral or employer who is discriminatory on the basis of age, sex, race, religious or political belief, marital status, handicap, or ethnic origin.
- Failed to cooperate due to circumstances beyond their control, such as a medical condition, court appearance, breakdown in transportation, inclement weather, family issues such as domestic violence, or a misunderstanding in the cooperation requirement.
- Become at least half-time students, since that makes them exempt.
- Were subject to job quit provisions but they quit their job to stay with another group member who moved to a new county for employment or school.
- Quit employment when they were under age 60 but the employer considers them retired.
- Left a job to follow a type of employment that moves, such as migrant labor.
- Accepted a new job that failed to materialize or resulted in less hours, if it was beyond the client's control.
- Have unreasonable employment, such as not being paid on schedule or at all.
- Are enrolled and actively participating in a community-recognized Dislocated Worker training program. The department may require proof of such enrollment and participation.

17. Disqualification Penalty for Failure to Cooperate in Work Requirements; Intent

Disqualification penalties are used to motivate individuals to participate in developing and cooperating with their FS plan. They are not intended to disadvantage persons or families. The penalties are imposed only after careful consideration of each individual's situation. This includes determining whether the person was able to do the activities assigned in their plan, whether they understood what was required, and whether they had a good reason for not doing the activities. Only when it is clear that the situation warrants it are disqualification penalties imposed. For some individuals, the penalty is necessary to convince them that it truly is their responsibility to achieve their highest level of self-sufficiency.

Cooperation: 461-130-0325

18. What Causes Disqualification

Mandatory clients must cooperate with their FS work requirements, or be subject to a disqualification penalty. In every situation, decide whether the client had a good reason for noncooperation before applying the penalty. For ongoing benefits, a 10-day notice is necessary before beginning a disqualification penalty.

Following are the offenses which, when committed without a good reason (FS D.16), cause disqualification for mandatory FS clients statewide.

- Failure to register for work.
- Failure to cooperate in determining mandatory or exempt status.
- Failure to cooperate with their JOBS requirements, if they would be FS mandatory in the absence of being JOBS mandatory (*see note below*).
- Being disqualified from getting unemployment compensation (UC) for failure to meet work search requirements (*see note below*).
- Failure to accept a bona fide offer of employment, as long as the position is not vacant due to strike or lockout, and it pays the applicable federal or state minimum wage.
- Quitting a productive job that averages at least 30 hours per week (or pays at least 30 hours per week times the federal minimum wage) within 30 days of applying for FS or while receiving FS. Reducing hours of work to less than 30 per week is also considered a job quit.
- In addition, OFSET clients who fail to keep scheduled appointments and complete work activities as assigned in their plan without a good reason are subject to disqualification.

Note: *Clients who are exempt for OFSET due to JOBS or UC participation, but would otherwise be OFSET mandatory, and fail to comply with their JOBS or UC job search requirements, are disqualified for FS. Applicants who are serving a JOBS or UC program disqualification for failure to cooperate at the time they apply for benefits are ineligible. For recipients who begin serving a JOBS or UC program disqualification, the disqualified person's benefits will end in the month in which the disqualification is to begin.*

QC Hot Tip

Job quit quite often results in a disqualification. Either an applicant or an FS client can be disqualified due to a job quit. These tips should be used anytime the worker learns that a job quit has occurred.

Look at job quit when a person voluntarily quits a job or when they reduce their work hours from 30 or greater a week (or was earning at least \$935.25 a month) to fewer hours.

- For applicants only – did the quit occur within the 30-day period prior to the filing date?
- For recipients – did the job quit occur at anytime the person was receiving benefits?

If yes,

- Now that the person is no longer working, are they OFSET mandatory (FS D.8)?
- Was the client working at least 30 hours a week (averaged) or earning at least \$935.25 a month before the job quit? (FS D.10)
- If the answer to each of these questions is yes, determine if there was good cause (FS D.16) for the quit. If no good cause, apply the OFSET disqualification.

For clients who lose their job for reasons other than voluntary quit, consider disqualification only if they were under a contract (such as a JOBS EDP or an OFSET Work Search Agreement) specifying they must maintain their job.

DQ notice: 461-175-0220
General requirements: 461-130-0320

19. The Disqualification Penalty

Mandatory clients serve the same progressive disqualification, regardless of which offense listed above they commit. In every case, only the person committing the offense serves the penalty.

A notice of disqualification must be sent anytime it is established that a mandatory household member failed to comply with the work requirements or voluntarily quit their job without good cause. This includes when the certification period is ending.

The notice sent to advise the client of their disqualification must tell them:

- The action that resulted in disqualification;
- The length of the minimum disqualification period;
- The reduced benefit amount; and
- How they can end the disqualification after the minimum period.

Notice Situation; Disqualification: 461-175-0220

Note: Use Notice Writer notice *FSC1FJQ* to close benefits and *FSC2FJQ* to reduce benefits. Senior and disability workers may also use the *Notification of Planned Action* (SDS 540).

The first time the client fails to meet a work requirement and is disqualified, they are removed from the FS benefits for at least one calendar month. The second time it must be for at least three calendar months. Every time thereafter, they are removed from the benefits for at least six calendar months.

Note: The disqualification periods are in full calendar months and not 30 days, 90 days, or 180 days.

These disqualification periods have minimum durations, but no maximum. They last until the client demonstrates cooperation. Therefore, for example, a client could be disqualified for the first time (which must last at least one month), never demonstrate cooperation and have the penalty last forever rather than just one month. In addition, these are full calendar months. Disqualification periods do not begin in the middle of a month.

Need group: 461-110-0630

Operational Flexibility: Local offices and districts decide what a disqualified client must do to demonstrate cooperation. They may decide this on a case-by-case basis, or have a standard in their area. They should assign a task that the client can complete during their minimum disqualification period. The requirement should also be reasonable, considering local labor market conditions. For example, a branch or area could decide all disqualified clients must complete two weeks of job search including at least two in-person interviews, in order to demonstrate cooperation.

In addition, for job quits (FS D.18 and FS D.20), cooperation is considered met if the client gets another job of similar wage or hours to the one they quit, or gets work hours restored to more than 30 hours per week if they reduced their work hours.

Although they are not included in the FS benefits, the disqualified client's income and resources continue to count when figuring the benefits for the household members remaining eligible.

Use of Income and Income Deductions
When There Are Ineligible or Disqualified Group Members: 461-160-0410

At the time of disqualification, the worker informs the client of their requirement to demonstrate cooperation in order to become eligible for FS again. The worker also explains what task will meet the requirement and gives the client the assignment in writing. The client is added back to the FS the first of the month after they complete their demonstration of cooperation or at the end of the minimum disqualification period, whichever is later. Benefits are not supplemented back to the date the client completed the assignment.

If the FS case closed because the certification period ended or due to the disqualification, and the client reapplies, the client must complete the assigned activities and the disqualification period before becoming eligible for FS again. Include the cooperation activities on the pending notice, *Notice of Pending Status* (DHS 210) or *Notification of Pending Status* (SDS 539H). After cooperation and if otherwise eligible, the person becomes eligible from the filing date (FS B.5) or the date otherwise eligible, whichever is later. Follow "add a person" (FS H.8) policy if adding this person to an open FS case.

Remove any disqualification applied in error, and do not count it as a time that the client failed to meet their work requirement. Also, remove the disqualification if the person leaves the filing group (FS C.2). If the person leaves the filing group, remove the disqualification from the case. The disqualification follows the person. If a disqualified client becomes exempt, remove the disqualification the first day of the month following the month this change became known. Do this even if it is during the minimum disqualification period. In addition, do not disqualify applicants who would be disqualified, but withdraw their application before benefits are approved.

DQ penalty, duration, determining cooperation and ending: 461-130-0320, 461-130-0330
Exclude from benefits: 461-110-0750
End DQ before min period: 461-130-0335
Count income and resources: 461-160-0410
End DQ eff. date: 461-180-0065

☞ SEE EXAMPLES OF THE DISQUALIFICATION PENALTY AND LIFTING THE DISQUALIFICATION ONE-PERSON NEED GROUPS #1 THRU #4 AND FOR MULTI-PERSON NEED GROUPS SEE #5 THRU #10 (FS D. EXAMPLES 19).

20. Disqualification for Job Quit in 30-Day Period Before Getting FS

Mandatory clients are not eligible to receive FS benefits if they voluntarily quit a productive job (FS D.10) without good cause in the 30 days before applying for FS benefits. If a member of the need group (FS C.6) quit a job in the 30-day period before the

filing date (FS B.5), determine if it was a voluntary job quit and if there was good cause. If it was a voluntary quit and good cause did not exist, the person is not eligible to receive benefits until the end of the disqualification period. As disqualification periods are in calendar months and not days, the client is ineligible until the end of the appropriate disqualification period. (Code the appropriate LV1, LV2, or LV3 onto FCAS.)

Note: Remember a job quit also includes a voluntary reduction of work hours to less than 30 hours a week or the equivalent at federal minimum wage.

The LV1, LV2, or LV3 is not lifted until the mandatory client shows compliance with the OFSET requirements. Clients disqualified due to applicant job quit must show compliance as if disqualified from an open FS case (FS D.19).

Job Quit by Applicants; FS: 461-135-0521

☞ SEE FS D.18 FOR HOW TO TREAT A JOB QUIT WHILE RECEIVING FS.

☞ SEE EXAMPLES OF DISQUALIFICATION FOR JOB QUIT IN 30-DAY PERIOD BEFORE GETTING FS, #1 AND #2. FOR AN EXAMPLE OF HOW TO TREAT A REDUCTION IN WORK HOURS PRIOR TO APPLYING FOR FS, SEE #3. FOR AN EXAMPLE OF BEING LET GO INSTEAD OF JOB QUIT, SEE #4. (FS-D. EXAMPLE 20).

21. Fleeing Felon and Violators of Parole, Probation, or Post-Prison Supervision

On August 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 became law. This law made fleeing felons and persons in violation conditions of parole, probation, or post-prison supervision ineligible for the Food Stamp program.

☞ SEE GP L FOR MORE INFORMATION ON HOW TO DETERMINE ELIGIBILITY AFTER A PERSON HAS BEEN IDENTIFIED AS A FLEEING FELON OR AS A PERSON WHO HAS NOT BEEN MEETING THE CONDITIONS OF THEIR PAROLE, PROBATION, OR POST-PRISON SUPERVISION.

☞ SEE FS F.14 ON HOW TO TREAT THE INCOME AND DEDUCTIONS OF AN INELIGIBLE GROUP MEMBER.

Need Group: 461-110-0630

Fleeing Felon and Violators of Parole, Probation, and Post-Prison Supervision: 461-135-0560

22. Food Stamps D – Nonfinancial Eligibility Examples

3. Student Examples

Examples of student status:

Example 1: Lucas (age 17) is attending University of Oregon full time. His financial aid did not include work study. He is not working 20 hours a week. There is no need to look at student status because he is under age 18. Establish a tickler to look at student status the month Lucas turns age 18.

Example 2: Kit (age 50) is attending college under a displaced worker program. There is no need to look at student status because he is over age 49.

Example 3: Belle (age 21) is attending beauty college. She is attending a program that does not require a high school diploma or GED. There is no need to look at student status because she is not participating in a higher education program.

Example 4: Julius (age 18) is attending high school full time. There is no need to look at student status because he is not participating in a higher education program.

Examples of ineligible student status situations (assume all of these students are attending college at least half time):

Example 5: Sophia (age 18) is living with a friend. She is working around the house doing housework and yard work in exchange for rent. They claim that she is doing this 20 hours a week. She does not meet the eligible student criteria because she is not paid for this work and there is no employer/employee relationship.

Example 6: James (age 23) was awarded work study. He is not currently participating in a work study job. He said that he has not gotten around to looking for a job but plans to do so. Pend the FS until he does look for a job and shows an interest in locating a job and actually performing work in a work-study job.

Example 7: Horatio (age 28) was awarded work study. He is interested in doing the work and needs the money. However, the school has stated that although he was awarded the work study, they do not have the money available and therefore cannot offer him a work-study job. He does not meet the eligible student criteria because he is not working in a work-study job and does not expect to do so during the quarter or semester.

Example 8: Jennifer (age 22) was not awarded work study but is working for the college 15 hours a week at \$9.00 an hour. She does not meet the eligible student criteria because she is not working 20 hours a week and her employment is not work study even though she is working for the college.

Example 9: Arabella (age 19) attended college during spring term and plans to return to college in the fall. She was awarded work study and worked until school let out in June. She was also awarded work study for the fall. It is July and she is not working in a work-study assignment and does not meet any other student criteria. She is considered a student during the summer even though she is not attending classes. Arabella is an ineligible student.

Example 10: Ana (age 26) is a graduate student and receiving a graduate teaching fellowship. She claims to be working 20 hours a week in this teaching fellowship. She is not working elsewhere and does not meet the eligible student criteria in any other way. She is not an eligible student as the fellowship is educational income and not considered employment.

Examples of eligible student status situations (assume all of these students are attending college at least half time):

Example 11: Adrien (age 21) is working 20 to 25 hours a week. He meets the eligible student criteria and may be eligible for FS if he meets all other eligibility criteria.

Example 12: Phoebe (age 19) is babysitting for a friend 20 hours a week at \$1 an hour. She claims she is not self-employed. She meets the eligible student criteria and may be eligible for FS if she meets all other eligibility criteria.

Example 13: Max (age 35) is receiving free rent for acting as apartment manager and maintenance person. He states he is actively working 20 to 30 hours a week at this job. This is an employer/employee relationship and he is being paid in-kind for his employment. He meets the eligible student criteria and may be eligible for FS if he meets all other eligibility criteria.

Example 14: Deborah (age 25) is attending college full time. Her college is being paid for by the state vocational rehabilitation (VR) program. The VR program considers her unfit for employment. She meets the eligible student criteria based on disability and may be eligible for FS if she meets all other eligibility criteria.

Example 15: Lizzie (age 45) is attending college under VA Chapter 31. In addition to the stipend she receives for going to school, the VA has

also located a VA work-study job for her. She is working 10 hours a week at this job. She meets the eligible student criteria more than one way. The VA has determined she is not employable and has placed her in college under a vocational rehabilitation program. She is also working in a federally funded work-study program (not title IV).

Housing and utility deduction examples when there is an ineligible student:

Example 16: Three students are sharing a residence and are applying for FS together. One of the students is ineligible. All three students pay an equal share of the housing and heating costs. The rent of \$600 is divided by the three that pay to arrive at \$200 share per person. There are two eligible persons in the filing group and so \$400 shelter costs plus the FUA are allowed.

Example 17: Three persons live in the same household, one adult and two children. The adult is an ineligible student. The children have child support income and the family is using their income to pay the \$650 rent. The two eligible persons are entitled to have a deduction for the amount of rent they pay, (\$650). They are not eligible for the FUA or LUA as their income is not being used to pay the utility costs.

Example 18: Three students are sharing a residence and are applying for FS together. One of the students is ineligible. The ineligible student pays the rent and heating costs. The eligible household members are not entitled to a deduction for the housing costs.

Example 19: Amanda (age 21) is attending college 3/4 time. She has college financial aid to assist with the costs, but no work study. She is also working for AmeriCorps 40 hours a week and gets an AmeriCorps stipend. She meets the eligible student criteria due to her employment and may be eligible for FS if she meets all other eligibility criteria.

19. Applying the Disqualification Penalty and Lifting the Penalty Examples

One-Person Need Groups

Example 1: Not meeting work requirements; disqualification notice sent

Facts:

Certification period:	December through March
Household composition:	John (age 40)
OFSET status:	Mandatory.

The contractor notified the department on 2/20 that John stopped performing his assigned activities.

Notices: *The FS00CON was sent requesting conciliation. John did not contact his worker. The disqualification notice (FSC1FJQ) was sent in March and he was told what he must do to regain benefits.*

Disqualification effective: *4/1 as LVI*

Situation 1: *John turned in his application for recertification on 3/10. He received the DHS 210 telling him what he needed to do by 5/1 to have his benefits recertified. Per the contractor on 3/24, John performed the assigned activities. John's FS case was recertified effective 5/1. Even though he demonstrated cooperation, he must serve the minimum disqualification.*

Situation 2: *John turned in his application for recertification on 4/5. He received the DHS 210 and was told what he needed to do to have his benefits recertified. On 4/26, the contractor stated that John began performing the assigned activities on 4/10. John's FS case was recertified effective 5/1.*

Situation 3: *John turned in his application for recertification on 4/10. He received the DHS 210 informing him of the activity he needed to do to have his benefits recertified. On 5/8, the contractor informed the worker that John completed the first week of assigned activities on 5/6. John's FS case was recertified effective 5/6.*

Situation 4: *John turned in his application for recertification on 7/3. He received a DHS 210 showing what he must do to complete the application process. John was scheduled to perform two weeks of activities. He called his worker on 7/10 and said he had been sick this week and was unable to do any activities. John's worker told him the restoration of benefits was contingent upon the completion of the work activities. He still needed to complete the activities even if he had good cause for not performing the initially scheduled activities. John completed his activities on 7/28 and was recertified effective 7/28.*

Example 2: Not meeting work requirements; disqualification notice not sent

Facts:

Certification period: December through March

Household composition: Jake (age 28)

OFSET status: Mandatory.

On 2/20, the contractor notified the department that Jake stopped performing his assigned activities.

Notices: The FS00CON, a notice for conciliation, was sent to Jake. Jake did not contact his worker. No notice of disqualification was sent to Jake.

Situation 1: On 4/5, Jake filed his application for recertification. Jake cleared all eligibility factors except the work requirement. He was recertified beginning 4/5 but was given a notice of disqualification effective 5/1 for a minimum of one calendar month and until he returned and performed at least one week of the assigned activities.

Situation 2: On 6/5, Jake came to the office about his recertification. He cleared all eligibility factors except the work requirement. He was recertified beginning 6/5 and agreed to do the assigned work activities. A disqualification was not applied as no notice was sent and there was a break in receipt of benefits of more than one month (April 1 - June 5). Too much time has passed to apply the penalty and review for possible exemption during the months when Jake's case was closed.

Example 3: Reduction in work hours without good cause; disqualification notice sent

Facts:

Certification period: October through December

Household composition: Jerod (age 24)

OFSET status: Exempt.

(He was working 24 hours a week at \$7.50 an hour which equates to more than 30 hours a week at federal minimum wage.) On 11/2, he reported he was now working 16 hours a week. The worker questioned the reduction in hours. The employer verified that Jerod was in fact working fewer hours due to his request for fewer hours. A reduction in work hours is treated like a job quit in OFSET. At the conciliation appointment on 11/10, Jerod said that he asked for fewer hours because he works at night and he wants to spend more time with friends in the evening. It was

determined that he did not have good cause for the reduction of work hours.

Notices: *The FS00CON (conciliation) and FSC1FJQ (disqualification) notices were sent. The disqualification also told him that one way to comply with the work requirements was to ask his employer to restore his work hours.*

Disqualification effective: 12/1

Situation 1: *Jerod completed the recertification process on 11/30. He reported that he had talked with his employer and he is again working 24 hours a week. He is again OFSET exempt because he is working the equivalent of 30 hours a week. Therefore, the recertification action was processed effective 12/1 without applying the disqualification. Code the appropriate LV1, LV2, or LV3 onto FCAS.*

Situation 2: *On 1/5, Jerod reapplied for FS. His work hours continue to be 16 hours a week. He was told that he cannot qualify for FS until he meets the work requirements. His supervisor told the worker that the busy season is over and he will not consider increasing Jerod's hours. A DHS 210 is given to Jerod asking him to do six job search contacts in two weeks. He arrived in the office on 2/8 with a completed DHS 475 showing he had completed the requested job search activity. The disqualification can be lifted 2/8, the date he completed the required work activity and the case is recertified.*

Example 4: *Employer-reduced work hours*

Facts:

Certification period: *October through December*

Household composition: *Kathy (age 24)*

OFSET status: *Exempt.*

(She was working 20 hours a week at \$10.50 an hour which equates to more than 30 hours a week at federal minimum wage.) On 11/2, she reported she was now working 12 hours a week. The worker questioned the reduction in hours. The employer verified that the market has slowed and they reduced the work hours. This reduction in work hours was not at Kathy's request. She is not subject to a job quit disqualification.

Multi-Person Need Groups

Example 5: Not meeting work requirements; disqualification notice sent

Facts:

Certification period: December through March

Household composition: Tim (age 32) and two children (ages 10 and 12)

OFSET status: Mandatory.

Tim failed to cooperate with his job search activities without good cause in February.

Notices: The FS00CON (conciliation) and FSC1FJQ (disqualification) notices were sent to Tim in February. On 3/17, Tim contacted his worker about his recertification. Benefits were recertified for April, May, and June for the children only. He was given a DHS 210 indicating the need to do six employer contacts in two weeks to have the disqualification lifted.

Disqualification effective: 4/1

Situation 1: Tim turned in his six employer contacts on 4/10. His needs were restored to the family's benefits effective 5/1.

Situation 2: Tim turned in his six employer contacts on 5/5. His needs were restored to the family's benefits effective 6/1 because a person can only be added to an open FS case the first of the month following the date they become eligible.

Situation 3: Tim reapplied for FS on 7/5. He said he worked 25 hours a week during June. He had wage slips and the worker verified that the employment ended June 30. Even though he did not do the requested two weeks of job search, the disqualification is lifted as he did locate a job and met the work requirements in June.

Example 6: Not meeting work requirements; disqualification notice not sent

Facts:

Certification period: December through June

Household composition: Thelma (age 30) and two children (ages 10 and 12)

OFSET status: Mandatory.

Thelma failed to cooperate with her job search activities without good cause in February.

Notices: *The FS00CON, a notice for conciliation, was sent to Thelma. She did not contact her worker. A notice of disqualification was not sent and the disqualification action was not coded on the computer.*

Situation 1: *Thelma filed her application for recertification on 6/5. Thelma's family cleared all the eligibility criteria except her job search requirement. Thelma's household, with her included, was recertified for FS effective 6/5. However, Thelma was given an FSC1FJQ notice on 6/5 informing her that she would be disqualified effective 7/1 and until she met the work requirements. Thelma turned in the six employer contacts on 7/15. Her needs were restored to the family's benefits effective 8/1.*

Situation 2: *Thelma contacted the branch about recertification on 8/5. Thelma's household, with her included, was recertified for FS effective 8/5. Thelma agreed to do job search for her work requirement. A disqualification was not applied as no notice was sent and there was a break in receipt of benefits of more than 30 days (July 1 - August 5).*

Situation 3: *Thelma contacted the branch about recertification on 8/5. Thelma refused to do job search or any other activity to meet the work requirement 8/5. The disqualification is applied as of 8/5 and the rest of the household is recertified for FS. Give her an SDS 540 or a Notice of Decision and Action Taken (DHS 456) informing her of the disqualification until she meets the work requirements.*

Example 7: *TANF/FS client not meeting TANF JOBS requirement*

Facts:

Certification period: *December through June*

Household composition: *Louise (age 30) and two children (ages 10 and 12)*

OFSET status: *Exempt.*

Louise was participating in JOBS. However, she failed to cooperate with her self-sufficiency plan in February and began TANF disqualifications effective 3/1. Louise was only OFSET exempt due to participating in JOBS, so she also must meet the OFSET requirements.

Notices: *Louise's worker sent a TANF disqualification notice only.*

Situation 1: *The JOBS disqualification was because she failed to cooperate with the job search activities without good cause. The TANF job search requirement is comparable to OFSET, so OFSET disqualifications also apply at the same time as the TANF. The FSC1FJQ notice was sent to Louise informing her of the FS DQ effective 3/1 and what she needed to do for FS. In addition, DQI income was coded onto FCAS for 3/1. Her needs were removed from the FS case effective 3/1. On 3/1, Louise tells her TANF worker she wants to cooperate and the TANF DJ is lifted. Louise again becomes OFSET exempt. Lift the OFSET DQ effective 4/1.*

Situation 2: *Louise is TANF disqualified due to failure to complete work search effective 3/1. Notice of OFSET disqualification for 3/1 was also sent. On 2/26, Louise told her worker she wants to cooperate. The TANF DJ is lifted. Louise becomes OFSET exempt. Lift the OFSET DQ effective 3/1 but leave the LV1, 2, or 3 coding on FCAS.*

Situation 3: *The JOBS disqualification was because she failed to cooperate with the mental health referral. This TANF requirement is not comparable to OFSET, so OFSET disqualifications cannot be applied. The DQI income was coded onto FCAS for 3/1. Her needs were not removed from the FS benefit group. She becomes mandatory for OFSET and needs to comply with an OFSET case plan beginning 3/1.*

Example 8: *Disqualification for recipient with a job quit*

Facts:

Certification period: *October through April*

Household composition: *Zane (age 28), Marilyn (age 26), and three children (ages 2, 4, and 7)*

OFSET status:

Zane is exempt due to working 35 hours a week; Marilyn is exempt to care for a child under age 6. Zane reported in December that he was no longer working. At the conciliation appointment, it was determined he did not have good cause for a job quit.

Notices: *The notice FSC2FJQ was sent to Zane. The disqualification was for one calendar month and until he met the work requirements. The notice also stated he needed to do 12 job search contacts and*

leave 4 applications within a 30-day period before he could again receive FS.

Disqualification effective: *1/1 for Zane only. Marilyn and the children continued to receive benefits.*

Situation 1: *Zane arrived in the office on 1/24 with a completed DHS 475 showing he had completed the requested job search activity. The disqualification was lifted as of 2/1.*

Situation 2: *Zane arrived in the office on 2/8 with a completed DHS 475 showing he had completed the requested job search activity. The disqualification can be lifted as of 3/1 because a person can only be added to an open FS case the first of the month following the date they become eligible.*

Example 9: *Ending the disqualification due to a change in status*

Facts:

Certification period: *October through April*

Household composition: *Gen (age 32)*

OFSET status: *Mandatory.*

She agreed to do 20 job search contacts a month. In November, she did not turn in the Job Search Verification (DHS 475) and when questioned, she stated that she did not get around to doing the job search. It was determined in December that she did not have good cause.

Notices: *The FSC1FJQ, notice of disqualification, was sent to Gen informing her that she needs to do 20 job search contacts and leave 4 applications within a 30-day period before she can receive FS again.*

Disqualification effective: *1/1*

Situation 1: *Gen came into the branch office on 12/26 to report and verify she is now working 30 hours a week. Gen is now exempt. Lift the disqualification and process the FS benefits for January based on the anticipated situation. Remove the LVI coding for January as she is now exempt and so cannot be asked to serve the disqualification in January.*

Situation 2: *Gen came into the branch office on 1/6 to report and verify she is now working 30 hours a week. Gen is now exempt. Lift the disqualification as of 2/1 and process the FS benefits for February based on the anticipated situation, including the anticipated*

earned income. Do not remove the LVI coding as she began to serve the disqualification before showing that she is now exempt.

Situation 3: *Gen came into the branch office on 3/26 to report and verify she is now working 30 hours a week. Gen is now exempt. Lift the disqualification and conduct an interview for recertification. All of the current information is needed to process the FS benefits based on the anticipated situation. She is not eligible until 4/1. Do not remove the LVI coding as Gen served the one-month disqualification.*

Situation 4: *On 5/5, Gen reapplied for FS. She stated that she did not get around to doing the job search due to morning sickness. It was determined that she is pregnant and therefore now exempt. Lift the disqualification and process the FS application as of the new filing date. Do not remove the LVI coding as she served the one-month disqualification.*

Example 10: *Ending the disqualification due to a change in status*

Facts:

Certification period: *October through April*

Household composition: *Joseph (age 32) and Maggie (age 30)*

OFSET status:

Joseph is Mandatory. Maggie is exempt as she is pregnant. Joseph failed to cooperate with his job search activities in November.

Notices: *The FS00CON (conciliation) and FSC1FJQ notices were sent to Joseph in late November.*

Disqualification effective: *1/1.*

Situation 1: *Joseph came into the branch office on 12/22 to report and verify he is now working 20 hours a week at \$8.00 an hour. He is now exempt. Lift the disqualification and process the FS benefits for January based on the anticipated situation. Remove the LVI coding for January as he is now exempt and so cannot be asked to serve the disqualification in January. A caution: if including the anticipated earned income for January would result in a reduction in benefits from the amount received in December, send a 10-day continuing benefit decision notice before adding the income.*

Situation 2: *Joseph came into the branch office on 1/15 to report and verify he is now working 20 hours a week at \$8.00 an hour. He is now exempt. He is complying with the intent of the OFSET program. Lift the disqualification for February (following add a person policy). Add both Joseph's needs and his anticipated earned income for February to FCAS. Send a 10-day continuing benefit decision notice if this change results in less benefits for February than were issued in January. Do not remove the LV1 coding as he began to serve the disqualification before showing that he was exempt.*

20. Disqualification for Job Quit in 30-Day Period Before Getting FS Examples

Example 1:

Facts:

Filing date: 2/26
Household composition: Robert (age 35)
OFSET status: Mandatory.

During the interview it was determined that he walked off the job on 2/15. The branch determined he did not have good cause for the job quit.

Notices: Denial notice (DHS 456) stating he is not eligible before 4/1.

One calendar-month period of ineligibility due to a job quit:
2/15 - 3/1 not eligible; 3/1 to 3/31 is the one month LV1 disqualification.

Example 2:

Facts:

Filing date: 3/10
Household composition: Elizabeth (age 32) and two children (ages 7 and 10)
OFSET status: Mandatory.

Elizabeth was employed 40 hours a week in Iowa. She quit her job on 2/18 and moved her family to Oregon. It was determined that she did not have good cause for the job quit.

Notices: Denial notice (DHS 456) stating she is not eligible before 5/1. However, the children may be eligible during this period.

One calendar-month period of ineligibility due to a job quit:
3/10 - 3/31 not eligible; 4/1 to 4/30 is the one month LV1 disqualification.

Situation 1: *The FS case was opened for the children only effective 3/10, without Elizabeth in the benefit group. She is still part of the financial group. The worker ticklers the case to add Elizabeth's needs to the FS case effective 5/1. At that time, a case plan is established and she also must begin to comply with the OFSET requirements.*

A voluntary reduction of work hours to less than 30 hours a week is treated like a job quit.

Example 3:

Facts:

Filing date: 4/19

Household composition: Richard (age 32)

OFSET status: Mandatory.

During the interview it was determined that his work hours were recently reduced. He was working 40 hours a week and is now working 20 hours a week. The branch determined that he asked to work fewer hours on 3/30 and he did not have good cause. This reduction is treated like a job quit.

Notices: *Denial notice (DHS 456) stating he is not eligible before 6/1.*

One calendar-month period of ineligibility due to reduction in work hours:

4/19 - 4/30 not eligible; 5/1 to 5/31 is the one month disqualification.

Example 4:

Facts:

Filing date: 1/21

Household composition: Lawrence (age 30)

OFSET status: Mandatory.

During the interview, Lawrence said he was fired on 1/15. The worker called the employer to verify and was told he did not show for work so the employer considers it a job quit. The branch determined he caused his own dismissal but did not voluntarily quit his job. Lawrence is not subject to disqualification due to voluntary job quit.

F. Financial Eligibility

1. Overview of Assets

Assets include both income and resources. Income is the monthly cash flow considered available to meet basic needs. Resources include liquid assets, such as cash in bank accounts, stocks, bonds, IRA, and KEOGH accounts. Resources also include nonliquid assets, such as vehicles and real property. An asset cannot be counted as both income and a resource in the same month. An asset counted as income in one month but that remains left over the following month becomes a resource.

☞ SEE AVAILABILITY OF RESOURCES IN CA A.1.

For FS, clients do not need to pursue assets they are not getting but could get. For example, a client who refuses to apply for unemployment benefits is not required to apply. Similarly, if a client has sustained a personal injury and could file a personal injury claim, they cannot be required to pursue the resource in order to qualify for FS.

Reimbursements (CA B.64) and in-kind income (CA B.41) do not count for FS. In addition, some assets do not count because they are excluded by federal law.

See the Counting Client Assets chapter of this manual for determining when to consider assets available, since assets that are not available do not affect eligibility (GP A.14). The chapter on Counting Client Assets also includes definitions of assets, more detailed explanations, and some assets (Indian/Native American benefits, motor vehicles, self-employment, and trusts) that are too complicated to display in a chart. A quick-reference chart showing how to treat most available assets under the FS program is in FS F.5.

Income that is withheld from a payment to repay an overpayment (CA A.2B) in that income source is considered unavailable unless it is repayment on a TANF IPV or client-caused overpayment.

☞ SEE AVAILABILITY OF INCOME IN GP A.18 AND CA A.2.

☞ SEE INCOME STANDARDS CHART IN MP-WG #7 AND RESOURCE LIMITS IN FS F.3.

☞ SEE FS F.13 FOR HOW TO COUNT AN OVERPAYMENT COLLECTED FROM TANF BENEFITS.

Requirement to Pursue Assets: 461-120-0330
Assets; Income and Resources: 461-140-0010
Availability of Resources: 461-140-0020
Determining Availability of Income: 461-140-0040

2. Countable Income Limit

The FS countable income limit is one of the tests used to determine whether clients are eligible for FS. All need groups (FS C.6) must pass this income test each month, unless they are categorically eligible (FS E.1) or they include a member meeting the FS elderly (GP A.13) or client with disabilities (GP A.10) criteria.

The countable income limit is as follows:

Need Group Size	Limit
1	\$1,127
2	\$1,517
3	\$1,907
4	\$2,297
5	\$2,687
6	\$3,077
7	\$3,467
8	\$3,857
Each additional person	\$ 390

Remember to code the correct income type (SSI, SSD, not SSB) so FCAS will skip this income test for clients with disabilities.

To use this income limit, the branch worker or computer system totals all of the group's countable income (GP A.18) each month. Next, the income is compared to the FS countable income limit for the group. When the income is equal to or exceeds the FS countable income limit, the application is denied, or benefits are suspended or stopped (FS H.8). This applies to all households that are not categorically eligible. The eligibility calculation continues further for groups whose income is under the limit.

☞ SEE NC B.2 FOR INFORMATION ON HOW TO COMPUTE INCOME FOR NC2S, OR PRORATE INCOME FOR NC1S PRIOR TO COMPARING THE GROUP'S INCOME TO THE COUNTABLE INCOME LIMIT.

☞ SEE FS F.14 FOR INFORMATION ON HOW TO COMPUTE INCOME FOR DISQUALIFIED NEED GROUP MEMBERS (FS C.6) PRIOR TO COMPARING THE GROUP'S INCOME TO THE COUNTABLE INCOME LIMIT.

Note: *Countable self-employment income is the gross income less allowable costs. For FS this means 50 percent of the SEC income or 100 percent of the SEN income.*

3. Resource Limit

The FS resource limit is another test used to determine whether clients are eligible for FS. All need groups (FS C.6) must pass this resource test each month, unless they are categorically eligible (FS E.1). The FS resource limit is as follows:

- \$3,000 when at least one member is age 60 or over, or meets the FS definition of clients with disabilities (GP A.10); and
- \$2,000 for all others.

To use this resource limit, the branch worker totals all of the financial group's (FS C.5) countable resources (both liquid and nonliquid) each month. Next, the worker or computer system compares the resources to the appropriate FS resource limit from the bullets above. The application is denied, or benefits are suspended or stopped after giving the appropriate notice (FS H.8), when the available resources exceed the FS resource limit. The eligibility calculation continues further for groups whose resources do not exceed the limit.

Categorically eligible groups are assumed to meet the resource limit. In addition, in groups where some members are categorically eligible and others are not, do not count the categorically eligible members' resources. Exclude these resources even if they are jointly owned with members who do not meet the categorical eligibility criteria.

- ☞ SEE FS-WG #5, "DETERMINING THE VALUE OF MOTOR VEHICLES FOR FS" FOR GUIDANCE ON HOW TO COUNT MOTOR VEHICLES WHEN THE HOUSEHOLD IS NOT CATEGORICALLY ELIGIBLE.

Use of Resources in Determining Financial Eligibility: 461-160-0010
Resource limits: 461-160-0015
Categorical Eligibility for FS: 461-135-0505
Motor Vehicle: 461-145-0360

4. Transfer of Resources of Noncategorically Eligible Households

Applicants and recipients of FS are not eligible if they make a disqualifying transfer of resources in order to qualify for benefits. Clients must report transfers of resources at application, at redetermination, and when the transfer occurs. The department must evaluate a transfer of resources to determine whether it was valid, whenever it becomes known that a transfer occurred within the preceding three months.

In order for the department to evaluate the transfer, the client must provide documentation showing the terms of the sale or disposal of the resource. They also must provide evidence, if they are claiming the transfer was valid. A transfer of a resource may be disqualifying if the transfer occurs during the three months preceding the filing date or during a certification period.

Asset Transfer; General Information and Timelines: 461-140-0210

Criteria for Valid Transfers. Consider a transfer valid if any of the following are true:

- The resource was excluded or owning the resource did not cause the group to exceed the resource limit, so transferring it does not change eligibility (GP A.14).
- The resource is transferred between people in the same financial group, since it is still counted regardless of who owns it.
- The resource was sold or traded for compensation near, equal to, or greater than its fair market value.
- The transfer settled a legally enforceable claim against the resource or client.
- The transfer was court-ordered.
- The transfer happened because the client was a victim of fraud, misrepresentation or coercion and legal steps have been taken to recover the resource.
- The resource is an annuitized annuity.
- The transfer is between members of the filing group and an ineligible student.
- The resource was transferred for reasons other than to qualify for benefits, e.g., a parent placing funds in an education trust fund.

☞ SEE RULE 461-140-0220 FOR MORE DETAILS.

When the transfer does not meet any of the criteria above, it may still be determined valid if the client can establish that their intent was not to transfer the resource in order to become eligible for FS. To prove this, the client would need evidence that they made a good-faith effort to sell or exchange the resource for compensation or for goods or services equal to fair market value.

Disqualifying of Invalid Transfer of Resources. If the department determines the transfer of resources was invalid, a disqualification of up to one year is imposed. The length of the disqualification depends on the amount of uncompensated value that was involved.

Here is the formula for determining the uncompensated value:

- Determine the fair market value of the resource.
- Subtract the compensation received for the transfer.
- Add this amount to the group's other countable resources.
- The amount that this total exceeds the group's resource limit is the uncompensated value.

☞ SEE EXAMPLES OF TRANSFER OF RESOURCES OF NONCATEGORICALLY ELIGIBLE HOUSEHOLDS (FS F. EXAMPLES 4)

The following chart shows the disqualification periods:

Amount of Uncompensated Value	Period of Disqualification
\$ 0.00 - 249.99	1 month
\$ 250.00 - 999.99	3 months
\$1,000.00 - 2,999.99	6 months
\$3,000.00 - 4,999.99	9 months
\$5,000.00 or more	12 months

Disqualification Due to a Resource Transfer; FS: 461-140-0260
Notice Situation; Asset Transfer Disqualification: 461-175-0310

Notify a client of disqualification with a basic decision notice (FS H.8) for applicants, and a timely continuing benefit decision (ten-day) notice for recipients, *Notice of Decision and Action Taken* (DHS 456) or *Notification of Planned Action* (SDS 540). The notice must specify the amount of the uncompensated value used in the calculation and the length of the disqualification period. The disqualification starts the date the branch imposes the disqualification period by closing or denying benefits.

Ending the Disqualification

The disqualification ends when the client has served the entire disqualification period and not before.

Adjustments to the Disqualification for Asset Transfer: 461-140-0300

5. Asset Quick-Reference Chart

Note: *This chart gives general information about treatment of assets. For more detailed information and complex situations, see the Counting Client Assets chapter.*

Key: “See Policy” indicates that the rule is too complicated for the table or the asset rarely occurs. Review the rule or Counting Client Assets reference to access the appropriate information.

This is an alphabetical list.

Type of Asset	Treatment	References
ACE (Active Corps of Executives)	Exclude	CA B.20 461-145-0110
Adoption Assistance	Unearned	CA B.1 461-145-0001
Agent Orange Disability Benefits	See policy	CA B.2 461-145-0005
Alaska Permanent Fund Dividend	Lump sum	CA B.3 461-145-0008
AmeriCorps	See policy	CA B.50 461-145-0365
AmeriCorps - VISTA	See policy	CA B.20 461-145-0110
Animals: • If pets or raised for food • Income-producing (see income-producing property)	Exclude See policy	CA B.4 461-145-0010
Annuities	Unearned	CA B.5 461-145-0020
Approved EPD Accounts	Excluded	CA B.7 461-145-0025
Bank Account	Resource	CA B.8 461-145-0030
Bonds	Resource	CA B.74 461-145-0520
Burial Arrangements	See policy	CA B.9 461-145-0040
Burial Space and Merchandise (One space per client)	Exclude	CA B.10 461-145-0050
Capital Assets (see Work-Related Capital Assets, Equipment and Inventory CA B.86 for more information)	See policy	CA B.11 461-145-0600
Cash and Foreign Currency that can be Converted to U.S. Currency	Resource	CA B.12 461-145-0060
Chaffee Housing Program	Unearned	CA B.37 461-145-0255
Child Support and Cash Medical Support: • Assigned to the department • To a third party • All others	Exclude See policy Unearned	CA B.13 CA B.40 (in-kind) 461-145-0080
Contributions	See policy	CA B.14 461-145-0086
Corporations	See policy	CA B.15 461-145-0088

Type of Asset	Treatment	References
Disability Benefit	See policy	CA B.16 461-145-0090
Disaster Relief (specific types)	See policy	CA B.17 461-145-0100
Disqualifying Income	Unearned	FS F.13 CA B.18 461-145-0105
Dividends	Unearned	CA B.19 461-145-0108
Domestic Volunteer Services Act (VISTA, RSVP, SCORE, ACE, Foster Grandparents, etc.)	See policy	CA B.20 461-145-0110
Earned Income; Definition	-	CA B.21 461-145-0120
Earned Income; Treatment: <ul style="list-style-type: none"> • Under 18 in school and under parental control • In-kind • Amount for future education for clients in military • Other (not flex) 	Exclude Exclude Exclude Earned	CA B.22 461-145-0130
Earned Income Tax Credit (EITC)	See policy	CA B.23 461-145-0140
Educational Income: <ul style="list-style-type: none"> • Title IV and BIA • Non-title IV or BIA (remainder after deducting costs) 	Exclude See policy	CA B.25 461-145-0150
Energy Assistance	See policy	CA B.26 461-145-0170
Experience Works	Exclude	CA B.52 461-145-0370
Family Abuse Prevention Act (FAPA) Payments	Unearned	CA B.27 461-145-0175
Farmers - additional self-employment costs	See policy	CA C.4 461-145-0931
Flexible Benefits for Health Insurance or Child Care	See policy	CA B.21 461-145-0130
Floating Homes and Houseboats	See policy	CA B.28 461-145-0185
Food Programs: <ul style="list-style-type: none"> • WIC, School Lunch • Nutrition Assistance Program • Tribal Food Distribution Program 	Exclude Unearned Ineligible for FS	CA B.29 461-145-0190 FS I.2 461-165-0030

Type of Asset	Treatment	References
Foster Care: <ul style="list-style-type: none"> • Foster care recipient gets FS • Foster care recipient excluded from file group • Foster care recipient lives in different HH group 	Unearned Exclude Self Employment	CA B.30 461-145-0200
Foster Grandparents	Exclude	CA B.20 461-145-0110
Garage Sale Proceeds <ul style="list-style-type: none"> • Sell personal items • Ongoing sale (more than 1 or 2 a year) 	Exclude Self- Employment	CA B.54 461-145-0390 CA C.1 461-145-0910
General Assistance (GA)	Unearned	CA B.57 461-145-0410
GI Bill	Educational Income	CA B.24 461-145-0150 CA B.82 461-145-0580
Gifts: <ul style="list-style-type: none"> • Periodic • One time 	Unearned Lump sum	CA B.31 461-145-0210
Green Thumb	Exclude	CA B.52 461-145-0370
Groundfish Disaster Benefits	Unearned	CA B.32 461-145-0230
Guardianship Assistance: <ul style="list-style-type: none"> • Recipient in filing group • Recipient not in filing group 	Unearned Exclude	CA B.30 461-145-0200
Home and Contiguous Property	Exclude	CA B.32 461-145-0220
Home equity loan or line of credit <ul style="list-style-type: none"> • Monthly payment • One time payment 	Exclude Lump sum	CA B.45 461-145-0330
Housing and Urban Development (HUD)	See policy	CA B.34 461-145-0230
Income-Producing Property	See policy	CA B.35 461-145-0250
Income-Producing Sales Contract: <ul style="list-style-type: none"> • Equity value • Income (minus costs) 	Exclude See policy	CA B.36 461-145-0240
Independent Living Subsidies	Unearned	CA B.37 461-145-0255
Indian/Native American Benefits	See policy	CA B.38 461-145-0260
Individual Education Account (IEA)	Exclude	CA B.39 461-145-0265

Type of Asset	Treatment	References
Inheritance: <ul style="list-style-type: none"> • Periodic • One time 	Unearned Lump sum	CA B.40 461-145-0270
In-kind Income	See policy	CA B.41 461-145-0280
Interest	Unearned	CA B.19 461-145-0108
Job Corps	See policy	CA B.42 461-145-0290
JOBS Plus: <ul style="list-style-type: none"> • NCP Plus • TANF Plus • Tribal TANF-Plus • UI Plus 	See policy See policy Earned Earned	CA B.22 461-145-0130
Jury Duty	Exclude	CA B.64 461-145-0440
Life Estate (when occupying the estate)	Exclude	CA B.43 461-145-0310
Life Insurance: <ul style="list-style-type: none"> • Payments to beneficiary (allow up to \$1500) • Equity value/term insurance 	Unearned Exclude	CA B.44 461-145-0320
LLC (Limited Liability Company or Corporation)	See policy	CA B.15 461-145-0088
Loans: <ul style="list-style-type: none"> • Cash on hand from loan • Interest from loan being repaid to client 	See policy Unearned	CA B.45 461-145-0330
Lodger Income	Self-employment	CA B.46 461-145-0340
Lump Sum Income	See policy	CA A.5 461-140-0120
Manufactured and Mobile Homes	See policy	CA B.47 461-145-0343
Military Income: Pay and Allowances <ul style="list-style-type: none"> • Basic Allowance for Housing (BAH) • Basic Allowance for Subsistence (BAS) • Family Subsistence Supplemental Allowance (FSSA) • Amount for future education for clients in military • Allotment 	Earned Earned Earned Exclude See policy	CA B.21 461-145-0120 CA B.48 461-145-0345
Motor Vehicles	See policy	CA B.50 461-145-0360
National and Community Services Trust Act (NCSTA)	Exclude	CA B.51 461-145-0365

Type of Asset	Treatment	References
National Older Americans Volunteer Programs Act: • Title III (Nutrition program) • Title V (Green Thumb, etc.)	Unearned Exclude	CA B.20 461-145-0110
Nutritional Assistance Program Benefits (Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands)	Unearned	CA B.29 461-145-0190
Older Americans Act: • Title III (Nutrition Program for the Elderly) • Title V (Green Thumb, etc.)	See policy Unearned Exclude	CA B.52 461-145-0370
OSIP	Unearned	CA B.57 461-145-0410
OSIP-IC	Excluded	CA B.57 461-145-0410
Overpayment, Repayment of • TANF CE or IPV • All other income sources	Unearned Exclude	FS F.1 FS F.13 CA A.2 CA B.18 461-140-0040 461-145-0105
Pre-TANF	Exclude	CA B.57 461-145-0410
Pension Plans: • Retired - monthly payments • Retired - other payments • Not retired, IRA, or KEOGH (after withdrawal penalty) • Not retired, other plans	Unearned See policy Resource Exclude	CA B.53 461-145-0380
Periodic Income	See policy	CA A.6 461-140-0110
Personal Belongings	Exclude	CA B.54 461-145-0390
Personal Injury Settlement: • Monthly payments • One time	Unearned Lump sum	CA B.55 461-145-0400
Plan for Self-Support (PASS) Assets	Exclude	CA B.56 461-145-0405
Post-TANF	Unearned	CA B.57 461-145-0410
Proctor Care	See policy	CA B.30 461-145-0200
Program Benefits (ERDC, TANF JOBS Plus, OSIP, Pre-TANF, Post-TANF, REF, SFPSS, TANF, etc.)	See policy	CA B.57 461-145-0410
Radiation Exposure Compensation Act	Exclude	CA B.58 461-145-0415

Type of Asset	Treatment	References
RARE	See policy	CA B.59
Real Property (not home): • Good-faith effort to sell • Equity if not for sale	Exclude Resource	CA B.60 461-145-0420
Recreational Vehicle's Equity	Resource	CA B.62 461-145-0433
Refunds	See policy	CA B.63 461-145-0435
Reimbursements	See policy	CA B.64 461-145-0440
Representative Payee Payments	See policy	CA B.65 461-145-0120 461-145-0490 461-145-0510
Reception and Placement Grant to Refugees	See policy	CA B.66 461-145-0455
Retirement Plans: • Retired - monthly payments • Retired - other payments • Not retired, IRA or KEOGH (after withdrawal penalty) • Not retired, other plans	Unearned See policy Resource Exclude	CA B.53 461-145-0380
Reverse-annuity Mortgage	Exclude	CA B.45 461-145-0330
Royalties	See policy	CA B.19 461-145-0108
Retired Senior Volunteer Program (RSVP)	Exclude	CA B.20 461-145-0110
Sale of a Home	See policy	CA B.60 CA B.35 (contract) 461-145-0460
Sale of a Resource (not home)	See policy	CA B.67 461-145-0460
School Lunch Programs (including before and after school)	Exclude	CA B.29 461-145-0190
SCORE (Service Corps of Retired Executives)	Exclude	CA B.20 461-145-0110
Securities	Resource	CA B.74 461-145-0520
Self-Employment - Allowable Costs	See policy	CA C.2 461-145-0920
Self-Employment - Definition	See policy	CA C.1 461-145-0910

Type of Asset	Treatment	References
Self-Employment - Exclusions	See policy	CA C.3 461-145-0930
Shelter-in-Kind (housing and utilities)	Exclude	CA B.68 461-145-0470
Social Security Benefits: • Monthly payments (not retroactive) • Representative payee fee • Retroactive payments to date of eligibility (not categ. elig.)	Unearned Exclude Lump sum	CA B.69 461-145-0490
Social Security Death Benefit (remaining after burial costs)	Lump sum	CA B.70 461-145-0500
Special Needs Payments (laundry allowance, special diet, meal allowance, restaurant meals, shelter exceptions, telephone allowances)	See policy	CA B.57 461-145-0410
Spousal Support	See policy	CA B.71 461-145-0505
State-funded Pre SSI Program (SFPSS)	Unearned	CA B.56 461-145-0410
Stipends	See policy	CA B.73
Stocks, Bonds, CDs, Other Securities: • Equity value • Interest and dividends	Resource Unearned	CA B.74 461-145-0520
Strikers' Benefits	See policy	CA B.75 461-145-0525
Supplemental Security Income (SSI): • Monthly payments (not retroactive) • Representative payee fee • Retroactive payments to date of eligibility (not categ. elig.)	Unearned Exclude Lump sum	CA B.72 461-145-0510
TANF, Tribal TANF, or TANF JOBS Plus	Unearned	CA B.57 461-145-0410
Tax refunds (Federal and state, property taxes, ERA)	Resource	CA B.76 461-145-0530
Ticket to Work (SSA)	Earned	CA B.77 461-145-0585 461-145-0120 461-145-0130
Tribal Food Distribution Program	Ineligible for FS	FS I.2 461-165-0030
Trusts	See policy	CA B.78 461-145-0540
Unemployment Compensation • Weekly/monthly payments • One time	Unearned Lump sum	CA B.79 461-145-0550

Type of Asset	Treatment	References
Uniform Relocation Act reimbursement	Exclude	CA B.80 461-145-0560
USDA Meal Reimbursement: <ul style="list-style-type: none"> • To child care provider • To provider’s child in filing group • To child in care 	Self-employment Exclude Exclude	CA B.81 461-145-0570
Vendor Payments	See policy	CA B.41 461-145-0280
Veterans’ Benefits: <ul style="list-style-type: none"> • Aid and Attendance • Spina bifida payments to children • Other monthly payments • One-time payments 	Unearned Exclude Unearned Lump sum	CA B.82 461-145-0580
Veterans’ Educational Benefits: <ul style="list-style-type: none"> • Chapter 30 (Montgomery GI Bill – active duty) • Chapter 31 (Vocational Rehabilitation program) • Chapter 32 (Veterans’ Education Assistance Program (VEAP)) • Chapter 35 (Dependent Educational Assistance Program) • Chapter 1606 (Montgomery GI Bill – selected reserve) • Chapter 1607 (Reserve Educational Assistance Program (REAP)) 	See Policy	CA B.25 (Educ) CA B.82 (VA) 461-145-0580 461-145-0585
Victim’s Assistance	See policy	CA B.83 461-145-0582
VISTA	See policy	CA B.20 461-145-0110
Vocational Rehabilitation Payment	See policy	CA B.84 461-145-0585
Welfare-to-Work - work experience	Earned	CA B.22 461-145-0130
Winnings: <ul style="list-style-type: none"> • Periodic • One time 	Unearned Lump sum	CA B.31 461-145-0210
Women, Infants, and Children (WIC)	Exclude	CA B.29 461-145-0190
Worker’s Compensation: <ul style="list-style-type: none"> • Monthly or periodic payments • One-time payments 	Unearned Lump sum	CA B.86 461-145-0590
Workforce Investment Act (WIA)	See policy	CA B.85 461-145-0300
Work-Related Capital Assets, Equipment, and Inventory	Exclude	CA B.87 461-145-0600

Type of Asset	Treatment	References
Youthbuild: <ul style="list-style-type: none"> • Under 18, in school and under parental control • Other 	Exclude Earned	CA B.34 461-145-0230

6. Prospective Eligibility and Budgeting

When we look at something *prospectively*, it means looking forward.

New applications. For FS eligibility on a new application, we always look at applicant circumstances prospectively. That is, we consider what we already know has happened in the current month (the month containing the filing date (FS B.5)) and what we expect will happen for the remainder of the month. When the whole month is considered, eligibility (GP A.14) and benefits are issued based on the same information. If the applicant is not eligible, the application is denied. This is prospective eligibility and prospective budgeting (GP A.2). It is used for new applications regardless of what reporting system is used for ongoing months. There is one exception to using actual income already received plus income expected for the remainder of the month. This exception is for cases certified in SRS when ongoing income that is expected to continue is converted.

Note: *An application is considered a “new application” only when it is received after a break in benefits. It is a “new application” if a household returns an application for redetermination after the prior certification period ends.*

If the amount of income that will be received or when it will be received is uncertain, the portion of the client’s income that is uncertain should not be counted by the department.

Example: *A client has received child support payments of differing amounts only twice in the past six months. None was received so far in the month of application. It is not known what amount will be received next or when the client will receive it again. Therefore, the child support should not be counted as anticipated income for the certification period. Be sure the client understands the need to report changes and that the decision and the reason to not use this income are carefully documented.*

Determining Availability of Income: 461-140-0040

When prospective eligibility and budgeting is used (both for new applications and for ongoing cases), there is no client-caused overpayment when anticipated information does not match what truly happens during the month, as long as the client reported true and complete information. Similarly, no supplement is issued when anticipated information makes benefits lower than they would have been if based on what really happened.

However, there may be an administrative overpayment if the department incorrectly processed the anticipated income reported and verified by the client.

Prospective Eligibility and Budgeting: 461-150-0020 and
Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060

- ☞ SEE CA A.2 ON AVAILABILITY OF INCOME.
- ☞ FOR INFORMATION ON FILING GROUPS (FS C.2) CONTAINING MIGRANT (GP A.22) OR SEASONAL (GP A.35) FARMWORKERS, SEE FS I.1.
- ☞ SEE EXAMPLES OF PROSPECTIVE ELIGIBILITY AND BUDGETING IN MPWG#22.

For ongoing months (GP A.26): Workers are encouraged to use SRS whenever possible.

Simplified Reporting System (SRS) (FS F.8) is used for many clients who are not in MRS. While in SRS, the benefits are based on prospective eligibility and budgeting similar to CRS. The SRS is used when circumstances have been anticipated over the redetermination period. In SRS, benefits will not change unless the client reports a change or a change is reported on the *Interim Change Report* form (DHS 852).

Prospective Budgeting of Variable Income: 461-150-0080

Change Report System (CRS) (FS F.7). Clients not in MRS for ongoing months have their benefits based on prospective eligibility and budgeting the same as new applications, above. Again, if a change is anticipated that will cause ineligibility for one month only, the case can be suspended rather than closed. When using prospective eligibility and budgeting, circumstances have been anticipated over the redetermination period (GP A.33) and will not change unless the client reports a change.

Retrospective Eligibility or Budgeting: 461-150-0030
Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060
Prospective Budgeting of Stable Income: 461-150-0070
Prospective Budgeting of Variable income; Not OHP; Not MRS: 461-150-0080
Effective dates; Changes in Income or Income Deductions That Cause Increases: 461-180-0020
Effective dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030

Transitional Benefit Alternative (TBA) (FS F.9) is for families that lose their eligibility for TANF. These families remain eligible for FS for five months at the same or a greater benefit level than they received the last month on TANF. During the months of frozen benefits, the household may report changes and the amount of benefits may increase. The benefits can only decrease if a household member applies for FS in another household or becomes ineligible for FS due to residency, being institutionalized, etc.

7. Change Report System

- ☞ SEE FS-WG #9.1 TO SEE CRS AT-A-GLANCE.

☞ SEE FS H.2 FOR THE CRS REPORTING REQUIREMENTS.

☞ SEE FS H.6 FOR MORE INFORMATION ON ACTING ON CHANGES AND FS H.8 ON THE EFFECTIVE DATE FOR ACTING ON CHANGES.

The Change Report System (CRS) (FS F.6) for FS is based on prospective eligibility and budgeting. Cases in this system are coded N in the Mand-Rprt field on FSMIS. Except for the ERDC companion cases or cases where all members are elderly (GP A.13) or clients with disabilities (GP A.10), the certification period is limited to six months. This is because it is not mandatory for clients to submit a report in order to keep receiving benefits in the CRS. ERDC clients are excluded from the six-month certification period limit because they file a periodic report each three to six months.

Note: Place FS cases with companion ERDC benefits in SRS whenever possible.

In this system, information is coded for the certification period. Clients are informed of changes they are required to report, and are given a *Change Report* (DHS 943) to use for reporting.

Clients in Change Report System must report when the *income source changes* in addition to the following:

- Clients who have earned income are required to report a change in their countable income (GP A.18) of \$100 or more a month.
- Clients are also required to report changes in unearned income of \$50 or more a month.

If no changes are reported for the certification period, benefits are issued for the same amount each month. When clients report changes, because it is a prospective system, take action only if the change is continuing and it will affect future benefits. For example, a client could receive a \$500 bonus on May 5, and report the change on May 12. Since the bonus was a one-time payment, there is no action to take on the case.

When clients report a change that will affect future months, action to increase benefits is taken for the following month. That is, a client could report on the last day of the month that someone joined their FS group. The new person's needs would be added for the following month's benefits. However, if they report the person will be joining the home next month, do not add that person's needs until the month following the month they actually move in.

Caution: When a person is added to the filing group (FS C.2), their income is also added. Sometimes this results in an increase in benefits. Other times the result is a decrease in benefits.

For changes that cause benefits to decrease, action is taken depending on when the change is reported. Clients are legally entitled to a timely continuing benefit decision (10-day advance) notice (FS H.8) when benefits will go down, so that they have time to adjust their household budgeting to the new amount. Therefore, if the client reports on

May 5 that someone left their filing group, the worker would remove the person from the benefits and send notice of the reduction for June. If the client reports on May 25 that someone left their FS group, the worker would remove the person from benefits and send notice of reduction for July (not for June).

When there is a companion ERDC case, the FS case may be in CRS, SRS or TBA. The redetermination period should end in the same month as ERDC.

Remember: *The food stamp certification period can be extended but not shortened (FS B.13).*

☞ SEE EXAMPLES OF CHANGE REPORT SYSTEM FOR ERDC (FS F. EXAMPLES 7)

Note: *In some cases, the income coded on UCMS for ERDC will not be the same as the income coded on FCAS for FS. In addition to the situation described in the preceding paragraph, some income, such as student income or self-employment income, may be treated differently by the two programs. Or if the ERDC certification period does not match the FS redetermination period, the income amounts may be different because the months in the period are different.*

Changes That Must be Reported: 461-170-0011
Prospective Eligibility and Budgeting: 461-150-0020
Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF 461-150-0060
Effective Dates; Adding a New Person to an Open Case: 461-180-0010
Effective Dates; Changes in Income or Income Deductions That Cause Increases: 461-180-0020
Effective Dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030

FS clients who have their unearned income converted are only required to report when the income conversion changes by \$50 or more. Clients who have their earned income converted are required to report (FS H.2) when the income conversion changes by \$100 or more a month. Clients in other programs are required to report within 10 days all changes in income, resources, and circumstances that may affect their eligibility for benefits or the amount of benefits they receive.

8. Simplified Reporting System

☞ SEE FS-WG #9.2 TO SEE SRS AT-A-GLANCE.

Intent and Overview

The Simplified Reporting System (SRS) (FS F.6) for FS is designed to stabilize benefits, increase accuracy, and be less work intensive than MRS or CRS. SRS is based on prospective eligibility (GP A.14) and budgeting (GP A.2). Cases in SRS are usually assigned a 12-month certification period. Most households must submit a report in the sixth month of the certification to continue getting benefits: NED households with no earned income in which all adult members are elderly (GP A.13) or clients with disabilities (GP 10) do not.

Who Should Be in SRS and Certification Periods

To be in SRS, the filing group (FS C.2) must meet all of the following criteria:

1. Not have a CMS case in MRS;
2. Not be eligible for TBA; and
3. Be certified for either six or 12 months.

Note: *Persons with a CMS case in MRS are not allowed in SRS because they have other mandatory report forms to complete.*

Simplified Reporting System (SRS); ERDC, FS: 461-170-0101

When possible, certify cases in SRS for 12 months, unless you need to use a shorter certification period to align with other programs.

Budgeting

SRS uses prospective eligibility and budgeting. Use actual expected income in the initial month if the income is just starting or ending or will be significantly different in subsequent months. Otherwise, convert or anticipate from the initial month.

For example, a person receiving \$100 a week UC benefits will have $\$100 \times 4.3 = \430 coded for the initial month in SRS. Another person reports their job just ended and they are receiving the final paycheck in the initial month. In addition, they applied for UC and expect one payment this month. Code the actual anticipated EML and UC income. Change the income in the second month to the converted UC only.

If income will increase in the second month, give or mail the client a *Notice of Reported Income* (DHS 7294) when you certify benefits. This allows DHS to change the benefit amount without 10-day notice.

☞ SEE EXAMPLES OF BUDGETING INCOME IN THE INITIAL MONTHS (FS F. EXAMPLE 6).

Reporting Requirements

The SRS reporting requirements are limited. The only changes that must be reported are:

- When countable income for the filing group exceeds the FS countable income limit (130 percent FPL) (FS F.2);
- New mailing address;

Note: For cases with NCIs, countable income is what remains after the NCI proration. However, FSMIS cannot make this distinction. The client notice lists the full, unprorated income for the filing group.

FS-only clients are given a *Simplified Change Report* (DHS 853) to report required changes. Clients with a companion CMS case (e.g., OSIPM and TANF) should receive the *Change Report* (DHS 943) form.

Most SRS cases must complete an *Interim Change Report* (DHS 852) in the sixth month of a 12-month certification. FS benefits from the seventh month are based on the DHS 852.

NED households are not required to complete the DHS 852. They are filing groups with:

- No earned income (EML, HCW, SEC, SEN, or TNG income types); and
- Every adult member is either 60 or older; or
- Meets the FS definition of clients with disabilities.

Identify these cases on FSMIS using HH Type NED.

Acting on Changes

SRS is a prospective system. When the client reports a change that will increase benefits, action is taken for the month following the month it is reported or the month the change occurs, whichever is later. For example, a client reports on the last day of the month that someone joined their household earlier that month. The new person's needs and income would be added for the following month's benefits after receiving required verification. However, if they report the person will be joining the home next month, do not add that person's needs until the month following the month they actually move in.

☞ SEE FS H.6 FOR MORE INFORMATION ON ACTING ON CHANGES AND FS H.8 ON THE EFFECTIVE DATE FOR ACTING ON CHANGES.

Act on all changes that:

- Are required to be reported for SRS; or
- Increase FS benefits; or
- Add a person to the filing group; or
- Are considered *verified upon receipt*.

Narrate only and act at *Interim Change Report* or the next recertification, whichever is earlier, for other changes. These are changes not required to be reported and not *verified upon receipt* that:

- Cause a decrease in benefits; or
- Contain incomplete information so that you cannot determine how the change will affect benefits.

Reported information is considered “*verified upon receipt*” when the information is not questionable and the provider is the primary source of the information. Changes that cannot be verified by client statement alone are:

- Income;
- Medical costs for a deduction;
- Legal requirement to pay court-ordered child support and the amount paid.

Hint: *If the client calls and reports a change in income, but it is unclear if filing group income will exceed the 130 percent level, send a DHS 853 with a note to remind the client when to report.*

When a change in mailing address is reported, change the mail address field on FCAS. Update the residence field only if new shelter costs are reported. A change in the mail address field allows the client to receive department mail. In addition, FSMIS puts the residence address on the *Interim Change Report* and asks the client to provide new shelter costs only if they have moved. Placing a new address in the residence field without new shelter costs will result in incorrect reporting of shelter costs. Remember to check for companion cases also needing update.

Interim Change Report (DHS 852)

Non-NED cases certified in SRS for more than six months are required to submit a completed DHS 852 in the sixth month. FSMIS issues the DHS 852 in the middle of the fifth month. The client is to report on the DHS 852 after the first of the sixth month.

Workers are expected to process the DHS 852 within 10 days after receipt. As part of the process, discrepancy lists and mainframe verification screens (BEIN/W204, DPPM, ECLM, HINQ, SMUX, and WAGE) need to be checked to ensure all available information is used. Benefits in months 7-12 are based on the DHS 852.

☞ SEE FS-WG#9 FOR FSMIS CODING INSTRUCTIONS AT INTERIM REPORT.

Reporting Changes – Overview : 461-170-0010
Changes that Must be Reported: 461-170-0011

Clients are not entitled to a 10-day notice if benefits go down based on changes on the DHS 852. They have waived this right by signing the DHS 852.

Use income information from the fifth month to project an accurate estimate for the remaining months of the certification period. This does not always mean using actual income. Some examples:

- Income received on a weekly or biweekly basis must be converted to a monthly figure.
- Income received sporadically, such as child support, must be averaged or otherwise anticipated.
- When the client indicates that overtime, bonuses, hours or other aspects of employment income are not expected to continue, use client contact and other information to determine representative income for ongoing months.
- Annualized self-employment income should change only if the client indicates that annual income is expected to change.

The DHS 852 is complete when all questions are answered, the required proof is provided, and the form is signed by the primary person (GP A.30) or authorized representative (FS B.14) has signed. When the DHS 852 has not been processed by the 15th day of the sixth month, the system sends the client a notice advising them that they have until the end of the sixth month to submit the report, and if it is not received, benefits will end. When an incomplete DHS 852 is received, the worker sends a *Notice of Incomplete Report* (DHS 487) notifying the client of the information required.

☞ SEE FS H.13 FOR ADDITIONAL INFORMATION ON THE USE OF THE DHS 487.

If a change in circumstance reported on the DHS 852 makes the client ineligible, send a close notice specifying the reason. The suspend-close notice for failure to complete the DHS 852 is not adequate.

If a completed report is not received by the end of the sixth month, the case suspends for the seventh month. If the report is not completed by the end of the seventh month, the client is no longer entitled to that month's benefits. FSMIS closes the case effective (FS H.7) the end of the seventh month. Clients must reapply to receive FS.

Federal regulations require the workers to give clients at least 10 days any time information is requested. Do not pend the DHS 852 to the end of the suspend month. If less than 10 days is remaining to process the DHS 852, let the client know they will need to reapply if you do not receive the information by that date. If it is so close to the end of the month that they cannot reasonably be expected to respond in time, it is good customer service to send an application with the DHS 487. The client must reapply after the case has suspend closed. If the DHS 852 is received after the case has closed, that date becomes the new filing date. Date stamp an application and mail it to the client along with brief instructions.

Note: *The DHS 852 is not an application. If a client receives the DHS 852 by mistake and completes it when the certification period is expiring, use the DHS 852 to establish the filing date. A new application (DHS 415F or SDS 539A) is required to gather all needed information and the client's signature on their rights and responsibilities. Conversely, an application can be used for processing at interim report as long as you also have the client sign a DHS 852. Signing the DHS 852 waives the client's rights to 10-day notice when changing their benefits for month 7.*

Notices

FSMIS sends the following notices automatically for SRS actions:

- Approval notices based on CRT SRS or REC SRS actions. The approval notices state the client's income reporting limit. Notices are tailored to NED and non-NED cases;
- Notification of being moved to SRS, when the reporting system changes during the certification period;
- An Interim Change Report (DHS 852) sent out around the 20th of the fifth month of the certification period for non-NED cases;
- Reminder notice to submit the DHS 852 if it has not been processed by the 10th day of month six;
- Suspend notice at the end of the month six when the DHS 852 has not been processed. This notice informs the client that their case will suspend at the end of the month, then close at the end of month seven if they fail to submit a complete report;
- Benefit notice for months 7-12 when the DHS 852 is processed;
- Suspend notice for month seven when processing the DHS 852 causes noncategorically eligible cases to go over the income limits;
- Notification of being removed from SRS during the certification period.

9. Transitional Benefit Alternative

☞ SEE FS-WG #9.3 TO SEE TBA AT-A-GLANCE.

☞ SEE FS H.6 FOR MORE INFORMATION ON ACTING ON CHANGES AND FS H.8 ON THE EFFECTIVE DATE FOR ACTING ON CHANGES.

Transitional Benefit Alternative (TBA) (FS F.6) is for families whose TANF cash benefits end which includes Program 2, and 82 cases and SFPSS. TBA is available for five months only. Cases in this system are coded T in the Mand-Rprt field on FSMIS and an end date in the RPT-due field. This is to tell the computer when the TBA period ends. To keep getting benefits after the TBA period ends, the family must reapply. Clients do not need to report any changes while in TBA.

TANF cash benefits are:

- TANF program 2 and 82 grants.
- TANF JOBS Plus.

- Tribal TANF.
- REF families receiving benefits funded by title IV-A are also considered to be receiving TANF.
- SFPSS grants.
- Pre-TANF cases are not eligible for TBA.

Note: *Only TANF cash cases moving from CP status to VP (EXT or M5) or CL status are eligible for TBA. TANF clients in Money Management are receiving cash benefits. Eligible households may receive TBA while receiving Post-TANF benefits.*

FS households cannot receive TBA when:

- The household violated a TANF provision and a penalty was imposed no later than the TBA effective date. This includes cases serving TANF penalties when TANF closes. This is most often due to noncooperation with a case plan or IPV (GP C.5). (Most commonly there will be DQI income coded on FS.)

Note: *This includes a TANF case closed at client request after receipt of a disqualification notice. If a TANF client serving a disqualification for noncooperation with JOBS gets a job and goes prospectively over income, the JOBS disqualification is lifted only after the client signs a PDP and demonstrates cooperation for 15 days. To be eligible for TBA, the TANF disqualification must be lifted before the TANF case closes. In addition, if the job must have been reported in a timely manner, the FS case should move to TBA. This also includes a group ineligible because an adult failed to apply for UC or to pursue other assets.*

- Any member of the FS filing group is receiving TANF cash (i.e., TANF ended for the family, but NPH continues for a child, or two families are receiving TANF (Program 2) and it ends for one family only).
- TANF benefits cannot have ended because of a change which results in ineligibility and the client failed to complete, in a timely manner, a required report for TANF. Generally this happens when the household did not complete the *Monthly Change Report* (DHS 859A), did not provide requested information or proof needed to continue TANF eligibility, or failed to submit a complete redetermination. It may also happen when a client fails to make a required change report for TANF within 10 days.
- An FS need group member (FS C.6) is ineligible for FS due to an OFSET disqualification (FS D.19), IPV, failure to cooperate with QC, a fleeing felon, violation of a condition of parole or probation or disqualified for trafficking or sale of FS.

- The TANF benefits ended because the family moved out of state or the primary person becomes institutionalized or goes to a treatment center that provides more than 50 percent of the meals.

Transitional Benefit Alternative (TBA) in the Food Stamp Program: 461-135-0506

Note: *No FS filing group member (FS C.3) may receive both TANF cash and FS using TBA in the same month. Therefore, if a member of the TBA group reapplies for TANF, their TBA must end effective the first of the next month when TANF cash is approved.*

The FS case in TBA remains with the head of household if an FS filing group separates. For example: Mom is head of household. Her 19-year-old daughter and grandson are part of Mom's filing group. The daughter goes to work and TANF closes. This filing group of three becomes eligible for TBA. The daughter and grandson move out and apply for FS at their new address. The daughter and her son have lost eligibility for TBA. Mom's FS case will continue in TBA for the full five months.

Clients with cases in TBA are not required to report any changes while receiving the transitional benefits. Their benefits during the five-month TBA period will generally not be less than the FS amount received in the month in which the client is no longer eligible for TANF. The one exception is when a member of the FS household moves out and applies for FS in another household. The normal CRS process for removing a household member and adding them to a new case will be followed.

For most cases, code the FS case as TBA for the first of the following month at the same time the action is taken to close or end TANF benefits. When a case is placed into TBA depends on the case situation. Always remember, the client must be notified of a change in reporting requirements before the effective date (FS H.7) of the change.

Example: *If the TANF case closes on November 24 effective November 30, code TBA on the FS case effective December 1 through April 30. However, if the TANF case is closed on CM on December 1 to end TANF November 30, the effective date for TBA is January 1 through May 31.*

☞ SEE FS-WG # 9 FOR FSMIS CODING INSTRUCTIONS.

Caution: Cases going into TBA are changing from SRS, CRS, or MRS. Their reporting requirements change while in TBA. The worker must make sure the client clearly understands the new change in reporting requirements and narrate this discussion with the client.

For cases moving to TBA, the certification period should be extended to the last month of the TBA period. This could be longer than the 12-month statutory limit if the case is going to TBA in the ninth or later month of the certification period.

Caution: Do not use transaction codes CRT or REC to extend the certification period.

Periodic Redeterminations; FS: 461-115-0450 |

Income is budgeted differently for cases in TBA. When a case is moved to TBA, change the TANF grant amount to zero. Make no other changes to the other income and case situation. Do not add any new anticipated income or deductions. In other words, use the exact income and case situation for the last month of FS before TBA minus the TANF grant. Generally, most households will receive the maximum FS allotment while in TBA. (The exception is with cases coded in MRS prior to receipt of TBA.)

☞ SEE EXAMPLES OF TRANSITIONAL BENEFIT ALTERNATIVE BUDGETING INCOME FOR TBA (FS F. EXAMPLES 9)

When the client reports a change that will affect future months, the client is given the choice to continue TBA or to reapply for FS. If they choose to reapply and the new situation results in more FS, end TBA and recertify the case for the first of the next month. If the result is fewer FS, do not recertify and continue the TBA to the end of the five-month period. If the worker determines it is best to continue TBA, send the client the Notice Writer notice FSG1F01 to let the client know the decision on their application.

Changes That Must be Reported: 461-170-0011 |

The only changes allowed in TBA are if a person leaves the household and applies in another household, if the household moves out of state, or the head of household becomes institutionalized.

Note: *The key here is if the person “applies for FS.” If the person who left the household does not apply for FS, do not remove them from the TBA case. Do not act on information gained on the monthly BENDEX or UC discrepancy lists. These lists are to be worked for TBA clients at the end of their TBA period. The discrepancy lists should not be worked while the household is in the TBA.*

☞ NOTICE-WRITER NOTICE FSRTB01 CAN BE USED TO NOTIFY THE HOUSEHOLD WHEN TBA BENEFITS ARE BEING REDUCED BECAUSE A PERSON LEFT THE HOUSEHOLD AND APPLIED FOR FS IN ANOTHER.

☞ THE NOTICE WRITER NOTICE FSCTB02 MAY BE USED TO END TBA EARLY.

There will be no overpayment for unreported changes that occur during the TBA period as there is no required reporting. As always, the department may end FS benefits if it learns that the household has moved out of state or at the client’s request. However, do not end TBA simply because mail has been returned as “undeliverable” with no forwarding address. TBA clients are not required to report a move or address change.

TBA ends early anytime a member of the FS TBA filing group begins to receive TANF cash benefits funded under title IV-A of the Social Security Act.

To get FS at the end of the TBA period, households must reapply for FS regardless of the number of months remaining in their certification period. In the fourth month of the TBA period, the computer will send the household a notice letting them know the TBA period is ending and they must reapply for FS if they wish to continue receiving benefits.

Notice Situation; APR, MRS, SRS, or TBA: 461-175-0270
Effective Dates; Cases Receiving Transitional Benefit Alternative (TBA): 461-180-0081

***Note:** Sometimes TBA eligibility is determined late or is adjusted. When this occurs the ending date on fcas may be incorrect. The worker needs to set up a tickler to track the TBA period and manually send the notice regarding the end of the TBA. Notice-writer notice FSC00WF should be sent to these households about 45 days before the end of the TBA period.*

10. Retrospective Eligibility and Budgeting (MRS)

- ☞ SEE FS-WG #9.4 TO SEE MRS AT-A-GLANCE.
- ☞ SEE FS H.2 FOR A COMPLETE LIST OF MRS REPORTING REQUIREMENTS.
- ☞ SEE FS F.6 FOR INITIAL MONTH BUDGETING OF MRS CASES.

When we look at something retrospectively, it means looking back.

Monthly Report System (MRS). Clients entered into the MRS have ongoing benefits based on retrospective eligibility (GP A.14) and budgeting (GP A.2). For them, we look back to their circumstances last month to determine whether they are eligible this month (the payment month) (GP A.28). If they are eligible based on last month's circumstances, we issue benefits based on those past circumstances. If they are not eligible based on last month's circumstances, we suspend the case if it is a one-month change or close the case if it is an ongoing change that causes ineligibility.

One exception to retrospective budgeting in MRS is for income from a terminated source that has already been counted prospectively. Treat income from a terminated source that was counted prospectively as follows:

- If the actual amount received was less than or equal to the anticipated amount, exclude the income.
- If the actual amount received was greater than the anticipated amount, count the difference between actual and anticipated amounts retrospectively.

Cases in MRS are limited to only those FS cases with a companion public assistance (GA, OSIP, or TANF) case that is in MRS. No other FS case will be allowed in MRS.

Cases in the MRS are coded M in the Mand-Rprt field on FSMIS. This is because it is mandatory for clients to submit a report in order to keep receiving benefits each month.

In this system, information is coded for one month and only remains the same if there are no changes reported for the following month. FS cases in MRS may be certified for up to 12 months.

Retrospective Eligibility or Budgeting: 461-150-0030
Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060

Certain clients cannot be required to report through the MRS. These are groups:

- Where at least one member is getting ERDC.
- That include at least one member who is a migrant (GP A.22) or seasonal (GP A.35) farm worker (FS I.1).
- Where all members are homeless (GP A.17).
- Where all adult members are elderly (GP A.13) or clients with disabilities (GP A.10) and no financial group (FS C.5) member has earned income.
- Residing on reservations.

Monthly Reporting System (MRS): 461-170-0100

MRS is a work-intensive system and should only be used when changes cannot be tracked another way. The department's expectation is that workers will process *Monthly Change Report* (DHS 859A) forms within five working days after receipt.

To enter clients into the MRS, use the *Notice of Change in Reporting* (DHS 456M) and the *Monthly Reporting System* (DHS 488) pamphlet. The UCMS computer system issues a DHS 859A mid-month for the client to use for reporting income and dependent care costs for that month. The worker uses the report to issue benefits for the following month. Workers also give the client a DHS 943 for reporting other changes when they happen.

Note: *The DHS 859A is issued by the Public Assistance computer system. FSMIS will not issue the DHS 859A.*

Caution: When a client is in MRS, they are required to report only income and dependent care costs on their DHS 859A. All other changes, such as a move, must be reported in the change reporting time frames via a *Change Report* (DHS 943). Prorated educational income and annualized income are never budgeted retrospectively, even when the case is in MRS to report income. In addition, clients in MRS who report changes by a mechanism other than on their DHS 859A, are entitled to a 10-day advance notice when benefits decrease.

The effective date for starting MRS is always the first of the month following the date MRP coding is put on FCAS.

When benefit groups (FS C.7) are entered into the MRS, the FSMIS computer system sends a continuing benefit decision notice (FS H.8).

Clients are not entitled to a 10-day advance notice when benefits go down due to changes reported on the DHS 859A. They have waived this right by signing the DHS 859A. Therefore, when they report on the DHS 859A that income went up during the report month, the worker uses the information to reduce benefits for the following month. (FSMIS sends the notice of reduction.)

In addition, since current month's benefits must always be based on what happened last month, a change that occurred last month still must affect this month's benefits, *even when it will not continue*. For example, a client could get a one-time bonus in their pay that makes their income exceed the limit, and spend it all in one day. When they report this change on their DHS 859A, it would cause ineligibility (one-month suspend) for the following month because it was available in the report month.

Some income is not subject to retrospective budgeting (i.e., annualized income, contract income, or educational income averaged over the period the income is to cover).

Clients in the MRS must submit a completed DHS 859A about the report month by the end of the following month (the payment month), in order for benefits to be issued. The report is complete only after all questions are answered completely and accurately, the required proof is provided and the primary person (GP A.30) or authorized representative (FS B.14) has signed the report. When the DHS 859A has not been processed by the 15th of the payment month, the system sends the client a notice advising them that they have until the end of the payment month to submit the report, and if it is not received benefits will suspend. When an incomplete DHS 859A is received, the worker sends a *Notice of Incomplete Information* (DHS 487) notifying the client of what other information is required and that the report must be completed by the end of the payment month.

☞ SEE FS H.13 FOR ADDITIONAL INFORMATION ON THE USE OF THE DHS 487.

Once a complete DHS 859A is received, the worker uses it to determine benefits for the payment month. Clients are not sent a DHS 859A in the last month of their certification period, since the income they report when they reapply for benefits is used as their DHS 859A that month.

If only an incomplete report or no report at all is received by the end of the payment month, the case suspends for that month and the client is no longer entitled to that month's benefits. However, if they turn in a complete DHS 859A for the suspend month, the worker uses it to determine benefits for the next month.

The worker uses retrospective eligibility and budgeting for the month following the month of suspension. Switch to using prospective eligibility and budgeting only after there has been a break in benefits of one or more calendar months, not counting the suspend month.

If the client does not submit a complete report for the suspend month, the computer system sends notice and closes the case effective (FS H.7) the end of that month.

When a Monthly Change Report is Considered Complete: 461-170-0110

Monthly Change Report Incomplete or Not Received: 461-170-0120

Notice Situation; APR, MRS, SRS, or TBA: 461-175-0270

Notice Situation; Failure to Submit Report for APR, MRS, SRS, or ERDC Re-application: 461-175-0280

11. Changing Budgeting Methods

It is possible to change reporting methods between CRS, MRS, SRS, and TBA. Whenever a change in budgeting (GP A.2) method is made, the household must be notified with a continuing benefit decision notice (FS H.8) prior to the effective date (FS H.7) of the change in method. This means the effective date for changing budgeting systems is always the first of the next month.

MRS to CRS: Cases may be changed from Monthly Reporting to Change Reporting whenever a change warrants the household's removal from MRS. This could occur at redetermination or any month during a redetermination period (GP A.33). The household must be notified in writing before the effective date (first of the month) of the change if the budgeting method is changed during a redetermination period. The computer sends the client the "W" notice. It must be received before the effective date. If the change to CRS is occurring at redetermination, carefully explain the change in reporting income to the client.

With the change from MRS to CRS, the case becomes prospectively budgeted. Only prospective or anticipated income will be used to compute the benefits. Remember to send a timely continuing benefit decision notice if this switch will reduce benefits.

CRS to MRS: Although it is preferred that cases not be placed into Monthly Reporting, this report system must be used when a companion PA case is in MRS. The change to MRS may occur at any time during a redetermination period. When entering clients into the MRS during the redetermination period, give them the *Notice of Reporting System Change* (DHS 456M), the *Monthly Reporting System* (DHS 488) pamphlet, the *Monthly Change Report* (DHS 859A), and the *Change Report* (DHS 943). They should receive these forms before the effective date of the change as the DHS 456M notifies the client of the change in budgeting.

With the change from CRS to MRS, the case becomes retrospectively budgeted. Only retrospective income will be used to compute the benefits. The one exception to retrospective budgeting is when income from a terminated source is counted prospectively: do not count the same income retrospectively the next month. If a case was in CRS in the prior redetermination, will be in MRS in the new redetermination, and there was not a break in benefits of more than one month, use retrospective budgeting. Prospective budgeting must be used anytime there is a break in benefits of one month or more.

CRS to SRS: Whenever possible, FS cases should be in SRS. To fully utilize the benefits of SRS, extend the certification period to the full 12-month limit (if appropriate) when placing the case into SRS. If the change in systems occurs during the certification period, the household must be notified in writing before the effective date (first of the month). The computer will send the client the “WC” notice. It must be received before the effective date. If the change to SRS is occurring at recertification, carefully explain the change in reporting income and changes to the client. Give or send the *Simplified Reporting System* (DHS 854) pamphlet (if case is in a 12-month certification period) and *Simplified Change Report* (DHS 853) form to each household when the case is placed into SRS.

Benefits will continue to be prospectively budgeted in SRS. Continue to use prospective or anticipated income to compute the benefits. Remember to send a timely continuing benefit decision notice if this switch will reduce benefits.

SRS to CRS: Sometimes it may be necessary to convert the case from SRS to CRS. This will happen when you need to process a reopen (ROP) action following a close. Be sure to inform the client of their new reporting requirements and send them the DHS 943 to report future changes.

SRS to MRS: There are times when a case is placed into MRS in the companion program. This commonly happens when a TANF client goes to work. When the report system in the companion program changes to MRS, it must change to MRS for FS also. This means that the client must be told about their new reporting requirements. They now must report income via the DHS 859A and all other changes as identified in CRS. When entering clients into MRS during the certification period, give them the DHS 456M, the DHS 488, and the DHS 943. They should receive these forms before the effective date of the change as the DHS 456M notifies the client of the change in budgeting. With the change from SRS to MRS, the case becomes retrospectively budgeted. Only retrospective income will be used to compute benefits.

CRS, MRS, or SRS to TBA: Cases may be changed from CRS, MRS, or SRS to TBA whenever a family becomes ineligible for TANF. This change can occur at anytime during the certification period. If the certification period is expiring before the end of the TBA period, extend the certification period to end the fifth month of TBA. Notify the household in writing before the effective date (first of the month) of the change in reporting requirements. The computer will send the client the “WD” notice. This notice must be received before the effective date. Also send or give the client the *TBA Report System* (DHS 856) pamphlet when the case is placed into TBA. It is recommended that this pamphlet be mailed with the *Notice of Decision or Action Taken* (DHS 456) when the client is informed their TANF cash benefits are ending.

TBA to CRS, MRS, or SRS: FS benefits must end when TBA ends and the client must reapply for FS. In addition, a household may become ineligible for TBA when it applies for TANF. Cases in TBA will not move to another report system. Households must reapply for FS when TBA ends.

☞ SEE FS F.9 FOR MORE INFORMATION ON TBA.

12. Income in Prospective Systems

Depending on how often income is paid and the type of income, there are different methods for anticipating how much to count each month.

☞ SEE MPWG22 FOR DETAILS AND EXAMPLES.

13. Disqualified Income (DQI) for Cash Recipients Serving a Penalty

When a TANF or Tribal TANF recipient has their cash benefits reduced, closed or ended for failure to comply with certain program requirements, their FS benefits must not go up due to the loss of cash. This does not apply to the loss of the voluntary Cooperation Incentive (COI) payment. In addition, when a TANF or SFPSS recipient is repaying a client-caused (CE) or Intentional Program Violation (FR) overpayment, the amount being repaid from the grant is also counted as income.

Code as DQI:

To prevent the FS from increasing when the cash is reduced or stops, count disqualified income (DQI) in the amount of the reduction. This applies whenever the client loses cash due to:

- Failure to comply with their JOBS program or self-sufficiency plan.
- Failure to comply with treatment for substance abuse and mental health.
- Disqualification for an intentional program violation (IPV).
- Failure to comply with pursuing child support, medical coverage and other assets.

Code as COP (client overpayment):

- Collection of a client-caused or SFPSS or TANF overpayment, or TANF IPV.

☞ SEE CA B.18 FOR MORE ON DISQUALIFYING INCOME.

Following are situations where counting DQI income does *not* apply:

- When the client began a grant reduction prior to September 23, 1996, and the reduction continues or progresses without the client committing a new failure to comply with a TANF program requirement.
- When the client was not receiving FS benefits at the time the TANF benefits were reduced.
- When an applicant has TANF approved at a reduced amount because of a failure to comply with a TANF requirement. This is because the client is not experiencing a reduction from a prior level. They are simply starting at a lower level.

Note: *TANF clients sometimes fail to comply with TANF program or JOBS requirements. Clients may not avoid the DQI if they ask to end or close TANF after receipt of a notice of impending disqualification or penalty. This voluntary closure may avoid the penalty for TANF. However, it does not avoid the DQI for FS.*

Note: *A TANF/FS client may have a DQI and serve disqualifications in both programs at the same time for the same offense. For example, if a client (who is mandatory for both TANF and FS) quits a job, which causes them to get reduced cash benefits, they will concurrently be penalized by having their needs removed from the FS companion case. Also code the DQI income.*

For clients who begin a JOBS or substance abuse or mental health disqualification after September 23, 1996, and have their FS case in prospective budgeting, track the case so the calculation can be changed as the client progresses through the different levels of grant reduction and closure.

End the DQI income when:

- The family has complied with the TANF requirement and the TANF penalty is lifted.
- The family no longer meets other TANF eligibility criteria (examples: over TANF income limits, no child in home, etc.).
- The TANF case has been closed for one year.

End the COP income when:

- The SFPSS or TANF overpayment is repaid.
- SFPSS or TANF cash benefits end.

Note: *Review the DQI and COP income at each recertification. Document this review on TRACS.*

Using the DQI or COP income type on FSMIS stops benefits from going up. The amount of the DQI is the amount the grant is reduced due to the penalty. The COI is a voluntary payment: therefore, the amount of the COI is not included in the DQI. The COP is the amount of the overpayment collection from the grant.

The DQI income is calculated as follows:

- Amount of TANF grant (less COI) before the disqualification, less the TANF grant after disqualification, equals the amount coded as DQI income on FCAS. The DQI income must be changed as the TANF disqualification progresses.

For TANF benefits that are closed or cash is stopped due to these penalties, use the benefit amount the group would be getting without a penalty, as the DQI entry.

Note: *When the client voluntarily requests closure of their cash or TANF-related Medicaid, or fails to complete their redetermination forms, this is not a change in their situation that would stop the DQI from being counted.*

☞ SEE DISQUALIFIED INCOME EXAMPLES (FS F. EXAMPLES 13).

Note: *The worker may choose to code the HH type of MNL on the case when DQI is first coded. This may resolve issues about tracking and changing the DQI every other month as the TANF case progresses through the disqualification levels. Do not forget to remove the MNL coding when the disqualification ends.*

The COP income is the amount of the SFPSS or TANF overpayment collection.

Note: *Enter the date the worker expects the OVP to be repaid in the comments field on the COP income line.*

Requirement to Pursue Assets: 461-120-0330
Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340
Clients Required to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: 461-120-0345
Disqualifications; FS, Pre-TANF, REF, TANF: 461-130-0330
Requirement to Attend an Assessment or Evaluation, or Seek Medically Appropriate Treatment for Substance Abuse and Mental Health; Disqualification and Penalties; Pre-TANF, REF, TANF: 461-135-0085
Disqualifying Income; FS: 461-145-0105
Intentional Program Violations; Penalties and Liability for Overpayments: 461-195-0621

14. Income and Income Deductions for Ineligible/Disqualified Group Members

Count the income, resources and deductions of ineligible household members as follows:

- See FS D.3 for treatment of income and deductions for ineligible students.
- See NC B.2 and 3 for treatment of income and deductions for ineligible noncitizens.
- Ineligible due to failure to comply with OFFSET requirements (FS D.19), Intentional Program Violation (IPV) (GP C.5), or fleeing felon, probation or parole violator disqualification (FS C.6). For this provision, IPV includes persons convicted for trafficking \$500 or more or for involving FS benefits in a transaction involving the sale of firearms, ammunition, or explosives.

Individuals who are disqualified for failure to comply with OFFSET, IPV or fleeing felons are included in the financial group (FS C.5) but not in the benefit group (FS C.7).

Count all of the ineligible individual's resources in the eligibility determination if this person is not categorically eligible (FS E.1) for FS. Count all of the income received by the ineligible individual. The entire household's earned income deduction (FS F.18), standard deduction (FS F.18), medical deduction (FS F.20),

dependent care deduction (FS F.19), court-ordered child support payment deduction (FS F.21) and excess shelter expenses will be allowed without a proration for the eligible benefit group members.

- Ineligible due to failure to obtain or provide an SSN (FS D.6).

Individuals who are disqualified for failure to obtain an SSN or for not providing their SSN are included in the financial group but not in the benefit group.

Count all of the ineligible individual's resources in the eligibility determination if this person is not categorically eligible for FS. Prorate the ineligible person's income by dividing the income by the number of persons in the financial group and multiplying this figure by the number of persons in the benefit group. Code the prorated income onto the FS case. The computer will not do this proration for individuals on FSUP with member type DH or DP.

The 20 percent earned income deduction is applied to the prorated earned income of the disqualified individual. For dependent care, court-ordered child support payments and shelter costs (FS F.22) (excluding the FUA/LUA/TUA), divide the amount of the cost billed to or paid by the ineligible individual for each deduction by the number of persons in the filing group (FS C.2) and multiply this figure by the number of persons in the benefit group. All but the ineligible person's share is allowed as a deduction. The computer does not make this determination, so remember to prorate the deductions before coding them onto FSUP.

Caution: Do not prorate the filing group's share of the utilities among eligible/ineligible group members.

15. People on Strike

Strikers include the following:

- Employees on strike;
- Employees involved in a concerted work stoppage effort; **and**
- Employees whose work stopped due to the expiration of a collective bargaining agreement.

Clients are not considered to be participating in a strike when:

- The work place is closed by the employer to resist the employees' demands (lock-out).
- They are unable to work because of striking employees (for example, a lumber mill strike may make truckers who deliver lumber unable to work).

- They end employment with the company involved in the strike and accept another full-time job. To qualify as full time, the job must be for 30 hours or more per week, and pay at least the federal minimum wage times 30 hours.
- The striker loses their job because the employer hired a permanent replacement.
- They are exempt from the work registration requirements under OFSET (FS D.7) the day prior to the strike due to a reason other than being employed 30 hours a week.

Clients cannot receive increased FS benefits because their income decreased due to participation in a strike. The client on strike is choosing not to access earned income that is available to them. Therefore, the pre-strike income is considered available in the eligibility determination (GP A.14).

To determine eligibility and benefits for applicants, count each striking member's full month's income prior to the strike. Also consider all other FS eligibility factors.

To determine eligibility for recipients, count either the pre-strike income or the current income (which could include strike benefits), whichever is more, for the duration of the strike.

Strikers are required to register for FS work programs. Let clients mandatory for work program participation know about jobs that are vacant due to a strike, but do not require them to accept the jobs.

Effect of Strikes: 461-130-0328

16. Special Treatment of Income

Some income types are rarely seen in the branch. Other types are treated differently depending on the individual case situation. For example, an in-home care giver may be an employee receiving a wage or may be self-employed. The determination must be carefully made for each client. The self-employment determination is not made based on who pays the income taxes, FICA, or worker's compensation for the client.

A person has self-employment income if they are working in their own business, trade or profession where they are responsible for obtaining or providing the service or product. Clients who are self-employed independently determine the manner, method and process of business operations, and they have full responsibility for the success or failure of the business operation. If the person does not meet these criteria, they are not self-employed.

☞ SEE CA C.1 FOR DEFINITION OF SELF-EMPLOYMENT AND CA-WG #1 FOR EXAMPLES AND MORE INFORMATION.

Self-Employment; General: 461-145-0910

For FS, self-employment income is generally annualized if the business has been in operation for more than 12 months, the income may be earned part of the year but intended to live on for the full year, and the client anticipates the income from the past is representative of the future. However, do not annualize the income if the past income does not reflect the household's actual income circumstances because the business is experiencing a substantial increase or decrease in business. In this situation, calculate the self-employment income based on anticipated earnings. In addition, income is not annualized if it is earned in part of the year, it is not intended to cover the full year, and the client has different employment for the other part of the year.

Program Benefits as Special Needs

Some department programs provide ongoing special needs payments (CA B.57) for laundry allowances, restaurant meals, shelter exceptions and telephone allowances. These are treated as unearned income. Exclude all other special needs payments as reimbursements. For example, if a client was receiving a check each month for a telephone allowance which included payment for a basic telephone and a life line. The amount for basic telephone would be considered unearned income (should be included in the utility deduction) and the amount for the life line is considered a reimbursement. When the GNT amount on FSMIS is different from the check amount issued on CMS, a MNL code must be used in the HH Types field on FCAS page one.

If the client has a pay-in and an ongoing special need, generally the special need will reduce the pay-in. The pay-in amount should be included in the monthly medical deduction (FS F.20) on FSMIS.

Program Benefits: 461-145-0410

Child Care Provider

A child care provider may be either self-employed or not self-employed.

They are self-employed when they take children into their home or place of business to provide care. Child care providers are also self-employed if they receive payments from DPU. Some child care providers advertise that they provide care and also hire other persons to assist with providing the care. These self-employed child care providers generally have allowable costs (CA C.2) associated with rent, utilities, meals and snacks, toys, etc. However, if they are running the child care center in their own home, they may be allowed a self-employment cost for rent and utilities only if it can be separated from their home shelter costs. The household may not be allowed to deduct the same cost from income and also as a shelter and FUA or LUA deduction.

Other people are hired to provide child care in the child's home. These people generally have no costs associated with their business. Remember, their cost to travel from home to place of business is a commuting cost and is not a self-employment cost. The 20 percent earned income disregard is for the commuting cost. Income may be coded as either SEC or SEN depending on whether or not there are allowable costs.

Caution: Do not forget to ask a child care provider if they are receiving USDA meal reimbursements for the children in care. USDA meal reimbursements must be included in the gross self-employment income.

Child care providers are not self-employed when they are hired as an employee of the parent (GP A.27). Code the gross income as EML. For example, a person hired by a child care business as an employee.

In-Home Care Givers

Homecare workers who provide in-home care to DHS client are considered the employee of the client. They are not self-employed or regarded as independent contractors. They are an employee of the person for whom they provide the services. The state makes referrals, sets the rate of pay, authorizes the maximum hours of service and pays the FICA and workers' compensation premiums. Some homecare workers are eligible for health insurance and paid leave based on the number of hours they work per month. In addition, the state also reimburses the care giver for transportation costs when the care giver transports the person in care for medical, shopping, etc., when authorized by SPD and OMAP. Code their gross income less the mileage reimbursement as HCW.

Adult foster care providers are self-employed when they operate a business in which they set or negotiate the rate of pay, decide on how many clients they can provide care for and possibly advertise for additional clientele. In-home care givers may have costs for house cleaning supplies or other unreimbursed expenses. Determine if the care giver asks for reimbursement of these costs before allowing the cost. Code this self-employment income as SEC or SEN depending on the situation.

Rental Property Income

Some clients gain income from renting out a part of their home or a separate residence. A key question is: Does a member of the filing group (FS C.2) actively work 20 hours a week managing the rental property? (Actively working includes collecting rent, taking applications, showing the apartments to prospective tenants and personally doing maintenance and repairs on the rented units.)

If the client is actively involved managing the property 20 hours or more a week, they are self-employed. If self-employed, determine if there are any allowable costs associated with the income. Code the income as SEC or SEN based on this determination. Narrate the type of costs that are allowed. If the client lives in the residence also, determine if their housing and utility costs can be separated from the costs used for the SEC. Only allow housing costs for the client's home that are separate from the costs allowed for the SEC.

If the client is not actively working as manager of the property 20 hours a week or more, it is not self-employment income. Treat the income according to the income-producing property policy. Income-producing property, which is not self-employment income, is allowed the actual costs of doing business. This is not the 50 percent deduction given for self-employment with costs. However, the allowable costs are the same as for self-employment.

☞ SEE CA B.35 FOR MORE INFORMATION ON INCOME-PRODUCING PROPERTY.

Determine and verify (FS B.11) the costs. The client may have tax papers for the prior year. If not, verify the costs before using them to offset the income.

Example: \$35,000 annual rental income (not self-employment) is computed as follows:

Annual rental income		\$ 35,000
less	repairs (rentals only, not home)	- 3,059
	licenses, fees, advertising, and office supplies	- 5,371
	utilities (rentals only, not home)	- 7,276
	sanitary services	- 2,500
	mortgage	- 6,000
	property taxes and insurance	- 2,570
	management fees (not paid to HH member)	- 7,200
	balance	\$ 1,024

In this example, the countable income from income-producing property is \$85.33 a month ($\$1,024 \div 12$). This income is coded as PTY on FCAS.

If this income is considered self-employment, the income of \$2,916.66 ($\$35,000 \div 12$) would be coded as SEC on FCAS.

California SSI recipient

Sometimes a client receiving SSI from California will apply for FS. This person is receiving FS benefits already in their SSI benefits. Therefore, this person is not eligible for FS from Oregon until the SSI benefits are transferred to Oregon. In California, the family members received FS in a separate filing group.

This creates a unique situation when the California FS has ended but the California SSI continues. When in this situation do the following:

- (A) If California SSI recipient is sole person in the Oregon FS filing group (FS C.3), the person is not eligible for FS from Oregon until the California SSI has ended.

Concurrent and Duplicate Program Benefits: 461-165-0030

☞ SEE FS G.7 REGARDING DUPLICATION OF PROGRAM BENEFITS.

- (B) If California SSI recipient is in an Oregon FS filing group that contains other group members who are not receiving FS in another state, take the following actions:
- Determine eligibility for the FS filing group. The person receiving California SSI is excluded from the FS filing group until the SSI is transferred to Oregon. This may take up to two months, depending upon notice requirements.

- Code the California SSI person as DH or DP and do not code their SSI income.
- Counsel the household to report the move to the social security office. They are creating a SSI overpayment.
- Ask for a copy of the SSI decision notice that changes the client's residency to Oregon and reduces the SSI amount.
- Set a tickler to follow up and to add the person to the FS case within the next two months.
- When California SSI changes to Oregon SSI, change the SSI person member type to AD, CH or HH and add the SSI income effective the first of the following month.

☞ SEE CA B.72 FOR TREATMENT OF SSI INCOME.

Farm Income

When a client states they have farm income, the first question to ask is, "Is the business/farm incorporated?" If the farm is incorporated, it is treated as incorporation income and the client is not self-employed. If the farm is not incorporated, proceed with the farm self-employment income determination.

☞ SEE CA B.15 FOR MORE INFORMATION ON CORPORATIONS.

When a farmer applies for FS, obtain a copy of the most recent tax papers, if at all possible. Schedule F is needed.

Note: *In addition to income tax forms, the client may also use the Income From Farm Operation (DHS 200C) to show farm income.*

Was the FS household actively involved in earning the farm income? If not, maybe they lease out the land, which is not considered self-employment income.

Ask the client if they are earning and/or expect to earn the same income this year. Do they also expect to earn the same income next year? Do they expect the costs to be the same each year?

Example: *A farmer has \$99,000 from the sale of livestock, produce, grains, etc. (look at Part 1 of Schedule F, form 1040.) Some of the incomes listed on this form are excluded for FS. If income is received from an excluded source, subtract the amount before arriving at the gross figure. The excluded incomes are:*

- *Lines 7 and 8: Disaster assistance is excluded. However, payments made for crop failure that is not connected to a presidentially declared disaster are counted as self-employment income.*

- *Line 8: Crop insurance payments are a nonrecurring lump-sum income and counted as a resource.*
- *Line 10: Federal and state gasoline tax credit or refund is excluded.*

Farmers who earn more than \$1,000 (gross) a year can receive a special farm credit for income. This special farm credit is allowed if, after all allowable costs, they have a zero balance or a negative figure on the farm income. Start with line 36 (net profit or loss) on the tax form. If it shows a loss, recompute the income allowing all allowable costs per CA C.2. Do not allow depreciation or amortization costs.

There may also be other costs that are not allowable for FS. Whether or not to allow these costs is determined in an interview (FS B.8) with the client. If after recomputing the income and allowable costs the net figure remains zero or a negative amount, the household is eligible for a special farm credit. If the final figure is 50 cents or higher, the gross income (before costs) is counted the same as all other self-employment income with costs.

☞ SEE CA C.4 FOR SPECIAL FARMING CREDIT.

☞ MAY USE DHS 200C OR NOTICE-WRITER FORM FS0200C TO IDENTIFY FARM EXPENSES.

If there is a need to recompute the farm income to determine if the household is eligible for the special farm credit, carefully review the costs with the client. These costs were true last year, are they still true this year? Determine if the costs are solely for the farm and do not include costs for the home. For example, are the costs for property taxes, mortgage, insurance, utilities, sanitary services and telephone noted for the farm billed separately from the utility, sanitation and telephone costs for the home. If these costs are billed on one bill and cannot be separated, the household is eligible for only one – the shelter deduction and FUA or LUA or a deduction from the self-employment income but not both. Also determine if any of the wages include wages to members of the filing group. This includes farm labor as well as bookkeeping costs. Wages paid to any member of the filing group is not an allowable cost.

There may be other costs that are questionable. For example, if there is an identified cost for commissions, why are they paying commissions?

Example: \$99,171 annual farm income. The computations based on tax forms are:

Countable Farm Income:	\$ 99,171
Less fertilizers and lime	- 6,769
lease on machinery	- 2,000
repairs/maintenance	- 3,646
gas, fuel, and oil	- 2,327
insurance (farm only and not home)	- 5,488
mortgage (farm only and not home)	- 22,461

supplies	- 274
utilities (farm only and not on home)	- 1,500
sanitary services (farm only, not on home)	- 1,497
telephone (farm only, not on home)	- 2,823
office costs (not wages paid to HH member)	- 375
registration and permits (farm only)	- 784
legal/professional fees	- 547
other costs	- 661
labor (excluding wages paid to the FS group)	- 41,911
balance	\$ 6,108

In this example, when the costs on the tax form for depreciation or amortization are removed, the balance is greater than zero. Use the income code SEC of \$8,265.25 (\$99,171 ÷ 12).

The balance in this example is not zero or in the negative, so follow self-employment policy and do not implement the special farm credit provision for farmers operating under a loss.

Additional Exclusions for Farming Costs; FS: 461-145-0931

However, if the final figure on the recomputed farm income was a negative \$6,000 for the year, the annualized monthly figure would be a negative \$500 (\$6,000 ÷ 12). In this situation, the income from the farm should be coded on FCAS as zero and the \$500 should be subtracted from other household income to reduce it by the \$500 credit.

Note: This is a manual process because the computer does not have a code to allow for the \$500 credit. Carefully narrate this action and the discussion about this income with the client.

17. When to Allow Deductions

FS clients receive certain deductions from their countable income, before comparing the income to the adjusted income limit (FS F.26). Deductions may or may not be appropriate, depending on whether the client has a cost for certain items. These include deductions for child support payments (FS F.21), dependent care (FS F.19), medical costs (FS F.20) and shelter costs (FS F.22).

The client is considered to have a cost when they incur a bill for these items, and they are responsible for paying the bill. Therefore, if someone outside the FS group pays the bill for them, it is not allowed as a deduction. This is regardless of whether the payment from others is by reimbursement, vendor payment or in-kind benefit. For example, when clients have health insurance that pays 80 percent of the costs (GP A.7) incurred, allow as a deduction only the 20 percent that the client has a responsibility to pay. Do not allow a medical deduction for costs written off by a medical facility.

Deductions are not allowed for services provided by someone in the filing group (FS C.2). For example, if an older child in the filing group provides child care while the parent (GP A.27) works, there is no deduction. This is because although the money has passed from one member of the filing group to another, it remains available to the group. It is not like paying rent, where the money is paid to someone outside the group. Therefore, it is not considered an allowable deduction.

Once a cost has been allowed as a deduction, it cannot be allowed again. Costs that are billed to the client but are delinquent are not allowed as a deduction.

Note: *When not allowing a deduction, a denial notice must be sent. Use the Notification of Planned Action (SDS 540) for the denial.*

☞ SEE EXAMPLES ON WHEN TO ALLOW DEDUCTIONS (FS F. EXAMPLES 17)

Overview of Costs: 461-160-0030

☞ SEE CA C.2 FOR IDENTIFYING TYPES OF ALLOWABLE COSTS AND CA C.3 FOR INFORMATION ABOUT SELF-EMPLOYMENT INCOME EXCLUSIONS DUE TO HAVING ALLOWABLE COSTS FOR DOING BUSINESS.

☞ SEE FS F.14 FOR HOW TO TREAT DEDUCTIONS FOR INELIGIBLE OR DISQUALIFIED NEED GROUP MEMBERS (FS C.6).

18. Standard Deduction and Earned Income Deduction

Every FS case gets a standard deduction. The standard deduction for a benefit group (FS C.7) of one through three persons is \$141. The standard deduction for a benefit group of four persons is \$147. The standard deduction for a benefit group of five persons is \$172. The standard deduction for a benefit group of six or more persons is \$197.

Every client with earned income also gets at least the first 20 percent of this income deducted. This includes self-employment income and training incentives that are not reimbursements for training expenses. Enter the full countable earned income (codes EML, HCW, SEC, SEN, and TNG) into FSMIS, and the system allows the 20 percent.

Reminder: *Clients, who are self-employed and have allowable costs (CA C.2) of doing business, get a 50 percent exclusion off the gross income. Some farmers get an additional deduction if they are operating the farm at a loss (CA C.4 and FS F.16). To do this, enter the income before the 50 percent exclusion and code it as SEC into FSMIS. If the income passes the countable income test, the 20 percent deduction is allowed.*

Self-Employment; Costs That Are Excluded To Determine Countable Income: 461-145-0920
Income deductions; FS: 461-160-0430

19. Dependent Care Deduction

Allow this deduction when the FS group has a cost for caring for a dependent who is in the filing group (FS C.2) and requires the care. The care must be necessary in order for the client to:

- Accept or maintain employment;
- Comply with OFSET (FS D.7) activities per case plan;
- Attend training or education preparing them for a job.
- Work Search

Note: Do not allow child care as a deduction when the cost of the care is being paid by JOBS or OFSET. A dependent care cost is only allowed for higher education when the cost is an unmet need after the educational income is computed on the Educational Income Calculation for ERDC and Food Stamps (DHS 7351).

Note: If a household incurs attendant care costs that could qualify under both the medical deduction and dependent care deduction, treat the cost as a medical deduction per FS.F20.

Educational Income; 461-145-0150

The person providing the dependent care must not be in the filing group (FS C.2), and must not be the dependent's biological, adoptive or step-parent.

To figure the amount of necessary dependent care hours related to the above bulleted items, allow the time the client is performing the activity, commuting time from the provider's residence to the activity, and meal breaks. Do not allow time when dependents are in school or other free care situations. In addition, allow up to five days per month when the dependent is scheduled for care but the care is not used, if the provider charges for this time. Often providers charge for care even when dependents are absent (due to illness, for example) in order to hold their slot until they return to care.

After determining the necessary dependent care hours from above, multiply it by the rate the client is being charged to determine the dependent care deduction. For example, in prospective budgeting: A client has 45 hours of dependent care each week and is charged \$2.50 per hour. $45 \text{ hours} \times \$2.50 \times 4.3 \text{ weeks} = \483.75 . Code the full amount of dependent that each person is receiving under that person in FSMIS.

QC Hot Tip

If the full cost of care is \$290 and two children are in care equally, code CC of \$145.00 on each child.

- ☞ SEE FS F.10 FOR MRS CASES CLAIMING DEPENDENT CARE COSTS.
- ☞ SEE NC B.3 FOR HOW TO TREAT DEDUCTIONS FOR FILING GROUPS (FS C.2) CONTAINING AN INELIGIBLE NONCITIZEN (FS D.5).

Dependent Care Costs; Deduction and Coverage: 461-160-0040
Income Deductions; FS: 461-160-0430

20. Medical Deduction for Elderly/Clients With Disabilities

Only clients who meet the FS definition of elderly (GP A.13) or clients with disabilities (GP A.10) are eligible for a medical deduction.

For these clients, a medical deduction is allowed for the costs (GP A.7) of services provided by, prescribed by, or used under the direction of a licensed medical practitioner.

Examples of medical costs include, but are not limited to:

- Health insurance premiums, deductibles, and coinsurance. (Includes Medicare premiums not covered by Medicaid and EPD participant fees.) Long-term-care insurance premiums are deductible if the insurance pays for services while an individual is receiving waived services, nursing facility services, or is in an intermediate care facility for the mentally retarded. A policy set up to pay a lump sum, similar to life insurance, is not deductible.
- Medical and dental care, including psychotherapy, rehabilitation services, hospitalization and outpatient treatment.
- Prescription drugs and medications prescribed by a licensed medical practitioner, as well as medical supplies and equipment, dentures, hearing aids, prostheses and prescribed eyeglasses. (Include postage costs for order-by-mail prescriptions.)
- Over-the-counter medications approved by a licensed practitioner or other qualified health professional. No prescription is required.
- Medical marijuana which is prescribed by a licensed medical practitioner is an allowed medical cost provided the individual has a Medical Marijuana Program card issued by the state. The cost can include the cost of the medical marijuana card and the cost to purchase or grow the medical marijuana. Please contact an FS Policy Analyst in Central Office if you have question about what to allow.

Note: *Medical supplies include prescribed adult-sized diapers, such as Depends. Medical supplies do not include special diets or special foods prescribed by a doctor. A person on a low- or high-sodium diet may purchase prescribed high-sodium foods with their food stamps. Some dietary drinks high in nutrients may be purchased on the medical card.*

- Nursing care, nursing home care and hospitalization, including payments on bills for people who were members of the household immediately prior to entering a state-certified hospital or nursing home.
- Maintaining an attendant, a home health aid, a housekeeper or dependent care services due to age or illness, including an amount equal to a one-person FS payment standard when the client furnishes the majority of the attendant's meals.
- Client offset payment when residing in a group living facility.

Note: Allow the service cost, which is the amount over room and board.

- Prescribed assistance animal, (such as a Seeing-Eye Dog, a Hearing Dog or Housekeeper Monkey), that have received special training to provide a service to the client. This deduction includes the cost of acquiring these animals, their training, food and veterinarian bills.

Note: Special training means the animal has been trained to do something for their owner that the animal would not normally know to do. The training needs to be related to providing a service the client needs due to their disability. Obedience training does not constitute special training.

Questions the worker may want to consider:

- What disability created the need for the service animal?
- What is the service the animal is providing?
- What is the training the animal received?

- The reasonable cost of transportation and/or lodging needed to obtain medical treatment or services.

Note: Use the same rate as approved by DMAP for medical transportation.

All medical costs must be verified. If the service is under the direction of a licensed medical practitioner, verification (FS B.11) (prescription, note or collateral contact) must be in the file. Additionally, the specific cost and frequency of use should be verified.

To determine medical amounts at application and recertification, use a reasonable estimate of the client's costs for the certification period. Arrive at this estimate by combining current and expected medical costs. Verify all current medical costs. Costs can include installment payments on a bill, as long as the bill has not been allowed previously, the installment plan arrangements were made with the creditor before the bill became past due and the client has not defaulted on the plan. Also verify current medical insurance cost and coverage, so that you can determine the portion of each medical cost that the client is responsible to pay. In addition, anticipate medical expenses reasonably certain to occur based on the client's medical history. Total the current and anticipated expenses, then average the total over the certification period.

Note: Medical costs paid by credit card are considered paid in full at the time the payment is made. The subsequent ongoing credit card payments are not allowable

as a medical deduction. For example: Lilly has a \$450 dental bill. She pays this bill in full with her credit card. The medical deduction will be the one-time payment of \$450 or the \$450 will be prorated over the remainder of the certification period.

Caution: Do not allow medical costs of other filing group (FS C.2) members who do not meet the FS definition of elderly or clients with disabilities.

☞ USE THE MEDICAL EXPENSE WORKSHEET FOR FOOD STAMPS (DHS 221MED) FORM TO CALCULATE THE ALLOWABLE ONGOING MEDICAL COSTS.

In the actual FS calculation for benefits, the first \$35 in medical deductions for the FS group is excluded. However, workers code the total allowable medical deductions to each eligible person, and FSMIS subtracts the first \$35.

☞ THE LIST OF MEDICAL EXPENSES (SDS 1238B) FORM (ON ACCESS) CAN BE HELPFUL WHEN TRACKING MEDICAL COSTS.

When the client subsequently reports unanticipated medical costs they have incurred during the recertification period, allow a deduction for the new or increased cost only if it is not past due or carried forward from a previous billing period. For medical costs that are reported in the certification period, the client can choose one of the following:

- Allow the cost the month after it is reported, or
- Average the cost as follows:
 - Whether paid, or not paid, and is not past due, average it from the first of the month after which it was reported to the end of the certification period.
 - If the client gets a medical bill that they have not paid, (and it is not past due), which is due after their certification period ends, allow the deduction in the next certification period, or
- Allow the amount of an installment payment, if the client and creditor made an installment plan before the bill became past due and the client has not defaulted on the plan.

After using one of these methods to determine how much of an unanticipated medical bill changes the deduction amount for each month, adjust benefits **for the future only**. No restoration of lost benefits is needed, because there has not been any administrative error.

Medical deductions are determined prospectively, and when there is a change, the new deduction amount only prospectively affects the future. Therefore, when a client reports a paid medical cost in the last month of their redetermination period (GP A.33), there is no adjustment to make. Benefits for the current month have already been issued, and prospectively, since the bill has been paid, there is no medical expense expected for the next certification period.

- ☞ SEE FS-WG #7 FOR EXAMPLES OF HOW TO CALCULATE FS MEDICAL DEDUCTIONS.
- ☞ SEE FS F.16 ON CONSIDERING PROGRAM BENEFITS FOR SPECIAL NEEDS.
- ☞ SEE EXAMPLES OF MEDICAL DEDUCTIONS FOR ELDERLY AND CLIENTS WITH DISABILITIES (FS F. EXAMPLES 20)

Medical Costs That are Deductible; FS, GA, GAM, OSIP, OSIPM: 461-160-0055
Medical Deduction; FS: 461-160-0415
Income Deductions; FS: 461-160-0430
Restoring Benefits: 461-165-0200

Effective Dates; Changes in Income or Income Deductions That Cause Increases: 461-180-0020
Effective Dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030

21. Child Support Payment Deduction

This FS deduction is different from the others, because it is based on what a member of the filing group *pays* rather than what they are *billed*. Clients paying legally obligated child support for children outside the household get this deduction. This means the child the support is paid for cannot be a member of the household group. Include amounts they are paying for current child support *and* arrearages, unless the payment is collected by Set-Off of Individual Liability (SOIL) recovery.

For example, in prospective budgeting: A client pays his court-ordered child support of \$200 per month as he can, depending on how his income varies. For this month and the last two months he paid \$125, \$200, and \$150. He expects payments to continue at about the same rate. $\$125 + \$200 + \$150 = \475 divided by 3 months = \$158.33 child support deduction allowed.

The COS deduction is limited to the amount a member of the filing group paid for child support. The amount a noncustodial parent pays toward the child's medical bills or for health insurance coverage (even if court ordered) is not allowed as part of the COS.

Note: The COS is allowed when court-ordered support is being paid by a filing group member for children who do not live in the household. The person ordered to pay the support must be in the filing group. The person whose income pays the support must be in the filing group. They may be the same person or two different persons, as long as they are in the same filing group.

QC Hot Tip

To allow the deduction for payment of child support both of the following must be true:

- The child support must be court-ordered; and

- The child(ren) the support is for cannot be in the same household group as the person ordered to pay the child support.

If each of the above is true, the client must verify the following before the deduction can be allowed:

- The support is court-ordered and which child(ren) the support is for; and
- The amount of child support he or she is paying.

If the support is being paid through the Oregon Department of Child Support, this information can be verified on SMUX.

Income Deductions; FS: 461-160-0430

22. Shelter Deductions; Housing

Allow a deduction for the shelter costs incurred where the filing group (FS C.2) is currently residing. The shelter deduction is made up of two parts: housing and utilities. This section deals with the housing costs (GP A.7) for most situations. The next section deals with utility costs for most situations.

- ☞ SEE FS D.3 FOR HOW TO TREAT SHELTER COSTS WITH AN INELIGIBLE STUDENT.
- ☞ SEE NC B.3 FOR HOW TO TREAT DEDUCTIONS FOR FILING GROUPS CONTAINING AN INELIGIBLE NONCITIZEN.
- ☞ SEE FS F.24 FOR HOW TO TREAT SHELTER COSTS FOR SPECIAL SITUATIONS SUCH AS AN UNOCCUPIED HOME.

Housing costs include the billed amounts for the following:

- Continuing charges for rent, mortgage (including a second mortgage) or other continuing payments leading to home ownership, including interest on such payments. Allow a shelter deduction for a reverse mortgage if the client has a balance owing on the mortgage. Do not include fees or deposits that are not continuing charges or for late payments. Allowable charges do not include rental fees for storage units or garages.

Note: *This includes payments on a home equity loan or line of credit if the home is listed as collateral on the loan and the financial institution is listed as a lien holder on the home.*

- Property taxes (even when they are deferred), state and local assessments and insurance on the structure of the home, but not costs to insure furniture or personal

belongings. Renters insurance is not an allowable deduction. Do not include payments on delinquent property taxes and their interest.

- Condominium and association fees charged to owners and renters to cover common area costs.
- Itemized housing costs paid at the time of closing, such as insurance or property taxes. Do not include closing costs.
- Costs that are not reimbursed by private or public sources, for repairing a home damaged or destroyed by a disaster (such as fire or flood).
- For homeless groups (GP A.17) living in their vehicle, payments on the vehicle and the portion of insurance payments that cover vehicle damage (comprehensive and collision, *not* liability, PIP, etc.).

The client can choose whether to get the housing deduction in the month the cost is billed or becomes due, or to average the cost over the period it is intended to cover. Therefore, a tax or insurance bill could be allowed as a deduction in one month, or averaged. For example, to average a tax bill for \$1,800 over a 12-month period, the deduction would be \$1,800 divided by 12 months = \$150 per month. This tax amount would be added to any payment amount plus averaged insurance amount, to calculate the total monthly housing deduction. Usually it is to the client's advantage to average the cost over a period of time and get increased benefits for the total certification period, rather than allowing the cost in one month and increasing benefits for one month only.

For housing costs that are billed on a weekly or biweekly basis, convert them to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15. For example, a client charged \$80 per week would have a housing cost of $\$80 \times 4.3 = \344 per month.

When a filing group shares housing costs with persons in the dwelling who are outside the group, allow as a deduction only the amount actually incurred by the filing group. For example, if two groups each pay half of the \$450 rent, allow a \$225 deduction. In addition, if the FS group collects the rent from the other group and then forwards the full amount on to the landlord, do not count the \$225 collected from the other group as income or as part of the shelter cost. This is because it is considered unavailable and does not affect the FS calculation.

In some instances, an FS group is not eligible for a shelter deduction because they are not responsible for the shelter costs. An FS group may not be responsible for the shelter costs if they are working around an apartment complex in exchange for rent. In this situation, the value of the rent is not counted as income as it is income-in-kind. In addition, the FS group is not allowed a deduction for the value of the rent as the group is not responsible for making the rent payment.

☞ SEE EXAMPLES OF SHELTER DEDUCTIONS; SHARED SHELTER SITUATIONS (FS F. EXAMPLES 22).

23. Shelter Deduction; Utilities

Utility costs (GP A.7) include billed amounts for heating and cooling, cooking fuel, electricity, water, sewer, well installation and maintenance, septic tank system installation and maintenance, garbage collection fees and the basic service fee and taxes for one telephone including cell phone or pager charges. If a household claims their vehicle as their home, allow gasoline as a utility cost when it is used for heat. The receipt of energy assistance does not affect the utility deduction as long as the group will incur and be billed for heating or cooling costs.

Note: Each filing group must have an identified utility bill. Utility costs included in rent are not generally a separately identified bill. To be separate, the rent receipt or identified billing statement must break out each identified cost (i.e., \$350 rent, \$50 electricity, \$20 water and sewer, etc.)

Each filing group (FS C.2) with allowable utility costs gets one of four standard utility allowances for their deduction. The standard amount is derived from the average utility costs for households in Oregon. One allowance, the Full Utility Allowance (FUA), includes heating/cooling costs. A second allowance, the Limited Utility Allowance (LUA), is allowed when the filing group has two or more utility costs, but not heating/cooling costs. A third allowance, the individual utility allowance (IUA), is used when the filing group has only one utility cost and it is not for heating or cooling or telephone. A fourth allowance, the telephone utility allowance (TUA) is used when the filing group has a cost for a telephone only.

Note: On the computer, the IUA and TUA are coded as TUA because they are the same amount.

To get the FUA, the filing group must be billed on a regular basis for its heating or cooling costs. Cooling costs do not include portable home fans. All fuels (including geothermal, solar panels, wood, oil, propane, gas and electricity) are considered heating costs if they are the primary source actually used for heating. The FUA is allowed based on the client's statement that they have these costs unless they are questionable. The filing group must incur an individual (out-of-pocket) expense for the heating/cooling costs.

Note: Wood heat is an allowed cost if the filing group buys wood. This does not include the cost of a cutting permit, gas for a truck to haul the wood, chain saw costs, etc. Do not allow FUA for use of space heaters, stoves, or electric blankets as a heat source. They qualify as utility costs, but not heat costs.

Allow the FUA if the client is billed for their individual usage or a flat rate for heating/cooling costs separate from the rent. Verification (FS B.11) is not necessary. Do

not allow the FUA for filing groups that are charged a flat amount for rent and utilities that does not separately identify heating and cooling costs.

Some clients have low-income housing and receive a HUD payment for utility costs. The HUD utility reimbursement (paid directly to the client or the utility company) may cover all or most of the heating bill. If the client is responsible for the balance of the bill, they are also eligible for the FUA.

In addition, filing groups receiving LIEAP at their current residence are eligible to receive the FUA. This eligibility for the FUA continues for the year, as long as they continue to live at that address.

When a filing group is sharing a dwelling with another group and they share utility costs, determine if the FS group is paying any part of the heating costs. If yes, each filing group that is paying a share of the heating costs is eligible to receive the FUA. There is no proration.

The second, third and fourth utility allowances (LUA, IUA and TUA) are for filing groups who have allowable utility costs but do not pay a heating/cooling cost. This includes those who have heating included in the cost of rent but pay for telephone, electricity, garbage, sewer, etc., separate from the rent.

Note: Cable TV or satellite is not an allowable utility cost. Phone cards also do not count as an allowable utility expense.

To receive the LUA, the filing group must be billed on a regular basis for at least two allowable nonheating utility costs. One cost may be for a telephone.

To receive the IUA, the filing group must be billed on a regular basis for one allowable nonheating utility cost. This cost cannot be for a telephone.

To receive the TUA, the filing group must be billed on a regular basis for basic service on a telephone. The telephone may be a land phone, a cell phone or an internet phone service. A filing group that pays only for a cell phone qualifies for TUA even if another filing group in the household has a land line available.

Note: The cost for phone cards is not a utility expense.

Clients with allowable costs get one of the four allowances. There is no additional deduction for actual utility costs in excess of the utility allowances. There is also no proration when two or more filing groups share a residence and each pay utility costs.

Shelter Cost; FS: 461-160-0420

QC Hot Tip

At each certification and recertification and anytime the client reports a move, assure how the home is heated and who is responsible for paying the heating costs. Narrate!

Only allow the FUA if the filing group is responsible for paying any part of the heating costs.

If not paying heating costs, carefully determine what utility costs the filing group is responsible to pay. Narrate which utility type. Allow the LUA if the filing group is responsible for paying at least two allowable utilities. Allow the IUA if the filing group is responsible for paying only one allowable utility (not phone). Allow the TUA if the filing group is responsible for paying the basic service on a telephone.

☞ SEE FS D.3 FOR HOW TO TREAT SHELTER COSTS WITH AN INELIGIBLE STUDENT.

☞ SEE NC B.3 FOR HOW TO TREAT DEDUCTIONS FOR FILING GROUPS CONTAINING AN INELIGIBLE NONCITIZEN.

☞ SEE FS F.24 FOR HOW TO TREAT UTILITY COSTS FOR SPECIAL SITUATIONS SUCH AS AN UNOCCUPIED HOME.

24. Nonstandard Living Arrangements (GP A.25)

Group Living. (also FS C.4) Clients living in a group living arrangement, such as RCF or domestic violence shelter may be eligible for a shelter deduction (FS F.22). The allowable shelter cost is the amount of the payment for the room only when the housing cost is separately identified. When the room and board is one payment and not separately identified, calculate the shelter cost by subtracting the Thrifty Food Plan from the room and board cost.

For example, an individual pays \$451.70 room and board:

$\$451.70 - \$200 = \$251.70$ allowable shelter. Allow this calculated amount, unless the client can prove the room cost exceeds it. In that case, allow the higher verified amount.

Note: *A DD client receiving brokerage services is not considered to be residing in a RCF.*

Income Deductions; FS: 461-160-0430

Unoccupied Home. In addition to shelter costs (GP A.7) incurred where the FS group resides, allow a deduction for a home the group is *not* occupying, if all of the following are met:

- The home is unoccupied because of illness, employment or training away from home, natural disaster or casualty loss;
- The FS group intends to return to the home;

- Any current occupants are not claiming shelter costs for FS; **and**
- The home is not leased or rented.

For an unoccupied home, allow only the actual verified utility costs as a deduction. Do this by adding the actual utility costs to the housing cost. Do not give the FUA or LUA for utilities on an unoccupied home.

Shelter Cost; FS: 461-160-0420

25. Benefit Levels

The United States Department of Agriculture (USDA) conducts studies to determine FS benefit levels. They look at the average cost of food for a household, considering the number of persons in the household. They expect that clients will shop with frugality, therefore USDA calls the FS benefit level the Thrifty Food Plan (TFP). The TFP is generally adjusted in October of each year to incorporate rising food prices due to inflation.

Following are the current FS benefit levels or TFP:

<u># in Benefit Group</u>	<u>Amount</u>
1	\$200
2	\$367
3	\$526
4	\$668
5	\$793
6	\$952
7	\$1052
8	\$1202
Each additional person	\$150

Clients with no income available for food based on the FS calculation, receive the entire FS benefit amount. Clients with some income available for food as determined by the FS calculation, receive the difference between the FS benefit level for their household size and their food income. For example, a three-person household has \$120 available to spend on food, based on their FS calculation. The benefit level for three persons is \$526 - \$120 available for food = \$406 FS benefits they are eligible for.

Income and Payment Standards; FS: 461-155-0190

26. Benefit Calculation

For clients who have passed the countable income limit (FS F.2) and resource limit (FS F.3), we perform the FS benefit calculation. **Elderly (GP A.13) and persons with disabilities (GP A.10) need only to meet the adjusted income limit (FS F.26).**

It is very helpful to understand the FS calculation in order to be able to explain changes or potential changes in benefit amounts to clients. Also, when coding changed information into the system record, understanding the process and knowing how much the benefit amount should change makes it easier to identify coding errors.

Amounts are rounded down for 1-49 cents and rounded up for 50-99 cents in each step of the calculation, except in step 9. The answer is rounded up for 1-99 cents in step 9. (FSMIS automatically does the rounding.) This means all of the following:

- For income, add all pay from the same income source before rounding. Round income amounts before converting, and again after converting.
- Round the cost of dependent care for each person before comparing it to the limits.
- Add medical costs for all persons before rounding and calculating the deduction.
- Do not round shelter costs until the excess shelter deduction has been computed.

Use of Rounding in Calculating Benefit Amount: 461-160-0060

Following is a description of the FS calculation, along with some examples to illustrate the process.

Note: *The 185 percent categorical eligibility income test (FS E.1) is not part of this calculation. This is because the worker must make a separate (manual) categorical eligibility determination before coding the case on the computer or computing benefits.*

Step 1 Add all types of income (rounded). If income includes self-employment with allowable costs (CA C.2) of doing business, the system will allow 50 percent exclusion for the costs. The subtotal is the client's FS countable income (GP A.18). This amount is compared to the FS countable income limit (FS F.2). Filing groups (FS C.2) that are categorically eligible or contain an elderly or a person with disabilities do not need to meet the FS countable income limit.

Note: *If the household is not categorically eligible or does not contain an elderly or a person with disabilities, and income is equal to or exceeds the countable income limit, it is not eligible for FS and the computation ends with this step.*

Step 2 Subtract 20 percent (rounded) of the earned income. (FS F.18)

- Step 3 Subtract the standard deduction (FS F.18) amount of \$141 for households of one through three persons, \$147 for a household of four persons, \$172 for a household of five, and \$197 for a household of six or more persons.
- Step 4 Subtract the dependent care deductions (FS F.19) (rounded).
- Step 5 Subtract \$35 from the allowed medical costs. (FS F.20)
- Step 6 Subtract the court-ordered child support deduction (FS F.21) (rounded).
- Step 7 Subtract the excess shelter costs (FS F.22 and FS F.23) (rounded). This requires a comparison of the subtotal through step 6 above to the client’s shelter costs. According to the FS calculation, half of this subtotal should be available for the client to pay their shelter costs. If half of this subtotal is less than the client’s shelter costs, then they have excess shelter and are entitled to another deduction. If half of the subtotal is equal to or more than the shelter costs, then the client has adequate funding for their shelter costs and does not have an excess to count as a deduction. For most FS groups, the excess shelter deduction is the actual amount up to a limit of \$446. However, for groups containing a member who is elderly or is a person with disabilities, the excess shelter deduction is the actual amount without a limit.
- Step 8 The resulting subtotal is the client’s FS adjusted income (GP A.18). It must be compared to the FS adjusted income limit below:

<u>Number in Benefit Group</u>	<u>FS Adjusted Income Limit</u>
1	\$ 903
2	\$1,215
3	\$1,526
4	\$1,838
5	\$2,150
6	\$2,461
7	\$2,773
8	\$3,085
Each additional person	\$ 312

Income and Payment Standards; FS: 461-155-0190

If the FS adjusted income is equal to or exceeds this limit, the group is not eligible unless they are categorically eligible. If the FS group’s adjusted income is below the limit or

they are categorically eligible, we continue the calculation to determine the benefit amount.

- Step 9 Multiply the subtotal in step 7 by 30 percent (rounding 1-99 cents to the next highest digit). This 30 percent of the FS adjusted income is the amount considered available to the group to spend on their food needs.
- Step 10 Subtract the subtotal in step 9 (the group's income available for food) from the TFP amount for the benefit group (FS C.7) size. The difference is the FS benefit amount (unless the situation meets one of the exceptions listed in FS F.27).

Income and Payment Standards; FS: 461-155-0190
Use of Rounding in Calculating Benefit Amount: 461-160-0060
Use of Income to Determine Eligibility and Benefits; FS: 461-160-0400
Income Deductions; FS: 461-160-0430

To manually compute benefits use the *Food Stamp Benefits Computation* form (DHS 221).

See the next two pages for sample FS calculations.

Sample FS Calculations		
(Note: These groups have already passed the countable income test)		
	Example 1	Example 2
	3 persons with \$300 rent <u>+385 FUA</u> \$685 shelter	2 persons with \$500 rent <u>+385 FUA</u> \$885 shelter
Step 1 (income)	\$514 TANF	\$500 SSB <u>+400 SSI</u> \$900 income
Step 2 (20% earned income deduction)	N/A	N/A
Step 3 (standard deduction)	<u>-\$141</u> \$ 373 <i>Subtotal</i>	<u>-\$141</u> \$ 759 <i>Subtotal</i>
Step 4 (medical over \$35)	N/A	\$85 - 35 benchmark <u>-\$ 50</u> \$ 709 <i>Subtotal</i>
Step 5 (dependent care)	N/A	N/A
Step 6 (child support)	N/A	N/A
Step 7 (excess shelter)	\$ 685 shelter <u>- 187 (½ of \$373)</u> \$498 excess, therefore <u>use -\$459 (maximum)</u>	\$885 shelter <u>- 355 (½ of \$709)</u> \$530 excess, therefore <u>use -\$530 (unlimited)</u>
Step 8 (compare adjusted income to the limit)	\$373 income <u>- 459 excess shelter</u> OK \$0 (adjusted income)	\$709 income <u>-530 excess shelter</u> OK \$179 (adjusted income)
Step 9 (multiply adjusted income from Step 7 by 30%, round up)	<u>X 30%</u> \$ 0 food funds	<u>X 30%</u> \$ 54 food funds
Step 10 (difference between TFP and food funds)	\$526 TFP <u>- 0 food funds</u> \$526 FS benefit	\$367 TFP <u>- 54 food funds</u> \$313 FS benefit

More Sample FS Calculations				
(Note: These groups have already passed the countable income test)				
	Example 3		Example 4	
	4 persons with	\$450 rent + 46 TUA \$496 shelter	6 persons with	\$300 rent + 272 LUA \$572 shelter
Step 1 (income)		\$ 980 earnings + 250 child support \$1,230 <i>Subtotal</i>		\$1,032 UC
Step 2 (20% earned income deduction)		- \$ 196 \$1,034 <i>Subtotal</i>		N/A
Step 3 (standard deduction)		- \$147 \$ 887 <i>Subtotal</i>		- \$197 \$ 835 <i>Subtotal</i>
Step 4 (medical over \$35)		N/A		N/A
Step 5 (dependent care)		- \$120 child care \$ 767 <i>Subtotal</i>		N/A
Step 6 (child support)		N/A		- \$150 child supp. \$ 685 <i>Subtotal</i>
Step 7 (excess shelter)		\$496 shelter - 383 (½ of \$767) \$ 113 excess, therefore <u>Use - \$113</u>		\$572 shelter - 342 (½ of \$685) \$230 excess, therefore <u>Use - \$220</u>
Step 8 (compare adjusted income to the limit)		\$767 income - 113 excess shelter OK \$654 (adjusted income)		\$685 income - 230 excess shelter OK \$455 (adjusted income)
Step 9 (multiply adjusted income from Step 8 by 30%, round up)		<u>X 30%</u> \$ 196 food funds		<u>X 30%</u> \$ 137 food funds
Step 10 (difference between TFP and food funds)		\$668 TFP - 196 food funds \$472 FS benefit		\$952 TFP - 137 food funds \$815 FS benefit

27. Exceptions to the FS Benefit Calculation

When the FS benefit calculation results in benefits of less than \$16, special amounts are issued, as follows:

- In the initial month (GP A.19), no benefits are issued if the prorated amount is less than \$10.
- For an ongoing month (GP A.26) with one- or two-persons in the benefit group, \$16 is issued.

- For an ongoing month, with three or more in the benefit group, the calculated amount will be issued. Except, if the calculated amount is \$1, \$3, or \$5, the group will receive \$2, \$4, or \$6 respectively.

Minimum Benefit Amount; FS, REF, TANF: 461-165-0060 |

28. Prorating Benefits

Initial month (GP A.19). When the benefit group (FS C.7) or an individual is eligible for less than a full month's benefits, they get benefits intended to cover only the days for which they are eligible. This happens when benefits are approved on a new case, for example. This partial month's benefit is called *prorated*.

Note: The exception is for filing groups (FS C.2) containing a migrant or seasonal farm worker (FS I.1). Their benefits are not prorated if they received FS in the prior month from any state.

To calculate prorated benefits, first determine the benefit amount for a full month. Next, divide the full benefit amount by the number of the days in the payment month. This will result in the benefit amount per day. Finally, multiply the daily benefit amount by the number of days the group or individual is eligible. The result is the prorated benefit amount.

Benefits for Less Than a Full Month: 461-160-0070

☞ SEE MP-WG #8 ON CALCULATING PRORATED BENEFITS FOR A CHART THAT SIMPLIFIES THIS CALCULATION.

At Recertification. Filing groups which establish their filing date (FS B.5) within the last month of their current redetermination period (GP A.33) and provide verification (FS B.11) within the 30-day processing time frame do not have prorated benefits.

- Filing groups which establish their filing date after the end of their current redetermination period and provide verification within the 30-day processing time frame have prorated benefits from the filing date. The exception is for filing groups containing a migrant (GP A.22) or seasonal (GP A.35) farm worker. Their benefits are not prorated if they received FS in the prior month from any state.
- For groups that are not given extra time, but submit verification after 30 days but within 60 days of the filing date, prorate the benefits from the date the verification was provided if they are eligible on that date.

Effective Dates; Initial Month FS Benefits: 461-180-0080

29. Food Stamps F - Financial Eligibility Examples

4. Transfer of Resources of Noncategorically Eligible Households Examples

Example 1: A client's resource limit is \$2,000 and they have \$1,500 countable resources. They give a countable resource with a fair market value of \$4,000 to a relative prior to applying for FS, so that they will be found eligible.

$$\begin{aligned} & \$4,000 \text{ (transferred)} + \$1,500 \text{ (other resources)} = \$5,500 - \$2,000 \\ & \text{(allowable resources)} = \$3,500 \text{ uncompensated value.} \end{aligned}$$

For this example, the client is disqualified for nine months for \$3,500 uncompensated value per the disqualification period chart.

6. Prospective Eligibility and Budgeting Examples

Example 1: In SRS: Filing date is 4/12. The applicant was just laid off work. As of the date of the interview on 4/13, he received one weekly pay check on 4/6 and expects to receive one more paycheck today. He has applied for UC and is currently serving the waiting week. This month's income is not expected to continue. Issue April benefits using actual anticipated earned income for April, then zero out his EML for future months. Do not count any UC because the waiting week is not a guarantee of benefits. Explain reporting requirements.

Example 2: In TBA: An FS case can never be certified or recertified using the TBA report system. Therefore, TBA will never be the report method for a first month of FS benefits.

7. Change Report System Examples

Example 1: The ERDC APR period runs from April through June and the FS redetermination period runs from May through July. The worker can do a four-month APR (July – October) for ERDC and a three-month FS redetermination (August – October) so both end in October. Or the APR period could run three months from July through September and the FS redetermination five months from August through December. The FS redetermination would then end at the same time as the October through December APR period. Once the end dates are aligned, a 12-month certification of both, with the FS case in SRS, is strongly encouraged.

9. Transitional Benefit Alternative Examples

Example 1: MRS to TBA. Joseph and his daughter, Anna, were receiving TANF (Program 2). On March 15, they report he went to work on March 5 and will be first paid on March 25. The TANF and FS cases are placed in MRS for April 1. On April 1, the DHS 859A is processed for April benefits. Joseph and Anna are ineligible for TANF. Action is taken on the TANF case to end TANF cash benefits effective March 31, convert the case to EXT for April 1. For FS, the DHS 859A must be processed to issue the April benefits based on the March earned income and GNT. On April 2, the FS case is converted to TBA effective May 1. For TBA, the GNT is changed to zero and the earned income used to issue the April benefits continues unchanged.

Example 2: CRS to TBA. Max and his child, Margaret, were receiving TANF (Program 2). On March 21, they report he went to work on March 12 and will get his first pay on March 31. This change was reported within 10 days of the start of the job and therefore timely reported. It was determined that the family is prospectively ineligible for TANF. The end of the 10-day notice period to close TANF or reduce FS is after March 31. Notice is given to end TANF effective April 30. On CM, the TANF case is closed effective April 30 and the case is converted to EXT, effective April 1. On FS, the case is converted to TBA, effective May 1. For TBA, the GNT is changed to zero and any other income that was used to issue the April benefits continues unchanged. If the only income used for April benefits was the GNT, no income is used for TBA.

Example 3: Josie and her child, Johanna, are in Pre-TANF. Josie calls October 15 to report she began a job on October 10. Her Pre-TANF benefits are ended and her TANF case moves to Post-TANF. She is not eligible for TBA because she did not receive TANF cash benefits under Program 2. Make any changes to FS as appropriate for the CRS or SRS reporting system. Remember to code the \$150 a month Post-TANF benefits.

Example 4: Erika and her child, Donald, receive TANF (Program 2). She reports on October 28 that she went to work October 15. The change was reported outside of the ten days required from the first day of work for TANF. The family is not eligible for TBA. Make any changes to FS as appropriate for the CRS or SRS reporting system. Remember to code the \$150 a month Post-TANF benefits.

Example 5: A client reports that someone joined their FS group. They are told they can apply for FS using the current situation. Recertify the case if the new benefit amount is greater than under TBA. Change the report to SRS or CRS with the recertification. Make no changes

to TBA if the new benefit amount is equal to or lesser than the amount under TBA.

Example 6: Children are removed from the household by child welfare and placed in foster care. These children remain coded as members of the TBA group for the five-month period. They are only removed from the group if their foster care provider begins to get FS for the children.

Example 7: Sarah was receiving TANF for herself and her 6-year-old son Adam. In April she started working and reported this information to the agency. Her TANF case ended April 30 as she was prospectively ineligible. Her FS case was converted to TBA effective May 1. On July 10, Sarah reapplies for TANF. She is placed in the Pre-TANF Program. Sarah continues to be TBA eligible until her TANF cash case is opened.

13. Disqualified Income (DQI) for Cash Recipients Serving a Penalty Examples

Example 1: A client with one child (age 4) has their TANF benefit of \$436 (\$404 plus COI) closed because of failure to cooperate in the JOBS program. Count \$404 DQI (the benefit amount they could be getting) on the companion FS case for one year unless they become ineligible for TANF due to other reasons. The client begins getting \$200 child support. Code $(\$404 - \$200 \text{ SUP}) = \$204 \text{ DQI}$ due to this change.

Example 2: A client with one child (age 5) has their TANF benefit of \$436 (\$404 plus COI) closed because of failure to cooperate with the JOBS program. Count \$404 DQI on the companion FS case for one year unless they become ineligible for TANF due to other reasons. The client begins working part-time and will earn \$400/month. Calculate the impact on their TANF eligibility as follows: $\$400 - \200 (50 percent disregard) = \$200. $\$404$ full benefit - \$200 countable earned income = \$204 DQI due to this change.

Example 3: A client with one child (age 2) has their TANF benefit of \$436 (\$404 plus COI) closed because of failure to cooperate in the JOBS program. Count \$404 DQI on the companion FS case. The client begins working and will earn \$700/month. This earned income exceeds the TANF countable income limit, so the client no longer qualifies for TANF. Remove the DQI income from the companion FS case due to this change.

Example 4: A client with one child is applying for TANF. In the Pre-TANF program she decides she does not want to comply with the alcohol

and drug (A&D) requirements. TANF is opened at DJ3 with a benefit of \$214. No DQI is coded on the companion FS case because the family did not receive and later lose the higher benefit amount. In two months, the case progressed to DJ5 and the TANF case is closed. Count \$214 DQI on the companion FS case. DQI remains on the FS case for one year because the case is closed with a JOBS disqualification, even if the case closed at the client's request. The exception to counting the DQI for one year is if the household becomes ineligible for TANF due to other reasons.

Example 5: A client with one child (age 8) has their TANF benefit of \$436 (\$404 plus COI) closed because of failure to cooperate with the work search component. Count \$404 DQI on the companion FS case for up to one year, unless they become ineligible for TANF due to other reasons. Also apply the OFSET disqualifications at the same time, as the client does not meet any of the OFSET exemptions and the JOBS work search requirements also apply to FS mandatory clients.

Example 6: A client with one child (age 2) has their TANF benefit of \$436 (\$404 plus COI) reduced because the client is not cooperating with mental health treatment. DQI of \$190 is coded on FSMIS (\$404 minus new grant of \$214). The worker, along with partners, determine it is harmful to the child to end the TANF benefits. Therefore, TANF continues for the child at level MA5 with a DQI of \$190. This DQI income continues to be coded on the FS case as long as the child remains eligible for FS and the parent (GP A.27) is not cooperating with the plan. Review this situation with each FS recertification. Do not end the DQI after one year because the TANF case is not closed.

Example 7: A client with one child (age 8) failed to comply with her TANF JOBS requirement. Following conciliation, a notice of disqualification was sent to the client. After receipt of the notice, she contacted the branch and asked that her TANF benefits end. DQI of \$190 (the full grant amount) is coded on FSMIS. End the DQI after one year if the client has not otherwise become ineligible for TANF before that date.

Example 8: A client with two children has a \$150 client-caused TANF overpayment. The TANF grant is reduced by \$20 a month to repay the overpayment. The COP of \$20 is coded on FCAS with an expected end date noted in the comment field. The COP is re-evaluated at each recertification and continues either until the overpayment is repaid or the TANF grant closes.

17. When to Allow Deductions Examples

Example 1: A client is allowed a deduction for \$300 per month rent. The client reports that they failed to pay their rent for two months because of a family emergency, and now they are being billed \$400 per month until the back rent is paid in full. Do not allow a deduction for the extra \$100 per month that the client is now being billed, because it was already allowed during previous months when they failed to pay their rent.

Example 2: A client eligible for medical deductions reports they were in the hospital for a few days, and now have a \$3,000 unanticipated medical bill. The client does not have a repayment plan with the provider, so the worker averages the bill over the remainder of the months in the certification period. When the client reapplies, they state they are still paying this bill at the rate of \$150 per month. Do not allow a deduction for this \$150 per month cost, because the entire bill was already allowed during the previous certification period.

20. Medical Deduction for Elderly/or Person With Disabilities Examples

Example 1: A 67-year-old client has been prescribed two medications has costs that amount to \$55 a month. He also has a medical insurance premium of \$100 per month that he pays. The client meets the definition of elderly for the FS program so he is eligible for medical deductions. Code \$155 on FSMIS as an MED deduction.

Example 2: A 29-year-old mother of two pays for medical insurance for herself and her son who receives SSI. The total insurance cost is \$249 a month. The portion she pays for herself is \$145. Since the mother does not meet the FS definition of an elderly or person with disabilities, she is not eligible for a deduction. However, her son receives SSI and is eligible for a medical deduction. Code \$104, the portion of the insurance that is for her son, on a line under her son, in FSMIS as an MED deduction.

Example 3: A 58-year-old man with a disability is told by his mental health counselor that he should be taking Melatonin to help him sleep and improve his mood. The cost of the melatonin is \$13 at the local store for a months supply. He also pays \$27 a month in prescription copays. Code \$40 on FSMIS as an MED deduction.

22. Shelter Deductions; Housing Examples

- Example 1:* Client reports renting her home and she has a roommate. They do not purchase and prepare meals together and each pays half the rent and half the utilities. This is a share-shelter situation. Allow half the rent, as owed by the client for the shelter deduction and the appropriate utility standard.
- Example 2:* Client is buying a home with a mortgage payment of \$600 a month. There is also a roommate who pays half the mortgage (\$300) plus half of the utilities. They are separate filing groups. Allow the client a shelter deduction of half the mortgage (\$300) plus taxes and insurance and the appropriate utility allowance. If the roommate applies for FS, he will receive a deduction for \$300 rent plus the appropriate utility allowance.
- Example 3:* Client is renting a house for \$500 a month. She is sharing the house with three other individuals who are paying her a flat \$150 a month toward the rent and utilities. They are each separate filing groups. The full rent is \$500 less \$150 less \$150 less \$150 = \$50 as her share of the rent. Code \$50 rent for the client and the appropriate utility allowance.
- Example 4:* Client is renting a house for \$500 a month plus heating costs. She is sharing the house with three individuals who are paying her a flat \$200 each toward the rent and another \$50 for the utilities. The full rent is \$500 less \$200 less \$200 less \$200 = \$0 as her share of the rent. Code zero rent for the client and allow the FUA because she pays the heating costs. In addition, she has income of \$100 from the excess rental income. Code the \$100 income as PTY. (See CA B.35)
- Example 5:* Client is buying a home with a \$500 mortgage payment plus \$50 a month taxes and \$25 a month insurance. She is sharing the home with two other persons who are paying her \$400 a month rent, which includes the utilities. The full shelter cost is \$575 less \$400 less \$400 = \$0 as her share of the mortgage, taxes and insurance. Code zero shelter and allow the FUA because she pays the heating costs. In addition, she has income of \$225 from the excess rental income. Code the \$225 income as PTY. (See CA B.35)

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G. Issuing Benefits for Food Stamps

1. General Information

FS benefits are issued using more than one method. The primary method is EBT.

☞ SEE IB A.1 FOR ISSUANCE METHODS.

2. FS Cash-Out (FSCO) Project for SSI or Seniors

When all members of a FS household are at least 65 years old or are SSI recipients and reside in Clackamas, Columbia, Multnomah or Washington counties, they receive their food stamp benefits through the “cash-out” program. This is called the FSCO project.

Clients receiving FSCO must meet the same eligibility criteria as other FS participants. To receive their benefits using FSCO, each person in the filing group must be one of the following:

- Individuals living alone who are 65 years of age or older or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act; **OR**
- Individuals living together, all of whom are 65 years of age or older or have been determined eligible to receive SSI benefits under title XVI of the Social Security Act.

The FSCO benefits may be issued in one of three ways:

- EBT – FS are issued as a cash benefit into an EBT account. These are accessed as cash transactions. For ongoing monthly issuances, these are available on the first day of each month. The staggered mail schedule used for EBT FS is not used for EBT FSCO.
- Direct Deposit (DD) – FS are issued by direct deposit into their private bank or credit union account. For ongoing monthly issuances, these are available on the third bank day of the month.
- Check – FS are issued by check and mailed to the client. For ongoing monthly issuances, these are mailed on the first mail day of the month.

These FSCO benefits are cash benefits and, as such, may be used to purchase food and nonfood items and for cash withdrawals. When a client’s status changes from FSCO to FS, the case manager must explain how this change will affect their benefits.

***Note:** FSCO clients may be exempted from EBT or Direct Deposit participation, if, in the professional judgment of the case manager and supervisor, the FS cash-out client has a medical or psychological condition (documented or not) that makes it*

very difficult for them to adapt to using an EBT card and they do not have a bank account for Direct Deposit. See Computer Guide Chapter IV-D.7 (7) on how to issue a check to FSCO clients.

FSMIS has been modified to support the FSCO project. The computer program will use the case coding to determine if the client is age 65 or older and/or receiving SSI. The branch cost center is used to determine if the client lives in the FSCO area. There is no need to change the codes on FSMIS. The REL ATP code will be the same whether benefits are issued as EBT (cash) FSCO or EBT FS. The two-character REL ATP code will be the same whether benefits are issued as EBT (cash) FSCO or EBT FS. The two-character REL ATP code will start with a “D” if the case is direct deposit or “E” for EBT or Check. FSMIS automatically determines if the client gets EBT FSCO or EBT FS.

To issue using EBT: To use the EBT issuance method, code the case the same as all other FS cases. The client must have an active EBT case and an EBT card. Normal ongoing issuances show up on FSUP page 3 with an EG.

☞ SEE COMPUTER GUIDE, CHAPTER X FOR A FULL EXPLANATION OF EBT TRANSACTIONS.

Note: *To change a FS case from receiving FSCO checks to EBT, type S in the CHG Status field and press {F9} to save on the EBCAS screen.*

To issue using Direct Deposit: To issue benefits using direct deposit, the client must have an EBT case. The EBT case must have an A-active or S-sent/submitted code in the status field on EBCAS. When there is an active EBT case and an active enrollment record, the direct deposit enrollment flag (DD) on FSUP page 1 will be Y. For normal monthly issuances, the Rel ATP code on FSUP page 3 will be DG.

Enrollment in Direct Deposit – The client must complete the *Direct Deposit – A Safer, Easier Way to Put Your Benefits in Your Account* form (AFS 7262). Send the completed form to the CMU unit. The DD enrollment record is created (submission code 1) and a prenote is sent overnight to the bank. The enrollment record becomes active the next day.

☞ SEE ISSUING AND RESTORING BENEFITS CHAPTER, SECTIONS 20-26, COMPUTER GUIDE SECTION X-D AND SPD GENERIC WORKER GUIDE F.4 FOR MORE INFORMATION.

Monthly issuances – During monthly processing, the system will check each FS cash-out case. If there is not a direct deposit account, the benefits will be sent to EBT.

Coding Initial/Exceptional Issuances – To issue initial benefits or any exceptional benefits (supplements, retroactive, etc.) through direct deposit, use D in the left-hand digit of the Rel-ATP. The client must have a direct deposit enrollment in active status (DD:Y) for you to use the D Rel-Code.

☞ SEE THE COMPUTER GUIDE, SECTION IV-C.82 FOR MORE INFORMATION ON REL-ATP CODES.

Direct Deposit Rejected – If the direct deposit could not be made, a notice is sent to DHS Accounting, which forwards the information to CMU. CMU will contact the field office. The local office must determine the appropriate action. If the client has an EBT card, they may use it to access their benefits. If the client cannot use EBT to access their benefits, the local office can cancel the EBT benefit and issue a revolving fund or special pay check. Use pay reason code 81-FS Cash-Out Replacement.

To issue using a Check: To issue using a check, the client's EBT case status must be changed to T on the EBCAS screen. Normal ongoing issuances show up on FSUP page 3 with a CG.

To issue initial benefits or any exceptional benefits (supplements, retroactive, etc.) by check, use C in the left-hand digit of the Rel-ATP. The client must have a T EBT case status for you to use the C Rel-Code.

Note: Using a T code on EBCAS status cuts the EBT connection to E-Funds, and EBT information will no longer be available. In order to complete transactions on untouched issuances on EBISH, or to view financial EBT transactions completed prior to bypassing EBT, you will need to reconnect to EBT.

FS Cash-Out: 461-165-0082

3. Access to Benefits via EBT

☞ SEE IB A.11 REGARDING HOW FS BENEFITS ARE ACCESSED VIA EBT.

4. EBT Benefit Aging

EBT benefits will age off the system after 12 months from the date of issuance if they are not used. Once they age off the system, they are expunged from the state and are no longer available and cannot be restored. Clients will receive a notice prior to benefits aging off letting them know they need to spend their benefits.

☞ SEE IB A.14 REGARDING FS BENEFITS AGING OFF AFTER 12 MONTHS OF NO ACCESS.

5. Client Moves Out of State; EBT

Unknown to many, access to Oregon FS benefits are available to clients visiting family or friends in another state. Most stores in other states can accept the Oregon Trail Card.

☞ SEE IB A.18 ON GIVING CLIENTS ACCESS TO BENEFITS IN THEIR EBT ACCOUNT WHEN THEY MOVE OUT OF STATE.

- ☞ SEE [HTTP://WWW.FNS.USDA.GOV/FSP/EBT/EBT_MAP.HTM](http://www.fns.usda.gov/fsp/ebt/ebt_map.htm) FOR AN FNS WEBSITE THAT SHOWS OTHER STATES WHERE THE EBT CARD MAY BE USED. MANY CLIENTS MOVING TO OR TRAVELING TO OTHER STATES WILL BE ABLE TO USE THEIR OREGON TRAIL CARD IN THE OTHER STATE.

6. Nonstandard Living Situations and EBT

- ☞ SEE IB A.19 ON HOW CLIENTS ACCESS THEIR BENEFITS WHEN LIVING IN A NONSTANDARD LIVING SITUATION (GP A.25).

7. Concurrent and Duplicate Program Benefits

Clients cannot get FS benefits in two different filing groups (FS C.2) in the same month. This is true in Oregon as well as from another state. There is one exception for clients in a DV situation. This is where the client leaves the filing group and moves into a DV shelter (GP A.11) or a safe home (GP A.34) and leaves the balance of the FS benefits with the abuser.

Concurrent and Duplicate Program Benefits: 461-165-0030

- ☞ SEE IB A.29 FOR INFORMATION ON VERIFYING STATUS WHEN A CLIENT MOVES TO OREGON FROM ANOTHER STATE.

***Note:** A person receiving SSI from California is also receiving FS as a part of the SSI payment. They are not eligible for FS from Oregon until the SSI is transferred to Oregon.*

- ☞ SEE FS F.16 FOR MORE INFORMATION.

***Note:** In a DV situation, ask the client to sign the Voluntary Agreement to Reduce, Close, or Deny Benefits and Notice of Decision & Action Taken (DHS 457D) or Voluntary Reduction Notice (SDS 540A) to remove self, plus any children from the FS case. This enables the FS worker to set up a new FS case for the new group. Do not forget to send the head of household for the original case a reduction notice letting them know another adult in their filing group voluntarily requested change.*

8. Benefits of Less than \$16

In the initial month, an FS benefit group is not eligible for benefits if the allotment is less than \$10. For ongoing months, FS benefits are issued as follows:

The minimum monthly FS benefit is \$16 for one- or two-person benefit groups. Clients will sometimes get zero benefits when it is their first month of benefits and the benefits are prorated (FS F.28). The minimum monthly FS benefit is the calculated amount for benefit groups of three persons or greater. Except if the calculated amount is \$1, \$3, or \$5, the benefits are \$2, \$4, or \$6 respectively.

Minimum Benefit Amount; FS, REF, TANF: 461-165-0060

☞ SEE FS F.27 FOR MORE INFORMATION ON BENEFIT CALCULATION.

☞ SEE IB A.33 FOR MORE INFORMATION.

9. Issuance of FS Benefits

For ongoing months, FS benefits issued by EBT are issued based on the last digit of the case number over the first nine calendar days of the month. Those people who are receiving FSCO are getting their benefits on the first of the month.

Issuance Date of Benefit: 461-165-0100

☞ SEE IB A.37 FOR MORE INFORMATION.

10. Prorating Benefits

☞ SEE FS F.28 FOR MORE INFORMATION.

11. Exceptions to Staggered Issuance

Ongoing FS benefits are issued using the staggered issuance except for the second month's allotment of FS benefits if the filing date (FS B.5) is after the 15th of the month and the application is not for a redetermination (GP A.32) of eligibility and FSCO.

☞ SEE IB A.38 FOR HOW BENEFITS ARE ISSUED WHEN THEY ARE NOT STAGGERED.

Exception to Staggered Issuance; FS: 461-165-0105

12. Issuing Expedited Food Stamps

Ensure that filing groups (FS C.2) qualifying for expedited services (FS B.6) receive their benefits by the seventh calendar day following the filing date (FS B.5).

Applicants qualifying for expedited FS who apply on or before the 15th of the month get only the initial month (GP A.19) of FS using expedited service. Any requested verification (FS B.10) must be provided before issuing the second and following months of benefits. Code FSMIS so that the second month's benefits are not automatically issued.

Applicants qualifying for expedited FS who apply after the 15th of the month may get the initial and second months FS using expedited service. Requested verification must be provided before issuing the third and following months of benefits. In this situation, it is recommended workers use a two-month certification and extend the certification period when the postponed verification is provided.

☞ SEE IB A.39.

13. Benefits to Survivors

☞ SEE IB A.43 FOR WHAT TO DO WHEN ALL MEMBERS OF THE FILING GROUP (FS C.2) DIE AND WHAT TO DO WHEN THE HEAD OF HOUSEHOLD DIES BUT OTHER MEMBERS OF THE FILING GROUP ARE ALIVE.

Endorsement and Survivorship of Benefits: 461-165-0140

14. Restoration of Benefits

FS clients may only have benefits restored or supplemented when the department made an error that caused the household to get fewer benefits than it was entitled to.

If a client notifies the office that a member of the filing group has left the household, the branch is to cancel any EBT card the member who left the household may have. If the office fails to cancel the card, this is an administrative error and the benefits that are used by the person who left must be restored to the filling group.

☞ SEE IB B.1 REGARDING THE RESTORATION OF BENEFITS.

Restoring Benefits: 461-165-0200
Effective Dates; Restored Benefits: 461-180-0130

15. Calculating Restored or Lost Benefits

Before issuing restored benefits for FS, check to be sure there is not an unpaid overpayment. In FS, the restored benefits must first of all be used to repay an existing overpayment before the balance can be given to the household.

Use the *Notice of Restoration of Lost Benefits* (DHS 362) to document restoration. This form also serves as the client's notice of restoration of benefits. Include all previous

months on the same DHS 362. In some instances the restoration is for a full 12 months, and is so great that it is not reasonable to give the full amount to the household at once. In this instance, note how the restoration will be divided and make a tickler to manually issue the restored benefits according to the schedule set on the notice. Notice Writer FS00362 can also be used instead of form DHS 362.

Note: Restorations are limited to the most recent 12-month period.

Effective Dates; Restored Benefits: 461-180-0130

Note: The full restoration is calculated minus the overpayment collection with the balance to the client. Restored benefits are issued using EBT. No checks are issued unless the case is FSCO or the household has moved out of state.

When an overpayment exists, complete the *Overpayment/Overissuance Change Report* (DHS 284A), and send it to the Overpayment Recovery Unit along with a copy of the completed DHS 362.

On FSMIS use transaction code ISS and a Rel-ATP code ED or ID to issue restored benefits. Calculate the amount manually and type it in the N/C Dollar Amount field with month/year for the restored benefits in the Ben-Mo-Yr field. Use transaction code ISR on a closed case.

☞ SEE IB B.2 ON HOW TO CALCULATE RESTORED OR LOST BENEFITS.

Calculating Restored and Supplemental Benefits: 461-165-0210
Methods of Recovering Overpayments: 461-195-0551

16. Replacing Benefits

Generally FS benefits are not replaced once they are placed into the client's EBT account. Clients are responsible for protecting their PIN.

☞ SEE IB B.3 ON REPLACEMENT OF FS BENEFITS.

Replacing Lost, Stolen, Destroyed or Undelivered Checks: 461-165-0220

17. Replacement of Benefits Due to a Disaster

FS benefits may be replaced when the value of food purchased with food stamps has been spoiled or destroyed in a disaster (e.g., due to fire, flood or loss of electricity).

Look at the following when determining if food may be replaced and the amount:

- The filing group (FS C.2) must be currently receiving FS.

- The request for help must be received within 10 days of the disaster or loss. The department must act on the request within 10 days of receipt.
- Verify (FS B.10) the disaster exists. That is, the filing group resides in a power outage area, the national disaster area, flood area, etc. Also, narrate the date the disaster or event occurred. If the spoilage occurred due to a misfortune such as loss of power to the filing group's residence (FS D.2) only, the verification may include statements from repair persons or the local utility company.
- The filing group must provide a detailed list of the spoiled food and the amount paid for that food. Also, ask the filing group where the food was located when it was spoiled (e.g., cupboard, refrigerator or freezer).
- Determine if the amount of food spoiled is a reasonable amount based on the situation. For example, refrigerated food will last about 24 hours without electricity. Food kept in a freezer will last about 48 hours and maybe longer if the freezer is kept closed and it is full. Also if the disaster happened at the start of the month, did they just get their FS and spend them on a full month's worth of food, or is it the end of the month and they have very little food left from the month?
- Assure the filing group has not received more than one replacement due to a disaster or spoilage within the past six months.
- The total value of the food being replaced cannot exceed a one-month FS allotment for the filing group.

Note: Do not replace the full FS allotment for the month; the replacement is only for the value of the lost food up to the current one-month allotment that the filing group is entitled to receive.

Once it has been determined that food was spoiled or lost due to a valid disaster or misfortune, issue the replacement using the ISS transaction code and an IH or EH issuance code. Code the actual dollars being issued (replaced) and the current month's date.

Carefully narrate the situation and decisions to show this is a replacement and not a duplicate issuance.

☞ SEE IB B.3 ON REPLACEMENT OF FS BENEFITS.

Replacing FS Benefits and EBT Cards: 461-165-0230

18. FS Coupons Returned to the Branch

With the passage of the Food & Nutrition Act of 2008 (formerly known as the Farm Bill), Congress has de-obligated the old Food Stamp Coupons. Effective June 18, 2009, coupons can no longer be redeemed or returned.

19. Issuing the Oregon Trail Card When the Client or Alternate Payee Cannot be Present

Sometimes a client or their alternate payee cannot come to the office to get their EBT card or their PIN. Under no circumstances should a PIN ever be released to another person (even if in the same filing group).

- ☞ SEE THE FIELD BUSINESS PROCEDURES MANUAL II.J (BPM.II.J.) OR THE SPD MANUAL, SUPPORT STAFF ASSISTANCE MANUAL A.10 (SSAM.A.10) FOR A PROCESS ON ISSUING THE PIN OR EBT CARD IN THESE CIRCUMSTANCES.

20. Replacing EBT Cards

Clients may request replacement of EBT cards that are lost, stolen or damaged.

For FS, EBT cards must be replaced within two days of the request. The local office must ensure the replacement card is on the same account and not on a second or duplicate account.

Immediately cancel the PIN on cards reported lost or stolen to protect the client's benefits. Narrate the date and time the report of lost or stolen card is received. The department is liable for replacement of benefits stolen after the date and time of the report.

- ☞ SEE IB A.9 FOR MORE INFORMATION ON REPLACING LOST, STOLEN OR DAMAGED EBT CARDS.

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H. Changes and Notices

1. Overview of Changes

Clients report changes in their circumstances by telephone, office visit, report form or other statements made in writing. The change is considered reported the day it is received by the department. When a change is reported for one program, consider it reported for all programs in which the client participates. When reported, the total change must be acted on, not just part of the change. For example, the client reports one job ended but started another job. The income from the new job must be verified and coded when the old income is removed. Another example is a client reporting the birth of a child. The father of the child also lives in the household. In FS, the child, the father, and his income must be placed on the case at the same time.

Clients in CRS or MRS are required to report certain changes, as described in FS H.2. However, when *any* change is reported, regardless of whether it was required or not, it must be acted on for FS. Sometimes, the action is simply to note that a change was reported, because it does not affect the benefit amount. Other times, the action will be to recalculate benefits and send the appropriate notice.

QC Hot Tip

Narrate the reported change and the action taken. If no action taken, narrate the reason why.

For CRS and MRS, clients must report most changes within 10 days of their occurrence. The 10-day time frame starts when the change occurs.

- The 10-day time frame for earned income begins the day the client receives the first paycheck from a new job or reflecting a change in rate of pay or the last day of employment when a job ends.
- The 10-day time frame for unearned income begins as soon as the client receives the new or changed payment.

This requirement to report within 10 days applies to all changes except income changes required by the *Monthly Change Report (Bond and Variable Data)* (DHS 859A) in MRS. The changes required on the DHS 859A are not subject to the 10-day time frame, because they are subject to the time frames related to the MRS. However, changes not required to be reported on the DHS 859A report form still must be reported within the 10-day time frame.

If the case is in SRS, the client is required to report changes as described in FS H.2 below. The FS office is required to act on all changes that a client is required to report and all changes that increase benefits. However, if the change decreases benefits, it is only acted on if the reported information is considered *verified upon receipt* (FS F.8).

For SRS, changes must be reported by the 10th day of the month after they occur.

Changes That Must be Reported: 461-170-0011

Clients in TBA are not required to report any changes. However, if a change is reported, the worker must take action if it will increase benefits. Do not take action if a reported change will reduce benefits while the household is receiving TBA, with one exception: if a household member applies for FS in another household, remove them from the TBA household so that they can be added to the other benefit group (FS C.7).

Changes That Must be Reported: 461-170-0011
Effective Dates; Cases Receiving Transitional Benefit Alternative (TBA): 461-180-0081

2. Changes That Must Be Reported

Following are the changes that FS clients must report. Clients cannot be required to report any more than these items. Therefore, if they fail to report something that changes their eligibility (GP A.14), but it was not a required change as listed here, there is no overpayment. For example, if rent is reduced for a client who did not move, the change is not required to be reported and there is no overpayment if the client does not report the change. However, if they fail to report a change that is required to be reported, and as a result, they receive more benefits than they were entitled to, then the department must file an overpayment.

FS clients in CRS or MRS must report:

- Changes in members of the filing group (FS C.2) and any resulting changes in income.
- Changes in employment, such as getting a job or quitting or losing a job.
- Changes in *source* of income.
- Changes in *amount* of income as follows:
 - For unearned income in the CRS, changes of more than \$50 per month, except a change in a public assistance grant.
 - For earned income in the CRS, changes of more than \$100 a month, except for the annual increase in state minimum wage.
 - For cases in the MRS, changes as required by the *Monthly Change Report (Bond and Variable Data)* (DHS 859A).

- When they move to a different dwelling, including the change in shelter costs resulting from the move.
- A change in the legal obligation to pay child support.
- When cash on hand, stocks, bonds and money in bank accounts reach or exceed the appropriate resource limit.
- The acquisition or change in ownership of nonexcluded vehicles.

Changes That Must be Reported: 461-170-0011 |

FS clients in SRS must report:

- When countable income (GP A.18) exceeds the countable income limit for FS (130 percent FPL) (FS F.2).
- When the mailing address changes.

Changes That Must be Reported: 461-170-0011 |

FS clients in TBA are not required to report any changes.

Changes That Must be Reported: 461-170-0011 |

3. Mass Changes

Some changes initiated by the state or federal government affect significant portions of or the entire caseload. Because the department is notified of these changes by the agencies responsible, clients do not need to report the changes. These changes include:

- Periodic cost-of-living adjustments to SSB, SSD or SSI benefits.
- Periodic cost-of-living adjustments to other assistance programs administered by the department.
- Changes in eligibility (GP A.14) criteria due to legislative or regulatory actions.
- Adjustments to the FS countable (FS F.2) and adjusted (FS F.26) income limits, Thrifty Food Plan (FS F.25), dependent care deduction (FS F.19), utility standard (FS F.23), excess shelter deduction and/or standard deduction (FS F.18). These adjustments generally are effective October 1.

For these mass changes, no client notice is required.

Notice Situation; Mass Changes: 461-175-0250 |

4. Mail Returned as Undeliverable by Post Office

☞ SEE MP WG #20

5. Prison Discrepancy Lists

Local practices and the Corrections Project are obtaining lists of persons in jail (county and state systems), verifying that the person is on benefits. They also attempt to determine if the person is scheduled to be incarcerated for at least 30 days. The Corrections Project is sending a notice to the FS worker letting them know the person is in jail. The notification will include a release date, if one is known.

A person is ineligible for FS when they are in prison. The local office is required to take action when information is received that a person is in prison. *This includes sending a close or reduction notice. For FS, the notice must always be a timely continuing benefit decision notice (10-day).* Workers may use notice FSC1PNE (to close) or FSR1PWE (to reduce) on Notice Writer.

Note: *If a one-person case and they are incarcerated, disable the PIN on the EBT card to protect the client's benefits until their release.*

For cases in CRS, MRS, or SRS:

1. Regardless of whether the release date is known, send notice to close or reduce benefits and remove the person from the FS case.
2. If the person is released before the effective date of the notice and contacts the local office before that date, the worker can do a ROP transaction or add the person to an open case as of the first of the next month. If the contact is made on the first of the next month or later, follow add a person policy for open cases or have the person reapply for closed cases.

☞ FOR CRS, MRS, OR SRS CASES, SEE EXAMPLE #1 IN PRISON DISCREPANCY LISTS EXAMPLES (FS H. EXAMPLES 5)

For cases in TBA:

1. Determine if the release date is known. If expected to be before the effective date of closure, narrate the incarceration report and that no action is needed due to expected release date.
2. For those persons with no release date or an expected release after the effective date of closure, determine if the person is head of household on the FS case.
3. If head of household is incarcerated, send notice of closure and close the TBA.

4. If the incarcerated person is not head of household, narrate the report and do not remove the person from the FS case.

☞ FOR TBA CASES, SEE EXAMPLE #2 IN PRISON DISCREPANCY LISTS EXAMPLES (FS H. EXAMPLES 5)

6. Action on Changes During the Certification Period

☞ SEE FS B.11 FOR MORE ABOUT VERIFICATION OF CERTAIN CHANGES.

☞ SEE FS H.12 FOR MORE ON USE OF DHS 210A.

☞ SEE FS-WG #8 FOR MORE INFORMATION ON PROCESSING CHANGES.

Note: When notified that an adult with an EBT card has left the household, be sure to cancel the card. If the card is not cancelled and the alternate payee continues to use it after being removed from the household, DHS must restore benefits.

CRS and MRS

Quite often changes are reported during the certification period. Sometimes these changes are reported with all the information needed to take action. Other times, the reported information is incomplete and additional information is needed. In these instances, send the *Notice of Information or Verification Needed* (DHS 210A) to the household giving them at least 10 days to provide the additional information. Clients may be allowed more than 10 days but not less. The worker notes the due date for the information on the DHS 210A. The due date depends on the time of the month and the individual client's situation. For example, a client reports a new job on April 30; the DHS 210A is sent asking for the additional information due by May 11 to allow the worker time to take appropriate action for June benefits.

Another example is a client reports on April 15 that they just got a job and will start working on April 20. The client will be working full time but does not know the rate of pay or pay dates. The DHS 210A is sent to the client. The worker gives a due date between May 1 and May 15 (worker choice) to provide the needed information. This allows the worker enough time to send a reduction notice or closure depending on the client's response to the request for additional information for June benefits.

When information is needed for continuing FS eligibility (GP A.14) during the certification period, send the DHS 210A and let the client know what specifically is needed and that the client may call or mail the requested information to the office.

The time to act on reported changes depends on if the result of the change is to increase, or decrease, or end benefits.

- *Increase:* If the result is to increase benefits and it is a change that must be verified (FS B.11), such as income, verify the new income amount or the end of the income

source before taking action to increase the FS benefits. The information must be requested using the form DHS 210A. If the requested verification is not provided by the due date, send notice to end or reduce benefits if lack of the verification means the worker is not able to accurately determine eligibility or benefit level.

Note: The effective date for the change depends on whether or not verification is received by the due date. See FS H.8 for more on effective dates.

- *Decrease or End:* If the result is to reduce or end benefits and it is a change that must be verified, such as income, immediately take action following the required 10-day notice time frames (FS H.7) to reduce or end benefits based on the reported change. Also, send a DHS 210A asking for verification of the new information when taking a reduce action. It may be necessary to adjust benefits and send a second notice of reduction after the verification is provided by the client. If the requested verification is not provided by the due date, send notice to end or reduce benefits if lack of the verification means the worker is not able to accurately determine eligibility or benefit level.

If the requested information is not provided by the due date, one of two actions is required:

- Send a 10-day continuing benefit decision notice to close or reduce benefits when unable to determine continued eligibility; or
- Send a 10-day continuing benefit decision notice to end a deduction (GP A.18) if the information needed is to compute benefits based on a reported change in a deductible cost. Most commonly this applies to a reported move but the new rent and utilities are unknown.

Sometimes the requested information is received between the date the close or reduce notice was sent and the effective date for the close or reduce action. When this occurs, recalculate benefits based on the new information and continue the certification period.

No additional notice is necessary if the prior notice anticipated the same or a lesser amount of benefits. If the requested information is received after the effective date for the closure, a new application is required. If the new information is received after the effective date for the reduction, action on the information is effective the first of the month following the date the information is received.

Federal regulations prohibit the state from requiring a client to come to the branch office in the middle of their certification period. The exceptions to having the client come to the office in the middle of the certification period are:

- An exempt person becomes mandatory and a meeting is set up to discuss OFSET (FS D.7) and write the case plan (this is an eligibility requirement); or
- When an OFSET case plan says the client is to come to the office to confer on the progress with their plan. Note the plan must identify this intent.

- ☞ SEE EXAMPLES ON ACTIONS WHEN HEAD OF HOUSEHOLD LEAVES THE CASE, EXAMPLES #1 AND #2 OF ACTION ON CHANGES DURING THE CERTIFICATION PERIOD (FS H. EXAMPLES 6)

SRS

Clients only need to report two changes while in SRS. However, clients may want to report changes that will increase their benefits. These changes are reduction in income or an increase in deductible costs (GP A.7) (i.e., shelter, child care, court-ordered support or medical). As always, anytime a client reports a change that will increase benefits, the worker is required to take action for the first of the next month.

As with CRS or MRS, an action is always necessary when a client reports a change that they are required to report. In SRS, this is primarily income over the countable income limit. The difference between SRS and CRS or MRS is that no action is necessary when a change is reported that will decrease benefits unless the information is considered *verified upon receipt* (FS F.8). In other words, does the worker have enough information to act on the reported change? If yes, take the action to reduce benefits after the appropriate notice period has ended.

TBA

Clients in TBA are not required to report changes. If the client reports a change that will increase benefits, they may reapply. If the group will get more FS using the current situation, recertify FS and end TBA. Continue TBA to the end of the TBA period if the change would reduce FS. Act only on the following changes that will decrease benefits: when a person in the TBA benefit group (FS C.7) moves into another household and applies for FS in that household, the person will be removed from the TBA benefit group and added to the new household after the appropriate notice period ends.

- ☞ SEE THE FOLLOWING SITUATIONS: EXAMPLE #3 FOR NEW INCOME; EXAMPLE #4 FOR NEW HOUSEHOLD MEMBER; AND EXAMPLE #5 FOR JOB QUIT OR NEW JOB OF THE ACTION ON CHANGES DURING THE CERTIFICATION PERIOD (FS H. EXAMPLES 6)

7. Transferring Cases Between Branch Offices Due to a Move

- ☞ SEE MULTI-PROGRAM WORKER GUIDE #21 (MP WG.21) FOR INFORMATION ON TRANSFERRING CASES.

8. Effective Dates (GP A.12)

- ☞ SEE CHANGES EXAMPLES #3, #4 AND #5 FOR NEW INCOME, JOB QUIT, AND NEW MEMBER (FS H. EXAMPLES 6).

Overview. The effective date is the day that an action will be taken or a change made on a case. When a change is not made on a case by the effective date, make the change as soon as possible and supplement benefits for the current month, restore lost benefits for past months or write an overpayment as appropriate. (Remember not to write an overpayment when the amount paid in error is due to an administrative error and is \$100 or less.)

The effective date for an action is determined by the type of action and the reporting system.

Actions to close or suspend are effective on the last day of a calendar month. Actions to increase or reduce benefits are effective on the first day of a calendar month.

☞ FOR ACTING ON CHANGES FROM THE REDETERMINATION, SEE FS B.21.

Approval. See FS B.16 for effective dates upon approval of an application or reapplication for FS.

Effective Dates; Initial Month FS Benefits: 461-180-0080

Denial. See FS B.16 for effective dates upon denial of an application or reapplication for FS.

Effective Dates; Denial of Benefits: 461-180-0060

Effective Dates for Changes Reported on DHS 859A Report Form. Generally, changes that cause benefits to be increased, reduced, closed, or suspended happen immediately, if they are reported on the form for the MRS. That is, changes causing closures or reductions reported on the *Monthly Change Report (Bond and Variable Data)* (DHS 859A) in MRS are effective the last day of the budget month (GP A.1). Changes causing increases or reductions reported on the DHS 859A are effective the first day of the payment month (GP A.28).

☞ SEE EXAMPLES OF ACTING ON CHANGES IN MRS, EXAMPLES #1 AND #2 OF EFFECTIVE DATES (FS H. EXAMPLES 8)

Effective Dates; Changes in Income or Income Deductions That Cause Increases: 461-180-0020
Effective Dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030

Employed Child Turns 18. Count the earned income of a child in the budget month after the month in which the child turns 18. (For example, a child turns 18 on January 22. For cases in MRS, the budget month after the child turns 18 is February, so the child's earned income will affect the benefit group's (FS C.7) March benefits. For cases in CRS, the child's earned income becomes countable (GP A.18) in February). For cases in SRS, count the earned income of a child in the seventh month if the child turned 18 during the first six months of the certification period unless the client provides verification of the child's earned income during the SRS period. Count the earned income of the child with the next certification action if the child turned 18 in the seventh or later month of the certification period.

Effective Dates for Changes Reported for SRS on Interim Change Report Form. Changes reported on the *Interim Change Report* form (DHS 852) that cause benefits to be increased, reduced, closed or suspended are effective with the seventh month of the certification period. That is, changes causing closure and reported on the DHS 852 in SRS are effective the last day of the sixth month of the certification period. Changes causing increases or reductions and reported on the DHS 852 are effective the first day of the seventh month of the certification period.

Note: An incorrect effective date on FSUP will result in an invalid notice to the client.

Effective Dates; Changes in the Simplified Reporting System (SRS); ERDC, FS: 461-180-0006

Effective Dates for Changes Reported Via Other Means. When changes are not reported on the DHS 859A or the DHS 852 forms, the effective date is not so immediate. Changes that cause closure or suspension of benefits are effective the last day of the month after the 10-day notice period expires.

Increased benefits. The effective date for changes that will increase benefits varies depending on whether or not verification is requested and when the proof is received. A reported change that will increase benefits is effective the first of the following month, if additional information or verification is not requested. If verification is requested on a DHS 210A and the client is given at least 10 days to provide the verification, the effective date for the change is:

- The first of the month following the date the client reported the change if the information is received no later than the 10th day (or later if given longer than 10 days). If the verification due date is after the first of the month, a restoration of benefits is necessary.
- The first of the month following the date the client provided the verification if the proof is received after the verification due date (at least 10 days).

Reduced Benefits. Changes causing reductions are effective the first day of the month after the 10-day notice period expires.

Effective Dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030
Effective Dates; Suspending or Closing Benefits and JOBS Support Service Payments: 461-180-0050
Effective Dates; Removing a Person: 461-180-0120

Changes causing increases have different effective dates, depending on when the client reports the change and whether it has to do with adding a person. If the client reports the change prior to the month in which it will occur, the effective date is the first of the month in which it will occur, unless the change is for adding a person.

When they report the **addition of a person**, the effective date is the first of the month after they report the person has joined the household. Even if they report that a person will join their household in advance, benefits are not increased until the month following when the change occurs. When the change is not reported until the month it occurs or

later, the effective date is the first of the month following the date the change was reported.

Effective Dates; Adding a New Person to an Open Case: 461-180-0010

- ☞ SEE EXAMPLE OF ACTING ON CHANGES IN CRS, #3 OF EFFECTIVE DATES (FS H. EXAMPLES 8)

SRS

Clients in SRS are only required to report when their income exceeds the countable income limit (130 percent FPL) (FS F.2) or when their mailing address changes. Anytime a client reports these changes, take the appropriate action. For income, close or reduce benefits at the end of the 10-day notice period. For all other reported changes in SRS, take action to reduce or close FS only if the reported change is considered *verified upon receipt* (FS F.8). Take action to increase benefits that are considered *verified upon receipt* using regular change reporting time frames.

Changes That Must be Reported: 461-170-0011
Effective Dates; Changes in the Simplified Reporting System (SRS); ERDC, FS: 461-180-0006

- ☞ SEE EXAMPLES OF ACTING ON CHANGES IN SRS, #4 THRU #9 OF EFFECTIVE DATES (FS H. EXAMPLES 8)

TBA

For cases in TBA, the benefits are frozen. Do not increase or reduce benefits during the TBA period, unless a member of the household applies for FS as a member of another household. Use regular CRS time frames. Only close FS benefits during the TBA period if the client requests case closure or it becomes known that the household has moved out of state or is otherwise ineligible for FS. All other reported changes that result in reduced benefits will be held until the household reapplies for FS after the TBA period ends. If the household reports a change that will increase benefits, they may reapply. End TBA and recertify if the group is eligible for more FS using the current situation.

- ☞ SEE FS F.9 FOR MORE INFORMATION ABOUT REAPPLYING WHILE GETTING TBA.

- ☞ SEE EXAMPLES OF ACTING ON CHANGES IN TBA, #10 AND #11 OF EFFECTIVE DATES (FS H. EXAMPLES 8)

Changes That Must be Reported: 461-170-0011
Effective Dates; Cases Receiving Transitional Benefit Alternative (TBA): 461-180-0081

Effective Dates for Special Circumstances. Situations that are exceptions to the effective dates described above are:

- Ending disqualifications that are not related to work programs. For an IPV (GP C.5) disqualification where the person is required to be in the filing group (FS C.2), end

the disqualification the day after the disqualification has been served. (This is assuming the person has no additional IPV period to serve and meets all other FS eligibility requirements.)

For other disqualifications requiring cooperation (such as when a client refuses to provide an SSN (FS D.6)), end the disqualification the date they agree to cooperate. Follow “add a person” policy to add this person to an open FS case.

Effective Dates; Ending Disqualifications: 461-180-0065 |

- The effective date for ending an employment program disqualification is the first of the month after the client fulfills the requirements to end the disqualification on an open FS case.

Effective Dates; Ending Disqualifications: 461-180-0065 |

- Reductions pending a hearing decision. When the department is upheld, begin work program disqualifications the first of the month following issuance of the hearing order. Work program disqualifications include failure to cooperate with OFSET, job quits, etc. See FS D.19 for a complete list of the work program disqualifications.

When the department is upheld on other issues, the effective date remains the same as in the original notice which caused the hearing request. Therefore, benefits issued in error from that effective date until the action is taken are an overpayment.

Effective Dates; Reductions Delayed Pending a Hearing Decision: 461-180-0105 |

- Restored benefits (IB B.1). When clients are underpaid benefits or have benefits denied or closed in error, they are entitled to a late payment for the benefits they should have gotten. This late payment is called a restoration of lost benefits. When an administrative error caused the underpaid benefits, the effective date of restoration is the date the error was made, up to a maximum period of 12 months.

Note: *We do not restore FS benefits for client-caused errors.*

Notice Situation; Restoring FS Benefits: 461-175-0320 |

When benefits have been suspended, the effective date is the month after the one-month suspension.

Effective Dates; Changes in Income or Income Deductions That Cause Increases: 461-180-0020
Effective Dates; Changes in Income or Income Deductions That Cause Reductions: 461-180-0030
Effective Dates; Suspending or Closing Benefits and JOBS Support Service Payments: 461-180-0050
Effective Dates; Removing a Person: 461-180-0120
Effective Dates; Restored Benefits: 461-180-0130 |

9. Notices; General Information

Overview. A decision notice must be sent to the filing group (FS C.2) when benefits are approved, denied, reduced or closed. The notice can be computer generated or sent manually. This includes when a client asks for more benefits for a specific reason.

Some examples include:

- Request to include a medical deduction that was paid in the prior certification period using a VISA and the client is now paying the VISA payment each month.
- Request for retroactive or restored benefits when they report today that the rent changed three months ago.
- Request retroactive or restored benefits for a person who moved in a month ago.

The notice must always contain certain information. Notices are standardized, so that most of the required information is preprinted. The standard, preprinted information consists of the hearing rights and procedures around hearings. The part that is not standard consists of the action that the department intends to take, the effective date (GP A.12) of that action, the reason for the action, the date of the notice and a contact person's name and telephone.

☞ SEE GP J.1 FOR GENERAL INFORMATION ON DECISION NOTICES.

☞ SEE GP J.3 FOR INFORMATION ON THE NOTICE PERIOD.

What a Decision Notice Must Include: 461-175-0010
Notice Situations; General Information: 461-175-0200

Types of Notices. Following are the three types of decision notices:

- *Basic decision notice.* This notice is mailed no later than the date of the planned action, gives the client a right to request a hearing, but does not give the right to continued benefits while the hearing decision is pending. This notice is generally sent on approval actions, denial actions, or when a certification ends.
- *Continuing benefit decision notice.* This notice is mailed in time to be received by the date benefits are or would be received, gives the client a right to request a hearing and gives the right to continued benefits while the hearing decision is pending. This notice is generally sent in situations where the client has waived their right to a timely (10-day) notice by reporting the information on and signing a *Monthly Change Report* (DHS 859A) or *Interim Change Report* (DHS 852).
- *Timely continuing benefit decision notice.* This notice is mailed no later than 10 calendar days before the effective date of the action. The 10-day count begins the day the notice is put into the mail. Remember that FSMIS computer-generated notices are not mailed until the working day after information is keyed into the system. Notice Writer notices generally take two days to be put into the mail. This

notice gives the client a right to request a hearing and gives the right to continued benefits while the hearing decision is pending. This notice is generally sent in prospective budgeting systems (FS F.6).

☞ SEE MP-WG #18 FOR ADDITIONAL INFORMATION ON 10-DAY NOTICE DEADLINES.

☞ SEE GP J.2 FOR ADDITIONAL INFORMATION ON THE TYPES OF NOTICES.

	Definitions for Chapter 461: 461-001-0000
	Notice Period: 461-175-0050
	Notice Situation; Lump-Sum: 461-175-0240
	Notice Situation; APR, MRS, SRS, or TBA: 461-175-0270
	Notice Situation; Prior Notice: 461-175-0300
Notice Situation; Removing an Individual From a Benefit Group (EXT, FS, MAA, MAF, OHP, REF, REFM, SAC, TANF) or Need Group (ERDC): 461-175-0305	

No Notice Required. For FS, no notice is needed when:

- Everyone in the benefit group (FS C.7) is deceased.
- A hearing upholds the department's decision, and a notice was sent before the client requested the hearing.
- The filing group has moved out of Oregon.
- Department mail has been returned with no forwarding address and the client's whereabouts are unknown.
- There is a mass change.
- A drug or alcohol treatment center is disqualified by FNS as a retailer or an authorized representative (FS B.14) or loses its state certification.
- A nonrelative adult foster care (GP A.6) home loses its state license.
- A client is notified of benefits changing month to month at application (usually given on the *Notice of Reported Income* (DHS 7294)).
- Client applied on a joint application for FS and cash benefits, when the receipt of a new public assistance grant reduces the FS (because the client received prior notice of this when they signed the *Your Rights and Responsibilities* (DHS 415R) or *Rights and Responsibilities* (SDS 539R)).
- A group was previously notified they would receive a restoration of benefits over a period of time, and the restoration payments end at the end of that time.
- Benefits reduction after they are extended when the expedited FS period ends and the *Notice of Pending Status* (DHS 210) or *Notification of Pending Status* (SDS 539H) pending items are received.

- ☞ SEE EXAMPLES FOR SITUATIONS WHERE NOTICE IS REQUIRED FOR CONCURRENT BENEFITS (FS B. EXAMPLES 9)

Notice Situations; General Information: 461-175-0200

Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210

Notice Situation; Nonstandard Living Situations: 461-175-0230

Notice Situation; Mass Changes: 461-175-0250

Notice Situation; Prior Notice: 461-175-0300

Notice Situation; Restoring FS Benefits: 461-175-0320

Notice Situation; Voluntary Action: 461-175-0340

10. Notice Situations

- ☞ SEE GP J.4 FOR GENERAL NOTICE SITUATION INFORMATION.

Continuing Benefits. For the last two notices above, the client must request continued benefits within a specific time frame, in order to qualify for the continued benefits. They must make the request either within 10 days of the mailing of the notice, or on or before the effective date (GP A.12) of the action. When this request period ends on a weekend or holiday, extend it to the next working day.

When the client makes this request timely, continue their FS in the same manner and amount as prior to the notice. Maintain benefits at this level until the hearing takes place or until another change in circumstances occurs that requires another notice and a new benefit amount.

When the hearing decision is in the favor of the department, the continued benefits are an overpayment, unless the hearing issue was a FS work program disqualification (FS D.19) issue. For those issues, impose the disqualification instead of writing an overpayment.

What a Decision Notice Must Include: 461-175-0010

When Notices are Void. Notices become void when the reduction or closure is not initiated on the effective date stated on the notice, unless the delay resulted from the client's hearing request. Also, the department may amend a decision notice with another decision notice or a contested case notice, amend a contested case notice, delay a reduction or closure of benefits as a result of a client's request for hearing or extend the effective date on a decision notice or a contested case notice and this does not cause a decision notice to become void. Once a notice becomes void, a 10-day notice is needed to reduce or close benefits for a future date.

Notice Situations; General Information: 461-175-0200

Unusual Notice Situations. The following situations do not follow the general rules stated above about when certain types of notices must be used:

- Benefits less than 30 days. Only a basic decision notice is required (like other approvals) when the initial approval notice tells the client when benefits will end.

However, if a separate notice is sent, it must be a timely continuing benefit decision notice.

- Intentional Program Violations (IPVs) (GP C.5). When the client signs a waiver, send a continuing benefit decision notice. When the client is disqualified through other legal proceedings, send a basic decision notice.
- The client enters an institution, is placed in skilled nursing care, intermediate care, long-term hospitalization, official custody or a correctional facility. Send a timely continuing benefit decision notice.
- Overpayments. Send a timely continuing benefit decision notice the first time a filing group is being notified that benefits will be reduced to recover an overpayment. If the overpayment then follows a person who was notified to a new group, send another timely continuing benefit decision notice.
- Restoration of lost benefits. Send a basic decision notice, *Notice of Restoration of Lost Benefits* (DHS 362) informing the client of the amount of the restoration, any offsetting that was done and the method of restoration.
- Client requests reduction of benefits or closure. When a client requests a reduction or termination of benefits by phone, send a timely continuing benefit decision notice. When a client requests a reduction or termination of benefits in person, send a basic decision notice. This may be done by having the client sign the *Voluntary Agreement to Reduce, Close, or Deny Benefits and Notice of Action Taken* (DHS 457D). When the primary person or another adult member of the filing group or the authorized representative signs a request to reduce or terminate benefits, send a basic decision notice.
- The filing group states that they wish to withdraw the application for benefits. Send the client a basic decision notice.
- Changing report method from CRS, MRS, SRS, or TBA to CRS, MRS, SRS or TBA during the certification period. A continuing benefit decision notice should be sent so that it is received before the effective date of the change.

Continuation of Benefits: 461-025-0311
Notice Situation; Benefits for Less Than 30 Days: 461-175-0205
Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210
Notice Situation; Disqualification; Disqualification: 461-175-0220
Notice Situation; Nonstandard Living Situations: 461-175-0230
Notice Situation; APR, MRS, SRS, or TBA: 461-175-0270
Notice Situation; Overpayment Repayment: 461-175-0290
Notice Situation; Restoring FS Benefits: 461-175-0320
Notice Situation; Voluntary Action: 461-175-0340

11. Using the *Notice of Pending Status (DHS 210)* or *Notification of Pending Status (SDS 539H)*

The DHS 210 or SDS 539H is used to inform applicants of verification needed to approve their request for benefits at certification and recertification.

- For 30-day processing, the pending notice must list proof needed to establish eligibility and state the application expiration date.
- For expedited service, the notice specifies verification that was not provided for the initial issuance and states when benefits will end if the requested verification is not returned on time. In addition, if the verification they provide causes a change in eligibility or benefits, the change will be made without further notice.

Once the determination is made that a pending notice is needed, benefits cannot be opened until the items pending for are received and processed. If an applicant fails to respond timely to a DHS 210 or SDS 539H, they must reapply and establish a new filing date to receive FS benefits. A denial notice is required.

☞ SEE FS B.10 FOR USING THE DHS 210 OR SDS 539H TO OBTAIN VERIFICATION.

12. Using the *Notice of Information or Verification Needed (DHS 210A)*

The DHS 210A is used within the certification period. The DHS 210A is sent to give clients at least 10 days to respond to a request for information.

Use a DHS 210A when:

- A client wants to add a new household member, including a newborn, to an ongoing case. Request name, DOB, SSN, citizen/alien status and income information (when appropriate).
- A client reports a change, but does not provide adequate information or proof required to act on the change.
- More information is needed to determine whether to act on a change.
- Eligibility becomes questionable.

Caution: For SRS, do not send a DHS 210A to pursue information on a change that was not required to be reported, if it is not to the client's advantage. For TBA, send a DHS 210A only if the change will benefit the filing group.

The information on the DHS 210A should be as specific as possible, so the client clearly understands what needs to be provided. The DHS 210A is not a timely notice. If the filing group fails to respond to the notice with information needed to determine eligibility, the worker must send a 10-day notice before reducing or closing benefits.

☞ SEE FS H.12 FOR MORE INFORMATION ON USING THE DHS 210A.

13. Using the *Notice of Incomplete Information (DHS 487)*

The DHS 487 is used within the certification period when a required report form is incomplete. The DHS 487 is sent to inform clients that more information is needed before the required report form can be processed.

Use a DHS 487 when:

- A *Monthly Change Report (Bond and Variable Data)* (DHS 859A) is received, but more information is needed to process the report form.
- An *Interim Change Report* (DHS 852) is received, but more information is needed to process the report for the next six-month period.

Benefits cannot be processed until the requested information is received. If the information is not received, FSMIS will automatically suspend and close benefits. FSMIS sends the notice and the worker does not need to send an additional notice.

☞ SEE FS F.8 AND FS F.13 ON USING THE DHS 487 FOR SRS AND MRS CASES.

14. Food Stamps H - Changes and Notices Examples

5. Prison Discrepancy Lists Examples

For cases in CRS, MRS, or SRS:

Example 1: The FS case is in SRS; Joseph is the only person in the filing group and was incarcerated on October 15. On October 25, the worker was notified. There is no release date. A closing notice was sent effective November 30, 2005. On November 21, Joseph contacts the office to say he is out and back at his prior address. There have been no changes in his situation. His FS case is reopened for December 1, 2005. He did not need to complete an application because he contacted the office before November 30, the effective date for FS closure.

For cases in TBA:

Example 2: The FS case is in TBA; Peter is the head of household and was incarcerated on October 15. On October 21, the worker was notified. There is no release date. A closing notice was sent effective November 30, 2005. On December 2, Peter contacts the office to say he is out and back with his family. The TBA case closed end of day November 30, he needs to reapply for FS.

6. Action on Changes During the Certification Period Examples

Actions when head of household leaves the case:

Example 1: On November 16, a client reports his wife left the home. She was head of household. The children have remained with him. He does not know where she went and the worker is not able to determine if she is still eligible for FS.

Keep her coded as head of household for her case and ask the father to reapply for FS for himself and the children. As an adult in the filing group, he may voluntarily reduce benefits (use the Voluntary Agreement to Reduce, Close, or Deny Benefits and Notice of Decision & Action Taken (DHS 457D)) for the following month to exclude himself and the children. This action will get him and the children FS benefits and the mother will be able to continue FS for herself. Send a reduction notice to the mother at the last known address letting her know the reason for the reduction. This process will avoid having the mother come to the office later that month or after the first of next month wanting her FS.

Example 2: On November 8, a client reports her husband is in jail for 90 days. He is head of household and not eligible for FS while in jail. Remove his needs from the FS case and change the head of household to the mother. Send a timely continuing benefit decision notice before removing his needs from the case. There is no need for a new application.

Example 3: New Income

A client's UC benefits end due to the start of a job. In all report systems, the ending of the UC and the start of the earned income must take place at the same time. Do not remove the UC income without also coding the new income that is replacing the UC. The direct actions to be taken depend on the report system for the case.

CRS: Send a DHS 210A and ask for proof of the income. Remove the UC income only when the new earned income is coded on the case.

MRS: Hold all actions until receipt of the DHS 859A showing the monthly income for the budget month.

SRS: If it is believed the new income will put the financial group over the countable income limit, send a DHS 210A requesting proof of the new income. If it is believed the new income will keep the group below the countable income limit, narrate the report and

take no additional action because the income is not verified. Only remove the UC income when the new income is coded on the case.

TBA: Take no action to change income on the TBA case. If the client thinks they are eligible for more FS if not in TBA, have them reapply. If they are eligible for more FS using the current situation, end TBA and give regular FS.

Example 4: New household member

A client reports that her husband has moved into the home. He is required to be a member of the FS filing group. He is employed and working 32 hours a week. Always add the person with their income. Therefore, his income must be coded on the case at the same time his needs are added to the group.

CRS: Send a DHS 210A asking for the information needed to add the husband to the case. This includes his SSN, along with proof of income. Only add his needs to the case when his income is added.

MRS: Send a DHS 210A asking for any needed information such as SSN. Hold all actions until receipt of the DHS 859A showing the monthly income for the budget month.

SRS: The report that her husband has joined the household must be treated as a request for benefits. Send a DHS 210A, asking for any information needed to add the husband to the case. This includes his SSN, along with proof of income.

TBA: Narrate the report. To get FS for the husband, the group will need to reapply for FS. His needs can be added only if the group will receive more benefits using the current situation. End TBA when benefits will be more using the current situation.

Example 5: Job Quit and New Job

A client reports she quit her job last Friday but began a new job today. She indicates her new job is for 15 hours a week at \$8.00 an hour.

CRS: Send a DHS 210A and ask for proof of the income from the new job and the reason for the job quit. Explore OFSET disqualification if good cause does not exist. Change the EML amount when the new earned income is verified.

MRS: Send a DHS 487 asking for reason for the job quit. Hold action on income until receipt of the DHS 859A showing the

monthly income for the budget month. Look for income from both sources in the transition month.

SRS: If it is believed the new income, in combination with other income, puts the group over the countable income limit, send a DHS 210A requesting proof of the income and the reason for the job quit. If it is believed the group's income will remain below the countable income limit, narrate the report and take no additional action due to lack of verification. Make a decision regarding good cause for job quit and possible disqualification when the DHS 852 is processed or at next recertification, whichever action is first.

TBA: Narrate the report only.

8. Effective Dates Examples

Acting on Changes in MRS Examples

Example 1: A client in MRS is paid on the fifth and 20th each month. They leave the household on August 15 and the remaining members report the change on their DHS 859A at the end of the month. Remove the client from the benefit group for September, but count the pay received August 5 because it was still available to the group at that time. Pay received on August 20 was not available since the client had already moved out.

Example 2: A client in MRS is paid on the fifth and 20th each month. They leave the household on August 21 and the remaining members report the change on their DHS 859A at the end of the month. Remove the client from the benefit group for September. Count the pay received August 5 because it was available to the group at the time. Count the pay received August 20 if it was made available to the rest of the household. Do not count the August 20 pay if the client took all of it with him when he left the household.

Acting on Changes in CRS Examples

Example 3: On February 10, a pregnant client in the CRS reports that her due date is March 3. She is advised to report it as soon as the baby is born. If the baby is born in February and she reports it that month, add the newborn to benefits effective March 1. If the baby is born in March and she reports it that month, add the newborn to benefits effective April 1. If the baby is born in February and she does not report it until March, add the newborn to the benefits effective April 1.

Acting on Changes in SRS Examples

Example 4: New Rent

On December 3, a client in SRS reports that her rent was increased by \$50 per month. The certification period is November 1 through October 31. Rent does not need to be verified. The worker does not find the amount questionable and therefore changes the rent amount on FSMIS, narrates the action and waits for receipt of the DHS 852 to determine changes for the seventh through 12th month of the certification period.

Example 5: New Address

On November 3, a client in SRS reports that she has moved to a new address. Her certification period is October 1 through September 30. She does not report the new shelter costs or household composition information. The worker changes the mail address field on FSMIS, effective December 1, narrates the action and waits for receipt of the DHS 852 to determine changes for the seventh through 12th month of the certification period. No further action is necessary because there is not enough information to determine if the change will increase or decrease benefits.

Caution: Change the residence address on FCAS only if the new shelter costs are reported.

Example 6: Reduced Work Hours

On January 5, a client in SRS reports that she is only working 32 hours a week. Due to a drop in business, her employer reduced all employees work hours. Her certification period is November 1 through October 31. The worker finds this questionable and wants verification before recomputing the benefits. The worker tells the client to submit proof of the reduction before taking action to increase benefits. The client may submit the proof now or wait and submit it with the DHS 852 in April along with the verification of March income for the May through October benefits.

Example 7: New Income Verified

On March 10, a worker from the Social Security Administration calls the branch office to report a client in SRS has been determined eligible for SSI and the first regular payment will be April 3. The certification period is November 1 through October 31. This information is considered verified upon receipt because it was reported by a party that is responsible for the

income. The worker narrates the information, sends a 10-day notice to reduce benefits and takes action for the April benefits.

Example 8: *Income Over 130 Percent*

On July 9, a client in SRS reports that their income last month increased over the countable income limit. The client expects to continue to receive this each month. The client was required to report this information. The worker sends a DHS 210A requesting proof of the income. If the requested verification is not received by the due date, the worker will also send a closure notice for lack of receipt of the requested information needed to accurately determine eligibility or benefit level. When the proof is received, the income must be adjusted if necessary following any required notices.

Example 9: *Change in Household Composition*

A household participates in SRS. A member of the SRS filing group leaves and becomes a member of another filing group. The new household is participating in CRS. The SRS filing group is not required to report changes in household size. However, the CRS filing group is required to report changes in household composition. What actions must the department take?

Remember: *Losing a member does not necessarily mean a decrease in food stamps (the departing member may have had income); and gaining a member does not necessarily mean an increase in food stamps (for the same reason).*

- *Remove the person from the losing SRS filing group (FS C.2). This may require a Timely Continuing Benefit Decision Notice if the result is less benefits.*
- *Add the person to the gaining CRS filing group. This may require a Timely Continuing Benefit Decision Notice if the result is less benefits. This action does not become effective until the needs of the person leaving the SRS filing group have been removed from FSMIS and the notice period has ended.*

Same situation as above except that neither household reported a change in household composition.

- *The SRS household was not required to report the change.*
- *The CRS household was required to report the change but did not. Would either household be overissued or underissued, and would a claim be appropriate?*

Let us take this in three parts:

- *The effect on the losing household's food stamps:*

First, let us consider the losing household in SRS, which is not required to report changes in household composition. There can be no over or underissuance because the household was not required to report the change.

- *The effect on the gaining household's food stamps;*

Second, the gaining household in CRS, which is required to report changes in household composition:

- *Calculate the benefit that the gaining household would have received, considering the new member's circumstances.*
- *Determine the first month in which the benefit would have changed, taking into account the extra time that will elapse if a Notice of Adverse Action is required.*
- *If the calculated benefit would be lower, the gaining household was overissued.*
- *If the calculated benefit would be higher, the gaining household was underissued. However, there would be no restored benefits because the household caused the underissuance (273.17(a)(1)).*

- *Claims:*

Third, the possibility of a claim.

- *For the losing household there can be no claim. This household met all of its reporting requirements.*
- *For the gaining household a claim is appropriate if there was an overissuance.*

Acting on Changes in TBA Examples

Example 10: On December 16, a client in TBA reports that she has moved to a new address and that her 17-year-old child is no longer living with her. She is now in a low-income housing complex and her rent is \$87 a month plus utilities. Her TBA period is November 1 through March 31. The worker codes the new address onto FCAS and narrates the action. The daughter's needs are not removed as she has not applied for FS in another household. The rent is not

adjusted as it will change the benefits. These changes will be acted on when the client reapplies after her TBA period ends.

Example 11: On November 5, a client on TANF reports her estranged husband has moved into the home. The worker sends a notice and closes TANF effective November 30, based on no deprivation. The family does not reapply for two-parent TANF and TBA begins December 1. The TBA filing group includes the client and children who received FS in November. The father is not added to the FS case in TBA. The group may apply for FS if they believe adding him and his income will increase the FS for the household. If he wants FS, the group must apply. His needs will be added only if the group is eligible for more FS using the new application. If eligible for more FS, the TBA must end and the group recertified for regular FS.

9. Notices; General Information Examples

Example 1: McKenzie just moved to Roseburg from Helena, MT. He files for FS on June 16. McKenzie received FS from Montana in June, but he will be eligible here July 1. Send a denial notice for June citing concurring benefits.

Example 2: Barbero's FS certification expires August 31. He sends in his completed recertification packet on July 16. Because this application will be used to determine eligibility for his net certification period, a denial notice is sent only if he is found ineligible beginning September 1.

Example 3: Meg is receiving FS benefits through March 31. In December, she applies for medical and FS benefits. The worker should clarify to Meg that she is already receiving FS and there is no need to reapply. Narrate this conversation. No denial notice is needed.

Worker Guide Forms Used in the Food Stamp Program

Following are the forms and their uses, as related to the Food Stamp (FS) program. The forms with the most high-volume use are grouped by type (for example, *applications*). The remainder of forms are listed in numerical order.

1. Applications

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 415F	<i>Application for All Services</i> Used at initial application and at recertification at self-sufficiency branches for clients receiving FS, cash, and/or medical benefits. This form also serves to work register all OFSET mandatory members of the filing group. For initial applications, the form is used with the DHS 6609 packet.	X	X	X		
DHS 415X	<i>List of Additional Household Members</i> Used to supplement DHS 415F for large households applying for benefits.	X	X			
DHS 415Y	<i>Reapplication for FS Services, filing page</i> Used at recertification at self-sufficiency branches to establish a filing date when the client picks up the DHS 6608 recertification packet.	X	X			
DHS 416E	<i>Examples of Proof of Eligibility Envelope</i> Clients may place their proofs in the envelope to take to the interview. May be used instead of the DHS 223.	X Paper only				
SDS 539A	<i>Application for: Financial/ Medical/ Social Services/Food Stamps–Redetermination of Eligibility–Adults</i> Used at initial application and redetermination at branches serving the aged/clients with disabilities when they are applying for multiple programs. The form also serves to work register all OFSET mandatory members of the filing group. Must be used with the SDS 539F.		X		X	

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
SDS 539F	<i>Application for Food Stamps - Part 1</i> Used at branches serving aged/clients with disabilities to establish the filing date and to gather information to screen for expedited service.		X		X	
SDS 539M	<i>Medicaid/Food Stamp Application for SSI Individuals and Couples</i> Used at initial application and redetermination at branches serving aged/clients with disabilities when all members of the FS group are receiving SSI. Must be used with the SDS 539F.				X	
DHS 6608	<i>FS Re-Application Packet</i> Prepackaged application packet used for recertification of open FS cases and consists of the following forms: DHS 415F Reapplication for FS Services DHS 415R Your Rights and Responsibilities DHS 223 Examples of Proof of Eligibility DHS 3400 Information and Referral for Low-Income Households DHS 6608A Interview Choices DHS 7280F OFSET Rights and Responsibilities DHS 9001 Discrimination Complaint Information DHS 9013 We Want to Serve You Well DHS 1005 Alternative Format Notification	X paper only				
DHS 6608A	<i>Reapplication Interview Choices</i> To use with mailed out recertification packets and allows a client to identify their hardship for an in-office interview.	X		X		

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 6609	<i>Information and Referral Packet</i> Prepackaged forms that apply to all applicants and is given the DHS 415F filing page is received. DHS 415R Your Rights and Responsibilities DHS 3400 Information and Referral for Low-Income Households DHS 7254 Oregon Telephone Assistance Program (OTAP) Application DHS 9001 Discrimination Complaint Information	X paper only				
DHS 6623	<i>Multi-Program Reapplication Packet</i> Used by SSP offices when a client is reapplying for TANF or medical along with Food Stamps.	X	X			
DHS 7476	<i>ERDC Re-application and Food Stamp Application</i> Used at redetermination at self-sufficiency branches for clients receiving ERDC and FS. The FS certification period and ERDC certification period should match.	X	X			

2. Pending Forms

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 210	<i>Notice of Pending Status</i> Used at application at self-sufficiency branches to notify the client of what further information is needed and by what date, in order to determine eligibility.	X	X	X		GS00210

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 210A	<i>Notice of Information or Verification Needed</i> Used to request information or verification on an open FS case. The notice notifies the client of the information needed for their continued eligibility and the due date.	X	X	X		GS0210A
DHS 487	<i>Notice of Incomplete Information</i> Notice to the client when the DHS 852, DHS 859A, or DHS 7476 is incomplete and cannot be processed, and gives the client the deadline for completing the report.	X	X	X		GS00487
SDS 539H	<i>Notice of Pending Status</i> Used at application at branches serving the aged/clients with disabilities to notify the client of what further information is needed and by what date, in order to determine eligibility.	X	X		X	

3. Rights and Responsibilities

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 222	<i>Facility as Authorized Representative</i> Used to notify A&D treatment centers and Group Care Homes of their responsibilities when they are the authorized representative.	None	X			
DHS 415R	<i>Your Rights and Responsibilities</i> Used at self-sufficiency branches with applications to explain client rights, responsibilities, and reporting requirements.	X	X			
SDS 539R	<i>Rights and Responsibilities</i> Used at branches serving aged/clients with disabilities with applications to explain client rights, responsibilities, and reporting requirements.		X		X	

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 7280F	<i>OFSET Rights and Responsibilities</i> Used to notify OFSET clients of their rights in the OFSET program, the requirements, good cause criteria, and penalties.	X	X			FS7832R

4. Client Report Forms and Related Forms

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 852	<i>Interim Change Report</i> Used by clients in the SRS report system to report the required information in the sixth month of the certification period. No benefits will be issued for the seventh month of the certification period until this form is submitted to the department and determined to be complete.	X	X			
DHS 853	<i>Simplified Change Report</i> Used by clients in SRS to report changes at times other than the Interim Change Report. Send a new DHS 853 to the client for future change reporting each time one is submitted to the department.	X	X			
DHS 859A	<i>Monthly Change Report</i> Used by clients to report changes in income when they are in the Monthly Report System (MRS). No benefits are issued until this form is submitted to the department and determined to be complete.	X	X			
DHS 943	<i>Change Report</i> Used by CRS clients to report all changes. In addition, used by clients in the MRS to report nonincome changes. Send a new DHS 943 to the client for future change reporting, each time one is submitted to the department.		X			

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 400	<i>Address Change</i> Used by CRS and MRS clients to report all the details when they move.	X	X			GS00400
DHS 456M	<i>Notice of Change in Reporting System</i> Notice to the client when they enter or reenter the MRS.	None	X	X		
DHS 487	<i>Notice of Incomplete Information</i> Notice to the client when the DHS 852 or DHS 859A is incomplete and cannot be processed, and gives the client the deadline for completing the report.	X	X	X		GS00487
DHS 488	<i>Monthly Report System</i> Pamphlet explaining requirements of the MRS, what information is needed and how it is used to calculate benefits.	X	X			
DHS 854	<i>Simplified Reporting System</i> Pamphlet explaining the requirements of SRS, what information is needed and how it is used to calculate benefits for cases certified longer than six months.	X	X			
DHS 856	<i>Transitional Benefit Alternative Reporting System</i> Pamphlet explaining the requirements of TBA, what information is needed and how it is used to calculate benefits.	X	X			
DHS 7294	<i>Notice of Reported Income</i> Notice to the client about how income was averaged or anticipated or counted when they are not in MRS.	X	X	X		FS07294 CM07294
DHS 7351	<i>Educational Income Calculation for ERDC and Food Stamps</i> Worksheet for calculating educational income.	X	X	X		

5. Miscellaneous

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 138A	<i>Affidavit Concerning Lost Check</i> Client's application to have benefits replaced when their FS are issued by check and have been lost.	X	X			
DHS 200C	<i>Income from Farm Operations</i> Worksheet for calculating net income from farm operations, especially when there is a loss which offsets other income sources.	None	X			FS0200C
DHS 208	<i>How to Use Your Oregon Trail Card</i> (EBT Card Brochure).		X			
AFS 215	<i>Authorization to Cancel Benefits Deposited to an EBT Account</i> Worker request to cancel EBT benefits.		X			
DHS 221	<i>Food Stamp Computation</i> Worksheet for hand-calculating food stamp benefits when computer systems are not available.	None	X			
DHS 221F	<i>Food Stamp Calculation for Noncitizens</i> Interactive step 1 and step 2 calculation worksheet for NC2 cases.			X		
AFS 222A	<i>Monthly List of Residents</i> Used by A&D treatment centers and Group Care Homes acting as authorized representative to report residents receiving FS each month.	None	X			
DHS 223	<i>Examples of Proof of Eligibility</i> Explains to the client what verifications may be required to determine eligibility.	X	X			
AFS 230	<i>Appointment Schedule - Food Stamp</i> Used to schedule interview appointments.	None	X			

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
AFS 231	<i>Designation of Authorized Representative or Alternate Payee</i> Used to designate persons with the authority to apply for benefits on behalf of the FS group or to designate persons to get an EBT card and use the benefits. The AFS 231 only needs to be completed when a nonfiling group member is named as AP or AR.	None	X		X	
SDS 246	<i>Assignment of PIN</i> Used to designate a proxy should a housebound client be unable to come to the branch office to get a personal identification number (PIN) for their EBT card.	X				
DHS 284	<i>Overpayment/Overissuance Report</i> Form forwarded to the Overpayment Recovery Unit when an overpayment is written.	None	X	X		
DHS 284A	<i>Overpayment/Overissuance Change Report</i> Form forwarded to the Overpayment Recovery Unit when the amount of a previously written overpayment is adjusted.	None	X	X		
DHS 284B	<i>Notice of Overpayment and Planned Action</i> Notice to the client prior to collection beginning on an overpayment.	None		X		
DHS 349	<i>Application for Emergency FS Assistance</i> Application which may be used with FNS approval, should an area in Oregon be declared a natural disaster.	X	X	X		
DHS 362	<i>Notice of Restoration of Lost Benefits</i> Notice to the client when benefits are issued to make up for an agency caused underissuance of benefits.		X	X		FS00362
AFS 368	<i>Collateral Contact Statement</i> A document which may be used to verify a client's situation when other, more reliable sources are not available.	X	X			FS00368

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 371	<i>Investigation Referral</i> Used to refer a case to the Investigator when information has been received through a community complaint or other source indicating that eligibility is questionable.			X		
AFS 375	<i>QC Request for Branch Assistance</i> QC's request to the branch for case closure, when a client has failed to cooperate with the federally-mandated case review.		X			
DHS 411	<i>Missed Appointment Postcard</i> Postcard sent to applicants when they miss their first intake appointment.	X	X			FSMA411
DHS 414	<i>Notice of Transfer</i> Notice of new branch office, sent to the client when the case is transferred to a different office or the client has moved to a new service area.		X	X		GS00414
DHS 415Z	<i>Enumeration Request</i> Used to verify that a client has applied for a new or duplicate Social Security Number, in order to meet the enumeration requirement for eligibility.	X	X			
AFS 419A	<i>Authorization for Information Regarding Financial Status</i> Used in instances where the client is unable to provide necessary verification of financial assets. The form gives the department permission to contact the financial institution directly in order to verify eligibility.	X	X			
AFS 442	<i>Pre-Hearing Summary</i> Summary of the issue when a hearing is requested. Forward the summary and supporting documents from the case record to the Hearings Unit.	None	X			
DHS 443	<i>Administrative Hearing Request</i> Form the client may use to put a request for a fair hearing into writing (must be completed by the department if it is a verbal request).	X	X	X		

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 456	<i>Notice of Decision and Action Taken</i> Hand-initiated notice to the client when benefits are approved, denied, reduced, or closed and there is no appropriate computer-generated notice.	X	X	X		GSC1 F01 (Close) GSD1 F01 (Deny) GSR1 F01 (Reduce)
DHS 457D	<i>Voluntary Agreement to Reduce, Close, or Deny Benefits</i> Notice signed by the client giving the department permission to take action on benefits immediately, which waives the right to a timely notice. Also used to withdraw an application request.	X	X	X		
DHS 475	<i>Job Search Verification</i> Form used by clients performing job search to verify employer contacts.	X	X			GS00475
DHS 491	<i>Statement of Person Living in the Household</i> Form used to verify the financial arrangements and how food is shared when the client lives with others.	X	X		X	GS00491
SDS 540	<i>Notification of Planned Action</i> Hand-initiated notice to the client when benefits are approved, denied, reduced, or closed, and there is no appropriate computer-generated notice.	X	X		X	
SDS 540A	<i>Agreement to Take Action</i> Notice signed by the client giving the Department permission to take action on benefits immediately, which waives the right to a timely notice. Also used to withdraw an application request.	X	X		X	
SDS 541	<i>Notice of Eligibility and Responsibilities</i> Notice tells the clients they are eligible, and their first and second months benefit amount.	None	X			
DHS 824F	<i>OFSET Appointment Letter</i> Form letter used to advise OFSET participants of a scheduled appointment.		X	X		FS0824F

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 851	<i>Verification of Earnings</i> Form sent to employers to verify earned income for a specified period. This is generally used to determine if there is an overissuance.		X	X		
DHS 857	<i>Free Meals or Free Milk at School or Child Care</i> Give to clients after they are determined eligible for FS so their children can get free school meals or WIC.	X	X			
DHS 859B	<i>Self-Employed Monthly Financial Statement</i> Worksheet used to determine whether a self-employed client has allowable costs related to their self-employment.	X	X			GS0859B
DHS 859C	<i>Paycheck Tracking Calendar</i> Tool for ensuring that clients report all of their earned income.	None	X			
SDS 905	<i>Notification of Case Transfer</i> Notice of new branch office, sent to the client when they have moved to an area served by a different branch.	X	X		X	
AFS 942	<i>Food Stamp Worksheet</i> Guide for considering all eligibility factors when determining FS eligibility.	X	X			
AFS 944	<i>Continuing your Food Stamps</i> Notice of FS expiration used when the certification is so short that the system will not issue the notice.	X	X			
DHS 1005	<i>Alternate Format Notification</i> Notice given to all applicants that forms and notices may be received under an alternate format.	X	X			
DHS 1058	<i>Declaration of Indigency</i> Statement of indigency by a sponsored noncitizen, used to exempt the noncitizen from deeming their sponsor's assets.	X	X			
DHS 1219 (Series)	<i>Series of Verification Forms</i> Series of forms used mostly by Quality Control to verify eligibility information. Forms in the series include:					

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
AFS 1219C	<i>Verification of Contributions</i>	X	X			
DHS 1219E	<i>Verification of Expenses</i>	X	X			
DHS 1219HC	<i>Verification of Household Composition</i>	X	X	X	X	GS121HC
DHS 1219HE	<i>Verification of Housing Expenses</i>	X	X		X	GS121HE
DHS 1219L	<i>Verification of Life Insurance</i>	None	X			
DHS 1219SA	<i>Verification of School Attendance</i>	X	X	X		GS121SA
DHS 1219SI	<i>Verification of School Information</i>	X	X			
DHS 1295	<i>Food Stamp Claim Data Sheet</i> Used to collect and organize case record information to be used in calculating an overpayment.	None	X			
DHS 2099	<i>Authorization for Use and Disclosure of Information</i> Used in instances where the client is unable to provide necessary verification. The form gives the department permission to contact a specific person or organization and share information about the client in order to verify eligibility.	X	X	X		
MSC 3288	<i>Consent for Release of Information</i> Consent form which must be signed by each person whose work history is accessed through the Social Security Administration on-line system (TPQY) prior to accessing the information.	None	X			
DHS 3400	<i>Information and Referral for Low-Income Households</i> Given to all FS households at each certification and recertification when they have income below 185% FPL.	X	X			
DHS 7253	<i>Link-Up America</i> Application for financial help to connect with a telephone service.	X	X			

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 7254	<i>Oregon Telephone Assistance Program</i> Notice and application to the client that because they are eligible for benefits, they can apply for a discount on their monthly telephone bill.	X	X			
AFS 7262	<i>Direct Deposit - A Safer, Easier Way to Put Your Benefits in Your Account</i> Used for clients in Cash-out counties using direct deposit.		X			
DHS 7832D	<i>Oregon Food Stamp Employment and Transition (OFSET) program Disqualification Referral</i> Contractor to complete and send to FS office when recommending disqualification.		X	X		
DHS 7832F	<i>OFSET Employment and Training Case Plan</i> Contractor completed case plan with OFSET mandatory clients.	X	X			
DHS 7832R	<i>OFSET Program-Client Agreement</i> Use to refer OFSET mandatory clients to contractor or for independent work search.	X	X			FS7832R
DHS 9001	<i>Discrimination Complaint Information</i> Form explains client complaint procedures, should they perceive that they are being treated with discrimination. It is mandatory for use with all applications.	X	X		X	
DHS 9013	<i>We Want to Serve You Well</i> An information only pamphlet that tells clients how to file a grievance.	X	X			

6. Outreach Publications

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 416	<i>10 Steps to Help You Fill Your Grocery Bag</i> (Flier)	X Paper only				

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
AFS 9206	<i>"Food Stamps Can Help Students Make Ends Meet."</i> Flier on food stamps rules for college students.	X paper only				
AFS 9207	<i>"Oregon Helps: Now Showing at a Computer Near You."</i> Bookmark (4" x 9") on using www.oregonhelps.org to find out if you might be eligible for food stamps.	X	X			
AFS 9208	<i>"Three More Reasons to Sign Up..."</i> Bookmark (4" x 9") explaining how food stamps make families eligible for free school meals and two phone assistance programs.	X paper only				
AFS 9209	<i>Answering Some Common Questions About Getting and Using Food Stamps</i> Common FS questions for applicants.	X paper only				
AFS 9210	<i>Are You One of Us</i> Food Stamp poster	X paper only				
AFS 9211	<i>"Food Stamps in 7 Days."</i> Flier on expedited Food Stamps.	X paper only				
AFS 9212	<i>"Are You Finding It Hard To Feed Your Family?"</i> Flier targeted to households with school-age children. Primary language is English, with Spanish, Russian, Vietnamese translation on reverse.	X	X			
DHS 9213	<i>"Staying Healthy on a Tight Budget."</i> Client brochure for seniors and people with disabilities and the Food Stamp Program. Includes eligibility guidelines.	X	X			
AFS 9216	<i>"Client Bill of Rights."</i> Poster – lists rights of Food Stamp recipients.	X paper only				
DHS 9217	<i>"Know Your Rights."</i> Flier – lists rights of Food Stamp recipients.	X	X			
DHS 9218	<i>"Food Stamps and You."</i> Client brochure on Food Stamp benefits.	X	X			

Form #	Title/Use	Paper	Forms Server		ACCESS	Notice writer
			PDF	fill in		
DHS 9219	<p><i>“Good News for Parents with Immigrant Children”</i> Client flier regarding rule change making legal immigrant children eligible. Primary language is Spanish, with Russian, Vietnamese, and English translations on reverse.</p>	X	X			
DHS 9220	<p><i>“I’m Getting Less Than \$10 in Food Stamps. Is it Worth It?”</i> Explains how Food Stamp eligibility may help with other program eligibility.</p>	X				

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Worker Guide FS Report Systems At-A-Glance

The FS program uses several report systems. The following are the basics about each report system at-a-glance.

Additional information about each report system is located in:

Change Report System (CRS)	FS F.7
Simplified Reporting System (SRS)	FS F.8
Transitional Benefit Alternative (TBA)	FS F.9
Monthly Report System (MRS)	FS F.10

1. Change Report System (CRS)

Purpose & Benefits	CRS is a report system with many reporting requirements. While in CRS, FS benefits may change each time the household reports a change that is expected to continue.
Who must be in CRS	Any FS case that cannot be in one of the other report systems must be in CRS.
Who cannot be in CRS	The clients who cannot be in CRS are: <ul style="list-style-type: none"> - Clients receiving FS under Transitional Benefit Alternative (TBA). - FS cases when the companion public assistance case is in MRS.
Certification Periods	FS cases in CRS are limited to a six-month certification period, except: <ul style="list-style-type: none"> - ERDC/FS households may be certified for 12 months if the ERDC certification form is being processed at least once each six months. - Households where all members are elderly or are persons with disabilities and there is no earned income may be certified for 12 months.
Budgeting	Use prospective budgeting. Anticipate the initial month's income considering all that has been received to date and anticipating what will be received yet in the month. For the second and future months of the certification, anticipate or convert the income to a monthly figure in the first month and use that amount continually until a change is reported.
Reporting	Report all required changes as outlined in FS H.2.

<p>Acting on Reported Changes</p>	<p>Act on all reported changes. Reported changes may increase or decrease benefits.</p> <p>Increase Benefits = Act immediately for the next month unless more information is needed. If more information is needed, send a <i>Notice of Information or Verification Needed</i> (DHS 210A) requesting the information. Do not act to increase benefits until the proof or information is provided. DO NOT hold benefits for the information.</p> <p>Decrease Benefits = Act immediately for the next month's benefits following the timely continuing benefit decision notice period to reduce benefits. If proof of income is needed, make the change and request the required proof via the DHS 210A. A second adjustment may be needed when the requested information or proof is received.</p>
<p>When does CRS end?</p>	<p>CRS is the default report system and ends when the case is placed into another report system.</p>
<p>FSMIS coding</p>	<p>There are no special Trans coding for CRS. The Mand Rpt field is "N."</p>

2. **Simplified Reporting System (SRS)**

<p>Purpose & Benefits</p>	<p>SRS is a report system with limited reporting requirements. While in SRS, FS benefits will generally remain unchanged for a six-month period.</p>
<p>Who can be in SRS</p>	<p>Any FS case not excluded from SRS.</p>
<p>Who cannot be in SRS</p>	<p>The following types of households cannot be in SRS:</p> <ul style="list-style-type: none"> - A companion PA case is in MRS - A case eligible for TBA - Certification period for less than six months.
<p>Certification Periods</p>	<p>A 12-month certification is recommended. Do not certify for less than six months.</p>

Budgeting	<p>Use prospective budgeting. Anticipate or convert ongoing income to a monthly figure in the first month and use that amount continually until a change is reported.</p> <p>For initial month, use actual and anticipated income only if the income is just starting or ending, or will be significantly different in subsequent months.</p>
Reporting	<p>Between report forms, the SRS client must report when:</p> <ul style="list-style-type: none">- Income exceeds the FS Countable Income Limit (130 percent FPL);- The mailing address changes. <p>Clients will still need to report the changes required in other programs. If they report a change that impacts FS, the worker will need to act on it for FS also.</p> <p>An <i>Interim Change Report</i> form (DHS 852) is due in the sixth month of the certification period and must be processed for benefits in months seven through 12.</p> <p>All cases certified for longer than six months must complete the DHS 852, except those cases with no earned income <u>and</u> all adult filing group members are elderly (GP A.13) or are clients with disabilities (GP A.10).</p>

Acting on Reported Changes	<p>In addition to acting on the <i>Interim Change Report</i>, act on <u>all</u> reported changes that the client is required to report. That is, any report that income is over the countable income limit.</p> <p>For all other changes:</p> <p>Increase Benefits = Act on changes that will increase benefits. Send a <i>Notice of Information or Verification Needed</i> (DHS 210A) if more information is needed first. If the change requires verification, (i.e., income, or medical) do not act to increase benefits until the proof is provided.</p> <p>Decrease Benefits = Do not act on information that will decrease benefits, unless the information is “<i>verified upon receipt</i>.” Only request proof if a client reports their income has exceeded the countable income limit. Carefully narrate.</p> <p>Information is “<i>verified upon receipt</i>” when it is not questionable and the provider of the information is the primary source. (Examples: employer, SAVE, worker’s compensation, client’s statement on new shelter costs, etc.)</p>
When does SRS end?	<p>End SRS anytime the client:</p> <ul style="list-style-type: none">- Becomes eligible for TBA;- Becomes ineligible (they may report income that exceeds 185 percent FPL and they are no longer categorically eligible, this may lead to being over income).

FSMIS Coding	<p>Use a transaction code (Trans) of SRS to place the case into or to remove a case from SRS.</p> <p>The Mandatory Reporting (Mand Rpt) field is “S.”</p> <p>Use household type code (HH Type) of NED when there is no earned income <u>and</u> all adult members are elderly or are clients with disabilities.</p> <p>Enter the sixth month of the certification period or the last day of the certification period, whichever date comes first, into the date field (Rpt Exp). (Always code last day of certification period if using NED in the HH Type field).</p> <p>Use the ADJ to extend the certification period to the full 12 months when placing the case in SRS that was certified for less than 12 months.</p> <p>Use ADJ to adjust benefits due to reported changes during the six months. Do not use SRS transaction code or touch the “S.”</p> <p>Use SRS, ADJ to process the interim report form in the sixth month. Change the Rpt flag from N to Y (as with MRP). Do not touch the “S” or change the Rpt Exp date.</p> <p>When converting a case from MRP to SRS, first do an MRP action to remove the MRP coding and record update. The SRS action can take place immediately following this action.</p> <p>At recertification, use REC, SRS and change the Rpt flag from N to Y. This will change the report expiration date.</p>
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3. Transitional Benefit Alternative (TBA)

Purpose & Benefits	TBA is a report system that freezes FS benefits for five months for clients whose TANF cash benefits end for a good reason.
Who must be in TBA	FS cases with TANF cash benefits ending and that are not excluded from being in TBA. (No one in the FS filing group can be getting TANF.)

<p>Who cannot be in TBA</p>	<ul style="list-style-type: none"> - Benefit groups that lose cash benefits due to moving out of state. - Failure to comply with reporting requirements (no <i>Monthly Change Report (Bond & Variable Data (DHS 859A)</i> or RI or did not report a required change within 10 days). - TANF cases being penalized for noncooperation (JOBS or Support DQ or IPV) and disqualification was not lifted when the case closed due to a new job; or received notice of TANF disqualification and voluntarily ended their TANF cash benefits. - FS filing groups with an ineligible member (IPV, QC, OFFSET disqualification, fleeing felon, etc.) <p><i>Note: This does not include members ineligible for FS due to noncitizen status.</i></p>
<p>Certification Periods</p>	<p>If the case is due to recertify prior to the end of the TBA period, extend the certification period to match the TBA end date. Do not recertify.</p> <p>TBA households must recertify at the end of the TBA period, even if the certification end date is later.</p>
<p>Budgeting</p>	<p>Use prospective budgeting. Change the TANF grant to \$0 and leave the rest of the FS case situation as it was the month before TBA begins. Do not code new income unless adding a new person to the case.</p>
<p>Reporting</p>	<p>No required changes to be reported during TBA.</p>
<p>Acting on Reported Changes</p>	<p>Increase Benefits = Client needs to reapply for FS. Determine if the new situation will result in more FS. If now eligible for more FS, end TBA and REC the case. If not eligible for more FS using the current situation, continue TBA unchanged to the end of the TBA period.</p> <p>Decrease Benefits = Only act to decrease benefits in one instance. That is if someone moves out of the household and applies for FS benefits in another household. In that event, remove them from the TBA case, allowing for the 10-day notice. Narrate.</p>

<p>When does TBA end?</p>	<p>End TBA early when the benefit group:</p> <ul style="list-style-type: none"> - Is no longer eligible for FS (e.g., moves out of state or requests case closure); - Head of household goes into a facility. - Applies for food stamps and will get more FS if not in TBA; or - Re-opens a TANF cash case.
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<p>FSMIS Coding</p>	<p>Use a transaction code (Trans) of TBS to enter or remove a case from TBA.</p> <p>The Mandatory Reporting (Mand Rpt) field is “T.”</p> <p>Enter the last month, day and year of TBA eligibility in the Report Expiration (Rpt Exp) field. The date is edited and cannot be greater than five months from the TBS effective date (D-Eff). Change the Y Cat El. field to C.</p> <p>Use the ADJ transaction to extend the certification period to match the Rpt Exp date. The end cert (Expr Cert) date must either match the Rpt Exp date or can be further into the future. If this date is not at least five months into the future, the certification must be extended.</p> <p>To remove a case from TBA, use the TBS transaction and change the Mand Rpt type to “N.” The system will remove the Rpt Exp date. If the certification period was extended and is longer than 12 months, the system will change the Expr Cert date to the end of the current month. The case must be recertified to continue benefits.</p>
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4. Monthly Report System (MRS)

<p>Purpose & Benefits</p>	<p>MRS is a labor-intensive report system with many reporting requirements. While in MRS, the client must complete a report form each month reporting household income and child care costs. All other required reporting items must also be reported separately from the monthly report form. All other changes must be reported within 10 days of occurrence.</p>
<p>Who must be in MRS</p>	<p>Anytime a companion public assistance case is in MRS, the FS case must also be in MRS.</p>
<p>Who cannot be in MRS</p>	<p>No FS case can be in MRS except when a companion PA case is in MRS.</p>
<p>Certification Periods</p>	<p>FS cases in MRS may be certified for up to 12 months.</p>
<p>Budgeting</p>	<p>Use retrospective budgeting. Actual income from the budget month (prior month) is used to calculate benefits for the following month.</p>

Reporting	Report all income on the <i>Monthly Change Report</i> (DHS 859A). All other changes (except income) must be reported as required in FS H.2.
Acting on Reported Changes	Act on all reported changes. Actual income must be reported for each month and is used to process the following month's benefits. All other reported changes are to be acted upon the same as with CRS.
When does MRS end?	Cases cannot be in MRS when MRS ends for the companion PA case.
FSMIS coding	Use a Trans code of MRP to place the case into or to take the case out of MRS. The Mand Rpt field is "M."

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B. Application Process and Verification Requirements

Note: This section covers the application process for Employment Related Day Care (ERDC) only. Please refer to the chapters on Food Stamp, Pre-TANF and TANF programs for information about the application process for these programs.

1. Intent

The application process should encourage convenient access to DHS child care assistance while resulting in enough information to determine eligibility and benefit level. The process should:

- Be flexible and convenient for clients who are balancing work and family responsibilities.
- Allow for changes from one program to another simply, and in a way that is easily understood by workers, clients and providers.
- Give the client information about how the program works.
- Offer resources to help clients find quality child care.
- Include an assessment of the client's child care needs.

Case Management Opportunity

When explaining the listing and provider requirements of the program, ask clients open-ended questions about how comfortable they are with their provider. What does the provider offer? How do you feel about leaving your child with this person? How does your child feel? What kind of activities are provided for your child? What information would you like to have about choosing the best child care provider for your child? What information or training do you think your provider would like to have? Explain that the local CCR&R can help answer questions for both parents and providers.

2. Application Process for ERDC (Not Transitioning from TANF)

Persons applying for ERDC begin the application process by contacting the local DHS branch or CCR&R where they live. This contact establishes the *date of request*.

- Although the application process should be completed as soon as possible, the applicant and worker have 45 days from the date of request to complete it. The 45 days can be extended if circumstances beyond the control of the applicant delay the eligibility decision past that limit.

- The date of request also establishes when benefits can begin. This is the first day of the month in which the request is made if eligibility requirements and application processing time frames are met.

Those applying for ERDC only can complete the *Application for ERDC Program* (DHS 7470) or the *Application for Services* (DHS 415F). Those applying for other programs must complete the DHS 415F. The application must be signed by the caretaker of the child(ren) requiring care.

Note: Caretakers can also get an application for the ERDC program, (DHS 7470), and establish a Date of Request at their local CCR&R. The CCR&R can also give them general information on the ERDC program and answer questions they may have. Their application must then be mailed or delivered to the local DHS branch office.

An intake interview is required to process the application. A face-to-face interview is preferable if it can be arranged around the applicant's work schedule; it is the most effective way to obtain information from the client and give the client information about the program. However, a phone interview is an option when a face-to-face interview is not practical.

*Note: Refer to the **Food Stamp** chapter if the client is also applying for food stamp benefits. FS requires a face-to-face interview and there are other eligibility factors that do not apply to ERDC.*

If eligibility cannot be determined at the intake interview, give or mail the client a *Notice of Pending Status* (DHS 210) explaining what is needed to determine eligibility.

When a client is over income, the client may reapply in a subsequent month. A new budgeting period is established and income is recalculated.

Application Process; General: 461-115-0010

Application Requirements: 461-115-0020

Date of Request: 461-115-0030

When an Application Must Be Filed: 461-115-0050

Offices Where Clients Apply: 461-115-0150

Application Processing Time Frames; Not FS or Pre-TANF: 461-115-0190

Interviews: 461-115-0230

3. **Transitioning from TANF to ERDC**

When the TANF case has gone over income, the client should be contacted right away to discuss ERDC eligibility instead of waiting for an application. Clients who have been receiving TANF child care assistance sometimes do not understand they need to apply to receive ERDC. In other cases, they think the notice telling them they are over income for TANF means they are not eligible for any assistance. The process for converting from TANF to ERDC is a lot simpler if it is done soon, rather than a month or so later. This also gives clients more time to budget for the ERDC copay.

For clients transitioning from TANF, application for ERDC can be made in one of the following ways:

- A phone call or office visit initiated by either the worker or the client. A new written application is not necessary as long as the worker has enough information to reliably predict the need for employment-related child care.
- A notice returned by the client. When a TANF case goes “no action” (NA) because of increased income, a computer notice (6E) is usually sent by the system. This notice serves as an application if the client fills it out and sends it back. Follow up must include a conversation with the client either in person or over the phone.
- Any other method that results in enough information to determine employment-related child care need.

When an Application Must Be Filed: 461-115-0050

4. Verification Requirements

Verify the following at initial application (this includes cases that are transitioning from TANF to ERDC):

- All countable earned and unearned income received 30 days prior to the date of request.

Note: *For new employment, acceptable verification includes first paycheck from a new job (if hours are representative of future) or, when no pay has yet been received, an employer statement including anticipated hours, pay dates and rate of pay. If verified by phone, narrate the conversation including anticipated hours, pay dates, rate of pay, the name of person who verified the information, employer name and phone number. Additional verification may be needed and requested if income is variable, questionable, or if income changes between the date of request and interview.*

- Citizen/Alien status of a child needing care (See Worker Guide NC #1 – Noncitizen Chart).
- Second parent unable to provide adequate child care.
- If questionable, anything that affects eligibility or benefit level.
- Verify or document why a child 12 or older needs care, or why a child with a disability needs special care.

Note: *Staff may not ask applicants or recipients to verify their citizenship solely on the basis of the client’s ethnicity or ability to communicate in English. If an applicant identifies a child needing care as a noncitizen on the application, noncitizen status must be verified.*

Verify the following changes during certification periods:

- Source of income and related changes such as new rate of pay. For new employment – see note above.
- If questionable, anything that affects eligibility or benefit level.

Note: For cases in SRS, changes that are not required to be reported and are not “verified upon receipt,” need to be narrated and acted on at Interim Change Report or the next recertification, whichever is earlier. Reported information is considered “verified upon receipt” when the information is not questionable and the provider of information is the primary source. Income changes cannot be verified by client statement alone.

☞ SEE CC E 7 REPORTING REQUIREMENTS AND CHANGES.

Verify the following at reapplication:

- All countable earned and unearned income received in the last 30 days. For new employment – see note above.
- If questionable, anything that affects eligibility or benefit level.
- At least once every 12 months, verify or document why a child 12 or older needs care, or why a child with a disability needs special care.

Verification; General: 461-115-0610

5. Approving the ERDC Application

If found eligible, send or give client the following forms:

- *Notice of Reported Income* (DHS 7294).
- *Child Care Provider Guide* (DHS 7492).
- A pre-headed *Child Care Provider Listing* (DHS 7494) or a *Child Care Provider Letter* (DHS 7494E) if the provider is already listed. (See the Listing Worker Guide at the end of this chapter for more details.)
- *Parent Guide to Child Care* (DHS 7478).
- Information about accessing the local CCR&R.

It is important to code the case on CMS as soon as eligibility is established. The billing form can not be sent until DPU has the completed listing form and CMS has been updated.

See Section III-G in the *Computer Guide* for information about coding and setting up the ERDC case on CMS. See “Program Changes” in the Worker Guide section of this chapter for more information on converting from TANF to ERDC and from ERDC to TANF.

☞ FOR REAPPLICATION PROCESS FOR ERDC, SEE CC E.3

6. Denying the ERDC Application

Deny the application in the following circumstances:

- Information obtained during the application period establishes ineligibility.
- The client fails to complete the application process. The application process is complete when the client has furnished all necessary information and required verification. Unless there are extenuating circumstances, an application should be denied if it is still incomplete 45 days after the initial date of request.
- The client withdraws the application for assistance, verbally or in writing.

In all denied cases, the client is sent a basic decision notice explaining the reason for the denial and the client’s right to a hearing.

Note: *Applications denied because the 45-day limit has expired ordinarily require a new application if the client still requests ERDC. However, the DHS worker has the option of updating and/or correcting the information already gathered. Factors that should be considered include circumstances beyond the client’s control, or care that has been provided in good faith by a provider in the belief the client is eligible for assistance.*

Application Processing Time Frames; Not FS or Pre-TANF: 461-115-0190
What a Decision Notice Must Include: 461-175-0010

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D. Nonfinancial Eligibility Requirements

Note: ERDC nonfinancial eligibility requirements include residency, citizen/alien status of child and age of child. Please refer to the chapters on the Food Stamp, Pre-TANF, and TANF programs if you need information about their nonfinancial eligibility requirements.

1. Residency

Families receiving child care assistance must be residents of Oregon. This means they are residing in the state and intend to remain, although there is no minimum time requirement. Persons on vacation are not considered residents.

Residency Requirements: 461-120-0010

2. Citizen/Alien Status of Child

(A) Alien Status Requirement

In addition to qualified noncitizens specified in Noncitizens A. (NC A.), the following noncitizens also meet the alien status requirement for ERDC.

- Victims of a severe form of trafficking under the Trafficking Victim's Protection Act of 2000.
- American Indians born in Canada.
- Noncitizens who are at risk for domestic violence. If one member of the filing group is at risk, the entire filing group is at risk. Thus, the benefit includes all of the members of the filing group.

(B) Determining and Calculating Benefits for Eligibility Groups with Ineligible Noncitizens

To qualify for ERDC, there must be at least one child who has a child care need who meets the citizen or alien status requirements (unless the caretaker relative has a current safety issue related to domestic violence).

The filing group must meet all other eligibility requirements to be eligible for child care benefits.

- Treat the entire filing group as if all members meet citizen/alien status when conducting the income tests.

Compare their countable income to the ERDC Gross Monthly Income Limit Chart.

- If the countable income exceeds the gross income limit, the filing group is not eligible except for self-employment income.

Filing Group; ERDC: 461-110-0350

Self-Employment; Costs That Are Excluded To Determine Countable Income: 461-145-0920

Self-Employment; Determination of Countable Income: 461-145-0930

Specific Requirements; ERDC: 461-160-0040

- If the countable income is equal to or below the gross income limit, calculate the copay from the number in the benefit group. If the copay amount is more than the child care benefit (subsidy) amount, the family is not eligible for ERDC.

Need Group: 461-110-0630

Citizenship and Alien Status Requirements : 461-120-0110

Age Requirements for Clients to Receive Benefits: 461-120-0510

Specific Requirements; ERDC: 461-135-0400

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150

3. Age of Children

Ordinarily, children must be younger than 12 for ERDC and younger than 13 for other child care programs to receive child care assistance. However, older children included in the filing group can receive child care assistance if DHS determines the child should not be left unsupervised during the hours the caretaker is working or participating in self-sufficiency activities. This determination must be documented and supported by one of the following:

- A verbal or written statement by a physician, nurse practitioner, psychologist, social worker, school counselor or other qualified professional who is familiar with the child.
- Eligibility for SSI.
- Supervision by a court.
- Receipt of foster care payments.
- Special needs designation as defined in Section F, (CC F.), of this chapter.
- Other unique circumstances where the child's safety or the caretaker's ability to work or participate in assigned activities will be significantly compromised if child care is not authorized. For example, child care might be necessary for an older child whose parent works an overnight shift.

Age Requirements for Clients to Receive Benefits: 461-120-0510

4. **Child Care Need**

Families receiving child care assistance must have a child care need as described in Section F.

Use of Income to Determine Eligibility and Benefits; FS: 461-135-0400
Dependent Care Costs; Deduction and Coverage: 461-160-0040

5. **Caretaker/Relationship**

A *caretaker* is the person who is responsible for the care, control and supervision of the child. To be eligible for child care assistance, the child must live with the caretaker.

- The child does not have to be related to the caretaker.
- Caretaker status ends when the responsibility for care, control and supervision is given to another person for 30 days or more, unless the caretaker is called to active duty – see below.

A parent is still considered the caretaker even though he/she is gone for 30 days or more *if* he/she is a member of the National Guard or U.S. Armed Forces Reserve unit *and* has been called to active duty away from the child's home.

Example: A single mom with two kids, ages 7 and 8, asks her neighbor to provide care for her children while she is away on active duty. Mom still has custody, even though she is out of the home for more than 30 days. In this case, you can authorize up to 172 hours of child care. Do not authorize more than full time hours. The provider should not bill for the time children are in school.

Definitions for Chapter 461: 461-001-0000
Filing Group; ERDC: 461-110-0350

6. **Copay Requirement; ERDC**

For ERDC, the client must have paid or made satisfactory arrangements to pay any copay amount owed to the current or past providers. Refer to Section F for more detailed information.

ERDC Requirement to Make Copay or Satisfactory Arrangements: 461-135-0415

7. Listable Provider

The client's provider must be listed or in the process of becoming listed. The only exception is for the temporary situations described in Section H. See Section G for complete information on listing and other provider requirements.

Specific Requirements; ERDC: 461-135-0400
Eligibility of Child Care Providers: 461-165-0180

8. Immunization Requirements

The intent of the requirement is to ensure that children in child care situations paid through DHS are immunized according to a schedule approved by the Oregon Health Division. This schedule and a list of county health departments can be found in *A Parent's Guide to Child Care* (DHS 7478) and the *Child Care Provider Guide* (DHS 7492). The state requirement allows for exemptions due to a medical condition or for religious reasons.

The application asks if children's shots are up to date. If the parent indicates they are not, they should be referred to the local health department and told they have until the end of the six-month certification period to bring the shot record up to date. If the re-application indicates the immunizations are still not up to date, contact the parent and remind them of the requirement. DHS will accept the client's word unless there is reason for doubt. If there is reason to doubt, DHS can require verification. In situations where there is no cooperation, the case worker may send a closing notice. However, the goal is to encourage the parent to get the child's immunizations current, so closing the case should be a last resort.

Specific Requirements; ERDC: 461-135-0400

E. Prospective Eligibility and Budgeting Income

1. Intent and Overview

This policy is intended to help the worker and client predict the family's income with a reasonable degree of accuracy using prospective eligibility and budgeting. Important considerations include:

- The copay the family is expected to pay should correspond with the amount of income they will receive for the same period.
- The copay for future months should be known in advance so both the family and the provider will know how much DHS will pay and how much the family will be expected to pay.
- The copay should remain stable over a period of several months, so the family can more accurately budget household income.
- Some differences between estimated income and actual income are to be expected. However, unanticipated changes or circumstances that substantially affect the family's income should be acted on, even if they occur in the middle of a budget period.

For information on what income is counted and when it is considered available, refer to the chart at the end of this chapter and to the manual section on Counting Client Assets. This section also has information about how to treat self-employment income. There are no resource limits for the ERDC program.

2. Certification periods with CRS and SRS

ERDC calculates certification periods by calculating anticipated income over a period of several months so the same amount of income is attributed to each month including the *initial month*. (Note: For FS, the initial month may differ – see FS F.8). When past income is not representative, the client and the worker jointly estimate future income using the best information available. Narrate the reason for the change in income and how the monthly figure was calculated. The anticipated monthly amount is used to determine program eligibility and the family's copay.

Change Reporting System (CRS)

CRS is assigned when there is a short-term child care need, the companion FS case is in TBA or there is no companion FS case.

Clients use the *Simplified Change Report* form (DHS 943) to report changes. They are not required to report income changes during the certification period unless it is a change in the source of income or rate of pay – see Reporting Requirements in section 7 below.

The certification period is limited to six months. It is not mandatory for clients to submit a report in order to keep receiving benefits when in the CRS.

Simplified Reporting System (SRS)

SRS is assigned when there is a companion FS case that is participating in SRS.

Clients use the *Simplified Change Report* (DHS 853) to report a limited number of changes – see Reporting Requirements in section 7 below. To continue receiving benefits in months seven through 12, the client must submit a completed *Interim Change Report* (DHS 852) in the sixth month of the FS certification period.

The ERDC case may continue to follow SRS requirements without a companion FS case in SRS only when:

- The ERDC case was certified in the fifth or sixth month of the FS certification period; **and**
- The companion FS case automatically closed because the *Interim Change Report* was not received.

Removing from SRS

When a worker closes the companion FS case, the ERDC case needs to be removed from SRS. Shorten the certification period if there are more than six months left (the certification period cannot be longer than six months when the ERDC case is not in SRS). Inform the client of their new reporting requirements and send the DHS 943 to report future changes.

Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060
Changes That Must be Reported: 461-170-0011

3. Processing the *ERDC Application, Reapplication, and Interim Change Report*

Initial Application

The initial certification period is set up based on income reported at the time of the initial application. After that, a system-generated DHS 7476 is sent to the client a few days before the beginning of the last month of the certification period. The client is asked to complete and return the review by the 10th of the last month of the certification period.

Application for Services (Food Stamps, Cash, Child Care, Medical, Domestic Violence) (DHS 415F), *Application for ERDC Program* (DHS 7470), and the *ERDC Reapplication and Food Stamp Application* (DHS 7476) ask clients to verify income received in the past 30 days and report what they currently receive. The intent is to use past income to help calculate a reasonably accurate estimate of future income.

When processing the DHS 415F and DHS 7470 applications, use the *Notice of Pending Status* (DHS 210) to give the ERDC applicant up to 45 days from the date of request to respond with needed verification. If verification is not received by the due date, send a denial notice to deny the application for ERDC.

When the client is approved for child care, send the client a *Notice of Reported Income* (DHS 7294) to show how the income was calculated and the copay amount.

☞ SEE CHILD CARE SECTION B FOR ADDITIONAL INFORMATION ON APPLICATION.

☞ SEE CHILD CARE WORKER GUIDE #3 – LISTING CHILD CARE PROVIDERS FOR PAYMENT.

Reapplication

For ongoing eligibility, a completed DHS 7476 is due by the 10th day of the last month of the certification period, and must be received no later than the last day of the month. If the DHS 7476 is not processed by compute deadline, the case is automatically closed – see note below.

If all eligibility requirements are met within 30 days of the close date, reopen the case effective the first day of the month following the close date. If the DHS 7476 is received without required verification or the form is incomplete, use the DHS 210 to notify the client what is needed and the date it is due. If required verification is not received by the due date, send a denial notice.

If the DHS 7476 or required verification is received after the end of the month following the certification period, treat it as a new application.

***Note:** When the certification date is not updated by compute deadline, the computer will automatically close the ERDC case and change the status to “AC” effective end of the month. A continuing benefit notice (CM 08A) is automatically sent by the computer prior to the end of the certification period to notify the client of the date benefits will end. If the client is receiving ERDC and medical, the case will be automatically converted from M5 to P2.*

Send an electronic connection request to DPU when reopening or restoring ERDC benefits to ensure a CCB is issued for that month.

Send the client a *Notice of Reported Income* (DHS 7294) to show how the income was calculated.

Interim Change Report (ICR)

During the sixth month of the certification period for cases using SRS reporting, the client must submit a completed *Interim Change Report* (DHS 852) to receive benefits in the seventh through 12th months.

When the DHS 852 has not been processed by the 15th day of the sixth month, the FSMIS system sends the client a notice advising them that they have until the end of the sixth month to submit the report, and if it is not received, ERDC and FS benefits will end. To prevent this notice from being sent when an ICR is received before the 15th of the month, process an ADJ action and change the “N” code to “H” in the form field on FSMIS.

When an incomplete DHS 852 is received, the worker sends a *Notice of Incomplete Report* (DHS 487) notifying the client of the information required.

Clients are not entitled to a 10-day notice if benefits go down based on changes on the DHS 852. Signing the DHS 852 waives the client's rights to 10-day notice when their benefits change. *An application can be used for processing at interim report as long as you also have the client sign a DHS 852.*

Use income information from the fifth month to project an accurate estimate for the remaining months of the certification period. This does not always mean using actual income. For example, income received on a weekly or biweekly basis must be converted to a monthly figure. Income received sporadically, such as child support, must be averaged or otherwise anticipated.

If a change in circumstance reported on the DHS 852 makes the client ineligible, send a closure notice specifying the reason. The closure notice for failure to complete the DHS 852 is not adequate.

If the ICR is not processed by compute deadline of the sixth month, the computer will automatically close ‘AC’ the case at the end of the month. If the client is receiving ERDC and medical, the case will be automatically converted from M5 to P2. If the ICR is not returned by the end of the seventh month, the client is no longer entitled to that month's benefits. Clients must reapply to receive benefits.

Send an electronic connection request to DPU when reopening or restoring ERDC benefits to ensure a CCB is issued for that month.

Send the client a *Notice of Reported Income* (DHS 7294) to show how the income was calculated.

Coding Work Hours

Code the monthly income amount and work hours on UCMS. Do not average the CC Work Hours. Instead, code the highest number of work hours anticipated for any one month during the certification period. For example, if the client anticipates working 103 hours in April, 156 in May and 98 in June, you would code 156 CC Wrk Hrs on UCMS.

Note: *When there is a companion Food Stamp (FS) case, the ERDC certification period should end at the same time.*

Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060
When a Re-application Form is Considered Complete or Not Received; ERDC: 461-170-0160
Notice Situation; Failure to Submit Report for APR, MRS, SRS, or ERDC Re-application: 461-175-0280
Effective Dates; Initial Month Benefits: 461-180-0070

4. Prospective Budgeting for ERDC

For ERDC, income is budgeted so the anticipated amount is the same for each month **including the initial month** - see OAR 461-150-0060.

When initial month income is significantly lower (i.e. zero), the initial month is still used to calculate an average for ERDC budgeting. When a client gets a new job, in most cases their initial month will be significantly lower compared to ongoing months. The number of months used to get an average will vary depending on the length of the eligibility period. See examples below.

Example 1: If the certification period is six months, add the total anticipated income for six months including the initial month and divide by six.

Example 2: An FS client in the third month of SRS applies for ERDC in March. The FS cert period expires in December with an Interim Change Report (ICR) due in June; use a four-month average to compute income for March - June. This income calculation will not match FS income. Remember to update FS income when income is verified upon receipt. At ICR, use the same calculation for both ERDC and FS for July – December.

Example 3: An FS client in the fifth month of SRS applies for ERDC in May. The FS cert period expires in December; use an eight-month average to compute income from May to December as an ICR would not be required for ERDC in this example.

If the client turns in the ICR for FS (due in June) and income reported on the ICR is different than the ERDC average on PCMS, update ERDC income at the same time as the FS income, since the income is *verified upon receipt*, for July - December.

☞ SEE MULTIPLE PROGRAM WORK GUIDE #22 TO DETERMINE TYPE OF INCOME AND BUDGETING EXAMPLES.

Prospective or Retrospective Eligibility and Budgeting; ERDC, FS, MAA, MAF, REF, REFM, TANF: 461-150-0060
Prospective Use of Stable Income: 461-150-0070
Prospective Budgeting: Annualizing Contracted or Self-employment Income: 461-150-0090

☞ SEE MULTIPLE PROGRAM WORK GUIDE #22 TO DETERMINE TYPE OF INCOME AND BUDGETING EXAMPLES.

Prospective Eligibility and Budgeting; ERDC: 461-150-0049
Prospective Use of Stable Income: 461-150-0070
Annualizing Contracted and Self-employment Income: 461-150-0090

5. Self-Employment Income for ERDC

The following is a brief description of how to treat self-employment income in the ERDC program. Self-employment income must be counted as income, but child care hours during self-employment time are not allowed. See Counting Client Assets, section C, for more details about allowable costs and a more complete description of self-employment income as it applies to all programs.

The self-employment income amount used to determine the client's copay is usually calculated by allowing a standard 50 percent deduction of the total gross amount received. This deduction is intended to cover the allowable costs of producing the income.

There are only two situations where the standard 50 percent deduction would not be used:

- If the client does not claim costs associated with producing self-employment income, do not allow a deduction.
- If the client can verify the actual cost of producing the income exceeds 50 percent of the total gross, a higher deduction can be used. The amount of the deduction is limited to costs that are verified and fit the definition of an allowable cost described in Section C of *Counting Client Assets*.

After subtracting the deduction, if any, from the gross self-employment income, what remains is used to determine the copay and is the amount to be coded as SLF on UCMS.

If the self-employment income was reported on the prior year's tax return and is a reliable indicator of current year income, the income is annualized **and** the prior year's return is used to determine income and deductions.

Self-Employment; Costs That Are Excluded To Determine Countable Income: 461-145-0920
Self-Employment; Determination of Countable Income: 461-145-0930

6. ERDC Certification Period Lengths and Coding with SRS

One- or Two-Month Certification Period – A one- or two-month ERDC certification period should be used only when it is reasonably certain the income and corresponding child care need will last two months or less, or when a shorter certification period is needed to match the certification date period of a companion OHP or Food Stamp case.

Three- to Six-Month certification period – Three- to six-month ERDC certification period should be used when the amount of income to be received in the certification period can be reliably predicted.

Twelve-Month certification period (used only with SRS) – A 12-month ERDC certification period is recommended when there is a companion FS case participating in SRS.

When there is an open companion FS case, align the ERDC certification end date. ERDC certification periods may be anywhere from one to 12 months when aligning end dates. Whenever appropriate, place the case in SRS. Keep in mind the DHS 852 is always sent out in month five of the FS certification period no matter when you are opening the ERDC case. See section 2 above for certifying for ERDC in the fifth or sixth month of the FS certification period.

Coding ERDC certification periods with SRS

An SRS case descriptor and SRS need resource (N/R) date is required for ERDC cases in SRS:

- When establishing a new ERDC certification period in months one through five of the FS cert period, the SRS N/R date on PCMS/CMUP should **match the Interim Change Report date** on FSUP.
- When establishing a new ERDC certification period in months five through 12 of the FS cert period, the SRS N/R date should **match the APR and FS end date**.

Simplified Reporting System (SRS); ERDC, FS: 461-170-0101
Anticipating With Periodic Review (APR); ERDC: 461-170-0150

7. Reporting Requirements and Changes

For cases in CRS

Cases in CRS must report the following changes within 10 days:

- A change in child care provider. The client will need a new listing form for the provider if the provider is not already listed. If the new provider is already listed for another client, this can be done electronically without a listing form.
 - ☞ SEE CC WG#3 FOR EXCEPTIONS FOR EXEMPT CENTERS.
 - ☞ SEE “HOW TO USE THE ELECTRONIC PROVIDER CONNECTION FORM” IN THE *LISTING CHILD CARE PROVIDERS WORKER GUIDE (CC WG#3.3)*.
- A change in employment status. This includes getting a new job or losing a job.
- A change in mailing address or residence.
- A change in membership of the filing group. Filing group changes that result in a reduced copay should be acted on for the following month. If the change results in increased copay, the change should be acted on for the following month only if there is adequate time for a *timely continuing benefit decision notice*.
- A change in source of income expected to continue. This includes a change in hourly or monthly rate of pay or starting to receive other income such as child

support. This does not include changes in the number of hours worked or one-time payments that will not continue such as an unanticipated bonus.

Caution: Clients will need to report changes required in other programs. If there is a companion FS case in CRS and a reported change will affect the Food Stamp benefit amount, an adjustment of FS income is required. Failure to act on the change would result in an FS payment error.

For cases in SRS

Cases in SRS must report the following changes by the 10th day of the month following the month of occurrence:

- A change in child care provider.
- A change in mailing address.
- Monthly income exceeding the FS countable income limit (FS-F.2).
- Loss of employment.
- A parent of a child or unborn or the spouse of the caretaker moves into the residence.

Act on all changes that are required to be reported for SRS or if the change reported is considered *verified upon receipt*. Changes that are not required to be reported and are not *verified upon receipt*, need to be narrated and acted on at *Interim Change Report* or the next recertification, whichever is earlier.

Reported information is considered “*verified upon receipt*” when the information is not questionable and the provider of information is the primary source. Income changes cannot be verified by the client statement alone.

☞ SEE FS F.8 – “SIMPLIFIED REPORTING SYSTEM” FOR MORE FS PROGRAM INFORMATION.

Changes and Considerations

Whether required to or not, if a client reports a change in income that is expected to continue, and will affect the future average, the worker needs to decide whether or not to take action on the ERDC case. ERDC allows for some discretion on the part of the case worker. The decision must be clearly narrated. The ERDC certification period should be shortened or the income recalculated over the remaining months of the period if this will make a significant difference in the copay.

The decision to adjust ERDC income should take into account the ability of the family to pay the current copay if it is not reduced, or an increased copay if income has gone up. Other considerations include the value of keeping the copay amount stable, cost to the

program when no adjustment is made for increased income, and workload involved if a family repeatedly requests adjustments for minor income fluctuations.

If the adjustment will result in decreased benefits (an increased copay), notice requirements apply. For example, if a client reports a raise on the 22nd of the month, no adjustment would be made until after the end of the following month, to allow for a timely notice. If the ERDC certification period ends in the meantime, no adjustment would be made. Instead, the new information would be used in calculating the average income for the next ERDC certification period.

Occasionally, an adjustment may require canceling and reissuing a *Child Care Billing* (CCB) form. This can occur only if the reissued CCB will result in an increase in benefits.

☞ FOR INFORMATION ON CANCELING AND REISSUING CCBS, SEE SECTION CC-H, *PAYMENT PROCESS*.

Specific Requirements; ERDC: 461-135-0400
Changes That Must be Reported: 461-170-0011
Simplified Reporting System (SRS); ERDC, FS: 461-170-0101
Actions Resulting From Changes in Household Circumstances; Simplified Reporting System (SRS); ERDC, FS: 461-170-0103
Anticipating With Periodic Review (APR); ERDC: 461-170-0150

8. ERDC Income Quick-Reference Chart

This chart does not include treatment of resources because there are no resource limits for the ERDC program.

Type of Income	Exclude	Count as Earned	Count as Unearned
Adoption Assistance (461-145-0001)	X		
Annuities, Dividends, Interest (461-145-0020)			X
Child Support and Cash Medial Support (461-145-0080)			X
Contributions (461-145-0086)			X
Disability Benefit received monthly or more frequently (461-145-0090)			X
Disaster Relief (461-145-0100)	X		
Domestic Volunteer Services Act -VISTA (461-145-0110)	X	X (applicant)	
Earned Income (461-145-0130) <ul style="list-style-type: none"> • Earned income of children • Earned income of adults in filing group 	X	X	
Earned Income Credit (461-145-0140)	X		
Educational Income (461-145-0150) <ul style="list-style-type: none"> • Title IV and BIA • Non-title IV or BIA (remainder after deducting costs) 	X X (actual payment)		
Energy Assistance (461-145-0170)	X		
Food Programs - WIC & School Lunch (461-145-0190)	X		

Type of Income	Exclude	Count as Earned	Count as Unearned
Foster Care (461-145-0200) <ul style="list-style-type: none"> In filing group Not in filing group 	X	X	
Gifts and Winnings (cash) (461-145-0210)	X		
HUD (461-145-0230) <ul style="list-style-type: none"> Paid to member of financial group Youth build 	X	X	
Income-Producing Contract (461-145-0240) <ul style="list-style-type: none"> Income (minus costs) 		X	
Independent Living subsidies (461-145-0255)	X		
Indian/Native American Benefits (461-145-0260)	X		
Individual Education Account (461-145-0145) (while it accumulates, is kept, and withdrawn for education)	X		
Inheritance (cash) (461-145-0270)	X		
In-Kind Income (461-145-0280) <ul style="list-style-type: none"> Earned Unearned 	X	X	
Job Corps (461-145-0290)		X	
JTPA (461-145-0300) <ul style="list-style-type: none"> Needs-based stipend OJT and work experience 		X	X
Life Insurance payments to beneficiary (461-145-0320)			X (allow up to \$1500 for costs)
Loans - Interest from loan being repaid to client (461-145-0330)			X
Lodger income (461-145-0340)		X (self-empl)	
National and Community Services Trust Act (461-145-0365) <ul style="list-style-type: none"> Child care allowance when client pays provider Child care allowance when client does not pay provider NCSTA payment if not paid to caretaker of children NCSTA payment if paid to caretaker of children 	X X	X	X
Older Americans Act (461-145-0370)	X		
Pension and Retirement Plans paid monthly (461-145-0380)			X
Personal Injury Settlement (461-145-0400)	X		
Program Benefits (461-145-0410) <ul style="list-style-type: none"> Paid directly to client ADC-EA dual payee or paid to provider 	X		X
Radiation Exposure Compensation Act (461-145-0415)	X		
Refunds (461-145-0435)	X		
Reimbursements (461-145-0440) <ul style="list-style-type: none"> Noncash or used for specific item Non-DHS ICCP reimbursement for child care 	X		X
Annuities; Not OSIPM (461-145-0020) <ul style="list-style-type: none"> Royalties Doing activity to accrue royalties Not doing the activity 		X	X
Self-Employment (461-150-0090)		X	
Social Security Benefits (461-145-0490)			X
Spousal Support (461-145-0505)			X
Supplemental Security Income (SSI) (461-145-0510)			X
Strikers' Benefits (461-145-0525)			X
Unemployment Compensation (461-145-0550)			X
Uniform Relocation Act reimbursement (461-145-0560)	X		

Type of Income	Exclude	Count as Earned	Count as Unearned
USDA Meal Reimbursement (461-145-0570) <ul style="list-style-type: none"> • Paid to provider • For a financial group's children 		X (self)	X
Veterans' Benefits (461-145-0580) <ul style="list-style-type: none"> • Aid and Attendance • Spina Bifida Payments to Children • Other monthly payments 	X X		X
Victim's Assistance (461-145-0582)	X		
Vocational Rehabilitation Payment (461-145-0585) <ul style="list-style-type: none"> • Payments for food/shelter/clothing (for other see Reimbursement) 			X
Worker's Compensation (461-145-0590)		X	

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F. Child Care Need, Copay, and Provider Rates

1. Intent

Child care need is defined as the gap between what resources the family has vs. what resources the family needs to maintain safe, dependable child care that supports children’s development and family self-sufficiency.

This policy is intended to define under what circumstances a family needs help with child care expenses to close this gap. The family’s financial and nonfinancial resources should be considered available to meet this need. For example, if there is another responsible adult in the household, the availability and suitability of the other adult to provide care needs to be explored. If the child is school-age, child care would ordinarily not be needed during school hours. Families should be encouraged to explore potential income, such as child support or tax credits, to help pay the child care expense.

Child care need also means that the care is necessary to maintain employment or participate in self-sufficiency activities. For child care related to employment, this means the nature of the parent’s work makes it necessary that someone else care for the child during working hours. Ordinarily, there is no child care need if the caretaker works at home and can care for their own child without significantly affecting their work.

For example, a resident apartment manager whose main duties consist of answering the phone and collecting rent would not generally require child care. Likewise, self-employed child care providers do not generally require child care for their own children. A reason many people become providers in the first place, is that it allows them to care for their own children and earn an income at the same time. They do not typically pay child care for their own children in order to care for other children.

Dependent Care Costs; Deduction and Coverage: 461-160-0040 |

2. Child Care Need; Requirement To Be Employed or in Self-Sufficiency Activities

DHS can help pay child care expenses only for persons who are *employed* or participating in DHS-approved *self-sufficiency activities*. The ERDC program is used only for clients not receiving TANF, unless the adult is not included in the TANF benefit group.

☞ SEE CONCURRENT TANF/ERDC BENEFIT GROUP MEMBERSHIP IN SECTION C OF THE CHILD CARE CHAPTER (CC C.4).

Employment normally means work that results in earned income. This includes paid work experience and paid practicum assignments. For ERDC, this includes work study. *Employment* for the purpose of ERDC does not include self-employment.

Self-sufficiency activities include Pre-TANF Program, JOBS Program and retention and activities approved by DHS. The activities should be specified in a written case plan mutually agreed on by the client and DHS or partner staff.

Child care for retention activities can be covered by the ERDC program as long as the client is primarily an employee rather than a student. As a general rule, clients enrolled in enough credit hours to qualify for financial aid are considered students and their class hours cannot be covered by the ERDC program.

Allowable need includes circumstances where an ERDC client loses a job and needs child care to look for another job. If there is an outstanding Child Care Billing (CCB) form, it can be used to pay for job search child care hours and a JOBS payment may be issued to cover the copay. This needs to be approved by branch staff and would not extend into the following month. If still unemployed in the following month, child care should be authorized in the Pre-TANF or JOBS Program.

Specific Requirements; ERDC: 461-135-0400
Dependent Care Costs; Deduction and Coverage: 461-160-0040
Standards for Support Service Payments: 461-190-0211
Special Payments; OFSET: 461-190-0360

3. **Child Care Need; Number of Allowable Child Care Hours**

The number of allowable child care hours is limited by the monthly maximum rate described in *Provider Rate Limits* unless extra hours are authorized by the worker.

☞ SEE CHILD CARE NEED; AUTHORIZING A HIGHER LIMIT FOR EXTRA HOURS IN THIS SECTION, (CC F.4).

DHS will help pay for the number of child care hours, up to the monthly maximum rate, necessary for caretakers to maintain their job or participate in approved activities. The system adds 25 percent to the hours coded by the worker on UCMS or JAS, to account for travel and meal time.

DHS will not help pay for child care hours when free care is available, such as during school hours for school age children who are able to attend school. DHS will not pay for child care hours during the time the client or the second parent is self-employed. Clients who are only self-employed are not eligible to receive child care benefits.

In a two-parent household, the second parent is ordinarily considered available to provide child care, unless both parents are at work or participating in DHS-approved activities during the same hours, or the second parent is physically or mentally unable to provide adequate care. The inability of the second parent to provide adequate care must be documented.

For a client who earns less than state minimum wage, determine the number of allowable child care hours by dividing countable income by the Oregon minimum wage. The resulting figure is the maximum number of hours that can be coded on the computer not

to exceed 172 hours. For persons in the start-up phase of employment that does not pay an hourly wage or salary such as working on commission, the number of allowable child care hours can be up to full time for the initial three months. Workers will need to determine, with the client, how many child care hours are needed.

Specific Requirements; ERDC: 461-135-0400
Age Requirements for Clients to Receive Benefits: 461-155-0150
Dependent Care Costs; Deduction and Coverage: 461-160-0040

4. Child Care Need; Authorizing a Higher Limit for Extra Hours

DHS can help pay for hours when the child care need is greater than work hours plus 25 percent. For part-time employment, additional hours can be authorized up to the monthly maximum by increasing the number of hours coded on UCMS. For full-time employment that requires more than 215 hours of care per month, the worker can authorize an additional amount above the monthly maximum limit. This is capped at 50 percent above the monthly maximum and is limited to the following situations:

- The commute time to and from work exceeds two hours per day.
- The caretaker works an overnight shift and care is necessary for both work hours and sleep hours. This would ordinarily not apply during the school year for school age children.
- The caretaker works a split shift and it is not feasible to care for the child between shifts.
- The caretaker consistently works more than 40 hours a week.
- Weekend work or other non-standard work hours require care by more than one provider, and the total of the allowable hours billed by both providers exceeds the maximum limit. For example, a provider caring for a child four days during the week may appropriately bill for full-time care. If another provider provides care on a Saturday, these additional hours exceed the limit.
- The caretaker needs child care for both full-time work and participation in DHS-assigned activities.
- There may be other unique circumstances where the caretaker's work schedule clearly requires that additional hours be authorized. The circumstances must be related to job retention and documented in the case file.

Take the following actions to authorize additional hours on the system:

- Enter an EXH case descriptor and EXH need/resource entry on UCMS coded to the payee.

- Match the end date of the EXH need/resource entry to the ERDC certification end date. The need for the additional hours should be reviewed with each re-application.
- Enter the **actual number of child care hours the client needs, up to a maximum of 323 hours**, in the CC WRK HRS field. The EXH code will override the usual 1.25 calculation. The number of hours entered in this field will appear on the billing form and determine the maximum dollar limit on the provider pay system.

The computer will calculate the additional authorized amount by dividing the number of hours on UCMS by 215, and multiplying that result by the regular monthly maximum.

Example: The parent rides the bus to work and has to transfer several times. It takes her three hours a day to travel from the provider's house to work and back again. She works eight hours a day and is required to take a one-hour lunch break, so she needs 12 hours of care per day. Her provider's normal schedule is from 7AM to 6PM, so there is an extra charge for care outside those hours. The worker calculates 12 hours X 22 days = 264, codes EXH, and enters 264 hours on UCMS. The computer divides 264 by 215 = 1.23 and increases the maximum limit by 23 percent.

Example: A parent works an overnight shift and needs care for his pre-school children for both work hours and sleep hours, a total of 17 hours per day. The worker calculates 17 hours X 22 days = 374. Since UCMS will accept no more than 323 hours, the worker enters 323 in the CC wrk hrs field. The computer divides 323 by 215 = 1.50 and increases the maximum limit by 50 percent.

Example: The parent's work schedule includes both weekday and weekend hours and she is not able to find a provider for both weekday and weekend care. She usually needs about 150 hours of weekday care per month and 60 hours per month on the weekends. Her weekday provider is eligible for the enhanced rate and is appropriately billing for full-time care. The worker adds 60 to 215 = 275, enters the EXH codes, and enters 275 in the CC WRK HRS field. The computer divides 275 by 215 = 1.27 and increases the maximum limit by 27 percent.

5. Child Care Need; Billing for Absent Days

DHS can pay for up to five days when a child is absent from care under the following circumstances:

- The child was scheduled to be in care on the absent days and the provider held the slot open for the child.

- The provider bills for the scheduled time the child was absent.
- It is the provider's policy to bill all families for absent days.

DHS will not pay for more than five consecutive absent days of scheduled care that continue from one month to the next, when the child does not return in the second month.

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150
Dependent Care Costs; Deduction and Coverage: 461-160-0040
Standards for Support Service Payments: 461-190-0211

6. Child Care Need; Older Children and Children with Special Needs

Older children (for ERDC, ages 12 through 17, and for all other programs, ages 13 through 17) can be eligible for payment of child care costs if DHS determines that the child should not be left unsupervised during the hours the parent is working or participating in self-sufficiency activities. This determination must be verified by one of the following:

- A verbal or written statement by a physician, nurse practitioner, psychologist, social worker, school counselor, or other qualified professional who is familiar with the child.
- Eligibility for SSI.
- Under court supervision.
- Receiving foster care payments.
- Other unique circumstances where the child's safety or the caretaker's ability to work or participate in assigned activities will be significantly compromised if child care is not authorized. For example, child care might be necessary for an older child whose parent works an overnight shift (in these circumstances, narration would be sufficient documentation).

To authorize payment for an older child, an SNA need/resource entry is required on UCMS.

A child, age newborn through 17 years old with special needs, is a child who requires a level of care over and above the norm for their age due to a physical, behavioral, or mental disability. The disability should be verified by one of the following:

- A physician, nurse practitioner, psychologist or clinical social worker.
- Eligibility for Early Intervention and Early Childhood Special Education Programs or school-age Special Education Programs.
- Eligibility for SSI.

The need for a higher level of care is determined by the provider and should be verified by the provider's statement on the *Special Need Child Care Rate Request* (DHS 7486) form. A new DHS 7486 should be completed when the provider changes, or at least once every 12 months. To authorize a higher payment, an SNR need/resource entry is required on UCMS.

Age Requirements for Clients to Receive Benefits: 461-120-0510
Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150

Note: *An older child with special needs, coded with an SNR need/resource code, does not also need an SNA need/resource code.*

7. Child Care Need; Supplementing for Very High Needs

In some rare cases, the special needs rate does not adequately cover the cost of caring for children who have very high needs and require a much higher level of care than other children of the same age. This includes, but is not limited to, children diagnosed as having extreme developmental delays, very high medical needs, severe physical limitations, autism or profound mental health issues.

For these children, DHS can pay an additional amount above the special needs rate. The amount of this payment is determined by how much additional care the child requires. The upper limit for the additional payment is \$5.00 an hour, up to \$840.00 per month. To qualify, the child must be eligible for the special needs rate as described in "Child Care Need; Older Children and Children with Special Needs" (CC F.6) in this section. In addition, the child must be enrolled or in the process of being enrolled with Early Intervention, Early Childhood Special Education or school-age Special Education programs, unless it is determined by a professional working with the child that enrollment is not appropriate.

The determination that it may cost an additional amount to care for a child with very high needs is made by one or more High Needs Specialists in each district. Staff who become aware of children with high needs in their caseloads should discuss the case with the specialist in their area. The district office will know who this is. If appropriate, the specialist will refer the case to the Inclusive Child Care Program to meet with the parent and the child care provider to assess the need for a higher payment level. This assessment must be supported by medical documentation.

Note: *The computer support for calculating the higher payment is not in place at this time. The High Needs Specialists have received instructions for calculating the supplemental payment by hand and paying through the special pay process.*

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150

8. Child Care Need; Copay Less Than DHS Payment Rate

The fact that a family's income may be less than the ERDC income standard does not always mean they are financially eligible for ERDC. Eligibility also depends on the maximum amount DHS will pay. Especially for families whose income is just under the maximum limit, the copay may be more than what DHS will pay. If so, the family is not eligible.

- Determine the copay amount by entering the client's monthly income amount and number of persons in the ERDC filing group using the internet copay calculator. (See "Determining the Copay," (CC F.12), in this section.)
- Determine how much DHS will pay based on area, the age of the child(ren), estimated hours of care, and type of care the family is using. (See "Child Care Rate Charts," (CC F.21), in this section.)
- If the family's copay is higher than the rate DHS will pay, the family is not eligible.

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150 |

9. Copay Requirement; Intent

The copay represents the financial investment the parent (or caretaker) makes in the care provided to their children. This investment increases as the family's income increases, but should remain affordable to support continued employment. The copay structure should encourage families to seek higher wages and better jobs. Increased income should not be canceled out by a higher copay and the loss of other benefits, such as food stamps.

The copay is also a means of allocating available program funds to families who need help the most.

10. Requirement to Pay Copay or Make Satisfactory Arrangements

For ERDC, the caretaker is responsible for paying the copay to the provider or making satisfactory arrangements with the provider to pay it. Satisfactory arrangements can include bartering or income in-kind. For example, a parent may provide child care for a provider's children instead of paying the copay. The parent and provider should be encouraged to put this agreement in writing and the parent should receive a receipt when the provider is paid, whether the payment is cash or in kind.

If the client has more than one provider, the copay should be paid to the one who provides the most care. This provider is called the *primary provider* – the other(s) are called the *secondary provider(s)*. If the copay exceeds the billed amount, DPU may change the primary provider designation or split the copay on future billing forms among all the providers who bill for care.

For families transitioning from TANF to ERDC, there is no copay the first month of ERDC eligibility if a billing form was already sent to the provider showing a zero copay.

If a provider indicates on the CCB that a client did not pay the required copay or make satisfactory arrangements to pay it, DPU will end benefits and send a closing notice as soon as timely notice requirements allow. DPU also codes a copay not met (CNM) case descriptor on UCMS and an “N” is coded in the copay met field on DPCS. If the client later requests ERDC, there is no eligibility until past copays are paid or satisfactory arrangements are made with the provider.

The period of ineligibility ends in either of the following circumstances:

- On the first day of the month in which the client makes the copayment or makes satisfactory arrangements with the provider; or
- On the first day of the month after three years have lapsed from the date the client failed to make payment.

The provider has up to 60 days after the CCB is processed to notify DHS that the copay or satisfactory arrangements have not been made. If not reported within 60 days, DHS will consider the copay requirement met.

Requirement to Make Copay or Satisfactory Arrangements; ERDC: 461-135-0415

11. Determining When Payment Arrangements Are Satisfactory

If an ERDC case has been closed because of an unmet copay, it can be reopened under any of the following circumstances:

- The provider agrees that the copay has been met or that satisfactory arrangements have been made.
- The client submits evidence that payment has been made, such as a receipt or canceled check.
- The client verifies the debt was discharged by a bankruptcy filing.
- The client has attempted to pay the provider but the provider refuses payment. This can occur when the copay is part of a larger bill that includes charges above the maximum rates. The case can be reopened if the client presents evidence of an attempt to pay the entire copay.
- The client attempts to pay the provider, but the provider cannot be located.

The effective date for reopening the case is the first of the month in which the copay requirement was met.

Example 1: Julie reapplies on August 15. On September 5, the worker receives verification that the copay was met on August 25. If all other eligibility factors are met for August, the case would be reopened effective August 1.

Example 2: Dan's case closed September 30 because he did not pay the August copay. Dan paid the August copay December 10. If all other eligibility factors are met, the case would be reopened effective December 1. There is no eligibility for October or November because the copay was not paid in those months.

Requirement to Make Copay or Satisfactory Arrangements; ERDC: 461-135-0415 |

☞ REFER TO THE PROCESSING UNMET COPAYS WORKER GUIDE, (CC WG#5), AT THE END OF THIS CHAPTER FOR DETAILED INFORMATION ON HOW TO PROCESS UNMENT COPAYS.

12. Determining the Copay

The copay is calculated by a mathematical formula that gradually increases the copay as family income increases. The maximum income limit is 185 percent of the Federal Poverty Level (see chart below). This calculation is available on the Children, Adults, and Families - Self-Sufficiency Programs Web page and can be accessed by going to <http://www.oregon.gov/DHS/children/childcare/main.shtml> and then clicking on "Copay Estimate."

To determine the correct copay amount, enter the number of persons in the ERDC benefit group in the *Choose Family Size:* field. Make sure to include all adult members of the filing group as well as older children who do not need child care.

Enter the monthly income amount (as described in Section E) in the *Enter Monthly Income* field. Click on *Calculate*. The copay amount will appear in the *Estimated Copay Amount* field. If the client is over the income standard, the screen will say *Income Exceeds Eligibility For Child Care Services*.

Hint: *Once you have brought up the copay calculation program pages, you can add it to your Internet Explorer Favorites list: click on "Favorites" in the upper toolbar, then click on "Add to Favorites," then click on which folder to put it in, then click on "OK." Also, once it is up, you can minimize it, rather than close, when you are finished with it. To use it again that same day, click on the lower toolbar and it will come up immediately.*

ERDC Gross Monthly Income Limit

# in ERDC Group	Gross Income Limit (185 percent of 2009 FPL)
2	\$2,247
3	\$2,823
4	\$3,400
5	\$3,976
6	\$4,553
7	\$5,130
8 or more	\$5,706

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150(9)

13. Provider Rate Limits; Intent

The limits established in the rate tables are intended to reflect the rates charged by most providers in the community. DHS uses a market rate survey based on what providers report to CCR&Rs throughout the state to determine this level. Parents receiving DHS child care assistance should have access to the same types and quality of care that is available to the majority of other parents in the community who use child care. The rate structure is intended to facilitate this access.

DHS provider rates are also structured to improve the quality of care available to DHS clients by offering an incentive to providers to obtain additional training. Providers who meet established training requirements can be paid at a higher rate and have access to billing options that more accurately reflect the market practices of the professional provider community.

14. Provider Rate Limits; Standard, Enhanced, and Licensed

There are three levels of rate limits: standard rate, enhanced rate and licensed rate. Providers who are not registered or certified by the Child Care Division or do not meet the qualifications for the enhanced rate qualify for the standard rate. Providers can qualify for the enhanced rate by meeting established training requirements. Providers can qualify for the licensed rate by becoming registered or certified by the Child Care Division. The differences between the three rate limits are:

- The enhanced and licensed rate definition of full-time care is 136 hours or more in the month. There is also an additional billing option of a part-time monthly rate.
- The standard rate definition of full-time care is 158 hours or more in the month. The part-time monthly billing option is not available for providers who qualify for the standard rate.

- ☞ FOR MORE DETAILED INFORMATION, SEE PROVIDER RATE LIMITS; HOURLY, PART-TIME MONTHLY, AND FULL-TIME MONTHLY RATES (CC F.17) BELOW.

15. Provider Rate Limits; Qualifying for the Enhanced Rate

Child Care Division (CCD) certified centers, registered, and certified families automatically qualify for the licensed rate because registration and certification training requirements meet or exceed the DHS enhanced rate requirements.

Family and in-home providers and staff of centers exempt from certification rules will qualify for the enhanced rate by working with the *Oregon Registry*. This program is part of the *Oregon Center for Career Development in Childhood Care and Education* located at Portland State University. Providers who meet their entry level requirements will qualify for the enhanced rate. Exempt centers will need to have at least one staff member who meets these standards for every 20 children in care. To qualify, the provider or staff person must:

- Have completed at least two hours of training on child abuse and neglect issues;
- Be currently certified in first aid;
- Be currently certified in infant and child CPR;
- Have a current food handlers permit; and
- Agree to complete a minimum of eight hours of additional training related to child care every two years.

Family providers who want to earn the enhanced rate will send copies of their training certificates and a one-page application to the Oregon Registry office. The Oregon Registry office will notify DHS when the provider qualifies, and future billing forms will be coded to authorize the enhanced rate.

Family providers who apply for CCD registration, do not need to make a separate application to the Oregon Registry office, if they choose not to. Once registration is approved, CCD notifies the Oregon Registry office and DHS.

Because many exempt centers are before and after school programs where the need for the part-time rate is the greatest, these centers will be given a one-time six-month grace period for staff to receive the necessary training. They can receive the enhanced rate during these six months by sending an application to the DHS Direct Pay Unit. The application asks for an assessment of current staff training levels and asks the director to sign a declaration that designated staff will achieve Oregon Registry entry level status within six months. Once this application is received, billing forms for the next six months will be coded to authorize the enhanced rate. If the necessary number of staff do not qualify by the end of the six-month period, the center will no longer qualify for the enhanced rate and will receive the standard rate instead.

16. Provider Rate Limits; Hourly, Part-time Monthly, and Full-time Monthly Rates

Providers eligible only for the *standard* rate will be paid at either the hourly or full-time monthly rate:

- The hourly rate limit applies when children are in care less than 158 hours per month.
- The full-time monthly rate limit applies when children are in care 158 hours or more per month.

Providers eligible for the *enhanced* or *licensed* rate will be paid at the hourly, part-time monthly or full-time monthly rates.

- The hourly rate applies when children are in care less than 136 hours per month, *unless* the provider has an established part-time monthly rate and charges all families part-time rate for part-time care.
- The part-time monthly rate applies if the provider has an established part-time monthly rate and children are in care between 63 and 135 hours per month. For these providers, the hourly rate applies when children are in care less than 63 hours a month.
- The full-time monthly rate applies when children are in care 136 or more hours per month.

| Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150

17. Provider Rate Limits; JOBS Exceptions to the Hourly Billing Requirement

If a child is usually in care less than 158 hours for the standard rate, or 136 hours for the enhanced or licensed rate, the provider cannot be paid at the full-time monthly rate. An exception can be made for clients participating in assigned JOBS activities in the following circumstances if the case manager determines there is no reasonable alternative:

- Appropriate care is not accessible to the participant at the hourly rate. For example, if a JOBS participant needs only 120 hours of care each month, but lives in a rural area where the only child care available charges by the full month only, the full-time monthly rate can be authorized.
- The participant is a teen parent using on-site care while attending educational activities and the provider is holding a slot open for the teen parent's child.

| Standards for Support Service Payments: 461-190-0211

18. Provider Rate Limits; Age and Special Needs Categories

The maximum allowable rate is determined in part by age or special needs of the children in care. The age categories on the provider rates charts are as follows:

- Infant: A child age Newborn to 1 year.
- Toddler: A child age 1 year to 3 years.
- Preschool: A child age 3 years to 6 years.
- School-age: A child age 6 years and older.
- Special Needs: A child who requires a higher level of care than what is usually required for their age due to a physical, behavioral or mental disability.

☞ SEE CHILD CARE NEED; OLDER CHILDREN AND CHILDREN WITH SPECIAL NEEDS (CC F.6) IN THIS SECTION.

Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150 |

19. Provider Rate Limits; Types of Child Care Providers

Allowable rates vary depending on the type of child care provided. The following describes the types of care listed in the child care rates charts.

- The *Standard Family Rate* applies to child care provided in the provider's own home or in the home of the child when the provider does not qualify for the enhanced or licensed rate described in this chapter.

☞ SEE PROVIDER RATE LIMITS; QUALIFYING FOR THE ENHANCED RATE (CC F.16) FOR MORE INFORMATION.
- The *Standard Center Rate* applies to child care provided in a facility that is not located in a residential dwelling, is exempt from Child Care Division certification rules and whose staff do not meet the requirements for the enhanced rate.
- The *Enhanced Family Rate* applies to child care provided in the provider's own home or in the home of the child, and the provider qualifies for the enhanced rate.
- The *Enhanced Center Rate* applies to child care provided in an exempt center whose staff meets the training requirements of the Oregon Registry entry level established by the Oregon Center for Career Development in Childhood Care and Education.
- The *Certified Family Rate* applies to child care provided in a residential dwelling that is certified by the Child Care Division as a *Certified Family Home*. To earn

this designation, the facility must be inspected, and both provider and facility are required to meet certain standards not required of a registered family provider.

| Child Care Eligibility Standard, Payment Rates, and Copayments: 461-155-0150

20. Provider Rate Limits; Child Care Rate Charts

The following are the child care rate charts. Because the market rate survey found that rates providers charged were higher in some areas of the state than in others, the state was divided into three areas, with a separate chart for each area. The zip code of the provider determines which chart to use. (Out-of-state providers use Group Area C.)

DHS Child Care Maximum Rates

Group Area A

STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate (FAM)		Standard Center Rate (NQC)	
	1-157 Hourly	158-215 Monthly	1-157 Hourly	158-215 Monthly
Infant	\$2.64	\$493	\$3.53	\$675
Toddler	\$2.64	\$466	\$3.41	\$671
Preschool	\$2.64	\$440	\$2.89	\$529
School	\$2.64	\$436	\$3.23	\$524
Special Needs	\$2.64	\$493	\$3.53	\$675

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate (QFM)			Enhanced Center Rate (QEC)		
	1-62 Hourly	63-135 Part-time	136-215 Monthly	1-62 Hourly	63-135 Part-time	136-215 Monthly
Infant	\$2.85	\$399	\$532	\$3.83	\$574	\$765
Toddler	\$2.85	\$378	\$504	\$3.65	\$570	\$760
Preschool	\$2.85	\$356	\$475	\$3.27	\$449	\$599
School	\$2.85	\$353	\$470	\$3.66	\$445	\$593
Special Needs	\$2.85	\$399	\$532	\$3.83	\$574	\$765

LICENSED RATE MAXIMUMS

	Registered Family Rate (RFM)			Certified Family Rate (CFM)			Certified Center Rate (CNT)		
	1-62 Hourly	63-135 Part-time	136-215 Monthly	1-62 Hourly	63-135 Part-time	136-215 Monthly	1-62 Hourly	63-135 Part-time	136-215 Monthly
Infant	\$3.00	\$420	\$560	\$4.25	\$645	\$860	\$4.50	\$675	\$900
Toddler	\$3.00	\$398	\$530	\$4.00	\$559	\$745	\$3.90	\$671	\$894
Preschool	\$3.00	\$375	\$500	\$4.00	\$516	\$688	\$3.85	\$529	\$705
School	\$3.00	\$371	\$495	\$4.00	\$450	\$600	\$4.30	\$524	\$698
Special Needs	\$3.00	\$420	\$560	\$4.25	\$645	\$860	\$4.50	\$675	\$900

Zip Codes for Group Area A:
Portland, Bend, Eugene, Corvallis, Springfield, Monmouth, and Ashland areas.

97004	97005	97006	97007	97008	97009	97010	97013	97015	97019	97022	97023
97024	97027	97028	97030	97031	97034	97035	97036	97041	97045	97055	97060
97062	97064	97068	97070	97080	97086	97106	97109	97112	97113	97116	97119
97123	97124	97125	97132	97133	97135	97140	97149	97201	97202	97203	97204
97205	97206	97209	97210	97211	97212	97213	97214	97215	97216	97217	97218
97219	97220	97221	97222	97223	97224	97225	97227	97229	97230	97231	97232
97233	97236	97239	97242	97258	97266	97267	97268	97292	97330	97331	97333
97339	97351	97361	97371	97376	97401	97402	97403	97404	97405	97408	97454
97455	97477	97478	97482	97520	97525	97701	97702	97707	97708	97709	

Group Area B

STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate (FAM)		Standard Center Rate (NQC)	
	1-157	158-215	1-157	158-215
	Hourly	Monthly	Hourly	Monthly
Infant	\$2.20	\$400	\$2.96	\$473
Toddler	\$2.20	\$396	\$2.91	\$467
Preschool	\$2.20	\$374	\$2.34	\$356
School	\$2.20	\$352	\$2.34	\$345
Special Needs	\$2.20	\$400	\$2.96	\$473

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate (QFM)			Enhanced Center Rate (QEC)		
	1-62	63-135	136-215	1-62	63-135	136-215
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	\$2.38	\$324	\$432	\$3.17	\$380	\$506
Toddler	\$2.38	\$321	\$428	\$3.11	\$375	\$500
Preschool	\$2.38	\$303	\$404	\$2.65	\$303	\$404
School	\$2.38	\$285	\$380	\$2.65	\$293	\$391
Special Needs	\$2.38	\$324	\$432	\$3.17	\$380	\$506

LICENSED RATE MAXIMUMS

	Registered Family Rate (RFM)			Certified Family Rate (CFM)			Certified Center Rate (CNT)		
	1-62	63-135	136-215	1-62	63-135	136-215	1-62	63-135	136-215
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	\$2.50	\$341	\$455	\$3.00	\$371	\$495	\$3.60	\$446	\$595
Toddler	\$2.50	\$338	\$450	\$3.00	\$345	\$460	\$3.52	\$431	\$575
Preschool	\$2.50	\$319	\$425	\$3.00	\$338	\$450	\$3.12	\$356	\$475
School	\$2.50	\$300	\$400	\$2.65	\$375	\$500	\$3.12	\$345	\$460
Special Needs	\$2.50	\$341	\$455	\$3.00	\$371	\$495	\$3.60	\$446	\$595

Zip Codes for Group Area B:
Salem, Medford, Roseburg, Brookings, and areas outside
the metropolitan areas in Eugene and Portland.

97002	97011	97014	97017	97038	97042	97044	97048	97049	97051	97053	97056
97058	97067	97071	97103	97107	97108	97110	97111	97114	97115	97117	97118
97122	97127	97128	97131	97134	97138	97141	97143	97146	97148	97301	97302
97303	97304	97305	97306	97307	97309	97310	97317	97321	97322	97325	97326
97327	97336	97338	97341	97343	97344	97348	97352	97355	97357	97362	97365
97366	97367	97370	97372	97374	97377	97378	97380	97381	97383	97385	97386
97389	97391	97415	97420	97423	97424	97426	97431	97444	97446	97448	97452
97456	97465	97470	97487	97489	97501	97502	97503	97504	97524	97534	97535
97756	97759	97760	97801	97812							

Group Area C

STANDARD RATE MAXIMUMS (Not Licensed)

	Standard Family Rate (FAM)		Standard Center Rate (NQC)	
	1-157	158-215	1-157	158-215
	Hourly	Monthly	Hourly	Monthly
Infant	\$2.20	\$374	\$2.64	\$421
Toddler	\$1.98	\$352	\$2.28	\$421
Preschool	\$1.76	\$348	\$1.93	\$312
School	\$1.76	\$348	\$1.93	\$312
Special Needs	\$2.20	\$374	\$2.64	\$421

ENHANCED RATE MAXIMUMS (Not Licensed)

	Enhanced Family Rate (QFM)			Enhanced Center Rate (QEC)		
	1-62	63-135	136-215	1-62	63-135	136-215
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	\$2.38	\$303	\$404	\$2.99	\$351	\$468
Toddler	\$2.14	\$285	\$380	\$2.55	\$344	\$458
Preschool	\$1.90	\$281	\$375	\$2.13	\$252	\$336
School	\$1.90	\$281	\$375	\$2.13	\$251	\$334
Special Needs	\$2.38	\$303	\$404	\$2.99	\$351	\$468

LICENSED RATE MAXIMUMS

	Registered Family Rate (RFM)			Certified Family Rate (CFM)			Certified Center Rate (CNT)		
	1-62	63-135	136-215	1-62	63-135	136-215	1-62	63-135	136-215
	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly	Hourly	Part-time	Monthly
Infant	\$2.50	\$319	\$425	\$2.50	\$375	\$500	\$3.52	\$413	\$550
Toddler	\$2.25	\$300	\$400	\$2.50	\$300	\$400	\$3.00	\$404	\$539
Preschool	\$2.00	\$296	\$395	\$2.25	\$300	\$400	\$2.50	\$296	\$395
School	\$2.00	\$296	\$395	\$2.40	\$300	\$400	\$2.50	\$270	\$360
Special Needs	\$2.50	\$319	\$425	\$2.50	\$375	\$500	\$3.52	\$413	\$550

Zip Codes for Group Area C: Balance of State, Other State Zips

97001	97016	97018	97020	97021	97026	97029	97032	97033	97037	97039	97040
97050	97054	97057	97063	97065	97101	97102	97121	97130	97136	97137	97144
97145	97147	97324	97329	97335	97342	97345	97346	97347	97350	97358	97360
97364	97368	97369	97375	97384	97388	97390	97392	97394	97396	97406	97407
97409	97410	97411	97412	97413	97414	97416	97417	97419	97425	97427	97428
97429	97430	97432	97434	97435	97436	97437	97438	97439	97441	97442	97443
97447	97449	97450	97451	97453	97457	97458	97459	97461	97462	97463	97464
97466	97467	97469	97472	97473	97476	97479	97480	97481	97484	97486	97488
97490	97491	97492	97493	97494	97495	97496	97497	97498	97499	97522	97523
97526	97527	97530	97531	97532	97533	97536	97537	97538	97539	97540	97541
97543	97544	97601	97603	97604	97620	97621	97622	97623	97624	97625	97626
97627	97630	97632	97633	97634	97635	97636	97637	97638	97639	97640	97641
97710	97711	97712	97720	97721	97722	97730	97731	97732	97733	97734	97735
97736	97737	97738	97739	97741	97750	97751	97752	97753	97754	97758	97761
97810	97813	97814	97817	97818	97819	97820	97823	97824	97825	97826	97827
97828	97830	97833	97834	97835	97836	97837	97838	97839	97840	97841	97842
97843	97844	97845	97846	97848	97850	97856	97857	97859	97861	97862	97864
97865	97867	97868	97869	97870	97873	97874	97875	97876	97877	97880	97882
97883	97884	97885	97886	97901	97902	97903	97904	97905	97906	97907	97908
97909	97910	97911	97913	97914	97918	97920					

H. Payment Process

1. Overview; Definitions

The provider payment process is intended to ensure that payments to providers are accurate and timely. Although largely an automated process, it should also be flexible enough to allow for individual circumstances.

- *Accuracy* means providers are paid only for child care provided or allowed by Department of Human Service (DHS) policy.
- *Timely* means the provider is paid as soon as possible after the care is provided. This requires prompt action by everyone involved in the payment process including clients, providers, branch staff, and Direct Pay Unit (DPU) staff.
- *Flexible* means that the DPU or branch staff has the ability to generate payments outside the usual process, when necessary to retain safe, stable child care that supports children's development.

2. Child Care Payment General Provisions

- Child care payments are made directly to the provider.
- Child care payments made to a provider are made on behalf of the family and do not constitute a contractual obligation or place DHS in an employer relationship with the provider.
- Child care payments cover only child care already provided.
- Payments are limited to the rates described in Section F (CC F.) of this chapter.

For ERDC, no provider payments will be authorized unless a primary provider has been designated. The primary provider is usually the one who provides most of the care and is responsible for collecting the copay.

Direct Provider Payments; General Information: 461-165-0160

3. JOBS Plus and ERDC Child Care Billings (CCBs)

Payments for JOBS Plus and ERDC child care are ordinarily paid directly to the provider using billing forms issued by the Provider Pay (PP) and Service Authorization (SA) system. See Sections III-G and V-B of the *Computer Guide* for a more detailed description of this process.

The following is a brief summary:

- The branch worker records client eligibility information, such as program, work hours, income (for ERDC), etc., on CMS.
- Information about the provider is recorded on the PP system by the DPU through the listing process.
- The SA system links the information on CMS and PP, and a child care billing (CCB) is issued to the provider. For ongoing cases, the CCB is issued at each EOM cutoff for the following month.
- After care is provided, the provider completes the CCB and sends it to DPU.
- The CCBs are batched and sent to data entry for payment. The payment is issued and recorded on PPS. Notices are sent to the parent and the provider.

4. The JCCB – JOBS Child Care Billing

The *JCCB – JOBS Child Care Billing* is generated online by a branch worker or DPU using JAS. The process is similar to the CCB process for ERDC clients.

☞ FOR A DETAILED DESCRIPTION OF THIS PROCESS, SEE THE *JCCB WORKER GUIDE* (CC WG#8).

The following is a brief summary of the JCCB process:

- The worker and client develop an employment or self-sufficiency plan that includes authorizing child care.
- The provider must be listed for DHS payments or be given a listing form to become listed.
- The worker authorizes child care on the JOBS Child Care Situation screen (WSIT) or requests DPU to set up WSIT and issue a JOBS Child Care billing. This screen is accessed from JAS and can be used to authorize ongoing monthly billings as well as billings for a specific period. The WSIT screen pulls information from three different computer systems – CMS, PP/SA, and JAS – to determine the amount authorized on the billing form.
- Once the child care situation is established on WSIT, the system sends the billing form to the provider. For cases coded to automatically issue, the JCCB is issued at EOM cutoff for the following month.
- After the care is provided, the provider completes the billing form and sends it to DPU.

- The JCCBs are batched and sent to data entry for payment. The payment is issued and recorded on PP. Notices are sent to the client and the provider.

5. **Payments for Employed TANF Clients Participating in JOBS**

If a client needs child care for both JOBS activities and work hours and the work hours are less than the JOBS activity hours, the work hours are coded on JAS as a “WO” activity and a JOBS child care voucher is.

If a client needs child care for both JOBS activities and work hours and the work hours are more than the JOBS activity hours, the work hours are coded on JAS as a “WO” activity and a Child Care Billing (CCB) voucher is used. The worker will need to close the WSIT situation or request DPU close the situation, code both the work “WO” and other JOBS activities hours on CMS (CC hours) and request DPU to issue a CCB.

☞ SEE CC WORKER GUIDE #2 FOR ADDITIONAL INFORMATION.

6. **Branch Authorized Child Care Payments**

There are a limited number of situations where a child care payment can be made by a branch authorized check instead of by CCB or JCCB. Unless otherwise specified, use ERDC code 89, or TANF/JOBS code 70.

A Special Pay check can be written:

- (1) To the client, as a reimbursement to a client for child care payments already made;
- (2) To the client and provider (as a dual-payee check), to pay for child care costs when the *provider has been denied listing*. This is to give the client time to look for a new provider and cannot exceed a 30-day period from the denial date;
- (3) To the client and provider (as a dual-payee check), *for an interim check* to meet the provider’s emergency. Interim checks are written to pay for a partial month’s care before the full month’s care is provided or when issuance of the billing form has been delayed. This applies only when future child care is jeopardized and making other arrangements would not be in the family’s best interest. Use program codes client was opened under for specific month.

A provider’s emergency is normally defined as a 72-hour eviction notice, shut-off notice, or unexpected expenses due to a domestic violence situation. The emergent situation must be caused by circumstances outside of the provider’s control especially when there has either been a DHS delay in issuing the billing form, UCMS not updated, or the client did not turn in paperwork timely for continued eligibility, etc.

- (4) To the client and provider (as a dual-payee check), for a one-time deposit made with job-retention funds to secure child care;
- (5) To the client and provider (as a dual-payee check), when the *computer system* support is not available to make full payment (i.e., high special needs, etc.);
- (6) To the provider, *under one of the above circumstances*, when the client is no longer available for signature or the client is in dispute with the provider.

To process a request for branch payment:

- (1) The worker must confer with DPU before any branch child care payments are issued. No branch check can be written if a garnishment has been received by DPU or an overpayment has been written against the provider;
- (2) Payment can only be made for care that has already been provided, as documented by attendance logs submitted by the provider;
- (3) Calculation of the payment due must include the deduction of the full copayment.

The provider will need to complete a billing form at the end of the month for all care provided during the month and a check for the balance still due will be sent.

Child Care Payments Paid Directly to a Client: 461-165-0190

7. **Billing Form Time Limits**

CCBs and JCCBs: Expire 90 days from the issue date. If they are received after that time, DPU must determine if the provider had good cause for returning the form late, before any replacement billing form is issued.

8. **Canceling and Reissuing Child Care Billings (CCBs)**

In most circumstances, CCBs are not canceled and reissued once they have been sent to the provider. In no case should a billing form be canceled and reissued if this results in a decrease in the authorized amount. However, there are limited situations where a billing form can be canceled and reissued to increase the authorized amount. These situations include:

- The original billing form was incorrect because of an administrative error.
- The client reported a change before the end of the month, but it was too late to adjust the CCB for the following month.

- Circumstances beyond the control of the client result in a significant loss of income.

To cancel and reissue a CCB, reduce income or increase hours on CMS, and GroupWise the DPU branch representative. DPU will need to know the case #, provider, month, and new copay amount or new number of authorized hours. A good way to do this is to use the electronic form *Child Care Billing Change/Issue Request*. If you would like a Word Perfect template to copy and paste to your e-mail system, contact your branch representative at DPU.

9. Canceling and Reissuing JOBS Child Care Billings (JCCBs)

If lost, exact duplicates of the original JCCB can be re-sent by the worker from the WJSS screen. JCCBs can also be canceled and replaced from the WJSS screen as long as the replacement JCCB is for an equal or larger amount of payment.

☞ FOR A DETAILED DESCRIPTION OF THIS PROCESS, SEE THE *JCCB WORKER GUIDE* (CC WG#8).

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Worker Guide Child Care Program Forms

This worker guide lists the primary forms and pamphlets used in Department of Human Services (DHS) Child Care assistance programs.

- DHS 437 *Authorization of Cash Payment*
Used by the worker to make child care payments directly to the client for a limited time. For example, it is used to reimburse the client for child care already paid during the initial month of eligibility.
- DHS 487 *Notice of Incomplete Information*
Notice to the client when the **DHS 852** is incomplete and cannot be processed, and gives the client the deadline for completing the report.
- DHS 852 *Interim Change Report*
Used by clients in the SRS report system to report the required information in the sixth month of the certification period. No benefits will be issued for the seventh month of the certification period until this form is submitted to the department and determined to be complete.
- DHS 853 *Simplified Change Report*
Used by clients in SRS to report changes at times other than the Interim Change Report. Send a new **DHS 853** to the client for future change reporting each time one is submitted to the department.
- DHS 854 *Simplified Reporting System*
Pamphlet explaining the requirements of SRS, what information is needed and how it is used to calculate benefits for cases certified longer than six months.
- DHS 859A *Monthly Change Report*
Used by REF and TANF clients to report their monthly earnings. Required of all clients in the MRS.
- DHS 943 *Change Report*
Used by clients to report changes between *ERDC Re-application and Food Stamp Application* (DHS 7476) due dates. Clients may also use the DHS 943 to report changes that cannot be reported on the DHS 7476.
- DHS 7294 *Notice of Reported Income*
Used to show how the monthly income was calculated from the client's reported income. Send a copy of this worksheet to the client to show how the income was calculated.
- DHS 7351 *Educational Income Calculation for ERDC and Food Stamps*
Used by workers to calculate monthly educational income for ERDC and FS. After calculating the monthly amount on this form, transfer the figure

to the DHS 7294 to average it over the certification period. Send a copy to the client to show how the income average was calculated.

DHS 7470 *Application for ERDC Program*

Mailed or given to clients who want to apply for ERDC **only**. This form is used to determine the client's eligibility for ERDC.

DHS 7476 *ERDC Re-application and Food Stamp Application*

Mailed to ongoing ERDC clients at the EOM deadline prior to the last month in the certification period. Clients report income and may report other household changes on this form. The information is used to determine the client's ERDC copay for the next period. It is also used to certify food stamps for a companion Food Stamp case.

Note: *The worker may need to explain to the client how to fill out this form. The worker and client determine together, for each type of income, a reasonable estimate of anticipated income for the next three to six months.*

DHS 7478 *Parent Guide to Child Care*

Given to clients when they begin using DHS child care assistance. It explains the listing process, how to locate good child care, how to contact local CCR&Rs, how to report changes in providers, the DHS child care rates, etc.

DHS 7484 *Child Care Need Statement for Older Children*

Mailed or given to ERDC who have a child age 12-17 and TANF clients who have a child age 13-17 who requires child care. The client indicates on this form why the older child needs care. Do not use this form if the DHS 7486 applies.

DHS 7486 *Special Need Child Care Rate Request*

Mailed or given to ERDC and TANF clients who have a child with special child care needs. The client and the provider indicate on this form why the child needs care at the special needs rate.

DHS 7492 *Child Care Provider Guide*

This is given to the client to give to the provider at application or when the client reports a new provider. It can also be mailed to the provider by DPU when the listing form indicates the provider does not have one. The *Child Care Provider Guide* contains information on provider requirements, the listing and payment process, DHS rates, instructions and samples of completed listing and billing forms, and other important information such as recognizing and reporting child abuse, and preventing the spread of infectious disease.

DHS 7494 *Child Care Provider Listing*

Filled out by the provider, then used to determine if the provider meets DHS listing requirements. For ERDC and TANF child care, the listing

form also sets up the “child care situation”—the link on the system between the client and the provider that initiates the Child Care Billing (CCB). The worker must ensure that the client is eligible for child care assistance and complete the “DHS Only” portion of the form before giving it to the client.

DHS 7494E *Child Care Provider Letter*

Given to the parent when their provider is already approved on the provider pay system. This letter tells the provider the parent is eligible for help with child care expenses. It takes the place of the DHS 7494 form for providers who are already listed.

DHS 7496 *Provider Report*

Used by child care providers to report any changes in name, address, phone number, and household composition (for family day care only), and to report arrests, convictions, or involvement with DHS child welfare. A perforated copy of the change report is in the DHS 7492. DPU also mails the form to providers on request.

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**Worker Guide
ERDC Eligibility Guide**

<p>Eligibility Requirements</p>	<ul style="list-style-type: none"> • Residency. • Citizen/Alien Status of child to receive care. • Immunization for child(ren) needing care. • Caretaker (no relationship to child required). • Age to receive care. • Employment-related child care need. • Satisfactory Copay Arrangement. <p>Provider must:</p> <ul style="list-style-type: none"> • Not be in the filing group; • Be listable; and • Meet requirements for direct pay. <p>Income limit – 185% FPL (copay must also be less than amount DHS will pay; otherwise client is ineligible)</p>
<p>Verification Required</p>	<p>At initial application:</p> <ul style="list-style-type: none"> • All countable earned and unearned income received 30 days prior to the date of request unless it is a new job. • If new job and no pay stubs have been received – employer statement including anticipated hours, pay dates and rate of pay. • Second parent unable to provide adequate care. • Citizenship or alien status of a child(ren) needing care. • Need for special needs rate. • Need for child care of child(ren) ages 12-17 (verify and document every 12 months). <p>When changes are reported: Source of income and related income changes.</p> <p>At reapplication:</p> <ul style="list-style-type: none"> • All countable earned and unearned income received in the last 30 days. • If new job and no pay stubs have been received – employer statement including anticipated hours, pay dates and rate of pay. <p>In all cases: Any questionable information.</p>
<p>Eligibility Determination Groups</p>	<p>Benefit Group for ERDC consists of all filing group members, including adults, noncitizens, and older children not receiving child care when coding # in ERDC. Unmarried children in the care and custody of the caretaker, who are age 18 or under the age of 19 and attending secondary school or vocational training at least half time, are included in the benefit group. This UCMS field (# ERDC) affects copay calculation.</p>

<p>Income Calculation</p>	<ul style="list-style-type: none"> • If representative of future income, use past 30 days to project future income. • If not representative, estimate future income based on best information available to client. • Remember to include all earned income – e.g., bonuses, tips, commissions, and any unearned income – in calculation. • See special rules on treatment of self-employment income. • Compare countable income to 185% FPL. If over, client ineligible.
<p>Listing</p>	<ul style="list-style-type: none"> • Provide parent with <i>A Parent's Guide to Child Care</i> (DHS 7478) and a copy of the <i>Child Care Provider Guide</i> (DHS 7492) to give to provider. • If client's provider is not listed, give listing form when client eligibility is cleared. The listing form guarantees first month of client's eligibility. • If already listed, give client the <i>Child Care Provider Letter</i> (DHS 7494E) to give to provider after client's eligibility is cleared. DHS 7494E serves as guarantee of client's eligibility. Send an electronic provider connection request to DPU to link already listed provider to case.
<p>Special Needs Rate and High Needs Rate</p>	<p>Special needs rate is for child(ren) who require a level of care over and above norm for age due to physical, behavioral, or mental disability. Criteria must be verified on <i>Special Need Child Care Rate Request</i> (DHS 7486). If rate exceeds special needs rate due to children with very high needs, refer to District High Needs Specialist.</p>
<p>Computer Screens to Check</p>	<p>UCMS and DPCS - Does client have unmet copay? DPPM - Is provider currently listed?</p> <p>UCMS</p> <ul style="list-style-type: none"> • Is # in ERDC correct? (# should include all filing group members) • Are CC Wrk Hrs coded? (Excluding SLF working hours.) • Is earned income (EML, SSI, SLF or SUP) coded? • Are noncitizen children and children not receiving child care coded as 'NO' Ingt? • If Special Needs Rate verification met – is child coded with N/R code of SNR with an end date that matches the certification end date? • If care for older child (age 12-17) authorized – is child coded with N/R code of SNA with an end date that matches the certification end date? <p>FCAS</p> <ul style="list-style-type: none"> • If companion FS case exists, have you adjusted CC deduction? See FS policy for information on CC deduction, i.e., maximums, when allowed, etc.

<p>Child Care Work Hours</p>	<ul style="list-style-type: none"> • Code work hours only. DO NOT include self-employment work hours. Computer calculates extra percentage for travel, breaks, etc. • Use highest month's anticipated hours in certification period. Do not average. • See special rules on calculating hours for two-parent families. • See special rules on authorizing extra hours.
<p>Authorizing Extra Hours</p>	<p>For full-time employment, maximum of 40 x 4.3 or 172 CC Work Hrs allowed. System adds 25% for 215 hrs max. If client's actual hours exceed 215, check to see if situation meets criteria for authorizing extra hours. If so, code UCMS with actual number of child care hours client needs in CC Wrk Hrs field and code EXH C/D and N/R on payee with an end date that matches the certification end date. Extra child care work hours have a maximum of 323 hours. System will not add 25% for travel when EXH is used.</p>
<p>Changes Clients are Required to Report</p>	<ul style="list-style-type: none"> • Changes in source of income that is expected to continue. • Changes in rate of pay that is expected to continue. • Changes in members of filing group. • Changes in address. • Changes in providers. <p><i>Note: See CC Section – Worker Guide #9 for SRS reporting.</i></p>
<p>Acting on Changes</p>	<ul style="list-style-type: none"> • If ongoing income change is reported, adjust the income if it results in a significant copay change. Either begin a new certification or adjust income for remainder of current certification period. Allow time for 10-day notice if change results in decreased benefits. DHS 7294 serves as a 10-day notice form. • Adjust work hours if needed. • Always narrate reported changes and action taken. <p><i>Note: If companion FS case exists, follow FS policy for acting on changes for FS case.</i></p>

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Worker Guide ERDC SRS Guide

<p>Who must be in SRS</p>	<p>Any ERDC case that has a companion FS case in SRS.</p> <p><i>Note: ERDC and FS companion cases should be in SRS whenever possible.</i></p>
<p>Who cannot be in SRS</p>	<p>The following types of households cannot be in SRS:</p> <ul style="list-style-type: none"> • An ERDC case with a short-term child care need • An ERDC case with no FS companion case • An ERDC case with a FS companion case in TBA • An ERDC case with a companion FS case certified for less than six months
<p>Certification Periods with SRS</p>	<p>When aligning end dates with the FS program, the certification period may be anywhere from one to 12 months.</p> <p>When closing the FS companion case, remove the ERDC case from SRS and shorten the certification period if there are more than six months left (the certification period cannot be longer than six months when the ERDC case is not in SRS).</p> <p>The only time an ERDC case may continue to follow the SRS reduced reporting requirements without a companion FS case is when:</p> <ul style="list-style-type: none"> • The ERDC case was certified in the fifth or sixth month of the FS certification period, and • The FS case closed automatically because the <i>Interim Change Report</i> (DHS 852) was not received.
<p>Reporting Requirements for ERDC SRS</p>	<p>The following changes must be reported by the 10th day of the month following the month of occurrence:</p> <ul style="list-style-type: none"> • A change in child care provider • A change in mailing address • Loss of employment • Monthly income exceeding the FS countable limit (130% FPL) • A parent of a child or unborn or the spouse of the caretaker moves in <p>An <i>Interim Change Report</i> form (DHS 852) is due in the sixth month of the certification period and must be processed for benefits in months seven through 12. Exception: ERDC cases opened in month five or six of the FS cert period may remain open in SRS if the (DHS 852) is not returned.</p>
<p>Acting on Reported Changes in SRS</p>	<p>In addition to acting on the <i>Interim Change Report</i>, act on all reported changes that the client is required to report.</p> <p>Increase benefits - Act on changes that will increase benefits. Send a <i>Notice of Information or Verification Needed</i> (DHS 210A) if more information is needed. If the change requires verification, do not act to increase benefits until the proof is provided.</p> <p>Decrease benefits - Do not act on information that will decrease benefits, unless the information is “<i>verified upon receipt.</i>” Only request proof if a client reports their income has exceeded the countable income limit. Carefully narrate.</p>

	<p>Changes that are not required to be reported and are not “<i>verified upon receipt</i>,” need to be narrated and acted on at <i>Interim Change Report</i> or the next recertification, whichever is earlier.</p> <p>Information is “<i>verified upon receipt</i>” when it is not questionable and the provider of the information is the primary source. (Examples: employer, worker’s compensation, etc.) Income changes cannot be verified by the client statement alone.</p> <p>Follow SRS policy and guidelines when acting on changes (FS-F.8).</p>
<p>SRS Coding</p>	<ul style="list-style-type: none"> ▪ SRS case descriptor (C/D) and need resource (N/R) needs to be coded on PCMS/CMUP (only on the payee). ▪ When establishing a new certification period in <u>months one through four</u> of a 12-month FS certification period, the SRS N/R date should match the <i>Interim Change Report</i> (Rpt Exp:) date on FSUP. ▪ When establishing a new certification period in <u>months five through 12</u> of the FS certification period, the SRS N/R date should match the certification and FS end date. <p>Processing the DHS 852 <u>before</u> compute deadline:</p> <ul style="list-style-type: none"> ▪ Use COMPUTE Incoming code and effective date first of the following month (this would generally be the first of the seventh month of the FS certification period). ▪ Update CC work hours on UCMS (DO NOT INCLUDE SELF-EMPLOYMENT WORK HOURS). ▪ Update the SRS N/R date to match the certification and FS end date, update EML, SUP, etc. ▪ Send DHS 7294. Narrate. <p>Processing the DHS 852 <u>after</u> compute deadline:</p> <ul style="list-style-type: none"> ▪ Use RESTORE Incoming code if the case is M5 only <u>and</u> is closed, otherwise use COMPUTE to convert from P2 to M5 and effective date first of the current month. ▪ Update CC work hours on UCMS. ▪ Update the SRS N/R date to match the certification end date, update EML, SUP, etc. ▪ Send DHS 7294. ▪ Send an electronic provider connection request to DPU to ensure a CCB is issued for the seventh month. Narrate. <p>Removing from SRS :</p> <ul style="list-style-type: none"> ▪ Use COMPUTE Incoming code. ▪ Remove the SRS C/D and N/R date from PCMS/CMUP. ▪ Review the certification end date (certification period cannot be longer than six months when not in SRS).

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Worker Guide CC-7: ERDC Eligibility Guide

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A. Overview of Medical Assistance Programs

1. Program Intent

The intent of the Medical Assistance programs is to ensure that low-income individuals and families in Oregon have access to medical care.

Most people eligible for a Medical Assistance program will receive either the OHP Plus benefit package, a comprehensive medical plan, the OHP Standard benefit package, a benefit plan similar to private health insurance, or, for clients ineligible for full benefits because of their immigration status, a medical benefit package that covers emergent medical needs only.

The eligibility for a specific program determines which benefit package a person will receive. Individuals eligible for BCCM, CEC, CEM, EXT, MAA, MAF, OHP, (except OHP-OPU), OSIPM, SAC, including children qualifying for Medicaid or CHIP under the 12-month continuous eligibility provisions, receive the OHP Plus benefit package. Individuals eligible for OHP-OPU receive the OHP Standard benefit package. Individuals eligible for a Medicaid program except for their noncitizen status receive the Citizen/Alien-Waived Emergent Medical (CAWEM) benefit package. Individuals eligible for CAWEM are only eligible for emergency medical benefits. Individuals eligible for QMB have limited benefits specific to Medicare coverage.

☞ FOR MORE INFORMATION REGARDING BENEFIT PACKAGES, GO TO [HTTP://WWW.OREGON.GOV/DHS/HEALTHPLAN/DATA_PUBS/WGUIDE/MAIN.S HTML](http://www.oregon.gov/dhs/healthplan/data_pubs/wguide/main.shtml) AND THEN CLICK ON DMAP WORKER GUIDE. SCROLL DOWN TO DMAP WORKER GUIDE #4.

☞ FOR MORE INFORMATION ABOUT CONTINUOUS ELIGIBILITY FOR MEDICAID AND CHIP CHILDREN (CEC, CEM), SEE MA.E.

2. Medical Assistance Programs; Overview

Continuous Eligibility for Non-CAWEM Children under age 19. Twelve-month continuous eligibility for children: Effective October 1, 2009, non-CAWEM children under age 19 qualify for 12 months continuous Medicaid or OHP-CHIP medical benefits. If a non-CAWEM child loses eligibility for Medicaid or OHP-CHIP before the end of the 12-month EXT, MAA, MAF, OHP, OSIPM or SAC redetermination recertification period, they should be converted to Continuous Eligibility Medicaid (CEM) or Continuous Eligibility CHIP (CEC) for the balance of the 12 months.

Note: CW children are also eligible for 12-month continuous eligibility. If a child's CW medical ends before the child's next scheduled 12-month redetermination, the medical is transitioned to SSP or SPD medical.

☞ FOR MORE INFORMATION ABOUT CONTINUOUS ELIGIBILITY FOR MEDICAID AND CHIP CHILDREN (CEC, CEM), SEE MA.E.

Medical Assistance Assumed (MAA). The Medical Assistance Assumed program provides medical assistance to people who have met the noncitizen or U.S. citizen requirements and are eligible for the Pre-TANF program or ongoing TANF benefits. Many clients opt not to receive TANF and receive MAA medical only. Non-CAWEM MAA children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for MAA prior to their next scheduled 12-month redetermination.

Medical Assistance to Families (MAF). The Medical Assistance to Families program provides medical assistance to people who are ineligible for MAA but are eligible for Medicaid using TANF (previously ADC) program standards and methodologies that were in effect as of July 16, 1996. Non-CAWEM MAF children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for MAF prior to their next scheduled 12-month redetermination.

Extended Medical Assistance (EXT). The Extended Medical Assistance program provides medical assistance for a period of time after a family loses their eligibility for MAA or MAF due to an increase in their child support or earned income. Non-CAWEM EXT children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for EXT.

Medical Assistance to Children in Substitute or Adoptive Care (SAC). The Medical Assistance to Children in Substitute or Adoptive Care program provides medical assistance to children placed in substitute care and children who are the subject of adoption assistance agreements. Non-CAWEM SAC children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for SAC prior to their next scheduled 12-month certification.

Oregon Health Plan Program (OHP). The Oregon Health Plan program provides medical assistance to many low-income individuals and families. The program includes five categories of people who may qualify for benefits. The categories are:

- Oregon Health Plan for Nonpregnant Adults; OHP-OPU. This category consists of uninsured adults who may qualify for medical assistance under the OHP-OPU (100 percent) income standard. A person eligible under OHP-OPU is sometimes referred to as a health plan new/noncategorical (HPN) client. Effective July 1, 2004, OHP-OPU is closed to new applicants. To be eligible for this program, an applicant must either be recertifying or transitioning from another Medicaid program without a break in assistance. OPU adults cannot qualify for Continuous Eligibility for Medicaid if they lose eligibility for OPU prior to their next scheduled certification.

Note: DMAP has requested approval for reopening OHP-OPU using a Reservation List process. If approved, DMAP tentatively plans on opening the Reservation List on October 1 or November 1.

Individuals already on the 2008 OHP Standard Reservation List were sent letters on August 31, 2009, asking if they wished to be added to a new OHP Standard Reservation List. The individual and any adult in their current filing group may be added to the new Reservation List. Adults who were children in the filing group when the request was added in 2008 may also be added to the new Reservation list.

- Oregon Health Plan for Children; OHP-OPC. This category consists of children who qualify for medical assistance under the OHP-OPC (100 percent) income standard. Non-CAWEM OPC children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for OPC prior to their next scheduled 12-month certification.
- Oregon Health Plan for Children; OHP-OP6. This category consists of children under the age of 6 who qualify for medical assistance with income from 100 percent up to 133 percent of the federal poverty. Non-CAWEM OP6 children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for OP6 prior to their next scheduled 12-month certification.
- Oregon Health Plan for Pregnant Females Under 185 Percent and Newborn Children; OHP-OPP. This category consists of pregnant females who qualify for medical assistance under the OHP-OPP (185 percent) income standard and their newborn children. Newborn children are coded as OPP only if the OHP countable income at the time they were added to the case is above 133 percent. If 100 percent to 133 percent, code as OP6. If less than 100 percent, code as OPC. Non-CAWEM OPP children may qualify for Continuous Eligibility for Medicaid if they lose eligibility for OPC prior to their next scheduled 12-month certification.
- Oregon Health Plan for Persons under 19; OHP-CHP. This category consists of uninsured persons under the age of 19 who qualify for medical assistance under the OHP-CHP (200 percent) income standard. This program is authorized by the Children's Health Insurance Program (CHIP) provision of the Federal Balanced Budget Act of 1997 and is not a title XIX (Medicaid) program. CHP children may qualify for Continuous Eligibility for CHIP if they lose eligibility for CHP prior to their next scheduled 12-month certification.

Citizen/Alien-Waived Emergent Medical (CAWEM). The Citizen/Alien-Waived Emergent Medical program provides limited medical assistance to ineligible noncitizens who would qualify for another medical assistance program (except OHP-CHP) except for their citizen/alien status. CAWEM children under age 19 do not qualify for Continuous Eligibility for Medicaid (CEM).

***Note:** Some CAWEM pregnant women may be eligible for OHP Plus benefits through the Pre-Natal CAWEM Expansion Pilot Program. See NC C.3 for more information. However, they do not qualify for CEM.*

Oregon Supplemental Income Program, Medical (OSIPM). Medical coverage for the elderly and for individuals with disabilities. OSIPM children under age 19 may qualify

for Continuous Eligibility for Medicaid (CEM) if they lose OSIPM eligibility prior to their next scheduled 12-month redetermination.

☞ FOR MORE INFORMATION ON ADULT PROGRAMS GO TO
[HTTP://WWW.DHS.STATE.OR.US/SPD/TOOLS/ADDITIONAL/WORKERGD/INDEX.HTM.](http://www.dhs.state.or.us/spd/tools/additional/workerGD/index.htm)

☞ FOR INFORMATION ABOUT THE MEDICARE MODERNIZATION ACT GO TO
[HTTP://EGOV.OREGON.GOV/DHS/MMA/](http://egov.oregon.gov/dhs/mma/)

Qualified Medical Beneficiaries (QMB). Additional medical coverage for Medicare recipients. QMB children do not qualify for Continuous Eligibility for Medicaid (CEM).

☞ FOR MORE INFORMATION ON ADULT PROGRAMS GO TO
[HTTP://WWW.DHS.STATE.OR.US/SPD/TOOLS/ADDITIONAL/WORKERGD/INDEX.HTM.](http://www.dhs.state.or.us/spd/tools/additional/workerGD/index.htm)

☞ FOR INFORMATION ABOUT THE MEDICARE MODERNIZATION ACT GO TO
[HTTP://EGOV.OREGON.GOV/DHS/MMA/](http://egov.oregon.gov/dhs/mma/)

Retroactive Medical Benefits. Clients who are eligible for BCCM, MAA, MAF, OSIPM, QMB-DW, REFM, or SAC are also potentially eligible for retroactive medical benefits. This also applies to CAWEM clients who receive medical benefits under those programs.

☞ SEE MEDICAL ASSISTANCE E.6 FOR MORE INFORMATION.

Breast and Cervical Cancer Medical (BCCM). The Breast and Cervical Cancer Medical program provides medical assistance to uninsured women who need treatment for cancer or precancerous conditions as determined by the Breast and Cervical Cancer Screening Program coordinated by DHS Health Services. DHS Health Services is responsible for ensuring that BCCM clients meet program eligibility requirements. DHS eligibility workers treat BCCM clients as presumptively eligible for Medicaid, i.e., we do not have to make the initial BCCM eligibility decision. All BCCM cases are maintained at the Statewide Processing Center in Salem. BCCM children could qualify for Continuous Eligibility for Medicaid (CEM).

☞ SEE MEDICAL ASSISTANCE (MA E.15) FOR MORE INFORMATION.

B. Application, Redetermination, Recertification, Verification

1. Application for Medical Assistance

Application assistance programs

Effective July 1, DMAP began administering two new programs – the Application Assistance Program and the Outreach and Enrollment Grant program.

Application Assistance Program and Outreach and Enrollment Grant Program providers work with families to help them complete the application process for their children. Neither program will work with adult only applications. Each program will stamp the application with a stamp that will include their provider number.

Each application assistance organization date stamps the application. The stamp includes their provider number.

- The Application Assistance Program provider identification stamp will always begin with “AA” followed by numbers.
- The Outreach and Enrollment Grant Program provider identification stamp will always begin with “GG” followed by numbers.

CM system coding for application assistance programs

Two need/resource items are used to track families with children applying for medical and getting assistance from the Application Assistance Program:

- AAP (Application Assistance Program Pending) is used to track cases with an applicant under age 19 whose family is working with an Application Assistance Program provider. The AAP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the AA number stamped on the application. Do not worry about removing or changing the AAP code if the application is denied; it will drop off the case automatically.
- AAA (Application Assistance Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Application Assistance Program provider. Once approved for medical, remove the AAP need/resource code and add the AAA code. The AAA end date is the month/year the child was approved for medical. The need/resource provider number is the AA number stamped on the application. Providers will be paid \$50 for each approved application, so it’s important to code cases correctly.

Two need/resource items are used to track families with children applying for medical and getting assistance from the Outreach and Enrollment Grant Program:

- GGP (Outreach and Enrollment Grant Program Pending) is used to track cases with an applicant under age 19 whose family is working with an Outreach and Enrollment Grant Program provider. The GGP end date is the month/year the application would be denied or closed if the application is not completed. The need/resource provider number is the GG number stamped on the application. Do not remove or change the GG if the application is denied; it will drop off the case automatically.
- GGA (Outreach and Enrollment Grant Program Approved) is used to track cases with a child under age 19 approved for medical assistance whose family was assisted by an Outreach and Enrollment Grant Program provider. Once approved for medical, remove the GGP need/resource code and add the GGA code. The GGA end date is the month/year the child was approved for medical. The need/resource provider number is the GG number stamped on the application. (Outreach and Enrollment Grant providers are not given a \$50 payment for approved applications.)

Application Process

Do not require an interview for medical applicants. If the client no shows a TANF, FS or other non-medical related appointment, do not deny the request for medical. Complete the medical application process through the mail and/or by phone as needed.

Pend end dates

The department is committed to increasing the number of children in Oregon with access to health benefits. To support Healthy Kids, we need to do everything we can to ensure families have an opportunity to clear eligibility for their children, including providing sufficient time for parents to respond to the pend notice.

- For medical programs, the client is entitled to the full 45-day pend period. Unless you are sure it will not be an issue for the family, do not pend to have eligibility items returned earlier than the 45th day.
- Sometimes 45 days is not enough. If the pend notice is sent late for a reason outside the client's control (application temporarily lost, late processing because of workload, etc.), the original 45 days should be extended as necessary to allow for some extra time. The DOR remains the same.
- To extend the 45 days, narrate your decision and the reason it was outside the client's control.

Special application handling from July 1, 2009, through December 31, 2009

The department is implementing medical policy changes to support the Healthy Kids plan (HK) effective October 1, 2009, and will be implementing additional changes effective January 2010.

To ensure that all children have an opportunity to be determined using the October and January policy changes, a new application procedure was implemented from July 1. The following procedure applies only to children applying or reapplying with a DOR of July 1, 2009, or later:

- Determine eligibility for children using current medical policy. If a child on an SSP or SPD application with a date of request (DOR) July 1 or later is denied medical, deny as per usual, but mail or shuttle a copy of the application to the OHP Statewide Processing Center (5503).
- When redetermining eligibility for children, redetermine eligibility using current medical policy. If you determine the child is no longer eligible for medical (over income, does not meet six-month CHP uninsurance requirement, over resource, etc.), close as per usual, but mail or shuttle a copy of the application to 5503.

OHP STATEWIDE PROCESSING CENTER (5503)
2850 NE BROADWAY
SALEM, OR 97303

- Do not send applications/reapplications for children who did not complete the application process. For example, do not send DD or AP denials or BEDded clients who did not respond to the pend notice.
- Do not send faxes or scanned applications.
- A cover sheet with the above address has been provided.
- No special information needs to be added to the applications. It does not matter how many applications are bundled together as long as there is a cover sheet on the top.
- 5503 will image the application. Effective with the October 1 medical policy changes, 5503 will redetermine eligibility. If not eligible using the October policy changes, 5503 will redetermine eligibility again using the January 2010 policy changes.

Applications used for SSP medical program eligibility

New medical program applicants must complete a new application. For ongoing clients, usually an application will not be required.

☞ SEE #5 OF THIS SECTION FOR MORE INFORMATION ABOUT REDETERMINATIONS AND HOW TO PEND FOR AN AMENDED OR NEW APPLICATION.

MAA, MAF. The OHP 7210, OHP 7210R. OHP 7201W or the DHS 415F may be used.

EXT. An application is not needed for EXT medical assistance.

SAC. When an application is made for SAC medical assistance, use the *Application for Children in Substitute Care* (DHS 1462) or the *Medical Assistance Application for Children in Adoptive Care* (DHS 1462A).

- All applications for SAC medical assistance are processed by the Children’s Medical Project Team at the Statewide Processing Center (5503). Children determined eligible for SAC medical assistance have their case coded at cost center 5503.
- DHS 1462, applications are completed by facilities on the behalf of children in substitute care. The DHS 1462 is also completed by foster care providers on the behalf of children approved for foster care in another state but who are currently residing in Oregon.
- DHS 1462A, applications are completed by adoptive parents for children subject of an adoption assistance agreement between the parents and a public agency of another state. These children are assumed eligible for SAC medical assistance.
- Completed applications can be faxed to 503-361-8660 or mailed to:

The Children’s Medical Project Team
Statewide Processing Center
PO Box 14520
Salem, OR 97309-9901

- For a child who has an immediate need for a medical ID card, please indicate “emergency application” on the fax cover sheet. Also, call the Statewide Processing Center to notify the Children’s Medical Project Team that the child’s emergency application has been faxed.

OHP. When people apply for OHP medical assistance and another program – for example, Food Stamps or child care – they use the DHS 415F. When applying for medical only, they may use the DHS 415F, OHP 7210, OHP 7210R or OHP 7210W. When applying for OHP-OPU because they were randomly selected from the OHP Reservation List, they must complete an OHP 7210R.

BCCM. An application for the BCCM program is initiated only when an uninsured woman is found to need treatment for either breast or cervical cancer, or precancerous conditions, after being screened by the Oregon Breast and Cervical Cancer Program coordinated by DHS Health Services.

Note: *If a client receiving benefits under another state’s Medicaid Breast and Cervical Cancer program is moving to Oregon and inquires about Oregon’s program, refer the client to the Oregon Breast and Cervical Cancer Program of DHS Health Services at 1-971-673-0581 (staff only) or 1-877-255-7070 (staff or clients). DHS Health Services needs direct contact with the client to determine if she meets the criteria for Oregon’s program and to coordinate treatment services, if eligible.*

- The *Breast and Cervical Cancer Medical (BCCM) Program Application* (DHS 1463), form is completed by a woman who has been screened by the Oregon Breast and Cervical Cancer Program and is found to need treatment for breast or cervical cancer, or precancerous conditions. The application is provided to the woman by an Oregon Breast and Cervical Cancer Program Coordinator after the woman is diagnosed.
- The woman receives assistance in completing the application by an Oregon Breast and Cervical Cancer Program Coordinator. The Coordinator determines eligibility for BCCM and refers the application to the Statewide Processing Center.
- A woman eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. A woman who has been screened by the Oregon Breast and Cervical Cancer Program and needs treatment but is eligible for another Medicaid program will have her case coded with that program coding and with a BCS case descriptor.
- A woman initially found eligible for BCCM may be required to complete and return an OHP 7210 or other DHS application to determine if the woman is eligible for another Medicaid program. This OHP 7210 application will be marked “BCP” on the label. If the woman submits the OHP 7210 to a branch office, it should be forwarded to the Statewide Processing Center.

☞ SEE MEDICAL ASSISTANCE E.15 FOR MORE INFORMATION.

General Information including Authorized Representative. The application must be signed by all adult members of the filing group or their authorized representative before medical benefits may be approved. Do not pend for signatures solely to deny the medical application. When there is not an adult in the filing group or an authorized representative, e.g., a homeless child applying for benefits, the person applying must sign the application.

A person or family may use an authorized representative to complete the application for them if needed. People who can be authorized representatives include a legally appointed guardian, a conservator, a person with power of attorney, a person authorized by the recipient and a person acting responsibly for the recipient. If needed, the branch may appoint a responsible person to be the authorized representative.

To designate an Authorized Representative or Alternate Payee, the client must complete the *Designation of Authorized Representative or Alternate Payee* (AFS 231) or the *OHP Optional Assistance* (OHP 7218) at application and at each redetermination. If health information is to be disclosed, an *Authorization for Use and Disclosure of Information* (DHS 2099) is required in addition to the above mentioned forms.

The application is completed when the person completes and signs the application and provides the necessary information and verification within 45 days from the date of request. The 45-day limit may be extended when circumstances exist that are beyond the control of either the person applying or the department. People may withdraw their application at any time.

2. **Date of Request (DOR)**

Overview

To start the application process:

- A client or someone authorized to act on their behalf must contact the department or another appropriate location with a request for benefits. This request can be in the form of a phone call, office visit or a written request by the applicant or another person or agency acting on behalf of the applicant.
- When the online OHP 7210W application is submitted online, it is time-stamped and a DOR established for the applicant.
- The department may also initiate the application process and establish a DOR for the client.

New applicants

The date of request for new applicants is the day medical care began, if the actual request is made no later than the next working day. If the request is received later than the next working day, the day the request is received by the department is the date of request.

To apply for medical, a person or someone authorized to act on their behalf must either contact a branch office serving the area they live in, an outreach center, including an authorized Federally Qualified Health Center (FQHC) or a Disproportionate-Share Hospital (DSH), or call the toll-free number 1-800-359-9517, with a request for benefits. A request may be in the form of a phone call, a visit to the office or in writing.

For new applicants, in order to maintain the original date of request, the person's application form must be received in a branch office no later than 45 calendar days from the date of request. If the 45th day falls on a weekend or holiday, the application must be received the following working day. If the application is not received within 45 days, the actual date the branch office receives the application becomes the new date of request. The 45-day policy does not apply to recertifications.

The date of request for a medical application, which is date stamped on the application form, may also be established by a branch, by the toll-free operator or by a worker at an outreach center. For OHP 7210W online applicants, a DOR is established when the OHP 7210W is successfully submitted by the applicant over the internet and received by the department.

DOR at redeterminations

For redeterminations (including OHP recertifications), the date of request is the date the application is received by the department, the date the client otherwise establishes a date of request or the department establishes a DOR for the client (as for example, when acting on a reported change).

Note: The requirement to submit a written application within 45 days of the original date of request affects new applicants. Ongoing clients have a written application already on file.

Randomly Selected OHP Standard Reservation List Applicants

Persons randomly selected from the OHP Standard Reservation List must establish a DOR within 45 days from the date the OHP 7210R is mailed. If the OHP Standard Reservation List Applicant does not establish a DOR within 45 days, the client may request an ADA accommodation. If the client does not qualify for an ADA accommodation, treat as a new OHP-OPU applicant.

☞ SEE MA E-8 FOR MORE INFORMATION ABOUT THE OHP STANDARD RESERVATION LIST PROCESS.

Date of Request: 461-115-0030
When An Application Must Be Filed: 461-115-0050
Authorized Representatives; General: 461-115-0090
Offices Where Clients Apply: 461-115-0150
Application Processing Time Frames; Not FS or Pre-TANF: 461-115-0190
OHP-OPU; Effective Dates for the Program: 461-135-1102
Reservation Lists and Eligibility; OHP-OPU: 461-135-1125
Effective Dates; Initial Month Medical Benefits: 461-180-0090

3. Reviewing for Multiple Medical Programs

Workers must review for all Self-Sufficiency medical programs when evaluating for initial medical eligibility and when acting on timely reported changes. When reviewing for initial medical eligibility:

When redetermining eligibility for adults receiving any medical benefit and children (under age 19) receiving QMB or CAWEM level benefits:

- First consider all Self-Sufficiency medical programs except OHP.
- If not eligible for any other medical, evaluate for OHP.

When redetermining eligibility for children (under age 19) receiving OHP Plus medical benefits:

- First consider all Self-Sufficiency medical programs except OHP.
- If not eligible for any other medical, evaluate for OHP.
- If not eligible for OHP, evaluate for Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC).

☞ SEE MA.E FOR MORE INFORMATION ABOUT 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

4. Referrals to SPD

Clients that indicate they have disabilities should be referred to SPD, if appropriate, using your local referral process. Do so only after evaluating for all “Plus” Self-Sufficiency medical programs. SPD referrals for applicants who may only be considered for OHP-OPU should be completed immediately, even in cases where the applicant will be pended for OHP-OPU eligibility.

Check with your lead worker or manager for more information about your branch’s referral process for OSIPM. CAF Self-Sufficiency and SPD have jointly developed a Worker Guide explaining the process. The SPD WG-4 “Presumptive Medicaid Decision Procedures” is available at: <http://www.dhs.state.or.us/spd/tools/program/osip/wg4.htm>

Clients referred to SPD for an OSIPM eligibility decision should be sent the GSOSIPR “OSIPM Referral” notice available on Notice Writer. Clients denied for Self-Sufficiency medical prior to the referral will also need to be sent the *Notice of Self Sufficiency Medical Program Eligibility Decision* (DHS 462C). The DHS 462C is available on the DHS forms web page and as a two part Notice Writer notice CM462C1 and CM462C2.

5. Redetermination of Medical Assistance Eligibility

☞ SEE #1 IN THIS SECTION FOR AN IMPORTANT APPLICATION PROCESS AFFECTING REDETERMINATIONS WITH A DOR FROM JULY 1, 2009, OR LATER.

Redetermination Process Defined

Redetermination is the process used to review eligibility to approve, close or deny the continuation of benefits. This process includes a review of the new or existing application and supporting documentation. It also includes an evaluation of eligibility for all Self-Sufficiency medical programs prior to ending benefits. People must cooperate in the process or their benefits will stop.

Frequency of Redeterminations

Redetermination is done at assigned intervals, whenever eligibility becomes questionable or when acting on a change that affects current medical eligibility.

- Periodic redeterminations are done every 12 months for the MAA and MAF programs. To ensure that children under age 19 have a 12-month period of eligibility, do not adjust the MAA/MAF redetermination date to match FS or other companion cases redetermination dates.

- Children receiving Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC) are redetermined at the end of their CEM or CEC period.

☞ SEE MA.E FOR MORE INFORMATION ABOUT 12-MONTH CONTINUOUS ELIGIBILITY FOR CHILDREN.

- Periodic redeterminations are done at least every 12 months for BCCM.
- There is no redetermination for EXT.
- OHP redeterminations are based on the OHP certification periods. See OHP Certification Period below.
- For all SSP medical programs, a redetermination is completed whenever a change has been reported that affects current medical eligibility.

Note: The CM system will close MAA and MAF cases based on the MAA or MAF need/resource item on CMUP and will send the “CR” close notice. The CM system will close MAA/TANF cases if the only child was an unborn or the only eligible child is turning 19. The CM system also automatically ends MAA for dependent children turning 19, even if there are other dependent children on the case. CM will not close if there is a protected AEN or pregnant woman.

There is usually no need for a new application at redetermination/recertification

Clients who are receiving a DHS program (even if the program is not a medical program) do not need to complete a new OHP 7210 or DHS 415F application when requesting medical.

It does not matter when the application was originally signed, as long as the client is currently receiving DHS program benefits at the time they make the request for medical.

Review the existing OHP 7210 or DHS 415F and all the information on the original application. Determine what eligibility items need to be verified and send a pend notice.

If there is no current application available in the imaging system or in the file, require a completed application.

Amending the original application

Sometimes an application may need to be amended. If someone has moved into the household and is in the medical filing group, the worker may pend to have the existing application updated by the client. (When a client updates an existing application, the client is amending the application).

- To request the application be amended to include the new filing group member’s name, SSN, DOB and other information in the “Tell us about the people in your household” section of the DHS 415F or question 2 of the OHP 7210. Send copies

of the pages of the DHS 415F or OHP 7210 that need to be amended to the client with a pend notice.

Instead of sending copies of part of the original application, caseworkers may use the DHS 415X “Additional Space for Other People Living with You” or OHP 7226 “Additional People” form.

- If the new person in the medical filing group is required to sign the application, request the application be amended to include the new filing group member’s signature. Send copies of pages 8 through 14 of the original DHS 415F or pages 3 and 4 of the original OHP 7210 to the client with a pend notice.

Example: Mary and her three children are receiving FS benefits. Mary loses her health insurance and requests medical. The worker may use the DHS 415F used for the FS application to determine eligibility for medical.

Pending for a new application

Instead of sending copies of part of the original application to be amended, the family may be sent a new application.

- When requesting a new application, completion of the application becomes an eligibility requirement. The family must be pended for completion of the new application.

Note: If the client submits a new reapplication packet, new signatures are also required. For example, in a two-parent household, require both parents to sign the reapplication. Do not use the signatures on the old application.

Example: Joan and her two children are receiving FS and ERDC. Joan reports that her husband John has returned to the household. Joan requests medical for herself, her husband Johan and their two children. The worker may use the DHS 415F used for the FS eligibility to determine eligibility for medical.

However, because John is new to the household and also must sign the application, the worker needs information about John and also John’s signature on the application. Instead of amending the existing application, the worker may opt to require a new application and sends a pend notice requesting the new application.

BED Coding for Periodic Redeterminations or When Acting on a Reported Change

For periodic redeterminations or when acting on a reported change that affects medical eligibility in the BCCM, CEC, CEM, EXT, MAA, MAF, OHP, OSIPM and SAC programs, give the filing group 45 days from the date of request to re-establish their eligibility.

Note: *Although client's report of a change must be timely in order to be eligible for the 45-days extension, a state agency's report of a change need not be timely.*

If there is not enough time to process the periodic redetermination or act on the reported change, add the BED need/resource item. The BED end date should provide enough time to pend and/or send a 10-day notice to close or reduce benefits.

If not removed, the CM case will use the BED code to send the 77B 10-day close notice on the 15th of the month. If the 45th day is after the 15th, the BED end date should be the next month.

☞ SEE MEDICAL ASSISTANCE WG-10 FOR MORE INFORMATION ABOUT BED CODING.

If the client is not eligible for medical anymore: If the client has turned in enough information to make an eligibility decision and they are no longer eligible, send a notice stating the specific reason why they are no longer eligible. Send a DHS 462A also.

If the client is still eligible, but for a reduced benefit package: If the client has turned in enough information to make an eligibility decision and they are no longer eligible for the same level of benefits, send a notice stating the specific reason why their benefits must be reduced. Send a DHS 462A also.

Example: CW notifies you the only eligible child has been removed from the MAA household. Before ending the parent's MAA medical, consider OHP-OPU for the parent. Pend as needed to verify OHP-OPU eligibility. If eligible for OHP-OPU, send a timely continuing notice of reduction, Notice of Decision or Action Taken (DHS 456), and convert the parent's MAA medical to OHP-OPU medical the first of the month after the timely continuing notice period.

If the client is not eligible for SSP medical anymore, but could be eligible for SPD medical: When a decision has been made that the client is not long eligible for SSP medical, determine if the client could be eligible for SPD medical. If they could be eligible for SPD medical, complete a referral and keep the SSP medical open until SPD has made a decision. Use the BED coding to keep the case open. Do not send a close notice or DHS 462A until SPD has made a decision.

☞ SEE MEDICAL ASSISTANCE B. 4 FOR MORE INFORMATION ABOUT SPD REFERRALS.

If the client's case has to be pended: Once the BED coding has been added to a pended case, if the client does not return the pended, the CM system will automatically send a timely continuing (10-day) close notice; the worker will not need to send a separate close notice. No DHS 462A is required.

Note: If circumstances or information needed to determine eligibility is expected to be received after the 45-day deadline and the client has no control over the circumstances or information, the 45-day application process may be extended.

☞ SEE MEDICAL ASSISTANCE WG-10 FOR MORE INFORMATION ABOUT BED CODING.

Periodic Redeterminations; Not EA, ERDC, EXT, FS, OHP, REF, REFM, or TA-DVS: 461-115-0430
Reservation Lists and Eligibility; OHP-OPU: 461-135-1125
Acting on Reported Changes; EXT, MAA, MAF, OHP, OSIPM, QMB, SAC: 461-170-0130
Effective dates; Redeterminations of EXT, GAM, MAA, MAF, OHP, OSIPM, SAC: 461-180-0085

6. OHP Certification Period

The intent of the OHP certification period is to give most people a continuous period of medical assistance and to review their eligibility on a periodic basis.

The certification period is the number of months between the person's initial eligibility and when a recertification of eligibility is due, or between one recertification and the next. The certification period is determined as follows:

- The initial certification period consists of the month containing the effective date for starting medical benefits and the following six months for OPU. For OPC, OP6, and CHP clients, the initial certification consists of the month containing the effective date for starting medical benefits and the following 12 months.
- For a recipient, the new certification period is the following six-month period for OPU. For OPC, OP6 and CHP recipients, the new certification period is the following 12-month period.
- When a person receiving OHP starts working under a JOBS Plus agreement, extend the certification period to one month beyond the end of the agreement. If the agreement ends early, shorten the period to the original date or the month following the month in which the agreement ends, whichever is later.

How to recertify BEDded Cases

If eligible for OHP, any month the client receives benefits because the case had been BEDded counts toward the next OPC, OP6, CHP or OPU certification period.

When recertifying a BEDded case, remove the BED code. Enter a Compute action for the first of the next month. Change the medical case descriptor if necessary and update the OPC, OP6, CHP or OPU need/resource end date. Change the medical start date on CMUP for the recertified client to the first of the next month.

For example, an OPC child's certification is due to end April 30. On April 14, the family reapplies for OHP benefits and the case is BEDded for 06/09. On May 5, the child is determined to be eligible for CHP. Remove the BED code. Compute for June 1, 2009,

and enter a CHP need/resource end date of 04/10. Change the child's medical start date to June 1.

Adding/removing persons from an OHP case

When a new person (other than a newborn) wants to be added to an ongoing case, the entire group must establish a new certification period. If the new certification would make the current benefit group ineligible, the original benefit group remains eligible for the remainder of their certification period.

Example: Mary and her two daughters are receiving OHP. Her son John had been living with his father, but has returned to live with Mary and his sisters. John is not receiving any health care coverage, so Mary applies for medical for John on October 15, 20XX.

Determine eligibility for Mary, her two daughters and John. If eligible, recertify Mary (giving her a new six-month OPU certification) and her two daughters (giving them a new 12-month certification) and certify John from October 15, 20XX and the following 12 months.

Note: If John is not eligible for medical, send a denial notice and DHS 462A notice. Keep Mary and her two daughters on their original certification.

When a person leaves an OHP benefit group, that person is still eligible through the end of the certification period as long as he or she meets the nonfinancial and specific program requirements. Those remaining in the original benefit group also are still eligible through the end of the certification period if they continue to meet the nonfinancial and specific program requirements. A different case will need to be opened for the person who left the group. If the person is paying premiums as required under the OHP-OPU program, the premium status from the original case will not be updated on the new case.

Information about OHP certifications

A pregnant woman eligible for OHP is not assigned an eligibility period. She is assumed eligible through the last day of the month in which the 60th day following her pregnancy falls. When her assumed eligibility period ends, she needs to reapply to continue to receive benefits even if the certification period for others in the group extends beyond her assumed eligibility period. The computer system uses the DUE need/resource date to determine the period of eligibility. If the pregnancy ends in a month other than the date coded, it is important to change the DUE need/resource date so the person receives the correct period of coverage.

Combining OHP households

When a recipient moves into the household of another recipient, they must be combined into one case if all of the recipients are required to be in the same filing group. When cases are combined, extend the certification period to the latest date for any of the persons in the group.

Affect of reported changes on the certification period

Once a person is determined eligible for OHP, any changes in the filing group's household composition, income or resources, does not affect their eligibility during their current certification period. However, other changes (such as residency, citizenship, and student status) can affect eligibility.

☞ SEE SECTION E (MA E) OF THIS CHAPTER FOR MORE INFORMATION.

Certification Period; OHP: 461-115-0530
Assumed Eligibility for Medical Programs: 461-135-0010

7. Verification of Eligibility

The intent of verification is to ensure that the verbal or written information given by a person is the true information.

People must provide verification of their eligibility when requested. Branch staff may determine what is acceptable verification for specific eligibility requirements and situations. An application may be denied or ongoing benefits ended when acceptable verification is not provided.

☞ FOR EXAMPLES OF DOCUMENTS USED FOR VERIFICATION, SEE MULTIPLE PROGRAM WORKER GUIDES #2 ON VERIFYING CLIENT INFORMATION.

For all medical assistance programs, verify the following whenever it is reported, changed or as needed for eligibility determination:

- **Pregnancy.** This must be verified by a medical practitioner, a health department or clinic, or a crisis pregnancy center or other like facilities. Due date verification is not required except when the only child is an unborn child for MAA and MAF or when a CAWEM client is part of the Pre-natal Expansion Pilot Program.

☞ FOR MORE INFORMATION ABOUT THE PRE-NATAL EXPANSION PILOT, SEE NC C.3.

- **Birth of a child.**
- **Amount of the premium for cost-effective employer-sponsored health insurance.**
- **Income.** If income cannot be verified, accept the client statement and narrate the income calculation. For example, if the client has moved to Oregon from another state, has no pay verification and the employer refuses to provide verification to the client or the department, accept the client's statement of gross earnings and narrate.

Note: Many OHP and MAF self-employed clients do not have verification of all their self-employment costs. If necessary, use the DHS 859B and other

client statements for verification of self-employment costs. If no verification is available, accept the client's statement. Do not pend for bank statements and other documentation unless the costs are questionable.

- Citizenship. Acceptable evidence of citizenship must be provided for certain Medicaid recipients.

☞ SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

For all other eligibility requirements – i.e., residence, age, resources – accept the person's statement unless it is questionable or inconsistent.

Any eligibility requirement may require verification when information is questionable or inconsistent with any of the following:

- Other reported information.
- Other information provided on the application.
- Other information received by the branch office.
- Information reported on previous applications.

EXT. Verify the following eligibility requirements for **EXT**:

- For initial EXT eligibility based on an increase in child support verify that at least one person in the EXT filing group received MAA or MAF for three of the six months preceding the first of the EXT eligibility period.
- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

MAA/MAF. Verify the following eligibility requirements for **MAA** and **MAF**:

- Social Security Number or an application for a number.
- Citizenship. Acceptable evidence of citizenship must be provided for some MAA/MAF recipients.

☞ SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

☞ SEE SECTION A.1 OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.
- Income.
- Incapacity for deprivation based on incapacity. Other deprivation requirements as needed.

☞ SEE TANF E IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES RELATED PROGRAMS CHAPTER FOR MORE INFORMATION ON DEPRIVATION.

SAC. Verify the following eligibility requirements for **SAC**:

- Social Security Number or an application for a number.
- Citizenship. Acceptable evidence of citizenship must be provided for some SAC recipients.

☞ SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.

☞ SEE SECTION A.1 OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.

- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.
- Income and resources for children in substitute care.
- Eligibility for adoption assistance for adopted children. The family of a child receiving adoption assistance from another state should have a letter or a copy of the Adoption Assistance Agreement from that state that will confirm the child's eligibility for adoption assistance.

OHP. When people apply for **OHP**, verify the following eligibility requirements for the initial application:

- Social Security Number or an application for a number.

☞ SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED.

- Alien status for persons who indicate they are not U.S. citizens but say they have legal immigration status.
 - ☞ SEE SECTION A.1 OF THE NONCITIZENS CHAPTER FOR MORE INFORMATION ON VERIFICATION OF ALIEN STATUS.
- American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program.
- Income from each month used to determine a person's eligibility.
- Mailing address.

Verify the following when an OHP case is being recertified:

- Citizenship. Acceptable evidence of citizenship must be provided for most OHP recipients as soon as possible after opening benefits. If the client is unable to provide documentation and says they need more time, extend the pend period.
 - ☞ SEE MEDICAL ASSISTANCE D.5 FOR MORE INFORMATION ABOUT WHEN CITIZENSHIP DOCUMENTATION IS REQUIRED
- Alien status if it has changed since the previous certification.
- Unearned income if it has changed since the previous certification.
- Earned income from each month used to determine eligibility.
- Mailing address. A mailing address is required to complete an application. However, there is no length of residency requirement for Medicaid. A person can move within the state, or from out-of-state, and the length of residency cannot be considered in determining eligibility.

In verifying a mailing address, workers should be reasonable and not create any barrier to accessing benefits. Medical cards may be sent to any place the person chooses, such as a post office, general delivery or public shelter, or the person may pick up the card at his/her local branch office. This choice is particularly applicable for newly arrived or homeless applicants.

- Clients can verify their mailing address by providing any of the following documents that show their name and address:
 - Oregon driver license;
 - Oregon identification card;
 - Oregon resident individual income tax form;
 - Current bill or statement (for example: phone, electric, credit card, bank, etc.);

- Rent, hotel or shelter receipt;
- Medical or other insurance card;
- Voter registration card;
- Marriage license;
- Vehicle registration;
- Federal income tax return;
- Any canceled envelope (except the envelope the OHP application came in).

If the client cannot provide any of the above documents, the worker can use other documentation not on the list that reasonably verifies the client's address. If the client does not have any documentation, a note explaining why may suffice. Workers need to exercise good judgment.

When An Application Must Be Filed: 461-115-0050
Verification; General: 461-115-0610
Required Verification; BCCM, MAA, MAF, OHP, SAC: 461-115-0705

C. Eligibility Determination Groups

One of the first steps in the eligibility determination process is forming eligibility groups. These groups identify who is considered in the household (household group), who must apply together (filing group), whose income and resources will be used to determine eligibility (financial group), whose needs are considered (need group) and who will receive benefits (benefit group). Five groups are used in making accurate eligibility determinations. However, it may not be necessary to evaluate everyone in the household in determining their eligibility for medical. Some people are assumed eligible.

1. Assumed Eligibility (Who is automatically eligible or has protected eligibility?)

Some individuals are *assumed eligible* for certain medical programs.

The following people are *assumed eligible* for medical assistance:

- Pregnant women who are eligible for and receiving medical assistance under BCCM, CEM, EXT, MAA, MAF, OPP, OSIPM and SAC and become ineligible while pregnant are assumed eligible for Medicaid.
- Pregnant women who are eligible for and receiving BCCM, CEM, EXT, MAA, MAF, OPP, OSIPM or SAC when their pregnancy ends are assumed eligible until the last day of the calendar month in which the sixtieth day after the last day of the pregnancy falls.
- A child born to a mother who is eligible for and receiving Medicaid based on BCCM, CEC, CEM, CHP, EXT, MAA, MAF, OPP, OSIPM or SAC program eligibility (including CAWEM) is assumed eligible until the end of the month in which the child becomes one year old.

Note: Pregnant CHIP clients are not assumed eligible for medical. Children born to pregnant CHIP clients are assumed eligible Medicaid children.

- A child who is the subject of an adoption assistance agreement with another state.
- A child in a state-subsidized, adoptive placement, if an adoption assistance agreement is in effect between a public agency of the state of Oregon and the adoptive parents that indicates the child is eligible for Medicaid.
- A recipient of SSI benefits.
- A client who receives both benefits under Part A of Medicare and SSI benefits is assumed eligible for the QMB-BAS program.
- A client is assumed eligible for REFM if –
 - The client is receiving cash assistance through the REF program;

- The client loses eligibility for cash assistance through the REF program only because of income or resources;
- The client loses eligibility for the EXT, MAA, MAF or SAC programs, but still meets the requirements of the REFM program; or
- The client had refugee-related medical assistance established in another state based on refugee status granted by the United States Citizenship and Immigration Services, and moved to Oregon within the client's first eight months in the United States.

Assumed Eligibility for Medical Programs: 461-135-0010

2. Household Group (Who is in the household?)

A household consists of people who live in the same house, apartment, or other dwelling. A dwelling can contain more than one household if it is divided into separate living units, such as an apartment house, or if a landlord/tenant relationship exists. To have a valid landlord/tenant relationship, the landlord must live independently and bill the tenant for rent at fair market value. They may share bathroom and kitchen facilities, but only in a commercial room and/or board establishment. When people live in more than one household during a month, they are considered to be living in the household where they spend 51 percent or more of their time.

A person who leaves the household for short periods is considered to still be in the household if they intend to return. If they are gone for 30 continuous days or more, they are no longer in the household unless they must still be included under one of the following:

- A parent gone because of employment while the other parent remains in the home. This includes people with jobs that customarily take them away from home, such as military service, truck driving or commercial fishing, and people looking for work.
- A parent or caretaker relative for a maximum of 90 days when they are staying in a residential alcohol or drug treatment facility.
- A person is receiving treatment in a general hospital and expected to return home. If they are not expected to return home, they remain in the household until they enter some other living arrangement, such as a nursing home.
- A child gone for illness, social service, or educational reasons. They are no longer in the household if they are admitted to a Medicaid facility such as a nursing home or residential treatment facility for more than 30 days.
- Children in foster care, if they are expected to return home within the next 30 days.

For OHP only, a child may be in a residential alcohol or drug treatment facility for more than 30 days and still be considered in the household. However, if the child's household is ineligible because of income, the child is a separate household for OHP only.

Household Group: 461-110-0210

3. Filing Group (Who must apply together?)

The filing group is the people from the household group whose circumstances are considered in the eligibility determination process. The filing group includes people who must apply together because of their relationship to eligible people.

When a household group member is in more than one filing group for the same program, the filing groups must be combined, unless specified otherwise in administrative rule.

For **EXT and MAA**, the filing group must include a dependent child or unborn.

People in the household group are included in the MAA filing group because of their relationship as follows:

- Parents of the dependent child.
- Parents of an unborn.
- Siblings of the dependent child. Siblings must be under 18 years of age or age 18 and attending school full time. (See below for exceptions for siblings receiving adoption assistance or for siblings who are minor parents.)
- For needy caretaker relatives of the dependent child, their spouse, and their dependent children.
- Caretaker relatives.

People in the household group may be excluded from the MAA filing group as follows:

- Exclude dependent children who have been or will be receiving foster care payments for more than 30 days.
- A sibling of a dependent child must be excluded from the filing group if the sibling is receiving adoption assistance.
- Allow minor parents to form a separate filing group with their dependent children when the minor parent lives with an adult relative who is not his or her parent or the parents of the minor are in the household, but are not applying for MAA for the minor parent or any of the minor parent's siblings.

For **MAF**, the filing group must include a dependent child or unborn.

People in the household group are included in the MAF filing group because of their relationship as follows:

- Parents of the dependent child.
 - Mother of an unborn.
 - Father of an unborn if:
 - No other dependent children are in the group; or
 - He is married to the mother; or
 - He is the father of another dependent child in the filing group.
 - Siblings of the dependent child if the siblings meet the following nonfinancial eligibility requirements:
 - Age – Under 18 years of age or age 18 and attending school full time.
 - Living with a Caretaker Relative – The caretaker must be one of the following relatives to the sibling:
 - (a) Any blood relative, including those of half-blood, and including first cousins, nephew, or nieces, and person of preceding generations as denoted by prefixes of grand, great-, or great-great.
 - (b) Stepfather, stepmother, stepbrother, or stepsister.
 - (c) A person who legally adopts the child and any person related to the person adopting the child, either naturally or through adoption.
- ☞ SEE TANF E IN THE TEMPORARY ASSISTANCE FOR NEEDY FAMILIES RELATED PROGRAMS CHAPTER FOR MORE INFORMATION ON DEPRIVATION.
- Citizen/Alien Status – The sibling must be a citizen of the U.S.; or be a citizen of Puerto Rico, Guam, the Virgin Islands or Saipan, Tinian, Rota or Pagan of the Northern Mariana Islands; or be a national from American Samoa or Swains Islands; or meet the alien status requirements for MAF.
 - Deprivation. – The sibling must meet a deprivation requirement of the MAA program.
- For needy caretaker relatives of the dependent child, their spouse, and their dependent children.

People in the household group may be excluded from the MAF filing group as follows:

- Exclude dependent children who have been or will be receiving foster care payments for more than 30 days.
- A sibling of a dependent child may be excluded for the filing group if the sibling is receiving adoption assistance and counting the sibling's income reduces the filing group's benefits.
- Allow minor parents to form a separate filing group with their dependent children when the minor parent lives with an adult relative who is not his or her parent.

For **OHP**, filing groups are formed from the household group as follows:

- A person forms his or her own filing group if not required to be in a filing group with another person.
- The following people are required to be in the same filing group, even if they are not applicants or do not meet all nonfinancial eligibility requirements.
 - People married to each other and each child of either spouse.
 - The parents of a child or unborn and the children of each parent.
 - Siblings under the age of 19.

Note: A child is defined as a person, including a minor parent, under the age of 19.

- A child whose caretaker relative is not the child's parent may form a separate filing group or may be in a group with the caretaker relative, at the option of the caretaker relative.

For **SAC**, the filing group includes only the child who meets all nonfinancial eligibility requirements.

Filing Group; Overview: 461-110-0310
Filing Group; EXT, MAA, TANF: 461-110-0330
Filing Group; MAF and SAC: 461-110-0340
Filing Group; OHP: 461-110-0400

4. Financial Group (Whose income and resources are counted?)

The financial group is the filing group members whose income and resources count in determining eligibility and benefits.

For **EXT**, **MAA**, and **MAF**, the financial group includes all the people in the filing group except the following:

- Caretaker relatives (other than parents) who choose not to be included in the need group. These people are known as non-needy caretaker relatives.
- People receiving SSI benefits.

For **OHP**, the financial group includes all the people in the filing group except caretaker relatives (other than parents) who choose not to be included in the need group.

For **SAC**, the financial group (which includes the same person as in the filing group) includes only the child who meets all nonfinancial eligibility requirements.

Financial Group: 461-110-0530

5. Need Group (What income standard is used?)

The need group consists of the people whose basic and special needs are used in determining eligibility. The number in the need group determines which income standard to use.

For **MAA**, the need group includes financial group members who meet all nonfinancial eligibility requirements. Noncitizen applicants do not need to meet citizenship or alien status requirements to be eligible for CAWEM benefits. The MAA need group cannot include:

- Individuals who do not provide a Social Security number or proof they applied.
 - ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).
- Parents who are in foster care and for whom foster care payments are being made.
- Siblings who do not meet deprivation requirements.
- Unborn children.

For **MAF**, the need group includes all financial group members who meet all nonfinancial eligibility requirements except for the following:

- Individuals who do not provide a Social Security number or proof they applied.
 - ☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).
- Parents who are in foster care and for whom foster care payments are being made.
- The father of an unborn child who has no eligible dependent children.

For **EXT**, the need group includes all members of the financial group. Individuals who do not provide a Social Security number or proof they applied.

☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

For **OHP**, the need group includes all the people in the financial group. For pregnant females, also include the unborn child(ren) in the OHP need group.

For **SAC**, the need group (which includes the same person as in the financial group) includes only the child who meets all nonfinancial eligibility requirements. Individuals who do not provide a Social Security number or proof they applied.

☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

Need Group: 461-110-0630

6. **Benefit Group (Who receives benefits?)**

The benefit group are those people who receive benefits.

For **CEC** and **CEM**, the benefit group is limited to those non-CAWEM children under age 19 who lost eligibility for EXT, MAA, MAF, OHP, OSIPM and SAC without having received benefits for 12 months.

For **EXT**, the benefit group consists of members of the need group who meet all financial and nonfinancial eligibility criteria.

For **MAA** and **MAF**, the benefit group includes all the need group members if the group meets the financial requirements.

For **OHP**, the benefit group consists of all the individuals who meet all the financial and nonfinancial eligibility requirements. Individuals who do not proved a Social Security number or proof they applied.

☞ FOR EXCEPTIONS, SEE NONFINANCIAL ELIGIBILITY REQUIREMENTS, SOCIAL SECURITY NUMBER (MA D.6).

For **SAC**, the benefit group (which includes the same person as in the financial group) includes only the child who meets all nonfinancial eligibility requirements.

Benefit Group: 461-110-0750

7. CAWEM

Noncitizens who meet all the financial and nonfinancial requirements of another medical program (except OHP-CHP), except for their citizenship/alien status, are eligible for limited emergency medical assistance. The policy for forming eligibility determination groups for CAWEM is the same policy for the program the person would qualify for if they did meet the citizenship/alien status requirement.

Specific Requirements; Citizen/Alien-Waived Emergent Medical (CAWEM): 461-135-1070
OHP-OPU; Effective Dates for the Program: 461-135-1102

D. Nonfinancial Eligibility Requirements

1. Age and School Attendance

To be eligible for CEM and CEC, a child must be non-CAWEM and under the age of 19.

To be eligible for MAA, MAF, and EXT medical assistance, a child must be under 18 years of age or age 18 and regularly attending school full time. The caretaker(s) may be of any age.

To be eligible for SAC medical assistance, the person must be under age 21. There are no school attendance requirements for SAC.

When determining eligibility for OHP medical assistance, use the following age requirements for each OHP category:

- OHP-OPU: A person age 19 or older who qualifies under the 100 percent income limit.
- OHP-OPC: A person under age 19 who qualifies under the 100 percent income limit.
- OHP-OP6: A person under the age of six who qualifies under the 133 percent income limit.
- OHP-OPP: A pregnant female of any age, or their newborn children under the age of one who qualifies under the 185 percent income limit.
- OHP-CHP: A person under the age of 19 who qualifies under the 185 percent income limit.

For CAWEM, the person must meet the age and school attendance requirements of the program they would qualify for if they met the program's alien/citizen requirements.

To be eligible for the BCCM program, a woman must be under age 65. (The BCC Screening program, coordinated by DHS Health Services, has its own eligibility criteria for screening services which includes a requirement that the woman be at least 40 years old.)

OHP child in school 461-001-0000; Age requirements: 461-120-0510
Regular school attendance: 461-120-0530
OHP-OPU, Effective Dates for the Program: 461-135-1102

2. Oregon Residence

To be eligible for medical assistance, people must be residents of Oregon. They must be currently living in Oregon and intend to remain in the state. There is no requirement that

they must have been in Oregon or intend to remain in the state for a minimum amount of time. Residents can leave the state for temporary purposes (e.g., vacation, school attendance, medical treatment, employment) and keep their residency as long as they intend to return to Oregon.

A new resident receiving medical assistance from another state may receive duplicate medical assistance from Oregon, if the person would be eligible in Oregon and would not otherwise receive medical care.

Residency requirements: 461-120-0010
Statement of intent to reside: 461-120-0050
Duplicate benefits: 461-165-0030

3. Eligibility for People in Correctional Facilities

An inmate of a public institution is not eligible for benefits. An inmate is a person living in a public institution who is:

- Confined involuntarily in a local, county, state, or federal prison, jail, detention facility, or other penal facility, including a person being held involuntarily in a detention center awaiting trial and a person serving a sentence for a criminal offense;
- Residing involuntarily in a facility under a contract between the facility and a public institution where, under the terms of the contract, the facility is a public institution;
- Residing involuntarily in a facility that is under governmental control; or
- Receiving care as an outpatient while residing in a public institution.

A public institution is an institution that is the responsibility of a governmental agency or over which a governmental agency exercises administrative control. Administrative control includes but is not limited to ownership and control of the physical facilities and grounds used to house inmates. A governmental agency exercises administrative control when it is responsible for the ongoing daily activities of a facility; for example, when facility staff members are government employees, or when a governmental agency, board, or officer has final authority to hire or fire employees of the institution. As used in this section, public institution relates to individuals residing in a correctional facility and not a medical facility.

Close benefits for inmates with a basic decision notice effective the last day of the month in which the notice is sent. If the inmate is released prior to the effective date for closure, and DHS is notified of the release prior to the effective date, restore medical benefits.

An individual is no longer an inmate when:

- The person is released on parole or probation;

- The person is on home- or work-release, unless the person is required to report to a public institution for an overnight stay; or
- The person is staying voluntarily in a detention center, jail, or county penal facility after his or her case has been adjudicated and other living arrangements are being made for the individual.

Eligibility for Inmates: 461-135-0950
Notice Situation, Nonstandard Living Situations: 461-175-0230

4. Incarcerated Pregnant Women Receiving Medical Assistance

An inmate as described in section 3 above is not eligible for benefits. However, a pregnant woman determined eligible for medical assistance is assumed eligible for medical assistance through the date her pregnancy ends.

If a pregnant woman receiving medical assistance becomes an inmate of a public institution, her medical benefits are suspended. However, her medical eligibility continues as an assumed eligible pregnant woman. Upon notification the pregnant woman has been released, her medical benefits are restored without an application if she continues to reside in Oregon.

To suspend medical benefits for a pregnant woman who becomes an inmate of a public institution:

- Create a separate medical case for the pregnant woman if she is not already on her own case.
- Use the “SUSM” incoming code to suspend medical benefits. The case will remain in suspense status for six months before the case is auto-closed showing a “SUSPCL” incoming code.
- Use the “IN” reason code and “IN” notice code. The notice code will initiate the “IN” CMS notice (Pregnant female benefits suspended – Incarceration).
- Add the “INM” case descriptor to the case.

To restore the pregnant woman’s medical benefits upon notification she is no longer an inmate of a public institution:

- Start medical eligibility effective the first day she is no longer an inmate of a public institution.
- Remove the “INM” case descriptor from the case.

- If her eligibility period has already passed, complete a *Request for Medical Eligibility* (AFS 148) form and submit it to Client Maintenance Unit.

When An Application Must Be Filed: 461-115-0050

Assumed Eligibility: 461-135-0010

Eligibility for Inmates: 461-135-0950

5. Citizen/Alien Status

Citizenship Documentation Requirements

The Deficit Reduction Act (DRA) of 2005 requires documentation of U.S. citizenship and identity in the case record for certain medical clients. Some clients are not affected by the documentation requirements in the Deficit Reduction Act:

- Noncitizens.
- CHIP children.
- Pregnant and post partum women who are assumed eligible for Medicaid (new applicants who are pregnant are not assumed eligible).

Some Medicaid clients are considered to have met the U.S. citizenship documentation requirements already and do not need to provide evidence of citizenship:

- SSI recipients.
- Medicare recipients.
- SSDI recipients.
- Assumed eligible newborns born in Oregon. Once determined to be an assumed eligible newborn born July 1, 2006, or later, the client is exempt from providing citizenship documentation. A new system code to track Oregon born AENs has been requested.

Application Processing

The CHIP Reauthorization Act of 2009 revised the citizenship documentation requirements. Effective April 1, 2009, Medicaid applicants need no longer provide citizenship documentation before their benefits can be opened for the first time.

Instead of waiting for the citizenship documentation, if the applicant is otherwise eligible for Medicaid, open their Medicaid benefits and pend for the citizenship documentation.

- For new applicants, pend for citizenship documentation for 45 days from the date of request. Remember, do not delay medical benefits to an otherwise eligible applicant who has been pended for citizenship documentation for the first time.

- If an applicant or recipient can get the documentation, but needs extra time, it is possible to authorize an extension of the 45-day pend period, but be very careful to provide a new pend notice with a new date and to track progress. Determine what new pend date to use by jointly determining with the client the length of time you both believe will be necessary.
- If the client is required to provide citizenship documentation and does not provide the necessary documentation within the time allowed, and does not request an extension, medical benefits must be closed with a timely continuing benefit notice.

Implementing the April 1, 2009, Policy Change

The CHIP Reauthorization Act of 2009 revised the DRA citizenship documentation requirements.

If the date of request (DOR) is on or after April 1, 2009, and the only eligibility item remaining is citizenship documentation:

- Except for an applicant whose medical benefits were previously closed on or after April 1, 2009, for not providing acceptable documentation, an applicant's medical assistance may not be delayed for citizenship documentation while the eligibility decision is pending if all other medical assistance eligibility requirements have been met.
- Open the Medicaid and pend for citizenship documentation. If the client has already been pended, you will need to resend a pend notice so the client will not think all eligibility criteria has been met when they get the approval notice.
- Add each pended recipient with the CIP need/resource item. Each recipient is provided a 'reasonable opportunity period'; a minimum of 45 days plus time for a 10-day closure notice to provide the pended citizenship documentation. If the recipient requests an extension, or if the eligibility worker has ordered a birth certificate and it has not arrived, the reasonable opportunity period can be extended.
- Each time the reasonable opportunity period is extended, staff must send a new pend notice which includes the new documentation due date, and narrate the action in TRACS. Be sure to change the CIP to CIE and add a new CIE end date. Once the documentation is received, staff should update the Person Alias/Update screen citizenship fields and narrate in TRACS.
- If the documentation is not received in the reasonable opportunity period and the client does not respond to the pend notice, a closure notice will be automatically sent, the CM system will automatically change the CIP/CIE case descriptor to CID and end Medicaid benefits. No further action will be required by the eligibility staff.
- If the benefits for a recipient are closed because they did not provide the citizenship documentation within the time frame allowed, and they reapply after

benefits are closed, determine if the individual had good cause for not requesting an extension. If there was good cause, restore the medical, code with CIE, and repond, extending the due date. Narrate in TRACS. If there was no good cause, pend for the documentation, but do not open medical while pending for the citizenship documentation.

If the DOR is prior to April 1, 2009, and the application is currently pending, and the applicant is otherwise eligible for a Medicaid program (the only item pended for is citizenship documentation):

- Open the Medicaid effective April 1, 2009. Resend a pend notice so the client will not think all eligibility requirements have been met when they get the approval notice. Once the pended recipient provides the citizenship documentation, send a 148 to retro medical back to the date of request.
- If all other eligibility criteria has been met but the applicant has not provided the citizenship documentation, open the Medicaid assistance. Review the CIP coding and, if necessary, repond for citizenship documentation and update the CIP to CIE with a new end date.
- If an applicant has been pended for citizenship documentation and other verifications, remove the CIP/CIE coding. These individuals cannot be opened while pending for citizenship documentation because other verification is also necessary to determine eligibility.

Examples:

Example 1: Jane is receiving CHP benefits with her mother, Ann Doe. Ann lost her job and applied for TANF/MAA on April 15. Jane and Ann's citizenship documentation is the only item remaining before MAA can be opened. Convert Jane and Ann to MAA and add the CIP coding for 06/09 to both Jane and Ann.

Example 2: Bill applied for OHP for his two children on March 15. The children are eligible for OHP except that Bill lost his children's citizenship documentation from California. Open the children's OHP-OPC medical effective April 1 (the date the new policy was effective), add the CIP coding to each child, and add OPC need/resource items with end date of 03/2010. Once the citizenship documentation is provided, send a 148 to add the children's medical from March 15 through March 31. In this example, the certification is 12 months. Following current policy, the initial prorated month does not count toward the 12-month certification.

Example 3: Frank applied for OHP for his two children February 15. The children are eligible for OHP except for citizenship documentation. Open the OHP-OPC medical effective April 1, add the CIP coding to each child, and add the OHP need/resource

items with an end date of 02/2010. In this example, consider March the first month when determining the 12-month certification. The initial prorated month does not count toward the 12 month certification, but March does count.

Note: *If the benefits for a recipient are closed because they did not provide the citizenship documentation within the time frame allowed, and they reapply after benefits are closed, determine if the individual had good cause for not requesting an extension. If there was good cause, restore the medical, code with CIE, and repond, extending the due date. Narrate in TRACS. If there was no good cause, pend for the documentation, but do not open medical while pending for the citizenship documentation.*

Recording Documentation

The DRA also requires the case record contain documentation to support the declaration of citizenship. DHS staff must view original documents or certified copies from the issuing agency.

You may be provided documentation by mail or in person. If mailed, place a copy in the case record and return original documents via regular mail.

You may also be provided documentation from contracted outreach facilities. Outreach facilities can attest they have viewed the original citizenship and identity documents. They use the *U.S. Citizenship and Identity Proof Documentation* (OHP 7203) form to verify which documents they have viewed. We can accept the OHP 7203 when it is date-stamped by the outreach center and bears the outreach facility identification code.

- DHS has made a commitment that there will be “no wrong door” for applicants and recipients who are providing documents. If an individual brings original documents to any DHS office or branch, even when the client’s case is in another branch, the following steps must be taken:
 - Accept whatever original documents or certified copies from issuing agencies the client brings in.
 - Copy and return the original documents to the client.
 - Date stamp the copies, make a note on them that we have viewed the original documents (some branches have a date stamp that already says this) and sign or initial.
 - Some branches review the documents provided, and if the documents meet the requirements of citizenship and identity for this provision, they update the CI Person/Alias Update screen before they send the copies to the appropriate branch. This is a decision that can be made on the branch level.

- Narrate in TRACS that the client brought in documentation, state what the documentation was and what branch it is being sent to, if it is going to another branch.
- If an individual provides fraudulent citizenship related documentation, we are required to report it to the agency that issued the document. For example, if a fraudulent birth certificate is submitted, notify the issuing state's vital records agency.

Once documented, we should not need to verify a client's U.S. citizenship status again. The expectation is that the citizenship field on Person/Alias Update will be a key tool in tracking citizenship documentation. If you look on Person/Alias Update and the citizenship field indicates acceptable verification has been provided, you do not need to reverify citizenship.

Copies of the accepted documents should be included in the case record. We can photocopy passports and other documents marked "Do not copy" for our files.

The case record includes:

- Imaged documents.
- Case file.
- Updated citizenship field on the client's Person/Alias Update screen Citizenship Field.

The Person/Alias Update citizenship field must be updated to reflect citizenship status. All reports, audits, and other reviews will use the citizenship field.

Acceptable Documentation

States are required to use the most reliable form of documentation available. A hierarchical list has been provided.

☞ SEE WORKER GUIDE MA-3: CITIZENSHIP AND IDENTITY DOCUMENTATION HIERARCHICAL LIST FOR THE COMPLETE HIERARCHICAL CITIZENSHIP DOCUMENTATION LIST.

- "Primary documents" from the hierarchical list are considered the most reliable and may be used to document both citizenship and identity.
- However, we can accept secondary documentation if primary documentation is available within 45 days, but secondary is already available. We can also accept secondary level documentation if a client has a passport but they do not have immediate access to it or their birth information is on BBCN.

- If it is determined that the client cannot obtain a higher level citizenship documentation within 45 days from the DOR, accept lower level documentation. Do not pend for higher level documentation.
 - If the applicant or recipient needs to order birth certificates from out of state, provide the list or the link to state vital records contacts at:
www.cdc.gov/nchs/howto/w2w/w2welcom.htm
- ☞ SEE FSM MULTIPLE PROGRAM WORKER GUIDE MP-3, VITAL STATISTICS, FOR A LIST OF OUT-OF-STATE VITAL RECORDS CONTACTS.

Hardship Criteria

In certain limited circumstances, we may be able to help assist with payments for citizenship documentation.

Pay via the *Authorization of Cash Payment* (DHS 437) using pay reason 30 or SPOTS object code 6913 (**do not** use code 6912). We can pay when the individual is unable to pay for the required documentation due to:

- Gross income is at or below 10 percent of the federal poverty level (FPL); or
- Liquid resources are less than \$100; or
- When income, less shelter and utilities, is less than 10 percent FPL; or
- When the client is homeless; or
- When there is domestic violence.

In circumstances where the individual meets one of these hardships, but has a resource to pay the cost of documentation, we will allow them to pay for the documents. We will not purchase driver's licenses in place of state I.D. We will not pay for passports or naturalization papers except in very rare circumstances. Consult a Medical Program Analyst before paying for passports or naturalization papers.

Payments cannot be made to reimburse the applicant or recipient.

To order a birth certificate for clients meeting the hardship criteria:

- Go to the CDC "Where to Write for Vital Records" website at:
<http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm>. The website has links to each state's vital records for birth certificate requests.
- Follow the state's instructions for ordering a birth certificate and complete the required letter or form. The requirements vary by state; for example, some states require the client or the client's parent sign a statement authorizing the request for a birth certificate.

- Mail the required letter or form requesting the birth certificate. Enclose a pay reason 30 revolving-fund check in the requirement amount.

Oregon's Vital Records Screens

Access to Vital Records screens is limited to viewing. **NEVER PRINT VITAL RECORDS SCREENS!** Narration and updating citizenship documentation fields on the Person/Alias Update screen fully meets the documentation requirements.

We have been given access to screens that provide birth, marriage, and divorce data.

The birth screens are:

BBCN Browse by child's name

- The mother's birthplace listed on BBCN is self-disclosed and does not meet documentation requirements.

BBMN Browse by mother's name

You may need to confirm name changes to verify identity. Vital records has also provided access to marriage and divorce screens:

For marriage:

BMBW Browse by bride

BMBH Browse by groom

BMBD Browse by date of marriage

For divorce:

BABW Browse by wife

BABH Browse by husband

BABD Browse by date

We have also been given access rights to death data:

BDBN Browse by name of deceased

BDBD Browse by date of death and county

☞ SEE THE COMPUTER GUIDE CHAPTER XIII(C) FOR MORE INFORMATION ABOUT THE VITAL RECORDS SCREENS.

The Citizenship Field on the Person/Alias Update Screen

- To access the Citizenship field on Person/Alias Update, go to the client's CI-FIND screen. Press F16.

There are three fields that are used to support citizenship. The first field is the “Cit” field. The Cit field indicates if client has met Medicaid required documentation of citizenship, including identification requirement:

An “A” in the Cit field means that the client has provided “Acceptable documentation” and has met the DRA requirements. The client has declared U.S. citizenship and provided Medicaid approved documentation of citizenship and identification.

A “D” in the Cit field means the client has declared U.S. citizenship but has not yet provided documentation.

An “X” in the Cit field means the client has not requested Medicaid or that no information is available.

An “N” in the Cit field means noncitizen who meets Medicaid/SCHIP alien status requirements, i.e., is eligible for full medical benefits (is not limited to CAWEM). A documentation source code is not allowed for persons with an “N” in the Cit field.

Note: Do not code a Refugee with an “N.”

A “C” in the Cit field means noncitizen who has not yet met the Medicaid/SCHIP alien status requirements (if otherwise meets medical program requirements may receive CAWEM benefit package). A document source code is not allowed for persons with a “C” in the Cit field.

The “V/R” field indicates whether the documentation has been reported but not verified or verified per the DRA requirements. A “V” means both citizenship and identity meet DRA requirements.

The next field identifies what source was used to report or verify citizenship and identity. For example, “PS” is the code for passport; “BP” is the code for public birth record and includes Vital Records screen verification such as BBCN.

To update the citizenship fields on Person/Alias Update:

- Tab to the bullet to the left of the “Cit” field. Enter an X on the bullet. Press F13. The Citizenship Update screen will display.
- Enter the appropriate codes in the Cit, V/R, and Src fields. Press F9 to save.
- F3 will return you to Person/Alias Update.

Alien Requirements Overview

To determine if an applicant meets the alien status requirements (except CAWEM), see section C.1 of the Noncitizens Chapter (NC C.1).

CAWEM applicants who are not documented (do not have a legal immigration status) are not required to declare or provide proof of their citizenship or immigration status. Nonapplicants do not have to meet the citizenship or alien status requirement. Nonapplicants are not required to declare or provide proof of their citizenship or immigration status. The disclosure of information regarding citizenship and alien status for nonapplicants is voluntary.

***Note:** Nonapplicants are persons who choose not to apply for benefits or who are not eligible to receive benefits, even though they may be required to provide verification of income and resources.*

To be eligible for the CAWEM program, a client must be ineligible for EXT, MAA, MAF, OHP (except OHP-CHP), OSIPM or SAC solely because they do not meet citizenship or alien status requirements. See section C.3. of the Noncitizens Chapter (NC C.3).

☞ SEE THE NONCITIZEN CHART IN THE MULTIPLE PROGRAMS WORKER GUIDE CHAPTER FOR MORE INFORMATION.

Citizen/Alien Status Requirements: 461-120-0110
 Alien Status; Not REF or REFM: 461-120-0125
 Declaration of Citizenship or Alien Status: 461-120-0130
 Application Processing Timeframes; Not Assessment, FS or TA-DVS: 461-115-0190
 Required Verification; OHP: 461-115-0705
 Assumed Eligibility for Medical Programs: 461-135-0010

6. Social Security Number

To be eligible for medical benefits, all applicants (except assumed eligible newborns and CAWEM applicants) must provide a Social Security number (SSN) or verify they have applied for one as a condition of eligibility.

Applicants who do not have to meet the SSN requirement include:

- A newborn is assumed eligible for medical benefits for up to one year.
- CAWEM applicants.

Nonapplicants do not have to meet the SSN requirement. It is only on a voluntary basis that a nonapplicant provide their SSN. Nonapplicants are persons who choose not to apply for benefits or who are not eligible to receive benefits, even though they may be required to provide verification of income and resources.

If an applicant has not been issued a SSN, assist the applicant in applying for a SSN. If an applicant does not recall their SSN, assist the client in verifying the number.

☞ SEE MULTIPLE PROGRAM WORKER GUIDE #2, VERIFYING CLIENT INFORMATION.

Do not deny or delay medical benefits to an otherwise eligible applicant pending the issuance or verification of an individual's SSN. However, if an applicant required to meet the SSN requirement refuses to apply for or provide an SSN, the applicant is not eligible for benefits.

Requirement to Provide or Apply for SSN: 461-120-0210

7. Pursuing Assets

To be eligible for medical assistance, people must actively pursue assets for which they have a legal right or claim, i.e., unemployment compensation, workers compensation, Social Security Benefits, or any third party which may be liable for payments. However, people applying for one of the department's programs are not required to apply for other programs it administers. People eligible for MAA, MAF, SAC, or EXT are not required to pursue SSI benefits.

To pursue assets, they must apply for and satisfy all requirements to receive benefits from other programs. They must also pursue legal remedies to obtain assets from any other source if they can secure legal counsel on a contingency fee basis. People do not have to pursue loans.

People without good cause who do not pursue assets they may be entitled to are not eligible for medical assistance. This ineligibility ends when they provide evidence that they are willing to cooperate. Only the individual who can pursue the asset is assessed the penalty and loses medical eligibility. Other individuals in the benefit group, such as other adults or children, continue to receive medical assistance.

For example: Unless there is good cause not to pursue, clients who have been in a car accident must help pursue third-party coverage. Clients may be pended for *Vehicle-Related Personal Injury* (DHS 451) or *Non-Vehicle-Related Personal Injury* (DHS 451NV) forms.

Pursuing UC

One key asset is unemployment compensation (UC). Most clients applying for or receiving EXT, MAA, MAF, OPC, CHP, OPP and OPU and SAC are required to pursue UC if it could be an available asset.

☞ SEE TANF E.7 FOR INFORMATION ABOUT MAA/MAF PWE APPLICANTS AND THE REQUIREMENT TO APPLY FOR UC TO MEET DEPRIVATION REQUIREMENTS.

As with other assets, pursuing UC means applying for UC and, if eligible, meeting the Employment Department work search (or other) requirements. If an individual does not have good cause not to pursue UC, that person is not eligible for SSP medical program benefits.

Pregnant women and pursuit of UC

- Unless the pregnant woman has good cause not to apply or is receiving TANF and determined to be JOBS exempt, require pregnant women at initial MAA application (not yet receiving Medicaid benefits) to pursue UC.
- Unless there is good cause, MAF and OHP pregnant women are also required to apply for UC.
- Once the pregnant woman's Medicaid benefits have begun, she has protected eligibility. Do not require ongoing pregnant Medicaid recipients to pursue UC as part of their eligibility for Medicaid. Once a pregnant woman is receiving Medicaid, she cannot be penalized for refusing to pursue UC.

Applicants

- MAA and MAF applicants may notify you they will not apply for UC. If an MAA or MAF applicant lets you know they choose not to apply for UC, determine if the client has good cause for not applying. If they do not have good cause, deny just the applicant who refuses to apply. Do not deny anyone else in the filing group such as the children or second parent.
- If you have pended the MAA or MAF applicant to pursue UC and the applicant does not respond to the pend notice (does not contact you about the UC requirement during the pend period), the entire filing group is denied assistance. You can let the CM system deny everyone on the application for failure to complete the application process ("DD" or "AP" denials). ***The denial is not for failure to pursue UC, but because the client did not complete the application process.***
- For OHP, if the adults are not applying for OHP for themselves or if they are applying for OHP-OPU and ineligible because they are new applicants, do not pend the adults for pursuit of UC.

Recipients

When pending a client at redetermination, add the BED coding and send the pend notice to require the client to pursue UC.

- If there is more than just UC pended and the client does not respond to the redetermination pend notice, let the CM system send the 77B BED close notice and end benefits for everyone in the household for failure to complete the redetermination process. The CM system will not end benefits for clients who have protected eligibility, such as AENs or women still in their protected eligibility period. ***The closure is not for failure to pursue UC, but because the client did not complete the redetermination process.***

- For OHP only, if there is an ongoing OHP-OPU client and the only item to pend is UC, recertify everyone else in the household. Pend the ongoing OHP-OPU client for UC and add the BED coding. Do not update the STD need/resource end date.

If the client pended for pursuit of UC does not respond to the pend notice, the CM system will send the 77B BED close notice and end benefits. CM will end benefits only for the person(s) whose medical was not recertified. It will not end medical for pregnant women or AENs.

If there is no ongoing OHP-OPU client, do not pend the adults for UC.

For EXT, MAA, MAF and OHP at redetermination/recertification, if a recipient notifies you that they choose not to apply for UC, determine if the client has good cause for not pursuing. If no good cause:

- Send a 10-day close notice and the DHS 462A and end the recipient's medical benefits. Do not end the benefits for anyone else on the case because the recipient refused to apply for UC. If the recipient is pregnant, do not require her to pursue UC as part of her medical redetermination.

For ongoing medically eligible clients not at redetermination:

- If an ongoing EXT, MAA or MAF client reports a change that indicates they might be eligible for UC, pend the client for UC, unless pregnant. If they do not respond, send a 10-day notice and DHS 462A and end their benefits.

Good Cause

For EXT, MAA, MAF and OHP if the client has been pended for pursuit of UC and contacts the department within the 45-day pend period with concerns about applying for UC, consider if the client has good cause for not pursuing UC before denying or ending benefits.

- To qualify as good cause, there must be a circumstance beyond the client's control for not pursuing.
- For example, pregnant applicants are not automatically exempt from pursuing UC unless also in JOBS and determined to be JOBS exempt. However, a pregnant client with health concerns may have good cause not to pursue UC.
- For example, attending college is not sufficient good cause. However, a teen parent in high school through the JOBS program may have good cause not to pursue UC.

Note: *The pursuit of UC policy applies to SAC children who are receiving behavioral rehabilitation services (BRS) and psychiatric residential treatment services (PRTS); however, BRS and PRTS children always have good cause not to apply for UC. (SAC cases are carried by the Children's Medical Project Team at the OHP Statewide Processing Center.)*

Frequently asked questions and answers

Question 1: For DV applicants, can we open medical without having them apply for UC?

Answer 1: Yes, you can give them good cause not to apply if it appears they are not available to look for work because of DV issues.

Question 2: I have an MAA/TANF client in JOBS. She is attending high school and you are telling me she has to apply for UC?

Answer 2: JOBS exempt clients do not have to pursue UC (it is in rule 461-120-0330). Technically, mandatory JOBS clients need to pursue UC, but I can see why you would not want a teen parent to have to do so as part of her medical eligibility. You can give her good cause for not applying for UC if it would interfere with her JOBS plan. Remember to narrate your decision. (It could turn out to be a QC error if you do not narrate it.)

Question 3: Why do we need to pend an OHP client for UC? It does not matter for them because it can not be a part of the three-month income average.

Answer 3: At field request and to streamline eligibility, we are no longer requiring OHP clients who are not eligible for benefits or not applying for benefits to apply for UC.

Question 4: What if my client tells me he is not going to pursue UC?

Answer 4: If he is a new MAA/MAF applicant and refuses to apply for UC, we do not need to pend him for pursuit, but we do have to consider whether he must be denied MAA or MAF. First, consider if he has good cause. If he does not have good cause for refusing to apply for UC, deny just him (just the person who refuses to apply for UC) and open the children and the second parent on the case, if there is one. (The penalty for failure to apply for UC only applies to the person that does not apply for UC). Send him a denial notice explaining the UC issue and a DHS 462A. The person who refused to pursue UC is still in the need group; his income and resources still affect the family's eligibility.

If he is an ongoing MAA/MAF client at redetermination and he refuses to apply, send him a close notice and a DHS 462A and continue the review process for the rest of the family. Let him know he can change his mind, pursue UC and get back on MAA/MAF at any time.

Question 5: My MAA client is pregnant. Does she need to pursue UC?

Answer 5: Yes, she does at initial application (unless she is exempt from JOBS participation. JOBS-exempt clients do not have to pursue UC). If she has health concerns or is unable to look for work, you can give her good cause not to apply for UC, but for medical only clients, it is usually better to have clients apply for UC and let the

Employment Department make a decision about whether the client is available to look for work. The good news is it is a prudent person (common sense) decision, so you can pretty much do what you want as long as it makes sense and you narrate it. If you are not sure, ask your lead or a policy analyst.

Do not pend pregnant clients already receiving Medicaid to apply for UC. Technically, they are required to pursue UC, but since they have protected eligibility status, we cannot end their benefits because they refused to apply for UC. Rather than create extra workload, the policy decision is not to require pregnant recipients to apply for UC.

Question 6: Why make MAA/MAF clients apply for UC if their WBA (weekly benefit amount) will not affect their medical anyway?

Answer 6: We called an Employment Department trainer about WBAs. The trainer said that WBA calculations expire and that we cannot know for sure what the current WBA amount is. It is better to have the client apply, let the Employment Department figure it all out and then make a decision.

Question 7: My MAA client is working part time and I know he is not eligible for UC because his earnings are over the WBA amount. I do not need to make him apply, do I?

Answer 7: Yes, have him apply for UC. Let the Employment Department make the decision. There are lots of ins and outs about UC that we do not know (just like they do not know all our rules).

Question 8: My MAF client is a college student. He did not quit a job to go to school but since he is in school I know he can not get UC. Why make him jump through hoops and apply for UC just to be denied?

Answer 8: We called an Employment Department trainer about this issue. The trainer said that the Employment Department does not automatically deny UC just because the UC applicant is a student. He needs to apply for UC. If he refuses, deny his medical with a denial notice and DHS 462A and open for the rest of the family.

Question 9: My MAA client quit work to go to school. Do I still need to make him apply for UC?

Answer 9: Yes. For EXT, MAA, MAF and OHP clients, quitting a job does not automatically make the client ineligible for UC. If he refuses to apply for UC, he will no longer be eligible for CAF SSP medical. Send a 10-day close notice and a DHS 462A and end his medical benefits. Narrate your decision.

Question 10: My MAA client applied for UC and I opened the case, but then he did not follow up on the UC.

Answer 10: *If he does not have good cause, send a 10-day close notice and a DHS 462A and end his benefits.*

Note: *Frequently, there is a time lag from the time the client initially applies for UC and the time the medical is opened. Before opening, check on the UC screens to see if the client is actually pursuing the UC. If not, then determine if the client has good cause. If no good cause, deny just the person who did not pursue U.C.*

Question 11: What if my MAA client does not want to look for work right now?

Answer 11: *This is a single-parent MAA only client (not JOBS exempt)? If so, unless she has good cause for not looking for work, send her a pend notice. If she does not start pursuing UC, send a 10-day notice of reduction and DHS 462A and end her medical. (Do not end medical for anyone else in the filing group.)*

Question 12: My MAA CWM client just lost his job. Do I need to pend him for UC?

Answer 12: *Yes, but only if he could be eligible for UC. Do not pend if UC is not an available asset. For example, if he is using someone else's SSN or does not have a work permit, it is not an available asset and there is no reason to pend him. Narrate why you did not require him to apply.*

Availability of Income: 461-140-0040
Requirement to pursue assets: 461-120-0330
Personal Injury Claim: 461-195-0303

8. Pursuing Assets; Health Care Coverage and Cash Medical Support

To be eligible for medical assistance, most people must pursue available health care coverage or cash medical support for members of the benefit group. Requirements vary by program, depending upon whether the asset is health care coverage or cash medical support.

Health Care Coverage Cooperation

Cooperation in pursuing health care coverage includes, but is not limited to, applying for, accepting, and maintaining all available cost-effective health care coverage, and identifying and providing information to the department in obtaining health care benefits.

Medicare: Adult clients must make a good-faith effort to obtain coverage under Medicare.

Pursuing claims for damages: Adults must pursue a claim for damages from personal injuries, including the completion of the *Vehicle Related Personal Injury* (DHS 451) and *Non-Vehicle Related Personal Injury* (DHS 451NV) personal injury forms.

Employee-sponsored health care coverage: Cooperation with health care coverage means that persons (except for pregnant women, OHP-CHP-eligible individuals, OHP-OPU-eligible individuals and persons excused for good cause) eligible for medical assistance are required to:

- Apply for, accept, and maintain cost-effective, employer-sponsored health insurance.

Insurance is considered cost-effective when the employee's share of the premium is equal to or less than the Cost-Effective Health Insurance premiums (HIP) standard. If the insurance is not cost-effective, the person cannot be required to apply for or accept the insurance. See Specific Eligibility Requirements, section E of this chapter (MA E.) for more information about obtaining employer-sponsored, cost-effective health insurance.

OHP-OPU clients: Cooperation with health care coverage includes the requirement that OHP-OPU clients cooperate with the FHIAP application process. In the OHP-OPU program, a person (except for American Indians/Alaska Natives; persons eligible for Indian Health benefits; and persons eligible under CAWEM) who has group health insurance available (but is not enrolled) through an employer is required to:

- Cooperate in determining eligibility for the Family Health Insurance Assistance Program (FHIAP). Under FHIAP, a person receives a monthly subsidy to cover a portion of the person's health insurance premiums.
- If eligible for FHIAP, the person must apply for and accept the health insurance and enroll all OHP-OPU recipients on the case who are eligible for the insurance.

Eligibility under the OHP-OPU program ends and the person receives assistance for the health insurance premiums under FHIAP. If not eligible for FHIAP, the person is not required to enroll in their employer's insurance and, if otherwise eligible, continues to receive benefits under the OHP-OPU program.

Cash medical support: Cash medical support is cash ordered to aid the custodial caretaker in meeting medical needs for the child. Cash medical support is part of the requirement to cooperate with the Division of Child Support and is included in the "Cooperation with the Division of Child Support" subsection below.

Cooperation with the Division of Child Support

Applicants for Medicaid assistance are required to agree to cooperate with the Division of Child Support to obtain health care coverage or cash medical support through a noncustodial parent unless they have good cause not to cooperate.

Exceptions to the requirement to cooperate with the Division of Child Support:

- Parents of OHP-CHP children are not required to cooperate with the Division of Child Support.
- Pregnant women are excused from cooperating with the Division of Child Support.
- Persons with good cause not to cooperate with the Division of Child Support (see the Good Cause subsection below).

Most Medicaid clients cannot be required by the department to complete paternity affidavits or pursue health care coverage or cash medical support at initial application or at redetermination of Medicaid eligibility. Signing the application is proof the client has agreed to cooperate. However, if the Division of Child Support sanctions an adult applicant for failure to cooperate during the application process, the adult applicant who failed to cooperate is denied. Use the CSM case descriptor to identify applicants denied for failure to cooperate.

What cooperation with the Division of Child Support includes:

Medical program recipients (except OHP-CHP clients, pregnant women, and persons excused for good cause) are required to:

- Assist the department and the Department of Justice, Division of Child Support in establishing paternity for a child and obtaining health care coverage and cash medical support.
- Assign cash medical support payments to the department. Once Medicaid coverage for a child receiving cash medical support begins, the Division of Child Support will send the cash medical support payment to DMAP.

☞ SEE THE CHILD SUPPORT CHAPTER FOR INFORMATION ON THE ASSIGNMENT PROCESS AND HOW TO IDENTIFY THE CASH MEDICAL SUPPORT PAYMENT

Applying the penalty for noncooperation with health care coverage and cash medical support:

Adults who do not cooperate and do not have good cause, are not eligible for medical assistance. There is no ineligibility for pregnant females who refuse to cooperate.

Note: *Medical-only clients may be disqualified for failure to pursue a cash medical support order. They cannot be disqualified for failure to pursue cash support not specifically dedicated to medical expenses.*

Additionally, only the individual who can legally assign rights and obtain the insurance is assessed the penalty for failure to meet this requirement, or in other words, loses medical eligibility. The other individuals in the group, such as other adults and children, continue to receive Medicaid.

Ineligibility for medical assistance ends when the person provides evidence that they are willing to cooperate.

Good cause for not cooperating with the Division of Child Support:

A person is excused for good cause from the requirement to obtain health care coverage or cash medical support from the Division of Child Support if:

- Cooperation would result in emotional or physical harm to the dependent child or to the person. The person's statement alone is sufficient evidence that harm would result. Additional evidence is not necessary to grant good cause.
- Continuing efforts to establish paternity or obtain medical support would be detrimental to the dependent child because the child was conceived as a result of rape or incest. The person's statement alone is sufficient evidence on the issues of conception and detrimental effect to the child. Additional evidence is not necessary to grant good cause.
- Legal proceedings are pending for the adoption of the child.
- The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption.

People who claim good cause for refusing to cooperate on grounds other than those listed above have 20 days from the date of refusal to provide the statement or evidence. If they have difficulty getting evidence, allow a reasonable time to provide the information. Consider them to have good cause if they have made a good-faith effort to provide verification but are unable to do so.

Medical assignment: 461-120-0315

Requirement to pursue assets: 461-120-0330

Clients Required to Obtain Health Care Coverage and Cash Medical Support: 461-120-0345

Medical cooperation: 461-120-0345

Good cause for failure to cooperate: 461-120-0350

Personal Injury Claim: 461-195-0303

9. FHIAP Referral Process; OHP-OPU Program

To be eligible for the OHP-OPU program, a person must not be covered by private major medical health insurance and must not have been covered by private major medical health insurance during the six months preceding the effective date for starting OHP medical benefits.

☞ SEE MEDICAL ASSISTANCE CHAPTER E.8, FOR MORE INFORMATION REGARDING SPECIFIC PROGRAM REQUIREMENTS FOR OHP-OPU.

An OHP-OPU applicant who has access to (but is not enrolled in) group health insurance available through his or her employer must cooperate in determining eligibility for the

Family Health Insurance Assistance Program (FHIAP). Exempt from this requirement are OHP-OPU clients who are American Indians/Alaska Natives, persons eligible for Indian Health benefits and for persons eligible under CAWEM.

For an OHP-OPU applicant to complete the application process, the Group Insurance Information form (442-091) is required. Once the application process is completed, medical assistance eligibility is determined.

If eligible:

- Certify OHP medical benefits.
- Make a referral to FHIAP for the OHP-OPU eligible person by mailing the Group Insurance Information form (442-091) along with a copy of the medical assistance application to:

FHIAP
PO Box 5880
Salem, OR 97304-0880

When a person receiving benefits under the OHP-OPU program reports he or she has access to (but not enrolled in) group health insurance available through his or her employer, the person needs to have the Group Insurance Information form (442-091) completed by the employer and returned. A referral is made for the person by simply mailing the Group Insurance Information form to FHIAP.

The referral will be processed by FHIAP to determine if the OHP-OPU person is eligible for a subsidy under that program. If eligible for FHIAP, the OHP-OPU person must apply for and accept the health insurance.

FHIAP staff will notify the OHP-OPU client and the OHP-OPU client's eligibility worker of the FHIAP eligibility determination:

- If FHIAP eligible, FHIAP staff will notify the OHP-OPU client's eligibility worker when a subsidy will start. The eligibility worker will end OHP-OPU benefits, send a decision notice, and narrate the information on TRACS.
- If not FHIAP eligible, FHIAP staff will notify the OHP-OPU client's eligibility worker and the person of the reason for the FHIAP denial.

A person eligible under a medical assistance program other than OHP-OPU can choose to receive benefits under FHIAP, if eligible for that program. However, a person cannot receive benefits from both programs. Clients should be advised to notify FHIAP that they have applied for DHS medical. Clients who receive FHIAP and DHS medical concurrently may incur a FHIAP overpayment.

Clients Required to Obtain Medical Coverage: 461-120-0345
Specific Program Requirements; OHP: 461-135-1100
Concurrent and Duplicate Program Benefits: 461-165-0030

E. Specific Eligibility Requirements

1. Medical Assistance Assumed (MAA)

To be eligible for MAA, a client must be a dependent child or a caretaker relative of a dependent child. However, a dependent child or caretaker relative cannot receive MAA while foster care payments are being made for the child.

There is one exception. If a child in foster care is expected to return within 30 days, the caretaker relative may be eligible for MAA based on the expected return of the child. Confirm the expected return date with CW.

Caretaker relatives can also receive MAA if their only child is an SSI recipient or their child is ineligible for MAA only because citizenship has not been documented yet.

Either parent whose only child is an unborn child can qualify for MAA if the mother's pregnancy has reached the calendar month before the month in which the due date falls.

The father of the unborn child can receive MAA even before the mother's pregnancy has reached the calendar month before the month in which the due date falls if there is another dependent child in the filing group.

Example: Mary is pregnant, due in six months. She's living with Dan, the father of the unborn and her three children from a previous relationship. Dan is the PWE. He was laid off from his last job and receives a small amount of UC, but the family is still under the MAA income limit. Mary and Dan are not married, but they meet the two-parent deprivation requirements based on unemployment. Even though Mary is not due for six months, everyone qualifies for MAA, including Dan.

A minor parent continues to be eligible for MAA if they lose TANF eligibility because they refuse to live with a parent or adult relative, or if they go over income due to deeming when they are required to **return** to live with a parent. The minor parent must also continue to meet all other TANF requirements.

People disqualified from TANF only because they have not cooperated with JOBS or substance abuse/mental health requirements are eligible for MAA as long as they continue to meet all other TANF eligibility requirements.

Persons serving a TANF or FS intentional program violation (IPV) penalty may still qualify for MAA, even if not pregnant.

2. Medical Assistance to Families (MAF)

When a family or child becomes ineligible for or is denied MAA because of their household composition or income, determine eligibility for MAF medical assistance prior to converting to EXT or other OHP Plus medical program.

Family members may be eligible for MAF when ineligible for MAA under the following situations:

- Situation 1: If a blended (yours/mine/ours) family is ineligible for MAA because of income, resources or other program requirements, eligibility may exist by forming separate filing groups under MAF.

For MAF, a blended family is one in which there is at least one child or unborn in common and the parents are unmarried. To fit in situation 1, there must also be at least one other child in the household from a prior relationship. If the only child is an unborn child in common, it is a situation 2 family (see below).

- Situation 2: A family is over income for MAA because of income from the father of an unborn child. If the father of the unborn child is not married to the mother and there are no other dependent children, the mother and the unborn child form a separate filing group. Deem the father's income to the mother. If the father of the unborn is also the father of another child in the household, consider situation 1.

Do not begin MAF benefits until the calendar month before the month in which the due date falls. For both MAA and MAF, if the only child is an unborn child, there is no eligibility until the month before the calendar month in which the due date falls.

- Situation 3: A family is over income for MAA because of income from an ineligible noncitizen. Eligibility for MAF may exist by deeming the noncitizen's income to the MAF need group.

When deeming the noncitizen's income, deduct the payment standard of the people who do not meet the citizenship or alien status requirements. However, explain to the family that they may choose not to apply for MAF benefits for one or more of their noncitizen children. If the family so chooses, deduct the payment standard for as many noncitizens as are needed to make the balance of the filing group eligible for MAF benefits.

For example, if there is an adult noncitizen and two noncitizen children who do not meet the alien status requirements, but only the adult has income, you may choose to deduct the payment standard for the adult only. The two noncitizen children may receive MAF CWM.

In families with more than one ineligible noncitizen with income, it is possible to remove only one of the ineligible noncitizens from the filing group. For example, in a family with an ineligible noncitizen mother who earns \$350 a month, an ineligible noncitizen father who earns \$400 a month and one citizen child, the

father can be removed and his income deemed, making the mother MAF CWM and the child MAF. Or, if more advantageous to the family, the mother and father can be removed, making the child MAF eligible.

- **Situation 4:** A family is over income for MAA because of income from the spouse of a needy caretaker relative. The spouse with income is removed to form a separate MAF filing group. If the spouse has any dependent children, they must be removed also. Deem the spouse's income to the MAF need group.
- **Situation 5:** A family with self-employment income is over income for MAA. Eligibility for MAF may exist by allowing for actual costs of producing self-employment income.

☞ SEE COUNTING CLIENT ASSETS C (CA C.) FOR MORE INFORMATION.

Filing Group; EXT, MAA, TANF: 461-110-0330

Filing Group; MAF and SAC: 461-110-0340

Specific Requirements; MAA, MAF, and TANF: 461-135-0070

3. Extended Medical Assistance (EXT)

Family members who are eligible for and receiving MAA or MAF may qualify for a period of EXT Medical after their eligibility for MAA/MAF ends.

When an MAA/MAF Filing Group May Be Eligible for EXT:

- The filing group must have become ineligible for MAA/MAF because of an increase in the caretaker relative's earnings or because of child support received. Do not require verification of the increased earnings or support.
 - If another change occurs in conjunction with the increase in the caretaker relative's earnings or in child support received, the filing group is not eligible for EXT if the other change, by itself, would have made the filing group ineligible for MAA/MAF.

Example: Anita and her two children, William and Sara, are receiving MAA when Robert, Anita's husband, returns to the household. His earned income puts the family over the income limit for MAA.

*The filing group is **not** eligible for EXT. It was not an increase in the caretaker relative's earnings that caused the filing group to become ineligible for MAA. While Robert is a caretaker relative, it was the earnings that he already had when he joined the filing group that made the filing group ineligible (not an increase in his earnings).*

EXT Eligibility Period

- If eligibility is a result of increased earnings of the caretaker relative, the eligibility period is for 12 months. Code with the AE2 need/resource item (more on coding below within this section).
 - There is no requirement that the family receive MAA/MAF for three of the six months prior to the beginning of the EXT period. However, to qualify for EXT based on increased earnings of the caretaker relative, the person has to have been eligible for and receiving MAA/MAF.
 - If a filing group meets the eligibility requirements for EXT based on a combination of increased income from the caretaker relative’s earnings and child support, even if either increase by itself does not make the filing group ineligible for MAA or MAF, the filing groups eligibility period is based on increased earnings.
- If eligibility is a result of increased income due to child support, the eligibility period is for four months. For EXT based on an increase in child support, the following requirements apply:
 - At least one member of the MAA/MAF filing must have been eligible for and receiving MAA/MAF in three of the six months prior to the beginning of the EXT eligibility period.
 - Do not count months the family received Medicaid in another state towards the three-of-six months requirement.
 - Do not count months on EXT towards the three-of-six months requirement.
 - The three-of-six month requirement does not have to be consecutive months.
 - If MAA/MAF was received for at least one day in a month, the whole month is counted.
- Retroactive MAA/MAF eligibility counts in determining if the filing group meets the three-of-six months requirement for a family that goes over the income limits due to an increase in child support.

☞ SEE MEDICAL ASSISTANCE E. 6 FOR MORE INFORMATION ABOUT DETERMINING ELIGIBILITY FOR RETROACTIVE MEDICAL ASSISTANCE.

Specific EXT Requirements

- Persons must have been members of the MAA/MAF benefit group when those benefits ended to be included in the EXT benefit group.

Example: Sally and her son Seth were receiving MAA until Sally received a promotion which put her over the MAA income limit. They are now

receiving EXT. Sally's daughter Joanne joins the household while the family is receiving EXT benefits.

Joanne is included in the EXT filing, financial and need group, but is not included in the EXT benefit group because she was not in the MAA benefit group when those benefits ended.

Example: Allison's MAA medical closed because she did not complete her redetermination. When she reapplied two months later for MAA for herself and her daughter Janie, she was over income for MAA because an increase in child support.

Allison and Janie are not eligible for EXT. They received MAA for three of the previous six months, but she was not receiving MAA when she went over the MAA income limit due to the increase in child support.

- The filing group must include a dependent child. A filing group is no longer eligible for EXT if it does not include a dependent child, but may regain EXT eligibility if it again includes a dependent child.
- Members of a benefit group who become ineligible for EXT may regain eligibility for EXT if they again meet EXT eligibility requirements.

Example: John and his two children became ineligible for EXT because they moved out of state. They moved back to Oregon and again met the eligibility requirements for EXT.

John and his children may be eligible to receive EXT for the remainder of the EXT eligibility period.

Example: Don, Cheri and their daughter Jenny are receiving EXT. Don moved out of the household. Cheri and her daughter continue to receive EXT, but Don loses eligibility.

If Don returns to the household, he may regain EXT eligibility for the remainder of the EXT eligibility period.

EXT CM Coding and Support

When EXT eligibility is based on increased child support:

- **EMS** with end date = fourth month
 - Enter this N/R when converting a CM case to EXT. The end date should be the fourth month of the EXT eligibility period.

- The CM case will automatically close at the end of the fourth month. An advance close notice and application packet will be mailed to the client prior to closure.
- When EXT eligibility is based on increased earned income:
 - **AE2** with end date = 12th month
 - (a) Enter this N/R when initially converting a CM case to EXT. The end date should be the 12th month of the EXT eligibility period. An EXT approval notice will automatically be mailed to the client.

EXT Effective Date

- If reported timely, start EXT medical the first of the month following the last month of MAA/MAF eligibility. No 10-day notice is required. Because no 10-day notice is required, some TANF/MAA cases will convert to TANF/EXT before the TANF can be closed. An individual can receive TANF and EXT on the same CM case. This applies even if the client is in the MRS.

Note: *When the family goes over the income due to an increase in child support, make sure the family has met the “three-of-six” months MAA/MAF criteria.*

Example: *Paul and Paula have been receiving MAA for the last six months. On December 30, they report timely that Paul has a new job and they will be over income for MAA in January. Begin EXT medical effective January 1.*

- If an MAA/MAF client does not report an increase in income or child support timely, they may still be eligible for EXT. Determine EXT eligibility based on the month they went over income for MAA/MAF.

Reminder: *The budget month used for the EXT determination is the month the client timely reports increased earnings or child support that will make them over the MAA/MAF income limit. If not reported timely, the budget month is the month before the month the client exceeded the MAA/MAF income limit due to increased earnings or child support.*

Assumed Eligibility for Medical Programs: 461-135-0010
Specific Requirements; EXT: 461-135-0095
Eligibility period; EXT: 461-135-0096
Earned Income: Treatment: 461-145-0130
Dependent Care Costs; Deduction and Coverage: 461-160-0040

4. **Medical Assistance to Children in Substitute or Adoptive Care (SAC)**

To be eligible for the SAC program, an individual must be under the age of 21 and:

- Live in substitute care covered by title IV-E of the Social Security Act.
- Live in a foster care or private institutional setting for which a public agency of Oregon is assuming at least partial financial responsibility.
- Live in an intermediate care facility, including an intermediate care facility for people with mental retardation, or a licensed psychiatric hospital.
- Receive independent living subsidy payments from the department to assist the individual to live independently when foster care payments were discontinued.
- Is a child for whom an adoption assistance agreement from another state is in effect, regardless if a payment is being made.
- In a state-subsidized adoptive placement, if an adoption assistance agreement is in effect between a public agency of Oregon and the adoptive parents indicating title IV-E or Medicaid eligibility.

A child in substitute care must meet all TANF nonfinancial and financial eligibility requirements.

Children subject to an adoption assistance agreement described above are assumed eligible for the SAC program.

When a child moves to Oregon from another state where an adoption assistance agreement is in effect between an agency in that state and the adoptive parents, the other state usually sends forms to Oregon's DHS Adoption Assistance Unit indicating the family has moved to Oregon and is eligible for medical assistance. Those forms are forwarded to the Children's Medical Project Team at the Oregon Health Plan branch. The team establishes medical assistance for the child and notifies the family of the coverage.

Instead of sending adoption agreement forms to the DHS Adoption Assistance Unit, a few states send the forms directly to the adoptive parents making them responsible for applying for the child's medical assistance at the local branch office. See section B.1., Application for Medical Assistance, of this chapter for information on the SAC application process.

5. **Citizen/Alien-Waived Emergent Medical (CAWEM) Medical Assistance**

To qualify for CAWEM, a person must meet all the nonfinancial and financial eligibility requirements for another medical assistance program, except the citizen/alien status and Social Security Number requirements.

Exception: There is no CAWEM eligibility under the OHP-CHP category.

You do not need to make a decision about whether the person is in need of immediate medical treatment or in need of childbirth (labor and delivery) services. Medical decisions are determined by the person’s medical provider pursuant to the administrative rules of the Office of Medical Assistance Programs. If a medical provider has questions about whether a condition is covered, they should contact DMAP at 1-800-336-6016.

Medical assistance is authorized under the program (MAA, MAF, OHP and SAC) for which the person would qualify if they met the citizen/alien requirement. CAWEM clients will receive a medical coverage letter when their case opens that says:

“COVERAGE IS LIMITED TO EMERGENCY MEDICAL SERVICES.
LABOR AND DELIVERY SERVICES FOR PREGNANT WOMEN
ARE CONSIDERED AN EMERGENCY.”

A child born to a CAWEM mother is an assumed eligible newborn (AEN). Add the child’s medical eligibility to the case using the AEN need/resource code.

Specific Requirements; Citizen/Alien-Waived Emergent Medical (CAWEM): 461-135-1070
OHP-OPU; Effective Dates for the Program: 461-135-1102

6. **Retroactive Medical Assistance**

When people are determined eligible for BCCM, MAA, MAF, OSIPM, QMB-DW, REFM or SAC, they may be eligible for retroactive medical assistance. People determined eligible for OHP are not eligible for retroactive medical assistance.

Eligible people may qualify for retroactive medical assistance for up to three months preceding their date of request. For example, if the date of request is August 7 and retroactive medical eligibility is established, retroactive eligibility begins May 7.

Eligibility is determined on a month-by-month basis. A person may be eligible in any one or all three of the months.

Except for SSN requirements, cooperation with DCS and JOBS requirements, they must meet all of the program’s eligibility requirements for each retroactive month.

People who are eligible for CAWEM because they met all the eligibility requirements (other than alien status) for MAA, MAF, or SAC, are eligible for retroactive medical benefits as mentioned above. Clients who are eligible for CAWEM through OHP are not eligible for retroactive medical benefits. This is because there is no eligibility for

retroactive medical benefits for OHP except one working day, therefore, people who receive CAWEM through OHP would not be eligible for retroactive benefits.

Example: John and his two children, Paul and Marie, were approved for MAA medical on their date of request, May 13. Marie has unpaid medical bills from February 16. It is determined that the family met financial and nonfinancial MAA eligibility requirements for each of the three months (February, March, April) prior to the date of request.

Start medical for Marie on February 16, the date the unpaid medical expenses incurred. Use the RM case descriptor to indicate retroactive medical. The rest of the family starts on the date of request.

Example: Same scenario as above, except that the family did not meet MAA financial requirements in March or April (they met all requirements in February).

Start medical on the date of request (May 13). Submit a Request for Medical Eligibility (AFS 148) to HMU for February.

Example: Frank and Mary have a February 15 date of request. They are not eligible in the initial budget month of February, but the worker floats the budget month to March and finds they are eligible for MAA effective March 1. They have a retroactive medical need for January 10 and February 16.

The worker reviews the family's MAA eligibility for January and finds them eligible for MAA on January 10.

Start medical effective March 1. Submit a Request for Eligibility (AFS 148) to HMU for January. There is not retroactive medical eligibility for February.

Specific Requirements; Retroactive Medical: 461-135-0875
Effective Dates; Retroactive Medical Benefits: 461-180-0140

7. OHP Eligibility Categories; Overview

To qualify for medical assistance under the OHP program, a person cannot:

- Be receiving or deemed to be receiving SSI benefits;
- Be eligible for Medicare, unless the person is a pregnant woman;
- Be receiving Medicaid assistance through another program; or

- Be enrolled in a health insurance plan subsidized by the Family Health Insurance Assistance Program (FHIAP).

OHP includes five categories of people who may qualify for medical assistance. The first category is used to determine eligibility for nonpregnant adults who are 19 years of age and older. Eligibility for pregnant women is always determined using the fourth category.

There are additional categories used to determine eligibility for children. Always determine eligibility for children beginning with the second category, OHP-OPC, before moving on to the other three categories. If the family's income exceeds the OHP-OPC income limit (100 percent), determine if the children might qualify under other categories, such as OHP-OP6, OHP-OPP or OHP-CHP.

Specific requirements; OHP: 461-135-1100

8. **First OHP Category: Oregon Health Plan (OHP-OPU Program)**

This category includes uninsured nonpregnant adults who are in a filing group with income under the (OHP-OPU) 100 percent income limit.

To be eligible for OHP-OPU, a person must be 19 years of age or older and must not be pregnant. An OHP-OPU person is referred to as a health plan new/noncategorical (HPN) client.

There are three groups of medical applicants that may be considered for OHP-OPU:

- Clients recertifying for OHP-OPU benefits without a break in assistance, and
- Clients converting from child welfare medical, BCCM, EXT, GAM, MAA, MAF, OHP-OPC, OHP-CHP, OHP-OPP, OSIPM, REFM or SAC to OHP-OPU without a break in assistance.
- Persons randomly selected from the OHP Standard Reservation List. To qualify, the randomly selected person must establish a DOR within 45 days of the date the OHP 7210R was mailed.

“Without a break in assistance” means that the OHP-OPU client requesting recertification established a DOR before their current certification expired.

“Without a break in assistance” also means a client converting from child welfare medical, BCCM, EXT, GAM, MAA, MAF, OHP-CHP, OHP-OPC, OHP-OPP, OSIPM, OYA medical, REFM or SAC applied for medical benefits while still receiving their prior medical program benefits. It could also mean that their worker re-evaluated the client's medical eligibility because of a reported change or eligibility review.

Example: Tina is a single adult who is not pregnant, has no children, and has no disabilities. She is currently not receiving benefits under any DHS medical program and was not randomly selected from

the OHP Standard Reservation List. She may not be considered for OHP-OPU.

Example: Marvin is a single adult who was selected from the OHP Standard Reservation List on October 15. He was mailed a letter letting him know he had been selected and that he needed to establish a DOR within 45 days of the date the OHP 7210R was mailed. The OHP 7210R was mailed October 26. On January 15, Marvin called his local SSP office and asked for medical. He may not be considered for OHP-OPU.

Example: Curt is a single adult who is receiving OHP-OPU. His certification ends on August 31. Curt turns his recertification in timely in August. Since Curt has reapplied timely, he can be considered for OHP-OPU.

Example: Larry is receiving OHP-OPU and his children are receiving OHP-OPC. His certification ends on August 31. He turns in his recertification late on September 1. His family is not eligible for MAA or MAF. Although his children can be considered for OHP, Larry cannot be considered for OHP-OPU.

☞ SEE MEDICAL ASSISTANCE CHAPTER B.3 FOR MORE INFORMATION REGARDING THE REQUIREMENT TO REVIEW FOR ALL MEDICAL PROGRAMS.

In addition to other OHP eligibility requirements, an OHP-OPU client:

- Must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than \$10,000 for each covered individual.

☞ SEE MEDICAL ASSISTANCE CHAPTER D.9 FOR MORE INFORMATION REGARDING THE FHIAP REFERRAL PROCESS WHEN HEALTH INSURANCE IS AVAILABLE THROUGH AN EMPLOYER.

- Must not have been covered by private major medical health insurance during the six months preceding the effective date for starting medical benefits. The six-month waiting period is waived if:
 - The person has a condition that without treatment would be life-threatening, or would cause permanent loss of function or disability;
 - The person’s private health insurance premium was reimbursed under the provisions of OAR 461-135-0990;
 - The person’s private health insurance premium was subsidized through FHIAP; or
 - A member of the person’s filing group was a victim of domestic violence.

- Some applicants who receive medical benefits through the Veteran’s Administration (VA) are not eligible for OHP. VA benefits are considered major medical. There are VA hospitals in Portland and Roseburg. There is also a VA hospital in Walla Walla, used by many Oregon veterans. There are clinics in Eugene, Bandon, Salem, Klamath Falls, Brookings, Bend, White City, and Warrenton. If an applicant has access (or has had access in the prior six months) to care through a local VA facility including the Walla Walla hospital), they are usually not eligible for OHP benefits. If the client says the hospital or clinic is not accessible or says that the Veterans benefits do not cover their medical needs, then the client may be OPU eligible. If you are not sure, contact a medical policy analyst.
- Must meet the following eligibility requirements:
 - OHP resource limit.
 - OHP budgeting requirements (using only the two-month income average to determine eligibility unless DV).
 - Payment of premiums unless exempt.
 - Selection of a medical, dental and mental health Managed Health Care Plan (MHCP) or Primary Care Case Manager (PCCM) if available, unless exempted by OAR 410-141-0060.

Higher Education Students. When an OHP-OPU person is attending a higher education institution full time, they are not eligible unless they:

- Meet the financial eligibility requirements for a Pell grant.
- Are in a program serving displaced workers under section 236 of the Trade Act of 1974.

Higher education institutions include all public and private universities, colleges and community colleges. Also included are all post-secondary vocational or technical schools that are eligible to accept Pell grants.

ABE, ESL, GED and high school equivalency programs are **not** considered higher education.

Full-time attendance at colleges and universities is enrollment of 12 or more credit hours per term or semester for undergraduates, and nine hours for graduate students. For vocational or technical schools, full-time status is attending classes and other required activities at least 12 hours per week.

A student’s enrollment status continues during school vacation and breaks. It ends when the student graduates, drops out, reduces their hours, is suspended or expelled or does not intend to register for the next school term (excluding summer term).

The Department of Education determines *Pell Grant eligibility* from a student's financial aid application, titled the *Free Application for Federal Student Aid (FAFSA)*. Eligibility is based on a formula called the Expected Family Contribution (EFC). Each year, Congress sets the ceiling for the EFC. For the 2008/2009 school year, the EFC limit was \$4, 042. For the 2009/2010 school year, the EFC limit is \$4, 618. If the student's EFC figure is less than the limit, the student meets the OHP Pell grant requirement. The student does not have to be actually receiving a Pell grant to meet this OHP requirement.

After financial eligibility is determined, the student is sent an award letter, the *Student Aid Report (SAR)*, which lists the EFC. All higher education students must either provide a copy of their SAR, or for undergraduates, a financial aid award letter from their school to verify they meet the OHP Pell grant requirement.

- If an undergraduate student has an EFC at or below the EFC ceiling, their SAR will state that they are eligible to receive a Pell grant.
- Graduate students cannot receive the Pell grant because it is an undergraduate program. However, all graduate students applying for financial aid complete an FAFSA and receive an SAR that includes their EFC figure.

To verify whether students are displaced workers under the *Trade Act of 1974*:

Step 1 Access ECLM. If the function key “10) TRA” does not appear at the bottom of the screen, the person is not a dislocated worker covered by the Trade Act.

Step 2 If the function key (it will be highlighted) appears at the bottom of the screen, the person is potentially eligible. For these persons, press F10 to access the Trade Act claim screen (ERTC). Look at the column beginning with “Prior SSN,” then go down 10 lines to the “Trng” field. If today's date is within the beginning and end dates in this field, the person is currently in a program under the Trade Act.

Specific requirements; OHP: 461-135-1100
Eligible and ineligible students; OHP-OPU: 461-135-1110
OHP-OPU; Effective Dates for the Program: 461-135-1102
Reservation Lists and Eligibility; OHP-OPU: 461-135-1125

Oregon Health Plan Program Premiums. When an OHP-OPU benefit group includes one or more nonexempt persons, a monthly premium is billed to the household. All clients eligible for OHP-OPU, if not exempt, are responsible for payment of premiums. Clients are exempt from paying a premium if they meet one of the following:

- Have OHP countable income at 10 percent or less of the Federal Poverty Level. Clients may become exempt due to income when their OHP is recertified. They may also become exempt within a certification, but only when the benefit group's OHP income is reduced to 10 percent or less of the FPL when an OHP-OPU client leaves the benefit group or when two OHP certified households are combined during a certification.

- American Indians and Alaska Natives – American Indian/Alaska Native tribal membership or eligibility for benefits through an Indian Health Program (HNA Case Descriptor).
- Are CAWEM (CWM Case Descriptor) eligible only.

Once the amount of the premium is established, the amount does not change during the certification period unless one of the following occurs:

- An OHP-OPU client becomes pregnant.
- A client becomes eligible for OHP-OPU following her assumed eligibility period as a pregnant female.
- An OHP-OPU client becomes eligible for another medical assistance program.
- An OHP-OPU client leaves the benefit group.
- OHP cases are combined during their certification periods.

A premium is considered paid on time when the payment is received by the OHP Billing Office on or before the 20th day of the month for which the premium was billed. The day the payment arrives in the OHP Billing Office's post office box is the date it is received. A premium not paid on time is past due.

***Note:** Once determined eligible, OHP-OPU clients cannot be found ineligible for benefits during a certification period for failure to pay past due premiums. Past due premiums only affect eligibility at certification and recertification.*

A nonexempt OHP-OPU client can be found ineligible for not paying premiums as follows:

- An OHP-OPU applicant who does not resolve unpaid premiums during the application processing time frame is denied.
- An OHP-OPU applicant joining an OHP filing group is denied if the applicant has a premium arrearage or the filing group includes a person with a premium arrearage and the unpaid premiums are not resolved during the application processing time frame.

Determining Eligibility for OHP-OPU Applicants with Unpaid Premiums. When applying or reapplying under the OHP-OPU program, a nonexempt applicant must pay all billed premiums to be eligible. Premiums must be paid before the applicant can be recertified. Include the requirement to pay premiums on the pend notice. If the unpaid premiums are not resolved within the 45 days from the date of request, deny medical assistance for that applicant.

Past arrearage can be canceled if the arrearage was incurred while the person was exempt from the requirement to pay a premium. As of June 1, 2006, clients with OHP countable income of 10 percent or less of the FPL when the premium is calculated at certification,

American Indians and Alaska Natives, and clients eligible under the CAWEM program are exempt.

The department will not attempt collection on any arrearage that is over three years old.

Updating the CM case

If exempt from paying premiums, code “WE” in the WAIV field on the UCMS screen.

If the premiums have been paid or adjusted to zero, but the CM case still has a “K” premium status, use the “CD” waiver code to bypass the online edits. If you do not use the WE or the CD coding, the OHP-OPU’s medical will end during overnight processing.

Premium requirement; OHP-OPU: 461-135-1120

The computer determines the amount of the monthly premium by determining the number of persons in the need group, their average monthly income, and the number of nonexempts in the benefit group.

The following table may be used to calculate the premium amount:

OHP PREMIUM by FPL

Number in Need Group	Percentage FPL	Premium Amount Billed for Each Nonexempt OPU Client
	< 10% to 50%	9.00
	50% to 65%	15.00
	65% to 85%	18.00
	85% to 100%	20.00

OHP PREMIUM EXEMPT BY INCOME AMOUNT

Number in Need Group	10% FPL Income Limit (income must be equal to or less than 10% FPL to be premium exempt)
1	\$ 90.25
2	121.42
3	152.58
4	183.75
5	214.92
6	246.08
7	277.25

8	308.42
9	339.58
10	370.75
+1	10% of FPL

OHP Premium Standards: 461-155-0235

Premiums are collected by the Oregon Health Plan Premium Billing Office. OHP premium bills will state where and how to send in payments.

By mail:

OHP Premium Billing Office
PO Box 1120
Baker City, OR 97814

Payments should be made by check, money order or cashier's check or over the phone using Visa, MasterCard or Discover. People who come to a branch office wanting to pay their premiums should be told to send payments to the above address. Their premium notice includes a return envelope. For questions about the billing (whether a payment was received, etc.), call the OHP Billing Office at one of the numbers listed on the billing notice toll-free 1-800-647-2729, or TTY: 1-866-203-8931.

9. Second OHP Category: Oregon Health Plan for Children (OHP-OPC)

These are persons under the age of 19 in a filing group with income under 100 percent of the income limit. If income is at or above 100 percent, the person may qualify at either the OHP-OP6 (133 percent) or OHP-CHP (201 percent) level. However, assumed eligible newborn children under the age of one who are at or above the OHP-OP6 (133 percent) are to be coded OHP-OPP and not OHP-CHP.

10. Third OHP Category: Oregon Health Plan for Children Under Age 6 (OHP-OP6)

These are persons under the age of six in a filing group with income over the OHP-OPC (100 percent) income standard, but below the OHP-OP6 (133 percent) income limit.

Specific requirements; OHP: 461-135-1100

11. Fourth OHP Category: Oregon Health Plan for Pregnant Females Under 185 Percent and Their Newborn Children Under One Year of Age (OHP-OPP)

This category includes pregnant females in a filing group with income below the 185 percent income limit and their assumed eligible newborn children at or above the OHP-OP6 (133 percent) income limit.

Specific requirements; OHP: 461-135-1100

12. Fifth OHP Category: Oregon Health Plan for Children (OHP-CHP)

These are persons who may qualify for medical assistance under the Children’s Health Insurance Program (CHIP). The CHIP program is not a Medicaid Title XIX program, but is provided through another federal program, title XXI, which was a provision of the federal Balanced Budget Act of 1997. They are under the age of 19 who are not eligible under the OHP-OPC, OHP-OP6, or OHP-OPP categories. The financial group’s income must be over the OHP-OPC (100 percent) income limit for children ages 6 through 18 or over the OHP-OP6 (133 percent) income limit for children under age 6 or over the OHP-OPP (185 percent) income limit but below the OHP-CHP (201 percent) income limit.

OHP-CHP persons must meet all the following requirements:

- Must provide or apply for an SSN.
- Must not be pregnant and have income less than 185 percent (code OHP-OPP if pregnant and less than 185 percent of the FPL).
- Pregnant children (under age 19) with income from 185 percent to 201 percent of the FPL may receive CHIP. Do not forget to add the DUE need/resource item, unborn child and father of the unborn to the CHIP child’s CM case.

Note: Eligibility for pregnant CHIP children may end during the pregnancy (their eligibility is not “protected”). However, they may be eligible for Continuous Eligibility for CHIP.

Note: Children born to pregnant CHIP women are assumed eligible for Medicaid for one year. Code the child as an OHP-OPP AEN on the CM case.

- Selection of a medical, dental and mental health Managed Health Care Plan (MCHP) or Primary Care Case Manager (PCCM) if available, unless they are exempt per DMAP OAR 410-141-0060.
- The person must not be covered by private major medical health insurance. Private major medical health insurance means health insurance coverage that provides medical care for physician and hospital services, including major illnesses, with a limit of not less than \$10,000 for each covered individual. Private major medical insurance does not include coverage under the Kaiser Child Health Program. The Kaiser Child Health Program is a partnership with selected elementary schools in the state, and provides health insurance for eligible children in kindergarten through sixth grade. Kaiser Child Health Program clients will have a group #11900 on their Kaiser medical identification card.

Note: Children receiving medical through the Kaiser Child Health Program are eligible for CHP. Once Medicaid is open for the child, Kaiser Permanente will close the Kaiser policy on the child. CHP children receiving services through Indian Health Services or who have TPR that the tribe pays the premium for are still eligible for CHP.

- The person must not have been covered by any private major medical health insurance in the past two months. The two-month waiting period is waived if any of the following are true:
 - The person has a condition that without treatment would be life-threatening or cause permanent loss of function or disability.
 - The person’s private health insurance premium was reimbursed under the policy for Reimbursement of Cost-Effective Employer-Sponsored Health Insurance.
 - The person’s private health insurance premium was subsidized by FHIAP.
 - A member of the filing group was a victim of domestic violence.
 - The private insurance ended because of job loss.

Specific requirements; OHP: 461-135-1100

***Note:** Remember the parents of CHIP children should never be forced to apply for, accept, and maintain other health insurance coverage as this is not an eligibility requirement in the CHIP program like it is in Medicaid.*

When a person is in a hospital and becomes ineligible for OHP because they no longer meet the age requirement for their category, they can continue to be eligible for OHP until the end of the month in which they are discharged from the hospital.

13. Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums (HIP)

Health Insurance Premium Payment (HIPP)

When a person living in the household has employer-sponsored group health insurance that covers a household member who is eligible for a medical assistance program (except CEC, OHP-CHP and OHP-OPU), the amount of the health insurance premium payment (HIPP) paid by the person (not the employer’s share of the cost), may be reimbursed by the department. Self-employed people who have group health insurance may also be reimbursed.

The person’s health insurance must be a comprehensive plan which includes physician and hospital services. Examples of major medical plans are: a Health Maintenance Organization (HMO); a Preferred Physicians Care Organization (PCO); a Point of Sale Plan (POS); or an Indemnity Health Insurance Plan. Examples of what would **not** be a major medical plan are: Medicare supplements, accident or replacement policies. The amount of the premium paid by the household must be cost effective using the following steps:

- Determine the number of people in the household group who are in the benefit group of any of the following programs: CEM, EXT, GAM, MAA, MAF, OHP (except CEC, OHP-CHP and OHP-OPU), OSIPM and SAC.
- Based on the number of benefit group members determined above, the maximum cost-effective premium is determined from the following table:

HIP Premium Standard	
CEM/EXT/GAM/MAA/MAF/OHP-OPC, OHP-OP6, OHP-OPP/SAC	
# in Benefit Group covered by insurance	Cost-effective premium amount (Employee cost)
1	\$ 82
2	\$164
3	\$246
4	\$328
5	\$410
6	\$492
7	\$574
8	\$656
9+	\$738

The insurance is cost-effective if the employee’s share (the premium the employee pays) is equal to or less than the amount determined from the table.

When determining the employee’s share of the employer-sponsored group health insurance premium amount, averaging may be necessary if the premium amounts are not deducted monthly.

Example: A client is paid every other Friday and \$66.50 is deducted from his/her check for employer-sponsored group health insurance premiums. Multiply \$66.50 X 2.15 to determine the monthly employer-sponsored group health insurance premium amount. In this example, the monthly employer-sponsored group health insurance premium is \$133.00.

Remember to consider the number of persons in the benefit group for the program listed above, and not the household group, in determining the HIPP standard. Dental insurance may be reimbursed, but only if the total of the premiums for both the health and dental insurance is cost-effective. If adding the dental insurance premium makes the total premium not cost-effective, only the health insurance premium may be reimbursed.

Example: A filing group consists of a father, mother and two children who receive Medicaid. The two adults receive OHP-OPU and the children receive OHP-OPC. The father has creditable employer-

sponsored, group health insurance available at a cost of \$245 per month that covers everyone in the filing group.

Step 1: Determine the number of people in the benefit group who receive EXT, GAM, MAA, MAF, OHP-OPC, OHP-OP6, OHP-OPP, OSIPM and SAC that are covered by the employer-sponsored group health insurance. In this example, the number is two (the two children who receive OHP-OPC).

Step 2: Use the premium table to determine the maximum cost-effective premium for the number determined in Step 1. In this example, the maximum cost-effective premium amount is \$164 (the amount is based on two people in the benefit group).

Step 3: If the maximum cost-effective amount is more than the employer-sponsored group health insurance premium amount, the filing group is eligible for HIPP reimbursement. In this example, the employer-sponsored group health insurance premium cost of \$245 is more than the \$164 maximum cost-effective amount for two. Therefore, the filing group would not qualify for HIPP reimbursement.

In this example, the employer-sponsored group health insurance premium actually covers all members of the benefit group, but because only two members of the benefit group are receiving benefits from a program that covers HIPP reimbursement, we cannot use the four person maximum to determine if the employer-sponsored group health insurance is cost effective.

In special situations, DMAP may pay the cost of health insurance premiums even if the premium is greater than the HIPP standard. This occurs when the premium cost is less than the estimated cost of paying medical providers on a fee-for-service basis. A medical documentation or narrative is also required.

☞ SEE DMAP WORKER GUIDE # 7 FOR MORE INFORMATION.

For new cases, the HIPP reimbursement starts on the date of request (the first month is prorated) or, if no one is eligible on that date, the reimbursement starts on the date of initial medical assistance eligibility.

For ongoing cases, the HIPP reimbursement starts on the first day of the month the insurance is effective, or the first of the month in which the person requests reimbursement, whichever is the latest.

People must report within 10 days any change in health care coverage or the amount of their premiums.

People who receive medical assistance (except OHP-CHP and OHP-OPU) must apply for, accept and maintain employer-sponsored cost-effective group health insurance if it is

available to them. If the insurance is available at a later date or open enrollment period, they must tell us when it will become effective.

If a person does not cooperate and does not have good cause, they are not eligible for medical assistance unless they are pregnant. There is no ineligibility for people who are pregnant. Only the individual who can legally assign rights and obtain the insurance is assessed the penalty for failure to meet this requirement and loses medical eligibility. The other individuals in the group, such as other adults or the children, continue to receive Medicaid. See Section D for good cause criteria. When an ineligible person agrees to cooperate by enrolling in their insurance plan at the earliest opportunity, they are eligible for medical assistance.

Clients req. to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP
(except OHP-CHP), OSIPM, SAC: 461-120-0345
Clients Excused for Good Cause from Compliance with OARs 461-120-0340 and 0345: 461-120-0350
Specific requirements; Reimbursement of Cost-Effective, Employer-Sponsored Health Insurance Premiums: 461-135-0990
Changes That Must be Reported: 461-170-0011
Effective dates; OHP Premium: 461-180-0097

14. Payment of Private Health Insurance (PHI)

In special situations, DMAP may pay for insurance premiums even if the premium is greater than what is allowed on the HIPP Standard Chart. This may occur when the cost for an individual's health services is less than the estimated cost of paying for those services on a fee-for-service (FFS) basis. The Health Insurance Group (HIG) administers the PHI program and they may request medical documentation before PHI can be approved. Payments for PHI generally go directly to the insurance carrier; however, in some cases, payments may be paid directly to the policyholder. The health plan may be a private individual/family or employer sponsored insurance.

HIG determines if the PHI premium payment is cost effective by:

- Reviewing the client's past claims and payments from state medical programs and/or private insurance carriers.
- Estimating the current and probable future health status of the client based on existing medical conditions or documentation.
- Evaluating the extent/limit of coverage available to the client under any health insurance

DMAP does not pay PHI premium payments for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance premiums.
- Clients eligible for HIPP

Refer a client for PHI to HIG if the client is ineligible for HIPP because the client's share of the premium exceeds the allowed amount on the HIPP Standard Chart, or their insurance is not an employer sponsored insurance plan, and the client has a medical condition that may make it cost effective for the state to pay the premium.

To make a PHI referral complete Sections 1 through 4 on the revised DHS 3073 and fax it to HIG at 503 373-0358. You must include a copy of the DHS 415H or SDS 415H.

Other documentation may be required such as the *Authorization for Use and Disclosure of Information* (DHS 2099), medical records, doctor letters or chart notes. If any of these are already available they should be faxed along with the DHS 3073. It is not necessary to request these before making the referral but if they are already available, sending them with the referral can shorten processing time.

Caseworkers and clients are notified by mail after the PHI eligibility determination has been made.

☞ SEE DMAP WORKER GUIDE # 7 FOR MORE INFORMATION.

15. Breast and Cervical Cancer Medical (BCCM)

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) amended Title XIX (Medicaid) of the Social Security Act to give the option of providing Medicaid eligibility to uninsured women who are screened by the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including precancerous conditions.

No income or resource limits exist for the BCCM program.

To be eligible for the BCCM program, a woman must:

- Have been screened by the Oregon Breast and Cervical Cancer Program, which is coordinated by the DHS Health Services and paid for by NBCCEDP, and is in need of treatment for breast or cervical cancer, or precancerous conditions.
- Be under the age of 65. (The BCC Screening Program, coordinated by DHS Health Services, has its own eligibility criteria for screening services which includes a requirement that the woman be at least 40 years old.)
- Be uninsured. She must not have creditable coverage for the needed treatment of breast or cervical cancer, or precancerous conditions, by health insurance.
 - Creditable coverage includes:
 - Individual or group health insurance.
 - Medicare.

- Medicaid.
- Armed forces insurance.
- Family Health Insurance Assistance Program (FHIAP).
- Oregon Medical Insurance Pool (OMIP).
- Not be eligible under any of the mandatory Medicaid programs (MAA, MAF, Medicaid for pregnant women and children or OSIPM).

The Oregon Breast and Cervical Cancer Program of DHS Health Services provides grants to local county health departments and tribes throughout the state to administer screening and diagnostic services. Local program staff provide case management services.

Because a woman must be screened by the Oregon Breast and Cervical Cancer Program and found to need treatment to be eligible for BCCM, the application process is initiated by an Oregon Breast and Cervical Cancer Program Coordinator who assists the woman in completing a BCCM application form upon receiving a diagnosis of cancer or precancerous condition. The coordinator submits the BCCM application form to the Statewide Processing Center to establish eligibility. If it appears the woman could be eligible for a mandatory Medicaid program, the coordinator will assist the woman in requesting an *Application for the Oregon Health Plan* (OHP 7210) from the application center. The OHP 7210 will be marked “BCP” on the label. If a woman submits the OHP 7210 to a branch office, it is to be forwarded to the Statewide Processing Center.

A woman found eligible for the BCCM program will have her case coded as program P2 with a BCP case descriptor. If the woman is later determined to be eligible under any of the mandatory Medicaid programs, her case will be coded with that program coding and with a BCS case descriptor.

A woman who loses eligibility for another medical program, but has her case coded with the BCS case descriptor, is still eligible for the BCCM program as long as she still needs treatment and continues to meet all other eligibility requirements for the program.

A woman is no longer eligible for the BCCM program when:

- Her course of treatment has been completed.
- She reaches age 65.
- She becomes covered for treatment of breast or cervical cancer by credible health insurance.
- She is no longer a resident of Oregon.

For information regarding the screening and diagnostic services of the Oregon Breast and Cervical Cancer Program, contact the local county health department or call DHS Health

Services at (503) 731-4273. Information about the program can also be found on the program's web page at <http://egov.oregon.gov/DHS/ph/bcc/index.shtml>.

16. **12-Month Continuous Eligibility for Non-CAWEM Children**

Effective October 2009, non-CAWEM children under age 19 who lose eligibility for EXT, CW medical, MAA, MAF, OHP, OSIPM or SAC medical may qualify for medical under the Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC).

CEM/CEC Eligibility Overview

Begin Continuous Eligibility for Medicaid (CEM) or Continuous Eligibility for CHIP (CEC), when the child:

- Was eligible for and receiving EXT, CW medical, MAA, MAF, OHP or OSIPM, but lost eligibility with time remaining until their next scheduled 12-month redetermination.

To qualify for CEM or CEC, the child must also:

- Be under age 19.
- Meet the alien status requirement for medical.

Note: Effective October 2009, LPR children (under age 19) meet the alien status requirement and qualify for full Medicaid and CHIP benefits without having to wait for five years.

LPR children turning age 19 may no longer qualify for full medical program benefits. When a child is turning age 19, determine if the 19 year old's LPR status began less than five years ago. If it began less than five years earlier, consider eligibility for CAWEM benefits.

☞ SEE THE WORKER GUDE NC-1 FOR MORE INFORMATION ABOUT IMMIGRATION STATUS REQUIREMENTS FOR MEDICAL

CEM and CEC benefits end when:

- The 12-month redetermination period from prior medical program eligibility ends.
- The child moves out of state.
- The child turns age 19.
- The family voluntarily requests the medical be closed.

Procedures and Examples

When a child is determined no longer eligible for EXT, MAA, MAF, OHP, OSIPM and SAC, review for all medical programs as per the usual ‘due process’ procedure.

☞ SEE MA.B FOR MORE INFORMATION ABOUT THE REDETERMINATION PROCESS AND ACTING ON REPORTED CHANGES

If found ineligible for EXT, MAA, MAF, OISPM, OHP, QMB and SAC medical programs, consider if the child is a U.S. citizen or meets the Medicaid/CHIP alien status.

- If the child is a U.S. citizen or meets the Medicaid/CHIP immigration status, convert to CEM/CEC for the remainder of their current eligibility period. Enter either the CEM (Continuous Eligibility for Medicaid) or CEC (Continuous Eligibility for CHIP) need/resource item and case descriptor. For the CEM/CEC end date, use the prior MAA/MAF/OHP/OISPM/SAC redetermination date.

Example 1: Regina is receiving CHP; her certification is due to end November 30, 20XX. Her mother reports that Regina has been added to her absent father’s health insurance plan through his employer. Acting on the reported change, the worker reviews medical program eligibility for everyone in the filing group and determines that Regina is eligible only under the Continuous Eligibility for CHIP (CEC) policy. The worker codes Regina with the CEC case descriptor and need/resource for 11/20XX.

Example 2: Seth is receiving MAA. His LPR status date is January 2008. His MAA redetermination need/resource end date is January 31, 20XX.

On October 2, Seth’s mother reports that her husband has returned home and that he earns about \$3,000 a month. Acting on the reported change, the worker determines that the family is not eligible for EXT, MAA, MAF, OHP, OSIPM or SAC and ends medical for the mother (sending a 10-day close notice and DHS 462A). The worker reviews Seth’s eligibility and finds Seth is eligible only for Continuous Eligibility for Medicaid (CEM). The worker enters the CEM case descriptor and CEM need/resource item for 01/20XX.

Example 3: Mark and his two children are receiving MAA. No one meets the disability criteria for OSIPM presumptive. Mark reports an increase in child support that makes the family ineligible for MAA. The worker converts the family to EXT for August 1, 2009, through November 30, 2009.

In November, the worker redetermines medical eligibility for the family and learns that Mark has a new job with health insurance. No one in the family is eligible for MAA, MAF, OHP (or OSIPM or

SAC). The children are converted to CEM. The worker enters the CEM case descriptor and CEM need/resource item on each CEM eligible child. The CEM need/resource end date is July/2010 (12 months from when the EXT began).

Example 4: Maria and her two children, Consuela and Antonio live with Antonio's father. Maria and Antonio's father are not married. They are over income for two-parent MAA, so Maria and Consuela receive MAF CAWEM (redetermination due April 30, 20XX), while Antonio receives OPC CAWEM (certified through March 31, 20XX).

Maria reports March 5 that she won her UC hearing and her UC has just begun. The UC amount exceeds the MAF income limit. The worker reviews eligibility for MAF **and** OPC and determines that the family is over income for MAA, MAF, OHP and ineligible for OSIPM. The worker realizes that neither child is eligible for CEM because they do not meet the alien status requirement. The worker sends a 10-day close notice and DHS 462A and ends MAF and OPC effective March 31.

Procedures for CEM/CEC children turning age 19:

CEM: Children turning age 19 are no longer eligible for Continuous Eligibility for Medicaid (CEM) unless pregnant. If pregnant, the CEM child will receive benefits through the end of the second month following the DUE date.

CEM children who are not pregnant will be sent advance and final medical close notices automatically by the CM system. The CM system will end their benefits at the end of the month following their 19th birthday.

CEC: Children turning age 19 are no longer eligible for Continuous Eligibility for CHIP. There is no protected eligibility for pregnant CEC children turning age 19.

CEM and CEC children will be mailed advance and final close notices and a reapplication packet. If there is a date of request (DOR) established before the CEM/CEC ends, add a BED code. Review for medical program eligibility and convert to a new program or end medical benefits with a 10-day close notice and DHS 462A.

Special 5503 OP6 procedure:

The OHP Statewide Processing Center (branch 5503) currently receives a monthly report of children turning age 6. 5503 staff review the report and redetermine eligibility for the each OP6's filing group. The procedure will remain, but be expanded to include Continuous Eligibility for Medicaid and CHIP.

Example: Chad is a U.S. citizen. He is certified to receive OP6 through June 30 of next year. Chad turns age 6 in February.

In January, the OHP Statewide Processing Center (5503) receives a report of OP6 children turning age 6. 5503 staff review Chad's eligibility to determine if he qualifies for any other DHS medical program. If not eligible for any other DHS medical program, 5503 will convert Chad to Continuous Eligibility for Medicaid (CEM) by adding the CEM case descriptor and need/resource item. The CEM end date will be 06/XX (the original OP6 certification end date)

Special 5503 MAA/MAF/OPP procedure:

The OHP Statewide Processing Center (branch 5503) will work a monthly report of pregnant children under age 19 whose MAA/MAF eligibility is ending because there are no dependent children on the case. The report will also list OPP children whose medical is ending.

Example: Felicia is age 16 and receiving OPP. The DUE date on her CM case is 08/09. In 07/09, 5503 will redetermine eligibility for Felicia's medical filing group.

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F. Financial Eligibility Requirements

Note: There are no financial eligibility requirements for the BCCM program.

1. Definition of Assets

An asset is either counted as income, counted as a resource, or excluded in any given month. When an asset is excluded, it is not counted as either income or a resource. An asset that is counted as income is excluded as a resource in that month. When determining financial eligibility, count all assets that are not specifically excluded. For more information on whether to count types of income or a resource, refer to the Counting Client Assets chapter, the MAA Asset Quick Reference Chart (section 8) or the OHP List of Income and Resources (section 13).

Definition of assets: 461-140-0010

2. Availability of Resources

An available resource is one that the person has a legal interest in and is available to be used for their support and maintenance. When a person states the resource is not available, they must provide proof that it is not available.

When a resource is jointly owned, only the portion of the jointly owned resource that can be legally attributed to the person is considered available.

A resource is not considered available in the following situations:

- A person has a legal interest in the resource, but it is unavailable because it is not in their possession.
- The resource is jointly owned with other people who are not in the financial group, who are unwilling to sell, and the person's interest is not reasonably salable.
- A person is verified by a doctor to be incompetent and there is no legal representative to act on their behalf.
- A person is a victim of domestic violence and the resource is jointly owned with a person who lives in the household the person left.
- The resource is an irrevocable or restricted trust and cannot be used to meet the person's basic monthly needs.
- A person does not know they own the resource.

Availability of resources: 461-140-0020

3. Treatment of Excluded Income

Excluded income remains excluded as long as it is kept in a separate account and not commingled with other funds. Excluded income that is commingled in an account with other funds that are not excluded remains excluded for six months from the date it is commingled, after which it is counted as a resource.

When an excluded resource is sold, the proceeds from that sale are considered available and can affect eligibility. Special rules apply to these situations. See rule 461-145-0460.

Excluded assets: 461-140-0070
Sale of a Resource: 461-145-0460

4. Resource Limits and Transfers

For MAA, MAF, and SAC, the need group is not eligible for benefits if the financial group has countable resources equal to or greater than the need group resource limit.

The resource limit for MAA, MAF, and SAC is \$2,500. However, an MAA need group that includes a Pre-TANF Program participant or TANF recipient who is progressing in a JOBS plan has a resource limit of \$10,000. If at any time a Pre-TANF Program participant or a TANF recipient no longer cooperates with their case plan, the resource limit is then reduced back to \$2,500.

To qualify for EXT, MAA, MAF, REFM, or SAC benefits, a filing group must not have made a disqualifying transfer of their assets within the preceding three years. They must report any potentially disqualifying transfer at application, redetermination, and when the transfer occurs. Making a disqualifying transfer of available assets will result in termination of benefits. When the client is ineligible for benefits because of a disqualifying transfer of assets, the client remains ineligible until the disqualification period ends or when the full equity rights in the asset are transferred back to the client or the client receives adequate compensation.

***Note:** A transfer of asset is only disqualifying if the client is an inpatient in a nursing facility or medical institution in which payment for the client is based on a level of care provided in a nursing facility.*

For OHP, there is no resource limit for persons whose eligibility is determined under the OHP-OPC, OHP-OP6, OHP-CHP or OHP-OPP categories.

The resource limit is \$2,000 for nonpregnant persons age 19 and over whose eligibility is determined under the OHP-OPU category.

Availability of resources: 461-140-0020
Resource Transfer: 461-140-0210

5. Availability of Income

Income includes both earned income from employment (including self-employment) and unearned income from sources such as Social Security, pensions, and child support.

Income is considered available immediately upon receipt, or when the person has a legal interest in the income and the legal ability to make the income available.

Earned and unearned income is considered to be available prior to any amounts subtracted for things such as garnishments, taxes, payroll deductions, or voluntary payroll deductions; i.e., IRAs, KEOGHs.

Earned income withheld or diverted at the request of an employee is considered available in the month the wages would have been paid. An advance or draw is money received that will be subtracted from later wages. An advance or draw is considered to be available when it is received.

When a person is usually paid monthly or twice monthly on the first or last day of the month, but is paid early or late because the regular payday falls on a holiday or weekend, they are still considered to be paid on the regular payday.

Income that should legally be paid directly to a person, but is paid to a third party for a household expense, is considered available to the person when the third party receives the payment.

Income is not considered available in the following situations:

- The income is withheld by an employer as a general practice, even if in violation of the law.
- The income is paid jointly to the person and other people and the others do not pay the person their share.
- The income is received by a person after they have left the household.
- In the MAF and OHP programs, if the client's abuser is not in the filing group, the abuser controls the income, and will not make the income available to the filing group.
- In the MAA program, if the client's abuser controls the income and will not make the income available to the filing group. This applies to all situations whether or not the abuser is in the filing group.

6. Income Deductions and Exclusions

Deductions are subtracted after the client has passed the countable income test.

Exclusions are subtracted prior to the countable income test.

MAA, MAF, OHP, OSIPM, QMB and SAC: If the client's earned income must be included in the eligibility determination, exclude the Making Work Pay tax credit authorized by The American Reinvestment and Recovery Act of 2009. For each working client, per month, apply the Making Work Pay tax credit exclusion as follows:

- Clients receiving SSI, SSDI, SSB, Railroad Retirement, Veterans Disability and Veterans Pension payments qualify for a \$38 exclusion from their earned income each month through December 2009.
- Clients who do not receive SSI, SSDI, SSB, Railroad Retirement or Veterans payments qualify for a \$100 earned income exclusion each month through December 2009.

Example: Sam is applying for MAA for himself and his daughter. He does not receive SSI, SSDI, SSB, Railroad Retirement or Veterans benefits. Sam made \$500 in the budget month. His countable earned income is: \$500 - \$100 = \$400 earned.

For EXT, exclude out-of-pocket dependent care costs necessary for the caretaker relative to maintain employment, including time required to commute, work, and take a meal break.

For MAA, exclude the Making Work Pay tax credit described at the top of this section.

For MAA applicants and recipients who get child support, exclude up to \$50 per dependent child or minor parent per financial group per month but not to exceed \$200 per financial group per month. The child support disregard is subtracted prior to the countable income test.

☞ SEE CS H FOR MORE INFORMATION ABOUT THE CHILD SUPPORT PASS-THROUGH AND DISREGARD, INCLUDING EXAMPLES

For MAA, there is only one income deduction for MAA clients not in the microenterprise component of JOBS. It is the earned income deduction for each member of the financial group who has earnings. **Individuals in the financial group with earned income are allowed a deduction of 50 percent of the group's gross earned income.** This includes all self-employment income. Clients are eligible for the deduction as long as they have earned income in the budget month. MAA clients must pass the countable earned income test to be eligible for the earned income deduction.

For individuals in the MAA financial group who are in the microenterprise component of the JOBS program and who have earned income from a microenterprise, business

expenses are deducted from the business' gross receipts. This is done according to general accounting principals and OAR 461-145-0920 by an accounting professional such as a certified public accountant or bookkeeper. The remainder is the individual's countable income. Compare the microenterprise income, together with the financial group's other countable income, to the Countable Income Standard. If the income is at or over the standard, the group is ineligible. If it is under the standard, apply the 50 percent earned income deduction to the microenterprise income and other countable earned income.

For MAF and SAC, exclude the Making Work Pay tax credit described at the top of this section.

Instead of allowing the TANF income deductions, use the following deductions and exclusions:

Exclude up to \$50 per dependent child or minor parent per financial group per month but not to exceed \$200 per financial group per month. The child support disregard is subtracted prior to the countable income test.

☞ SEE CS H MORE INFORMATION ABOUT THE CHILD SUPPORT PASS-THROUGH AND DISREGARD, INCLUDING EXAMPLES

- Determine the amount of a self-employed person's countable earned income by reducing the amount of their gross sales or receipts by the amount of their costs of producing the income. See Section B of the Counting Client Assets chapter for allowed costs.
- Once the amount of countable earned income is determined (including countable self-employment income) allow the following deductions from each person's earned income:
 - The first \$120, plus one-third of the balance of their earned income; and
 - A dependent care deduction up to \$200 for each dependent under age 2, and \$175 for each dependent age 2 and over. Costs may be incurred for hours worked, meal and commuting time, medical leave, and work-related training.

For OHP, exclude the Making Work Pay tax credit described at the top of this section.

All self-employed people who are "principals of a business entity" have a \$10,000 gross income limit. If gross income equals or exceeds \$10,000, they are not eligible for OHP. If gross income is less than \$10,000, they are allowed to exclude 50 percent of their gross sales and receipts when determining their countable earned income. This is intended to allow for their costs of producing the income.

☞ SEE #9 OF THIS SECTION FOR MORE INFORMATION ABOUT THE \$10,000 BUSINESS ENTITY INCOME TEST.

If their total countable income is over income standards using the 50 percent exclusion, then do not allow a 50 percent exclusion. Instead, determine countable income by subtracting the actual costs of producing self-employment income. See Counting Client Assets, Section C – Self-Employment income.

Economic Recovery Payment: 461-145-0143
 Dependent Care Costs: 461-160-0040
 Earned Income Deduction; MAA: 461-160-0160
 Earned Income Deductions; MAF and SAC: 461-160-0190
 Unearned Income Deductions; MAF and SAC: 461-160-0200
 Self employment: 461-145-0920
 Self-Employment; Determination of Countable Income: 461-145-0930
 Income Standard; OHP, REFM: 461-155-0225

7. Budgeting and Income Standards

Budgeting is the process of determining whether a person meets all the nonfinancial and financial eligibility requirements in a calendar (budget) month.

For OHP budgeting, see sections 9 and 10. This section does not include OHP.

Prospective budgeting: For EXT, MAA, MAF and SAC in the Change Reporting System (CRS), use actual income in the initial month. Actual income is the income already received in the initial month plus all the income that reasonable may be expected to be received within the initial month. To arrive at reasonably anticipated income, the client and the worker jointly determine the anticipated income to be counted. Workers will count only income that is reasonably certain to be available.

There is no overpayment based on incorrectly anticipated information unless the client withheld information or provided false information. No supplement is issued based on incorrectly anticipated information.

For ongoing months, income is budgeted prospectively so that anticipated income is the same for each month.

Converting, Averaging and Annualizing

For OHP, see sections 9 and 10.

Converting Stable Income: For stable income received once a month, the monthly amount is used to anticipate what the group's income will be for each month.

- For stable income received once a week, convert it to a monthly amount by multiplying it by 4.3.
- For stable income received once every other week, convert it to a monthly amount by multiplying it by 2.15.

Averaging Variable Income: To arrive at the average amount for prospective budgeting, first convert to a monthly income amount.

For variable earned income based on an hourly wage when the past is representative, monthly income is determined by calculating an average number of hours per pay period, then these hours are multiplied by the hourly wage and converted to a monthly amount under section (1) of this rule.

For variable earned income involving various rates of pay (overtime, shift differential, tips) when the past is representative, monthly income is determined by calculating the average income per pay period, then the average income is converted to a monthly amount under section (1) of this rule.

For variable earned or unearned income when the past is representative and income cannot be calculated using the above guidance, monthly income is determined by averaging the income over --

- A representative period of months by totaling the income for those months and dividing by the number of months used; or
- A representative number of pay periods and converting to a monthly amount under section (1) of this rule.

For variable earned and unearned income when the past is not representative of the income the financial group will receive during the eligibility period, the client and the Department jointly determine the anticipated income.

Annualizing Income: For all but OHP (and REFM), contract income must be annualized when a full year's income is received in less than a 12-month period; e.g., school employees and contract employees. To annualize nonself-employment income, add the income from a 12-month period and divide by 12. If past income is not representative, use anticipated income. The resulting figure is the annualized income.

If the contract income is received monthly or on an hourly or piecework basis, treat as stable income.

Contract income that is not the annual income and not paid on hourly or piecework basis is prorated over the period the income is intended to cover.

Annualize self-employment income when it is received during less than a 12-month period but is intended as a full year's income or when the business has operated for a full year and the previous year is representative of the income and costs will be during the budget month.

Use the most recent state and federal income tax forms, or the estimates of next year's anticipated income if there will be a substantial increase or decrease in next year's self-employment income. Divide the income - reported or anticipated, according to the situation - by 12 to arrive at the income for each month.

☞ SEE CCA SECTION C FOR MORE INFORMATION ON SELF-EMPLOYMENT INCOME, INCLUDING MICROENTERPRISE INCOME

Prospective Eligibility and Budgeting: 461-150-0020
 Use of Prospective or Retrospective: FS, MAA, MAF, REF, REFM, TANF: 461-150-0060
 Prospective Budgeting of Stable Income: 461-150-0070
 Prospective Budgeting of Variable Income; Not OHP; Not MRS: 461-150-0080
 Prospective Budgeting: Annualizing Contracted or Self-employment Income: 461-150-0090

When to Use Retrospective Eligibility or Budgeting: For MAA cases in retrospective eligibility or budgeting, the budget month is the month before the payment month. Retrospective eligibility or budgeting is used for benefit groups who are also receiving TANF and are in MRS.

To determine eligibility retrospectively, use information from the last day of the budget month to evaluate all eligibility factors except income and resources; use information from the entire month to evaluate income and resources. To budget retrospectively, the income and resources for the entire budget month will be used to calculate the benefit amount.

The form used for the MRS is the *Monthly Change Report (DHS 859A)*.

Use of Prospective or Retrospective: FS, MAA, MAF, REF, REFM, TANF: 461-150-0060

Send a continuing benefit decision notice when a client enters or reenters MRS.

Notice Situation; APR, MRS, SRS, or TBA: 461-175-0270

8. MAA Asset Quick Reference Chart

Note: This chart does not include treatment of assets for a TANF/MAA client working under a JOBS Plus agreement. See Counting Client Assets Chapter for that specific situation.

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Adoption assistance: 461-145-0001	X				
Agent Orange Disability Benefits 461-145-0005 • Aetna Life and Casualty • Agent Orange Act of 1991 (Dept. of Veterans Affairs)	X		X		
Alaska Permanent Fund Dividend 461-145-0008					X
Animals: 461-145-0010 • If pets are raised for food • Income-producing (see income-producing property)	X				

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Annuities, Dividends, Interest 461-145-0020			X		
Bank account: 461-145-0030 • Except - exclude if already counted as income for that month or • If excluded income as per 461-140-0070	X X				X
Burial arrangements: 461-145-0040 • Burial fund				X	X
Burial Space and Merchandise 461-145-0050 • Space - one per client • Merchandise for client and specific relatives				X X	
Cash and Foreign Currency that can be converted to U.S. currency 461-145-0060					X
Census Income: 461-145-0130	X				
Child support 461-145-0080 • Cash medical support	X				
Cash child support • Exclude up to \$50 per child or minor parent, up to \$200 per financial group, per month • Count the balance as unearned income • Paid to a third party (same as above; allow up to \$50 per child minor parent, up to \$200 per financial group per month • All others	X X		X		
Contributions: 461-145-0086			X		
Disability benefit: 461-145-0090 • Employer sponsored disability insurance • All other payments, if received monthly or more frequently than monthly • Other payments		X	X X (if periodic)		X (if lump sum)
Disaster Relief (specific types): 461-145-0100	X				
Dividends, Interest and Royalties 461-145-0108 • Except that royalties (client actively engaged in the activity)		X	X		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Domestic Volunteer Services Act 461-145-0110 • VISTA: -If comp. less than min. wage -If more than min. wage • Title II or title III (RSVP, SCORE, ACE, Foster Grandparents, etc.)	X X	X			
Earned income: 461-145-0130 • Under 18 in vocational, GED, or high school • In-kind • Welfare to work (see welfare-to- work below) • Other • Income remaining after month of receipt	X	X X			X
Earned Income Credit (state and federal): 461-145-0140	X				
Economic Stimulus Payment (\$250 from ARRA) 461-145-0143	X			X for 10 months	
Educational income: 461-145-0150 • Title IV and BIA • Non-Title IV or BIA (remainder after deducting costs)	X	X (work study, fellows hips, etc.)	X (grants, loans, etc.)		
Energy assistance: 461-145-0170 • Federal (not paid w/public assist.) • Federal or state one-time for weatherization or heat repair • Other	X X X				
Food Programs (WIC, School Lunch) 461-145-0190	X				
Foster care: 461-145-0200 • Foster care room and board, special needs • Remaining amount	X	X			
Gifts and winnings (cash): 461-145-0210			X (if periodic)		X (if lump sum)
Home and contiguous property 461-145-0220 • Living in • Temporarily unoccupied (see CA B.32 for details)				X X	

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
HUD: 461-145-0230 <ul style="list-style-type: none"> • Paid to third party • Paid directly to client • Youthbuild <ul style="list-style-type: none"> - Age 19 or under - Over age 19 • Escrow for Family Self-Sufficiency • Family Investment Centers 	X X(unless lump sum)		X (if lump sum)		
Income-producing contract 461-145-0240 <ul style="list-style-type: none"> • Equity value • Income (minus cost) 	X		X		
Income-producing property: 461-145-0250 <ul style="list-style-type: none"> • Equity (if producing income or the property is animals) • Income (minus costs) 		X (20 hr/wk-SLF)	X (not 20 hr/wk)		X(unless in microenterprise)
Independent Living Subsidies: 461-145-0255	X				
Indian/Native American Benefits (See Counting Client Assets)					
Individual Education Account: 461-145-0265	X			X	
Inheritance (cash): 461-145-0270			X (if periodic)		X (if lump sum)
In-kind income: 461-145-0280	X (except unearned third party payments)				
Job Corps: 461-145-0290 <ul style="list-style-type: none"> • Living allowance • Readjustment allowance • Support service covered by covered by client's OHP benefits • Other reimbursements see 461-145-0440 		X X	X		
Life estate: 461-145-0310 (when occupying the estate)	X				
Life insurance: 461-145-0320 <ul style="list-style-type: none"> • Payments to beneficiary • Equity value/Term insurance 	X		X (allow up to \$1,500 for costs)		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Loans: 461-145-0330 • Cash on hand from loan (must be written loan agreement dated before receipt of money) • Interest from loan being repaid to client	X		X		
Lodger income: 461-145-0340 (to be lodger income the boarder must pay for rent and meals)	X (per minimum contribution table at 461-155-0350)	X (SLF)			
Making Work Pay tax credit 461-145-0143 \$38 if eligible for \$250 economic stimulus payment \$100 if not eligible for \$250 payment	X			X	
Microenterprise: 461-145-0920, 461-145-0930		X			
Motor vehicles: 461-145-0360	Up to \$10,000 combined equity value				
National and Community Services Trust Act (NCSTA): 461-145-0365 (See Counting Client Assets chapter.)					
Older Americans Act: 461-145-0370 • Title III (Nutrition Program for the Elderly) • Title V (Green Thumb, etc.)	X	X			
Pension and retirement plans: 461-145-0380 • Retired - monthly payments • Retired - other payments • Equity			X X(if periodic)		X (if lump sum) X
Personal belongings: 461-145-0390	X				
Personal injury settlement: 461-145-0400 • Monthly payments • Other			X		X
Plan for Self Support (PASS) assets: 461-145-0405	X				
Program benefits: 461-145-0410	X				
Radiation Exposure Compensation Act: 461-145-0415	X				
Real property: 461-145-0420 • Good faith effort to sell • Equity if not for sale	X			X	
Real property under Interim Ass't Agreement: 461-145-0430 See Counting Client Assets chapter.					
Recreational vehicle's equity: 461-145-0433					X
Refunds: 461-145-0435 • Utility and rent deposit refunds	X (month of receipt)			XS	X (month after receipt)

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Reimbursements: 461-145-0440 • Non cash reimbursement • Cash reimbursement - if used for identified expense and expense isn't covered by MAA benefits - if not used for identified expense or covered by MAA benefits	X X		 X(if periodic)		 X(if lump sum)
Sale of a Resource (including home) 461-145-0460 • If reinvested in another excluded resource • If there's any left over	X		 X		
Self-employment including microenterprise: 461-145-0910 thru 461-145-0950		X			
Shelter-in-kind (except for child support) 461-145-0470	X				
Social Security Benefits: 461-145-0490 • If received by an SSI recipient • Monthly payments • Other payments	X		 X X (if periodic)		 X (if lump sum)
Social Security Death Benefit: 461-145-0500 (remaining after burial costs)					X (lump sum)
Spousal support: 461-145-0505			X		
Supplemental Security Income (SSI): 461-145-0510	X (SSI recipients are not in MAA financial group)				
Stocks, bonds, CDs, other securities: 461-145-0520 (see Dividends, Interest and Royalties above, also)					X
Strikers' benefits: 461-145-0525			X		
Tax refunds: 461-145-0530 (Federal and state income taxes, property taxes, ERA)					X
Trusts: 461-145-0540 (see Counting Client Assets)					
Unemployment Compensation: 461-145-0550, 461-145-0143 • Monthly payments • Other	X \$25 ARRA supplemental payment		 X		 X
Uniform Relocation Act reimbursement: 461-145-0560	X				

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
USDA Meal Reimbursement: 461-145-0570	X (if for member of filing group)	X (SLF)			
Veterans' benefits: 461-145-0580 <ul style="list-style-type: none"> • Aid and Attendance • Educational (see Educational Income) • Spina Bifida Payments to Children • Other monthly payments • Other payments, not monthly 	X X X		X X (if periodic)		X (if lump sum)
Victim's assistance: 461-145-0582 <ul style="list-style-type: none"> • PL 103-286 or PL 103-322 • Reimbursement for lost item (see Reimbursement) • Payments for pain and suffering (see Personal Injury Settlement) 	X				
Vocational Rehabilitation Payment 461-145-0585 <ul style="list-style-type: none"> • Payments for food/shelter/clothing • Other (see Reimbursement) 			X		
Welfare-to-Work work experience income: 461-145-0120, 461-145-0130 <ul style="list-style-type: none"> • First \$260 earned per month • Remainder earned per month 	X	X			
Worker's Compensation 461-145-0590 <ul style="list-style-type: none"> • Monthly or more frequent payments • Other 		X (if still considered employed)	X (if periodic)		X (if lump sum)
Workforce Investment Act: 461-145-0300 <ul style="list-style-type: none"> • Needs-based stipend <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Adult OJT and work experience <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Support services already covered by MAA benefits <ul style="list-style-type: none"> - other 	X X X	X	X X		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Work-related capital asset, equipment & inventory: 461-145-0600					
• Capital asset & Equipment - if in JOBS microenterprise - other	X				X
• Inventory - if in JOBS microenterprise - other	X				X(minus costs)

9. OHP Budget Month

When determining financial eligibility for OHP programs, first determine the initial budget month. The budget month is one of the following:

- For all applicants, it is the month of application.
- For people reapplying in the last month of their OHP certification period, and for people moving from another medical assistance program to OHP, it is the last month of their current eligibility period.
- When adding a new person to the filing group, it is the month the person is to be added.
- Any month falling within 45 days of the date of request for applicants who are not eligible using the budget month described above.

Example: Ed, Martha, and their two children reapply for OHP benefits on October 19. Using October as the budget month, the family is over income for OHP. Since the forty-fifth day from the date of request falls in December, both November and December can be used as budget months to determine OHP eligibility. First look at November, and if eligible, medical benefits would start November 1 and there would be no break in medical benefits. If not eligible using November as the budget month, close benefits if there is time to send a timely closure notice for benefits to end effective October 31, and then look at December as the new budget month. If eligible using December as the new budget month, medical benefits would start December 1. There would be a break in benefits, but the adults would still be eligible for OHP Standard because they are not considered new applicants if reapplying for benefits and are found eligible any time within 45 days of the date of request.

If Ed and Martha had reapplied on October 10, December could not be considered as a budget month because it does not fall within 45 days of the date of request.

The budget month is the calendar month from which nonfinancial and financial information is used to determine eligibility and benefit level.

Budgeting: 461-150-0055

When an Application Must be Filed: 461-115-0050

10. OHP \$10,000 Business Entity Income Test for Principals

A “principal” is a person with significant authority in a business entity, such as the proprietor of a sole proprietorship – including a person who meets the definition of “self-employed” in rule 461-145-0910, a partner of a partnership, a member or manager of a limited liability company, or an officer or principal stockholder of a closely held corporation.

If an OHP financial group includes a principal, the business entity must pass a \$10,000 gross income test. The business entities gross income cannot be prorated among principals for the purpose of the gross income test. If the group does not include a principal, go to number 10.

Example: Bill and Tom are equal partners (both have 50 percent ownership) and principals in a carpet cleaning business that grosses approximately \$11,500 monthly. Bill applies for OHP and reports on the application that his share of the gross income is \$5,750. Bill is not eligible for OHP because the business entity does not pass the \$10,000 gross income test.

Calculate the average monthly gross income of the business entity using the following steps:

- (A) Total the business entity’s gross income from the three calendar months prior to the budget month.
- (B) Divide the total of the three months income by three. The result is the average income that is assigned to the budget month.

If the average is less than \$10,000, eligibility for OHP can be determined for the group. Go to number 10.

If the average is equal to or greater than \$10,000 and the group includes a child, pregnant person, or a victim of domestic violence, total the business entity’s gross income received and anticipated to be received in the budget month. If that single month’s income is less than \$10,000, eligibility for OHP can be determined for the group. Go to number 10.

If the single month’s income is equal to or greater than \$10,000, the group is ineligible for OHP and is denied.

Budgeting: 461-150-0055; Use of income: 461-160-0700

Determining Availability of Income: 461-140-0040

11. OHP Budgeting and Eligibility

Do not annualize, convert, or prorate the financial group's income. Use the gross countable income available for each month of the budgeting process.

Calculate the amount of the financial group's average income using the following steps:

- (A) Total the financial group's gross income from month prior to the budget month and the budget month.
- (B) Except for self-employment income, divide the total of the two months income by two. The result is the average income that is assigned to the budget month.
- (C) For self-employment income the average income that is assigned to the budget month is determined as follows:
 - (1) Exclude 50 percent of the average self-employment income.
 - (2) If any applicants are not eligible using the 50 percent exclusion, exclude actual self-employment expenses from self-employment income.

If the need group includes children or a pregnant person who were not eligible using average income, repeat the above steps using the gross income received or anticipated to be received in the budget month to determine eligibility for **all** children and pregnant persons.

If the need group includes a victim of domestic violence, and any of the need group members are not eligible using average income, repeat the above steps using the gross income received, or anticipated to be received, in the budget month to determine eligibility for all applicants.

The average income assigned to the budget month is used to determine OHP eligibility for the need group as follows:

Compare the average income to the OHP Countable Income Standards of 100 percent. If the average income is below the 100 percent standard and the group meets all other eligibility requirements, the group is eligible for OHP. There is no need to evaluate eligibility using income received in the budget month.

Use the OHP case descriptors for each eligible person as follows:

- OPU – Nonpregnant adults
- OPC – Children
- OPP – Pregnant persons, regardless of age

If the average income equals or exceeds the 100 percent income standard, nonpregnant adults (except DV) are not eligible. Determine eligibility for the remaining members of the need group as follows:

Compare the average income to the OHP Countable Income Standards of 133 percent, 185 percent and 201 percent, as appropriate. If the average income is below an income standard for all remaining members of the need group, and **all** of these members of the need group meet **all** other eligibility requirements, these members of the need group are eligible for OHP.

Use the OHP case descriptors for each eligible person as follows:

- OP6 – Children under six (income between 100 percent and 133 percent FPL)
- CHP – Nonpregnant children (income between 133 percent and 201 percent FPL)
- CHP – Pregnant children under age 19 (income between 185 percent and 201 percent FPL)
- OPP – Pregnant persons, regardless of age (income up to 185 percent FPL)

If the need group includes children or a pregnant person who were not eligible using the average income, determine eligibility for **all** children and pregnant persons in the need group using the amount of countable income received and anticipated to be received in the budget month.

If the need group includes a victim of domestic violence, and any of the need group members are not eligible using the financial group's average income, determine eligibility for everyone in the need group using the amount of countable income received and anticipated to be received in the budget month.

Use the following process to determine eligibility using budget month income:

Compare that single month's income to the OHP Countable Income Standards of 100 percent, 133 percent, 185 percent and 201 percent. If the single month's income is below an income standard and the group meets all other eligibility requirements, each child, nonpregnant adult (DV), and pregnant person whose eligibility is determined utilizing the income standard is eligible.

Use the OHP case descriptors for each eligible person as follows:

- OPC – Children (income below 100 percent FPL)
- OP6 – Children under six (income between 100 percent and 133 percent FPL)
- CHP – Children under age 6 (income between 133 percent and 201 percent FPL), children age 6 and older (income between 100 percent and 201 percent FPL)
- CHP – Pregnant children under age 19 (income between 185 percent and 201 percent FPL)
- OPP – Pregnant persons, regardless of age (income up to 185 percent FPL)
- OPU – Nonpregnant adult - DV only (income below 100 percent FPL)

An assumed eligible newborn is coded as OHP-OPC, OHP-OP6, or OHP-OPP, depending on income level. An assumed eligible newborn at or above the OHP-OP6 (133 percent) Income Standard is not to be coded OHP-CHP.

Budgeting: 461-150-0055
Use of income: 461-160-0700
Income Standard; OHP: 461-155-0225

12. OHP Income Standards

The income standards for OHP are as follows:

If a financial group contains a person with significant authority in a business entity – a “principal” – the gross income of the business entity cannot exceed \$10,000. See number 9 above.

Oregon Health Plan for Adults (OHP-OPU) and Children (OHP-OPC)

OHP 100% Countable Income Standard

<u>No. in Need Group</u>	<u>Amount</u>
1	\$ 867
2	1,167
3	1,467
4	1,767
5	2,067
6	2,367
7	2,667
8	2,967
9	3,267
10	3,567
Each additional person	300

Oregon Health Plan for Children Under Age 6 (OP6)

OHP 133% Countable Income Standard

<u>No. in Need Group</u>	<u>Amount</u>
1	\$1,153
2	1,552
3	1,951
4	2,350
5	2,749
6	3,148
7	3,547
8	3,946
9	4,345
10	4,744
Each additional person	399

Oregon Health Plan for Pregnant Females of any age and their Assumed Eligible Newborn Children Under Age One (OHP-OPP)

OHP 185% Countable Income Standard

<u>No. in Need Group</u>	<u>Amount</u>
1	\$1,604
2	2,159
3	2,714
4	3,269
5	3,824
6	4,379
7	4,934
8	5,489
9	6,044
10	6,599
Each additional person	555

Income Standard; OHP: 461-155-0225
Determining Availability of Income: 461-140-0040

Oregon Health Plan for Children Under Age 19, including Pregnant Females with Income no less than 185 Percent FPL (OHP-CHP)

OHP 201% Countable Income Standard

<u>No. in Need Group</u>	<u>Amount</u>
1	\$1,815
2	2,441
3	3,067
4	3,694
5	4,320
6	4,947
7	5,573
8	6,200
9	6,826
10	7,453
Each additional person	627

Income Standard; OHP: 461-155-0225
Determining Availability of Income: 461-140-0040

13. OHP List of Income and Resources

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Adoption assistance: 461-145-0001	X				
Agent Orange Disability Benefits 461-145-0005 • Aetna Life and Casualty • Agent Orange Act of 1991 (Dept. of Veterans Affairs)	X		X		
Alaska Permanent Fund Dividend 461-145-0008					X
Animals: 461-145-0010 • If pets or raised for food • Income-producing (see income-producing property)	X				
Annuities, Dividends, Interest 461-145-0020			X		
Bank account: 461-145-0030 • Except - exclude if already counted as income for that month or • If excluded income as per 461-140-0070	X X				X
Burial arrangements: 461-145-0040 • Burial fund				X	X
Burial Space and Merchandise 461-145-0050 • Space - one per client • Merchandise for client and specific relatives				X X	
Cash and Foreign Currency that can be converted to U.S. currency 461-145-0060					X
Census Income: 461-145-0130	X				
Cash medical support • Exclude cash medical support • All other child support, including 3 rd party payments	X		X		
Contributions: 461-145-0086 • Charitable to assist with medical bills • Other	X		X		
Disability benefit: 461-145-0090 • Employer sponsored disability insurance • All other payments, if received monthly or more frequently than monthly • Other payments		X	X X (if periodic)		X (if lump sum)
Disaster Relief (specific types): 461-145-0100	X				

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Dividends, Interest and Royalties 461-145-0108 • Except that royalties (client actively engaged in the activity)		X	X		
Domestic Volunteer Services Act 461-145-0110 • VISTA: -If comp. less than min. wage -If more than min. wage • Title II or title III (RSVP, SCORE, ACE, Foster Grandparents, etc.)	X X	X			
Earned income: 461-145-0130 • Under age 19 • In-kind • In-kind for principal of business entity • TANF -PLS • NCP-PLS • Welfare to work • Income remaining after month of receipt	X X	X X X	 X		 X
Earned Income Credit (state and federal): 461-145-0140	X				
Economic Stimulus Payment (\$250 from ARRA) 461-145-0143	X			X for 10 months	
Educational income: 461-145-0150 • Title IV and BIA • Non-Title IV or BIA (remainder after deducting costs)	X	X (work study, fellowships, etc.)	X (grants, loans, etc.)		
Energy assistance: 461-145-0170 • Federal (not paid w/public assist.) • Federal or state one-time for weatherization or heat repair • Other	X X X				
Food Programs (WIC, School Lunch) 461-145-0190	X				
Foster care: 461-145-0200 • Foster care room and board, special needs • Remaining amount	X	X			
Gifts and winnings (cash): 461-145-0210			X (if periodic)		X (if lump sum)
Home and contiguous property 461-145-0220 • Living in • Temporarily unoccupied (see CA B.32 for details)				X X	

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
HUD: 461-145-0230 <ul style="list-style-type: none"> • Paid to third party • Paid directly to client (except for Youthbuild) • Youthbuild 	X		X		
<ul style="list-style-type: none"> • Escrow for Family Self-Sufficiency • Family Investment Centers 	X	X(19 and above)			
	X(wages under age 19)	X(wages 19 and above)	X(stipend)		
Income-producing contract 461-145-0240 <ul style="list-style-type: none"> • Equity value • Income (minus cost) <ul style="list-style-type: none"> - if receive monthly - if lump sum 					X
Income-producing property: 461-145-0250 <ul style="list-style-type: none"> • Equity (if producing income or the property is animals) • Income (minus costs) 		X (20 hr/wk-SLF)	X (not 20 hr/wk)		X
Independent Living Subsidies: 461-145-0255	X				
Indian/Native American Benefits (See Counting Client Assets)					
Individual Education Account: 461-145-0265	X				X
Inheritance (cash): 461-145-0270			X (if periodic)		X (if lump sum)
In-kind income: 461-145-0280 <ul style="list-style-type: none"> • Child support • If principal of business entity 		X (if earned)	X		
<ul style="list-style-type: none"> • Other 	X				
Job Corps: 461-145-0290 <ul style="list-style-type: none"> • Living allowance • Readjustment allowance • Support service covered by covered by client's OHP benefits • Other reimbursements see 461-145-0440 		X X	X		
Life estate: 461-145-0310 (when occupying the estate)	X				
Life insurance: 461-145-0320 <ul style="list-style-type: none"> • Payments to beneficiary • Equity value/Term insurance 	X		X (allow up to \$1,500 for costs)		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Loans: 461-145-0330 • Cash on hand from loan • Interest from loan being repaid to client	X		X		
Lodger income: 461-145-0340 (to be lodger income the boarder must pay for rent and meals)		X (SLF)			
Making Work Pay tax credit 461-145-0143 \$38 if eligible for \$250 economic stimulus payment \$100 if not eligible for \$250 payment	X			X	
Microenterprise: 461-145-0920, 461-145-0930		X			
Motor vehicles: 461-145-0360	X				
National and Community Services Trust Act (NCSTA): 461-145-0365 (See Counting Client Assets chapter.)					
Older Americans Act: 461-145-0370 • Title III (Nutrition Program for the Elderly) • Title V (Green Thumb, etc.)	X	X			
Pension and retirement plans: 461-145-0380 • Retired - monthly payments • Retired - other payments • Equity			X X(if periodic)	X	X (if lump sum)
Personal belongings: 461-145-0390	X				
Personal injury settlement: 461-145-0400 • Monthly payments • Other			X		X
Plan for Self Support (PASS) assets: 461-145-0405	X				
Program benefits: 461-145-0410			X (see rule for exceptions)		
Radiation Exposure Compensation Act: 461-145-0415	X				
Real property: 461-145-0420					X
Recreational vehicle's equity: 461-145-0433					X
Refunds: 461-145-0435 • Utility and rent deposit refunds	X (month of receipt)			X	X (month after receipt)

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Reimbursements: 461-145-0440 <ul style="list-style-type: none"> • Principal of business entity • Non cash reimbursement • Cash reimbursement <ul style="list-style-type: none"> - if used for identified expense and expense isn't covered by OHP benefits - if not used for identified expense or covered by OHP benefits 	X		X		
Sale of a Resource (including home) 461-145-0460 <ul style="list-style-type: none"> • Other than a home <ul style="list-style-type: none"> - if excluded and reinvested in another excluded resource - if there's any left over • A home - If the financial group intends to buy another home within 3 months <ul style="list-style-type: none"> - If not reinvested in another home 	X				X
Self-employment including microenterprise: 461-145-0910 thru 461-145-0950		X			
Shelter-in-kind 461-145-0470 <ul style="list-style-type: none"> • Unless child support or received by principal of business entity 	X		X		
Social Security Benefits: 461-145-0490 <ul style="list-style-type: none"> • If received by an SSI recipient • Monthly payments • Other payments 	X		X		
Social Security Death Benefit: 461-145-0500 (remaining after burial costs)					X (lump sum)
Spousal support: 461-145-0505			X		
Supplemental Security Income (SSI): 461-145-0510			X		
Stocks, bonds, CDs, other securities: 461-145-0520 (see Dividends, Interest and Royalties above, also)					X
Strikers' benefits: 461-145-0525			X		
Tax refunds: 461-145-0530 (Federal and state income taxes, property taxes, ERA)					X
Trusts: 461-145-0540 (see Counting Client Assets)					
Unemployment Compensation: 461-145-0550, 461-145-0143 <ul style="list-style-type: none"> • Monthly payments • Other 	X \$25 ARRA supplemental payment		X		X

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Uniform Relocation Act reimbursement: 461-145-0560	X				
USDA Meal Reimbursement: 461-145-0570	X (if for member of filing group)	X (SLF)			
Veterans' benefits: 461-145-0580 <ul style="list-style-type: none"> • Aid and Attendance • Educational (see Educational Income) • Spina Bifida Payments to Children • Other monthly payments • Other payments, not monthly 	X X X		X X (if periodic)		X (if lump sum)
Victim's assistance: 461-145-0582 <ul style="list-style-type: none"> • PL 103-286 or PL 103-322 • Reimbursement for lost item (see Reimbursement) • Payments for pain and suffering 	X		X		
Vocational Rehabilitation Payment 461-145-0585 <ul style="list-style-type: none"> • Payments for food/shelter/clothing • Other (see Reimbursement) 			X		
Worker's Compensation 461-145-0590 <ul style="list-style-type: none"> • Monthly or more frequent payments • Other 		X (if still considered employed)	X		
Workforce Investment Act: 461-145-0300 <ul style="list-style-type: none"> • Needs-based stipend <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Adult OJT and work experience <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Support services already covered by OHP benefits <ul style="list-style-type: none"> - other 	X X X	X	X X		
Work-related capital asset, equipment & inventory: 461-145-0600 <ul style="list-style-type: none"> • Capital asset & Equipment • Inventory 	X X (if client is SLF)				

13. OHP List of Income and Resources

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Adoption assistance: 461-145-0001	X				
Agent Orange Disability Benefits 461-145-0005 • Aetna Life and Casualty • Agent Orange Act of 1991 (Dept. of Veterans Affairs)	X		X		
Alaska Permanent Fund Dividend 461-145-0008					X
Animals: 461-145-0010 • If pets or raised for food • Income-producing (see income-producing property)	X				
Annuities, Dividends, Interest 461-145-0020			X		
Bank account: 461-145-0030 • Except - exclude if already counted as income for that month or • If excluded income as per 461-140-0070	X X				X
Burial arrangements: 461-145-0040 • Burial fund				X	X
Burial Space and Merchandise 461-145-0050 • Space - one per client • Merchandise for client and specific relatives				X X	
Cash and Foreign Currency that can be converted to U.S. currency 461-145-0060					X
Census Income: 461-145-0130	X				
Cash medical support • Exclude cash medical support • All other child support, including 3 rd party payments	X		X		
Contributions: 461-145-0086 • Charitable to assist with medical bills • Other	X		X		
Disability benefit: 461-145-0090 • Employer sponsored disability insurance • All other payments, if received monthly or more frequently than monthly • Other payments		X	X X (if periodic)		X (if lump sum)
Disaster Relief (specific types): 461-145-0100	X				

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Dividends, Interest and Royalties 461-145-0108 • Except that royalties (client actively engaged in the activity)		X	X		
Domestic Volunteer Services Act 461-145-0110 • VISTA: -If comp. less than min. wage -If more than min. wage • Title II or title III (RSVP, SCORE, ACE, Foster Grandparents, etc.)	X X	X			
Earned income: 461-145-0130 • Under age 19 • In-kind • In-kind for principal of business entity • TANF -PLS • NCP-PLS • Welfare to work • Income remaining after month of receipt	X X	X X X	X		X
Earned Income Credit (state and federal): 461-145-0140	X				
Economic Stimulus Payment (\$250 from ARRA) 461-145-0143	X			X for 10 months	
Educational income: 461-145-0150 • Title IV and BIA • Non-Title IV or BIA (remainder after deducting costs)	X	X (work study, fellowships, etc.)	X (grants, loans, etc.)		
Energy assistance: 461-145-0170 • Federal (not paid w/public assist.) • Federal or state one-time for weatherization or heat repair • Other	X X X				
Food Programs (WIC, School Lunch) 461-145-0190	X				
Foster care: 461-145-0200 • Foster care room and board, special needs • Remaining amount	X	X			
Gifts and winnings (cash): 461-145-0210			X (if periodic)		X (if lump sum)
Home and contiguous property 461-145-0220 • Living in • Temporarily unoccupied (see CA B.32 for details)				X X	

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
HUD: 461-145-0230 <ul style="list-style-type: none"> • Paid to third party • Paid directly to client (except for Youthbuild) • Youthbuild 	X		X		
<ul style="list-style-type: none"> • Escrow for Family Self-Sufficiency • Family Investment Centers 	X	X(19 and above)	X(stipend)		
Income-producing contract 461-145-0240 <ul style="list-style-type: none"> • Equity value • Income (minus cost) <ul style="list-style-type: none"> - if receive monthly - if lump sum 			X X		X
Income-producing property: 461-145-0250 <ul style="list-style-type: none"> • Equity (if producing income or the property is animals) • Income (minus costs) 		X (20 hr/wk-SLF)	X (not 20 hr/wk)		X
Independent Living Subsidies: 461-145-0255	X				
Indian/Native American Benefits (See Counting Client Assets)					
Individual Education Account: 461-145-0265	X				X
Inheritance (cash): 461-145-0270			X (if periodic)		X (if lump sum)
In-kind income: 461-145-0280 <ul style="list-style-type: none"> • Child support • If principal of business entity 		X (if earned)	X X		
<ul style="list-style-type: none"> • Other 	X				
Job Corps: 461-145-0290 <ul style="list-style-type: none"> • Living allowance • Readjustment allowance • Support service covered by covered by client's OHP benefits • Other reimbursements see 461-145-0440 		X X	X		
Life estate: 461-145-0310 (when occupying the estate)	X				
Life insurance: 461-145-0320 <ul style="list-style-type: none"> • Payments to beneficiary • Equity value/Term insurance 	X		X (allow up to \$1,500 for costs)		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Loans: 461-145-0330 • Cash on hand from loan • Interest from loan being repaid to client	X		X		
Lodger income: 461-145-0340 (to be lodger income the boarder must pay for rent and meals)		X (SLF)			
Making Work Pay tax credit 461-145-0143 \$38 if eligible for \$250 economic stimulus payment \$100 if not eligible for \$250 payment	X			X	
Microenterprise: 461-145-0920, 461-145-0930		X			
Motor vehicles: 461-145-0360	X				
National and Community Services Trust Act (NCSTA): 461-145-0365 (See Counting Client Assets chapter.)					
Older Americans Act: 461-145-0370 • Title III (Nutrition Program for the Elderly) • Title V (Green Thumb, etc.)	X	X			
Pension and retirement plans: 461-145-0380 • Retired - monthly payments • Retired - other payments • Equity			X X(if periodic)	X	X (if lump sum)
Personal belongings: 461-145-0390	X				
Personal injury settlement: 461-145-0400 • Monthly payments • Other			X		X
Plan for Self Support (PASS) assets: 461-145-0405	X				
Program benefits: 461-145-0410			X (see rule for exceptions)		
Radiation Exposure Compensation Act: 461-145-0415	X				
Real property: 461-145-0420					X
Recreational vehicle's equity: 461-145-0433					X
Refunds: 461-145-0435 • Utility and rent deposit refunds	X (month of receipt)			X	X (month after receipt)

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Reimbursements: 461-145-0440 <ul style="list-style-type: none"> • Principal of business entity • Non cash reimbursement • Cash reimbursement <ul style="list-style-type: none"> - if used for identified expense and expense isn't covered by OHP benefits - if not used for identified expense or covered by OHP benefits 	X		X		
Sale of a Resource (including home) 461-145-0460 <ul style="list-style-type: none"> • Other than a home <ul style="list-style-type: none"> - if excluded and reinvested in another excluded resource - if there's any left over • A home - If the financial group intends to buy another home within 3 months <ul style="list-style-type: none"> - If not reinvested in another home 	X				X
Self-employment including microenterprise: 461-145-0910 thru 461-145-0950		X			
Shelter-in-kind 461-145-0470 <ul style="list-style-type: none"> • Unless child support or received by principal of business entity 	X		X		
Social Security Benefits: 461-145-0490 <ul style="list-style-type: none"> • If received by an SSI recipient • Monthly payments • Other payments 	X		X		
Social Security Death Benefit: 461-145-0500 (remaining after burial costs)					X (lump sum)
Spousal support: 461-145-0505			X		
Supplemental Security Income (SSI): 461-145-0510			X		
Stocks, bonds, CDs, other securities: 461-145-0520 (see Dividends, Interest and Royalties above, also)					X
Strikers' benefits: 461-145-0525			X		
Tax refunds: 461-145-0530 (Federal and state income taxes, property taxes, ERA)					X
Trusts: 461-145-0540 (see Counting Client Assets)					
Unemployment Compensation: 461-145-0550, 461-145-0143 <ul style="list-style-type: none"> • Monthly payments • Other 	X \$25 ARRA supplemental payment		X		X

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Uniform Relocation Act reimbursement: 461-145-0560	X				
USDA Meal Reimbursement: 461-145-0570	X (if for member of filing group)	X (SLF)			
Veterans' benefits: 461-145-0580 <ul style="list-style-type: none"> • Aid and Attendance • Educational (see Educational Income) • Spina Bifida Payments to Children • Other monthly payments • Other payments, not monthly 	X X X		X X (if periodic)		X (if lump sum)
Victim's assistance: 461-145-0582 <ul style="list-style-type: none"> • PL 103-286 or PL 103-322 • Reimbursement for lost item (see Reimbursement) • Payments for pain and suffering 	X		X		
Vocational Rehabilitation Payment 461-145-0585 <ul style="list-style-type: none"> • Payments for food/shelter/clothing • Other (see Reimbursement) 			X		
Worker's Compensation 461-145-0590 <ul style="list-style-type: none"> • Monthly or more frequent payments • Other 		X (if still considered employed)	X		
Workforce Investment Act: 461-145-0300 <ul style="list-style-type: none"> • Needs-based stipend <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Adult OJT and work experience <ul style="list-style-type: none"> - if under age 19 or, if caretaker relative, under age 20 - other • Support services already covered by OHP benefits <ul style="list-style-type: none"> - other 	X X X	X	X X		
Work-related capital asset, equipment & inventory: 461-145-0600 <ul style="list-style-type: none"> • Capital asset & Equipment • Inventory 	X X (if client is SLF)				

8. MAA Asset Quick Reference Chart

Note: This chart does not include treatment of assets for a TANF/MAA client working under a JOBS Plus agreement. See Counting Client Assets Chapter for that specific situation.

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Adoption assistance: 461-145-0001	X				
Agent Orange Disability Benefits 461-145-0005 • Aetna Life and Casualty • Agent Orange Act of 1991 (Dept. of Veterans Affairs)	X		X		
Alaska Permanent Fund Dividend 461-145-0008					X
Animals: 461-145-0010 • If pets are raised for food • Income-producing (see income-producing property)	X				
Annuities, Dividends, Interest 461-145-0020			X		
Bank account: 461-145-0030 • Except - exclude if already counted as income for that month or • If excluded income as per 461-140-0070	X X				X
Burial arrangements: 461-145-0040 • Burial fund				X	X
Burial Space and Merchandise 461-145-0050 • Space - one per client • Merchandise for client and specific relatives				X X	
Cash and Foreign Currency that can be converted to U.S. currency 461-145-0060					X
Census Income: 461-145-0130	X				
Child support 461-145-0080 • Cash medical support	X				
Cash child support • Exclude up to \$50 per child or minor parent, up to \$200 per financial group, per month • Count the balance as unearned income • Paid to a third party (same as above; allow up to \$50 per child minor parent, up to \$200 per financial group per month • All others	X X		X X		
Contributions: 461-145-0086			X		

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Disability benefit: 461-145-0090 <ul style="list-style-type: none"> Employer sponsored disability insurance All other payments, if received monthly or more frequently than monthly Other payments 		X	X X (if periodic)		X (if lump sum)
Disaster Relief (specific types): 461-145-0100	X				
Dividends, Interest and Royalties 461-145-0108 <ul style="list-style-type: none"> Except that royalties (client actively engaged in the activity) 		X	X		
Domestic Volunteer Services Act 461-145-0110 <ul style="list-style-type: none"> VISTA: <ul style="list-style-type: none"> -If comp. less than min. wage -If more than min. wage Title II or title III (RSVP, SCORE, ACE, Foster Grandparents, etc.) 	X X	X			
Earned income: 461-145-0130 <ul style="list-style-type: none"> Under 18 in vocational, GED, or high school In-kind Welfare to work (see welfare-to-work below) Other Income remaining after month of receipt 	X	X X			X
Earned Income Credit (state and federal): 461-145-0140	X				
Economic Stimulus Payment (\$250 from ARRA) 461-145-0143	X			X for 10 months	
Educational income: 461-145-0150 <ul style="list-style-type: none"> Title IV and BIA Non-Title IV or BIA (remainder after deducting costs) 	X	X (work study, fellows hips, etc.)	X (grants, loans, etc.)		
Energy assistance: 461-145-0170 <ul style="list-style-type: none"> Federal (not paid w/public assist.) Federal or state one-time for weatherization or heat repair Other 	X X X				
Food Programs (WIC, School Lunch) 461-145-0190	X				
Foster care: 461-145-0200 <ul style="list-style-type: none"> Foster care room and board, special needs Remaining amount 	X	X			
Gifts and winnings (cash): 461-145-0210			X (if periodic)		X (if lump sum)

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Home and contiguous property 461-145-0220 • Living in • Temporarily unoccupied (see CA B.32 for details)				X X	
HUD: 461-145-0230 • Paid to third party • Paid directly to client • Youthbuild - Age 19 or under - Over age 19 • Escrow for Family Self-Sufficiency • Family Investment Centers	X X(unless lump sum) X X(incentive) X X (utilities) X (service payments)	 X(OJT and WE) X (wages)	X (if lump sum) X (stipends)		
Income-producing contract 461-145-0240 • Equity value • Income (minus cost)	X		X		
Income-producing property: 461-145-0250 • Equity (if producing income or the property is animals) • Income (minus costs)		X (20 hr/wk-SLF)	X (not 20 hr/wk)		X(unless in microenterprise)
Independent Living Subsidies: 461-145-0255	X				
Indian/Native American Benefits (See Counting Client Assets)					
Individual Education Account: 461-145-0265	X			X	
Inheritance (cash): 461-145-0270			X (if periodic)		X (if lump sum)
In-kind income: 461-145-0280	X (except unearned third party payments)				
Job Corps: 461-145-0290 • Living allowance • Readjustment allowance • Support service covered by covered by client's OHP benefits • Other reimbursements see 461-145-0440		X X	X		
Life estate: 461-145-0310 (when occupying the estate)	X				

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Life insurance: 461-145-0320 • Payments to beneficiary • Equity value/Term insurance	X		X (allow up to \$1,500 for costs)		
Loans: 461-145-0330 • Cash on hand from loan (must be written loan agreement dated before receipt of money) • Interest from loan being repaid to client	X		X		
Lodger income: 461-145-0340 (to be lodger income the boarder must pay for rent and meals)	X (per minimum contribution table at 461-155-0350)	X (SLF)			
Making Work Pay tax credit 461-145-0143 \$38 if eligible for \$250 economic stimulus payment \$100 if not eligible for \$250 payment	X			X	
Microenterprise: 461-145-0920, 461-145-0930		X			
Motor vehicles: 461-145-0360	Up to \$10,000 combined equity value				
National and Community Services Trust Act (NCSTA): 461-145-0365 (See Counting Client Assets chapter.)					
Older Americans Act: 461-145-0370 • Title III (Nutrition Program for the Elderly) • Title V (Green Thumb, etc.)	X	X			
Pension and retirement plans: 461-145-0380 • Retired - monthly payments • Retired - other payments • Equity			X X(if periodic)		X (if lump sum) X
Personal belongings: 461-145-0390	X				
Personal injury settlement: 461-145-0400 • Monthly payments • Other			X		X
Plan for Self Support (PASS) assets: 461-145-0405	X				
Program benefits: 461-145-0410	X				
Radiation Exposure Compensation Act: 461-145-0415	X				
Real property: 461-145-0420 • Good faith effort to sell • Equity if not for sale	X			X	
Real property under Interim Ass't Agreement: 461-145-0430 See Counting Client Assets chapter.					

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Recreational vehicle's equity: 461-145-0433					X
Refunds: 461-145-0435 • Utility and rent deposit refunds	X (month of receipt)			XS	X (month after receipt)
Reimbursements: 461-145-0440 • Non cash reimbursement • Cash reimbursement - if used for identified expense and expense isn't covered by MAA benefits - if not used for identified expense or covered by MAA benefits	X X		X(if periodic)		X(if lump sum)
Sale of a Resource (including home) 461-145-0460 • If reinvested in another excluded resource • If there's any left over	X		X		
Self-employment including microenterprise: 461-145-0910 thru 461-145-0950		X			
Shelter-in-kind (except for child support) 461-145-0470	X				
Social Security Benefits: 461-145-0490 • If received by an SSI recipient • Monthly payments • Other payments	X		X X (if periodic)		X (if lump sum)
Social Security Death Benefit: 461-145-0500 (remaining after burial costs)					X (lump sum)
Spousal support: 461-145-0505			X		
Supplemental Security Income (SSI): 461-145-0510	X (SSI recipients are not in MAA financial group)				
Stocks, bonds, CDs, other securities: 461-145-0520 (see Dividends, Interest and Royalties above, also)					X
Strikers' benefits: 461-145-0525			X		
Tax refunds: 461-145-0530 (Federal and state income taxes, property taxes, ERA)					X
Trusts: 461-145-0540 (see Counting Client Assets)					

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Unemployment Compensation: 461-145-0550, 461-145-0143 • Monthly payments • Other	X \$25 ARRA supplemental payment		X		X
Uniform Relocation Act reimbursement: 461-145-0560	X				
USDA Meal Reimbursement: 461-145-0570	X (if for member of filing group)	X (SLF)			
Veterans' benefits: 461-145-0580 • Aid and Attendance • Educational (see Educational Income) • Spina Bifida Payments to Children • Other monthly payments • Other payments, not monthly	X X X		X X (if periodic)		X (if lump sum)
Victim's assistance: 461-145-0582 • PL 103-286 or PL 103-322 • Reimbursement for lost item (see Reimbursement) • Payments for pain and suffering (see Personal Injury Settlement)	X				
Vocational Rehabilitation Payment 461-145-0585 • Payments for food/shelter/ clothing • Other (see Reimbursement)			X		
Welfare-to-Work work experience income: 461-145-0120, 461-145-0130 • First \$260 earned per month • Remainder earned per month	X	X			
Worker's Compensation 461-145-0590 • Monthly or more frequent payments • Other		X (if still consider ed employ ed)	X (if periodic)		X (if lump sum)

Type of Asset	INCOME			RESOURCES	
	Exclude	Earned	Unearned	Excluded	Count
Workforce Investment Act: 461-145-0300 • Needs-based stipend - if under age 19 or, if caretaker relative, under age 20 - other • Adult OJT and work experience - if under age 19 or, if caretaker relative, under age 20 - other • Support services already covered by MAA benefits - other	X		X		
Work-related capital asset, equipment & inventory: 461-145-0600 • Capital asset & Equipment - if in JOBS microenterprise - other • Inventory - if in JOBS microenterprise - other	X				X
					X(minus costs)

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G. Types of Decision Notices

1. Types of Decision Notices

A decision notice is a written notice sent to the benefit group describing the action taken on an application or the benefits. There are three types of decision notices that can be given to clients. They are:

- A Basic Decision Notice. This notice is mailed no later than the planned date of action on the case.
- A Continuing Benefit Decision Notice. This notice is mailed in time to be received by the date that benefits are or would be received.
- A Timely Continuing Benefit Decision Notice. This notice must be mailed no later than 10 calendar days before the effective date of the action or 15 calendar days for clients in the Address Confidentiality Program. Deadlines for 2008 are included in MP-18.

Medical clients do not always need a notice.

For example, no notice is required when a TANF/MAA child is placed in a psychiatric residential treatment (PRTS) facility such as Albertina Kerr or Children's Farm Home: the child is still part of the TANF household and remains TANF eligible. The MAA medical is ended the day before the PRTS placement began. The Children's Medical Project team at 5503 opens the SAC (C5 program) medical the day after the MAA ends.

***Note:** To end the MAA medical, but keep the TANF open, enter a Compute action on the UCMS screen for the first of the next month. Keep the child as a "CH" in-grant, but end the medical the day before the C5 medical is supposed to open. Add the "NMD" (no medical) case descriptor.*

Another example of "no notice required" occurs when a client is certified eligible for OHP and then moves out of the original OHP household. Open the person on their own OHP medical case for the balance of their original certification. Leave the "sending case" with the same #OHP need group on the UCMS screen. No notice is required because no one's benefits were ended or reduced.

***Note:** When someone leaves an OHP certification and needs his or her own CM case for the balance of the certification, it may be necessary to shorten the "OHP cert end" date on the UCMS screen. When creating the new CM case, instead of the usual "C" OHP update code, use the "W." The "W" update code allows eligibility workers to manually shorten the OHP cert end date. The CM system does not send an approval notice when the "W" OHP update code is used.*

2. What a Decision Notice Must Contain

A decision notice must do all of the following:

- Specify the action (close, reduce, approve), the effective date of the action, the date the notice is mailed and the reason for the action.
- Inform the client of their right to a hearing before an impartial person. This includes the following:
 - Specifying the method and time frame for requesting a hearing;
 - Informing the client of their right to representation (including legal counsel);
 - Informing the client about availability of free legal help; and
 - Informing the client of their right to have witnesses testify on their behalf.
- Cite the administrative rule that supports the action being taken on the case.

Continuing Benefit Decision notices and Timely Continuing Benefit Decision notices must also inform clients of their right to continuing benefits. Clients are entitled to a continuation of benefits if they request a hearing by the later of the following:

- Within 10 days of the mailing of the notice; OR
- On or before the effective date of the action.

What a Decision Notice Must Include: 461-175-0010

3. Medical Program Notice Situations

Send a Basic Decision Notice if:

- An application for medical is denied.
- An application for medical is approved.

***Note:** The CM system automatically sends approval notices except for a couple situations: When adding retroactive medical to MAA or MAF and there is a break in the retroactive medical coverage, send the GSRETRO approval notice. When opening benefits for SAC, add the IC notice code.*

- The client has been placed in skilled nursing care, intermediate or long-term care.
- A client (or another adult filing group member or their authorized representative) makes a signed written request to withdraw their application or end their benefits.

- The client is placed in official custody or a correctional facility. End medical benefits the end of the calendar month.
- The client's mail has been returned and their whereabouts are unknown. Send a basic decision notice to their last known address. If the client's whereabouts become known during the benefit month, restore benefits.
- A client receives benefits for less than 30 days.

Note: *This does not happen very often. To be able to end benefits using a basic decision notice, the notice must be sent by the planned medical benefit end date. If that is not possible (as for a prior month's eligibility), then open benefits back to the eligibility begin date. Close or reduce to other benefits using a timely continuing notice.*

For example: It is October 15 and you are starting work on an MAA application. Mary and her two children applied for MAA on September 5. Mary notified her worker timely on September 25 that her UC would begin in October. Checking her UC, it is apparent that Mary and her two children are over income for October MAA, but they are eligible for OPU and OPC.

Since it is too late to send a basic decision notice to end MAA for September 30, open the family on MAA for September and October, send a timely continuing notice and reduce Mary to OPU for November 1. Certify the children as OPC.

- A client has moved out of state and becomes eligible for benefits in another state.

Notice Situations; General Information: 461-175-0200
Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210
Notice Situation; Nonstandard Living Situations: 461-175-0230
Notice Situation; Removing a Person From a Benefit Group or Need Group: 461-175-0305
Notice Situation; Voluntary Action: 461-175-0340

Send a Continuing Benefit Decision Notice if:

- Ending benefits based on information reported to DHS through the MRS, interim change report or periodic review form.

Note: *This will not happen often, as there are only a few self-sufficiency medical cases in MRS.*

For example: Shelly reports on her DHS 859A that she has moved out of state to join her boyfriend. If processing the MRS report timely, send the continuing benefit decision notice and end medical for the end of the month.

Notice Situations; General Information: 461-175-0200
Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210
Notice Situation; APR, MRS, SRS or TBA: 461-175-0270

Send a Timely Continuing Benefit Decision Notice if:

- Benefits are reduced or closed.

Example: Ellie completed and turned in her reapplication for OHP. The worker pended for verifications needed to determine eligibility, and BEDded the case. The client did not return the requested verifications in the 45-day processing time frame. Based on the BED date, a timely continuing benefit decision notice (77B) is automatically sent and the case automatically closed effective the last of the month following notice.

- The client has moved out of state, the information was not reported through the MRS and the client is not eligible for benefits in the other state.
- Client was receiving a Health Insurance Payment (HIP) reimbursement and the cost of the Employer Sponsored Insurance goes up. Client is no longer eligible for the HIP reimbursement.
- A change affecting eligibility is reported.

Example: Suzy and her son Timmy are receiving OHP. Suzy calls her worker to report that her son, Timmy, has moved to Texas to live with his girlfriend. Send a timely continuing benefit decision notice to close Timmy's OHP benefits effective the first of the month following notice.

Example: Stan and his son were receiving MAA medical. Stan reports he married Susan and when the eligibility worker redetermines eligibility, Stan and his son are over the MAA income limits based on Susan's income. Stan is not eligible for any medical program, but his son is eligible for CHP. Send a timely continuing benefit decision notice to close Stan's benefits for the first of the month following notice.

Example: Child Welfare contacts the CAF worker to tell them they removed the only child from an MAA household. Worker redetermines eligibility for the adult on the case, and finds them eligible for OHP-OPU. Send a timely continuing benefit decision notice and reduce the benefits for the first of the month following notice.

Notice Situations; General Information: 461-175-0200

Notice Situation; Client Moved or Whereabouts Unknown: 461-175-0210

Notice Situation; Removing an Individual From a Benefit Group: 461-175-0305

Notice Situation; Voluntary Action: 461-175-0340

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OHP Categories (with CM Case Descriptors, FPL Limits and Age Requirements)

CHP	CHIP child under age 6, from 133% to 201% FPL. From 6 to under age 19, 100% up to 201% FPL.
OP6	Child under age 6, from 100% up to 133% FPL.
OPC	Child under age 19, up to 100% FPL.
OPP	Pregnant women of any age up to 185% FPL.
OPU	Non-pregnant age 19 and older, up to 100% FPL.

Other OHP Related CM Case Descriptors

ADA	Approved for an ADA accommodation.
CID	Denied or closed; did not provide acceptable citizenship verification.
CIE	Pend extended for acceptable citizenship verification.
CEM	Continuous eligibility for non-CAWEM children..
CIP	Pending acceptable citizenship verification.
CWM	CAWEM; Eligible for emergency services only.
CWX	Pre-Natal CAWEM Expansion Program pilot.
FHP	Not medically eligible; receiving FHIAP.
FHT	FHIAP client transferred to OHP-OPU 6/1/08.
HNA	Client has Native American/Alaska Native status.
OHS	OHP eligible full-time student.

OHP Program CM Need/Resource Items

AEN	Tracks assumed eligible newborn eligibility.
CEM	End of 12-month continuous eligibility Medicaid
CEC	End of 12-month continuous eligibility CHIP
CHP	End of CHP certification.
CIE	End of extended citizenship pend
CIP	End date of citizenship pend.
ESP	OPU only. employer-sponsored insurance and availability date.
DUE	Tracks pregnant woman's due date.
HIP	Approves cost effective ESI reimbursements.
HPI	Identifies income used for OHP eligibility.
LPR	Beginning of five-year LPR period.
OP6	End of OP6 certification.
STD	Determines end of OPU certification period.

OHP Eligibility Requirements

Citizen/Noncitizen Status

☞ US citizen or approved noncitizen	461-120-0110
☞ Must sign citizen/noncitizen statement	461-120-0130

SSN

☞ Except for CWMs and AENs	461-120-0230
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Pursuing and Assigning Benefits/Assets

☞ Client must pursue and assign health insurance and other third party resource, unless good cause	461-120-0345 461-120-0315 461-120-0350
☞ Except for good cause client must pursue medical support	461-120-0350
☞ CHP and OPU clients cannot get HIP	461-135-1100

Specific Requirements

☞ OPU must meet income limits using 2-month average (unless DV)	461-135-1100
☞ Must be ineligible for Medicare (unless pregnant) and Plus benefit package medical	461-135-1100
☞ OPU and CHP must not have medical or have had medical for the past 6 months unless waived	461-135-1100
☞ CHIP must not have medical or have had medical for the past 2 months unless waived	461-135-1100

Resource Limits

☞ \$2,000 for OPU	
☞ No resource limit for other OHP	461-160-0015

Income Limits

☞ Countable income must be below the OHP limits	461-155-0225
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Age

☞ OHP age requirements	461-120-0510
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CEM/CEC

☞ Children under age 19 only	461-135-xxxx
☞ Use only if child is not eligible for any other program AND it has been less than 12 months since the last redetermination	
☞ Approve for balance of the 12-month period.	

OPU

☞ OPU is closed to new medical eligibles; applicants must have received a medical program that provides the PLUS benefit package OR have been continuously eligible for OPU OR have been randomly selected from the reservation list	461-135-1102 461-135-1125
☞ Some OPU clients must pay premiums	461-135-1130
☞ Exempt if HPI less than or = 10% FPL at recertification.	461-135-1120
☞ Exempt if CAWEM or verified Native American/Alaska Natives	461-135-1120
☞ \$2,000 resource limit	461-160-0015
☞ Select managed care, unless exempt	461-141-0060
☞ Uninsured for 6 months, unless waived	461-135-1100
☞ Exempt from copays	410-120-1235
☞ Have a different benefit package	410-120-1210
☞ If full-time in higher education, must receive Pell Grant, meet the income eligibility for Pell Grants or be in a displaced worker program	461-135-1110
☞ Cannot use budget month except for DV	461-160-0700

Native American/Alaska Native (HNA)

☞ "HNA" means the client is a tribal member or eligible for Indian Bureau Health benefits.	
☞ You must verify Native American/Alaskan Native status. Once verified and the HNA case descriptor is added to the CM case, the case descriptor may not be removed.	
☞ Do not have to pay copays.	
☞ Do not have to pay OHP premiums.	
☞ Have the option of selecting a Managed Health Care plan.	
☞ If OPU, receive the standard benefit package.	

Processing OHP Standard Reservation List Applications

☞ 5503 will process.	
☞ 5503 will send applications for persons age 60 and older to SPD.	
☞ 7210R applications received in local DHS/AAA office. If there is no emergent need, date stamp the application and forward to 5503, unless they are age 60 and older. (Narrate that the application has been received.)	

OHP Premium Requirements

OHP Premium Status Codes

The Premium Status displays on each OPU client's CI-FIND screen and on UCMS when certifying the case.

- C Current.
- I Initial. Status not updated by OHP Premium Billing Office.
- K Arrearage of OHP2 premiums.

OHP Premium Payment Requirements

- ☞ OPU clients applying for OPU may be responsible for paying premiums, including past due premiums.
- ☞ OPU clients are exempt if CWM, HNA or their HPI income at recertification is 10% or less of the FPL.
- ☞ If exempt, code the Waiv field on UCMS with "WE." All past billed premiums will be automatically removed (you do not need to adjust them manually on MMIS).
- ☞ To bypass the K edits on UCMS, enter "CD" in WAIV.

Due Process Coding and Notices

- ☞ Do not let benefits end if the client has established a DOR. Add the Bypass End Date (BED) coding to prevent the automatic closure; i.e., we no longer deny at recertification, instead we close the case if no longer eligible.
- ☞ The BED end date should provide long enough to get any needed pended items and/or the 10-day close notice.
- ☞ If ineligible for ongoing benefits, send the appropriate close notice (over income, over resource, etc.) and also send the DHS 462A.
- ☞ For new OPU applicants, send just the DHS 462A notice.

OHP Notices

OHP CM Reason Codes and Notices

- DB CHP; Ineligible Noncitizen
- DD OHP; 45 Day Limit
- DF OPU; Premium Past Due
- DM OHP; Eligible for Medicare
- DN OPU; OPU Receiving Major Medical
- DO OHP; Over Income
- DP OHP; Resident of Public Institution
- DR OHP; Does Not Meet Residence Requirements
- DT Deny Medicaid: Did not Verify Citizenship
- DU OHP; Unable to Locate
- DW Close Medicaid: Did not Verify Citizenship
- DX OHP; Resources Exceed Limits

OHP CM Approval Notices

- 1F Health Insurance Premium Reimbursement Approved (HIP)
- 1K OHP Program- OPC/OP6/CHIP/OPP Approved
- 2K OHP Program - OHP Standard Approved
- 3K OHP Program – CAWEM OPC/OP6/OPP Approved
- 4K OHP Program - CAWEM OPU Approved
- 5K Pregnant CHIP Approved
- 6K CEM/CEC Approved

Mid-Month OHP CM Notices (mailed about the 15th)

- 23B Health Insurance Sign-up – Advance (HIP)
- 24B Health Insurance Not Elected – Benefits End (HIP)
- 25B Health Insurance Premium Reimbursement Ending
- 32B OHP Closes, Pregnancy Ends
- 34B OHP Period Ends – Final Notice (AFS)
- 35B Notice to Apply for Medicare
- 36B Medicare Eligible, OHP ends (when OHP recipient turns 65)
- 38B OHP child Removed at 19 – Advance Notice
- 40B OHP Period Ends – Advance Notice (SDSD)
- 41B OHP Period Ends – Benefits End (SDSD)
- 50B OHP Closes; Age 6 at 133% Level
- 52B OHP Closes; Age 1 at 185% (AENs)
- 58B OHP; Available Employer Sponsored Insurance – Final
- 59B OHP Child Removed at Age 19 Final Notice
- 74B OHP Closes; Pregnancy Ends – Advance Medical; 19 Year Old Must Apply for Medical - Advance
- 75B Medical; 19 Year Old Must Apply for Medical – Final Eligibility/Review/Verification Not Completed
- 92B CEM/CEC Period Ends – Advance Notice
- 93B CEM/CEC Period Ends – Final Notice
- 89B Pregnant CHIP Period Ends – Advance Notice
- 90B Pregnant CHIP Period Ends – Final Notice

OHP NOTR Notices

- CMCAREC Due Process Close At Recertification; OHP
- CMCITPD Pend Medical; Proof of Citizenship
- CMCITST Medical; Citizen/Alien Status Met
- CMCOHOM OHP; Medicare Begins, Close
- CMCOHPC OHP/CHP; Major Medical Begins; Close
- CMCOHST OHP; Ineligible Student
- CMCOFHP OHP; Close, No Coop w/FHIAP
- CMC00CL Unable to Locate or Other State Benefits – Close
- CMC00CR Eligibility Review/Verif. Not Done –Close
- CMC2FHP OHP; End Medical, FHIAP Begins
- CMD0ARR OHP; Deny – Premium Past Due
- CMD0CAW OHP; Not Eligible Except for CAWEM

- CMC00DU Unable to Locate – Deny
- CMC00DW Close Medical; Didn't Verify Citizenship
- CMC0NSB Moved to Other State – Close
- CMC0OPP OHP Closes; Pregnancy Ends
- CMD00DT Deny Medical; Did not Verify Citizenship
- CMDODEN OHP; OHP Medical Denial Notice
- CMDOPUO OPU; Over Income
- CMDOHPM OPU, CHP; Deny – Private Health Insurance
- CMMAA1C MAA/MAF Medical Benefits Approved
- CMMED01 Not Eligible for Medically Related Travel Payment
- CMMEDTR Notice of Transfer
- CMMHCEN Medical; Medical Approved – Enrolled
- CMOHP01 Notice of Transfer – OHP
- CMOPHEN OHP; OHP Approved, Enroll in Plan
- CMR0FHP OHP; Reduce, No Coop w/FHIAP
- CMR2STD Reduce Benefits to Standard
- CM462A1 Deny or Close Medical Eligibility, Part 1
- CM462A2 Deny or Close Medical Eligibility, Part 2
- CM462C1 Deny or Close SSP Medical Eligibility, Part 1
- CM462C1 Deny or Close SSP Medical Eligibility, Part 2
- GSMAPRV Medical Benefits Approved
- GS00210 Notice of Pending Status
- GSOH210 OHP Notice of Pending Status
- GSO211 OHP Health Plan Choice

Resources

DMAP Client Services Unit: 1-800-273-0557
OHP Premium Billing Office: 1-888-647-2729
 PO Box 1120 TTY: 1-866-203-8931
 Baker City, OR 97814

OHP Central Processing Branch: 1-800-699-9075
OHP Standard Reservation List: 1-800-699-9075

Faxes: 503-373-7866
 503-378-6295

GroupWise: reservation.list

OHP Program Analysts: SSP-Policy, Medical
 Joyce Clarkson 503-945-6106
 Michelle Mack 503-947-5129
 Carol Berg 503-945-6072
 Christy Garland 503-945-6119
 Julie Cherney 503-947-2316
 Vonda Daniels 503-945-6088

C. Requirement to Cooperate, Noncooperation Penalties, and Good Cause

1. Requirement to Cooperate with DHS and DCS in Obtaining Support Payments, Health Care Coverage Through an Absent Parent, and Cash Medical Support

Child Support for TANF Applicants. To be eligible for TANF, caretaker relatives must cooperate (unless good cause exists – see items 3 through 6, below) with DHS and with DCS in establishing paternity and obtaining support payments for all children in the benefit group.

Child Support for TANF Recipients. TANF recipients must also cooperate (unless good cause exists, see items 3 through 6 below) with DHS and DCS in establishing paternity and obtaining support payments for all children in the benefit group. (This does not apply to TANF recipients in the SFPSS or Post-TANF programs.) When a TANF recipient who is required to cooperate does not cooperate (and does not have good cause for the noncooperation), the recipient will be subject to the penalties in item 8 below (CS C.8).

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340(1)

Cash Medical Support. To be eligible for all programs except ERDC, FS, OHP-CHP, and REFM, Medicaid recipients must cooperate (unless good cause exists, see items 3 through 6 below) with DHS and DCS in establishing paternity and obtaining cash medical support for all children in the benefit group.

- Medicaid applicants at initial application and Medicaid recipients at redetermination need only sign the application. Do not require completion of a paternity affidavit as a condition of Medicaid eligibility at initial application or at redetermination.

Health Care Coverage Through an Absent Parent. To be eligible for all programs except ERDC, FS, OHP-CHP, and REFM, the client must cooperate, unless good cause exists (see items 3 through 6, below), in establishing paternity and obtaining health care coverage through an absent parent.

- For TANF, Medicaid, and REF, the caretaker relative must cooperate for the dependent children in the benefit group.
- Medicaid applicants at initial application and Medicaid recipients at redetermination need only sign the application. Do not require completion of a paternity affidavit as a condition of Medicaid eligibility at initial application or at redetermination.
- For EA and EA medical, clients are required to cooperate only if health care coverage through a noncustodial parent can be made available in time to meet the emergent medical need.

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340
Clients Required to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: 461-120-0345

2. Evidence of Cooperation

Cooperation with child support, health care coverage through an absent parent, and cash medical support exists when the client provides information that DHS and DCS need or request to establish paternity, or to establish, modify, or enforce a child support order, for the child(ren) in the TANF or Medicaid benefit group.

Note: Medicaid applicants at initial application and Medicaid recipients at redetermination need only sign the application. Do not require completion of a paternity affidavit as a condition of Medicaid eligibility at initial application or at redetermination.

The client demonstrates cooperation by doing all of the following:

- Supplying sufficient information to enable DCS to proceed with appropriate action. *Sufficient information* includes, but is not limited to, as many of the following elements of information as the client knows (or can reasonably be expected to find out) regarding any and all noncustodial parents of such dependent children:
 - Full legal name and nicknames.
 - Social Security Number.
 - Current or last known address.
 - Current or last known employer, including name and address.
 - If a student, current or last known school.
 - Criminal record, including where and when incarcerated.
 - Date of birth, or age.
 - Race.
 - Date and place of each child’s conception (if paternity is not established).
 - Any known group or organizational affiliations of the noncustodial parent.
 - Names and addresses of close friends or relatives.
- Any other information DHS or DCS may request that would help locate or identify a noncustodial parent of a child in the benefit group.
- Supplying documentation or explanation of efforts to get information requested by DHS or DCS (if unable to provide any necessary information listed above).
- Keeping appointments with DHS and DCS related to establishing paternity.

- Returning telephone calls or responding to correspondence when requested by DHS or DCS.
- Otherwise demonstrating a good faith effort to obtain necessary information and to locate and identify each alleged parent or noncustodial parent, establish legal paternity, establish and enforce a support order, and obtain support payments, to the full extent possible allowing for the client's individual circumstances.

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340

3. Good Cause for Failure to Cooperate; Child Support, Health Care Coverage Through an Absent Parent, and Cash Medical Support

A client may claim good cause for not cooperating with DHS and/or DCS to establish paternity or to collect child support, health care coverage through an absent parent, and cash medical support.

Note: Caretaker relatives of OHP-CHP, or REFM children are not required to cooperate with DCS for cash child support, health care coverage through an absent parent, or cash medical support.

- *Good cause* for failure to cooperate with support, health care coverage through an absent parent, and cash medical support requirements exists when any of the following are true:
 - Cooperation is reasonably anticipated to result in emotional or physical harm to the child(ren) in the family.
 - Cooperation is reasonably anticipated to result in emotional or physical harm to the client or to other caretaker relatives of the child(ren) involved.
 - One of the following circumstances exists and DHS believes that continuing efforts to obtain support would be detrimental to the child(ren):
 - (a) The child was conceived as a result of incest or rape.
 - (b) Legal proceedings for adoption are under way before a court.
 - (c) The parent is being helped by a public or licensed private social agency to resolve the issue of whether to release the child for adoption. This good cause reason is limited to three months.
- If good cause is found, DCS will take no action to establish paternity or child support or to enforce child support.
- When DCS determines that a client is not cooperating and there is an open TANF or Medicaid case, DCS will tell the DHS branch office. The DHS branch office is

responsible for determining if the client had good cause or if noncooperation penalties shall be applied.

On a closed TANF or former ADC case where past-due support remains assigned to Oregon or to another state, and the former client is not cooperating, DCS may determine if the former client has good cause for not cooperating. DCS will make this determination pursuant to all DCS rules and policy regarding good cause. If DCS determines that the former client has good cause for not cooperating, DCS will not pursue collection of assigned arrears if doing so could lead to harm to the former client or to the children. If the former client does not have good cause for not cooperating, DCS will continue to pursue assigned arrears (but there will be no reduction of TANF benefits, since the former client is no longer receiving TANF).

- If good cause is found on an open TANF or Medicaid case, DHS should:
 - 1) Code the case with good cause. Good cause coding should be added to the absent parent field on PCMS or CMUP. Valid good cause codes are A, B, C and M. Entering A, B, C or M will stop DCS from pursuing paternity and/or support from the absent parent on which the coding was added.
 - 2) Notify the appropriate DCS worker that the case has been coded good cause by phone or email.
 - 3) Check the following day that the child support case has good cause coding. When the child support case has good cause coding, the SJ7F screen will contain a grid stating “Good Cause.”
- The need for continued good cause coding should be reviewed at each redetermination.
- When DCS is told by an obligee who is applying for or getting TANF or medical assistance that the pursuit of paternity and/or support may cause a safety concern for the obligee or the obligee’s child(ren) and the TANF or medical case has not already been coded with good cause for noncooperation with child support, the following steps shall be followed:
 1. The DCS worker who learns that the obligee has a concern will send an email to GC.Request@state.or.us and the DHS worker (if DCS is able to identify the worker). (Email sent to GC.Request@state.or.us is directed to designated Central Office analysts.)
 2. The email sent by DCS will include the name of the obligor, the name of obligee, the name(s) of the children and any information the DCS worker has about the safety concern.
 3. The same day that DCS sends the email, one of the designated Central Office analysts who receive email sent to GC.Request@state.or.us will code

the TANF or medical-only case with good cause for noncooperation with child support.

4. The Central Office analyst who adds the coding in #2 above will narrate the addition of good cause coding on TRACS and will email the DCS worker and the appropriate DHS staff letting them know that the good cause coding has been added. The email will include any pertinent information that the Central Office analyst learned from review of the case.
5. The DHS worker will proceed with determining whether there is good cause for noncooperation with child support.
6. If the DHS worker determines that the case should be coded with good cause for nonpursuit of support, the worker will leave the case coded good cause. If the DHS worker determines that the case should not be coded with good cause, the worker will remove the good cause coding. The worker will narrate on TRACS whether the determination was to leave or remove the good cause coding. The worker will also email the DCS worker (and copy the Central Office analyst who sent the email) to let the DCS worker know whether good cause coding has been removed.

Clients Excused for *Good Cause* from Compliance with OAR [461-120-0340](#) and [-0345](#): 461-120-0350

4. Good Cause; Branch Office Responsibilities

The DHS branch office is responsible for informing clients of their right to claim good cause, both when the client applies for assistance and at each redetermination of eligibility. When the client applies for TANF, Medicaid, or OSIPM, and one or both parents of any child in the benefit group are absent from the benefit group, the branch office will:

Explain to the client that unless the client has good cause for not cooperating:

- Cooperation in efforts to obtain child support payments, health care coverage through an absent parent, and cash medical support is a condition of eligibility for TANF.
- Cooperation in efforts to obtain health care coverage through an absent parent and cash medical support is a condition of eligibility for Medicaid, except for medical benefits for a pregnant female.
- Ask the client to read and sign a *Cooperating with Child Support Enforcement and Pursuing Third Party Resources* form (DHS 428A), except for medical benefits for a pregnant female who chooses not to cooperate with DCS.

Note: For OHP, this requirement is met by having the client sign the “Oregon Health Plan Rights and Responsibilities” Application for the Oregon Health Plan (OHP 7210).

- Explain to the client the purpose of the referral to DCS, and encourage the client to cooperate with DHS and DCS for the benefit of the children.

Confidentiality of Client’s Address. Explain to clients that under state law, certain information that is confidential under DHS rules could be released during legal proceedings. For example, the client’s home address could be revealed to the noncustodial parent if the address appears in the noncustodial parent’s copy of a support order.

Contact Address. If the client does not want their address revealed, determine if there is good cause for not pursuing support per rule 461-120-0350. If the client does not want to claim good cause but does not want their address known to the noncustodial parent, the client may ask DCS to use a contact address. The contact address must be in Oregon and will be used for child support purposes only. The contact address will only be used once DCS adds the address to the DCS computer system. If the contact address was not requested at the time the child support case was created, the home address may have already been included on child support paperwork sent to the other party on the case or to court.

If DHS knows the client would like to use a contact address, DHS should notify DCS of this by calling or emailing the appropriate DCS worker.

Cautions:

- Due to the nature of the linkage between the DHS (CM) computer system and DCS’s Child Support Enforcement Automated System (CSEAS), the client’s address on CSEAS will show the same address as on CMS. The only place the contact address will appear on the CSEAS system is on a separate screen in CSEAS, accessible to DCS staff.
- If a contact address has been in place for six months, DCS will attempt to contact the client to ask if the address of record is still valid prior to initiating a new legal action. The contact address will stay in effect until retracted by the client.
- It is very important that clients be alert to picking up mail at their contact address. If clients do not pick up their DCS mail, they may lose an opportunity to establish paternity or to help determine a proper monthly support or arrearage amount. If the client does not respond to a mailed notice, DHS could also determine that they have failed to cooperate with the support requirement.
- Even if the client claims good cause per rule 461-120-0350, the client may want to designate a contact address (for mailing support information only). This is because support enforcement agencies are required by law to provide services (including establishment of paternity) not only to custodial parents but also to *noncustodial parents* – including self-alleged fathers – who apply for services. If the only

address on the case is the DHS address, this is the address that will be on the legal documents during any subsequent proceedings. If the client claiming good cause wants to use another address, proceed as above.

- DCS **cannot** guarantee that the client’s actual home address will not be revealed during enforcement or court proceedings. Designating a contact address simply decreases the likelihood of this occurring, and enables DCS to proceed on what could otherwise be a good cause case.

Nondisclosure of Information based on a Claim of Risk. Also tell the client that DCS has further protections available for clients who would cooperate if their personal identifying information will not be revealed. This is known as the “nondisclosure of information” process.

Advise the client that, before initiating any court proceedings, DCS will notify the client in writing that:

- DCS must include the client’s personal identifying information in any motions, pleadings, petitions, orders, or other legal documents filed with the court; **and**
- To avoid having their personal identifying information revealed in court documents, the client may file a “nondisclosure of information” request with DCS. To file a “nondisclosure of information” request, the client must provide a contact address.

If the client files a “nondisclosure of information” request in response to receiving notification from DCS of a forthcoming legal action, DCS will reveal the client’s personal identifying information to the court only in the form of sealed documents submitted to the court. These documents do not become “Public Record.”

- The client can contact DCS to request nondisclosure of information. However, if DHS knows the client would like to request nondisclosure of information, DHS should:
 - 1) Code the case with good cause until DCS has coded the child support case as “nondisclosure of information.” (Once the child support case has been coded with Claim of Risk, a grid with “COR” will display on the SJ7F screen).
 - 2) Notify the appropriate DCS worker of the “nondisclosure of information request” by phone or email.
 - 3) Have the client fill out the *Do Not Release Information Based on Claim of Risk* (DHS 8660B) and fax to the appropriate DCS office.

Case Management Opportunity

If the client claims “good cause” due to a domestic violence situation, discuss with the client any crisis intervention or domestic violence counseling services that may be locally available.

Clients Excused for *Good Cause* from Compliance with OAR [461-120-0340](#) and [-0345](#): 461-120-0350
Confidentiality -- Finding of Risk and Order for Nondisclosure of Information: 137-055-1160

5. Evidence of Good Cause; Child Support, Health Care Coverage Through an Absent Parent, and Cash Medical Support

Evidence of good cause for noncooperation includes, but is not limited to:

- A client’s statement, for clients who believe that pursuing support will put their safety or the safety of their child(ren) at risk.
- Birth, medical, or law enforcement records as evidence of incest or rape.
- Court records, other legal records, or written statements from a public or licensed private social agency or an attorney regarding possible or pending adoption of the child(ren) in question.
- Sworn statements from individuals, other than the client, with knowledge of the circumstances that provide the basis of the client’s claim of good cause.

6. Encouraging Cooperation

To encourage clients to cooperate, emphasize these points:

- Support from the noncustodial parent could help lessen the child’s feelings of abandonment or desertion.
- Establishing paternity can entitle the child to receive SSB or veteran’s benefits on the alleged father’s account, should the alleged father die or become entitled to disability benefits.
- Support payments can help families pay for living expenses and become self-sufficient, especially after the family is no longer eligible for TANF or Medicaid.
- If the client is interested in good cause, also inform the client that there may still be options for safely collecting support, such as by establishing a contact address and/or filing a “nondisclosure of information” request – see item 4, (CS C.4), above. Give the client a copy of the *Safety Packet* (DHS 8660) to aid in the discussion of options for safely collecting support.

7. **Determining Noncooperation**

DHS or DCS may determine if a client is not cooperating. DCS must advise DHS whenever they determine noncooperation. DHS shall then:

- If the client claims good cause under rule 461-120-0350 for not cooperating, ask the client for further information and work with the client to determine if the client qualifies for a good cause exception.
- If the client does not claim good cause under rule 461-120-0350 for not cooperating, or if the client claims good cause and DHS determines that the client does not have good cause, apply penalties per items 9 or 10 (CS C.9 OR CS C.10), below.

8. **Penalties for Noncooperation; Child Support**

The penalties for failure to cooperate with support requirements are:

- For benefit groups **not currently receiving** TANF, where the failure to cooperate occurs during the process of applying or reapplying for TANF, total ineligibility for the filing group.
- For benefit groups **receiving** TANF when failure to cooperate is determined, the net monthly TANF benefit amount, after income deductions and reductions for JOBS noncooperation are applied (where applicable), shall be reduced by the following percentages:
 - 25 percent for the month following the month in which failure to cooperate is determined.
 - 50 percent for the second month following the month in which failure to cooperate is determined.
 - 75 percent for the third month following the month in which failure to cooperate is determined.
 - 100 percent (total ineligibility for the benefit group) for the fourth month following the month in which failure to cooperate is determined, and all subsequent months in which failure to cooperate continues.

***Note:** Before applying the 100 percent level of penalty, use the existing grant termination staffing process to assess the family's situation. When appropriate, involve community partners in the family assessment.*

***Note:** There is no requirement to cooperate with child support (and no penalties for noncooperation), for clients in the SFPSS or Post-TANF programs.*

- Once a penalty has ended (see Section C.10. of this chapter), any subsequent penalties for noncooperation with DCS will start at the first level (25 percent, per

above) for clients who were previously disqualified or penalized for noncooperation but later had full benefits restored.

- For TANF-related medical, no eligibility for the person who fails to cooperate.
- For FS, when a TANF payment is reduced or ends due to DCS noncooperation, count the amount the TANF benefit payment would have been if not reduced for noncooperation, for the duration of the penalty.

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340(4)

9. Penalties for Noncooperation; Health Care Coverage Through an Absent Parent and Cash Medical Support

The penalty for failure to cooperate with health care coverage through an absent parent or cash medical support is:

- For all programs except OHP, removing the needs of the person who refuses to cooperate.
- For OHP, removing the person who refuses to cooperate from the benefit group.
- Additionally, when calculating FS benefits, if a cash payment is reduced or ends due to this penalty, count the amount the cash payment would be if the penalty had not been imposed for the duration of the penalty.

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340(4)
Clients Required to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: 461-120-0345(3)

10. Ending Support Penalties When Client Cooperates

End the support noncooperation penalties when the client cooperates by completing the necessary forms, providing requested information, scheduling an appointment with DCS, or taking whatever other actions are required to indicate cooperation as listed above.

Client Required To Help Department Obtain Support From Noncustodial Parent; TANF: 461-120-0340(5)
Clients Required to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: 461-120-0345(4)

11. Pregnant Women – Special Considerations

- For EXT, GA, MAA, MAF, OHP, OSIP, and REF, there is no penalty for pregnant clients who fail to cooperate.

- A pregnant woman may be eligible for Medicaid even if she does not pursue support.

Clients Required to Obtain Health Care Coverage and Cash Medical Support; EXT, GAM, MAA, MAF, OHP (except OHP-CHP), OSIPM, SAC: 461-120-0345(3)

12. Special Considerations; Support

- Explain to clients that under state law, certain information that is confidential under DHS rules, such as the client's address, may be released during legal proceedings. Refer to Section D, (CS D.), for more information on DCS referrals.
- If any clients who are not required to pursue child support want help getting the support, refer them to their local county district attorney (or to the DCS branch office for those counties where DCS provides such services in lieu of the district attorney).

13. Coordination on Cases Excused from the Requirement to Pursue Child Support, Health Care Coverage Through an Absent Parent, or Cash Medical Support

General

Self-Sufficiency and Child Welfare agree to work together, and with other impacted agencies, such as the Division of Child Support (DCS) and the Oregon Youth Authority, on cases that have been granted good cause or a permanent exemption and that transition from one program to another.

- TANF and Medicaid Assistance – Clients receiving TANF or Medicaid assistance are excused from the requirement to pursue child support (OAR 461-120-0340 (1)) and the requirement to pursue medical coverage (OAR 461-120-0345 (1) (a)) if:
 - Helping the Child Support Program could result in emotional or physical harm to the child or to the caretaker relative;
 - The child was conceived as a result of incest or rape and efforts to obtain support would be detrimental to the child; or
 - The parent is working with a public or private social agency to help decide whether to release the child for adoption.
- Child Welfare – Clients receiving services from Child Welfare are excused from the requirement to pursue child support if:
 - The biological mother conceived the child as a result of incest or rape and efforts to obtain support would be detrimental to the child;
 - The biological parents have signed a relinquishment of parental rights or have been terminated of parental rights by a court action;

- A child who has been adopted through the State of Oregon comes back into state care because of emotional or physical treatment needs; or
- The Assistant Director of Children, Adults and Families, or their designee, determines that pursuit of child support is not in the best interest of the child.

Coordination on Cases

In order to support the transition and coordination of cases that have been excused from the requirement to pursue child support or medical support because of good cause or a permanent exemption, Child Welfare and Self-Sufficiency agree that:

- Whichever program makes a determination of good cause or permanent exemption “owns” the determination until or unless that program is no longer providing services. This means only the program that made the determination of good cause or permanent exemption may change the determination until or unless that program is no longer providing services.
- A determination of good cause or permanent exemption applies to all open cases that involve the same obligee and obligor without regard to which program made the determination of good cause or permanent exemption and whether the children are receiving multiple services. This means, for example, that if a Self-Sufficiency client were excused from pursuing child support for good cause, that client would also be granted a permanent exemption for not pursuing child support if the client subsequently opens a case with Child Welfare.
- Once a case closes, or services are no longer provided by a program, that program may not change a determination of good cause or permanent exemption that it made prior to the case closing.
- When there has been a determination of good cause or permanent exemption and services are closed with one program, such as Self-Sufficiency, and opened with another program, such as Child Welfare, the new program providing services will follow steps (1) through (3) set out below.
 1. The new program providing services will determine whether good cause or permanent exemption is still appropriate by contacting the person who originally claimed good cause or permanent exemption.
 - 2.(a) If it is determined after contact with the person who originally claimed good cause or permanent exemption that there are still safety or other issues that continue to make good cause or permanent exemption appropriate, the new program providing services will code the newly-opened case with good cause or permanent exemption.
 2. (b) If it is determined after contact with the person who originally claimed good cause or permanent exemption that there are no

longer safety or other issues, the new program providing services will not code the newly-opened case with good cause or permanent exemption and will notify DCS that good cause or permanent exemption coding should be removed from the Child Support case and pursuit of child or medical support resumed.

3. If, pursuant to (2)(b) above, it is determined after contact with the person who originally claimed good cause or permanent exemption that there are no longer safety or other issues, the new program providing services will give notice to the person who originally claimed good cause or permanent exemption. Notice to the person who originally claimed good cause or permanent exemption must be documented by the program providing notification.

Coordination with Partner Agencies

When the Oregon Youth Authority has excused a case from the requirement to pursue child support or medical support, Child Welfare and Self-Sufficiency shall coordinate with the Oregon Youth Authority in the same manner as if Child Welfare or Self-Sufficiency had excused the client from pursuit of child support because of good cause or a permanent exemption.

When a case has been excused from the requirement to pursue child support or medical support, regardless of which program has made the determination of good cause or permanent exemption, Child Welfare and Self-Sufficiency will work with the Division of Child Support to support transition and coordination of the case.

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B. Specific Types of Assets

1. Adoption Assistance

Adoption assistance is financial assistance provided to families adopting children with special needs. Adoption assistance may be state or federally funded. Federal adoption assistance is authorized by the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). State adoption assistance is authorized by ORS 440.335.

- (1) For all programs except ERDC and FS, treat adoption assistance as follows:
 - (a) Exclude the entire amount of adoption assistance from Oregon.
 - (b) Exclude the portion of adoption assistance that is for the special needs of the child when the adoption assistance is from other states. This includes needs such as special diet, special clothing, counseling, and medical costs not covered under title XIX. Count the rest of the adoption assistance as unearned income.

Note: Children receiving adoption assistance are excluded from the TANF and MAA filing group. This means that the AA income is excluded when determining eligibility for TANF or MAA and when calculating the TANF benefit level.

☞ SEE TANF C.3 TANF/MAA FILING GROUP.

- (2) For ERDC, exclude adoption assistance.
- (3) For FS, adoption assistance is counted as unearned income.

461-110-0330
461-145-0001

2. Agent Orange Disability Benefits

- (1) For all programs except GA and GAM:
 - (a) Exclude benefits from the Agent Orange Settlement Fund made by Aetna Life and Casualty Insurance Company for settling Agent Orange disability claims.
 - (b) Count payments made under the Agent Orange Act of 1991, and issued by the U.S. Treasury through the Department of Veterans Affairs, as unearned income.
- (2) For GA and GAM, count all Agent Orange payments as lump-sum income (CA A.5).

461-145-0005

3. Alaska Permanent Fund Dividend

The Alaska Permanent Fund Dividend is issued annually to eligible Alaskan residents who apply for the payment. Out-of-state residents, except military personnel and students who claim Alaska as their residence, are not eligible unless they resided in Alaska and filed for the payment before leaving the state.

Count Alaska Permanent Fund Dividend payments as lump-sum income (CA A.5).

461-145-0008

4. Animals

Exclude pets and animals raised as food for the financial group.

Treat income-producing animals according to the policy on income-producing property (CA B.34).

461-145-0010

5. Annuities; Not OSIPM

(1) For the purposes of this policy:

- (a) An annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether maintained in the original account or used to purchase an annuity, if the Internal Revenue Services recognizes the account as dedicated to retirement or pension purposes. (The treatment of pension and retirement plans is covered in CA B.52).
- (b) In this section of policy only: “*Child*” means a biological or adoptive child who is:
 - (A) Under age 21; or
 - (B) Any age and meets the Social Security Administration criteria for blindness or disability.
- (c) “*Commercial annuities*” mean contracts or agreements (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.

(2) An annuity is counted as a resource if:

- (a) The annuity does not make regular payments for a lifetime or specified number of years; or

- (b) The annuity does not qualify for exclusion as a resource under subsection (4)(c) of this rule.
- (3) If an annuity is a countable resource under this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular payments already received, minus any early withdrawals, and minus any surrender fees.
- (4) Commercial annuities and payments from such annuities are counted as follows:
 - (a) In all programs except OSIP, OSIPM, and QMB, annuity payments are counted as unearned income to the annuitant.
 - (b) In the OSIP and QMB programs:
 - (A) For a client in a nonstandard living arrangement (461-001-0000), if a client or the spouse of a client purchases or transfers an annuity prior to January 1, 2006, the transaction may be subject to the rules on resource transfers at OAR 461-140-0220 and following. For an annuity that is not disqualifying but meets the criteria of OAR 461-140-0220, or for a client in a standard living arrangement, the annuity payments are counted as unearned income to the annuitant.
 - (B) If a client or the spouse of a client purchases an annuity on or after January 1, 2006, the annuity is counted as a resource unless it is excluded under paragraph (C) of this subsection.
 - (C) An annuity described in paragraph (B) of this subsection is excluded as a resource if the criteria in subparagraphs (i), (ii), and (iii) of this paragraph are met, except that if an unmarried client is the annuitant, the requirements of subparagraph (iv) of this paragraph must also be met and if a spouse of a client is the annuitant, the requirements of subparagraph (v) of this paragraph must also be met.
 - (i) The annuity is irrevocable.
 - (ii) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this subparagraph, the actuarial life expectancy is established by the actuarial tables of the Office of the Chief Actuary of the Social Security Administration.
 - (iii) The annuity is issued by a business that is licensed and approved to issue *commercial annuities* by the state in which the annuity is purchased.

☞ SEE SPD WORKER GUIDE #E, TREATMENT OF ANNUITIES.

- (iv) If an unmarried client is the annuitant, the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:
 - (I) The department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.
 - (II) The child of the client, if the department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the client, in the event that the child does not survive the client.
- (v) If a spouse of a client is the annuitant, the annuity must specify that, upon the death of the spouse of the client, the first remainder beneficiaries are either of the following:
 - (I) The client, in the event that the client survives the spouse; and the department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.
 - (II) A child of the spouse and the client in the event that this child does not survive the spouse.
- (D) If an annuity is excluded under paragraph (C) of this subsection, annuity payments are counted as unearned income.
- (c) For OSIPM, see CA B.6

Note: For OSIP, OSIPM, and QMB, the purchase of an annuity or transfer of an annuity prior to January 1, 2006, may be subject to transfer of resource policies. Refer to SPD WG E.1 to determine if the annuity will pay out over the client's life expectancy based on the client's age and sex.

☞ SEE OAR 461-140-0210 THROUGH 461-140-0300 REGARDING TRANSFER OF RESOURCES.

461-145-0020

6. Annuities; OSIPM

In the OSIPM program:

- (1) For the purposes of this policy:
 - (a) An annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether

maintained in the original account or used to purchase an annuity, if the Internal Revenue Services recognizes the account as dedicated to retirement or pension purposes. (The treatment of pension and retirement plans is covered in CA B.52).

- (b) “*Child*” means a biological or adoptive child who is:
 - (A) Under age 21; or
 - (B) Any age and meets the Social Security Administration criteria for blindness or disability.
 - (c) “*Commercial annuity*” means a contract or agreement (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.
- (2) An annuity that does not make regular payments for a lifetime or specified number of years is a resource.
 - (3) When a client applies for medical benefits, both initially and at periodic redetermination (see OAR 461-115-0050 and 461-115-0430), the client must report any annuity owned by the client or a spouse of the client.
 - (4) By signing the application for assistance, a client and the spouse of a client agree that the department, by virtue of providing medical assistance, becomes a remainder beneficiary as described in sections (8) and (10) of this rule, under any *commercial annuity* purchased on or after February 8, 2006.
 - (5) If the department is notified about a *commercial annuity*, the department will notify the issuer of the annuity about the right of the department as a preferred remainder beneficiary, as described in sections (8) and (10) of this rule, in the amount of medical assistance provided to the client.
 - (6) For a client in a *nonstandard living arrangement* (461-001-0000), if a client or the spouse of a client purchases or transfers a *commercial annuity* prior to January 1, 2006, the transaction may be subject to the rules on resource transfers at OAR 461-140-0220 and following. For an annuity that is not disqualifying but meets the requirements in OAR 461-140-0220, the annuity payments are counted as unearned income to the annuitant.
 - (7) Sections 8 and 9 of this rule apply to a *commercial annuity* if:
 - (a) The client is in a *nonstandard living arrangement* (See OAR 461-001-0000), and the client or the spouse of the client purchases an annuity from January 1, 2006, through June 30, 2006; or
 - (b) The client is in a *standard living arrangement* (See OAR 461-001-0000), and the client or the spouse of a client purchase an annuity on or after January 1, 2006.

- (8) A *commercial annuity* covered by section (7) of this rule is counted as a resource unless the annuity is excluded by meeting the following requirements:
- (a) If an unmarried client is an annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:
 - (A) The department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.
 - (B) The child of the client, if the department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the client, in the event that the child does not survive the client.
 - (b) If a spouse of a client is the annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that, upon the death of the spouse of the client, the first remainder beneficiaries are either of the following:
 - (A) The client, in the event that the client survives the spouse; and the department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.
 - (B) A child of the spouse; and the client in the event that this child does not survive the spouse.
 - (c) An annuity covered by section (7) may not be excluded unless the annuity meets all of the following requirements:
 - (A) The annuity is irrevocable.
 - (B) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this paragraph, the actuarial life expectancy is established by the actuarial tables of the Office of the Chief Actuary of the Social Security Administration.
 - (C) The annuity is issued by a business that is licensed and approved to issue a *commercial annuity* by the state in which the annuity is purchased.
- (9) If an annuity is excluded as a resource under section (8) of this rule, the annuity payments are counted as unearned income. If an annuity is a countable resource under section (8) of this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the

☞ SEE SPD WORKER GUIDE E., TREATMENT OF ANNUITIES.

annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

(10) This section lists the requirements for a *commercial annuity* purchased by the client or the spouse of the client on or after July 1, 2006, when a client is in a *nonstandard living arrangement*, and the annuity names the client or the community spouse as the annuitant. Annuities that meet all of the requirements of this section are counted as unearned income to the annuitant. The treatment of annuities that do not meet all requirements of this section is covered in sections (11) and (12) of this rule.

(a) The annuity must comply with one of the following paragraphs:

(A) The first remainder beneficiary is the spouse of the client, and in the event that the spouse transfers any of the remainder of the annuity for less than fair market value, the department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(B) The first remainder beneficiary is the annuitant's child, and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than fair market value, the department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(C) The first remainder beneficiary is the department for up to the total amount of medical benefits paid on behalf of the client.

(b) The annuity must be irrevocable and nonassignable.

(c) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this subsection, the actuarial life expectancy is established by the actuarial tables of the Office of the Chief Actuary of the Social Security Administration.

☞ SEE SPD WORKER GUIDE E., TREATMENT OF ANNUITIES

(d) The annuity is issued by a business that is licensed and approved to issue a *commercial annuity* by the state in which the annuity is purchased.

(11) If the client is the annuitant and a commercial annuity does not meet all of the requirements of section (10) of this rule, or the spouse of the client is the annuitant and a *commercial annuity* does not meet the requirements of subsection (10)(a) of this rule, there is a disqualifying transfer under OAR 461-140-0210 and following. See OAR 461-140-0296(5) and (6) for calculation of the disqualification period.

(12) Regardless of whether a *commercial annuity* is a disqualifying transfer of resources, if the annuity does not meet all of the requirements of section (10) of this rule, the annuity is counted as a resource with cash value equal to the amount

of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

461-145-0022

7. **Approved Accounts; OSIP-EPD and OSIPM-EPD**

Persons participating in the OSIP- or OSIPM- Employed Persons with Disabilities Program are allowed to set moneys aside in an approved account.

- (1) All moneys in an approved EPD account are excluded as income or a resource during the determination of eligibility. However, the exclusion can only be made if the account has been designated as an Approved Account and approved as such by the local branch prior to the eligibility determination.
- (2) Moneys deposited in the approved account that the client wants to be considered as an Employment and Independence Expense to be used as a deduction from countable income must be approved by the branch prior to the deposit being made.
- (3) If moneys from the approved account are used for a purpose not consistent with the definition of approved account in OAR 461-001-0035, the client may be prohibited from utilizing an approved account for the next 12 months for the purposes of the determination of eligibility.

461-145-0025

8. **Bank Account**

A bank account includes a money market account and an account in a financial institution. Except it does not include stock, bond, or certificate of deposit (CD) accounts which are covered under Stocks, Bonds, and Other Securities (CA B.73).

Money in a bank account belonging to one or more members of the financial group is generally counted as a resource unless excluded in CA A.2 or OAR 461-140-0020.

- (1) Money in a bank account is excluded as a resource when:
 - (a) In an approved account excluded under OAR 461-145-0025; or
 - (b) A burial fund excluded under OAR 461-145-0040.
 - (c) A designated bank account is an *excluded* asset for OSIP-IC or OSIPM-IC if:

(A) The account is designated to receive program benefits by direct deposit through electronic funds transfer; and

(B) The benefit funds are not commingled with other assets of the client.

461-140-0020

(d) Funds from excluded income if excluded as a resource under OAR 461-140-0070.

(e) An Individual Education Account if excluded under OAR 461-145-0145.

(f) Money for a plan for self-support if excluded under OAR 461-145-0405.

(g) Proceeds from the sale of a home if excluded as a resource under OAR 461-145-0460.

(2) Interest and dividends earned on funds in a bank account are counted as unearned income, unless the account is excluded as a resource under section (1).

461-145-0030

(3) For all programs except OSIP-IC, treat bank accounts held jointly with people not in the financial group as follows:

(a) For FS, count all funds in the account unless the client proves some or all are not available. Count the available amount.

(b) For all other programs, count only those funds contributed to the account by the client. Exclude other funds unless there is clear evidence they are available to the client.

☞ BE SURE TO REVIEW RULE 461-140-0070 ON EXCLUDED RESOURCES BEFORE DETERMINING THE AVAILABILITY OF FUNDS.

9. Burial Arrangements and Burial Fund

Burial arrangements may include prepaid arrangements that make allowance for burial costs. They are generally made with a licensed funeral director, burial insurance, or burial trust funds designating a funeral director as the beneficiary. Burial arrangements do not include a burial space.

Burial space is covered in CA B.10 or OAR 461-145-0050.

Burial funds are an identifiable fund set aside for a client's burial costs. A burial fund does not include a burial space.

- (1) A burial arrangement is treated as follows:
 - (a) For ERDC, FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF, exclude the equity value of one prepaid burial arrangement for each member of the filing group.
 - (b) For grandfathered OSIP and OSIPM clients, exclude up to \$1,000 combined equity value of burial arrangements with a licensed funeral director (plus accrued interest) and life insurance policies. Count the amount of combined cash and equity value of all life insurance and burial arrangements that is over \$1,000 as a resource.
 - (c) For all remaining programs, treat a burial arrangement the same as a burial fund.
- (2) A burial fund is treated as follows:
 - (a) For GA, OSIP, OSIPM, and QMB:
 - (A) A burial fund can only be established from cash, bank accounts, burial contracts, stocks, bonds, or life insurance policies.
 - (B) Burial funds cannot be excluded if they are commingled with nonburial-related assets. The amount set aside for burial must be in a separate account to be considered excluded from resource consideration.
 - (C) The burial fund may be established only from the countable resources of the client (such as cash, burial contracts, bank accounts, stocks, bonds, or life insurance policies). A burial fund may be established if the countable resources of the client exceeds allowable limits. A burial fund exclusion applies only if the burial fund makes the client ineligible due to excess resources.
 - (D) The following calculation determines the exclusion for a burial fund:
 - (i) Exclude up to \$1,500 of a burial fund from resources for each of the following:
 - (I) The client.
 - (II) The client's spouse.
 - (ii) Subtract both the following from the amount each client may set aside for a burial fund:
 - (I) The face value of life insurance policies owned by the client that have already been excluded from resources.

- (II) The amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs.
 - (E) Exclude all interest earned on excluded burial funds or increases in the value of excluded burial arrangements if left in the fund.
 - (b) For all other programs, the value of the burial fund is counted as a resource.
- (3) There is no penalty or overpayment for the time period during which the burial arrangement or burial fund existed if a client:
 - (a) Canceled an excluded burial arrangement, **or**
 - (b) Used excluded burial funds for any purpose other than burial costs.

Note: From September 27, 1987, to November 5, 1989, Oregon state law prohibited establishing irrevocable burial trust funds. Burial trust funds established on or after November 5, 1989, may be irrevocable.

☞ REFER TO RULE CA B.43 OR 461-145-0320 FOR POLICY ON LIFE AND TERM INSURANCE.

461-145-0040

10. Burial Space and Merchandise

Burial spaces include conventional grave sites, crypts, mausoleums, urns, and other repositories that are traditionally used for the remains of deceased persons. They also include headstones and the opening and closing of the grave.

- (1) For ERDC, FS, MAA, MAF, OHP, REF, SAC, and TANF, exclude the equity value of one burial space per financial group member.
- (2) For GA, OSIP, OSIPM, and QMB, burial space is excluded if owned by the client and designated for themselves, their spouse, minor and adult children, siblings, parents, and the spouse of any of these people.

Burial merchandise includes, but is not limited to, caskets, liners, burial vaults, markers, and foundations. The equity value of burial merchandise is excluded as a resource if owned by the client and designated for:

- (1) In ERDC, FS, MAA, MAF, OHP, REF, SAC, and TANF, a member of the financial group.

- (2) In GA, GAM, OSIP, OSIPM, and QMB, exclude burial merchandise owned by the client and designated for themselves, their spouse, minor and adult children, siblings, parents, and the spouse of any of these people.

461-145-0050

11. Capital Assets

Capital assets are property that contribute toward earning self-employment income, including microenterprise, either directly or indirectly. Capital assets generally have a useful life of over one year and a combined value of \$100 or more.

☞ SEE WORK-RELATED EQUIPMENT AND INVENTORY FOR MORE INFORMATION (CA B.86).

461-145-0600

12. Cash

Count cash (including cash on hand, cash in a safe deposit box, and cash held by others) as a resource.

Count as a resource foreign currency that can be converted to U.S. currency. The value of foreign currency is its value in U.S. currency, determined by the current exchange rate.

461-145-0060

13. Child Support and Cash Medical Support

- (1) Child support and cash medical support paid by a non-custodial parent for a dependent child or minor parent in the financial group (see OAR 461-110-0530) are considered income of the dependent child or minor parent, whether the support is paid voluntarily or in accordance with an order to pay child support.
- (2) “Pass-through” means child support, up to \$50 per dependent child or minor parent per financial group per month and not to exceed \$200 per financial group per month, that is sent to the client before any remaining amount of current child support is withheld by the State. Pass-through includes current child support only.

“Disregard” means child support, up to \$50 per dependent child or minor parent per financial group per month and not to exceed \$200 per financial group per month, that is not counted as income of the client. Disregard includes current child support only.

- (3) In the ERDC program, child support is considered countable unearned income if it is received by the financial group or is countable under OAR 461-145-0280. Otherwise it is excluded.
- (4) In the FS program, child support and cash medical support are treated as follows:
 - (a) Child support payments the group receives that must be assigned to the Department to maintain TANF eligibility are excluded, even if the group fails to turn the payments over to the department.
 - (b) Child support payments received by a filing group (see OAR 461-110-0370) with at least one member working under a TANF JOBS Plus agreement are excluded, except:
 - (A) It is considered countable unearned income in the calculation of the wage supplement.; and
 - (B) Any pass-through pursuant to section (2) above is considered countable unearned income.
 - (c) All other child support, including any pass-through pursuant to section (2) above, is considered countable unearned income.
 - (d) Cash medical support is considered countable unearned income except to the extent it is used to reimburse (see OAR 461-145-0440) an actual medical cost.
 - (e) Payments made by a noncustodial parent to a third party for the benefit of the financial group are treated in accordance with OAR 461-145-0280.
- (5) In the MAA, MAF, REFM, SAC, and TANF programs:
 - (a) In determining initial eligibility, except for disregard pursuant to section (2) above, child support received by the Division of Child Support is considered countable unearned income, if continued receipt of the child support is reasonably anticipated. These payments are excluded when determining the benefit amount.
 - (b) In determining ongoing eligibility, except for clients working under a TANF JOBS Plus agreement and except for child support passed through to the client and disregarded pursuant to section (2) above, child support received by the Division of Child Support is considered countable unearned income, if continued receipt of the child support is reasonably anticipated. These payments are excluded when determining the benefit amount.
 - (c) For clients working under a TANF JOBS Plus agreement:
 - (A) Child support is excluded in determining countable income.

- (B) Child support is excluded when calculating the TANF portion of the benefit equivalency standards.
- (C) All child support paid directly to the client is considered countable unearned income in the calculation of the wage supplement.
- (d) All other child support payments:
 - (A) Paid directly to the financial group that are not turned over to the Department or to the Division of Child Support or that are paid to a third party on behalf of a member of the financial group is are considered countable unearned income.
 - (B) Paid directly to the financial group that are turned over to the Department or to the Division of Child Support are considered countable unearned income except for any amount of pass-through and disregard pursuant to section (2) above.
- (e) Cash medical support is excluded in determining countable income.
- (f) Cash medical support is excluded.
- (6) In the OSIP, OSIPM, and QMB programs, all child support and cash medical support paid to the financial group are considered countable unearned income. Child support and cash medical support paid by the financial group are not deductible from income.
- (7) In the SFPSS program, notwithstanding section (5) above, for on-going eligibility and benefit determination:
 - (a) Except for disregard pursuant to section (2) above, child support is considered countable unearned income.
 - (b) Cash medical support is excluded in determining countable income.
 - (c) Payments made by a noncustodial parent to a third party for the benefit of the financial group are treated in accordance with OAR 461-145-0280.

461-145-0080

14. Contributions

Contributions are monies not gifts or winnings (CA B.30) given voluntarily to a financial group member by someone who is not in the group.

- (1) For all programs except FS and as provided in (3), count contributions as unearned income.

- (2) For FS, count contributions as unearned income. However, exclude cash contributions from charitable sources if all the following are true:
 - (a) The contribution is from a private, nonprofit charitable organization.
 - (b) The contribution is based on need.
 - (c) The contribution does not exceed \$300 per quarter.
- (3) For OHP, charitable contributions raised by a community to assist with a client's medical expenses are not counted as income or against the resource limit (461-160-0015).

☞ FOR NONCASH CONTRIBUTIONS, REFER TO CA B.40 OR OAR 461-145-0280 (IN-KIND INCOME).

☞ SEE CA B.65 FOR INFORMATION ON HOW TO TREAT REFUGEE RESETTLEMENT GRANTS.

461-145-0086

15. Corporations and Business Entities

- (1) Identifying Corporations
 - (a) A closely held corporation is usually incorporated by one or a small number of owners. For example, a farmer or a farming family incorporates their farming business.

Note: The owner of a closely held corporation will have legal documents showing the date the business was incorporated.
 - (b) A Subchapter S-corporation is incorporated under Chapter S of the Internal Revenue code. Each shareholder is responsible to file his or her own taxes on the profits the corporation distributes. For example, a law firm or other partnership may incorporate their business under Chapter S.
 - (c) Other corporations include companies that sell stock to investors. Proctor & Gamble, AT&T, and Starbucks, are examples of businesses that sell stock to investors. Owning stock in a corporation does not make the individual self employed.

Note: To locate information on the business see the Secretary of State website at www.sos.state.or.us, Corporation Division. If the business is licensed as a corporation in Oregon, the business name should appear in a business name search.

(2) When a Client's Corporation is Considered Self-Employment

For FS, the owner or shareholders of a corporation are not self employed. For all other programs, the owner of a corporation is considered self employed if they meet self-employment criteria listed per OAR 461-145-0910.

(3) Treatment of Income

- (a) If an individual works for the corporation, he is considered an employee of the corporation. Treat the profits distributed to shareholders of a closely held or Subchapter S-corporation as earned income if they are employees of the corporation. If profits for the current year are expected to be similar to the prior year, treat the profits reported on the most recent IRS 1040 as periodic income (CA A.6).
- (b) If a shareholder of a corporation is not an employee of the corporation and not receiving a salary, count any dividends as unearned income.
- (c) In the FS program, income from business entities and corporations is treated as follows:
 - (A) If a client is actively working in a corporation, the income is treated as earned income.
 - (B) If a client is actively working in an unincorporated business entity, refer to CA C.1 to determine if the income is treated as earned or as self-employment.
 - (C) If a client is no longer actively working to produce the income, the income is treated as unearned.
 - (D) Income from a limited liability company is treated as follows:
 - (i) If a client is a member or a manager member, the income is treated as self-employment income.
 - (ii) If a client is a manager but not a member, the income is treated as earned income.
- (d) If a client owns stock in a corporation, the value of the stock is a countable resource. However, if ownership of the stock is necessary for the client to be employed by the corporation, the resource is excluded.

Example 1: A farmer incorporates his farm, is the sole owner and worker and all of the corporation's assets are related to the farming operation. The farmer's stock in the corporation is essential to his employment. Therefore, the equity value of his stocks is not counted as a resource.

Example 2: An attorney has stock in a Subchapter S-corporation. The ownership of this stock may or may not be required as a condition of his employment for that corporation. If the ownership is required, the equity value of his stocks is not counted as a resource. If ownership is not required, the equity value of his stocks is counted as a resource.

461-145-0088

(4) Corporation Expenditures Benefiting a Principal

In the FS, OHP, OSIP, OSIPM, and QMB programs, an expenditure by a business entity or corporation that benefits a principal, such as a car or housing payment, is considered available when the expenditure is made. For purposes of this rule, a principal is a person with significant authority in a business entity or corporation, including sole proprietor, a self-employed person (see OAR 461-145-0910), a partner in a partnership, a member or manager of a limited liability company, and an officer or principal stockholder of a closely held corporation.

(5) Corporate Assets

Except in cases where the owners of corporations are considered to be self employed, assets held and owned by the corporation are not considered the client's assets.

☞ SEE CA B.63.

16. Disability Benefit

(1) This policy covers public and private disability benefits, except the following:

- (a) Agent Orange disability benefits (covered in OAR 461-145-0005 or CA B.2).
- (b) Radiation Exposure Compensation Act payments (covered in OAR 461-145-0415 or CA B.57).
- (c) Social security based on disability or SSI (covered in OAR 461-145-0490 and OAR 461-145-0510 or in CA B.68 and CA B.71).
- (d) Veterans' benefits (covered in OAR 461-145-0580 or CA B.81).
- (e) Workers' compensation (covered in OAR 461-145-0590 or CA B.85).

(2) For each disability payment covered under this policy:

- (a) If received monthly or more frequently:

- (A) In the ERDC, FS, MAA, OHP, REF, REFM, SAC, and TANF programs, income from employer-sponsored disability insurance is counted as earned income (see OAR 461-145-0130 or CA B.22) if paid to a client who is still employed while recuperating from a temporary illness or injury.
 - (B) Except as provided in paragraph (A) of this subsection, the payment is counted as unearned income.
- (b) All payments other than those in subsection (a) of this section are counted as periodic or lump-sum income (see OAR 461-140-0110 and OAR 461-140-0120 or CA A.6 and CA A.5).

461-145-0090

17. Disaster Relief

A major disaster is any natural catastrophe such as a hurricane or drought, or, regardless of cause, any fire, flood or explosion, which the President determines causes damage of sufficient severity and magnitude.

An *emergency* is any occasion or instance for which the President determines that federal assistance is needed to supplant state and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe.

Disaster Unemployment Assistance is emergency assistance authorized under P.L. 100-107 and received by individuals who are unemployed as a result of a major disaster. Individuals receiving *Disaster Unemployment Assistance* are not eligible for other unemployment compensation and cannot receive both at the same time. Payments are limited to 26 weeks.

- (1) Except as otherwise stated in Sections (2) to (6) or in OAR 461-140-0070, the following payments precipitated by an emergency or major disaster, are not counted as income or resources when determining eligibility for or benefit levels.
 - (a) Payments received under the Disaster Relief Act of 1974 (P.L. 93-288, Section 312(d)) as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707, Section 105(i)).
 - (b) Disaster assistance comparable to subsection (a) of this section provided by states, local governments, and disaster assistance organizations.
 - (c) Payments from the Federal Emergency Management Agency (FEMA).
 - (d) Individual and Family Grant Assistance program (IFG).
 - (e) Grants or loans by the Small Business Administration (SBA).

- (f) Voluntary disaster assistance organizations, such as the Red Cross.
- (g) Private insurance payments for losses due to a *major disaster* such as flood, wind, land movement.
- (2) Government payments designated for the restoration of a home damaged in a disaster are excluded as income or resources in the month of receipt and as a resource in subsequent months, if the household is subject to a legal sanction if the funds are not used as intended.
- (3) Each payment made to farmers under the Disaster Assistance Act of 1988 (P.L. 100-387) for crop losses or failure in a disaster is excluded.
- (4) Income received from public and private organizations by individuals working in disaster relief efforts and funded under a National Emergency Grant by WIA Title 1 (P.L. 105-220) is excluded. An individual is eligible under this funding source if he or she is a dislocated worker, a long-term unemployed individual, or is temporarily or permanently laid off as a consequence of the disaster. Eligibility under this funding source is limited to a period of up to six months per disaster.
- (5) *Disaster Unemployment Assistance* is excluded as both income and a resource.
- (6) Payments for flood mitigation received by a homeowner under the National Flood Insurance Act of 1968, as amended by P.L. 109-64, are not counted as income or resources.

461-145-0100

18. Disqualifying Income; FS

FS benefits received by TANF recipients may not increase when the TANF cash payment ends or is reduced due to a penalty. Eligibility for and the level of food stamp benefits is determined as if the client were receiving benefits without the reduction in TANF benefits due to the penalty.

☞ SEE FS F.13 FOR MORE INFORMATION ON DQI INCOME.

TANF disqualifying income is the difference between the TANF cash payment prior to the penalty and the TANF cash payment once the penalty is imposed. The loss of the TANF cooperation incentive payment (see OAR 461-135-0210) is not included in the disqualifying income.

The disqualifying TANF income is counted as unearned income when the TANF cash payment is reduced due to any of the following reasons:

- (1) Failure to pursue assets per rule 461-120-0330.

- (2) Failure to help the department obtain child support from a noncustodial parent per rule 461-120-0340.
- (3) Failure to obtain medial coverage per rule 461-120-0345.
- (4) Failure to comply with requirements of the employment programs imposed under 461-130-0330.
- (5) Failure to seek treatment for substance abuse or mental health evaluation and treatment under 461-135-0085.
- (6) TANF intentional program violation (IPV) imposed under 461-195-0621.
- (7) Repayment of a TANF client-caused or IPV overpayment as defined in 461-195-0501 and 461-195-0601. Do not include repayment on an overpayment resulting from aid paid pending due to a hearing request.

Once imposed, the disqualifying income ends when the TANF penalty is lifted, the household becomes ineligible for TANF for other reasons, the overpayment is repaid, or if the TANF cash or MAA case has been closed for at least 12 months.

461-145-0105

19. Dividends, Interest, Royalties

- (1) Dividends are counted as unearned income unless the dividends are from a trust described in CA B.77 (10), in which case the dividends are not counted as income.
- (2) Interest income is counted as unearned income.
- (3) Royalties are counted as unearned income, except that royalties are counted as earned income if the client is actively engaged in the activity from which the royalties are accrued.

461-145-0108

20. Domestic Volunteer Services Act (VISTA, RSVP, SCORE, ACE)

- (1) Treat payments under (title I of Public Law 93-113 Domestic Volunteers Service Act of 1973) including VISTA, University Year for Action and Urban Crime Prevention Program as follows:
 - (a) For ERDC, MAA, MAF, OHP, REF, REFM, SAC, and TANF, exclude these payments unless the total value of all VISTA compensation is equal to or greater than compensation at the state minimum wage. If so, count as earned income.

- (b) For GA and GAM, count VISTA payments as unearned income.
- (c) For all other programs:
 - (A) Exclude VISTA payments if the client is receiving program benefits when they join VISTA. Continue to exclude the payments until the client has a break in receiving benefits of more than one month.
 - (B) Count VISTA payments as earned income for clients who joined VISTA before applying for program benefits.

Note: Clients join VISTA as of the date they take the oath. If the client has a previous VISTA contract and received FS benefits in another state, use the date they begin the new assignment in Oregon.

- (2) Exclude title II of Domestic Volunteer Services Act (Public Law 93-113) payments (National Older Americans Volunteer Programs), which include:
 - (a) Retired Senior Volunteer Program (RSVP) Title II, Section 201.
 - (b) Foster Grandparent Program Title II, Section 211.
 - (c) Older American Community programs.
 - (d) Senior Companion program.
- (3) Exclude title III payments (National Volunteer Programs to Assist Small Businesses and Promote Volunteer Service by Persons with Business Experience), which include:
 - (a) Service Corps of Retired Executives (SCORE) Title III, Section 302.
 - (b) Active Corps of Executives (ACE) Title III, Section 302.

461-145-0110

21. Earned Income; Defined

Earned income is income received in exchange for an individual's physical or mental labor. Earned income includes, all of the following:

- (1) Compensation for services performed, including wages, salaries, commissions, tips, representative payee fees, sick leave, vacation pay, draws, or the sale of one's blood or plasma.

☞ FOR A MILITARY BASIC PAY EXCLUSION, SEE CA B.47.

- (2) Income from on-the-job training, paid job experience, JOBS Plus work experience, or Welfare-to-Work work experience.

- (3) In-kind income, when the client is an employee of the person providing the in-kind income and the income is in exchange for work performed by the client.

☞ SEE DEFINITION OF IN-KIND INCOME IN CA B.40 OR OAR 461-145-0280.

Note: Earned in-kind income may include rent or utilities credit that a client receives in exchange for work performed. To determine the amount, subtract the amount the client pays for rent from the amount the dwelling usually rents for. For example, the rent is \$550, but the client pays only \$100 because of work done for the landlord. The earned in-kind income is \$450 (\$550 - \$100).

- (4) For self-employment, gross receipts and sales, including mileage reimbursements, before costs.
- (5) In:
- (a) The FS program, *cafeteria plan* (see OAR 461-001-0000) benefits and funds placed in a flexible spending account.
 - (b) All programs except the FS program, *cafeteria plan* benefits that an employee takes as cash as well as funds placed in a flexible spending account.

Note: Health insurance purchased with flexible benefits must be assigned to the department, per rule 461-120-0315.

- (6) Income from work-study.
- (7) Income from profit sharing that the client receives monthly or periodically.
- (8) The fee for acting as an individual's representative payee, as long as the individual is not included in the filing group.
- (9) In the FS, OHP, OSIP, OSIPM, and QMB programs, an expenditure by a business entity that substantially benefits principal (see OAR 461-145-0088).

461-145-0120

22. Earned Income; Treatment

All earned income not specifically identified below is counted as earned income.

☞ SEE CA B.21 FOR DEFINITION.

- (1) Treat JOBS Plus income as follows:
- (a) For all programs, client wages received under the Oregon Employment Department UI JOBS Plus or the Tribal TANF JOBS Plus programs are counted as earned income.
 - (b) For all programs except FS and TANF, count the JOBS Plus income from TANF-PLS as earned income.
 - (c) For all programs except TANF, count the JOBS Plus income from NCP-PLS as earned income.
 - (d) For FS:
 - (A) When JOBS Plus income is earned by TANF-PLS clients:
 - (i) Count it as earned income in determining initial FS eligibility.
 - (ii) Exclude it in determining ongoing eligibility.

Note: When a person is receiving TANF JOBS Plus, continue to code the TANF grant and the extra JOBS Plus \$10 payment as unearned income.

- (B) Count as earned income any TANF-PLS JOBS Plus wages received after the month that the client last worked under a JOBS Plus agreement.

☞ SEE ES B.15 FOR EMERGENCY FS PAYMENTS WHILE PARTICIPATING IN TANF JOBS PLUS.

- (e) For TANF:
 - (A) When JOBS Plus income is earned by NCP-PLS clients, count it as earned income in determining initial TANF eligibility.
 - (B) When determining the need for TANF supplements for TANF-PLS clients, treat the income as follows:
 - (i) Exclude it in determining the countable income limit and in calculating the benefit equivalency standards.
 - (ii) Count it as earned income in calculating the wage supplement.

☞ SEE ES B.13 FOR MORE ON TANF JOBS PLUS AND ES B.14 FOR CALCULATING THE TANF SUPPLEMENT.

- (C) Count as earned income any JOBS Plus wages received after the month that the client last worked under a JOBS Plus agreement.

Note: *When a JOBS Plus client whose selection is based on receiving UI is eligible for TANF or FS, switch them to TANF-PLS. TANF clients are a higher priority for JOBS Plus selection.*

- (2) Treat Welfare-to-Work work experience income as follows:
 - (a) For EXT, MAA, MAF, REF, REFM, and TANF, exclude the first \$260 earned per month. Count the remainder as earned income.
 - (b) For FS and OHP, count all Welfare-to-Work income as earned income.
- (3) For ERDC and OHP, exclude all earned income of children.
 - (a) For ERDC, a child must be in the care and custody of the caretaker. They do not need to have a biological or legal relationship to the caretaker. The child must be:
 - (A) Under the age of 18; or
 - (B) Under the age of 19 and in secondary school or vocational training at least half time.
 - (b) For children who turn 19 and are reapplying for OHP as adults, income earned prior to age 19 is counted.
- (4) For FS, exclude
 - (a) A cafeteria plan benefit, including flexible spending plans, that an employee cannot elect to receive as cash which is designated and used to pay for child care, medical care, or health insurance unless it is reimbursed by the department; **or** allowed as an earned income deduction.

Note: *In FS, cafeteria plan benefits taken as cash or used to pay for a service paid by the department are counted as earned income. The intent is not to allow “double-dipping” by the client; that is, being reimbursed twice for the same cost.*
 - (b) The earned income of an individual under age 18 if they are under the parental control of another member of the household and:
 - ☞ PARENTAL CONTROL IS DEFINED IN FS C.3.
 - (A) Attending elementary or high school;
 - (B) Attending GED classes recognized by the local school district;
 - (C) Completing home-school elementary or high school classes recognized by the local school district; **or**
 - (D) Too young to attend elementary school.

(c) In-kind earned income, except as provided in section (7).

☞ SEE CA B.21 FOR A DEFINITION OF EARNED INCOME AND CA B.40 FOR IN-KIND INCOME.

461-145-0120, 461-145-0280

(d) Any amount deducted from base pay for future educational costs under Public Law 99-576, 100 Stat. 3248 (1986), for clients on active military duty.

(e) Income remaining after the month of receipt is a resource.

(5) For EXT, MAA, MAF, REF, REFM, SAC, and TANF programs;

(a) Exclude the earned income of the following financial group members in the month of receipt. Count any money remaining after the month of receipt as a resource.

(A) Dependent children under age 19, or minor parents (under age 18), who are full-time students in grade 12 or below (or the equivalent level of vocational training, GED courses, or home schooling approved by the local school district).

(B) Dependent children under age 18 who are part-time (as defined by the institution) students in grade 12 or below (or the equivalent level of vocational training, GED courses, or home schooling approved by the local school district), and are not employed full time.

(C) Dependent children too young to be in school.

(b) Income remaining after the month of receipt is a resource.

(c) In-kind earned income is excluded (see CA B.40 and CA B.67).

(6) For MAA, MAF, REF, REFM, SAC, and TANF, exclude all in-kind income except unearned third party payments.

(7) In the FS and OHP programs, earned In-kind income (CA B.40) is excluded unless it is an expenditure by a business entity that benefits a principal (CA B.15). If it benefits a principal, it is treated as countable earned in-kind reimbursement (CA B.63).

(8) In the MAA and MAF programs, earned income that would result in MAA or MAF ineligibility is excluded for a caretaker relative in an MAA or MAF filing group with at least one person eligible for and receiving MAA or MAF prior to meeting the three of six month requirement. (See OAR [461-135-0095](#).)

(9) In all programs except the EXT and FS programs, and for an OSIPM client in *nonstandard living arrangement* (see OAR [461-001-0000](#)), the income of a

temporary employee of the U.S. Census Bureau employed to assist in taking the census is excluded.

461-145-0130

23. **Earned Income Tax Credit (EITC)**

Earned Income Tax Credit (EITC) are federal and state tax programs for low-income families. EITC may be received in one of two ways:

- As an advance in the employee's paycheck.
- As one annual payment received at the time of the normal income tax returns.

For all programs exclude all EITC payments.

461-145-0140

24. **Economic Recovery Payment**

The economic stimulus act (officially “The American Recovery and Reinvestment Act of 2009”) was signed into law on February 17. The Act provided a special one-time only \$250 payment to persons receiving social security (SSB, SSI, SSDI), Railroad Retirement, Veterans' Disability and Veterans' Pension payments.

Exclude the \$250 as income in the month of receipt. Exclude the \$250 as a resource in the month of receipt for the following nine months.

461-145-0143

25. **Educational Income**

- (1) Educational income is income designated specifically for educational expenses. To be considered educational income, the income must be given to one of the following:
 - (a) A student at a recognized institution of post-secondary education. Post-secondary education is education offered by institutions primarily to individuals age 18 or older. Admission may or may not require a high school diploma or equivalent.
 - (b) A student at a school for people with disabilities.
 - (c) A student in a vocational education program.

- (d) A student in a program that provides for completion of secondary school diploma or the equivalent.

☞ SEE WG-MP #14 AND OAR 461-145-0150 FOR MORE ON EDUCATIONAL INCOME.

- (2) To determine the amount of educational income to exclude, use education expenses listed in the financial aid award letter unless one of the following is true:
 - (a) The information is not available in the award letter, or the student provides verification of amounts different from those listed in the award letter. In these situations, use the verified amounts from the student.

Note: Do not require additional verification if the amounts are listed in the award letter (unless the student wants to use different amounts and can verify those amounts).

- (b) The student receives child care benefits (i.e., ERDC or other child care subsidies). In that situation, exclude from educational income the amount the student actually pays for child care (e.g., the ERDC copay) instead of the amount shown in the award letter.
 - (c) The student states actual transportation costs exceed the amount allowed for the expense in the award letter. In that situation, calculate the number of commuting miles to and from school and multiply by \$0.20. Exclude the calculated amount or the amount from the award letter, whichever is greater.

Note: If a FS client begins receiving ERDC, remember to recalculate FS educational income because the exclusion for child care expenses has changed.

- (3) Exclude the following items:
 - (a) Educational income authorized by the Carl D. Perkins Vocational and Applied Technology Education Act, Title IV of the Higher Education Act, or made available by the Bureau of Indian Affairs (BIA).
 - (b) All income from educational loans.
- (4) Exclude the cost of the following items from remaining educational funds (including non-title IV work study):
 - (a) Tuition, mandatory fees, books and supplies, transportation, required rental or purchase of equipment or materials charged to students enrolled in a specific curriculum, other miscellaneous personal expenses (except room and board), and loan originator fees and insurance premiums required to obtain an educational loan.

(b) Additionally for all programs except ERDC, exclude dependent care costs.

☞ SEE FS D.3 AND F.19 OR OAR 461-160-0430 FOR INFORMATION ON FS DEPENDENT CARE DEDUCTIONS FOR STUDENTS.

☞ FOR ERDC, REFER TO RULE 461-150-0049 FOR BUDGETING EDUCATIONAL INCOME.

☞ FOR ERDC AND FS, USE THE *EDUCATIONAL INCOME CALCULATION FOR ERDC AND FOOD STAMPS* WORKSHEET (DHS 7351).

Note: The DHS 7351 is not used for calculating medical eligibility.

- (5) For a participant in the Parents as Scholars (PAS) component of the JOBS program who is approved for PAS pursuant to OAR 461-190-0199, exclude all remaining educational funds, including those funds intended for room and board.
- (6) For all programs, after allowing exclusions, treat the remaining income as follows:
- (a) Count work study, fellowships, and teaching-assistant income not excluded per section (3) or (4) of this rule as earned income. This may include work study provided through the VA program or other educational programs.
 - (b) For all programs except OHP, count other educational income (grants, loans, Montgomery GI Bill [VA Chapter 30, 32, or 35 or chapter 1606 or 1607], etc.) by prorating it over the period it is intended to cover, then begin counting the prorated amount in the first month of the period if the client has already received the income. If income has not been received, begin counting the prorated amount in the month of the period it is expected to be received.
 - (c) For OHP, count other educational income in the month received.

☞ SEE CA B.81 OR OAR 461-145-0580 FOR MORE ON VETERANS' BENEFITS.

(7) Count the VA Chapter 31 subsistence allowance according to CA B.81. When participating in this program, the VA pays all tuition, books and fees. All education costs are provided for the student except transportation and child care.

(8) Clients may be attending school under the displaced workers program. In this instance, the student will continue to receive weekly UC benefits while attending school. Treat Displaced Worker payments the same as UC benefits.

☞ SEE CA B.78 OR OAR 461-145-0550.

26. Energy Assistance

For all programs, exclude all energy assistance payments or allowances made under any federal, state, or local law (Public Law 96-249). These payments include:

- (a) Energy assistance payments provided through a Department of Health and Human Services Low-Income Assistance Program.
- (b) Energy assistance payments provided through the Low-Income Energy Assistance Act of 1981 under Public Law 97-35, Section 2605(F) (LIEAP).

☞ SEE CA B.33 OR OAR 461-145-0230, ON HOW TO TREAT UTILITY PAYMENTS RECEIVED BY THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE RURAL HOUSING SERVICE.

461-145-0170

27. Family Abuse Prevention Act (FAPA) Payments

FAPA payments are court-ordered payments to victims of domestic violence made under authority of ORS 107.718(1)(h). A payment is considered available when actually received by the victim of abuse.

For all programs, the first \$2,500 is excluded. The excess above \$2,500 is counted as a resource.

461-145-0175

28. Floating Homes and Houseboats

- (1) Floating homes and houseboats are treated in the same manner as real property under OAR 461-145-0420.

☞ SEE CA B.59 FOR REAL PROPERTY.

- (2) Floating homes and houseboats are subject to OAR 461-145-0220 and 461-145-0250 if applicable.

☞ SEE CA B.32 FOR HOME OR CA B.34 FOR INCOME PRODUCING PROPERTY.

461-145-0185

29. Food Programs; Other than the FS Program

- (1) For all programs, exclude the following:

- (a) Benefits from the Special Supplemental Food Program for Women, Infants and Children (WIC). Also, exclude WIC demonstration project coupons that may be exchanged for food at farmers' markets.
- (b) The value of supplemental food assistance under the Child Nutrition Act and the National School Lunch Act. This includes the Special Milk Program, School Breakfast Program, the Summer Food Service Program, the Commodity Program, and the Child and Adult Food Program.

Note: This exclusion does not apply to providers.

☞ SEE MP-WG #16 FOR MORE INFORMATION ON SCHOOL LUNCH PROGRAM.

- (c) Benefits from the Senior Farm Direct Nutrition program (OAR 461-135-1175).

461-135-1175

- (d) Nutrition Assistance Program benefits received in Puerto Rico, American Samoa, or the Commonwealth of the Northern Mariana Islands.

- (2) FS clients receiving Tribal Food Distribution Program products are not eligible to receive FS in the same month per OAR 461-165-0030. For all other programs, Tribal Food Distribution Program benefits are excluded.

461-165-0030

☞ SEE FS I.2 FOR INFORMATION ON TRIBAL FOOD DISTRIBUTION PROGRAMS.

461-145-0190

30. Foster Care/Guardianship Assistance Payment

Foster care is when an individual is placed in the home of relatives or other individuals or families by a federal, state, or local governmental foster care program. This could be child or adult foster care.

Guardianship Assistance payments are made by Child Welfare, for children under age 18, when a person has agreed to be the guardian of the child. These payments are authorized under a foster care waiver.

A foster care payment is:

- (1) The payment the foster care provider receives from the foster care program, **and**
- (2) For adults in foster care, this also includes their room and board payment and any service payment the client is required to pay the provider.

Note: *An adult in foster care is required to pay the room and board part of the foster care payment. Children in foster care do not make this separate payment.*

Note: *Per TANF C.5, MA C.5, and OAR 461-110-0630, parents in foster care for whom foster care payments are being made cannot have their needs counted for MAA, MAF, or TANF.*

Note: *Proctor care administered by or under contract to a state agency is a form of foster care. Treat these situations and income the same as foster care.*

Treat foster care/guardianship assistance payments as follows:

- (1) For all programs except ERDC and FS:
 - (a) If the provider of foster care/guardianship is in the financial group:
 - (A) Exclude the amount the placement agency identifies as room and board, clothing, and personal incidental needs (including recreational expenses) of the foster care/guardianship assistance client.
 - (B) Exclude the amount designated for special need items of the foster care/guardianship assistance client.
 - (C) Count the remaining amount as earned income.
 - (b) If the provider of foster care/guardianship is not in the financial group, exclude the foster care payments.
- (2) For ERDC, count the payments as unearned income only if the person in foster care/guardianship assistance is in the filing group.

☞ SEE FS C.4 REGARDING INCLUDING OR EXCLUDING THE FOSTER CARE PERSON FROM THE FS FILING GROUP.
- (3) For FS, count the payments for foster care or guardianship assistance as follows:
 - (a) If the person receiving the foster care or assistance is a member of the household group, but not the filing group, exclude the income.
 - (b) If the person receiving the foster care or assistance is a member of the filing group, count the payment from the foster care program as unearned income for the care provider.

Note: *Do not count the room and board or service payment as income that the foster care client is paying to the provider when they are in the same filing group. This is because foster care person's income has been counted already and income that changes hands between financial group members is not counted.*

- (c) If the person receiving the foster care or assistance is not a member of the household group, count the payment (both parts) as self-employment income for the foster care provider.

461-145-0200

31. Gifts and Winnings

Gifts are items given to or received by an individual on or for a special occasion, such as a holiday, birthday, graduation, wedding, etc. They are not given or received on a regular basis.

Winnings are prizes given to an individual in a contest, game of chance, or similar event. *Winnings* in the form of money may be distributed periodically (e.g., monthly) or in a lump-sum.

- (1) Gifts and winnings in the form of either a gift card or certificate are excluded.
- (2) For employment related items, see CA B.22 (OAR 461-145-0130).
- (3) For all programs except ERDC, treat in-kind gifts and winnings according to policy for the specific type of asset. Treat gifts and winnings in the form of money as periodic or lump-sum income. (OAR 461-140-0110 and OAR 461-140-0120).
- (4) For ERDC, exclude all gifts and winnings.

461-145-0210

32. Groundfish Disaster Benefits

People working in the commercial fishing industry may qualify for Groundfish Disaster benefits. These benefits are disbursed through the Oregon Employment Department to persons involved in the commercial fishing industry in Oregon's coastal communities.

To qualify for Groundfish Disaster benefits, a groundfisher must be working with the Oregon Employment Department as a displaced worker. They must also commit to not return to work in the commercial fishing industry.

The groundfisher eligible for these benefits may receive assistance for up to nine months. The monthly payments can be as much as \$1,500 for a family or \$1,000 for an individual. The payments may be less if the person is receiving unemployment compensation.

Groundfish Disaster benefits are counted as unearned income for all programs.

461-140-0010

33. Home

Home Defined

A home is the place where the filing group lives. A home can be a house, boat, trailer, mobile home, or other habitation. A home also includes the following:

- (1) Land on which the home is built and contiguous property.
 - (a) For all programs except FS, GA, GAM, OSIP, OSIPM, and QMB, property must meet all the following criteria to be considered contiguous property:
 - (A) It must not be separated by land owned by people outside the financial group.
 - (B) It must not be separated by public rights-of-way, such as roads.
 - (C) It must be property that cannot be sold separately from the home.
 - (b) For the FS, GA, GAM, OSIP, OSIPM, and QMB programs, contiguous property is property not separated by land owned by people outside the financial group. In addition:
 - (A) Contiguous property may be separated by public rights-of-way, such as roads; **and**
 - (B) Property is contiguous even when it can be sold separately from the home.
- (2) Other dwellings on the land surrounding the home that cannot be sold separately from the home.
- (3) Additionally for FS, land that the financial group is building, or plans to build, their home on.

Exclusion of home and other property

- (1) For a client who has an *initial month* (defined in OAR 461-001-0000) of long-term care or waived services on or after January 1, 2006:
 - (a) For purposes of this subsection:
 - (A) “*Child*” means a biological or adoptive child who is
 - (i) Under age 21; or
 - (ii) Any age and meets the Social Security Administration criteria for blindness or disability.
 - (b) The value of a home is excluded if the financial group occupies the home and has equity in the home of \$500,000 or less.

- (c) The home is countable as a resource if the client has equity in the home of more than \$500,000, unless one of the following requirements is met:
 - (A) The spouse of the client occupies the home.
 - (B) The child of the client occupies the home.
 - (C) The client is legally unable to convert the equity value in the home to cash.
 - (D) The home equity is excluded under OAR 461-145-0250.
- (2) For all other financial groups, the value of a home is excluded when the home is occupied by any member of the financial group.
- (3) In the FS program only, exclude the value of a home when it is occupied by the financial group. Additionally for FS, exclude the value of land the group is building, or plans to build, their home on. If the FS financial group owns (or is buying) the home they live in and has separate land they intend to build on, only exclude the home in which they live. Treat the land they intend to build on as real property (CA B.59) or OAR 461-145-0420.

Exclusion during temporary absence

If the value of the home is excluded above, the value of a home remains excluded in each of the following situations:

- (1) In all programs except GA, GAM, OSIP, OSIPM, and QMB during the temporary absence of all members of the financial group from the property, if the absence is due to illness or uninhabitability from casualty or natural disaster, and the group intends to return home.
- (2) For FS, if the financial group's absence is due to employment or training for future employment.
- (3) For GA, GAM, OSIP, OSIPM, and QMB, if the client's absence is due to receiving care in a medical institution and one of the following is true:
 - (a) The absent client is a single adult who has provided convincing evidence that they will return to the home. The evidence must reflect the subjective intent of the client, regardless of the client's medical condition. A written statement from a competent client is sufficient to prove the intent.

☞ SEE OAR 461-160-0630 FOR MORE INFORMATION.

Review this at each redetermination after the client has been absent from the home for six consecutive months.

- (b) The home remains occupied by the client's spouse, child, or a relative dependent on the client for support. For the purposes of this paragraph, the

home is considered occupied when it is temporarily vacant but the home expenses are maintained and the individual intends to return.

☞ FOR NONEXCLUDED HOMES, SEE CA B.59 OR RULE 461-145-0420.

- (c) For MAA, MAF, REF, REFM, SAC, and TANF, if all members of the financial group are absent due to one of the following:
 - (A) The members are employed in seasonal employment, and intend to return to their home when the employment ends; **or**
 - (B) The members are searching for employment and the search requires the filing group to relocate away from their home. Exclude the home for up to six months from the last date all members left their home to search for employment. After the six months, if a member of the financial group does not return, the home is no longer excluded.

Note: If a home is sold or transferred, review the transaction to determine its effect on the client's eligibility.

461-145-0220

34. Housing and Urban Development

- (1) Treat payments from HUD made to a third party as follows:
 - (a) For EA, ERDC, FS, GA, GAM, OHP, OSIP, OSIPM, and QMB, exclude these payments.
 - (b) For MAA, MAF, REF, SAC, and TANF use the payment in determining Shelter-in-Kind income (CA B.67).
- (2) Treat HUD payments made directly to a member of the financial group, except Youthbuild Program payments and Family Investment Centers payments, as follows:
 - (a) For EA and OHP, count as unearned income.
 - (b) For ERDC, GA, GAM, OSIP, OSIPM, and QMB, exclude these payments.
 - (c) For FS, exclude payments for utilities. Count other payments as unearned income.

Note: Groups who receive utility reimbursements are still eligible for the utility allowance (FUA) if they pay heating costs above the reimbursement (FS F.23).

- (d) For MAA, MAF, REF, and SAC, use the payment in determining Shelter-in-Kind income. If the payments are made in a lump sum, count as unearned income.

- (3) Treat Youthbuild Program payments as follows:
 - (a) For ERDC and OHP, treat Youthbuild payments as earned income.
 - (b) For FS, exclude payments to clients age 18 and under who are under the control of an adult member of the filing group (FS C.3). Treat other Youthbuild payments as earned income.
 - (c) For TANF, if the Youthbuild Program participant is a dependent child in the filing group, or a caretaker relative age 19 or younger, exclude the payments. If the participant is a caretaker relative over age 19, treat the payments as follows:
 - (A) Exclude incentive payments that are reimbursements for specific expenses not covered by program benefits, e.g., transportation, school supplies, etc.
 - (B) Count on-the-job training (OJT) or work experience payments as earned income.
 - (C) Count the bonus payment (the incentive payment for attendance) as unearned income.
- (4) Exclude the equity value of escrow accounts that are established for families participating in the Family Self-Sufficiency (FSS) program sponsored by HUD.
- (5) Treat payments issued under the Cranston-Gonzalez National Affordable Housing Act, Public Law 101-625 (Family Investment Centers) as follows:
 - (a) Count wages as earned income and stipends as unearned income.
 - (b) Exclude service payments for items such as child care, basic education, literacy or computer skills training, employment training, or counseling assistance in attaining a GED, etc.

461-145-0230

35. Income-Producing Property

- (1) Income-producing property is any real or personal property that generates income for the financial group. Examples of income-producing property are:
 - (a) Livestock, poultry, and other animals.
 - (b) Farmland, rental homes (including a room or other space in the home or on the property of a member of the financial group), vacation homes, condominiums.
- (2) Count the income from income-producing property as follows:

- (a) If a financial group member actively manages the property 20 hours or more per week, treat as self-employment income. (CA C.1, CA C.2 AND CA C.3).

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- (b) If a financial group member does not actively manage the property 20 hours or more per week, count as unearned income with exclusions allowed only in accordance with OAR 461-145-0920. Necessary costs are the actual costs allowable in determining countable self-employment income (CA C.2).

461-145-0250, 461-145-0920

***Note:** When the income from income-producing property is treated as unearned income, actual costs are allowed to offset the income. Allow the 50 percent self-employment deduction for FS only when the income is counted as earned income and the household has allowable costs.*

***Note:** For FS, when a filing group is renting out rooms in their home they are not eligible for more than one deduction using the same costs. So if interest on the mortgage payment is used to reduce the income, it cannot also be allowed as a shelter cost.*

- (3) Treat the equity value of income-producing property as follows:
- (a) For MAA, MAF, REF, REFM, SAC, and TANF, count it as a resource.
 - (b) For EA, ERDC, and OHP, exclude it.
 - (c) For FS, count as a resource unless one of the following is true:
 - (A) Exclude the equity value of property that produces an annual countable income that is similar to other properties in the community with comparable market value.
 - (B) Exclude the equity value of income-producing livestock, poultry, and other animals.
 - (C) Exclude the equity value if selling the resource would produce a net gain to the financial group of less than \$1,500.
 - (D) Exclude the value of work-related property or capital assets under CA B.86 or OAR 461-145-0600.

- (d) For GA, GAM, OSIP, OSIPM, and QMB, count as a resource, except as follows:
- (A) Exclude up to \$6,000 of the equity value if the property produces an annual countable income of at least six percent of its equity value.
- (B) Exclude the total equity value if **all** the following are true:
- (i) The property is used in a trade or business of a member of the financial group as evidenced by two or more of the following:
- (I) The good faith intention of making a profit.
- (II) Its use is part of a regular occupation for a member of the *financial group*.
- (III) Holding out to others as being engaged in the selling of goods or services.
- (IV) Continuity of operations, repetition of transactions, or regularity of activities.
- (V) A business tax return, including forms such as Profit or Loss from Business or Profession (Schedule C), Computation of Social Security Self-Employment (Schedule SE), Farm Income and expenses (Schedule F), Depreciation and Amortization (Form 4562), or U.S. Partnership Return of Income (Form 1065).
- (ii) The property is essential to the client's self-support.
- (iii) The property is in current use or, if not in use for reasons beyond the control of the financial group, there must be a reasonable expectation that the required use will resume.

461-145-0250

Examples of income-producing property for Food Stamps:

Example 1: Client reports renting out a room in her home. She receives \$200 a month rent. The client is billed \$500 a month for shelter (rent or mortgage) and pays separately for heating the home. This is a shared shelter situation. Subtract the \$200 rent payment from the shelter costs and allow the client a shelter deduction of \$300 and the FUA. There is no countable income from renting the room.

Example 2: Client reports renting out part of her home to two other individuals. She receives \$400 a month from each. The client is billed \$500 mortgage payment plus \$50 a month taxes and \$25 a month insurance. This is a shared shelter situation. Subtract the

\$400 + \$400 from the client's \$575 shelter costs to leave an excess rental income of \$225. Code zero shelter cost for the client and allow the FUA because she pays the heating costs. Code the \$225 excess rental income as PTY. She is probably not actively working 20 hours a week at renting these two rooms, so the income is not self-employment. The \$225 can only be reduced further if there is an allowable cost. For example: \$5 a month advertisement fee to the local paper regarding the room rental. In that situation the income could become \$220 instead of \$225. Do not allow a cost for mortgage, taxes, insurance, or utilities because they have already been considered for the shelter cost and FUA determination.

Example 3: Client reports buying a motel. She lives in the manager's apartment and manages the motel. She also does part of the maid work each day. She is actively working in the motel more than 20 hours a week. The client is not being billed separately for rent and utilities from the motel mortgage and utility bills. Do not allow the shelter cost or FUA. There are allowable costs to running this business. Code the gross income from the business as SEC.

Example 4: Client has two rental cabins on the same property as his home. He is in the process of repairing and fixing these cabins. He has rented one cabin for \$500 and plans to rent the second cabin for \$500 soon. He is doing all of the repairs himself in his spare time. He estimates he is working on the repairs about 15 hours a week. He is spending an average of \$250 a month to make these repairs and he provides receipts for the past three months. The units are in sad repair and will take many more months of work. Each unit has its own utility meter and the utilities are put into the renter's name. His mortgage payment for the full property is \$1,100 a month plus taxes and insurance. Allow him the full shelter cost of \$1,100 plus taxes and insurance. He has rental income of \$500 less the allowable cost for repairs. There is no allowable cost for mortgage, taxes, insurance, or utilities because there are no separately identified bills for each structure. Code \$250 as PTY (\$500 rental income less actual costs of \$250).

Example 5: Client owns two houses. He lives in one and rents out the other for \$1000 a month. Each house has its own mortgage, taxes, and insurance. The renter is responsible for all utilities at the rental. Currently there are no repairs or other costs associated with renting the house. The mortgage, taxes, and insurance on the rental totals \$900 a month. Rental income of \$1000 less allowable costs of \$900 = \$100 excess income. Code \$100 as PTY.

36. Income-Producing Sales Contract

An income-producing contract is an agreement between two parties where one party is to pay the other party on an ongoing basis for property or goods. A common income-producing contract exists when the client sells land or a home to another party and the other party pays the client an agreed upon monthly or periodic payment.

- (1) Treat the equity value of income-producing sales contracts as follows:
 - (a) For GA and GAM, count it as a resource.
 - (b) For all programs except GA and GAM, exclude it.
- (2) For all programs except GA and GAM, count the income received from the sales contract, per CA B.67 and OAR 461-145-0460.

461-145-0240

37. Independent Living Subsidies/Chaffee Housing Program

Independent Living Subsidies are payments made and services provided by Child Welfare to children ages 16 through 20. These payments also include payments under the Chaffee Housing Program. The subsidies are to assist the individuals to live independently when their foster care payments were discontinued on or after the date they reached 16 years of age.

Note: For a description of these payments, see OAR 413-030-0400 to 0455.

- (1) For all programs except EA and FS, exclude all independent living subsidies issued by Child Welfare.
- (2) For EA and FS, count the payments as unearned income.

Note: See Educational Income for Chaffee Education and Training Grant – CA B.24 and MPWG #14.

461-145-0255

38. Indian (Native American) Benefits

Individuals enrolled as a member in a tribe or band may receive income from the tribe. The income may or may not be prescribed by law. The recipient should have documentation showing the type of payment and where it originated.

Note: The tribal office may also verify if the payment is made under a specific public law (P.L.) and the P.L. number.

Process to determine Indian income

Anytime a client states they are Native American, determine the following:

- Name of the tribe the person has a membership.
- What benefits do they receive from the tribe or from Bureau of Indian Affairs (BIA).
- Ask if they receive any kind of income, including per capita payments, and how often received.
- Verify the kind of payment and if it issued under a specific public law number. The treatment of income for some public laws is noted in this policy. If the public law number is not present in this policy, contact a program analyst with the public law number to research and determine if the income is counted or excluded.

- (1) For all programs, count as unearned income any payments distributed by the tribe or band, which is not excluded under public law. This can include profit share or per capita income from tribal casinos, timber sales, or sale of oil reserves. Payments made to tribal members from these profits are counted if the income is anticipated to be recurring (monthly, quarterly, semi-annually, or once a year). One time payments are nonrecurring and are counted as lump sum income. (CA A.5). Treat recurring payments received less often than monthly as periodic income. (CA A.6).

Caution: Some per capita payments for timber or mineral sales may be counted while others are excluded. They are excluded only if the sales are off lands held in trust by the Secretary of the Interior. The tribal office will know if any part of the per capita payment was from lands held in trust.

- (2) Commercial fishing income received by members of the Yakima, Warm Springs, Umatilla, or Nez Perce tribes under the Columbia River Fishing Treaty is counted as earned income.

Note: Members may argue the income is excluded, but the treaty only excludes the income for income tax purposes. The treaty does not exclude the income for cash, medical, or food stamp eligibility.

- (3) Treat general assistance payments as follows:
 - (a) For all programs except FS, exclude Bureau of Indian Affairs (BIA) General Assistance program payments. Count as unearned income for FS.
 - (b) Some tribes use tribal funds for general assistance programs. The payments received under general assistance programs funded by the tribe are counted as unearned income.

Note: The Bureau of Indian Affairs (BIA) considers our cash programs as a prior resource to their General Assistance program. If BIA General Assistance payments continue after the client has started receiving benefits from the department, remind the client to tell BIA about receiving department benefits.

- (4) See Educational benefits in Counting Client Assets B.24 or OAR 461-145-0150 for how to treat BIA educational income.
- (5) Treat payments from tribal-TANF the same as TANF in Counting Client Assets B.57 (OAR 461-145-0410 for program benefits).
- (6) Payments made under the Old Age Assistance Claims Settlement Act (P.L. 98-500, Section 8) to heirs of deceased Indians are excluded except for per capita shares in excess of \$2,000. The first \$2,000 of each payment is excluded as income and as a resource. Count the remainder as lump sum income.
- (7) For all programs, exclude the following:
 - (a) The value of Indian lands held jointly with the tribe, or land that cannot be sold without the approval of the Bureau of Indian Affairs.
 - (b) Funds, assets, or income received from the trust fund established and paid to the Puyallup Tribe of the State of Washington under Section 9(b) of the Puyallup Tribe of Indians Settlement Act of 1989 (P.L. 101-41).
 - (c) Payments to the Confederated Tribes of the Colville Reservation under the Grand Coulee Dam Settlement Act, section 7(b) (P. L. 103-436).
- (8) For GA and GAM, count Indian benefits described in subsection (9) through (15) of this section as periodic or lump sum income unless the client verifies that such benefits are excluded by public law for state-funded programs.
- (9) Assistance paid for Child Welfare under the Indian Child Welfare Act of 1978, (P.L. 95-608) is excluded. This act provides for child and family service grant programs in preparation and implementation of child welfare codes. The programs may include, but are not limited to, family assistance, including homemaker and home counselors, day care, after school care, and employment, recreational activities, and respite care.
- (10) Tribal payments for child care are treated as follows:
 - (a) Provider-direct payments are counted as the provider's earned income.
 - (b) All client-direct payments are excluded.

Note: The client is not allowed a child care deduction for FS for the reimbursed part of their cost.

- (11) Many tribes or bands have received judgments or settlements under public law or a treaty with the United States. Some but not all are identified below. For all programs except GA and GAM, exclude the following payments as income or resources:

Note: There may be other payments excluded under other public laws. Call the policy unit if a client provides information regarding payments under a specific public law not listed in this policy.

- (a) Payments from the distribution of funds held in trust to the Seminole Indians of Florida under P.L. 84-736.
- (b) Payments from the distribution of funds held in trust to the Pueblos of Zia and Jemez tribes of Florida under P.L. 84-926.
- (c) Per capita payments from a distribution of judgment funds and made by the Indian Claims Commission to the Blackfeet and Gros Ventre Tribes of the Fort Belknap Reservation in Montana under P.L. 92-254.
- (d) Payments from the distribution of funds held in trust to the Stockbridge Munsee Indian Community of Wisconsin under P.L. 92-480.
- (e) Payments from the distribution of funds held in trust to the Burns Indian Colony in Oregon under P.L. 92-488.
- (f) Relocation assistance payments to members of the Navaho or Hopi Tribes under P.L. 93-531, section 22.
- (g) Income derived from distribution of receipts from submarginal land held in trust by the United States under Public Law 94-114, section 6, for the following tribes:
 - Assiniboine and Sioux Tribe of Montana;
 - Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin;
 - Blackfeet Tribe of Montana;
 - Cherokee Nation of Oklahoma;
 - Cheyenne River Sioux Tribe of South Dakota;
 - Chippewa Tribe of Minnesota;
 - Crow Creek Sioux Tribe of South Dakota;
 - Devil's Lake Sioux Tribe of North Dakota;
 - Fort Belknap Indian Community of Montana;

- Keweenaw Bay Indian Community of Michigan;
 - Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin;
 - Lower Brule Sioux Tribe of North Dakota;
 - Navajo Tribe of New Mexico;
 - Oglala Sioux Tribe of South Dakota;
 - Rosebud Sioux Tribe of South Dakota;
 - Shoshone – Bannock Tribes of Idaho;
 - Standing Rock Sioux Tribe of North Dakota;
- (h) Per capita payments made by the Indian Claims Commission from the disposition of funds held in trust to the Grand River Band of Ottawa Indians under Public Law 94-540.
- (i) Indian Claims Commission payments on judgment funds to the Confederated Tribes and Bands of the Yakima Nation or Apache Tribe of the Mescalero Reservation under P.L. 95-433, Section 2.
- (j) Payments made by the Indian Claims Commission to the Passamaquoddy Tribe and Penobscott Nation and the Houlton Band of Maliseet Indians or any of their members received under the Maine Indian Claims Settlement Act of 1980 (P. L. 96-420, sections 5 or 9(c)).
- (k) Payments on judgments funds to the Turtle Mountain Band of Chippewas, Arizona under P.L. 97-403.
- (l) Payments on judgment funds to the Blackfeet, Gros Ventre, and Assinoboine tribes (Montana) and the Papago (Arizona) under P.L. 97-408.
- (m) Judgment funds held in trust and per capita and interest payments disbursed to the Red Lake Band of Chippewa Indians under P.L. 98-123, section 3.
- (n) Judgment funds held in trust and per capita and interest payments made to the members of the Assiniboine Tribe of the Fort Belknap Indian Community (Montana) and the Assiniboine Tribe of the Fort Peck Indian Reservation (Montana) under P.L. 98-124, section 5.
- (o) Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior under P.L. 99-146, Section 6(b). The funds are distributed to the following reservations:
- Wisconsin: Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Lac Courte Oreilles Band of

Lake Superior Bands of Chippewa Indians of the Lac du Flambeau Reservation, Sokaogon Chippewa Community of the Mole Lake Band of Chippewa Indians, Red Cliff Reservation, St. Croix Chippewa Reservation;

- Michigan: Keweenaw Bay Indian Community (l'Anse, Lac Vieux Desert, and Ontonagon Bands);
 - Minnesota: Fonde du lac Reservation, Grand Protage Reservation, Nett Lake Reservation (including Vermillion Lake and Deer Creek), White Earth Reservation;
- (p) Payments and funds held in trust to the White Earth Band of Chippewa Indians in Minnesota under the White Earth Reservation Land Settlement Act of 1985, Section 16 (P.L. 99-264).
- (q) Per capita payments and income from a distribution of funds held in trust to the Saginaw Chippewa Tribe of Michigan under P.L. 99-346, Section 6(b)(2).
- (r) Judgment payments disbursed to the Umpqua Tribe Cow Creek Band under Public Law 100-139.
- (s) Settlement payments, funds distributed or held in trust to members of the Seneca Nation under P.L. 101-503, Section 8(b) the Seneca Nation Settlement Act of 1990.
- (t) Payments to the Aroostook Band under the Micmacs Settlement Act (P.L.102-171).
- (u) Distributions of judgment funds to the Ottawa and Chippewa Indians of Michigan under P.L. 105-143, Michigan Indian Land Claims Settlement Act.
- (12) Per capita payments from the distribution of judgment funds to the Confederated Tribes of the Umatilla Indian Reservation under P.L. 91-259 are excluded, except per capita payments in excess of \$2,000 are counted as lump sum income (CA A.5).

Caution: The exclusion for the per capita payments made from funds held in trust under this law does not apply to per capita payments received from other assets owned by the tribe.

- (13) Per capita payments for assets held in trust to the Sax and Fox Tribe of Oklahoma and Sac and Fox Tribe of the Mississippi in Iowa by the Indian Claims Commission under P.L. 94-189, Section 6 (The Sac and Fox Indian Claims Agreement), are excluded except per capita payments in excess of \$2,000 are counted as lump-sum income (CA A.5).

- (14) Per capita payments distributed or held in trust to the Chippewas of Mississippi under P.L. 99-377 Section 4(b), to those with affiliation with the Mille Lac, White Earth, and Leech Lake Reservations in Minnesota, and paid by the Indian Claims Commission are excluded except per capita payments in excess of \$2,000 are counted as lump-sum income (CA A.5).
- (15) Funds distributed to the Hoopa Valley Tribe and the Yurok Tribe under P.L. 100-580, the Hoopa-Yurok Settlement Act, and paid by the Indian Claims Commission are excluded except per capita payments in excess of \$2,000 are counted as lump-sum income (CA A.5).
- (16) Funds appropriated in satisfaction of judgments awarded to the Seminole Indians under P.L. 101-277 and paid by the Indians Claims Commission are excluded except per capita payments in excess of \$2,000 per financial group member receiving such payment. Payments are allocated to members of the Seminole Nation of Oklahoma, Seminole Tribe of Florida, the Muccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida.
- (17) For all programs except GA and GAM, the interests of individuals in trust or restricted lands are not counted as a resource under P. L. 93-134, P.L. 97-458 and Public Law 103-66. In addition, payments received from these lands are excluded.
- (18) For all programs except GA and GAM, exclude per capita payments from judgment funds held in trust by the Secretary of the Interior (trust fund distributions) under P.L. 98-64.

Note: Per capita payments may be authorized for specific tribes under other public laws. Also, the funds in (10) and (11) are disbursed from different sources and therefore are treated differently.

- (19) For all programs except GA and GAM, treat payments made under P.L. 92-203, section 29, Alaska Native Claims Settlement Act as follows:
 - (a) For FS, exclude the entire payment.
 - (b) For all other programs, except FS, GA, and GAM, exclude only the tax-exempt portion of the payment. Count the remainder as unearned income.
- (20) For all programs except GA and GAM, treat payments made under Public Law 100-241, section 15, Alaska Native Claim Settlement Act Amendments of 1987, as follows:
 - (a) Exclude the value of stock, partnership interest, land, or interest in land and an interest in a settlement trust.
 - (b) Exclude the first \$2,000 of each per capita payment per financial group member receiving such payment per year.

- (c) Count the amount over \$2,000 as lump sum income (CA A.5).

461-145-0260

39. Individual Education Account (IEA)

The IEA is an asset accrued by JOBS Plus participants. Exclude the IEA while it accumulates, while it is saved, and when it is withdrawn for educational purposes.

For the FS program, also exclude funds in a qualified tuition program under section 529 of the Internal Revenue Code or in a Coverdell education savings account.

461-145-0145

40. Inheritance

- (1) An inheritance may be received in the form of monies, property, or other assets.
- (2) An inheritance is treated as follows:
 - (a) In all programs except for the ERDC program:
 - (A) A noncash inheritance is treated according to the policy for a specific type of asset inherited.
 - (B) A cash inheritance is counted as periodic (see OAR 461-140-0110) or lump-sum income (see CA A.5 and 461-140-0120).
 - (b) In the ERDC program, an inheritance is excluded.

461-145-0270

41. In-Kind Income

In-kind income is compensation in a form other than money (such as food, clothing, cars, furniture, and payments made to a third party). (See OAR 461-001-0000.)

☞ SEE CA B.67 FOR HOW TO TREAT SHELTER-IN-KIND INCOME.

- (1) For all programs, treat unearned third-party payments as follows:
 - (a) Count payments made to a third party that should legally be paid directly to a member of the financial group as unearned income. This includes court-ordered support payments that the noncustodial parent makes voluntarily to the landlord or mortgage company on behalf of the financial group.
 - (b) Treat payments made to a third party that the payee is not legally obligated to pay directly to a member of the financial group and that the group does

not have the option of taking as cash, and payments made by the noncustodial parent to a third party, that are court-ordered but not designated as child support, as follows:

- (A) For FS, exclude these third-party payments (except per (4) below) unless they are transitional housing payments for the homeless.

Note: Transitional housing for the homeless is a shelter or residence for homeless individuals as they transition to regular housing. There is generally a time limit for the transition period and it may be 24 months.

- (B) In MAA, MAF, REF, REFM, SAC, and TANF, except for child support (see 461-145-0080), these third party payments are excluded.
- (C) In OHP, these third-party payments are counted (except per (5) below).
- (D) For all other programs, exclude these third-party payments.

☞ FOR INFORMATION ON HOW TO TREAT OTHER THIRD-PARTY PAYMENTS MADE BY A NONCUSTODIAL PARENT, SEE CA B.13 OR OAR 461-145-0080.

- (2) For all programs except EXT, MAA, MAF, OHP, REF, REFM, SAC, and TANF, treat earned in-kind income according to CA B.21 and CA B.22 (OAR 461-145-0130).
- (3) For all programs except EXT, MAA, MAF, OHP, REF, REFM, SAC, and TANF, treat unearned in-kind income (except third-party payments) as follows:
- (a) Exclude court-ordered community service work or bartering. Bartering is the exchange of goods of equal value.
- (b) Treat items such as cars and furniture according to the administrative rule for the specific type of asset.
- (4) For EXT, MAA, MAF, REF, REFM, SAC, and TANF, exclude all in-kind income (except unearned third party payments).

461-145-0280

- (5) For FS and OHP, exclude in-kind income except count as income child support (461-145-0080) or the expenditures (payments for food, clothing, cars, furniture, shelter, etc.) by a business entity that substantially benefits a principal who is a member of the OHP financial group. A “principal” is a person with significant authority in the business entity, such as the proprietor of a sole proprietorship, including a person who is self-employed, or a partner of a partnership, or a member or manager of a limited liability company, or an officer or principal stockholder of a closely held corporation (OAR 461-145-0088).

Example: Mr. Clean is a partner in a business called Just Right Cleaners. The business makes monthly payments for his car of \$420 each month, house payment of \$1,025, car insurance for \$87.50 for a total of \$1,532.50. These amounts are considered in-kind income and, as well as any other income paid to Mr. Clean, are considered countable income and used to determine eligibility.

461-140-0040
461-145-0120
461-145-0470

42. Job Corps

Job Corps payments are treated as follows:

- (1) A living allowance payment is counted as earned income.
- (2) A readjustment allowance payment is treated as follows:
 - (a) In all programs except the FS program, this payment is counted as earned income.
 - (b) In the FS program, this payment is counted as lump-sum income (CA A.5).
- (3) A support service payment for an item already covered by the benefits of the benefit group is counted as unearned income. All other support service payments (including clothing allowances) are excluded.
- (4) A reimbursement is treated as provided in CA B.63 or OAR 461-145-0440.

Note: JOBS participants in Job Corps get JOBS child care payments instead of a TANF child care payment.

Note: PIVOT (Partners in Vocational and Occupational Training) is a Job Corps program for participants 17-21 years of age, who have had a child by age 17. Treat PIVOT living allowance payments as (1) above.

461-145-0290

43. Life Estate

- (1) A *life estate* (See OAR 461-001-0000) is the right to property limited to the lifetime of the person holding it or the lifetime of some other person. In general, a *life estate* enables the owner of the *life estate* to possess, use, and obtain profits from property during the lifetime of a designated person while actual ownership of the property is held by another individual. A *life estate* is created when an individual owns property and then transfers their ownership to another while retaining, for the rest of their life, certain rights to that property. In addition, a *life*

estate is established when a member of the financial group purchases a *life estate* interest in the home of another individual.

- (2) For all programs except OSIP, OSIPM, and QMB, if a financial group is living in real property while a member holds a *life estate* in this property, the property is treated as a home (see OAR 461-145-0220). In all other situations, a *life estate* is treated as real property (see OAR 461-145-0420).

☞ SEE DMAP WORKER GUIDE #7 FOR MORE INFORMATION.

- (3) In the OSIP, OSIPM, and QMB programs:
 - (a) A transfer for less *than fair market value* (see OAR 461-001-0000) in which a member of the financial group retains a *life estate* is a disqualifying transfer. A transfer is considered for less than *fair market value* if the *fair market value* of the transferred resource on the day prior to the transfer is greater than the sum of the value of the rights conferred by the *life estate* plus the compensation received for the transfer. For purposes of this subsection, the value of the rights conferred by the *life estate* is established by the Life Estate and Remainder Interest Table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(A).
 - (b) If a member of the financial group purchases a *life estate* interest in the home of another individual on or after July 1, 2006, the purchase is considered a transfer of resources unless the client resides in this home for at least 12 consecutive months after the date of the purchase. The value of the transfer for a client who does not reside in the home for at least 12 consecutive months is calculated by using the purchase price of the *life estate*.

Note: See SPD Worker Guide E.3 located at http://www.dhs.state.or.us/spd/tools/additional_man/workergd/e.3.htm for an example and the Life Estate and Remainder Interest Table. For technical assistance, contact Estates Administration.

☞ SEE OAR 461-140-0210 FOR MORE ON TRANSFER OF RESOURCES.

461-145-0310

44. Life Insurance

Note: *Burial insurance that has cash surrender value is treated in the same manner as life insurance.*

- (1) Count payments made to the beneficiary of a life insurance policy as unearned income. Allow a deduction, not to exceed \$1,500, for the cost of the deceased person's last illness and burial cost (if these costs were not otherwise insured).

- (2) Treat the equity value of a life insurance policy as follows:
- (a) For all programs except GA, GAM, OSIP, OSIPM, and QMB, exclude the cash surrender value of the life insurance policy.
 - (b) For grandfathered OSIP and OSIPM clients, the total exclusion available for life insurance and burial arrangements is limited per OAR 461-145-0040 (2)(b).
 - (c) For GA, OSIP, OSIPM, and QMB, except as provided in (b) above, exclude the total cash surrender value of life insurance policies owned by the client or their spouse if the total face value of all policies is less than or equal to \$1,500. If the total face value of all policies is more than \$1,500, count the entire cash surrender value as a resource. The total face value does not include dividend additions that increase the death benefit and cash surrender value.
 - (d) Exclude all term insurance that has no cash surrender value.
 - (e) For GA, GAM, OSIP, OSIPM, and QMB, the cash surrender value of a policy acquired through a viatical settlement is excluded. A viatical settlement allows a third party to acquire the life insurance policy from a terminally ill person at an agreed upon percentage of the life insurance policy face value.

461-145-0320

45. Loans and Repayment of Loans

This policy covers proceeds of loans, loan repayments, and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the other rules in this division of rules.

- (1) A “reverse-annuity mortgage” means a contract with a financial institution under which the financial institution provides payments against the equity in the home that must be repaid when the homeowner dies, sells the home, or moves. A “reverse-annuity mortgage” is sometimes referred to in the private sector as a reverse mortgage or a home equity conversion mortgage. The proceeds of a home equity loan or *reverse-annuity mortgage* are considered loans.

Note: A reverse mortgage can be received by a person age 62 or older as a loan against the equity in their home. The loan is due for repayment when the borrower permanently moves out or sells the property or upon death of the borrower.

- (2) A loan is defined as:
- (a) Except for FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, a written agreement between the borrower and lender. The written agreement must stipulate a repayment plan, and be signed and dated before the receipt of money.
 - (b) In the FS, GA, GAM, OHP, OSIP, OSIPM, and QMB programs, the loan agreement may be written or oral and state when repayment is due to the lender.
 - (c) For GA, GAM, OSIP, OSIPM, and QMB, a “bona fide loan agreement” means an agreement that:
 - (A) Is enforceable under state law;
 - (B) Is in effect at the time the cash proceeds are provided to the borrower; and
 - (C) Includes an obligation to repay and a feasible repayment plan.
 - (d) “Negotiable loan agreement” means a loan agreement in which the instrument ownership and the whole amount of money expressed on its face can be transferred from one person to another (i.e., sold) at prevailing market rates.
- (3) Payments for a purported loan that do not meet the requirements of (2) are treated as unearned income.
- (4) When the financial group receives cash proceeds as a borrower from a loan:
- (a) Treat educational loans according to CA B.24 or OAR 461-145-0150.
 - (b) If the loan is used to purchase a noncash asset (e.g., a car), treat it according to the policy for that asset.
 - (c) For ERDC, EXT, FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF, exclude loans obtained by the financial group in the month received. If retained after the month of receipt, treat in accordance with OAR 461-140-0070.
 - (d) For GA, GAM, OSIP, OSIPM, and QMB:
 - (A) If the loan is a bona fide loan agreement, the money provided by the lender is not income but is counted as the borrower’s resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).
 - (B) If the loan is not a bona fide loan agreement, the money provided by the lender is counted as income in the month received and is counted

as a resource if retained in the month following the month it was received.

- (5) Unless the loan is considered a transfer of assets for less than *fair market value* (see section (6) below), when a member of a *financial group* is the lender, the loan is treated as follows:
 - (a) In the GA, GAM, OSIP, OSIPM, and QMB programs:
 - (A) If the loan is both a *negotiable loan agreement* and a *bona fide loan agreement*, the loan is counted as a resource of the lender valued at the outstanding principal balance.
 - (B) If the loan does not qualify under paragraph (A) of this subsection, the transfer of assets to the borrower may be considered a transfer for less than *fair market value* (see OAR 461-001-0000). If the transfer is not disqualifying, payments against the principal are counted as income to the lender.
 - (C) Interest income received by the lender is counted as unearned income whether the loan is a *bona fide loan agreement* or not.
 - (b) In all programs other than the GA, GAM, OSIP, OSIPM, and QMB programs, count as unearned income payments made to the financial group on the interest portion of a loan the group has made to someone else. Exclude payments received on the principal.
- (6) In the GA, GAM, OSIP, OSIPM, and QMB programs, in a transaction occurring on or after July 1, 2006, if a client or a spouse of a client uses funds to purchase a mortgage or to purchase or lend money for a promissory note or loan, the balance of the payments owing to the client or spouse of the client is a transfer of assets for less than *fair market value*, unless all of the following requirements are met:
 - (a) The total value of the transaction is being repaid to the client or spouse of the client within that person's actuarial life expectancy as established by the Period Life Table of the Office of the Chief Actuary of the Social Security Administration.

☞ SEE SPD WORKER GUIDE E. TREATMENT OF ANNUITIES
 - (b) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.
 - (c) The contract is not cancelled upon the death of the client or the spouse of the client (who made the transaction).

Example: An applicant states she is meeting her needs with a \$300 loan from her sister each month. She has applied for SSI. The sister confirms she is loaning the money and expects repayment when her sister's income begins. This meets the definition of a loan for FS, OSIP

and QMB. It can only be considered a loan for ERDC, MAA, MAF, REF, SAC, or TANF if the agreement was written prior to the receipt of the funds.

461-145-0330

46. Lodger Income

A lodger is a member of the household who pays the filing group for room and board and who is not a member of the filing group. Lodger income is the amount the lodger pays the filing group for room (rent) and board (meals).

Lodger income is treated as follows:

- (1) In the MAA, MAF, REF, REFM, SAC, and TANF programs, lodger income not excluded under OAR 461-155-0350 is treated as self-employment income.
- (2) In all programs except MAA, MAF, REF, REFM, SAC, and TANF, lodger income is treated as self-employment income.

461-145-0340

47. Manufactured and Mobile Homes

- (1) Manufactured and mobile homes are treated in the same manner as real property under OAR 461-145-0420.

☞ SEE CA B.59 FOR REAL PROPERTY.

- (2) Manufactured and mobile homes are subject to OAR 461-145-0220 and OAR 461-145-0250 if applicable.

☞ SEE CA B.32 FOR HOME OR CA B.34 FOR INCOME PRODUCING PROPERTY.

461-145-0343

48. Military Income

This policy is regarding pay and allowances of a member of a uniformed service. This income is treated as follows:

- (1) For all programs, military pay and allowances of a member of the United States Armed Forces in the financial group is counted as earned income (CA B.22). Except for FS, the amount reduced from basic pay for the GI Bill is excluded per PL 99-576, Veterans Education Act of 1984.

- (2) For all programs except FS, the military pay and allowances of a member of the United States Armed Forces, who is not in the filing group, but available to the financial group is counted as unearned income.
- (3) For FS, if the member of the United States Armed Forces is not included in the filing group, income available to the financial group from this source is counted as unearned income. The additional pay made, due to deployment to a designated combat zone per the Consolidated Appropriations Act of 2005 (PL. 108-447), is excluded. The additional pay must be the result of the deployment to a designated combat zone and not received immediately prior to serving in the combat zone.

In FS, the absent military member of a household is not included in the FS filing group. Only the money they send home, or make available to the group at home, is counted as unearned income. This income is generally made available to the FS filing group in one of several ways:

- (a) Via a direct deposit of all or a portion of the military person's pay into a joint bank account;
- (b) Via an allotment arrangement made by the military person for a portion of his or her pay to be sent to the filing group; or
- (c) Via a direct payment (such as a check) from the military person to the filing group.

All three of these methods are called military service allotments. Regardless of the arrangement made by the absent military member, only the portion of his or her pay, to which the filing group has access, is counted as unearned income to the group.

Workers are required to determine if any of the military allotment available to the filing group should be excluded for FS because the military person is deployed to a designated combat zone.

Procedures for determining the amount of military allotment to count:

- Establish the amount of the military person's pay that was available to the filing group prior to deployment to a designated combat zone.

Available means income that the filing group received and could spend as well as any of the income that may have been direct deposited and automatically used to pay the mortgage, utilities, common bills, etc.

Note: If, in the unlikely instance that the military person was a member of the filing group immediately prior to deployment, that person's military income needs to change from the gross earned income to their net military pay for this step.

- Next, determine the amount of military pay that the deployed person is making available to the filing group now.
 - If the current amount is equal to or less than the amount the household was receiving prior to the deployment to a combat zone, count all of the allotment as unearned income.
 - Exclude any portion of the deployed person’s military pay that exceeds the amount the group received prior to deployment to a combat zone.
 - Code the countable part of the military allotment as WAR on page 2 of the FCAS screen.

How to verify this income.

There are several ways the family at home can verify the situation.

- The deployed person’s military pay record (Leave and Earnings Statement – LES) is sometimes sent directly to the family at home or can be mailed to the family by the deployed person. The LES will identify the combat zone and if combat pay is being received.
- Deployment to a combat zone can also be established via a copy of the deployment orders.
- If the family does not have a copy of the LES, they may be able to access the information via the web at <https://mypay.dfas.mil/mypay.aspx>. To do this, they need the SSN of the deployed person and their password.
- The filing group may also seek assistance from the local base financial office for the needed combat zone and pay information.
- If the payment is coming to the filing group via direct deposit, the bank statement can also verify the monthly allotment.

The additional pay is excluded when an absent military person with one of these two pay codes is deployed to one of the following combat zones.

- 301 Incentive pay: hazardous duty
- 310 Special pay: duty subject to hostile fire or imminent danger

List of the combat zones allowed the exclusion:

- | | | | |
|-------|--|-------|------------|
| (301) | The Adriatic Sea | (320) | Kuwait |
| (302) | Afghanistan | (321) | Kyrgyzstan |
| (304) | Albania | (322) | Macedonia |
| (305) | Arabian Sea Portion that lies north of 10° North Latitude and west of 68° East Longitude | (323) | Oman |
| (306) | Bahrain | (324) | Pakistan |

(307)	Bosnia	(325)	Persian Gulf
(308)	Croatia	(326)	Philippines (only troops with orders that reference Operation Enduring Freedom (OEF))
(310)	Djibouti	(327)	Qatar
(311)	Egypt	(328)	Red Star
(312)	The Federal Republic of Yugoslavia (Serbia and Montenegro)	(329)	Saudi Arabia
(313)	Gulf of Aden	()	Somalia
(314)	Gulf of Oman	(330)	Tajikistan
(315)	Herzegovina	(331)	Turkey
(316)	The Ionian Sea north of the 30 th Parallel	(332)	United Arab Emirates
(317)	Iraq	(333)	Uzbekistan
(318)	Israel	(334)	Yemen
(319)	Jordan		

461-145-0345

49. Motor Vehicle; FS

☞ SEE CA B.50

461-145-0360

50. Motor Vehicle

☞ SEE CA A.3 FOR HOW TO DETERMINE THE FAIR MARKET VALUE OF VEHICLES.

- (1) For FS, MAA, MAF, REF, REFM, SAC, and TANF, exclude up to \$10,000 equity value of all licensed and unlicensed motor vehicles. Count the remaining equity value as a resource.

☞ SEE TANF G-3 FOR MORE INFORMATION ON HOW TO DETERMINE THE RESOURCE VALUE OF MOTOR VEHICLES FOR TANF.

- (2) For EA, ERDC, and OHP, exclude all motor vehicles.
- (3) For GA and GAM, exclude up to \$4,500 equity value of one licensed motor vehicle selected by the financial group. Count any remaining equity in that vehicle and the total equity value of all other vehicles as a resource.
- (4) For grandfathered OSIP and OSIPM financial groups, exclude one motor vehicle in operating condition and count the equity value of any other motor vehicles as a resource.

- (5) For OSIP, OSIPM, and QMB:
 - (a) Exclude the total value of a vehicle selected by the financial group if it is used for employment or necessary and continuing medical treatment. If not, exclude the first \$4,500 of the fair market value.
 - (b) Count the amount above \$4,500 as a resource.
 - (c) Count the total equity value of all other vehicles as a resource.
- (6) For OSIP and OSIP-EPD clients, if a vehicle was purchased as an employment and independence expense (see OAR 461-001-0035), or with moneys from an approved account (CA B.7), exclude the total value of the vehicle.

☞ SEE CA B.61 OR OAR 461-145-0433 FOR INFORMATION ON HOW TO TREAT RECREATIONAL VEHICLES.

461-145-0360

51. National and Community Services Trust Act (NCSTA/AmeriCorps)

- (1) The National and Community Service Trust Act (NCSTA) of 1993 (P.L. 103-82) amended the National and Community Service Act (NCSA) of 1990 (P.L. 101-610) that established a Corporation for National and Community Service. The Corporation administers national service programs providing living allowance, educational award, child care, and in-kind benefits.
- (2) NCSTA payments, including AmeriCorps (except AmeriCorps VISTA which is covered in OAR 461-145-0110) are treated as follows:
 - (a) The living allowance (stipend benefits) is excluded.
 - (b) Educational award and in-kind benefits are treated as follows:
 - (A) In the GA program, these benefits are treated according to the policy for the specific type of asset.
 - (B) In all programs except GA, these benefits are excluded.
 - (c) The child care allowance is treated as follows:
 - (A) For clients in the ERDC, MAA, REF, SAC, and TANF programs who are eligible for direct provider payment of child care, the allowance is counted as unearned income. The allowance is excluded only if the client already pays the provider. The provider may be paid for only the costs not covered by the allowance.

(B) For clients in the FS program who are receiving a child care deduction, the allowance is excluded as income and the deduction is allowed only for the costs not covered by the allowance.

(C) In all other programs, the allowance is excluded.

Note: The programs administered by the corporation under the NCSTA include AmeriCorps USA and AmeriCorps NCCC. The corporation also oversees the Senior Corps, the Earth Corps, and Learn and Serve. For information on how to treat AmeriCorps VISTA benefits, see CA B.20 (OAR 461-145-0110).

461-145-0365

52. Older Americans Act

For all programs except FS, GA, and GAM, exclude benefits under title III of the Older Americans Act of 1965 (Nutrition Program for the Elderly). For FS, GA, and GAM, count these benefits as unearned income.

For all programs except FS, count as earned income benefits paid to persons age 55 and older under title V of the Older Americans Act of 1965. The organizations receiving title V funds are: Green Thumb, Experience Works, American Association of Retired Persons, National Association for Spanish-Speaking Elderly, National Council on Aging, National Council on Black Aging, National Council of Senior Citizens, National Urban League, U.S. Forest Service. For FS, exclude all payments made under title V of this Act.

Note: In Oregon, some seniors working for Easter Seals may also be paid using title V funds. Confirm the funding source before excluding the income.

461-145-0370

53. Pension and Retirement Plans

(1) Pension and retirement plans include the following:

- (a) Benefits employees receive only when they retire. These benefits can be disbursed in lump-sum (CA A.5) or monthly payments.
- (b) Benefits that employees are allowed to withdraw when they leave a job before retirement.
- (c) The following retirement plans and annuities if purchased by a client with funds from the plans authorized by section 401 of the Internal Revenue Code of 1986:

(A) Traditional Defined-Benefit Plan.

(B) Cash Balance Plan.

- (C) Employee Stock Ownership Plan.
 - (D) Keogh Plan.
 - (E) Money Purchase Pension Plan.
 - (F) Profit-Sharing Plan.
 - (G) Simple 401(k).
 - (H) 401(k).
- (d) Retirement plans and annuities purchased by a client with funds from plans authorized by section 403 of the Internal Revenue Code of 1985 at subsections (a) or (b).
- (e) The following are retirement plan and annuities if purchased by the client with funds from the plans authorized by section 408 of the Internal Revenue Code of 1986.
- (A) Individual Retirement Annuity.
 - (B) Individual Retirement Account (IRA).
 - (C) Deemed Individual Retirement Account or Annuity under a qualified employer plan.
 - (D) Accounts established by employers and certain associations of employees.
 - (E) Simplified Employee Pension (SEP).
 - (F) Simple Individual Retirement Account (Simple-IRA).
 - (G) Roth IRA.
- (f) The following retirement plans and annuities offered by governments, nonprofit organizations, or unions:
- (A) 457(b) Plan.
 - (B) 401(c)(18) Plan.
 - (C) Federal Thrift Savings Plan under 5 USC 8439.
- (2) An annuity purchased by the spouse of a client with funds from a retirement plan described in (1)(c) of this subsection is not considered a retirement plan and is treated in accordance with a CA B.5 or CA B.6 (OAR 461-145-0020 and OAR 461-145-0022).

- (3) Treat benefits the client receives from pension and retirement funds as follows:
 - (a) Count monthly payments, minus any penalties for early withdrawal, as unearned income.
 - (b) Count all other payments as periodic (CA A.6) or lump-sum income.
- (4) In all programs except OSIP, OSIPM, and QMB, count the value of pension and retirement plans that allow clients to withdraw funds before retirement as follows:
 - (a) For all programs except FS and OHP, count as a resource the equity value of the plan, minus any penalty for early withdrawal.
 - (b) For FS, the value of retirement accounts identified in sections 401(a), 403(a), 403(b), 408, 408(k), 408(p), 408A, 451(b), or 501(c)(18) of the IRS code, or in a federal Thrift Savings Plan Account are excluded resources.
 - (c) For OHP, exclude the equity value of the plan.
- (5) In the OSIP, OSIPM, and QMB programs:
 - (a) Except for an annuity purchased with funds from a retirement plan described in subsection (1)(c) above:
 - (A) The equity value of a pension or retirement plan is excluded as a resource if the individual is eligible for monthly or periodic payments under the terms of the plans and has applied for these payments.
 - (B) The equity value of all pension and retirement plans not covered by paragraph (A) of this subsection that allow clients to withdraw funds minus any penalty for withdrawal, is counted as a resource.
 - (b) The equity value of an annuity purchased with funds from a retirement plan described in subsection (1)(c) above is excluded as a resource if it meets the payout requirements of 461-145-0022(10)(c). Otherwise, the equity value is counted as a resource.

461-145-0380

54. Personal Belongings

Personal belongings are such items as household furnishings, clothing, heirlooms, keepsakes, and hobby equipment. For all programs, exclude the value of all personal belongings.

461-145-0390

55. Personal Injury Settlement

- (1) For all programs except ERDC, treat personal injury settlements as follows:
 - (a) Count monthly payments as unearned income.
 - (b) For clients in all programs except grandfathered clients in OSIP and OSIPM, count all other payments as periodic (CA A.6) or lump-sum income (CA A.5).
 - (c) For grandfathered OSIP and OSIPM clients, count the balance from personal injury claims after the department's lien is satisfied as lump-sum income. If the lien was not filed due to the recipient's failure to notify the department of the claim, count the payment as unearned income.
- (2) For ERDC, exclude all personal injury settlements.

☞ FOR WORKERS' COMPENSATION PAYMENT, SEE CA B.85.

461-145-0400

56. Plan for Self-Support

A plan for self-support allows a client to retain a part of his or her assets for a specific period of time so they can meet specific occupational goals. The Social Security Administration may establish a plan for self-support with SSI recipients. SPD may also establish a plan for self-support with some GA, GAM, OSIP, OSIPM, or QMB clients that are not eligible for SSI.

- (1) This policy covers two types of plans for self-support.
 - (a) A plan for self-support approved by the Social Security Administration.
 - (b) A plan of self-support approved by the department (see OAR 461-135-0708).
- (2) Assets listed in an approved plan for self-support are treated as follows:
 - (a) In the Food Stamp program, assets designated for use in an approved plan for self-support are excluded.
 - (b) In all programs except FS, if assets are identified to meet a specific cost directly related to the occupational goal:
 - (A) Resources identified to meet costs, such as purchase of equipment for a trade or business, transportation, books, and maintenance costs at school, are excluded.

- (B) An income deduction is allowed for the amount identified to meet allowable costs necessary for complying with the plan for self-support including:
 - (i) Room and board, and other maintenance requirements, if the client must be away from home; and
 - (ii) Above-normal expense, if the client remains at home but must buy meals or incur other known expenses while away from home during the day.

461-145-0405

57. Program Benefits

- (1) Treat Pre-TANF Program payments as follows:
 - (a) In FS, count a payment for basic living expenses made directly to the client as unearned income. Exclude all other payments.

Note: For clients being certified for FS at the same time that Pre-TANF Program payments are being made, count payments for basic living expenses that can reasonably be anticipated. For other clients with ongoing prospectively budgeted FS benefits, count these payments after giving 10-day notice only if the payments can be anticipated for next month.
 - (b) In all programs except FS, exclude these payments.
- (2) Treat EA and TA-DVS payments as follows:
 - (a) In ERDC and FS, count a payment made directly to the client as unearned income. Exclude dual payee and provider-direct payments.
 - (b) In all programs except ERDC and FS, exclude these payments.
- (3) Exclude payments from ERDC and TANF child care unless the client is the provider.
- (4) Exclude payments from EXT, GAM, MAA, MAF, OHP, OSIPM, QMB, REFM, and SAC.
- (5) Treat Food Stamp payments as follows:
 - (a) Exclude the value of an FS benefit in all programs except EA. In EA, count the value as a resource when determining the emergency food needs of the filing group.
 - (b) Exclude OFSET service payments.

- (6) Treat benefits from GA, OSIP (except OSIP-IC), Post-TANF, REF, SFPSS, TANF, and tribal-TANF (including the 10 percent late-processing fee discussed in OAR 461-165-0150) as follows:
- (a) In the EA program, count these payments as unearned income, except exclude these payments for a benefit group whose emergent need is the result of domestic violence.
 - (b) In the ERDC program:
 - (A) Post-TANF payments are excluded.
 - (B) All other payments are counted as unearned income.
 - (c) In the FS program:
 - (A) Treat GA, OSIP, Post-TANF, REF, SFPSS, and TANF payments as unearned income.
 - (B) Treat an amount received as a late processing payment as lump-sum income.
 - (C) Treat payments made to correct an underpayment as lump-sum income (CA A.5).
 - ☞ SEE CA A.5 FOR LUMP SUM INCOME.
 - (D) Treat ongoing special needs payments for laundry allowances, special diet or meal allowance, restaurant meals, accommodation allowances, and telephone allowances as unearned income. Exclude all other special needs payments as reimbursements.
 - Note:** *In FS, the MNL HH-type to prevent the system from counting special needs payments that are excluded.*
 - Note:** *For FS, for telephone allowances: if a client was receiving a check each month for a telephone allowance which included payment for a basic telephone and a life line, the amount for basic telephone would be considered unearned income and the amount for the life line is considered a reimbursement.*
 - Note:** *For FS, if a client is eligible for a special need but rather than receiving a check has their pay-in reduced, the pay-in amount is considered a medical deduction plus any other out-of-pocket expenses that may be allowable medical deductions.*
 - (d) In the OHP program:
 - (A) Exclude GA payments from income for purposes of determining OHP eligibility.

- (B) Benefits from the Post-TANF program are excluded.
- (C) Treat benefits from OSIP (except OSIP-IC), Post-TANF, REF, SFPSS, and TANF (including the 10 percent late-processing fee discussed in OAR 461-165-0150) as follows:
 - (i) Count the payments as unearned income if all the individuals included in the benefit group for the cash payment are also in the OHP financial group.
 - (ii) Count a prorated share as unearned income if any of the individuals in the cash payment are not included in the OHP financial group. Determine a prorated share by dividing the total payment by the number of individuals in the TANF benefit group.
 - (iii) Exclude a payment made to correct an underpayment caused by the department if the underpayment occurred prior to the budget period.
- (e) In all programs except the EA, ERDC, FS, and OHP programs:
 - (A) Exclude these payments in the month received, and count any portion remaining following the month of receipt as a resource.
 - (B) Exclude payments made to correct an underpayment.
- (f) In all programs:
 - (A) Exclude JOBS, REF, and TANF JOBS Plus support service payments.
 - ☞ FOR HOW TO TREAT JOBS PLUS INCOME, SEE CA B.22.
 - (B) Treat REF and TANF client incentive payments as follows:
 - (i) Except in TANF, count the cooperation incentive payment (see OAR 461-135-0310) as unearned income.
 - (ii) Count progress and outcome incentive payments other than in-kind payments as lump-sum income (see OAR 461-140-0120). Exclude all other incentives.

☞ SEE CA B.21 AND CA B.22 OR OAR 461-145-0120 FOR TREATMENT OF SUBSIDIZED WAGES (E.G., JTPA WORK EXPERIENCE AND JOBS PLUS WAGES).

Note: *When a person is receiving TANF JOBS Plus, continue to code the TANF grant and the extra JOBS Plus \$10 payment as unearned income.*

- (7) Payments from OSIP-IC are treated as follows:
- (a) In the FS program, these payments are counted as unearned income and assets held in a contingency fund (see OAR 411-030-0020) are counted as a resource.
 - (b) In all other programs, these payments and funds held in a contingency fund are excluded.

461-145-0410

58. Radiation Exposure Compensation Act

Radiation Exposure Compensation Act payments are issued to compensate individuals for injuries or deaths resulting from exposure to radiation from nuclear testing or uranium mining.

For all programs, these payments are excluded.

461-145-0415

59. RARE

The Research Assistance for Rural Environments (RARE) is a program administered through the University of Oregon. The program assists rural communities in their efforts to improve their economic, social, and environmental conditions. Local communities request the assistance of this program and provide part of the funding. The program is supported through grants from various federal and state agencies. In addition, this program sometimes includes funding from The National and Community Services Trust Act (AmeriCorps).

RARE participants are graduate-level people who reside in the local community. They work in this program for 11 months and receive monthly living stipend and medical health insurance.

The stipend may include funding from the Corporation for National and Community Services (AmeriCorps). The stipend may be counted differently depending on their participation in AmeriCorps. If the RARE participant is also getting funding from AmeriCorps, they will have a signed agreement showing this participation.

With proof of AmeriCorps participation, count the RARE living allowance (stipend benefits) as follows:

- (1) For FS, MAA, MAF, OHP, SAC, and TANF, exclude these payments.

- (2) For ERDC, count as earned income if paid to a caretaker. If not, exclude it.

461-145-0365

Note: Ask each RARE participant to provide a copy of the AmeriCorps contract before excluding the stipend income.

Without proof of AmeriCorps participation, count the RARE living allowance (stipend benefits) as follows:

- (1) For all programs except ERDC, count as earned income.
- (2) For ERDC, count as earned income if paid to a caretaker. If not, exclude it.

461-140-0010

60. Real Property

Manufactured, mobile homes, and floating homes and houseboats are treated the same as real property.

Real property is land, buildings, and whatever is erected or affixed to the land and taxed as real property.

☞ SEE CA B.34 OR OAR 461-145-0250 FOR TREATMENT OF INCOME-PRODUCING PROPERTY.

☞ SEE CA B.32 OR OAR 461-145-0220 FOR TREATMENT OF PROPERTY USED AS THE GROUPS HOME.

- (1) The client has the burden of proof of establishing the fair market value of real property. The department may determine the methodology that will most accurately reflect the value. If decided it is the most accurate, fair market value of real property may be determined using the highest value identified by the county assessor on the most recent property tax statement. The exception is if a real estate appraisal is submitted showing the property is expected to sell for less on the open market.
- (2) Treat real property that is not income-producing (CA B.34) or the financial group's home (CA B.32) as follows:
 - (a) For MAA, MAF, REF, REFM, SAC, and TANF, count as a resource the equity value of all real property that is not excluded under a TANF Interim Assistance agreement (CA B.60).
 - (b) For EA, ERDC, and OHP, exclude real property.

- (c) For FS, exclude the equity value of real property that the financial group is making a good-faith effort to sell at a fair market price. If the group refuses to make a good-faith effort to sell, count the equity value of the property as a resource. In addition, the resource is excluded if selling it would produce a net gain of less than \$1500 to the financial group.
- (d) For GA, GAM, OSIP, OSIPM, and QMB:
 - (A) Exclude real property that was the home of the financial group if they are making a good-faith effort to sell at a reasonable price. If the group refuses to make a good-faith effort, count the equity value of the property as a resource.
 - (B) Count the equity value of all other real property as a resource unless the financial group is making a good-faith effort to sell the property. The equity value is counted after the property is excluded for nine months unless the failure to sell is for reasons beyond the reasonable control of the financial group.

Note: A good-faith effort to sell property includes listing the property for sale in the local newspaper, putting a “For Sale” sign on the property, and/or listing the property with a real estate company.

461-145-0420

61. Real Property Excluded Under an Interim Assistance Agreement; MAA, MAF, REF, REFM, TANF

For MAA, MAF, REF, REFM, and TANF, treat real property where the equity value puts the financial group over the TANF resource limit as follows:

- (1) Exclude real property for a maximum of nine months if the financial group signs and complies with the terms of the Interim Assistance Agreement. After the ninth month, count the equity value of the property as a resource.
- (2) To comply with the terms of the Interim Assistance Agreement, the financial group must agree to do the following:
 - (a) Make a good-faith effort to sell the property; **and**
 - (b) Use the proceeds from the sale of the property to reimburse the department for all benefits paid under the terms of the Interim Assistance Agreement. The reimbursement will not exceed the net proceeds of the sale of the property.
- (3) The amount of benefits paid while the financial group has excess real property is an overpayment if the financial group fails to notify the department that they have the property.

- (4) The amount of the benefits paid while the financial group has excess real property up to the net proceeds of the sale of the property is an overpayment if the property sells and the group does not repay the department per the terms of the Interim Assistance Agreement.

Note: If the financial group has excess real property, complete a TANF Resource Referral form (DHS 647B) and file in the case record with the following:

- *A signed copy of the TANF Interim Assistance Agreement (DHS 418).*
- *A copy of the legal description of the property.*
- *A copy of the deed or purchase agreement (if available).*

Track the case for the entire 9-month exclusion period. Close the case at the end of the exclusion period.

If the client reapplies, check to see if they still have the property or if the property sold. If the client still has the property, they remain ineligible. If the property sold while the case was closed, and the client did not reimburse the department, compute an overpayment.

Use receipt code 216 when the client makes a payment based on the terms of the TANF Interim Assistance Agreement.

461-145-0430

62. Recreational Vehicles

Recreational vehicles include the following:

- They are used primarily for amusement and not for day-to-day transportation; **and**
 - They cannot be licensed as a motor vehicle for use on a public highway. However, they may be registered or licensed as a nonmotor vehicle.
 - An ATV, boat, camper, dune buggy, plane, snowmobile, or trailer, unless it qualifies as a capital assets (CA B.86) or work-related equipment.
- (1) For all programs except ERDC and OHP, count the equity value of recreational vehicles as a resource. Except for FS, the value is excluded if by selling the vehicle the proceeds would be less than \$1500 to the financial group.
 - (2) For ERDC and OHP, exclude recreational vehicles.

☞ SEE CA B.49 OR OAR 461-145-0360 FOR INFORMATION ON HOW TO TREAT MOTOR VEHICLES THAT DO NOT MEET THE DEFINITION OF RECREATIONAL VEHICLES.

461-145-0433

63. Refunds

Exclude the following refunds in the month they are received:

- (1) Refunds on merchandise that was purchased or received as a gift.
- (2) Refunds of utility and rental deposits.

Count any refund amount remaining after the month of receipt as a resource.

☞ SEE CA B.75 OR OAR 461-145-0530 FOR INFORMATION ON TAX REFUNDS.

461-145-0435

64. Reimbursement

“*Reimbursement*” means money or in-kind compensation provided specifically for an identified expense.

- (1) For the treatment of USDA meal reimbursements, see OAR 461-145-0570.

☞ SEE USDA MEAL REIMBURSEMENT PER CA B.80.

- (2) For the treatment of reimbursements for self-employed clients, see OAR 461-145-0920.

☞ SEE SELF-EMPLOYMENT; COSTS THAT ARE EXCLUDED TO DETERMINE COUNTABLE INCOME PER CA C.2.

- (3) Except as provided in section (1) and (2) above, a *reimbursement* (see OAR 461-001-0000) is treated as follows:

- (a) In the ERDC program, a *reimbursement* is excluded, except that a *reimbursement* for child care from a source outside of the department is counted as unearned income.

Note: *Payments for extra expenses, such as meal reimbursements for training or conferences, JTPA lunch payments, DHS shelter payments for attendants or housekeepers, and premiums for cost-effective employer-sponsored health insurance are not considered to be expenses paid by program benefits and are excluded as reimbursements. Exclude all jury-duty payments.*

- (b) In the FS program:

- (A) A *reimbursement* in the form of money for a normal household living expense, such as rent or payment on a home loan, personal clothing, or food eaten at home, is unearned income.

☞ SEE TREATMENT OF EARNED INCOME (CA B.22) IF AN EMPLOYER IS REIMBURSING THE CLIENT FOR HEALTH INSURANCE OR CHILD CARE IN A CAFETERIA PLAN.

Note: Shared shelter is not a cash reimbursement.

☞ SEE IN-KIND INCOME, CA B.40 OR OAR 461-145-0280.

- (B) Any other *reimbursement*, except as in (3)(c) below, is treated as follows:
- (i) An in-kind *reimbursement* is excluded.
 - (ii) A *reimbursement* in the form of money is excluded if used for the identified expense, unless the expense is covered by program benefits.
 - (iii) A *reimbursement* is counted as periodic or lump-sum income (see OAR 461-140-0110 and 461-140-0120) if not used for the identified expense.
 - (iv) A *reimbursement* for an item already covered by the benefits of the *benefit group* (see OAR 461-110-0750) is counted as periodic or lump-sum income.
- (c) In the FS and OHP programs, an expenditure by a business entity that benefits a *principal* is counted as earned income (see OAR 461-145-0130).
- (d) In all programs except the ERDC and FS programs, a *reimbursement* is treated as follows:
- (A) An in-kind *reimbursement* is excluded, except as provided in subsection (c) of this section for the OHP program.
 - (B) A *reimbursement* in the form of money is excluded if used for the identified expense, unless the expense is covered by program benefits.
 - (C) A *reimbursement* is counted as periodic or lump-sum income if not used for the identified expense.
 - (D) A *reimbursement* for an item already covered by the benefits of the *benefit group* is counted as periodic or lump-sum income.

65. Representative Payee Payment

Representative payees receive payments on behalf of other people who are required to have a representative payee. Some representative's charge a fee to the person they are receiving the payments for.

- (1) Fees paid by a client, to a representative payee, who is required by the Social Security Administration to receive payments through a representative payee is excluded. The amount of the exclusion is limited to the amount authorized by the Social Security Administration. Criteria for this exclusion are in OAR 461-145-0490 and 461-145-0510.
- (2) Fees received by a financial group member, as a representative payee, are counted as earned income per OAR 461-145-0120.
- (3) When a representative payee, who is a member of the financial group receives benefits for another person as their representative payee, treat the income as follows:
 - (a) Excluded as long as the payments are being disbursed as intended for the person requiring the payee per OAR 461-140-0040.
 - (b) Counted as unearned income if the payments are being kept by the financial group member and not being disbursed as intended for the person requiring the payee.

66. Reception and Placement Grants

A Reception and Placement (R&P) grant is a payment made by the United States Department of State through national refugee resettlement agencies to local resettlement agencies, refugee sponsors, and refugees. The R&P grants are provided to the resettlement agencies to help with the costs of initial resettlement of refugees in the United States. The resettlement agencies provide a part of this grant to refugees, usually in their first month after arrival, for their initial resettlement needs, and not for ongoing living expenses.

- (1) For ERDC, REF, REFM, and TANF, R&P grants are excluded from consideration as income and resources for purposes of determining program eligibility or benefit levels, except as provided in OAR 461-140-0070.
- (2) For FS, any amount paid directly to an FS household from an R&P grant is unearned income. For in-kind payments made by the Resettlement Agency, see CA B.41 or OAR 461-145-0280.
- (3) For GA, MAA, MAF, OHP, OSIPM, and QMB, an R&P grant determined to be available to the refugee case is considered unearned income.

67. Sale of a Resource

- (1) For all programs except ERDC, EXT, MAA, MAF, REF, REFM, SAC, and TANF, treat proceeds from the sale of a resource as follows:
 - (a) Count proceeds from the sale of a resource (other than a home) received on a monthly or other periodic basis as unearned income. Treat proceeds received on a lump sum basis as follows:
 - (A) If the proceeds are from the sale of an excluded resource, exclude the amount reinvested in another excluded resource. Count the remainder as a resource.
 - (B) Count the proceeds from all other sales as a resource. If the proceeds put the benefit group over the resource limit, treat the proceeds as periodic (CA A.6) or lump-sum income (CA A.5).
 - (b) For all clients except those eligible for OSIPM under 461-135-0771, exclude the proceeds from the sale of the financial group's home, if they intend to reinvest the proceeds in another home within three months from receipt of funds.
 - (c) For clients eligible for OSIPM under 461-135-0771, exclude the proceeds from the sale of the financial group's home, if they intend to reinvest the proceeds in another home within 12 months from receipt of funds.
 - (d) Count the proceeds from the sale of a home that are not reinvested in another home as a resource. Except for GA and GAM, if the proceeds put the benefit group over the resource limit, count the monies as periodic or lump-sum income.
 - (e) In the FS program, if a self-employed client sells a work-related asset (CA B.11), including equipment and inventory (CA B.86), the proceeds of the sale are treated as self-employment income.
- (2) For MAA, MAF, REF, REFM, SAC, and TANF, if the proceeds are from the sale of an excluded resource, exclude the amount reinvested in another excluded resource. Count all other proceeds from the sale of a resource as unearned income.
- (3) For ERDC and EXT, exclude all proceeds from the sale of a resource.
- (4) Any costs that are excluded under OAR 461-145-0920 are subtracted from the proceeds from the sale of a resource if the proceeds are treated as income under this rule. This is true even though the income is not from self-employment. Use the actual costs and not the allowed self-employment deduction identified in CA C.3.

☞ SEE CA B.35 OR OAR 461-145-0240 FOR INFORMATION ON HOW TO TREAT THE PROCEEDS FROM A RESOURCE SOLD ON CONTRACT.

68. Shelter-in-Kind Income

Shelter-in-kind is when an agency or person outside the household provides the financial group's shelter, or makes a payment to a third party for some or all of the group's shelter costs. Shelter costs are housing costs (rent or mortgage payments, property taxes) and utility costs, not including cable TV or nonbasic telephone charges. (See OAR 461-001-0000.)

- (1) For all programs except GA, GAM, OSIP, OSIPM, and QMB, shelter-in-kind does not include temporary shelter provided by a domestic violence shelter, homeless shelter, or residential alcohol and drug treatment facilities.
- (2) For GA, GAM, OSIP, OSIPM, and QMB, shelter-in-kind also includes situations where the client has no shelter costs.
- (3) Except as provided in section (4):
 - (a) For ERDC, count earned shelter-in-kind as earned income. Unearned shelter-in-kind is excluded.
 - (b) For EXT, MAA, MAF, REF, REFM, SAC, and TANF, except for child support, shelter-in-kind payments are excluded.
 - (c) For GA and GAM, exclude shelter-in-kind payments.
 - (d) For FS, an expenditure by a business entity for shelter costs of a principal (see OAR 461-145-0088) is counted as earned income. See CA B.22 when shelter is part of earned income. See In-Kind Income (CA B.40) when the payments are made by the noncustodial parent. Exclude all other shelter-in-kind housing and utility payments.
 - (e) For OHP, shelter-in-kind payments are excluded, except if the shelter payment is provided by a business entity in which the client is a principal, the payment is countable income. A "principal" is a person with significant authority in the business entity, such as the proprietor of a sole proprietorship, including a person who is self-employed, or a partner of a partnership, or a member or manager of a limited liability company, or an officer or principal stockholder of a closely held corporation.

☞ SEE OAR 461-140-0040.

Example: Sara is the principal owner of a bakery which is an incorporated business. She states on her application that she currently does not receive wages. She also has not received draws from the business. Bank statements and canceled checks show payments made for her

home in the amount of \$1,275 per month, tax payments monthly in the amount of \$127, utility payments (electricity, gas, water, garbage, and phone bills) totaling \$380 per month. The total amount of these payments, \$1,782, is countable income for her.

☞ SEE CA B.40, IN-KIND INCOME FOR INFORMATION ON HOW TO TREAT SHELTER-IN-KIND PAYMENTS RECEIVED AS CHILD SUPPORT.

(f) For OSIP, OSIPM, and QMB, treat shelter-in-kind income as follows:

(A) Unearned *shelter-in-kind* income is treated as follows:

- (i) *Shelter-in-kind* payments from HUD are excluded.
- (ii) If all *shelter costs* (see OAR 461-001-0000) are covered by a payment, the Shelter-in-Kind Standard for total shelter (see OAR 461-155-0300) is counted as unearned income.
- (iii) If only rent or mortgage costs are covered by a payment, the Shelter-in-Kind Standard for housing costs (see OAR 461-155-0300) is counted as unearned income.
- (iv) If the client has no *shelter costs*, the Shelter-in-Kind Standard for total shelter (see OAR 461-155-0300) is counted as unearned income.

(B) Earned *shelter-in-kind income* is treated as follows:

- (i) If shelter is provided for services related to the employer's trade or business and acceptance of the shelter is a condition of employment, the *shelter-in-kind income* is treated in accordance with paragraph (A) of this subsection.
- (ii) Except as provided in subparagraph (i) of this paragraph, the *fair market value* (see OAR 461-001-0000) of the shelter is counted as earned income.

(4) A payment for which there is a legal obligation to pay to a member of the *financial group* that is made to a third party for shelter expenses of a member of the *financial group* is counted as unearned income.

461-145-0470

☞ SEE CA B.33 FOR PAYMENTS MADE BY HUD.

69. Social Security Benefits

For this section, a payment is retroactive if it is issued in any month after the calendar month for which it would normally be received.

Treat all SSB as follows:

- (1) Count monthly payments as unearned income.
- (2) Count all other payments as periodic or lump-sum income except as provided in (3) below.
- (3) In the OSIP (except OSIP-EPD) and OSIPM (except OSIPM-EPD) programs, count retroactive payments as unearned income in the month of receipt except as follows:

When retroactive payments are made through the representative payee of an individual who is required to have a representative payee because of drug addiction or alcoholism, the retroactive payments may be required to be made in installments. If the payments are made in installments, the total of the benefits to be paid in installments is considered unearned income in the month in which the first installment is made. Any remaining amount from a retroactive payment after the month of receipt is counted as an excluded resource for nine calendar months following the month in which the payment is received. After the nine-month period, any remaining amount is a countable resource.

- (4) The representative payee fee paid by a client who is required by the Social Security Administration to receive payments through a representative payee is excluded. The amount of the exclusion is limited to the amount authorized by the Social Security Administration. The representative payee must be a community-based nonprofit social services agency which is bonded or licensed by the state. They may collect the lesser of 10 percent of the monthly benefit amount or \$37 (\$72 a month in any case in which SSA determined the individual has an alcohol or drug addiction and is incapable of managing such benefits). (The amounts are as of December 1, 2007.)

☞ SEE CA B.56 FOR HOW TO TREAT INCOME FROM PLAN FOR SELF SUPPORT OR CA B.77 FOR TICKET TO WORK.

461-145-0490

70. Social Security Death Benefit

Money remaining from Social Security Death benefits after the payment of burial costs is treated as lump-sum income (see OAR 461-140-0120).

461-145-0500

71. Spousal Support

“Spousal support” is income paid (voluntarily, per court order, or per administrative order) by a separated or divorced spouse to a member of the *financial group* (see OAR 461-110-0530).

OAR: 461-001-0000

- (1) For ERDC, MAA, MAF, OHP, OSIP, OSIPM, QMB, and SAC programs, spousal support is counted as unearned income.
- (2) For FS:
 - (a) Payments made by the separated or divorced spouse to a third party for the benefit of the *financial group* are excluded, except that a payment for which there is a legal obligation to pay to a member of the *financial group* that is made to a third-party for shelter expenses of a member of the *financial group* is counted as unearned income.
 - (b) Spousal support (see OAR 461-001-0000) is counted as unearned income.
- (3) In the REF and TANF programs:
 - (a) For clients not working under a TANF JOBS Plus agreement, if the spousal support is received by the department or the Department of Justice, and if continued receipt of the *spousal support* is reasonably anticipated, the spousal support is:
 - (A) Counted as unearned income when determining eligibility; and
 - (B) Excluded when determining the REF and TANF benefit amount.

Note: For example, receipt of spousal support can be reasonably anticipated if the support is secured by wage garnishment or if it has been received in each of the two months before the payment month.
 - (b) For clients working under a TANF JOBS Plus agreement:
 - (A) *Spousal support* is excluded in determining countable income.
 - (B) *Spousal support* is excluded when calculating the TANF portion of the benefit equivalency standards.
 - (C) *Spousal support* received by the client is counted as unearned income when calculating the wage supplement.
 - (c) Other *spousal support* payments (not covered under subsections (a) or (b) of this section) are counted as unearned income.

☞ SEE RULE 461-160-0200 FOR INFORMATION ON THE UNEARNED INCOME DEDUCTION FOR SPOUSAL SUPPORT FOR MAF, AND SAC.

461-145-0505

72. SSI

- (1) For ERDC, FS, GA, GAM, and OHP, count monthly SSI payments as unearned income. Exclude the representative payee fee for clients who must receive payments through a representative payee under P.L. 101-508 or P.L. 103-296. In this instance the representative payee must be a community-based nonprofit social services agency which is bonded or licensed by the state. They may collect the lesser of 10 percent of the monthly benefit amount or \$37 (\$72 a month in any case in which SSA determined the individual has an alcohol or drug addiction and is incapable of managing such benefits). (These amounts are as of January 1, 2006.)

Note: When disability is based on drug addiction or alcoholism, P.L. 103-296 requires that payments to SSA clients be made through an authorized representative.

- (2) For ERDC, GA, GAM, and OHP:
 - (a) Count SSI monthly payments as unearned income.
 - (b) Count SSI lump-sum payments according to the specific program policy on lump-sum.

☞ SEE OAR 461-140-0120.

☞ SEE OSIP E.3 AND GA E.6 IN THE SPD MANUAL; SEE CA A.5 FOR FS.

- (3) For EXT, MAA, MAF, REF, REFM, and TANF:
 - (a) Exclude SSI monthly and lump-sum payments, even if received by a financial group member, if that person will be removed from the group the following month.
 - (b) Treat SSI lump-sum in a bank account held jointly with other financial group members according to CA B.8.
 - (c) Exclude SSI retroactive lump-sum payments in the month paid and the next month, even if the recipient is in the financial group. Count the remainder as a resource after those two months, if the SSI recipient is still in the group.
- (4) In FS, count monthly SSI payments as unearned income and exclude any lump-sum SSI payments.

Note: Clients receiving SSI from California also get FS benefits with the SSI. These clients are not eligible for FS from Oregon until the California SSI ends.

- (5) For OSIP and OSIPM (not OSIP-EPD or OSIPM-EPD), exclude retroactive lump-sum SSI payments for nine months after receipt. After the nine-month period, any remaining amount is counted as a resource. For the purpose of this subsection, a payment is retroactive if it is issued in any month after the calendar month for which it is intended.

☞ SEE CA B.56 FOR HOW TO TREAT INCOME FROM PLAN FOR SELF SUPPORT OR CA B.77 FOR TICKET TO WORK.

461-145-0510

73. Stipends

A stipend is a fixed or regular payment for services rendered. The stipend may include a living allowance, personal expenses or reimburse a person for their costs, such as, a person's time or transportation.

A stipend may be excluded, or counted as earned or unearned income. How it is treated depends on the funding source of the stipend and the program.

First, determine the funding source. The client may not know; you will need to ask the organization. For example, a community agency, college or university, etc., may obtain AmeriCorps, WIA, or some other type of funding to fund the stipend.

Once identified, check in Counting Client Assets.

- The stipend income is countable if it is not specifically excluded in one of the sources in Counting Client Assets, per OAR 461-140-0010.
- If the funding source is not covered in this section of the manual, for FS it is counted as earned income (use the TNG income code on FCAS) and unearned income for all other programs.

Some of the stipend funding sources identified in Counting Client Assets are:

- VISTA (including AmeriCorps VISTA) or various programs under the Domestic Volunteer Services Act (CA B.20).
- Youthbuild Program (CA B.33).
- Job Corps (CA B.41).

- Programs under the National Community Services Trust Act (including AmeriCorps) (CA B.50).
- Programs funded by the Older Americans Act (CA B.51).
- RARE (CA B.58).
- Veterans Administration (CA B.81).
- Vocational Rehabilitation (CA B.83).
- WIA (CA B.84).

Some examples of stipend income that may or may not be funded by sources identified in Counting Client Assets are:

- A tribal member receives a stipend to attend training or GED classes. This income is from the tribe and not funded under a law that excludes the stipend.
- A College or University may pay a stipend to a student in a faculty fellowship program. This income may be from the College or University using state or grant funds and is not funded by a law that excludes the stipend.
- A volunteer in a Community program receives a stipend for the time they worked on a project. This income may be from the community via a grant, state, or local funds and is not funded under a law that excludes the stipend.
- A student is receiving an income each month from ROTC funds each month while attending school. This income is considered a stipend and is not excluded.

74. Stocks, Bonds, and Other Securities

- (1) Except as provided in section (2) below, securities, including stocks, bonds, and certificates of deposit (CDs), are counted as a resource.
- (2) The value of a savings bond issued by the United States Department of the Treasury is excluded during the minimum retention period if the owner has received a denial of a request for a hardship waiver based on financial need.
- (3) A request for a hardship waiver may be made to the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division, PO Box 1328, Parkersburg, West Virginia 26106-1328.

75. **Strikers' Benefits**

Strikers' benefits are payments made to strikers by their union, whether or not based on the striker's participation in picketing. Treat these payments as follows:

- (1) For all programs except FS, count as unearned income.
- (2) For FS, exclude these payments, unless the striker's current income is higher than their pre-strike income. If so, count as unearned income.

☞ SEE FS F.15 FOR MORE INFORMATION ON DETERMINING FS ELIGIBILITY OF A STRIKER AND INCOME CALCULATION.

461-145-0525

76. **Tax Refund**

For all programs, count the following types of tax refunds as a resource.

- (1) Federal and state tax refunds.
- (2) Property tax refunds, including Elderly Rental Assistance (ERA).

☞ SEE CA B.23 ON TREATMENT OF EARNED INCOME TAX CREDIT.

461-145-0530

77. **Ticket to Work**

Ticket to Work is a Social Security program mandated under the Ticket to Work and Work Incentives Improvement Act of 1999. The intent is to enable social security beneficiaries to obtain, regain, or maintain employment and to reduce their dependency on cash assistance.

Ticket to Work is for most Social Security Disability (SSD) and Supplemental Security Income (SSI) clients who are between age 18 and 65. The program is voluntary. Recipients may use the "ticket" to obtain vocational rehabilitation, employment, or other support services from an approved provider of their choice to help them to go to work and achieve their employment goals. The recipient may be placed in on-the-job training or in school.

Most recipients participating in the Ticket to Work program are not receiving money from SSA for Ticket to Work. Instead, SSA is sending payments to the provider to reimburse the provider for their costs to provide the services. The recipient may continue to get SSD or SSI while in the training, etc. They may be paid a wage when work begins. They lose SSD or SSI when their income exceeds the allowable limits for SSD or SSI.

Some recipients of Ticket to Work will receive a stipend or training allowance. For FS, the stipend from a vocational rehabilitation program is counted as earned income. For all other programs, the stipend is counted as unearned income.

For all programs, count the income from employment as earned income. Count the SSD or SSI received by the client as unearned income.

Note: For TANF, REF, REFM, MAA, and MAF, if the Ticket-to-Work participant receives SSI, the stipend does not count as income because the SSI recipient is not in the Financial Group.

461-145-0585
461-145-0120
461-145-0130

78. Trusts

- (1) Trust funds are money, securities, or similar property held by a person or institution for the benefit of another person.
- (2) This section applies to all trust funds in the FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF programs. It also applies to GA, GAM, OSIP, OSIPM, and QMB for trust funds established before October 1, 1993:
 - (a) Trust funds are counted as a resource if the fund is legally available for use by a member of the financial group for items covered by program benefits. For OSIP, OSIPM, and QMB, the amount of the trust that is considered legally available is the maximum amount that could be distributed to the beneficiary under the terms of the trust, regardless of whether or not the trustee exercises his or her authority to actually make the distribution.
 - (b) Trust funds are excluded if the fund is not available for use by a member of the financial group. The financial group must try to remove legal restrictions on the trust, unless that would cause an expense to the group.
 - (c) The part of the fund available for use for medical expenses covered by the medical program for which the financial group is eligible is counted.
- (3) In the ERDC program, all trust funds are excluded.
- (4) In the OSIP, OSIPM, and QMB programs, trust funds established on or after October 1, 1993, are treated in accordance with sections (5) through (11) of this rule. In the GA and GAM programs, trust funds established on or after October 1, 1993, are treated in accordance with sections (5) through (9) of this rule.
- (5) A trust is considered established if the financial group used their resources to form all or part of the trust and if any of the following established a trust, other than by a will:

- (a) The client.
 - (b) The client's spouse.
 - (c) Any other person, including a court or administrative body, with legal authority to act in place of or on behalf of the client or the client's spouse.
 - (d) Any other person, including a court or administrative body, acting at the direction or upon the request of the client or the client's spouse.
- (6) If the trust contains resources or income of another person, only the share attributable to the client is considered available.
- (7) Except as provided in section (10) of this rule, the following factors are ignored when determining how to treat a trust:
- (a) The purpose for which the trust was established.
 - (b) Whether or not the trustees have or exercise any discretion under the trust.
 - (c) Any restrictions on when or if distributions may be made from the trust.
 - (d) Any restrictions on the use of distributions from the trust.
- (8) If the trust is revocable, it is treated as follows:
- (a) The total value of the trust is considered a resource available to the client.
 - (b) A payment made from the trust to or for the benefit of the client is considered unearned income.
 - (c) A payment from the trust other than to or for the benefit of the client is considered a transfer of assets covered by OAR 461-140-0210 and following.
- (9) If the trust is irrevocable, it is treated as follows:
- (a) If, under any circumstances, the funds transferred into the trust are unavailable to the client and the trustee has no discretion to distribute the funds to or for the benefit of the client, the client is subject to a transfer-of-resources penalty as provided in OAR 461-140-0210 and following.
 - (b) If, under any circumstances, payments could be made to or on behalf of the client, the share of the trust from which the payment could be made is considered a resource. A payment from the trust other than one to or for the benefit of the client is considered a transfer of assets that may be covered by OAR 461-140-0210.
 - (c) If, under any circumstances, income is generated by the trust and could be paid to the client, the income is unearned income. Payments made for any

reason other than to or for the benefit of the client are considered a transfer of assets subject to disqualification per OAR 461-140-0210.

- (d) If any change in circumstance makes assets (income or resources) from the trust unavailable to the client, the change is a disqualifying transfer as of the date of the change.
- (10) Notwithstanding the provisions above in this rule, the following trusts are not considered in determining eligibility for OSIPM and QMB:
- (a) A trust containing the assets of a client determined to have disabilities by SSI criteria that was created before the client reached age 65, if the trust was established by one of the following and the state will receive all funds remaining in the trust upon the death of the client, up to the amount of medical benefits provided on behalf of the client:
 - (A) The client's parent.
 - (B) The client's grandparent.
 - (C) The client's legal guardian or conservator.
 - (D) A court.
 - (b) A trust established between October 1, 1993, and March 31, 1995, for the benefit of the client and containing only the current and accumulated income of the client. The accumulated amount remaining in the trust must be paid directly to the state upon the death of the client up to the amount of medical benefits provided on behalf of the client. The trust is the total income in excess of the income standard for OSIPM. The remaining income not deposited into the trust is available for the following deductions in the order they appear prior to applying the patient liability:
 - (A) Personal-needs allowance.
 - (B) Community spouse monthly maintenance needs allowance.
 - (C) Medicare and other private medical insurance premiums.
 - (D) Other incurred medical.
 - (c) A trust established on or after April 1, 1995, for the benefit of the client and containing the current and accumulated income of the client. The accumulated amount remaining in the trust must be paid directly to the state upon the death of the client up to the amount of medical assistance provided on behalf of the client. The trust contains all the client's income. The income deposited into the trust is distributed monthly in the following order with excess amounts treated as income to the individual subject to the rules on transfer of assets in division 140 of this chapter of rules:

- (A) Personal needs allowance and applicable room and board standard.
 - (B) Reasonable administrative costs of the trust, not to exceed a total of \$50 per month, including the following:
 - (i) Trustee fees.
 - (ii) A reserve for administrative fees and costs of the trust, including bank service charges, copy charges, postage, accounting and tax preparation fees, future legal expenses, and income taxes attributable to trust income.
 - (iii) Conservatorship and guardianship fees and costs.
 - (C) Community spouse and family monthly maintenance needs allowance.
 - (D) Medicare and other private medical insurance premiums.
 - (E) Other incurred medical care costs as allowed under OAR 461-160-0030 and 461-160-0055. Contributions to reserves or payments for child support, alimony, and income taxes. Monthly contributions to reserves or payments for the purchase of an irrevocable burial plan with a maximum value of \$5,000. Contributions to a reserve or payments for home maintenance if the client meets the criteria of OAR 461-155-0660 or 461-160-0630.
 - (F) Patient liability not to exceed the cost of waived services or nursing facility care.
- (11) For a trust signed on or after July 1, 2006:
- (a) Notwithstanding the provisions of subsections (2) through (9), a trust that meets the requirements of subsection (b) below is not considered in determining eligibility for OSIPM or QMB, except if the client is age 65 or older when the trust is funded or transfer is made to the trust. The transfer may constitute a disqualifying transfer of assets under OAR 461-140-0210 and the following.
 - (b) This section applies to a trust that meets all of the following conditions:
 - (A) The trust is established and managed by a nonprofit association.
 - (B) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
 - (C) The trust is established by the client, client's parent, grandparent, or legal guardian, or a court for clients who have disabilities.

- (D) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state an amount equal to the total medical assistance paid on behalf of the beneficiary under the state plan for Medicaid.
 - (E) The trust contains the resources or income of a client who has a disability that meets SSI criteria.
- (12) In the GA, GAM, OSIP, OSIPM, and QMB programs, the provisions of this rule may be waived for an irrevocable trust if the department determines that denial of benefits would create an undue hardship on the client if, among other things:
- (a) The absence of the services requested may result in a life-threatening situation.
 - (b) The client was a victim of fraud or misrepresentation.

461-145-0540

79. Unemployment Compensation Benefit

Count most UC benefits received weekly or bi-weekly as unearned income and retroactive payments as lump-sum income (CA A.5) or (OAR 461-140-0120).

The American Recovery and Reinvestment Act of 2009 funded an additional \$25 weekly in unemployment compensation (UC) benefit payments. Payments are for the UC claim weeks beginning February 26, 2009, through December 26, 2009. Clients will begin seeing the additional \$25 UC benefit the first week of March.

- For all SSP/SPD medical programs, all TANF and TANF related programs (including Pre-TANF, single-parent and two-parent TANF, Post-TANF, TA-DVS and SFPSS), the \$25 increase is excluded.
- For the ERDC and FS, the \$25 benefit increase is countable UC income.

The Weekly Benefit Amount does not include the additional \$25 benefit. However, the \$25 is included in the check amount on the E-PAY- Payment List.

If the client does not have any earnings or overpayments withholding, use the Weekly Benefit Amount (WBA) on ECLM- Claim Summary Display for all but ERDC and FS. For ERDC and FS, use the WBA plus \$25.

If the client has earnings or an overpayment withholding, use the E-PAY-Payment List screen to determine the amount of countable UC income.

- For all programs but ERDC and FS, add the check amount, amount of overpayment withheld, amount of child support withheld and amount of federal and state taxes withheld. Subtract \$25 from the total.

- For ERDC, add the check amount, amount of overpayment withheld, amount of child support withheld and the amount of federal and state taxes withheld.
- For FS, add the check amount, amount of child support withheld, amount of federal and state taxes withheld.

Countable UC Income When You Cannot Use the WBA					
<i>E-Pay amounts</i>	<i>Check amount</i>	<i>Overpayment</i>	<i>Child Support</i>	<i>Taxes</i>	<i>Subtract \$25</i>
ERDC	X	X	X	X	
FS	X		X	X	
Medical	X	X	X	X	X
All TANF	X	X	X	X	X

461-145-0550

Note: Countable UC income includes garnishments and taxes. Work Share is also countable as UC income. UC benefits received while participating in Trade Act activities are also countable income.

80. Uniform Relocation Act and Real Property Acquisition Policies Act

Reimbursements from the Federal Uniform Relocation Assistance Act (42 U.S.C 4621-4625) and from the Real Property Acquisition Policies Act of 1970 (42 U.S.C. 4651-4655) are counted as a resource for GA and GAM and excluded for all other programs.

461-145-0560

81. USDA Meal Reimbursement

USDA meal reimbursements are cash reimbursements for family day-care providers who serve snacks and meals. The reimbursements are made by the Department of Education and the amount of the reimbursement is determined by family size and income.

- (1) Count USDA meal reimbursements made to child care providers as self-employment income.
- (2) Exclude the USDA meal reimbursements for a filing group member.

Child care providers often have young children of their own who are present at the same time as children in care. When the provider receives the USDA meal reimbursement, they submit the voucher for both the children in care and their own children who were present for the snacks and meals.

Exclude the part of the meal reimbursement for the providers own children as follows:

- (a) Determine the total number of children (not in filing group) who receive meals or snacks.
- (b) Determine the total number of the children (in filing group) also receiving meals or snacks.
- (c) Total (a) and (b) above.
- (d) Determine the total amount of monthly meal reimbursement.
- (e) Divide the total from (c) into the meal reimbursement in (d) to arrive at the amount of reimbursement per child.
- (f) Multiply the result of (e) by the number of children in (a) to arrive at the countable USDA meal reimbursement. Count as SEC.

USDA Meal Reimbursement Worksheet

_____	(a)	Total number of children who receive meals or snacks (not in filing group).
_____	(b)	Total number of children, in the filing group, receiving meals or snacks.
_____	(c)	Total children in (a) and (b) above.
_____	(d)	Amount of monthly meal reimbursement.
_____	(e)	divided by _____ (c) = _____ (amount of reimbursement per child)
_____ X _____	(a)	= _____ (count as SEC).

☞ SEE CA C.2 OR OAR 461-145-0920 FOR MORE INFORMATION ON SELF-EMPLOYMENT COSTS.

461-145-0570

82. Veterans' Benefits

- (1) Treat veterans' benefits, other than Aid and Attendance and educational or vocational rehabilitation training benefits, as follows:
 - (a) Count monthly payments as unearned income.

- (b) Count other payments as periodic (CA A.6) or lump-sum income (CA A.5 or OAR 461-140-0120).
- (2) Treat veterans' Aid and Attendance payments as follows:
 - (a) For FS, count these payments as unearned income.
 - (b) For OHP and QMB, exclude these payments.
 - (c) For OSIP, OSIPM, and QMB clients receiving long-term care or title XIX-waivered services, treat as follows:
 - (A) Exclude the entire payment when determining financial eligibility.
 - (B) Count the entire payment as unearned income when calculating monthly benefits or patient liability.
 - (C) Exclude payments for services not covered by the department's programs.
 - (D) The client is required to repay to the department the amount of the payments received by the client for costs and services already paid for by the department, up to the amount of institutional and home- or community-based waived care provided to the client during months covered by the payments. Any unrecovered third-party resource or payment above the actual cost is counted as lump-sum or periodic income.
 - (d) For all other programs, treat Aid and Attendance payments as follows:
 - (A) Exclude payments for services not covered by the department's programs.
 - (B) Reimbursements paid to the client for costs and services already paid for by the department are third-party resources and should be recovered from the client. Count any unrecovered third-party resource or payment above the actual cost as lump-sum or periodic income.
- (3) Exclude payments under Public Law 104-204 to children of Vietnam veterans who are born with spina bifida.
- (4) Treat educational benefits from the Veterans' Administration according to CA B.25 or OAR 461-145-0150.

Note: If an applicant/recipient's Aid and Attendance income makes the total income over the 300 percent of SSI, an income cap trust is not needed.

Note: Educational benefits from the VA include the Montgomery GI Bill (Chapter 30), Survivors and Dependents Educational Assistance (DEA)

(Chapter 35), Selected Reserve Educational Assistance Program (Title 10, Chapter 1606), Reserve Educational Assistance Program (Chapter 1607), Active Duty Veterans Educational Assistance Program (VEAP) (Chapter 32), and VA Work Study.

There are other types of VA educational assistance. Please call Central Office for how to handle the other types.

- (5) For FS, count VA vocational rehabilitation maintenance payments for food, shelter, and clothing as unearned income.
- (6) For FS, count the VA Chapter 31 subsistence allowance paid while the veteran with disabilities participates in training or a vocational rehabilitation plan as earned income. For all other programs, it is unearned income.

***Note:** The Chapter 31 VA Vocational Rehabilitation program is for veterans with disabilities and a few dependents. Look for VA disability income also. (For FS, use income type code TNG.)*

461-145-0580
461-145-0585

83. Victims' Assistance

- (1) Payments made under Public Law 103-286 to victims of Nazi persecution, and payments under 42 U.S.C 10602, the Crime Act of 1984 (VOCA), are:
 - (a) Excluded as income and amounts retained are excluded as a resource as long as the amounts are not commingled with other funds for all programs except GA and GAM.
 - (b) In the GA and GAM programs, these payments are counted as unearned income.
- (2) For other types of victims' assistance:
 - (a) Treat payments that are considered a reimbursement (see OAR 461-001-0000) for a lost item according to CA B.63 or OAR 461-145-0440.
 - (b) Treat payments for pain and suffering as personal injury settlements according to CA B.54 or OAR 461-145-0400.

461-145-0582

84. Vocational Rehabilitation Payment

- (1) Count Vocational Rehabilitation Maintenance payments for food, shelter, and clothing as unearned income.
- (2) For FS, count a training allowance or stipend from a vocational rehabilitation program as earned income. For all other programs, it is counted as unearned income.
- (3) Treat Vocational Rehabilitation payments for special itemized needs connected with the evaluation, planning, or placement activity as a reimbursement. These special need payments include:
 - (a) Child care.
 - (b) Clothing.
 - (c) Second residence.
 - (d) Special diet.
 - (e) Transportation.

461-145-0585

85. Workforce Investment Act (WIA)

Treat Workforce Investment Act (WIA) of 1998 (PL 105-220) payments made under title I-B (see OAR 151-020-0030) as follows:

- (1) Count need-based (stipend) payments as unearned income, except as follows:
 - (a) Exclude for MAA, MAF, OHP, REF, REFM, SAC, and TANF clients under the age of 19 (or under the age of 20 if the client is a caretaker relative); **and**
 - (b) Exclude for all FS clients.
- (2) Count OJT and work experience payments as earned income, except as follows:
 - (a) Exclude for EXT, MAA, MAF, OHP, REF, REFM, SAC, and TANF clients under the age of 18 (or under the age of 20 if the client is a caretaker relative); **and**
 - (b) Exclude for FS clients who are:
 - (A) Under the age of 19 and under the control of an adult member of the filing group; **or**

- (B) Receiving OJT payments under the Summer Youth Employment and Training Program.

Note: FS clients age 18 and younger are considered under the control of an adult member of the household when they or the adult state they are under the adult's control (see FS C.3).

- (3) For FS, exclude the training stipend received under Section 402, rehabilitation payment.
- (4) Count support service payments for items already covered by the benefits of the benefit group as unearned income. Exclude all other support service payments (including lunch payments and clothing allowances).
- (5) A reimbursement (OAR 461-145-0440) is treated as provided in CA B.63.

461-145-0300

86. Workers' Compensation

- (1) For workers' compensation payments received monthly or more frequently:
- (a) Except as provided in subsection (b) of this section, these payments are counted as unearned income.
- (b) In the ERDC, FS, MAA, MAF, OHP, REF, REFM, SAC, and TANF programs, income from temporary workers' compensation is counted as earned income (see OAR 461-145-0130 or CA B.22) if paid to a client who is still employed while recuperating from a temporary illness or injury.
- (2) All workers' compensation payments other than those in section (1) are counted as periodic or lump-sum income (see OAR 461-140-0110 and OAR 461-140-0120 or CA A.6 and CA A.5).

461-145-0590

87. Work-Related Capital Assets, Equipment, and Inventory

“Work-related equipment” is property essential to the employment or self-employment of a financial group member. Examples are a tradesman's tools, a farmer's machinery, and equipment used to maintain an income-producing vehicle.

“Inventory” is goods that are in stock and available for sale to prospective customers.

- (1) A capital asset (CA B.11 OR OAR 461-001-0000), other than work-related equipment and inventory, is treated as follows:
- (a) For all programs except FS, MAA and TANF, treat the equity value of all capital assets according to the type of asset it is.

- (b) For FS, exclude the equity value of capital assets used in a business as follows:
 - (A) For nonfarm assets, as long as the financial group is actively engaged in self-employment activities;
 - (B) For farm assets, for one year from the date the person quit self-employment as a farmer.
 - (c) For MAA, REF, REFM, and TANF:
 - (A) For a self-employed client participating in the microenterprise component of the JOBS program, exclude the value of capital assets.
 - (d) For all other clients, treat the capital asset according to rules for that asset.
- (2) Treat work-related equipment as follows:
- (a) For EA, ERDC, FS, and OHP, exclude the equity value of work-related equipment as a resource.
 - (b) For GA, OSIP, OSIPM, and QMB, exclude the value of equipment needed by a client who has a disability or is blind, to complete a plan for self-support (CA B.55 or 461-135-0708 and 461-145-0405) as long as the plan is in effect. For all other equipment, count the equity value of the equipment as a resource except as provided in OAR 461-145-0250(3)(c).
 - (c) In the MAA, REF, REFM, and TANF programs:
 - (A) For a self-employed client participating in the microenterprise component of the JOBS program, the equity value of the equipment is excluded.
 - (B) For all other clients, the equity value of the equipment is treated as a resource.
 - (d) For MAF and SAC, count the equity value of work-related equipment as a resource.
- (3) Treat inventory as follows:
- (a) For EA, ERDC, FS, and OHP, exclude the value of inventory as a resource as long as the client is engaged in self-employment activities.
 - (b) For GA, OSIP, OSIPM, and QMB, exclude the value of inventory needed by a client who has a disability or is blind to complete a plan for self-support, as long as the plan is in effect. For all other inventory, count the equity value of the inventory as a resource.
 - (c) In the MAA, REF, REFM, and TANF programs:

- (A) For a self-employed client participating in the microenterprise component of the JOBS program, the wholesale value of inventory remaining at the end of a quarter, less encumbrances, is counted as a resource.
 - (B) For all other clients, the wholesale value of inventory remaining at the end of a month, less encumbrances, is counted as a resource.
 - (d) For MAF, REF, and SAC, count the wholesale value of inventory remaining at the end of the month, minus any encumbrances, as a resource.
- (4) For FS, count the full amount received from the sale of work-related equipment or inventory as part of the household's self-employment income.

461-145-0600

Worker Guide Identifying and Budgeting Self-Employment Income

The purpose of this worker guide is to help caseload-carrying staff identify self-employment, determine allowable costs, and budget income correctly for self-sufficiency programs.

1. Overview

Self-employment is a category of earned income. Because most programs treat self-employment differently than wages, all earned income must be identified either as self-employment or as earnings.

2. Identifying Self-Employment

Per OAR 461-145-0910, except as provided below, a client is self-employed if he or she:

- Is considered an independent contractor by the business that employs them; or
- Meets four or more of the following criteria:
 - Is engaged in an enterprise for the purpose of producing income. For example, the person operates under their own business name, advertises or otherwise solicits for business.
 - Is responsible for obtaining or providing a service or product by retaining control over the work or services offered. For example, the person establishes their own hours, territory and methods of work and determines what services they will offer.
 - Has principal responsibility for the success or failure of the business operation by assuming the necessary business expenses and profit or loss risks connected with the operation of the business. This could mean providing the equipment, supplies and materials needed to do a job or to produce the income; risk of loss. This is principal responsibility for their own business. If, for example, the client is a freelance tattoo artist, we would consider their own potential for gain or loss, not that of the tattoo parlors they work in.
 - Is not required to complete an IRS W-4 form for an employer or does not have federal income tax or FICA payments withheld from a pay check.
 - Is not covered under an employer's liability insurance or workers' compensation. Many definitions of self-employment hold this as an absolute test.

- ☞ FOR FS, INCORPORATED BUSINESSES ARE NOT SELF-EMPLOYMENT. REFER TO CA B.15 FOR CORPORATIONS.

Home care providers paid by SPD are not self-employed.

Child care providers paid by DPU, adult foster care providers paid by SPD, realty agents and clients who sell plasma, redeem beverage containers, pick mushrooms for sale or similar enterprises, are considered to be self-employed.

If a financial group member actively manages the property 20 hours or more per week, the income is treated in the same manner as self-employment income. If a financial group member does not actively manage the property 20 hours or more per week, the income is counted as unearned income with exclusions allowed only in accordance with OAR 461-145-0920.

In most cases, determining whether an individual earns money from an employer or through their own business is relatively simple. For example, sales associates working the cash registers at Target are undoubtedly employees of the corporation. Conversely, a person who works as a gardener, advertises his work, sets his own schedule and prices and is solely responsible for all business decisions is clearly self-employed.

However, many working individuals have a balance of responsibilities and freedoms that fall between these two extremes. The next section of this worker guide will walk through several case situations, using the six tests tied to the rule above to answer the question: is this person self-employed?

3. Examples of Client Work Situations

- (1) A married couple has incorporated their tile installation business. They select the stock, set the process, hire their own employees and determine their own business methods. They take a salary from their business.
- (2) A glassblower makes beads, ornaments and other decorative items on demand for a local shop owner. The owner sets the prices and puts in orders according to current need. The glassblower purchases his own supplies. He only does business with one shop. He does not have tax withholding through the business and is not covered by their employee worker comp/liability policy because they consider him an independent contractor.
- (3) A woman works for a tax accounting business every January through April. She travels among three of the business's offices as scheduled, and has a desk and computer set up at each location for her use. She takes as many clients as she can each day, and is paid commission of 50 percent of what her clients are charged. The business has her fill out a W-4 and covers her under their liability policy. She tells us she is self-employed because she is not contractually obligated to work only for them.

- (4) An exotic dancer pays weekly rental for her “station” in the club. She is paid no salary, but keeps all her tips. The club provides a DJ and expects her to work a minimum of 20 hours per week. She is responsible for providing her own outfits.

	Tile Company	Glass blower	Accountant	Dancer
<i>Work = occupation</i>	yes		yes	yes
<i>Control over services</i>	yes		no	yes
<i>Resp. success/failure</i>	yes		no	yes
<i>No W-4 form</i>	yes		no	yes
<i>No Workers Comp</i>	yes		no	yes
<i>Self-employed?</i>	Yes *	Yes	No	Yes

Reasons for these decisions:

Tile company. The couple owns the company and have total control. *They cannot be considered self-employed for FS because the company is incorporated.

Glassblower. The glassblower is considered an independent contractor, so there is no need to go through the five-criteria test.

Accountant. She is covered by the business liability policy, files a W-4, and is directed by the company. She is not self-employed.

Exotic dancer. The dancer is paid nothing by the club she works in; she merely pays a fee to be allowed to work there. The club is not her employer; they provide no income, no Workers Comp, no UC, no benefits. She is free to perform in multiple clubs. Although she has to work a minimum number of hours, she sets her own schedule.

4. Occupations That May Be/Not Be Self-Employment

Below are some examples of occupations that are usually challenging. For each of these, an example of a self-employed client vs. an employee is given, again using the test of meeting at least four out of the five criteria.

Ministers/Religious Leaders

- (1) Minister A is selected by the local Methodist church to fill their vacancy. The church provides housing, a living stipend and insurance for the minister and his family, but no salary. The church reports his compensation and covers him with the liability policy. The minister takes his other living expenses out of the love offerings (membership donations/pledges) made at the end of each service and for officiating at other ceremonies (e.g., weddings and funerals) as required.
Decision: He is **not** self-employed. He meets none of the tests.
- (2) Minister B has started his own small church. It is not affiliated with or authorized by any existing religious organization. He has total control over how he presents

his theology and over the content of his communication with parishioners. He is supported by donations, plus income from yard sales, bake sales, etc.

Decision: He is self-employed. The church and the person are one. He meets all five tests for self-employment.

Hairstylists

- (3) Hairstylist A rents out a station in a local salon. Her station rental pays for the chair, her share of electricity, use of the salon towels, sinks, etc. She purchases all her own hair products, sets her own hours and prices, decides which services she will offer. She is not on the salon's payroll.

Decision: Because of the costs incurred, the lack of employee status through taxes and her freedom to make decisions, she is self-employed.

- (4) Hairstylist B works at a chain salon. She is hired for an hourly rate, plus tips. Her hours, services offered and the cost of those services are set by the company. She files a W-4 and is covered by liability.

Decision: She is **not** self-employed.

Taxicab Drivers

- (5) Cab driver A uses a car that the cab company provides. The company pays the insurance on the vehicle and he pays for gas and maintenance. His gross income is a percentage of his fares and is based on a sliding scale. He also receives tips, but they are separate from the fare percentage. He has chosen to work nights; he determines which fares he will accept and the geographic area he will serve. He uses a Schedule C for his taxes.

Decision: He is self-employed.

- (6) Cab driver B works for a medi-cab company. She rents her cab and pays gas and maintenance. Her pay is a percentage of the fares, plus tips. She can only pick up fares given to her by dispatch. She does not control her territory or hours.

Decision: She is **not** self-employed.

Newspaper Carriers

- (7) Newspaper carrier A picks up copies of the Oregonian each morning at 3:00. He puts each copy into a plastic bag before he delivers them to the subscribers. When the subscriber's monthly fee is due, the carrier encloses the bill with the newspaper. The subscribers will mail him the payments which average about \$2,400 a month. He sends them to the Oregonian. He pays for gas, insurance, and maintenance of his vehicle, cost of the papers, plastic bags and rubber bands. The Oregonian considers him an independent contractor but will reimburse him for gas. He uses a Schedule C for his taxes.

Decision: He is self-employed. His gross income is \$2,400.

- (8) Newspaper carrier B works for the Healthy Food Weekly (HFW). He drives a car that the company provides. The company pays the insurance on the vehicle and

reimburses him for gas. He delivers the weekly paper to a paper stand every Monday so that they can be available to readers each Tuesday morning. He is paid on a weekly basis on the number of deliveries he makes each week. HFW pays him \$.75 for each delivery to the paper stand and his average weekly pay is \$100. Federal and state income taxes are being deducted from his pay check. HFW also offers a health insurance policy for him at a reduced rate since he is not a full-time employee.

Decision: He is **not** self-employed. His income will be counted as EML.

5. Examples of Self-Employment Situations

Real estate agents

Selling Avon, Mary Kay, Party Light, Pampered Chef, etc.

Selling blood plasma

Collecting and redeeming beverage containers

Picking mushrooms, collecting firewood, picking brush, etc. for sale

Running a franchise (e.g., McDonald's)

6. Examples of Non-Self-Employed Jobs

Beautician hired by salon

Jobs in which the person receives both wages/salary and commission

Incorporated businesses (FS only)

7. Verification

Independent contractor status must be verified. Acceptable verification includes:

- A signed contract specifying this.
- A 1099 (Miscellaneous Income) form issued by the business.
- A narrated conversation with the employer.

Income, including money from self-employment, must be verified for all programs.

Acceptable proof of self-employment income includes:

- Income tax return – state and federal, including Schedules C and F (for OHP, income tax returns can be used to check the accuracy of past income calculations, but not to determine the monthly average income)
- Check stubs or copies of contracts specifying payment schedule
- Self-employment bookkeeping records

- Copies of personal checking and savings account bank statements
- Copies of business account bank statements
- Proof of salary, stipend, allowance, donations, or gifts received
- Copy of any contract or work agreement
- Statement from organization or business explaining access rights to an organization's or business' bank accounts

Exception: For JOBS Microenterprise, the client must provide an income statement quarterly to the department. It must be prepared by a certified public accountant, bookkeeping firm or other entity approved by the department according to generally accepted accounting principles and OAR 461-145-0920.

The *Self-Employment Income* (DHS 859B) form may be used to help collect information about costs related to producing self-employment income. The form **cannot** be accepted as verification of either income or costs for self-employed clients.

For FS, self-employed clients can be certified once without income verification. At the time of certification, explain to the client – in writing – that they must begin keeping income records. Use a DHS 210A listing acceptable proof and using either the DHS 852 month or the end of the certification period as the due date. Include a list of acceptable proof. If they reapply without income verification, they will be denied. Narrate the conversation and notice given.

Clients with marginal employment – such as homeless people – sometimes report very limited earnings from collecting and redeeming beverage containers, selling plasma, returning airport luggage carts for the deposit money, etc. In many cases, requiring them to provide written verification of self-employment earnings would be an unreasonable barrier to eligibility. To get an acceptable estimate of their income, ask the client about their typical monthly earnings. Narrate their response. If the person is not sure about how much money they earn, ask:

- What the money is spent on. For example, if the client says they make enough to buy cigarettes for the month, how much do they smoke? If he picks up cans to pay his OHP premium, does he have any money left over after paying?
- How many days a week they typically pick up cans (or how many times a month they sell their plasma). If the person says he picks up three or four bags of cans a week, about how many cans fit in one bag?
- How much walking around money they get? Most of the time, how much money do you have in your pocket?

Note: *If the client is claiming marginal income, but substantial living expenses, income verification must be provided.*

Verify self-employment costs as follows:

- ERDC: Verify costs if the client wants to claim actual expenses above 50 percent.
- FS: Ask the client what costs they have related to their self-employment. Narrate the client's statement about allowable costs to support use of the SEC 50 percent income exclusion. Do not verify unless questionable.
- MAF: Use the client's statement from either the DHS 859B or the application. Verify only if questionable.
- OHP: Verify costs only when questionable if the client wants to claim actual expenses above 50 percent.
- TANF/MAA: Verify costs only for JOBS Microenterprise. Costs must be verified along with income as specified above, by providing an income statement quarterly to the department.

8. Treatment of Self-Employment Income

For all programs:

- Self-employment is defined the same, except that corporations cannot be considered self-employment for FS. Once you have determined that a person is self-employed, treat them that way for all benefits.
- Gross self-employment income (including microenterprise) is the gross sales or receipts (before costs).
- Self-employment income is counted as earned income.

The differences are in how allowable costs are treated.

ERDC. There are three options for applying self-employment costs. The client may choose to:

- Claim no costs.
- Use the standard deduction of 50 percent.
- Claim costs over 50 percent of self-employment, if those costs can be verified.

FS. Self-employed clients who have no costs have their gross self-employment income coded as SEN. That income is given the same 20 percent deduction as all other earned income. Most self-employed clients do have allowable costs. Their income is coded as SEC and is given a 50 percent deduction before the 20 percent earned income deduction is applied.

MAF. For MAF, all allowable costs are deducted from self-employment income, then compared to the countable income limit. Cases that pass that test then have their adjusted income calculated using the MAF formula.

OHP. In the OHP program, first compare gross monthly income from self-employment to the \$10,000 income limit. If average monthly gross income from self-employment exceeds the \$10,000 limit, the filing group is ineligible. If the gross income is under the \$10,000 limit, deduct costs as follows:

- 50 percent deduction from monthly SLF income, or
- Actual expenses if above 50 percent.

TANF/MAA. Self-employment is treated the same as other earned income and given a 50 percent disregard by CMS. The only exception is for JOBS Microenterprises. The earned income deduction for income earned in the Microenterprise is 50 percent of the client's countable income calculated per OARs 461-145-0920 and 461-145-0930.

9. Case Scenario

Amy Jefferson applies for cash, medical, day care and food benefits for herself and Billy, her three-year-old son. Amy is a hairstylist. She pays \$460 per month for a space at The Hair Biz. Her rental pays for her share of utilities, exclusive use of her chair, access to a sink, a supply of towels, her share of the receptionist's salary and use of the laundry facilities. Amy sets her own hours, usually putting in 30-35 hours per week. She determines which services to offer, sets her own prices and is solely responsible for collecting the income from her work. Amy is determined to be self-employed.

She provides a copy of the bookkeeping log that she is keeping for tax purposes. Amy's budget month income of \$1,750 closely matches her ongoing average of \$1,800 per month. Her allowable costs for space rental and supplies total \$670.

ERDC. Amy is not eligible as she is self-employed.

FS. Amy has allowable costs, so she is given the 50 percent self-employment income deduction. Because Amy was not self-employed last year, the worker anticipates her income at \$1,800 per month, codes it as SEC and the computer deducts 50 percent.

MAF. Deduct all allowable costs from self-employment income before the countable income test. Amy's budget month income of \$1,750 minus her allowable costs of \$670 leaves a total of \$1,080, which is over the countable income limit. Amy is over income for MAF.

OHP. Amy has allowable costs, so 50 percent is deducted from her three-month averaged income of \$1,800 to leave \$900 HPI. Amy is income eligible for OPU; her son qualifies for OPC. The deduction of 50 percent was applied by the worker, because she does not have costs that equal more than half of her income.

TANF/MAA. Amy's budget month income of \$1,750 is over the countable income limit. She is over income for TANF and MAA. The 50 percent earned income deduction can be applied only after the applicant passes the countable income test.

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A. Issuing Benefits

Issuing benefits is a separate function from eligibility determination. Consider the security of the benefits and the household's circumstances in determining the appropriate method of issuing benefits.

1. General Information

Issue cash benefits by one of the following methods:

- Issue TANF and health-insurance premium reimbursements (HIP) when combined with TANF by Electronic Benefits Transfer (EBT), unless benefits are delivered by direct deposit.
- For all other programs, issue benefits by check (printed check or direct deposit) to the primary person or the authorized representative, or by vendor payment.
- For all benefit groups with members working under a JOBS Plus agreement, the employer pays benefits in the form of wages, which are reimbursed by DHS.

Issue FS benefits by one of the following methods:

- Except for FS cash-out (FSCO) clients and FS JOBS Plus clients, FS benefits are issued via EBT.
- FSCO clients may choose to receive benefits by either EBT or Direct Deposit.
- FSCO clients without a bank account and who are unable to adapt to EBT are issued FS benefits by check.
- For all benefit groups with members working under a FS JOBS Plus agreement, the employer pays FS benefits.

2. Electronic Benefit Transfer

The Oregon Trail Card (EBT) system makes FS and CMS-issued TANF benefits and HIP reimbursements (TANF and HIP equal cash) available to clients by using a plastic debit card at *point-of-sale* (POS) devices and *automated teller machines* (ATMs). EBT operates through a partnership between a contractor (eFunds) and DHS. The DHS EBT computer system is EB (electronic benefits). The system functions through an interface among EB, CI-FIND, CMS and FSMIS on one side, and eFunds's system on the other.

One advantage of the Oregon Trail card is benefit availability. Weekends and holidays do not affect when a client receives their benefits. The client will know when their benefits are available.

There are two types of accounts available in the system: a cash account and a FS account. Cash benefits issued by CMS will be deposited in the cash account. For FSCO, FS benefits will be deposited to the cash account unless they opt for direct deposit of their FS cash benefits. All other FS benefits will be deposited in the FS account.

FSCO clients must be issued their FS benefits through the EBT or DD system. On a case-by-case basis, FSCO clients who are unable to adjust to the EBT system may receive their benefits by check only if direct deposit is not an option. If, in the professional judgment of the case manager and supervisor, the FSCO client has a medical or psychological condition (documented or not) that makes it very difficult for them to adapt to using an EBT card, the client may be issued their FS benefits by check.

Note: Cash direct deposit is not affected by EBT. Clients whose cash benefits are directly deposited into a bank account will remain in direct deposit unless changed by the worker. Companion FS benefits will be issued by EBT, unless they are for FSCO clients who have an alternative method (direct deposit or check).

New clients may be issued an Oregon Trail card and select a *personal identification number* (PIN) before their eligibility is determined; generally after the initial screening interview. This provides better client service by eliminating the need for multiple visits to the branch office. When benefits are issued, they will be deposited to the EBT account.

The Oregon Trail card and PIN together control access to client accounts. The PIN is a four-digit number known only to the client. The selection device encrypts the PIN as the numbers are selected: there is no way to view the PIN on the system. If a client forgets their PIN, they must come into the local office and select one.

3. How Does EBT Work?

The responsibilities of those involved in EBT are as follows:

- The client contacts the branch and has an interview. Branch staff set up a CMS or FS case. The case can be in pending status.
- The EB system creates an EBT case or connects the CMS/FS case to an existing EBT case. The EBT case and client information is sent to eFunds.
- When branch staff determine that the client may be eligible for benefits, branch card-issuance staff give the client EBT information and an EBT card.
- DHS's EB system sends the card information to eFunds.
- The client selects a PIN for their card.
- Branch staff determine eligibility and issue benefits using CMS and FSMIS.

- Benefit issuances are sent to the eFunds system. For regular issuance, an overnight process will send the data to eFunds. For immediate issuance, the data is transmitted to eFunds online when the worker authorizes it.
- The client uses their card and PIN to buy food or withdraw cash at a POS device. They may also withdraw cash at an ATM. Each time the client uses their EBT card, they get a printed receipt showing the balance in their account. If the transaction is denied, the receipt includes the reason (e.g., incorrect PIN or insufficient funds).

4. **Setting Up the EBT Case/Changing Payees**

EBT Case Creation. EBT cases are created automatically by the EB system when you add a CMS or FS case. To ensure that a single EBT case is created for clients with companion cases, the cash payee and FS head of household need to be the same person. EBT cases are also created when the EBT payee changes (e.g., whenever the FS head of household or cash payee changes).

Note: If an old FS case exists in the computer files, but no EBT case was created, an ADJ transaction will establish the EBT case.

Changing Payees. When the EBT payee is changed, the EB system recognizes that benefits need to be issued to the EBT case with the current payee connection. The connection between the EBT case and the previous payee is automatically changed. The EBT Case Detail screen displays the case numbers of the eligibility cases connected to the EBT case. It also displays the payee's status for each eligibility case as "C" (current payee) or "P" (previous payee).

Benefits cannot be transferred from one EBT account to another. If there are any benefits remaining in the previous payee's account, they must be withdrawn by the previous payee or their alternate payee. Balances cannot be transferred between EBT cases.

Note: When an FS payee changes, it is actually a delete of the old FS case and an add of a new case (a case number change).

5. **About EBT Alternate Payees**

During the eligibility interview, discuss the potential need for an alternate payee. Inform the head of household that an alternate payee will have their own Oregon Trail card and PIN, giving access to the client's benefits. The client needs to decide whether they want alternate payees. Make sure that the head of household understands that the alternate payee will have access to benefits without the client giving any further authorization.

- If the alternate payee is not also an adult member of the FS group, the client will need to provide written authorization on the *Designation of Authorized Representative or Alternate Payee* (AFS 231), identifying their alternate payee.

- If the alternate payee is a member of the filing group, the AFS 231 is not to be filled out.

Access to each type of account (cash and FS) can be controlled separately. The primary payee chooses which account(s) an alternate payee will have access to. Benefits spent by an alternate payee will not be replaced.

If a client decides they no longer want their alternate payee to have access to their account(s), the client should call their case worker to remove an alternate payee, or to select a new alternate. Requests for changes to alternate payees are processed on the EBCAS screen. If the client wants to block access by the alternate payee temporarily, they can call eFunds Customer Service and have the alternate payee's card status changed to INACTIVE. This is the only status reason that can be changed back to ACTIVE. The client can also call eFunds Customer Service and request that an alternate payee's card be deactivated/canceled if they need to end an alternate's access immediately.

***Note:** When notified that an adult with an EBT card has left the household, be sure to cancel the card. If the card is not cancelled and the alternate payee continues to use it after being removed from the household, DHS must restore benefits.*

***Note:** Designated branch staff may inactivate or cancel the EBT card online.*

Alternate Payees; EBT: 461-165-0035

6. EBT Help/EBT Problems

eFunds provides telephone assistance through separate numbers for clients, DHS staff and retailers. eFunds Customer Service number is an *Automated Response Unit (ARU)* that is available 24 hours a day, seven days a week. You can also reach a person at eFunds Customer Service 24 hours a day, seven days a week. To speak to a person at eFunds Customer Service, clients must stay on the line. This includes clients who have rotary phones or who need language services other than Spanish or English.

Help for Clients. Using the ARU, clients can check their benefit balance and review their last 10 transactions; or transfer to a Customer Service representative to report a card lost, stolen or damaged or request other assistance.

The client should call eFunds for all card losses. For protection of their benefits, clients should call eFunds Customer Service to report a lost/stolen card or a compromised PIN as soon as they discover the loss or suspect that someone knows their PIN.

The client Customer Service number is printed on the training pamphlet and on the back of each Oregon Trail card. The number is 1-888-997-4447. This is a toll-free call. eFunds has a variety of bilingual staff. If they do not have someone on staff who speaks the client's language, they have access to other resources, such as the Telephone Language Interpreter Services. Call Optimal Phone Interpreters (OPI) at 1-877-746-4674.

- ☞ SEE MULTIPLE PROGRAM WORKER GUIDE #11, SUBSECTION B.3, INTERPRETER SERVICES, (MP WG#11.B.3) FOR FURTHER INFORMATION.
- ☞ FOR MORE INFORMATION, SEE 2005 SELF-SUFFICIENCY ACTION REQUEST SS-AR-05-014
([HTTP://WWW.DHS.STATE.OR.US/POLICY/SELFSUFFICIENCY/PUBLICATIONS/SS-AR-05-014.PDF](http://www.dhs.state.or.us/policy/selfsufficiency/publications/ss-ar-05-014.pdf)) OR THE TELEPHONIC INTERPRETING SERVICES PUBLICATION FROM OPI (<http://www.dhs.state.or.us/policy/selfsufficiency/publications/ss-ar-05-014att.pdf>).

Help for Staff. eFunds Customer Service number is 1-800-831-5235. While this is listed as a different number than eFunds Customer Service number for retailers, it reaches the same customer service staff as the number for retailers (merchants). Staff should use this number primarily for assistance with card issuance equipment problems.

For issues other than equipment problems, staff should call the DHS Service Desk at 503-945-5623 or 1-888-457-3375.

Help for Retailers. To make FS transactions with the EBT card, retailers must be approved by FNS. If retailers need information about becoming certified to accept Oregon Trail cards, refer them to FNS at 503-326-5971. Retailers that have questions about using the EBT card or need other assistance, such as equipment problems, can call eFunds at 1-800-831-5235.

7. Client Training; EBT

Each branch or district will designate staff to provide Oregon Trail card training to new clients and their alternate payees. Depending on local resources and needs, the training could be given in a group setting, as part of an orientation or on a one-on-one basis. The training may consist of two parts.

Each branch or district has a video that can be played continuously or at selected training times.

The second part of the training is the *How to Use Your Oregon Trail Card (EBT Card Brochure)* (DHS 208) client pamphlet. The DHS 208 is available through Distribution Services. Go over the pamphlet with the client to ensure they are familiar with the process. Some clients may need more individualized training.

8. Card Issuance and PIN Selection; EBT

Card issuance involves:

- Providing Oregon Trail card training to new clients and their alternate payees.
- Issuing original and replacement Oregon Trail cards to clients and their alternate payees.

- Helping the client and alternate payee with the PIN selection process.
- Helping the client and alternate payee use the POS device, the PIN pad and the printed receipt.

The branch worker who determines cash or FS eligibility does not issue the Oregon Trail card to the client. This separation of responsibility is an important security measure. The branch or district decides who will issue EBT cards from the office.

The branch person authorized to issue EBT cards must:

- Positively identify the client.
- Log out an EBT card and record it on the client's EBCRD screen.
- Have the client select a PIN on a POS device.
- After the client has successfully selected the PIN, perform a balance inquiry with the client to verify that the card and PIN are working properly. When the balance inquiry is completed, the system prints a statement for the client.

During PIN selection, emphasize the need for the client to keep their PIN secret. Also, inform the client of the need to call eFunds Customer Service as soon as they discover that their card is missing or that they have compromised their PIN. A PIN is compromised any time the payee feels that someone else may know the number. Emphasize to the client to call eFunds Customer Service number and not the local branch office. When a client has reported a card lost or stolen, eFunds Customer Service staff will deactivate the card. This will prevent anyone from using the card to obtain benefits.

Branch card-issuance staff may deactivate an EBT card to prevent the loss of benefits. Once a card has been DEACTIVATED (e.g., coded as lost or stolen), a new card must be issued. eFunds Customer Service staff will direct the client to contact their local office for a replacement card.

***Note:** When SPD/AAA staff determine that a client is not able to come into the office to select a PIN, the branch will use a special process as described in SPD procedures.*

☞ SEE THE SPD SUPPORT STAFF ASSISTANCE MANUAL II.A.10.

9. Replacing Lost, Stolen, or Damaged EBT Cards

Clients must call eFunds Customer Service to report a lost, stolen or damaged card. They need to report these problems as soon as they are aware of them; their benefits are at risk if someone else uses the card. The branch office can also cancel a lost, stolen or damaged card.

The client must come into the local office to get a replacement card. Before issuing a replacement, the card issuer must verify the client's identity and ensure that the old card is no longer active. When the client gets a new card, they can use their old PIN or select a new one.

If someone finds a lost card, it should be returned to address on the back of the card. The card will then be destroyed. Cards returned to branch offices should be destroyed. Cards left in Automated Teller Machines (ATMs) will not be returned to clients and must be replaced by the branch.

☞ SEE FS G.20 FOR MORE INFORMATION ON REPLACING FS EBT CARDS.

10. **Forgotten or Compromised PINs; EBT**

The eFunds system keeps track of the number of times an incorrect PIN is used during the day. Anytime someone attempts to use the EBT card and enters an incorrect PIN, the transaction is rejected and the number of "PIN fails" increases. If a person fails to enter the correct PIN four times in one calendar day, the card/PIN is locked up, to be released after midnight. If the client does not know their PIN or cannot wait until the next day, they must come into the local office to select a new PIN. It is not necessary to cancel the EBT card to assign a new PIN.

Note: If the client successfully uses their PIN after fewer than four failures, the PIN fail number resets to 0. It also resets every day at midnight.

If a client forgets their PIN or believes that someone else knows what it is, they should call eFunds Customer Service to report it. eFunds Customer Service staff will invalidate the PIN. eFunds staff will also advise the client to go into their local office to select a new PIN.

11. **Access to Benefits Via EBT**

Cash Benefits

Clients and their alternate payees may access cash benefits (including FS cash-out benefits) in two ways, through POS devices at some retailers displaying the "Oregon Trail Card Accepted Here" sign and at participating ATMs. As retailers sign up to participate in the Oregon Trail card project, they decide what amount of cash they will allow a client to withdraw per visit using the POS device. Each store will have their own policy, so the client should ask how much cash they can get back, and if they can do cash-only withdrawals. Clients will not be charged for a cash purchase or a purchase with cash back. They have two free POS cash-only withdrawals each month. After the two free withdrawals, there will be an 85-cent charge for each subsequent withdrawal in a calendar month. Retailers can sell clients money orders at a minimal fee, for all or part of their cash benefits. This would count as a purchase, not one of the two free withdrawals.

This option provides a good solution to both the client and retailers as the client does not leave the store with large amounts of cash and the retailer reduces security issues by not being required to keep large amounts of cash on hand.

ATMs

Some clients choose to use ATMs to access their cash benefits. There is an 85-cent deduction from the client's TANF account for each ATM transaction, plus any bank surcharges. Many ATMs have a surcharge and the amounts differ. Most ATMs will accept the Oregon Trail card.

The following is a partial list of ATMs that are participating:

- US Bank.
- Bank of America.
- First Security Bank.
- Chetco Federal Credit Union.
- Card Capture Services.

There are other participating ATMs that have an Oregon Trail card sign on them. For others, the only way to know if the ATM accepts the card is by trying.

ATM Misdispense

If clients contact the branch to report they received the wrong amount from an ATM (a misdispense), refer them to eFunds Customer Service Desk 1-888-997-4447. Federal banking laws require a resolution within 30 days but it sometimes takes as long as 45 days. If the bank finds the ATM out of balance, eFunds will credit the client's EBT account. Narrate when client calls to report a misdispense.

Access Fee for EBT-Issued Benefits: 461-165-0096

Food Stamp Benefits

Clients access their FS benefits through POS devices at retailers displaying the Oregon Trail sign. The client can make as many food purchase transactions as they need each month with no transaction fees. The retailer is responsible for ensuring that only allowable food items are purchased from the FS account. By doing two separate transactions, a client with FS and cash benefits can pay for food and nonfood items with their Oregon Trail card. The client receives no change or cash back on an FS transaction. A return of a FS purchase results in a credit to the client's FS benefit account.

Clients can also access their Oregon Trail card FS benefits when no POS device is available by using an off-line voucher system with retailers that have been approved to accept FS benefits. This includes nontraditional retailers such as route delivery providers.

These retailers, and traditional retailers when their terminals are down, will use an off-line voucher system. However, not all retailers will process voucher transactions when their terminals are down. If they will not, the client will either have to return when their terminals are back up, or go to a different store. The voucher works similar to a credit card transaction. The retailer fills out the voucher, which is then signed by the client. The retailer compares the signatures on the voucher and the Oregon Trail card, and then calls for telephone confirmation of benefit availability by eFunds. The retailer calls the eFunds Help Desk number. The off-line voucher system applies to purchases from FS benefits only.

Note: Because elderly and SSI clients in the cash-out demonstration area receive FS benefits in their cash account, they will not be able to use the voucher system.

12. Retailer Issues; EBT

Overcharges

When clients report that a retail store has deducted money from their account in error, (i.e., the store said the card did not work and they paid cash or left the groceries but the amount was deducted) print a copy of the transaction from EBT Financial History, give it to the client and suggest they take this back to the store for resolution. If the issue cannot be resolved at this level, have the client call eFunds and file a claim with their research department. eFunds will research the issue and credit the client's account, if appropriate.

Undercharges

Retailers cannot identify clients unless the retailer has a voucher with the client's name. Sometimes clerks fill out the voucher and get approval but fail to record the entire card number. It is appropriate to provide the retailer with this information if the voucher information is available on EBT Financial History.

For POS transactions, the only client information retailers have is the Oregon Trail card number, or only the last four digits. They may contact branch offices to request help when the client's account is not deducted because the store made an error. If the client can be identified, contact the client and encourage them to take their Oregon Trail card to the retail store where the error occurred. If the retailer has only the last four digits of the card, the branch will be unable to assist them.

Retailers contacting the branch regarding equipment problems should be referred to the eFunds Customer Service Desk for Retailers at 1-800-831-5235.

☞ FOR ATM MISDISPENSE PROBLEMS, SEE ACCESS TO BENEFITS VIA EBT IN THIS SECTION (IB A.11).

Other Retailer Information

- Retail stores cannot require identification in addition to the Oregon Trail card. The card and the PIN are the identification.
- For voucher transactions, the signature on the card reverse, and the voucher signature are the client identification.

13. Availability of Benefits Via EBT

Benefit authorizations are transmitted to eFunds in one of three ways:

- For a client's regular monthly benefit, there is the monthly transmission to eFunds. Benefits sent this way are available by 8:00 a.m. For FS, the benefits are available on the calendar day equal to the last number of the FS case number. For CMS and FS cash-out, benefits are available on the first of the month. Benefits will be available on these dates regardless of which day of the week it falls. Weekends and holidays do not affect availability of benefits.
- The second method is the daily transmission. For CMS, benefits sent this way are available to the client by 8:00 a.m. the calendar day following the benefit authorization, but no earlier than the first of the payment month. For FS, once the monthly report has been processed, the benefits are available on the next day or the calendar day equal to the last number of the FS case number.
- The third method is immediate issuance. Benefits sent this way are available to the client immediately. FS benefits will be available the same day as issued when an immediate issuance release code such as IA, IX, or IJ, is used on FSMIS. TANF benefits are available immediately when issuing from the EBT Immediate Cash Issuance screen (EBISS).

14. EBT Benefit Aging

Aging Process. If an issuance does not have any withdrawals for 12 benefit aging periods, it becomes inactive and the remaining balance is “aged off” and expunged from the state. Benefits that have aged off cannot be restored to the client.

Note: Benefits issued through direct deposit (cash and FS cash-out) are not affected by the aging process.

- eFunds tracks which issuances have not been accessed by an EBT payee for each aging period. Aging periods are from the 16th of each month through the 15th of the following month. Partial months are not counted. For example, an issuance available June 3 would not be counted in the aging period beginning May 16 and ending June 15. Instead, because eFunds does not include partial months, it would first be included in the aging period beginning June 16 and ending July 15.

- eFunds tracks each benefit issuance, not the total account balance. The system works on a “first-in, first-out” basis. Purchases are deducted from the balance of the oldest issuance first. For clients who wish to accumulate benefits in their account, making a small purchase each month will only preserve the oldest remaining issuance, not more recent ones.

Client Notification. Notice WCN005R-A: EB12 – Unused Benefits May be Lost – will be sent monthly to all clients with a balance of \$2.00 or more that has not been accessed for 12 months. Information on this notice will be displayed on the Client Notice Log – LOGI. The notice is mailed mid-month.

Tracking Aged Benefits. Information about aged benefits is available in the EB system and as the EBT Vendor File Aging Listing report (WEB0355R-A) on ViewDirect.

- For 90 days after the issuance has been aged off, the aging transaction will display on the client’s EBT Financial History screen (EBFHL) with the Msg-Type “S1014”: and the Trans-Type “DEL.” The aged off issuance will also display on the client’s EBT Benefit Issuance History screen (EBISH) with the benefit status code “D.”
- FS issuances that have been aged off will display on page 3 of FSUP. When none of the original FS issuance was accessed by the client, and the original issuance amount is aged off and expunged, the aged issuance displays as canceled. When the aged off issuance is a portion of the original issuance amount, it is displayed as an adjustment.
- Cash issuances that have been aged off will display on WISH. When none of the original cash issuance was accessed by the client, and the original issuance amount is aged off, the aged issuance displays as canceled. When the aged issuance is a portion of the original issuance amount, it is displayed as an adjustment.

Restoring Aged Benefits. Benefits will remain in clients EBT accounts for 12 months. Once the benefits age off, they are expunged from the account and sent back to FNS and the benefits cannot be restored to the client.

15. Using EBT Benefits to Make Voluntary Repayments

By completing and signing the *Voluntary Agreement to Reduce, Close or Deny Benefits* (DHS 457D), clients may choose to make voluntary repayments of part or all of their FS or cash account balance. Branch staff with appropriate RACF authority may reduce, in whole dollar amounts, the available FS or cash benefit using the EBT Adjustments/Conversion screen. Cash adjustments will display on the WISH screen.

To Avoid an Overpayment. The client’s FS or cash account balance is reduced on the EBT Adjustments/Conversion screen by entering the amount of available balance to be reduced to avoid an overpayment. An “N” should be entered in the repayment of overpayment field.

To Repay an Overpayment. The client's FS or cash account balance is reduced on the EBT Adjustments/Conversion screen by entering the amount of available balance to be reduced to repay an overpayment. A client may also choose to reduce a cash balance in order to repay a FS overpayment. A "Y" should be entered in the repayment of overpayment field. An *Overpayment/Overissuance Change Report* (DHS 284A) must be completed and sent to Overpayment Recovery so that the client's overpayment may be reduced.

16. Canceling EBT Issuances

Clients may request EBT issuances canceled by completing and signing the *Authorization to Cancel Benefits Deposited to an Electronic Benefits Transfer Account* (AFS 215). EBT issuances may be canceled on the EBT Benefit Issuance History (EBISH) screen by branch staff with the appropriate RACF authority. Only issuances that have not been accessed may be canceled. FS issuance cancellations will display on page 3 of FSUP. Cash issuance cancellations will display on WISH.

17. When the FSMIS and CMS Cases Close; EBT

The Oregon Trail card account does not close when a case is closed: the client is entitled to use whatever amounts remain in their account. In addition, the client may still need EBT services from the local office (e.g., they may need to add an alternate payee, get a replacement card, select a new PIN, etc.)

When a case is closed, advise the client to hold on to their card. If they reapply, they may use the same card if they meet all the following:

- The primary payee for the case has not changed.
- They still have the card.
- The card has not had the status changed to anything other than INACTIVE.
- The card is still in good working order. The client can perform a balance inquiry to make sure the card still works.

If they do not meet any of these conditions, issue a new card to the client.

When benefits end because a person has died, and there are no other persons in the FS benefit group, branch staff with RACF authority remove the balance from the FS account using the EBADJ (EBT Adjustments/Conversion) screen. For all other benefits, the balance belongs to the client's survivors. Determine if DHS should designate an alternate payee.

18. When a Client Moves Out of State; EBT

The Oregon Trail card can be used to access FS and cash benefits in almost all locations in the U.S. When a client leaves the state with benefits remaining they will need to locate a retailer or ATM that accepts the Oregon Trail card.

Cash Clients. If the client does not have an active card or valid PIN and has **only** cash or FS cash-out benefits remaining, use the EBADJ (EBT Adjustment/Conversion) screen to convert the benefits. Issue a special pay check using special pay reason code 5.

FS Clients. If the client does not have an active card or valid PIN and has FS benefits remaining, issue a new card and have the client select a PIN by phone. The card is to be mailed to the client. The PIN is not to be mailed to the client. The client must remember the PIN they selected. The identity of the client must be verified to the satisfaction of the card issuer.

***Note:** The simplified card/PIN issuance procedure above is only for remaining benefits. The procedure for issuing cards when the client cannot be present, found in the CAF Field Business Integrity Manual and SPD Support Staff Assistance Manual, is used for ongoing benefits.*

19. Nonstandard Living Situations; EBT

Some clients receive their FS benefits in nonstandard living situations. Some considerations that may not apply to clients living independently include:

- The client may designate an employee of the facility as their alternate payee, or may choose to use their benefits for themselves.
- Facilities may use FS benefits through a POS device in the facility, through vouchers or by shopping at the store with cards. How this is done will be decided on a facility-by-facility basis depending on FS volume. Cash benefits can also be accessed through the POS in some facilities. The facility with a POS device can swipe the Oregon Trail card and transfer FS benefits to the facility's account. Clients in semi-independent living may shop for themselves and swipe the card at the store. In some instances, facilities with a smaller FS volume will use vouchers to transfer FS benefits. To have a POS device or use vouchers, the facility must be authorized by FNS as a retailer.
- When the facility accesses FS benefits, they should determine a prorated daily amount based on that individual's FS benefit, with the facility swiping the card weekly or biweekly based on the cost of meals for the week. Facilities that are not authorized as a retailer and must shop with individual cards will need to use FS benefits carefully to ensure that one half of the benefits are left in the client's account should they leave the facility before the 15th.

- The facility should ensure that the client has their card and that the amount in their EBT account reflects the full balance that the client is entitled to. If the client is entitled to any part of the EBT funds already deducted, the facility can process an FS purchase refund. This will debit the center's daily transactions and credit the client's FS benefit account.

When the client leaves a facility, they need to call the local office to update their address, have the facility removed as their authorized representative and/or alternate payee and select a new representative or payee, as needed.

20. Direct Deposit (DD)

Direct Deposit (DD), also called Electronic Fund Transfer (EFT), is an issuance method for cash benefits (including FS cash-out). Direct deposit is not affected by EBT. Clients with a bank checking or savings account may prefer to use DD instead of EBT. There is a fee to withdraw EBT benefits from an ATM but there is no fee to withdraw money from a personal bank account. Additionally, benefits issued by DD are not subject to the aging process, such as those issued to EBT accounts.

Clients whose cash benefits are directly deposited into a bank account will remain in direct deposit unless changed by the worker. Companion FS benefits will be issued by EBT, except for FS cash-out. Benefits direct deposited into bank accounts will not be displayed on EBT screens. Using DD, clients can have their benefits deposited directly into their checking or savings account. DD is available for CMS-issued benefits, including cases in the MRS and reimbursement of cost-effective, employer-sponsored health insurance premiums (HIP). Special cash payments cannot be made via DD. DD is also available for FSMIS-issued benefits for FS cash-out clients only.

Benefits are replaced only if some problem with coding the case prevents direct deposit. Once DHS transmits the electronic transfer to the client's bank, credit union or savings and loan account, the benefits are considered the same as a check the client has cashed.

The Client Maintenance Unit (CMU) does the DD data entry for all clients. CMU is also responsible for resolving problems with deposits. Report all problems to CMU at 503-378-4369. Branches should send all authorizations they receive to CMU using the state shuttle (if available), or mail them.

21. How to Sign-Up for DD

The sign-up procedure for DD is as follows:

- The branch will give a *Direct Deposit – A Safer Easier Way* (AFS 7262) and a pre-addressed, postage-paid envelope to any new or ongoing clients who want to sign up for DD.

- Clients who want to use DD complete the AFS 7262, or take it to their financial institution.
- The bank, credit union or savings and loan enters the account number and routing number shown on the AFS 7262 and returns the form to the client.
- The client then returns the DD authorization to the address on the form, using the pre-addressed, postage-paid envelope.
- DHS sends a pre-note to the client's bank to ensure that the account is open and all information is accurate.
- When the client's first DD is successfully completed, a computer notice is sent to inform the client. The notice is recorded in the client notice file (LOGI).

22. DD Check Redirects

Clients receiving their CMS cash benefits via DD may get their benefits redirected, just like other clients.

For CMS-issued benefits, the benefit redirect is processed using HLD1/HLD2. These checks are redirected to the branch. The hold may be generated by the worker or the system. All holds are listed on HLD2 (accessed via HLD1) and the *List of Branch Held Checks* report (WCM0120R-A) on ViewDirect.

23. Removing Clients from DD

The DD authorization becomes invalid when either of the following occurs:

- The DD is rejected (e.g., the client's account is closed, the payee changed or the CMS/FS case is closed); **or**
- A client indicates that they no longer want to receive their benefits through DD.

When the client indicates that they no longer want to receive benefits via DD, contact CMU to make the change. When CMU closes the DD record, the system sends a notice to confirm the change in issuance method.

24. Check Registers and Assistance Summaries

For CMS

Check registers and assistance summaries show the codes for cash payments. The indications of direct deposit issuances are:

- A DD beside the check amount under the heading DD.

- A DD series of check numbers.

The assistance summary will show the electronic deposit as a regular CP with no DD notation.

For FS

Page 3 of FSUP and the Electronic Deposit Transaction Register report (WEB387X-B) on ViewDirect show the codes for FS cash-out benefits issued by DD. The indications of direct deposit issuances are:

- A two-digit release code (REL ATP) starting with a “D” (e.g. DG indicates direct deposit for a monthly batch issuance).

25. Rejected DD

When a client has DD and reports that they did not receive a deposit because their bank account closes or their account number changes, the worker needs to take action to issue the monthly benefits. Below is a summary of what to do:

- Call CMU (503-378-4369). CMU needs to know the client closed their bank account or their account number changed. CMU receives a notice when a DD did not go through. It can take six to 10 days for the notice to get to CMU. A call from the worker allows CMU to change the DD status so DHS does not try to make any further DDS to the closed account.
- When you are sure DHS did not make a DD, issue the client a check. Use either the Special Cash Pay process online, or, if you judge that the client needs the money right away, issue the check through the revolving fund. In either case, use code 03 for CMS and code 81 for FS cash-out benefits.

Note: It is unnecessary to do a check replacement or go through the check replacement procedure. Because DHS could not make an electronic deposit, the client needs a check instead of the DD.

This transaction will show on the MCR1 screen for CMS replacements and FSUP page 3 for FS cash-out replacements. If the client wants to continue using DD, they must complete a new *Direct Deposit - A Safer Easier Way* (AFS 7262) and send it to CMU.

26. Replacement Checks for DD Benefits

To determine if a client in DD is entitled to a replacement check, for CMS-issued benefits, look at the WCMI or UCMS screen to determine if the case is coded Y in the DD field. The Y will be deleted if the DD cannot be made.

- If DD is not coded Y, check MCR1 to determine if cash payment was issued. If no special cash payment was issued, issue a replacement check. If a special cash

payment check was issued but not received, issue a replacement using the check replacement procedure. Otherwise, do not issue replacement benefits.

- If DD is coded Y, but the client claims no deposit was made, contact CMU.

For FS-issued benefits, look at FSUP to see if Y displays in the DD field and FSUP page 3 to determine whether and how the issuance was made.

- If a direct deposit issuance is indicated and BR also displays, check EBISH to see if the issuance was deposited into the EBT account.
- If a direct deposit issuance displays, there is no BR status indicated for that issuance and client claims no deposit was made, contact CMU (503-378-4369).

27. FS Cash-Out (FSCO) Project for SSI/Senior

☞ SEE FS G.2 FOR INFORMATION ABOUT FOOD STAMP CASH-OUT.

28. Legal Status of Benefit Payments

- Under Oregon law, cash benefits are not subject to assignment, transfer, garnishment, levy or execution, as long as they can be identified as program payments and are separate from other money in the client's possession.
- A cash payment accrues to and becomes vested in the client when issued.
- Except for EBT, consider a benefit issued if the check has been handed to the client in the branch office, or mailed to the client. Consider a benefit issued, and received by the client, when a direct check deposit is made to the client's bank account.
- For EBT, consider benefits issued and received when an EBT card and personal identification number (PIN) have been issued in person to the client, or the EBT card and PIN have been received by the client in the mail, and the benefits have been deposited to the client's EBT account.
- FS benefits in the EBT account remain available for client access as long as the account is active. The EBT system removes them after three calendar months without account activity.

☞ SEE ITEM 14 (IB A.14), EBT BENEFIT AGING, OF THIS SECTION.

- Cash benefits, including FS cash-out, are unrestricted and do not require accountability for individual expenditures or amounts. FS benefits are required by Federal Law to only be used for allowable food items.

Note: Stores accepting FS benefits are required by federal law to restrict the usage to allowable food items.

Legal Status of Benefit Payments: 461-165-0010

29. Concurrent and Duplicate Program Benefits

Clients cannot receive benefits of the same type (cash, medical, FS) for the same time period from Oregon. For example, a client cannot receive FS benefits in Portland and also receive FS benefits as a member of another household in Klamath Falls for the same time period. Another example is that no person may receive both foster care/adoption assistance and TANF for the same dates. The exceptions to this rule follow:

- A client receiving TANF for themselves and their children may also receive ERDC for children who are in the household group but cannot be included in the TANF filing group.
- A client may receive TA-DVS and cash payments from other programs for the same time period.
- A child who is an ERDC benefit group member may also be a member of the following benefit groups:
 - A TANF benefit group when living with a non-needy caretaker relative, if the caretaker relative is not the parent.
 - An OSIP-AB benefit group.
- FS clients who leave a filing group that includes a person who abused them and enter a domestic violence shelter/safe home may receive FS benefits twice that month.
- A QMB-BAS client may also receive medical benefits from EXT, MAA, MAF or OSIPM.

Clients cannot receive benefits of the same type (cash, medical, FS) for the same time period from Oregon and another state, except as follows:

- Medical benefits may be authorized for an eligible client if an Oregon provider refuses to bill another state and the client would not otherwise receive medical care. Accept the client's statement as verification that a provider will not bill another state for needed medical services.
- Basic needs payments, support services and medical benefits may be authorized during the Pre-TANF Program, if it has been verified that benefits from another state will end by the last day of the month in which the client applied for TANF. These may be issued even if the client has received TANF from that state for the same month.

- ☞ FOR HOW TO PROCESS FS WHEN AN SSI RECIPIENT MOVES TO OREGON FROM CALIFORNIA, SEE FS F.16.

Applicants for FS from another state are not eligible in Oregon if they have already received their FS through EBT, even when they are unable to access the benefits. The state they left is responsible for issuing their FS benefits by a method they can use here.

If eligible, prorate benefits based on the application filing date unless the applicant is a migrant or seasonal farm worker.

- ☞ FOR MORE INFORMATION ON MIGRANT AND SEASONAL FARMWORKERS, SEE FS I.1.

For all other programs, use the following procedure to determine if the client received benefits from another state while receiving benefits in Oregon:

- Contact the other state to see if benefits were issued to the client.
 - ☞ FOR TELEPHONE OR FAX NUMBERS USED TO VERIFY BENEFITS IN OTHER STATES, SEE MP WG#4.
- If benefits were issued, but then returned and canceled, that is proof that the client did not receive benefits from the other state.
- If benefits were issued but not returned and canceled, have the client sign a statement that they did not receive benefits from the other state. If the other state says the benefit check was cashed, ask them to send a copy of the check to Oregon. Use the replacement check procedures to determine if the signature on the other state's check is the client's. If it is, the client is responsible for the overpayment.

Concurrent and Duplicate Program Benefits: 461-165-0030 |

30. Assigning a Payee; Not EBT

When benefits are not issued by EBT, a person may be payee for a case regardless of whether they receive benefits on that case. They may be the payee for more than one program or case. The payee is the primary person or authorized representative.

Assigning Payee; Not EBT: 461-165-0040 |

31. Emergency Payee for TANF

An emergency payee for ongoing TANF may be used when the dependent children are abandoned by the caretaker relative for reasons such as the caretaker relative's death or

whereabouts unknown and there are no other relatives immediately available to be the children's caretaker.

- An emergency payee may be used for up to two payment months.
- An emergency payee does not have to be related to the dependent child.
- An emergency payee may not be used for initial payments.

The emergency payee may be included in the benefit group if all the following are true:

- They meet all eligibility requirements except relationship and cooperation with JOBS.
- Their income and resources are counted.
- There is no other caretaker relative in the benefit group.

When an emergency payee or alternate payee is named, and benefits are issued via EBT, issue that person an EBT card and they must also select a PIN.

Change the payee and case name during the 60-day emergency period. Use an authorized representative or alternate payee (if benefits issued via EBT) designated by the client or the branch when the caretaker relative has not relinquished care, control and supervision of the children.

Emergency Payee; ADC-BAS: 461-165-0045

32. Dual Payee: When to Use

For OSIP and REF, use a dual-payee check for protective payments if the benefit group has shown they are not able to properly manage benefits meant to meet their needs. Issue the dual-payee check in both the name of the client and the name of the service provider.

Issue TA-DVS checks for shelter, moving costs, property taxes and home repairs as dual-payee or vendor checks. The supervisor or manager must authorize an exception to this policy in advance and only when necessary to prevent putting the client at risk of harm.

To make sure a JOBS payment is used to meet a specific need, the branch office may write a special cash pay or dual-payee revolving fund check in the name of both the client and the vendor.

Dual Payee; When to Use: 461-165-0050
Benefits; TA-DVS: 461-135-1230

33. Prohibition Against Benefits in Amounts Less Than \$10

In the FS program, a benefit group is not eligible for benefits in the initial month if the allotment is less than \$10. For ongoing months, FS benefits are issued as follows:

- An eligible, including categorically eligible, benefit group of one or two persons receives a minimum monthly allotment of \$16.
- An eligible benefit group of three or more persons receives the calculated allotment. A categorically eligible benefit group of three or more persons does not receive an allotment, but the case remains open with zero net allotment.

☞ SEE FS G.8 FOR INFORMATION ABOUT FS BENEFITS OF LESS THAN \$10.

For TANF and REF, do not issue benefits if the computed monthly benefit is less than \$10. People who do not receive a cash payment because the monthly benefit is less than \$10 are eligible for medical benefits. The \$10 limitation does not apply to:

- Special payments, such as one-time special needs, emergency assistance, supplements or a benefit amount under \$10 due to recovery of an overpayment.
- Dual-payee payments made in money management cases if the monthly benefit amount is \$10 or more. Issue to the client any remaining funds after the dual-payee payments are made.
- Wage supplements issued to JOBS Plus participants.

Minimum Benefit Amount; FS, REF, TANF: 461-165-0060 |

34. Immediate and Advance Issuance

Provide the client with an immediate issuance of benefits for new, reopened and restored cases if the client is eligible for a benefit and has emergent needs that must be met before a benefit can be issued through the automated computer system; or for FS, meets the criteria for expedited service.

Provide immediate issuance of benefits as follows:

- For cash benefits, issue by EBT using the EBT Immediate Cash Issue Screen (EBISH), revolving fund check or the special cash pay system.
- For medical benefits, issue a temporary medical ID card.
- For FS, except for FSCO clients who receive a check or DD, issue by FSUP into the EBT account.

- For FSCO clients who receive benefits by check or DD, issue a revolving fund check (code 80).

Immediate Issuance of Benefits: 461-165-0070
Timely Issuance of TANF Benefits for Clients in MRS: 461-165-0150

35. Method for Delivery of Benefits

Benefits are delivered several ways, depending on the program and client situation. Send all mailed benefits to the client's address. A rural route box number is acceptable as a client address.

Make either of the following exceptions on a case-by-case basis if directions to the home are included in the case record.

A post office box number can be used if any of the following is true:

- There is no mail service to the client's home.
- The client lives in a nonstandard living arrangement.
- There have been verified cases of benefits being stolen from home mailboxes in the client's neighborhood.

Use General Delivery only if it is the client's sole means of mail receipt.

Method for Delivery of Benefits: 461-165-0080

36. Alternate Methods for Delivery of Non-EBT Benefits

Redirect non-EBT cash benefits to the branch office if any of the following is true. The benefit group:

- Is unstable (i.e., moving constantly, and the branch needs to re-establish contact when there has been an unreported change of address).
- Is transferred to a new branch.
- Has not cooperated in completing a QC review.
- Must be contacted personally to obtain essential information that may affect eligibility or the correct computation of the benefit amount.

Additionally, if an FSCO client receives a check for the value of their FS benefit because they are unable to adapt to EBT, DD is not an option, and has a history of theft from their mail or lives in an area that has been identified by branch staff, or postal inspectors as high-risk for mail loss, they may receive their benefits redirected to the branch.

37. Issuance Date of Benefit

For all cash payments and for medical assistance:

- Date an authorized cash payment check on the first day of the payment period, or as soon as possible thereafter.
- Mail checks so they can be delivered to the client on the first day of each month. Exceptions are:
 - Initial month benefits for new/reopened/restored cases.
 - Cases in MRS.
 - Cases with no special needs or service coding receive the \$1.70 OSIP payment in advance for the benefit period, from the date of eligibility to the end of the calendar year.
 - If the first day of the month falls on Sunday or a holiday, mail the check in time for the client to receive it on Saturday or the mail day preceding the holiday.
 - Checks redirected to the branch office may be released any time on the workday preceding a weekend or holiday.

Benefits issued by EBT should be available on the first day of each month, except for the following:

- Initial month benefits for new/reopened/restored cases.
- Cases in MRS.
- Held cash benefits.
- FS benefits sent through staggered issuance.

FS benefits issued by EBT (except FSCO) are staggered based on the last digit of the case number over the first nine calendar days of the month. For FS changes that could not be made in time to adjust the monthly allotment, issue a supplement within 10 days of the date the change was reported.

Issuance Date of Benefit: 461-165-0100

38. Exception to Staggered Issuance; FS

The second month's allotment of FS benefits is not subject to staggered issuance if the filing group applies after the 15th of the month and the application is not for a

redetermination of eligibility. Once eligibility for FS benefits is established for these groups, benefits are issued as follows:

- If the FS case is opened by the last day of the initial month of eligibility, the computer will prorate benefits for the initial month and will automatically issue benefits for the second month on the first of that month; **or**
- If the case is opened after the initial month of eligibility, the computer will prorate benefits for the initial month and will automatically issue benefits for the second month on the same day if the FS benefits are issued using a prior month issuance code.

Federal regulations require that clients who qualify for FS and apply after the 15th of the month have their second month's benefits excluded from staggered issuance. The computer automatically issues the second month's benefits, even if the client is placed in the MRS. If the second month's benefits are incorrectly calculated due to a change that the branch could not act on, a supplemental payment may be made.

Exception to Staggered Issuance; FS: 461-165-0105

Note: FSCO clients are not subject to staggered issuance of their benefits.

39. Issuing Expedited FS

To ensure that FS expedited benefits are received by the seventh calendar day following the date of application, authorize immediate issuance benefits on the system by the seventh calendar day after the filing date.

Note: Applicants for expedited FS who apply on the first through the 15th of the month and do not supply complete verification are not eligible for the second month's benefits. Remember to code FSMIS so that the second month's benefits are not automatically issued.

When these benefit groups provide the postponed verification, issue the second month's benefits:

- Within seven working days of receipt of the verification; **or**
- On the first of the month, whichever is later. Do not delay benefits for cases in the MRS. Issue benefits even if the report has not been received. Use the last month's report to determine the benefit amount.

Applicants for expedited FS who apply after the 15th of the month and do not supply complete verification are not eligible for the third month's benefits. When these benefit groups provide the postponed verification, issue benefits according to regular staggered issuance procedures.

40. Alternatives to Direct Money Payment

For OSIP, REF, and TANF, the alternative to direct money payment is protective payments when the goal is to ensure that the benefits are used to meet basic needs. For REF and TANF, protective payments may be made whenever clients demonstrate such an inability to manage funds that DHS determines their benefits are not being used in their best interest. Protective payments should be used particularly if mismanagement of funds, caused by repeated interruptions of TANF benefits, poses a threat to the health and safety of children in the household.

Protective payment methods include the following:

- Payments to authorized representatives.
- Dual-payee payments.
- Vendor payments.

Alternatives to Direct Money Payment: 461-165-0110 |

If the branch is paying a client's benefits by vendor payment, all money left over after the client's bills are paid are to go to the client. The branch may not retain leftover TANF grant money.

Legal Status of Benefit Payments: 461-165-0010 |

41. Protective Payment; General Information

For OSIP, REF and TANF, protective payment is part of case management. Additionally for REF and TANF, protective payment should be discussed as part of case planning decisions around potential disqualifications to reduce the risk of harm to the children and cannot continue for longer than 24 months.

Review all protective payment plans monthly for REF and TANF, and every six months for OSIP cases. This review can be part of the redetermination of eligibility.

☞ FOR INFORMATION ON PAYMENT PROCEDURE FOR CLIENT IN HOSPITAL SEE
RULE 461-165-0120

42. Payment of Benefit Out of State

For all programs except FS, send benefits out of state if clients are absent from Oregon and they establish their intent to return within 60 days.

If clients are detained out of state beyond 60 days for medical reasons, determine continued eligibility and require the client to provide documentation of the need to remain in the other state.

For medical benefits, out-of-state medical expenditures must have prior authorization.

Refer out-of-state medical providers to DMAP for approval and copies of Oregon’s fee schedule so they can accurately bill for medical services provided to the client.

Advise people receiving medical assistance, who are temporarily leaving Oregon, that they will receive only emergency medical coverage while they are out of state. If the client needs specific information, contact the “out-of-state” coordinator at DMAP.

Clients who are enrolled with an FCHP or PCO should contact their respective plan offices for information and/or authorization for out-of-state medical coverage.

Send FS benefits out of state when: restoring lost benefits; DHS determines there is a need to send benefits out of state; or the client has an EBT account with residual benefits that they cannot access. FSCO benefits issued by DD into the bank account cannot be sent, restored, or replaced, if they were received by the bank.

Payment of Benefit Out of State: 461-165-0130

43. Endorsement of Benefits

The client or the client’s payee must endorse checks issued in payment of a benefit. The endorsement on the check must be the same as the name appearing as payee.

The client can endorse a check with a mark or thumbprint if duly witnessed by two people giving their full names and addresses.

The person with power of attorney may:

- Act as authorized representative or alternate payee.
- Endorse and cash the benefit check as in the following example:

John Doe (Recipient)
by Richard Jones (Power of Attorney)

For all programs except FS, any cash benefit issued to clients before their death is available to their survivors.

Checks may be endorsed in the name of the deceased beneficiary by the surviving spouse or next-of-kin, or by the administrator of their estate. Use the following procedure:

- Before the next of kin endorses a check, the check must be presented to the branch office.

- Rubber-stamp the endorsement on the check only if it has been determined that the client died on or after the first day of the period for which the payment was provided.
- The endorsement must show both the name of the deceased beneficiary and the name of the surviving spouse or next of kin, as well as the relationship of the endorser to the beneficiary.
- The person who endorses the check receives the proceeds of the benefit.

For cash benefits in an EBT account (except for FS cash- out), designate an adult survivor as the alternate payee. Issue the payee an EBT card and PIN to access the balance in the EBT account.

For FS, there is no survivor's right to benefits unless the survivor is included in the filing group. When the survivor is not in the group:

- Ask them to return non-negotiated FSCO checks to the branch.
- For FS benefits that were issued via EBT, delete the remaining benefits from the EBT account.

Endorsement and Survivorship of Benefits: 461-165-0140 |

When the only survivor(s) is a child in the filing group, make the guardian an authorized representative and give them an EBT card and pin to access any remaining benefits. Send a 10-day notice to close the FS case and allow the child(ren) to reapply with their guardian following case closure.

☞ FOR INFORMATION ON LATE PROCESSING FEES; TANF-BAS IN MRS, SEE RULE 461-165-0150.

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B. Client Losses and Restoration of Benefits

1. Restoring Benefits

Authorize restoration or supplemental payment of benefits, even if the benefit group is currently ineligible, if a benefit group received fewer benefits than it was entitled to because of any of the following:

- A change that would cause an increase in benefits was reported before the first of the payment month, but too late for the branch to adjust the next payment.
- The branch caused an administrative underpayment. *Administrative underpayments* include, but are not limited to, the following:
 - Failing to take action on information reported. For example, not canceling the EBT card of alternate payees who leave the household.
 - Using an incorrect effective date.
 - Denying, closing or reducing benefits in error.
 - Making calculation errors.
 - The branch was directed to restore benefits in a hearings decision.
 - The repayment of an overpayment was too much.
 - A court decision finds benefits to be wrongfully withheld and its action entitles a client to restoration of benefits.
 - An IPV disqualification is reversed. Participation in an IPV hearing automatically constitutes a request for restoration of benefits. Do not restore benefits to a disqualified person based solely on the fact that a criminal conviction could not be obtained.
- The amount restored is issued in addition to the benefits that a currently eligible group is entitled to receive. For FS, the branch office must honor reasonable requests by benefit groups to restore benefits in monthly installments.
- A benefit group that moves from the state can still receive any restoration of benefits due it.

Restoring Benefits: 461-165-0200

2. Calculating Restored/Supplemented Benefits

Calculate the amount of benefits to restore using the following process:

- 1) Determine the effective date the benefit group is eligible for lost benefits. The benefit group is not eligible for restored benefits any month that eligibility for those benefits cannot be established. Give the benefit group an opportunity to prove eligibility for questionable months.
- 2) Calculate the correct benefit amount for the months the benefit group was underpaid, or closed or denied in error.
- 3) Subtract the amount the benefit group actually received from the amount they should have received.
- 4) Offset the amount of restored benefits with previous overdue or suspended overpayments.

Restore benefits to the group containing the largest number of people who were benefit group members at the time the loss occurred. If the location of this group is unknown, restore benefits to the benefit group containing the primary person at the time the loss occurred.

☞ FOR CALCULATING RESTORED FS BENEFITS, ALSO SEE FS G.15. USE THE DHS 221 OR FSCALC.

Calculating Restored and Supplemental Benefits: 461-165-0210

3. Replacing Benefits

Lost, Stolen, or Undelivered Checks

Payment alert procedures begin when a payee reports a check was lost, stolen, destroyed, or not received and completes an *Affidavit Concerning the Lost Check* (DHS 138A).

Issue a replacement check if the original check is still outstanding and the payee claims any of the following:

- The original check was not received. Allow five postal service working days from the date the original check was issued before issuing a replacement.
- The original check was received, but not endorsed. Issue a replacement check without a waiting period if the unendorsed check was received and has been lost, stolen or destroyed.
- The original check was received and endorsed, but not cashed before it was lost, stolen or destroyed. Issue a replacement check if the check was destroyed and remnants of the check are provided as evidence **or** if the check was noted by the payee “for deposit only.”

Issue a replacement for an original check (which the payee has reported as lost, stolen destroyed, or not received) that is processed by the State Treasurer for payment only after:

- The Administrative Payments Unit has begun forgery procedures; **and**
- The client has completed a forgery packet.

The written report by the Oregon State Police on the handwriting analysis of the check signature is binding on DHS. The payee has the right to prove the analysis incorrect.

Do **not** issue a replacement check in either of the following situations:

- The client fraudulently cashes a dual-payee check without the second party's signature. The second party can take civil action against the client to recover the money, but the branch office does not replace the check to the second party.
- A check has been direct deposited to the account specified by the client.
- A check was issued in the TA-DVS program, as requested by the client, to a vendor or as a dual payee check and the client decided not to use that vendor and no safety concern was identified related to use of the vendor.

Replacing EBT Benefits (Cash and FS)

Do not replace benefits issued via EBT:

- When benefits are considered to be issued and received because the card and PIN have been issued in person to the client and the benefits have been deposited to the client's account.
- When EBT benefits were issued by a state other than Oregon. EBT states either convert client's remaining FS benefits to coupons or issue a check. Cash benefits are converted to a check.

Benefits issued via EBT are replaced under the following circumstances:

- EBT benefits that were accessed by the wrong person because the Department of Human Services (DHS) inadvertently switched cards and issued a card and PIN to someone unrelated to that case or failed to cancel an EBT card when removing an alternate payee from a case. When reported by the client, deactivate the card issued to the wrong client, issue a card and PIN to the correct client and replace the amount of lost benefits.

Example: In the process of issuing cards to several clients, the card issuer enters a card number on Mary Munro's case but assigns the card to Bad Pitt and helps Bad select his PIN. Bad Pitt's case was in pending status and with no benefits but Mary Munro has available both TANF and FS benefits. Bad Pitt takes his new card (on Mary

Munro's case) and leaves the office. To Bad's delight, he finds both cash and food benefits available and promptly depletes both accounts. The branch realizes the error after Bad emptied both accounts. The branch deactivates Bad's card, issues a card and PIN to Mary, and replaces the amount of lost benefits.

Example: Tobey reports on May 15 that his brother, William, has left the household. The branch removes William from the case effective June 1 but fails to note that he is an alternate payee. In June, William continues using Tobey's benefits. Because DHS failed to cancel William's access to Tobey's benefits, we must restore the loss to Tobey.

- For FS, replace the value of food destroyed due to either a verified household misfortune, (e.g., a fire or loss of electricity) or a state or federally declared disaster (e.g., a flood or earthquake). The branch must replace the value of food destroyed within 10 calendar days if the benefit group:
 - Reports the disaster loss within one month of the disaster and the last issuance of FS benefits.
 - Has not been issued two replacements for disaster losses within the past six months and the amount replaced does not exceed one month's allotment.

Note: If the U.S. Department of Agriculture has issued a disaster declaration and the household is otherwise eligible for emergency FS benefits, the household cannot receive both disaster benefits and benefits to replace the value of lost food.

Replacing Lost, Stolen, Destroyed or Undelivered Checks: 461-165-0220

4. Non-negotiated Check Replacement Procedures

Original CMS or Special Cash Pay (SPL) Check Not Negotiated. First, the branch uses MCR1, RCIQ or the branch office's check register to verify that an original check was issued. Verify the payee name, check number, amount and date of the check.

Next, the branch has the payee complete an *Affidavit Concerning the Lost Check* (DHS 138A). The payee must fill out every section, except payment alert number. When the payee signs the form, it must be notarized.

The branch calls Forgery Services (in the DHS General Accounting Unit) and gives them the information needed to complete a *Request for a Payment Alert and Follow-Up* (DHS 435A).

Payroll assigns a Payment Alert number to be written in the designated area of the DHS 138A.

The branch writes the Payment Alert number on the DHS 138A and forwards the original to Forgery Services.

The branch can issue a replacement check by computer or by revolving fund (for emergent needs). The procedures are described below:

- By computer:
 - If the client did not receive the check, wait five mailing days from the date the check was issued before issuing a replacement.
 - If the check was lost, stolen or destroyed but **not** endorsed, issue a replacement check without a waiting period.
 - If the payee endorsed the check before it was lost, stolen or destroyed, issue a replacement only if the remnants of the check are provided as evidence, or the check was noted by the payee *for deposit only*.
 - To issue the replacement check, complete an *Authorization for Special Cash Payment* (DHS 437) using pay reason code 03. Refer to the reverse side of the DHS 437 for more information. The computer will generate a check and it will be mailed to the payee.
- By revolving fund (for emergent needs):
 - Write the replacement check number on the DHS 437 and the DHS 138A.
 - Send the *Revolving Fund Check and Supporting Document Transmittal* (AFS 288) to the Microfilm Unit.

Original Provider Check From PP/SA Not Negotiated. Only DPU may replace provider checks issued by PP/SA. Branch offices are not authorized to replace provider checks issued by PP/SA.

Note: *There are two reasons why the branch should never replace a provider check issued by PP/SA:*

- *When a provider has multiple claims paid all on one check, each claim must be manually adjusted to reconcile the payment record, **and***
- *If the branch and DPU both replace provider checks, it is very likely there could be duplicate payments on the same claim.*

If the provider contacts the branch with a request for a replacement check, the branch must tell the provider to call DPU. The provider must wait at least five mailing days from the date the check was issued before requesting a replacement check.

After receiving a request for a replacement check, DPU will contact Forgery Services and give them the information needed to complete a DHS 435A.

DPU will notify the local branch office that the provider will come in to complete the DHS 138A. The local branch office will obtain the payment alert number from Forgery Services, assist the provider in completing the DHS 138A, notarize the form, and send to General Accounting, Forgery Services. Forgery Services will make a replacement decision and notify DPU who will replace the check and mail it to the provider.

If the provider wants a replacement check right away, DPU will make a determination of emergent need and contact the branch for issuance of payment.

Criteria DPU will use to determine emergent need:

- The payment is at least \$100; **AND**
- The provider is in a crisis (in jeopardy of losing housing, utilities or vehicle use). Proof of crises is required. Documents can be supplied through the branch or faxed to DPU; **OR**
- DHS has made an error causing a financial hardship for the provider by an undue delay in payment through no fault of the provider.

Food Stamp Cash-Out (FSCO) Checks Not Negotiated. Should any FSCO clients be unable to adapt to EBT and are instead issued a check, these are the two methods for replacing FSCO checks.

When the client needs a replacement **right away**, use the following procedure:

- The branch completes the top portion of the DHS 138A using information from FSMIS.
- The branch gives the DHS 138A to the payee. When the payee signs the form, it must be notarized.
- The branch calls Forgery Services and gives them the information needed to complete a DHS 435A.
- Forgery Services assigns a Payment Alert number to be written in the designated area of the DHS 138A.
- The branch writes the Payment Alert number on the DHS 138A and forwards the original to Forgery Services.
- The branch types a revolving fund check and codes it “FS 81.”
- The payment information is entered on SPL5 as a FS load sheet.

If the client does not need a replacement right away, use the computer, using “RB” release ATP code.

Administrative Checks Not Negotiated. Have the payee complete a DHS 138A. After the payee signs the form, it must be notarized.

- Forward the DHS 138A to Forgery Services.
- Forgery Services will complete the necessary paperwork and issue a replacement check to the payee.

5. Negotiated Check Replacement Procedure

To replace a check that is reported lost, stolen, destroyed or not received, but has been processed by the State Treasurer for payment, **Forgery Services** will send a forgery packet to the branch when the original check is returned from the State Treasury as paid.

The packet includes:

- *Affidavit, Claimant's Endorsement Forged* (DHS 163).
- *Handwriting Exemplar* (AFS 597). The AFS 597 is not needed if the payee has completed one within the last six months.
- *Payee Statement Concerning Endorsement* (AFS 980).
- Photocopy of the original paid check, front and back.
- Postal Lost Check Report (for checks not received).
- Signature page.

Note: *DD benefits, received by the bank into the account specified by the client, are not replaced.*

If the original check was issued by CMS, Special Cash Pay (SPL) or PP/SA, or was a FS cash-out check, **branches** will do the following (except as noted for provider checks issued by PP/SA):

- Make a preliminary determination whether the payee cashed the original check, before authorizing a replacement. (DPU will do this for checks issued by PP/SA.)
- Briefly review the copy of the paid original check with the payee to determine whether the signature on the check is the payee's.

If the payee acknowledges the endorsement and a replacement check was issued:

- Complete an *Overpayment/Over issuance Report* (DHS 284). (DPU will do this for checks issued by PP/SA.)
- Complete the AFS 980. Have the payee sign the form.
- Forward the AFS 980, the rest of the forgery packet, and all copies of the DHS 284 (except pink copy) to Forgery Services.
- File the pink copy of the DHS 284. (DPU will do this for checks issued by PP/SA.)

If the payee does not acknowledge the endorsement and a replacement check was issued, have the payee complete the entire forgery packet. If the payee requests a replacement check, explain the policy on overpayments and intentional program violations. Have the payee complete the entire forgery packet, then issue a replacement check.

- If the payee does not come to the branch to complete the forgery packet, consider putting a hold on the next check. (This does not apply to checks issued by PP/SA. DPU will take the necessary action on PP/SA checks.)
- If the payee is no longer available to complete the forgery packet, **branches** will do the following, except for checks issued by PP/SA. DPU will do the following for PP/SA checks:
 - Note this information on the AFS 980.
 - Note if the case was closed and the date of closure.
 - Return the forgery packet to Forgery Services.

***Note:** Always complete and return the forgery packet by the due date printed on the forgery packet.*

If **Forgery Services** determines that there is good reason to believe that the client or provider may have endorsed both the original check and the replacement check:

- Forgery Services will forward the packet to the Overpayment Recovery Unit (ORU).
- ORU will log the information and then forward the packet to the Oregon State Police.
- The Oregon State Police will review the packet to determine whether the client was the likely endorser of the original check, and will advise ORU or DPU.
- ORU will then advise Forgery Services of the State Police determination.
- If Forgery Services determines that DHS should establish an overpayment against the client for the amount of the replacement check, they will ask ORU to write the overpayment and pursue collection.

Forgery Services will return the original check to the State Treasurer if they do not receive the forgery packet within 30 days from the date the original check was cashed. This action could result in legal proceedings against the state or the payee.

6. Dual-Payee Checks

Replace **dual-payee** checks only if:

- The client completes an affidavit that the unendorsed check has been lost, destroyed, or stolen; **or**
- The client has endorsed the check and the second party completes an *Affidavit Concerning the Lost Check* (DHS 138A). The second party must sign a statement that they will reimburse the state and will not hold the client responsible if the original check is negotiated. Issue the replacement check to the second party only (no dual-payee is required).

If a dual-payee check is reported lost, stolen, destroyed or not received, determine which payee is affected by the missing check (that is, determine which payee is claiming the loss).

- If only one payee is claiming the loss, only that payee must complete a DHS 138A.
- If both payees are claiming the loss, each payee must complete their own DHS 138A.

Example: A client receives a check payable to herself and her landlord. She signs the check and gives it to her landlord to sign and use for her rent payment. The landlord then loses the check. Since he is the only one affected by the loss (the client has paid her landlord), he is the only one who must complete a DHS 138A.

If the dual-payee check has been processed by the State Treasurer for payment, a forgery packet must be done for each payee claiming the loss.

Replacing Lost, Stolen, Destroyed or Undelivered Checks: 461-165-0220 |

7. Subsequent Action on Payment Alerts

Forgery Services will follow up on all payment alerts and close the check file if the original check is not paid within 60 days.

If the original check is returned to the branch office or DPU, the branch (DPU, if the check was originally issued by them) will verify whether a replacement check has been issued:

- If a payment alert and replacement have been issued, send the original check to the Client Maintenance Unit (CMU) for cancellation.
- If no payment alert or replacement has been issued, attempt to deliver the check to the payee. Send the original check to CMU for cancellation if it cannot be delivered to the client or provider.

Notify Payroll immediately if:

- The original check is given to the payee after a payment alert has been called in.

- A replacement check is issued after the DHS 138A and the payment alert have been processed stating, “No replacement will be issued.”
- Any business calls or writes to the branch about checks returned to them from the State Treasurer’s office.

A. Definitions

1. The *budget month* is the calendar month from which nonfinancial and financial information is used to determine eligibility and benefit level for the payment month.

461-001-0000
2. *Budgeting* is the process of calculating the benefit level.

461-001-0000
3. A *caretaker relative* is the person, regardless of age, who is responsible for the care, control, and supervision of the dependent child and is related to the child in any one of the following ways:
 - a. The biological parent.
 - b. The adoptive parent and people related to the child through the adoption who meet the degree of relationship specified below.
 - c. Blood relative or half-blood relative (sharing one common natural or adoptive parent). This includes siblings, aunts, uncles, first cousins, first cousins once removed, nephews, nieces, and persons of preceding generations denoted by the prefixes of grand, great-, or great-great-.
 - d. Stepfathers, stepmothers, stepbrothers, or stepsisters.
 - e. The spouse of anyone listed above.

If any of the preceding relationships are established through marriage, the relationship remains the same even if the marriage is terminated by death or divorce.

Definitions for Chapter 461: 461-001-0000
Requirement to Live With a Caretaker or Caretaker Relative: 461-120-0630

A *non-needy caretaker relative* is a caretaker relative (other than a parent) for TANF who is not required to apply for benefits with the dependent child, and does not wish to do so.

4. *Categorical Eligibility for Food Stamps*

A Food Stamp filing group is considered categorically eligible when all its members meet one of the following:

- Receive benefits or determined eligible to receive benefits or services from any one of, or a combination of, the following programs: EA, ERDC, GA, HSP, Pre-TANF, SSI, TA-DVS, TANF, TANF-JOBS Plus, and TANF Transition services.
- Be considered to be receiving SSI under 1619(a) or 1619(b) of the Social Security Act.
- The financial group countable income is below 185 percent of the federal poverty level and they are authorized to receive TANF information and referral services.

No filing group member is considered categorically eligible if a member of the filing group is disqualified from receiving FS due to an IPV or the head of household is disqualified for failure to comply with OFSET work requirements.

☞ SEE FS E, FOR MORE INFORMATION ON CATEGORICAL ELIGIBILITY.

461-135-0505

5. *Child* means the offspring of a biological or legal (step or adoptive) parent. The term “child” does not include unborns. The following additional program-specific definitions apply:
- a. For TANF and TANF-related medical (EXT, MAA, MAF, REFM), the term *dependent child* means the following:
 - A person who is not a caretaker relative of a child in the household. This person is unmarried or married but separated, and is under age 18, or is 18 and a full-time student in secondary school or the equivalent level of vocational or technical training; **or**
 - A minor parent whose parents have chosen to apply for benefits for the minor parent. This does not apply to minor parents who are married and living with their spouse.
 - b. For ERDC, *child* includes children who have no biological or legal relationship to the caretaker, but are in the care and custody of the caretaker and are:
 - Under age 18; **or**
 - Age 18 and in secondary school or vocational training at least half time.

461-001-0000

☞ SEE FS C.3.

- c. For GA, GAM, and OSIP, *child* means an individual under age 18.
- d. For OHP, *child* means a person, including a minor parent, who is under age 19.
- e. For OSIPM and QMB, *child* means unmarried people living with their parent(s) and:
 - Under age 18; or
 - **Under age 22**, and attending full-time secondary, post-secondary, or vocational/technical training designed to prepare the person for employment.

461-001-0000

6. *Community-based care* is any of the following:

- a. Adult foster care – Room and board and 24-hour care and services for the elderly or for disabled people age 18 and older. The care is contracted to be provided in a home for five or fewer clients.
- b. Assisted living facility – A program approach within a physical structure, which provides or coordinates a range of services available on a 24-hour basis, for support of resident independence in a residential setting.
- c. In-home services – People living in their home receiving services determined necessary by SPD or MHDDSD.
- d. Residential care facility – A facility that provides residential care in one or more buildings on contiguous property for six or more physically handicapped or socially dependent people.
- e. Specialized living facility – Identifiable services designed to meet the needs of persons in specific target groups that exist as the result of a problem, condition, or dysfunction resulting from a physical disability or a behavioral disorder and require more than basic services of other established programs.
- f. Independent choices – In-home services recipients in demonstration sites who receive a cash benefit to coordinate in-home services under a section 1115 demonstration waiver.

461-001-0000

7. *Costs* are bills incurred by the client, that the client has a legal responsibility to pay.

461-160-0030

8. *Custodial parents* means parents who have physical custody of their child(ren). Custodial parents may be receiving benefits as dependent children or as caretaker relatives for their own children.
- 461-001-0000
9. In the REF, SFPSS, TA-DVS, and TANF programs, “*disability*” means for purposes other than determining eligibility:
- a. An individual with a physical or mental impairment that substantially limits the individual’s ability to meet the requirements of the program; or
 - b. An individual with a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or who is regarded as having such an impairment as defined by the Americans with Disabilities Act (42 USC 12102; 28 CFR 35.104).
10. In the FS program, a *disabled* individual or an individual with a disability means an individual who meets any of the following:
- a. Receives SSI benefits under title XVI of the Social Security Act; SSB benefits based on blindness or disability criteria under titles I, II, X, XIV, or XVI of the Social Security Act; or OSIP, or other state or federal supplement under section 1616(a) of the Social Security Act.
 - b. Receives state general assistance benefits based upon disability or blindness criteria under title XVI of the Social Security Act; or is a recipient of disability-related medical assistance under title XIX of the Social Security Act; or receives interim assistance benefits pending the receipt of SSI.
 - c. Receives a state or federally administered supplemental benefit under section 212(a) of Public Law 93-66.
 - d. Receives an annuity payment under section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible for Medicare by the Railroad retirement Board; or section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and meets the disability criteria used under title XVI of the Social Security Act.
 - e. Receives VA benefits for nonservice or service-connected disability rated or paid as total under title 38 of the United States Code.
 - f. Receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(i) of the Social Security Act.

Note: PERS disability or workers compensation from SAIF or Department of Labor does not meet the requirements for FS disability because they are not based on SSA criteria.

- g. Is the surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for a service connected death or pension benefits for a nonservice connected death under title 38 of the United State Code and has a disability considered permanent under section 221(i) of the Social Security Act.
 - h. Is a veteran or the surviving spouse of a veteran, considered by the VA to be in need of Aid and Attendance benefits under title 38 of the United States Code.
 - i. Is a veteran or the surviving spouse or child of a veteran and is considered permanently incapable of self-support under title 38 of the United States Code.
- 461-001-0015
11. *Domestic violence shelters* are public or private nonprofit residential facilities providing services to victims of domestic violence. If the facility serves other people, a portion must be used solely for victims of domestic violence.
- 461-001-0000
12. The *effective date* is the day that action will be taken or a change made on a case.
13. For FS, *elderly* means a person age 60 or older.
- 461-001-0015
14. *Eligibility* is the decision as to whether a person qualifies, under financial and nonfinancial requirements, to receive program benefits.
- 461-001-0000
15. *Family stability* in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means the characteristics of a family that support healthy child development, including parental mental health, drug and alcohol free environment, stable relationships, and a supportive, flexible, and nurturing home environment.
16. *Family stability activity* in the JOBS, Pre-TANF, Post-TANF, SFPSS, TA-DVS, and TANF programs means an action or set of actions taken by the client, as specified in a case plan, intended to promote the ability of one or both parents to achieve or maintain family stability.

17. For FS, *homeless* means the filing group does not have a fixed or regular nighttime residence **or** the group's primary residence is one of the following:

- A supervised shelter that provides temporary accommodations.
- A halfway house or residence for people who may become institutionalized.
- A temporary accommodation in another person's or family's residence for 90 days or less.
- A place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (hallway, bus station, lobby, or similar places).

461-001-0015

18. Income:

a. *Adjusted income* is countable income minus income deductions.

461-001-0000

b. *Countable income* is the amount of available income remaining after allowing exclusions.

461-001-0000, 461-140-0040

c. Income *deductions* are specified amounts subtracted from countable income.

461-001-0000

d. *Deemed assets* are the portion of the income and resources of a person not in the financial group used to determine eligibility and benefit level for a financial group member.

461-145-0810

e. *Earned income* is income received in exchange for a person's physical or mental labor.

461-145-0120

f. *Periodic income* is income received on a regular basis less often than monthly.

461-001-0000

g. *Lump-sum income* is income received too infrequently or irregularly to be reasonably anticipated, or received as a one-time payment. Lump-sum income includes but is not limited to:

- Retroactive benefits covering more than one month, whether received in a single payment or several payments.
- Income from inheritance, gifts, winnings, and personal injury settlements.

461-001-0000

19. The *initial month* of eligibility means any of the following:

- In all programs, the first month a benefit group (see OAR 461-110-0750) is eligible for a program benefit in Oregon after a period during which the group is not eligible.
- In all programs except the FS program, the first month a benefit group is eligible for a program benefit after there has been a break in the program benefit of at least one full calendar month. If benefits are suspended for one month, that is not considered a break.
- In the FS Program:
 - The first month for which the benefit group is certified following any period during which they were not certified to participate, except for migrant and seasonal farmworkers (see OAR 461-001-0015).
 - For migrant and seasonal farmworkers, the first month for which the benefit group is certified following any period of one month or more during which they were not certified to participate.
- In the OHP program, the first month of a redetermination or recertification period.

461-001-0000

20. *Long-term care* is the system through which SPD and mental health provide a broad range of social and health services to eligible adults who are aged, blind, or have disabilities for extended periods of time. This includes nursing homes and state hospitals (Eastern Oregon and Oregon State Hospitals).

461-001-0000

21. *Marriage* means the union of a man and a woman who are legally married. *Legally married* means a marriage uniting a man and a woman according to the provisions of either:

- The statutes of the state where the marriage occurred.
- The common law of the state in which the man and woman previously resided while meeting the requirements for common law marriage in that state.

- The laws of the country in which the man and woman previously resided while meeting the requirements for legal or cultural marriage in that country.

461-001-0000

22. For FS, a *migrant farmworker* is an individual who regularly travels away from their permanent residence overnight, usually with a group of laborers, to seek employment in an agriculturally related activity. If any member of an FS household fits the definition of migrant farmworker at any time during the redetermination period, budget the household according to the policy on migrant farmworkers.

461-001-0015

23. A *minor parent*, for ERDC, EXT, MAA, MAF, and TANF is a parent under the age of 18.

461-001-0000

24. Need:

- a. *Need* is the amount at the Department of Human Services (DHS) payment standards that represents the client's need for items covered by the benefit.
- b. *Special needs* are costs in addition to standard allowances. If required, they must be used to determine:
 - Initial eligibility and
 - Ongoing eligibility for non-waivered GA clients, and non-waivered OSIP and OSIPM clients, in SPD/AAA facilities, and clients in mental health facilities.

461-155-0010

25. A *nonstandard living arrangement* is:

- a. In the GA, GAM, OSIP, OSIPM, and QMB programs, a client is considered to be in a *nonstandard living arrangement* when the client is applying for or receiving services in any of the following locations:
 - A nursing facility.
 - An intermediate care facility for the mentally retarded (ICF/MR).
 - A psychiatric institution, if the individual is not yet 21 years of age or has reached the age of 65.
 - A community-based setting covered by a waiver under title XIX of the Social Security Act.

- b. In all programs except GA, GAM, OSIP, OSIPM, and QMB, a *nonstandard living arrangement* means each of the following locations:
- Foster Care.
 - Residential Care Facilities.
 - Drug or Alcohol Residential Treatment Facilities.
 - Homeless or Domestic Violence Shelters.
 - Lodging house if paying for room and board.
 - Correctional facilities.
 - Medical institutions.

461-001-0000

26. The *ongoing month* is one of the following:

- For all programs except FS and OHP, any month following the initial month of eligibility, if there is no break in the program benefit of one or more calendar months.
- For FS and OHP, any month in the certification period following the initial month of eligibility.

461-001-0000

27. *Parent* means the biological or legal (step or adoptive) mother or father of a person or unborn child.

- a. If the mother lives with a male, and either she or the male claims that he is the father of the child/unborn and no one else claims to be the father, he is treated as the father even if paternity has not been legally established.
- b. A stepparent relationship exists if:
- The person is legally married to the child's biological or adoptive parent; **and**
 - The marriage has not been terminated by legal separation, divorce, or death.
- c. A legal adoption erases all prior legal and blood relationships and establishes the adoptive parent as the legal parent. However, the biological parent is also considered a parent if both of the following are true:

- The child lives with the biological parent; **and**
- The legal parent (the adoptive parent) has given up care, control, and supervision of the child.

461-001-0000

Note: To establish the filing group in this situation, treat the biological parents and biological siblings of the adoptive child the same as if there had been no adoption. However, in this situation, the biological parents are never considered the parents for child support enforcement. Workers should refer the absent adoptive parents for child support enforcement.

28. For all programs except Emergency Assistance (cash and medical), the *payment month* is the calendar month for which benefits are issued.

461-001-0000

29. For all programs except FS, *primary person* means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits. The primary person for individual programs is as follows:

- For EXT, MAA, MAF, and TANF the parent or caretaker relative.
- For ERDC, the caretaker.
- For GA, GAM, OSIP, OSIPM, and QMB, the client or their spouse.
- For OHP, REF, and REFM, the applicant, caretaker, caretaker relative, or parent.

461-001-0000

30. For FS, *primary person* means:

- a. An adult in the filing group who is designated by the group to serve as the primary person. The household designates the primary person by identifying them as the applicant on the filing page of the application. This is most likely the person coded “head of household” in the FSMIS system. Where there is no adult, the group can designate another responsible person in the filing group.
- b. Once the primary person has been designated, the filing group cannot choose a different person to be the primary person during the same certification period or during an OFSET/job quit disqualification period, unless there is a change in the composition of the household group.

461-001-0015

31. *Questionable information* is any client statement that is inconsistent with any of the following:

- Other reported information.
- Other information provided on the application.
- Other information received by the branch office.
- Information reported on previous applications.

461-115-0610

32. *Redetermination* is the process used to review eligibility to approve or deny continuing benefits. This process includes a review of the application and supporting verification documents.

33. *Redetermination period* means the months between initial eligibility and when a redetermination is due or between one redetermination and the next.

34. *Safe homes* are private homes that provide a few nights lodging to victims of domestic violence. The homes must be recognized as such by the local domestic violence agency, such as crisis hot lines and shelters.

461-001-0000

35. For FS, *seasonal farmworkers* are people employed in agricultural employment of a seasonal or temporary nature. If any member of an FS household fits the definition of seasonal farmworker at any time during the redetermination period, budget the household according to policy on seasonal farmworkers. Seasonal farmworkers are not required to be absent overnight from their permanent residence when:

- Employed on a farm or ranch performing field work related to planting, cultivation, or harvesting operations; **or**
- Employed in a canning, packing, ginning, seed conditioning, or related research or processing operation, **and** transported to or from the place of employment by means of a day-haul operation.

461-001-0015

36. *Sibling* means the brother or sister of a person. “Blood-related” means they share at least one biological or adoptive parent. “Step” means they are not related by blood, but are related by the marriage of their parents.

461-001-0000

37. *Spouse* means a person who is legally married to another person. For ERDC and FS, the spouse includes a person who is not legally married to another, but is presenting themselves to the community as the husband or wife by:
- Representing themselves as husband and wife to relatives, friends, neighbors, or tradespeople, and
 - Sharing living expenses or household duties.

461-001-0000

38. *Standard living arrangement* means a location that does not qualify as a nonstandard living arrangement.

461-001-0000

B. Confidentiality of Client Information

Applicability

- This policy is applicable to Self-Sufficiency permanent and temporary employees, volunteers and contractors of any self-sufficiency program who either work at a Department of Human Services (DHS) site or have access to any DHS database, case management software or the GroupWise system for the State of Oregon.

Intent

- To preserve the confidentiality and privacy of client information.
- To work together with partners, other agencies and the client for the benefit of the client.
- To summarize how information about clients may be used and disclosed consistent with confidentiality requirements.

Expectations

- Employees, volunteers and contractors covered by this policy may only use or disclose information that identifies a self-sufficiency client as permitted by either this policy or by a current and valid written authorization from the client.

1. Confidentiality is Presumed

All information that identifies an individual client is confidential. The department may not release or disclose client information, except as specifically authorized by the client in writing, by statute or administrative rule, or as ordered by a court. This policy summarizes the situations in which use and disclosure is permitted.

Use the *DHS Notice of Privacy Practices* (DHS 2090) to inform clients about how DHS may use or disclose their information.

Obtain a signed *Authorization for Use and Disclosure of Information* (DHS 2099) from the client if there is any question regarding whether a release of information is required. View the request as one of honoring and respecting the choice and dignity of your client, not as an impediment to providing services.

2. Enforcement and Sanctions

DHS employees who violate DHS policies and procedures regarding the safeguarding of information about an individual are subject to disciplinary action by DHS up to and including dismissal, and legal action by the individual.

DHS employees who knowingly and willfully violate state or federal law for improper use or disclosure of information about an individual are subject to criminal and civil penalties.

Example: Criminal sanctions of up to 10 years in federal prison apply to anyone who sells client information.

DHS Policy AS-100-09 (Enforcement, Sanctions, and Penalties for Violations of Individual Privacy)

3. Minimum Necessary Requirement

Staff must make reasonable efforts to limit the client information they are using, requesting, or disclosing to the minimum necessary in the particular situation.

This requirement does not apply to:

- Disclosures or requests by a health care provider for treatment.
- Disclosures made to the individual about his or her own protected information.
- Uses or disclosures authorized by the individual that are within the scope of the authorization.
- Disclosures required by law.

The minimum necessary standard should be considered at the time the worker and client are mutually completing a written *Authorization for Use and Disclosure of Information* (DHS 2099).

☞ SEE DHS POLICY AS-100-04 FOR MORE INFORMATION ABOUT THE MINIMUM NECESSARY REQUIREMENT AND EXCEPTIONS.

4. Situations in Which a Written Authorization is Not Required

There are a number of instances in which federal and state law and rule allow information about a client to be used and disclosed *without* written authorization and as necessary to administer DHS programs (including title XIX).

Here are some examples:

- When the information is health or treatment information (but not HIV or substance abuse treatment information) and is being released for the purposes of treatment, payment, or health care operations. The minimum necessary standard applies to releases for purposes of payment or health care operations.

- When the information being released is nonhealth information that is necessary to carry out the intent of an assistance or service program connected with or operated by the department or designated agency.
- When the information is nonhealth information and is being released to a DHS contractor (JOBS, Family Support and Connections...) in order to administer DHS programs.

Disclosure of Client Information: 461-105-0130

- When the information being released is about a specific client and is being released to that client. This exception means that DHS clients have access to their own information without signing an authorization.
- When the information is nonhealth information and is being released to an Oregon attorney who represents that client if both of the following requirements are met:
 - The attorney states that he or she currently is representing the client.
 - The attorney states that the client has authorized disclosure of the client information to the attorney.

Disclosure of Client Information: 461-105-0130(4)

- When using de-identified information (limited data sets).

☞ SEE POLICY AS-100-07 (DE-IDENTIFICATION OF CLIENT INFORMATION AND USE OF LIMITED DATA SETS) FOR MORE INFORMATION ON DE-IDENTIFICATION OF INFORMATION.

- When exchanging nonhealth, nontreatment information with other governmental or private, nonprofit agencies if necessary to assist applicants or recipients of public assistance to access and receive other governmental or private, nonprofit services that will benefit or serve the applicant or recipient. This exception includes instances in which a DHS worker is in a position to advocate for a client without disclosing health or treatment information. Nevertheless, reasonable efforts must be made to obtain the applicant or recipient's authorization in advance.

Disclosure of Client Information: 461-105-0130

- To report suspected abuse of a child or an adult (elder abuse or abuse of a person with a mental illness or developmental disability).

Note on Reporting Substance Abuse Information:

- Child Abuse: If necessary, substance abuse treatment information may be disclosed to Child Welfare in order to make an *initial* report of suspected abuse of a child. Any subsequent disclosure of substance abuse information would require a court order or written authorization by client.

- Elder Abuse or Abuse of a Person with a Mental Illness or Developmental Disability: Substance abuse treatment information may *not* be disclosed without authorization in order to report suspected elder abuse or abuse of a person with a mental illness or developmental disability. If it is necessary to make a report without authorization, the report must be done without revealing a person is in substance abuse treatment or has a substance abuse problem.

Note on Reporting Mental Health Information:

- Child Abuse: While the reporting of child abuse is mandatory under law, mental health records are not required to be part of that reporting. Release of mental health records requires a court order or written authorization by the client.
- Elder Abuse or Abuse of a Person with a Mental Illness or Developmental Disability: While the reporting of elder abuse and abuse of a person with a mental illness or developmental disability is mandatory under law, mental health records are not required to be part of that reporting. Release of mental health records requires a court order or written authorization by the client.
- To conduct any investigation, prosecution, or criminal or civil proceeding in *connection with* administering DHS programs or for any legally authorized audit or review by a governmental entity in relation to administering DHS programs.
- To the extent needed to provide emergency medical treatment. This includes Alcohol & Drug (A&D) or mental health treatment.
- When DHS believes in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public *and* the report is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Example: If DHS believes a person to be suicidal, information may be released without authorization to a mental health provider.

Uses and Disclosures of Client or Participant Information: 410-014-0020

- When DHS has a court order signed by a judge.

The following sections in this chapter provide more detailed examples in determining whether an authorization is required. If you have any questions, contact your local DHS Privacy Point Person, a Central Office Program Analyst, or the Central Office CAF Privacy Representative.

5. Use of Information Within DHS

“Program Use” refers to the sharing of client information within the self-sufficiency program or the sharing of information between program staff and DHS administrative staff that support or oversee the program, such as the exchange of information between an eligibility worker and the overpayment unit. Program use of information is permitted without a written authorization from the client but is subject to the minimum necessary standard.

“Cross-Program Use” refers to the sharing of information about a self-sufficiency client with another DHS program, such as Child Welfare or Vocational Rehabilitation. The following are circumstances which would allow for sharing of information without a client’s authorization:

1. As necessary for the administration of self-sufficiency programs;
2. The disclosure is intended to benefit the client, or to assist client in accessing other services;
3. For mandatory reporting of child or elder abuse; or
4. Self-Sufficiency is a member of the local county multi-disciplinary child abuse team as statutorily defined; **and** the information shared is necessary for the prevention, investigation, and treatment of child abuse.

While we strive to work together with other program areas to better serve the client, at times we may be limited by federal and state laws in sharing client information across programs without a written authorization. Unless the sharing of information is for a purpose described above, an authorization will generally be required. For other types of information in the absence of written authorization, the permissibility of cross-program use of information (within DHS) depends on the intended use of the information.

***Note:** Cross program use of physical health, substance abuse, mental health and vocational rehabilitation information records require written authorization and may be limited to the particular program areas named on the authorization form. If such limitation is noted on the authorization form, disclosure is limited to the programs named, and minimum necessary standards apply.*

6. Disclosure of Information (Outside of DHS)

In general, client information may not be used or disclosed without client authorization for purposes other than those related to the administration of DHS programs. However, nonhealth information may be disclosed to other governmental or private, nonprofit agencies if necessary, to assist applicants or recipients of public assistance programs to access and receive other services that will benefit or serve the applicant or recipient. Reasonable efforts must be made to obtain the applicant or recipient authorization in advance: *however*, DHS applications for benefits inform clients that we may verify what

they report to us. Do not disclose health or treatment information for these purposes without client authorization.

Disclosure of Client Information: 461-105-0130

Disclosure and use of public assistance records limited; contents as privileged communication; exceptions: ORS 411.320

The following provides some examples of common situations:

(A) State and Federal Agencies

- Subject to the minimum necessary standard, client information may be disclosed without a written authorization to state and federal agencies such as the Department of Justice, Secretary of State Audits Divisions, or Food and Nutrition Service that provide administrative support or oversight to the DHS program whose information is being disclosed.
- No authorization is required to provide sufficient information to accomplish a referral on behalf of a client.

(B) Alcohol and Drug (A&D) and Mental Health (MH) Providers, Managed Care Plans and Medical Providers

- No authorization is required to provide sufficient information to accomplish a referral on behalf of a client; reasonable efforts to obtain an authorization must be made.
- No authorization is required to provide information necessary for activities related to payment, including billing and collection.
- Obtain an authorization to share information about substance abuse treatment and HIV for purposes of treatment. An authorization is not required to share other information for treatment purposes.
- Obtain an authorization to receive or provide information for purposes other than treatment, referral, payment.

(C) Social Security Administration (SSA)

- No authorization is required to report suspected fraud or abuse to SSA.

(D) Medical Transportation

- No authorization is required to provide sufficient information to accomplish a referral on behalf of a client or to obtain the appropriate level of care during transportation.
- No authorization is required to provide information necessary for activities related to payment, including billing and collection.
- **An authorization is required** to provide information for other purposes.

(E) Nonmedical Transportation

- No authorization is required to provide sufficient nonhealth information to accomplish a referral on behalf of a client. No authorization is required to provide information necessary for activities related to payment, including billing and collection.
- **An authorization is required** to obtain or provide information for other purposes.

(F) Child Care Providers

No authorization is required to release to the client's childcare providers:

- The program for which the client is eligible.
- The amount of the DHS child care payment.
- The client's copayment amount.
- Reasons for a delay in payment. Do not disclose any information that is not specific to the reason for the delay.

Release of Client Information to Service Providers and Legal Bodies: 461-105-0110(2)

(G) Housing

- No authorization is required to provide nonhealth information to accomplish a referral on behalf of a client.
- No authorization is required to provide information necessary for activities related to payment, including billing and collection.
- **An authorization is required** to provide information for other purposes.

Disclosure of Client Information: 461-105-0130

(H) Employers

- No authorization is required to disclose the minimum necessary information when needed to verify questionable information reported by the client.
- **An authorization is required** to obtain or provide information for other purposes.

(I) Law Enforcement

No authorization is required when law enforcement is involved in carrying out public assistance laws, investigating proceedings connected with administering

the benefit programs of the department, or reporting a crime related to abuse (see exception for EBT information below);

The department may release the client's address, Social Security number and photo (if available) to a law enforcement officer without an authorization if the law enforcement officer makes the request in the course of official duty, supplies the person's name, and states that the client:

- (a) is a fugitive felon (someone fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, that would be classified as a felony or is violating parole or probation); or
- (b)(i) For all programs except FS, has information that is necessary for the officer to conduct official duties of the officer and the location or apprehension of the client is within the officer's official duties.
- (b)(ii) For clients only in the FS program, has information that is necessary to conduct an official investigation of a fugitive felon or someone violating parole or probation.

Exception: If domestic violence has been identified in the household, do not release information about a victim of domestic violence unless a member of the household is wanted as a fugitive felon or is violating probation or parole.

No authorization is required when you are disclosing personal knowledge about a client that does not come from the interaction by the client with the department.

- **An authorization is required** to provide other client-specific information to a law enforcement officer. This requirement includes when a law enforcement officer is requesting information about the owner of an EBT card. DHS cannot release EBT information regarding the owner of the card to anyone, even an arresting officer. DHS may take information from the officer regarding the card, including the number of the card, in order to take the necessary steps internally to correct the situation.

Release of Client Information to Law Enforcement Officers: 461-105-0100

(J) Insurance Companies

- **An authorization is required** to disclose client-specific information.

(K) Public and Elected Officials

Except for social security numbers, health, treatment and domestic violence information, no authorization is required to provide the minimum necessary information in response to a staff member in the office of a member of the Oregon State Legislature or United States Congress who has received a

complaint from a client and the program responding is provided with a copy of the written complaint.

- Oral authorization is required if a DHS worker is contacted by a staff member in the office of a member of the Oregon State Legislature or United States Congress who has received only an oral complaint. The DHS worker will confirm with the client that the worker may speak with the staff member regarding the client. Confirmation from the client should be documented in the client's file.

Client Authorization for Release of Client Information to Third Party: 461-105-0070
Release of Client Information to Service Providers and Legal Bodies: 461-105-0110(4)

(L) Other Interested Persons (Neighbors, Friends, Advocates, Attorneys)

- If other interested persons are present while **the client** is disclosing information about themselves, authorization is not needed.

An authorization is required if **the worker** is disclosing any client-specific information while other interested persons are present.

Attorneys. Client information – other than health or treatment information – may be disclosed to an Oregon attorney who represents that client if all of the following requirements are met:

- (a) The attorney states that he or she currently is representing the client.
- (b) The attorney states that the client has authorized disclosure of the client information to the attorney.
- (c) The identity of the attorney is verified in accordance with Section 20, Verification.

Disclosure of Client Information 461-105-0130(4)

(M) Research

- Disclosure or review of department records for research purposes is prohibited unless the designated CAF manager to approve research requests has authorized the specific person or organization and their research subject.

For situations not covered here, or for other questions, contact your local DHS Privacy Point person, a Central Office Program Analyst, or the Central Office CAF Privacy Representative.

(N) Foster Care and Adoption Assistance

- For all programs except FS, no authorization is required to disclose information for purposes directly connected with foster care and adoption assistance under title IV-E of the Social Security Act.

OAR 461-105-0130(3)

Note: An Authorization is required to share mental health or substance abuse treatment information.

7. Requirement to Track Certain Disclosures

DHS must list on the *Disclosures of Protected Health Information* (DHS 2097) and disclosures of protected health information (PHI) that are not otherwise allowed by a client's authorization or to carry out treatment, payment or health care operations. The DHS 2097 should be kept in each client's case file and should stay with the file if the case is transferred to another office.

Disclosures that must be logged on the DHS 2097 include:

- PHI disclosed in response to mandatory child abuse or elder abuse reporting laws to an entity authorized by law to receive such a report.
- PHI about an individual that is ordered to be disclosed pursuant to a court order in a court case or other legal proceeding. Include a copy of the court order with the accounting of the disclosure.
- PHI about an individual provided to law enforcement officials pursuant to a court order. Include a copy of the court order with the accounting of the disclosure.
- PHI about an individual provided by DHS staff to avert a serious threat to the health or safety of the person or others.
- PHI about an individual that is disclosed pursuant to a Public Record request.

Disclosures that are not required to be listed on the DHS 2097 include those that are:

- Authorized by the client.
- Made to carry out treatment, payment, or health care operations.
- Made to the client.
- Made to persons involved in the client's health care.
- Made to correctional institutions or law enforcement officials having lawful custody of an inmate.

8. Access and Disclosure of Client Information to Clients, Representatives, and Family Members

Client records are subject to redaction prior to access or disclosure. Client records frequently include information pertaining to other individuals, and must be redacted. Redaction should be done by first copying the original record, then blacking out with a permanent marker the information to be withheld, and finally making a copy of the redacted record. In most cases, the following information should be redacted:

- Names, social security numbers, dates of birth, addresses and phone numbers of all third parties (those not in the filing group).
- All Drug and Alcohol treatment records pertaining to someone other than the individual.
- All medical, mental health and vocational rehabilitation records pertaining to someone other than the individual.
- Any records relating to domestic violence.
- Information that would cause harm to the client or to another person; then follow the required procedure outlined below.
- If information requested is being withheld, you must indicate generally the nature of the document or information withheld: e.g., psychotherapy notes of Dr. Jones, June 2003.

For more information on redacting records, please contact the CAF Subpoena Coordinator.

A. Client Access to Their Own Information

Clients have a right to access their records, which include medical and mental health information and reports, subject to certain limitations as outlined in OAR 461-105-0060(6)(confidential informants) and in the **Client Privacy Rights Policy AS-100-02**. If DHS denies access because of a good faith belief that its disclosure could cause harm to the client or to another person, the decision to deny must be made by a licensed health care professional or other designated staff, and DHS must make a review of this denial available to the client. If the client wishes to have this denial reviewed, the review must be done by a licensed health care professional who was not involved in the original decision.

When a client, or person or entity to which he or she has given written authorization, requests access to their own case record, use the *Access to Records Request Form* (DHS 2093). A client does not need to complete the *Authorization for Use and Disclosure of Information* (DHS 2099) form in order to access their own records. A staff person must be present while the client or authorized representative has access to original documents from the case record.

Except for HIV information, case record information may be requested by the client and released to the client by telephone if the client is able to satisfy the branch as to their identity.

Release of Information to the Client: 461-105-0060

☞ SEE DHS POLICY AS-100-02, SECTION (4)(D) AND FORM DHS 2093 FOR MORE INFORMATION ON CLIENT RIGHTS TO THEIR OWN INFORMATION.

B. Family Members

The department is generally required to make the minimum necessary information in the case record of a client available to a family member if the family member is a member of the filing group or is authorized by a member of the filing group. This minimum necessary standard does NOT allow sharing of alcohol and drug or mental health records unless the client to whom the records pertain has authorized access on the DHS 2099. The primary person and filing group members may only have access to the client information that is related to the time during which they had that position in the case. If the family member is not in the filing group, there must be a signed authorization before information may be disclosed to the family member.

Release of Information to the Client: 461-105-0060

C. Non-needy Caretaker Relatives

A non-needy caretaker relative is considered to be the primary person on a case, and may have access to client information; with the exception of drug and alcohol and mental health records, unless the individual to whom the records pertain, has authorized access on the DHS 2099. However, they may only have access to client information that is related to the time during which they were the primary person on the case.

D. Guardians

No authorization is required for that subject matter/information over which the guardian has authority. The guardian has the same access to the client file as the client in those areas. A guardian with full powers would have access to the entire file. If unclear, ask to see the order of court appointment.

Release of Information to the Client: 461-105-0060

E. Legal Services (Private Attorney or Legal Aid)

Client information, other than health or treatment information, may be disclosed without a written authorization to an Oregon attorney who represents that client if both of the following requirements are met:

- (a) The attorney states that he or she currently is representing the client.

- (b) The attorney states that the client has authorized disclosure of the client information to the attorney.

Disclosure of Client Information: 461-105-0130

9. Authorization for Use and Disclosure of Information

A client gives written authorization for release of information by completing the *Authorization for Use and Disclosure of Information* (DHS 2099). The DHS 2099 is expected to be mutually completed in the presence of the client whenever possible to facilitate discussion and case planning, as well as making sure the client understands the form before signing. The worker should also answer any questions the client has about the DHS 2099 and explain to the client the client's right to request limitations on the disclosure of their information.

There may be various barriers to client understanding of the DHS 2099. These barriers may include physical or mental disabilities, limited English proficiency or the inability to read. The presence of a barrier to understanding does not necessarily mean that the person is incapable of giving informed consent.

There is no need to obtain witness of a client signing the DHS 2099 unless there are other reasons for doing so (for example, client request, mental competency issue, etc.).

There should be only one record holder listed per form. The form must include the signature of the individual on the form. In situations where an authorization for release of information is required, staff may not even identify a person as being a client of the department until the authorization has been completed.

The DHS 2099 must include a specific purpose for which information will be disclosed. Information may not be disclosed beyond the purpose that is listed on the DHS 2099. If it is necessary to disclose information beyond the purpose listed on the DHS 2099, a new DHS 2099 must first be completed, listing that specific purpose, before information may be disclosed.

- Do not request unnecessary information about a client or more than is needed.

The DHS 2099 is valid for one year, unless otherwise specified.

Provide the release form in the appropriate native language or in an alternate format (Braille, large print, etc), as necessary.

☞ FOR INFORMATION ON COMPLETING THE DHS 2099, SEE THE *SELF-GUIDED INSTRUCTIONS FOR COMPLETING THE "REVISED" AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION FORM* (DHS 2099i).

If you believe that an outside agency, organization or business is incorrectly citing confidentiality laws as a reason to withhold information that you need, you may contact the DHS Privacy Office or your Cluster Privacy Coordinator for assistance.

Oral Authorization: Except for health, treatment, and domestic violence information, an oral authorization from the client is sufficient to allow oral release of case record information specified by the client to third parties. An oral authorization to release information to a third party is valid for a period of 30 days, unless a shorter time period is given. The worker should document the oral authorization.

OAR 461-105-0070

10. Non-DHS Authorization Forms

The use of a non-DHS authorization form is permissible if the authorization contains all of the following information:

- (A) A description of the information to be disclosed, that identifies the information specifically;
- (B) The identity of the person, classification of persons or DHS program area authorized to make the disclosure;
- (C) The identity of the person, classification of persons or entity to whom the information may be disclosed;
- (D) The purpose of the disclosure;
- (E) An expiration date, or an expiration event;
- (F) The dated signature of the individual, the individual's attorney or the individual's personal representative.
 - If the authorization is signed only by individual's personal representative, a description or explanation of the representative's authority to act for the individual, including copies of any court documents appointing the personal representative, must also be provided.

☞ POLICY AS-100-03, PROCEDURE DEVELOPMENT, SECTION 1G, PAGE 8.

11. What if the Client Refuses to Sign the Authorization?

An individual does not have to sign the release form and sometimes will refuse to sign a release form. The worker should talk through with the client what specific objections the client has to the release and why. It may also help to explain to the client why it is helpful to the department to be able to receive and share certain information about the client. If, following that conversation, the client still does not want to authorize disclosure of their information; the worker should explain to the client that they are then responsible for providing any information that would otherwise have been obtained with the authorization.

Failure to sign an authorization cannot be the basis for denying program services to otherwise eligible applicants. However, if the release of information is necessary to obtain documentation related to eligibility for the program, a denial would be based on the lack of required verification necessary to determine program eligibility and not on the refusal to sign the authorization.

If verification is needed to ensure compliance with JOBS program activities but the client will not sign a release of information allowing a provider to directly provide information related to a client's compliance with their JOBS activities, the client is then responsible for bringing in proof of compliance with their JOBS activities to their case manager.

For example, if a client is in Alcohol & Drug (A&D) treatment but does not authorize disclosure of information from the treatment provider to the worker, then it is the client's responsibility to provide the needed information to the worker. If the client does not provide this information to their case manager, the case manager will be unable to determine whether the client is complying with their case plan. The client may then be conciliated and disqualified if good cause is not found. However, the client may not be disqualified for refusing to sign the authorization.

General Requirements; Pre-TANF, REF, TANF: 461-130-0315

12. Revocations (or Cancellations) of Authorizations

A valid revocation should be treated similarly to the situation of a client who refuses to sign an authorization, as discussed in Item 11 (GP B.11). A revocation about A&D information may be made orally. For all other information, the request must be in writing.

Write the method and date of the cancellation on the authorization form, add the current date if different from the cancellation date, initial the cancellation entry, and place the authorization form in the client file.

If the authorization has been placed in an information system, make sure the cancellation is noted in those systems as well as in the paper file.

13. Requests to Restrict Use or Disclosure of Client Information

A client has the right to request a restriction on use or disclosure of their information. Use the *Restriction of Use and Disclosures Request Form* (DHS 2095) for this purpose. DHS is not obligated to agree to a restriction and may deny a request for restriction or may agree to a restriction more limited than what the client requested.

When *approving* a client request for restriction on use and disclosure of their information, use caution. You must be able to provide adequate safeguards to the information in question. If safeguards cannot be provided, the request must be denied. When *denying* a client's request, complete the bottom portion of the DHS 2095 and send a copy of the DHS 2095 to the CAF Privacy Representative.

Exception: Certain information, such as alcohol and drug (A&D) and mental health (MH) information may only be used and disclosed as authorized by the client. This means that if a client has asked for disclosure of their A&D or MH information to be restricted to a particular entity or person, staff may not deny the restriction and, instead, must abide by that restriction.

AS-100-02

14. Further Disclosure (Re-Disclosure) of Information

Further disclosure is any use or disclosure of information obtained under an authorization form:

- With any program in DHS or person or entity outside DHS not listed on the authorization form; or
- For any purpose not listed on the authorization form.

Information received by the department that is otherwise confidential or privileged under state or federal law may not be further disclosed to another person or entity unless the client provides written authorization for disclosure of that information or another exception applies. This requirement means that, prior to further disclosure of information, the applicant or client must first fill out, sign and date an *Authorization for Use and Disclosure of Information* (DHS 2099) form for that disclosure.

Example: The department often obtains copies of the medical records of an individual in connection with an eligibility determination or for case planning purposes. These medical records obtained from a third party may not be used for cross-program purposes, or redisclosed to another person or entity outside DHS unless permitted under the original authorization, or a new authorization is obtained, or another exception applies.

15. Suspected Child Abuse/Elder Abuse

Department employees are required to comply with Oregon Child Abuse reporting laws (ORS 419B.010-419B.015), Elder Abuse reporting laws (ORS 124.060 and 124.065), and Mentally Ill Persons and Persons with Developmental Disabilities reporting laws (ORS 430.735-430.765). Speak with your supervisor if you have any questions about abuse reporting.

When there is suspected abuse, the worker must do all the following:

- Comply with the abuse reporting laws by making a mandatory report.

- Narrate the referral in TRACS by stating **only** “Referral made to [agency].” Do not narrate the abuse itself.

Example: A referral of child abuse to Child Welfare is narrated in TRACS as “Referral to CW.”

- If the report included disclosure of protected health information, log the disclosure on the *Disclosures of Protected Health Information* (DHS 2097).

Note: Please refer to the booklet “What You Can Do About Child Abuse” (DHS 9061) for more information on reporting child abuse and mandatory reporting.

Note on Reporting Alcohol and Drug (A&D) Information:

- Child Abuse: If necessary, A&D treatment information may be disclosed to Child Welfare in order to make an *initial* report of suspected abuse of a child. Any subsequent disclosure of A&D information would require a court order or a written authorization by the client.
- Elder Abuse or Abuse of a Person with a Mental Illness or Developmental Disability: A&D treatment information may *not* be disclosed without authorization in order to report suspected elder abuse or abuse of a person with a mental illness or developmental disability. If it is necessary to make a report without authorization of suspected elder abuse or abuse of a person with a mental illness or developmental disability, the report may be made but must be done without revealing a person is in A&D treatment or has an A&D problem.

Note on Reporting Mental Health Information:

- Child Abuse: While the reporting of child abuse is mandatory under law, mental health records are not required to be part of that reporting. Release of mental health records requires a court order or written authorization by the client.
- Elder Abuse or Abuse of a Person with a Mental Illness or Developmental Disability: While the reporting of elder abuse and abuse of a person with a mental disability is mandatory under law, mental health records are not required to be part of that reporting. Release of mental health records requires a court order or written authorization by the client.

Uses and Disclosures of Client or Participant Information: 410-014-0020(2)(f)(g)

16. Alcohol/Drug (A&D) and Mental Health Information

Pursuant to federal A&D law and state mental health law, a client has the right to authorize use and disclosure of A&D or mental health treatment information to “DHS,” or to a specific program within DHS, such as Self-Sufficiency, or to a specific person (name or title).

A&D and mental health treatment information may be used only for the specific purpose listed on the *Authorization for Use and Disclosure of Information* (DHS 2099) form. A client has the right to informed consent when filling out the DHS 2099. This means the worker has told the client he or she may authorize the use of A&D and mental health information to “DHS” as a whole or may limit disclosure to a specific program such as to the Self-Sufficiency Program.

Federal A&D law prohibits unauthorized use, disclosure and re-disclosure of A&D treatment information. State mental health law prohibits unauthorized use, disclosure and re-disclosure of mental health information. These laws:

- Give a client the right to restrict to what entity or person and for what purpose treatment information may be used or disclosed.
- Require that the client’s right to limit use and disclosure of A&D and mental health information be communicated to the client.
- Prohibit re-disclosure of A&D and mental health treatment information without the specific authorization of the client.
- Allow a client to authorize use and disclosure of information by filling out and signing a release (such as the DHS 2099) that includes the:
 - Name of the person or program making the disclosure.
 - Name or title of the individual or organization to which disclosure is to be made.
 - Name of the client.
 - Purpose of the disclosure, which must be specific.
 - How much and what kind of information is to be disclosed.

Cross Program Use: Cross program use of A&D and mental health treatment information is permitted only when the client has signed an authorization.

Section (3)(b) of DHS Privacy Policy AS-100-03, Use and Disclosure of Client or Participant Information, states that “internal communication within DHS is permitted without individual authorization...” *with the exception that “alcohol and drug, mental health and vocational rehabilitation record disclosure may be limited to particular program areas named on the authorization form. If a limitation in internal disclosure is noted on the authorization form, disclosure is limited to the parties named.”* This means that if the appropriate authorization is not in place, A&D and mental health information may not be shared internally between DHS clusters, such as Self-Sufficiency and Child Welfare, for the purpose of meetings or staffings including Family Decision Meetings, Medical Review Teams, Multi-Disciplinary Teams, etc. This does not prohibit A&D and mental health information from being shared if the information is de-identified and provides only generalities about a situation.

If A&D or mental health treatment information is used or disclosed more broadly than the client has authorized on the DHS 2099, the person using the information or making the disclosure may be in violation of federal or state law.

17. Domestic Violence

In addition to safeguarding personal information for all clients, it is critical to be mindful of safety issues for clients who are in domestic violence situations. This applies to all self-sufficiency programs. If there is any likelihood that an abuser may access the file, proceed with caution. Branch procedures might include keeping domestic violence/abuse information in a separate file or attached separately so that it can be easily removed. This separation would include the safety assessment (if used), the TA-DVS addendum (if used), any safety or case planning documents, and any information from the domestic violence service providers. It is also a good practice to remove references to domestic violence. When printing TRACS narratives, use a black felt marker to cross out any references to domestic violence before sharing the narrative.

When it is safe to Narrate: Narrate what you actually see (Mary came in with a black eye and a broken tooth). Record the client's description of what happened (Mary said, "My boyfriend got a little drunk and threw a bottle at me."). Narrate any history of abuse, abuser criminal history, other factors that might inform case planning efforts. If the client identifies the abuser as "boyfriend/girlfriend; wife/husband; roommate; family member" ask for the actual name and record it in TRACS. Put all information supplied by others in quotations. Document initial safety planning with the client. Document any other information pertinent to working with the client or pertinent to the safety of the client; such as a child support, good cause determination or support services related to domestic violence.

Do not narrate any reference to child abuse (See 15. above) but note referrals to child welfare.

Treat the TRACS TA-DVS Eligibility and Assessment addendum and DVAA TRACS Narrative Supplemental as narratives. Do not use these online tools if the abuser is in the household or if the abuser (or abuser's family member) works for DHS or a partner agency with access to TRACS.

Caution: Be especially careful when providing any information on DHS cases identified as involving domestic violence.

If domestic violence has been identified in the household, do not release information unless the case record shows that the person requesting the information is currently residing in the household. In cases where the reported abuser is no longer in the household, but is requesting information, remember that he is only entitled to see information from the time he was a household member and an applicant or recipient.

Use of Alternative Identities on CMS and TRACS: In some cases you may have a client request use of an alternative identity or they may be going through a name change to protect their identity or location from an abuser.

You must have permission from your manager to use an alternative identity on the system. The manager or his/her designee needs to contact central office to authorize release of the procedure to code alternative identities.

When using an alternative identity, eligibility information (e.g. client identifying information, citizenship, relationship, social security numbers, Oregon residency, etc) should be secured. A file containing the confidential information could be kept in the manager's office, put in a separate folder marked confidential, kept in the hard file in a envelope marked "do not disclose" or otherwise protected. Check with your manager or DV point person to determine the process used in your branch.

Safety Tools in the Child Support Program: There are two ways to address potential safety concerns and confidentiality in the child support program. If a client indicates it is not safe to pursue child support, we can grant good cause. DCS will take no actions to pursue paternity establishment, medical support or child support. If the client wants to pursue support but would like to protect information during pursuit, there is an additional tool. A client may request nondisclosure based on "Claim of Risk" which protects not only the client's resident address but personal identifying information such as where the client works, their social security number, their driver's license number and where the child attends school. These options are explained in the *Client Safety Packet on Good Cause; Oregon Child Support Program* (DHS 8660).

Address Confidentiality Program (ACP) through Department of Justice, Crime Victims' Services Division: Is a program that provides a substitute address and mail forwarding for victims of domestic violence, sexual assault, stalking and human trafficking who have qualified for participation in the program. A participant in the program is given a card which will identify them as a participant. When presented with the identification card, Self-Sufficiency and SPD programs will not enter a resident address in the CMS or FSMS systems. Only the substitute address (ACP P.O. Box) that is shown on the ID card should be entered into our systems. The resident address will be kept in the hard file in an envelope marked confidential and should not be released to anyone without consultation with central office or the manager.

Self-Sufficiency and SPD Staff should be aware that:

- An additional five days should be allowed for sending notices requiring 10 days or less for service.
- For managed care enrollment, an out-of-area enrollment exception needs to be requested.
- For child care payments issued through the Direct Pay System, care that is provided by someone using the ACP PO Box, the maximum payment rates will default to Region A.

Notice Period: 461-175-0050

People selected for the program have completed safety planning with a local domestic violence service provider or district attorney based victims' assistance program. For

further information about the program you can access their web page at www.doj.state.or.us/crimev/confidentiality.shtml.

To apply for the program, the client should be referred to your local domestic violence and sexual assault service provider or the local crime victims' assistance program through your local district attorney. The victim will work with an application assistant who can help them decide if the program is appropriate for them.

Other ways to protect information in domestic violence cases: There are several options available that victims may use to protect their address from being used in public records including voter's registration, driver's license and court proceedings. You can refer clients to the individual agencies to learn more information or to the local domestic violence service provider who may help the client plan around these options. Legal aid has information about confidentiality protections for victims of domestic violence, sexual assault and stalking on their web page at www.oregonlawhelp.org.

18. HIV/AIDS

According to Oregon Revised Statutes 433.045(3), in no instance may a department employee reveal to any person or agency that a client is HIV positive (a person who is HIV positive has been exposed to the AIDS virus) without a written client authorization. On the *Authorization for Use and Disclosure of Information* (DHS 2099) form, the authorization must specifically identify HIV test results in Section B and be initialed in the correct box below Section B.

Information on a client's HIV status may not be included in the case record unless necessary to determine eligibility. Workers must judge whether a report containing information about HIV is needed to determine eligibility. If not, the information must be destroyed. If HIV information is needed for eligibility determination, the report should be retained, but marked with a notation that the information cannot be released to any person or agency.

Do not enter HIV status information into any shared communication system such as TRACS.

19. When You Receive a Subpoena

A subpoena is not a court order. A court order is signed by a judge. A subpoena is almost always signed by an attorney. The department must comply with a court order to provide testimony or documents unless the department is able to persuade a judge to amend or rescind the order. In response to a subpoena, the department must file written objections within 10 days or appear to present objections in court (or convince the attorney to drop the subpoena), but a subpoena alone does not require testimony or release of documents. If the time period to object to a subpoena is not waived, there must either be a court order or a valid written authorization from the client for the department to release documents or provide testimony.

How you respond to a subpoena will depend on what the subpoena is directing you to do.

- If the case record or worker is subpoenaed to appear before a judge, you should testify or release client information in the judicial proceeding if at least one of the following is true:
 - (A) The proceedings are directly connected with administering a self-sufficiency program (except that release of information about substance abuse treatment and mental health still requires an authorization); or
 - (B) The client has given a current and valid written authorization for release of specific information sought that covers both the purpose of the proceeding and those present in court; or
 - (C) A judge directs you to provide the information.

If there is no valid client authorization and the proceeding is not about the self-sufficiency program, take a copy of the records requested and appear as directed by the subpoena. Give the presiding judge a copy of the state statutes that relate to the confidentiality of client records. (ORS 411.300, 411.320, 411.335, as well as 179.505 (behavioral health), 411.117 (domestic violence), 412.074 (TANF)).

Release of Client Information to Service Providers and Legal Bodies: 461-105-0110

☞ SEE GENERIC PROGRAM INFORMATION CHAPTER FOR MORE INFORMATION.

These statutes provide an explanation of the laws governing confidentiality of client information and let the judge know that we can provide the information if he or she orders us to do so. Testify only to the extent that the judge orders you to testify.

If a case record or a worker is subpoenaed and the subpoena directs the record or worker to provide documents or appear in a deposition or an attorney's office or in an administrative hearing where a judge will not be present, do the following:

- Look at the date you are asked to appear or provide documents. If the subpoena gives the agency less than five working days to comply, contact the DHS Central Office subpoena liaison **immediately** and fax a copy of the subpoena to them at (503) 373-7032. You should also check the client file to see if the client has signed an authorization to release information to the attorney, and fax any releases that may apply. Note that a release in the file may not cover the scope or purpose of the request. If time permits, contact the attorney or agency that issued the subpoena. Explain that ORS 410.150, 411.300, 411.320, and 411.335 prohibit the department from disclosing client information without the client's written release. Ask that the subpoena be withdrawn and for brief written confirmation that the department is not required to comply with the command of the subpoena.
- If you cannot reach the attorney or the attorney is not willing to withdraw the subpoena, **immediately** contact the DHS Central Office subpoena liaison and fax a copy of the subpoena and any related authorizations to share information to the liaison at (503) 373-7032.

- The department may file written objections or seek to quash the subpoena, especially if only documents are requested. If only documents are requested, do not provide them in the absence of a court order or valid written, client authorization or specific direction from the Attorney General's office (AG) contact or confidentiality analyst.
- If a subpoena for your testimony is not quashed, the person subpoenaed should appear as directed by the department's AG contact or the subpoena liaison. You would bring any documents directed: however, actual testimony or release of documents at this hearing would still require a court order or valid, written authorization.
- If the worker or the case record is subpoenaed for a grand jury and the proceedings are not directly connected to administering the department's programs, or the client has not given written authorization for the release of specific information, immediately contact the subpoena liaison. Fax a copy of the subpoena to them at (503) 373-7032.

20. Verification

In every situation in which information is shared, with or without an authorization, inside or outside of DHS, staff, volunteers and contractors are required to take reasonable steps to verify the identity of the individual receiving the information, unless the department workforce member fulfilling the request already knows the person or has already verified identity.

☞ SEE OAR 407-014-0020(6)

[HTTP://WWW.OREGON.GOV/DHS/ADMIN/DWSSRULES/ADOPTED/407_014_A.PDF](http://www.oregon.gov/dhs/admin/dwssrules/adopted/407_014_A.PDF)

When releasing information to a client's attorney without an *Authorization for Use and Disclosure of Information* (DHS 2099) form, staff must verify that the individual is an attorney. Instructions for how to do this are at: <http://intranet.dhs.state.or.us/caf/>

If the person is not known to the DHS staff member fulfilling the request, take one of the following reasonable precautions to verify that the individual with whom staff is communicating is that same attorney:

- Ask to see an identification badge or driver license when the request is made in person.
- Conference call in another DHS employee who knows the attorney, will recognize the attorney's voice, and can then verify identity.
- Ask for a phone number at the same location you can call back that will confirm you are communicating with a law firm or legal services.
- An e-mail from the attorney's e-mail address that will serve to verify that the attorney is the person on the phone.

- The fax number or address to which you will send the documents is that of the attorney. You can confirm fax number on the Oregon State Bar website: <http://www.osbar.org/members/start.asp>
- A fax from the attorney's fax number that will serve to verify that the attorney is the person on the phone.
- Another reasonable approach.

21. Forms and References

Forms

- DHS 2090, *Notice of Privacy Practices*
- DHS 2093, *Access to Records Request Form*
- DHS 2094, *Amendment of Health Record Request Form*
- DHS 2095, *Restriction of Use and Disclosures Request Form*
- DHS 2096, *Accounting of Disclosures Request Form*
- DHS 2097, *Disclosures of Protected Health Information (PHI)*
- DHS 2099, *Authorization for Use and Disclosure of Information*

References

DHS Policy

- AS-100-01, *General Privacy*
- AS-100-02, *Client Privacy Rights*
- AS-100-03, *Uses and Disclosures of Client or Participant Information*
- AS-100-04, *Minimum Necessary Information*

Oregon Administrative Rules

- 407-014-0000
(Privacy Definitions)
- 407-014-0020
(Uses and Disclosures of Client or Participant Information)

- 407-014-0030
(Client Privacy Rights)
- 407-014-0040
(Minimum Necessary Standards)
- 461-105-0060
(Release of Information to the Client)
- 461-105-0070
(Client Authorization for Release of Client Information to Third Party)
- 461-105-0100
(Release of Client Information to Law Enforcement Officers)
- 461-105-0110
(Release of Information to Service Providers and Legal Bodies)
- 461-105-0120
(Release of Information on Child Support and Paternity Cases)
- 461-105-0130
(Disclosure of Client Information)

Oregon Revised Statutes

- 179.505 (Disclosures of written accounts by health care services provider)
- 124.050 - 124.095 (Elder Abuse)
- 410.150 (Use of files; confidentiality; privileged communications)
- 411.117 (Requires confidentiality in domestic violence cases)
- 411.320 (Public Assistance, Disclosure and use of public assistance records limited; contents as privileged communication; exceptions)
- 412.074 (Use and custody of records of Temporary Assistance for Needy Families (TANF) program)
- 412.094 (Public officials to cooperate in locating and furnishing information concerning parents of children receiving public assistance, and in prosecuting nonsupport cases; use of information restricted)
- 430.735 - 430.765 (Abuse of Persons with Mental or developmental disabilities)
- 419B.005 - 419B.045 (Child Abuse)

Federal Law

- 7 CFR 272.1

- 42 CFR Part 2
- 45 CFR Part 164.522 - 164.528

L. Fleeing Felon and Violators of Parole, Probation, or Post-Prison Supervision

This policy applies to the FS, GA, and TANF programs only. It does not apply to TANF-related medical or child care programs.

On August 22, 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 became law. This law made fleeing felons and persons in violation of conditions of parole and probation ineligible for the Food Stamp and TANF programs.

1. Who is a parole, probation, or post-prison supervision violator?

A parole, probation or post-prison supervision violator is a person who is violating a condition of federal or state probation or parole, or post-prison supervision under Oregon law. Oregon uses the term “parole” if the crime occurred prior to November 1, 1989, and the term “post-prison supervision” if the crime occurred on or after that date. Local, state or federal corrections agencies or the courts determine if a person is in violation. DHS does not make the determination.

Whenever a worker receives a report from a local, state or federal corrections agency or the courts that a person is in violation of conditions of parole, probation or post-prison supervision, the client is ineligible for FS and TANF benefits and must be disqualified. The disqualification continues until the local, state or federal corrections agency or the courts report that the person has complied and is cooperating with the conditions of their parole, probation or post-prison supervision.

***Note:** Sometimes an applicant informs a worker that they are in violation of their parole or probation. When this occurs, their statement is accepted and the client becomes ineligible for benefits.*

☞ **TIMELY CONTINUING BENEFIT DECISION NOTICES (10-DAY) TO REDUCE (GSR1OP2) OR TO END (GSC1OP1) BENEFITS ARE AVAILABLE ON NOTICE WRITER.**

Need Group: 461-110-0630

Fleeing Felon and Violators of Parole, Probation, and Post-Prison Supervision; FS, GA, GAM, and TANF: 461-135-0560 |

The client who is in violation of parole, probation or post-prison supervision is ineligible and is removed from the need group. The client is treated the same way as any client who is ineligible for other nonfinancial eligibility reasons. Other eligible persons in the benefit group will remain eligible for benefits. The parole, probation or post-prison supervision violator’s income and resources are counted the same as individuals disqualified for other reasons.

2. Who is a Fleeing Felon?

A fleeing felon is an individual who is avoiding prosecution or custody (jail or prison) for a crime, or an attempt to commit a crime, that is classified by state law as a felony.

To be a fleeing felon, the individual must be aware of a warrant for their arrest and have fled or concealed himself or herself to avoid:

- Appearing in court regarding a crime that is considered a felony; or
- Going to jail or prison after conviction of a felony.

The law of the place from which the person is fleeing determines if the crime is considered a felony, or in the case of New Jersey, is a high misdemeanor under the law of New Jersey. For example, a crime may be considered a felony in California but not in Oregon. However, if the person fled from California, they are also ineligible in Oregon.

The existence of an outstanding felony warrant for a person's arrest does not automatically establish the person is fleeing for purposes of the FS or TANF programs in Oregon. A person wanted for a felony may not have fled their home or the local area. They may not have initiated actions to conceal themselves or to avoid arrest. A person may have moved out of an area and not be aware of the arrest warrant. The police may know where the person is but choose to not arrest them at this time. Therefore, workers are to first determine if the client knows they are wanted for a felony and what actions have been taken to resolve the issue to remain eligible for benefits.

Need Group: 461-110-0630

Fleeing Felon and Violators of Parole, Probation, and Post-Prison Supervision; FS, GA, GAM, and TANF: 461-135-0560

3. Receiving Report for Fleeing Felon

(A) There are several ways for local offices to learn that a person is a fleeing felon.

Question on Application:

A question on all applications for FS or TANF benefits asks clients if they, or anyone they want benefits for, have an outstanding arrest warrant. Whenever the household answers yes, the worker must ask more questions to determine if the person is a fleeing felon for FS and TANF purposes. The additional question should include:

- Where was the arrest warrant issued? (city, county, state)
- When was the warrant issued?
- What is the reason for the warrant?
- Is it for a felony or a misdemeanor?

- When did the client learn about the warrant?
- Did the client move here after they learned the arrest warrant was issued?
- What steps has the client taken to resolve the issue?
- If they have not taken steps to resolve the issue, why not?
- Does the client have the mental or physical ability to resolve the issue?
- If they lack the financial ability to resolve the warrant, has the client asked the district attorney or courts to pay for their return and was this request denied? (Ask for a copy of letter.) Maybe the other state has decided not to extradite.

If the applicant is disqualified as a fleeing felon, let them know what steps are needed to take substantial effort to resolve the matter for future eligibility.

Carefully narrate the discussion, all responses and the decision. An applicant is a fleeing felon and ineligible for benefits if the applicant knew about the felony warrant and has taken actions to avoid the police or has done nothing while mentally or physically able to take actions to resolve the issue. Workers are not expected to contact the issuer of the warrant.

The ineligible applicant is removed from the need group, and is treated the same as an applicant who is ineligible for other nonfinancial eligibility reasons. Other eligible persons in the case will remain eligible for benefits. The fleeing felon's income and resources are counted the same as other disqualified individuals.

☞ A BASIC BENEFIT DECISION NOTICE TO DENY (GSG1OF1) IS AVAILABLE ON NOTICE WRITER.

Not claimed on Application–Information received from other sources

Workers may learn that a client is a fleeing felon from other sources. These sources may include:

- Social Security Administration, HUD or Veterans Administration.
- Law enforcement or local, county or state corrections offices.
- Staff in FS or TANF offices from other states.
- USDA Office of Inspector General or another federal agency (such as the U.S. Marshals office).

Note: *If law enforcement notifies the department that a person is a fleeing felon, they may also ask the local office to delay taking action for a set period of time because it will interfere with their investigation or the apprehension of the felon. Narrate the request and the approximate time frame for the delay.*

Caution: The law regarding fleeing felons is treated differently by different federal and state agencies. Therefore, workers must make a separate determination and not depend on the determination made by other agencies, law enforcement, SSA or another state. Some agencies, such as the SSA, conduct matches with the police looking for arrest warrants. They may not determine if the warrant is for a felony or if the person knows of the felony warrant and is fleeing.

Actions to take when local offices receive word from someone other than the client:

- In rare instances, the worker may receive enough information upon receipt of the report to make a fleeing felon determination and disqualify the applicant or the client.
- If there is not enough information to determine fleeing felon status, the worker shall inform the client of the report within 10 days of receipt of the information. Send the client the notice writer notice (GSG1OF1) giving them time to resolve the issue. The client may contact the public defenders office in the location of the felony warrant or a criminal lawyer to obtain guidance on how to proceed with resolving the warrant.
- Give the client 20 days to make substantial effort to resolve the issue and provide proof that they have taken the recommended steps to resolve the problem.
- If the client states the arrest warrant is not for a felony or is no longer outstanding, ask them to provide proof or the worker can contact law enforcement (with client consent) to verify before taking any disqualifying actions.
- If the client does not verify the resolution or the attempt to resolve the issue by the twentieth day, make the disqualification determination. Send a closing or reduction notice to clients and deny applicants.

☞ TIMELY CONTINUING BENEFIT DECISION NOTICES (TEN-DAY) TO REDUCE (GSR1OF2) OR TO END BENEFITS (GSC1OF3) ARE AVAILABLE ON NOTICE WRITER.

Note: For FS, take action to determine who is or is not a fleeing felon and make disqualification decisions regardless of the report system.

An overpayment for cash or FS begins after the department learned that the client is ineligible due to this law. The exception to this is if it is determined through the IPV process that the client knew of the arrest warrant and failed to correctly answer the question on the application. Administrative overpayments exist if the department did not take timely action to determine if they are fleeing or apply the disqualification.

Any person determined ineligible for being a fleeing felon is removed from the need group. Others besides the fleeing felon may still be in the need group. Their income and resources are counted the same as other disqualified individuals.

☞ SEE GENERIC PROGRAM INFORMATION L EXAMPLES SECTION FOR FLEEING FELON EXAMPLES 1 - 7.

(B) After the disqualification notice is sent

Often clients will provide information that shows they have contacted a criminal lawyer or the public defenders office and have begun steps to resolve the issues after the notice of disqualification is mailed.

Disqualification notice sent but not yet effective:

If the client contacts the office with needed information to lift the disqualification after the disqualification notice is mailed but before the effective date for both FS and TANF, restore the benefits without applying the disqualification.

Disqualification notice sent and on or past the effective date:

Sometimes clients do not contact the local office to provide the needed information until after the effective date of the action. When this occurs, follow add a person policy for each program.

For FS: Add the person to the need and benefit groups effective the first of the next month following the date the information is received. Do not supplement.

If the fleeing felon is the only person on the FS case, set the filing date as the date the information is received. Issue prorated benefits if otherwise eligible.

For TANF: Follow “add a person” policy.

☞ SEE GENERIC PROGRAM INFORMATION L EXAMPLES SECTION FOR FLEEING FELON EXAMPLE 8.

Examples of fleeing felon:

Example 1: There is a felony warrant for a client’s arrest. The police know where the client is living and have chosen not to pick them up. Absent other facts, this person is not a fleeing felon.

Example 2: A client is wanted in another state for a felony conviction. The former state knows where they reside and has not decided if they want to extradite the client. Absent other facts, this person is not a fleeing felon.

Example 3: A client applied for benefits in Oregon on October 16. She left Washington State on October 15. The worker learns after calling Washington to verify the client was not receiving benefits there, that the client had five felony arrest warrants and was due to be in

court on October 16 about the separate charges. She is a fleeing felon and is ineligible for FS and TANF.

Example 4: A client moved to Oregon and later learned there is a felony warrant. He contacted the other state and told them where he is. He offered to return to the other state if they will pay his travel costs, as he cannot afford the trip. The state declined to send him the funds to transport him to that state. This person is not a fleeing felon.

Example 5: A client learns of the arrest warrant but due to mental health issues is unable to pursue the steps needed to resolve the issue. This person is not a fleeing felon.

Example 6: A client is informed of the felony warrant and declined to turn herself in. Absent other facts, this person is a fleeing felon.

Example 7: A client was convicted of a felony and moved away prior to confinement. He is a fleeing felon.

Example 8: The police report a person is a fleeing felon on October 16. On October 20, the first fleeing felon letter is sent to the client notifying them of the problem and giving them 20 days to resolve the issue. No response is received by November 10. Notice of reduction or closure is sent effective November 30 or December 1.

- Client contacts the office November 28 with proof of how the client is resolving the issue. Restore benefits effective December 1.*
- Client contacts the office on December 2 and provides the needed information to prove they are taking steps to resolve the issue.*

For FS, add the person to the need and benefit groups effective January 1. If the only person in the filing group, set December 2 as the filing date and make a new eligibility determination following an application and interview, etc.

For TANF, add the person to the need and benefit groups effective January 1.

Worker Guide Confidentiality Statutes

This worker guide contains copies of the state confidentiality statutes.

1. 411.320; Disclosure and use of records limited; contents as a privileged communication; exception

- (1) For the protection of applicants for and recipients of public assistance, except as otherwise provided in this section, the Department of Human Services shall not disclose or use the contents of any public assistance records, files, papers or communications for purposes other than those directly connected with the administration of the public assistance laws of Oregon or as necessary to assist public assistance applicants and recipients in accessing and receiving other governmental or private nonprofit services, and these records, files, papers and communications are considered confidential subject to the rules and regulations of the Department of Human Services. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance or child support enforcement laws, their contents are considered privileged communications.
- (2) Nothing in this section prohibits the disclosure or use of contents of records, files, papers or communications for purposes directly connected with the establishment and enforcement of support obligations pursuant to the title IV-D program.
- (3) Nothing in this section prohibits the disclosure of the address, social security number and photograph of any applicant or recipient to a law enforcement official at the request of such official. To receive information pursuant to this section, the officer must furnish the department the name of the applicant or recipient and advise that the applicant or recipient:
 - (a) Is fleeing to avoid prosecution, custody or confinement after conviction for a felony;
 - (b) Is violating a condition of probation or parole; or
 - (c) Has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the applicant or recipient is within such official duties.

2. 412.074; Use and custody of records of the Temporary Assistance for Needy Families program.

- (1) Except as otherwise provided in this section, no person shall, except for purposes directly connected with the administration of the temporary assistance for needy

families program, delivery or administration of programs and services the Department of Human Services is authorized to deliver and administer pursuant to ORS 409.010 or as necessary to assist public assistance applicants and recipients in accessing and receiving other governmental or private nonprofit services and in accordance with the rules of the department, solicit, disclose, receive, make use of, or authorize, knowingly permit, participate in, or acquiesce in the use of, any list of or names of, or any information concerning, persons applying for or receiving such aid, directly or indirectly derived from the records, papers, files, or communications of the department or acquired in the course of the performance of official duties.

- (2) Nothing in this section prohibits the disclosure and use of information about applicants and recipients as is necessary to carry out the child support enforcement laws of this state and of the United States.
- (3) Nothing in this section prohibits the disclosure of the address of any applicant or recipient to a law enforcement official at the request of such official. To receive information pursuant to this section, the officer must furnish the agency the name of the applicant or recipient and advise that the applicant or recipient:
 - (a) Is fleeing to avoid prosecution, custody or confinement after conviction for a felony;
 - (b) Is violating a condition of probation or parole; or
 - (c) Has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the applicant or recipient is within such official duties.

3. Supporting State and Federal Citations:

The federal and state confidentiality laws that may apply include the following:

- **7 USC § 2020(e)(8), 42 USC § 602(a)(1) and 1396(a)(7), 7 CFR § 272.1(c), 42 CFR § 431.000 et seq. and 45 CFR § 205.50** – Prohibits use or disclosure of information concerning applicants or recipients of public assistance programs (e.g., food stamps, aid and services to needy families with children and medical assistance) without the client's consent, except for purposes directly connected with the administration of public assistance programs. Violation of these federal laws risks reduction or loss of federal funds for public assistance.
- **ORS 411.320** – Prohibits disclosure or use of DHS client records except for purposes directly related to the administration of the public assistance laws, with certain exceptions. Criminal penalties are mandated for violation of this nondisclosure rule. ORS 411.990; OAR 461-105-0060 to 461-105-0130.

- **ORS 412.074** – Prohibits disclosure or use of aid to needy families’ client records, with certain exceptions. Criminal penalties are mandated for violation of this nondisclosure rule. ORS 418.990; OAR 461-105-0130.
- **42 USC § 654 (26)** – Requires states to safeguard all confidential information related to the child support programs. See also 45 CFR § 303.21.
- **ORS 25.260 (Temporary. See Section 132, Chapter 746, Oregon Laws 1997)** – Prohibits disclosure or use of support enforcement records, files, papers or communications for purposes other than those directly connected with the administration of the public assistance laws with certain exceptions. Criminal penalties are mandated for violation of this nondisclosure rule. ORS 25.990. See also OAR 137-055-1140.
- **20 USC § 1232g, 34 CFR § 99.33, ORS 192.496 and 326.565, OAR 581-021-0350** – Prohibits agencies to whom school records are disclosed from redisclosing “personally identifiable information” without the prior consent of the parent or eligible student unless subject to a court order or legal subpoena, and only then after making reasonable efforts to notify the parent or eligible student of the order or subpoena. Disclosure to a parent may be limited where there is a court order, state statute or legally binding document which specifically revokes the rights of the parent in cases of divorce, separation or custody. 34 CFR 99.4, OAR 581-021-0230. (See, for example, 42 USC § 654 (26); Section 132, Chapter 746, Oregon Laws 1997.)
- **42 USC § 5106(b)(4) and 45 CFR § 1340.14(i); ORS 419B.035** – Records of child abuse are confidential and not accessible for public inspection. (The identity of the informant and any identifying information “shall be removed from the record or shielded from view before records are viewed or copies.” OAR 413-010-0080.)
- **42 USC 290dd and 42 CFR Part 2; ORS 430.399(6)** – Records regarding the identity, diagnosis, prognosis or treatment of patient of alcohol or drug treatment are confidential.
- **26 USC § 6103** – Prohibits disclosure of tax return information obtained by state employees in regard to child support cases. Criminal penalties are mandated for a violation of this nondisclosure rule. 26 USC § 7213(a)(2).
- **ORS 314.835** – Prohibits disclosure of tax information received by another agency for any purpose other than that specified in the provision of the law allowing disclosure. Criminal penalties are mandated for a violation of this nondisclosure rule. ORS 314.991.
- **ORS 192.501 and 192.502** – Provides numerous exemptions from public disclosure of records. In particular, subsections (1)-(4) and (8)-(10) of ORS 192.502.

- **ORS 40.225 to 40.295** – Privileges, particularly the psychotherapist-patient, physician-patient, nurse-patient, clinical social worker-client and counselor-client privileges. And, especially ORS 40.270 (OEC 509), the public officer privilege that prohibits examination of a public officer in regard to public records determined to be exempt from disclosure under ORS 192.501 to 192.505.

4. Suggested Procedure

When you hand the judge a copy of the state statutes, tell the judge something like the following:

Your honor, it is my understanding that both federal and state law prohibit the disclosure of information contained in DHS client files without the client's consent, unless the purpose of disclosure is directly connected with the administration of the public assistance programs or the enforcement by the proper authorities of the child support laws of the state, or as ordered by a court. This restriction on disclosure includes testimony concerning information directly or indirectly derived from the records. In fact, it is a Class A misdemeanor to disclose such information in violation of the law.

Ask the judge for guidance and answer questions at the direction of the judge.

Worker Guide Contacts for Statewide Verification of Assistance

This worker guide is intended to help workers determine if an applicant for assistance in Oregon has already received benefits in another state.

This is a list of central phone numbers or fax numbers that workers can use to find out if a person applying for assistance in Oregon has already received benefits in another state or American territory. If the client has a different phone number for a specific worker in another state or territory, use that number. Please notify the policy unit of any changes to the numbers on this list.

Note: For fax requests please provide the name, social security number, and date of birth for everyone on the case.

<u>State</u>	<u>Phone Numbers</u>	<u>Fax Numbers</u>	<u>Additional Information</u>
Alabama	FS: 334-242-1700 MEDICAL: 334-242-5010 TANF: 334-242-0513	TANF: 334-242-1773	FS: Phone request only. MEDICAL: Phone request only. TANF: Fax request only.
Alaska	General: 907-465-3360	General: 907-465-3651	Phone or Fax request.
American Samoa	General: 011-684-633-2609		
Arizona	General: 602-542-9935	General: 623-873-4278	Fax request first, then phone.
Arkansas	General: 501-682-8269 General: 800-482-8988		Phone request only.
California	General: 916-651-8848 Option 4	General: 916-651-8866	Fax request only.
Colorado	General: 303-866-3860 MEDICAL: 800-221-3943		Phone request only.
Connecticut	General: 860-647-1441	General: 860-647-5888	Phone or Fax request.
Delaware	General: 800-372-2022 Option 5	General: 302-255-4454	Phone or Fax request.
District of Columbia (DC)	General: 202-724-5506	General: 202-724-7924	Fax request only.
Florida	General: 866-762-2237 Option 2		Phone request only.
Georgia	General: 800-869-1150	General: 404-657-9703	Phone or Fax request.
Guam	General: 671-735-7279		Phone or Email request. email: linda.susuico@dphss.guam.gov
Hawaii	General: 808-586-5733 TANF: 808-586-5725 FS: 808-586-5720		Phone request only.
Idaho	General: 208-334-5815	General: 208-334-5817	Phone or Fax request.
Illinois	General: 217-524-5007 General: 217-524-4174	General: 217-557-1370	Phone or Fax request.
Indiana	General: 317-233-0826	General: 317-233-0828	Phone or Fax request.
Iowa	General: 515-281-6899	General: 515-281-4597	Phone, Fax or Email request. email: sbagley@dhs.state.ia.us
Kansas	General: 785-368-8129	General: 785-296-6960	Phone or Fax request.
Kentucky	General: 502-564-7514	General: 502-564-4021	Phone or Fax request.
Louisiana	General: 225-342-2342 MEDICAL: 225-922-1542	General: 225-342-6996	Phone or Fax request.

<u>State</u>	<u>Phone Numbers</u>	<u>Fax Numbers</u>	<u>Additional Information</u>
Maine	General: 207-287-2826	General: 207-287-5097	Phone or Fax request.
Maryland	General: 800-332-6347 Option 5	General: 410-333-3331	Phone or Fax request.
Massachusetts	General: 617-348-8500 General: 800-445-6604 MEDICAL: 800-841-2900		Phone request only.
Michigan	General: 517-373-3908	General: 517-335-6236	Phone or Fax request.
Minnesota	General: 651-431-4001		Phone request only.
Mississippi	General: 800-948-4060 MEDICAL: 601-359-6050	General: 601-359-4550	Fax or Email request. email: sawilder@mdhs.ms.or.us
Missouri	General: 573-751-3221	General: 573-751-3677	Phone or Fax request.
Montana	General: 406-444-1788 MEDICAL: 406-444-4543 TANF: 406-444-9291		Phone request only.
Nebraska	General: 402-471-3121		Phone request only.
Nevada	General: 775-684-0615		Phone request only.
New Hampshire	General: 603-271-4238	General: 603-271-4637	Phone or Fax request. * plus written auth from client for fax
New Jersey	General: 609-588-2401	General: 609-631-4507	Fax request only. Attn: Joyce
New Mexico	General: 505-841-7700 General: 800-283-4465	General: 505-841-7754	Phone or fax request.
New York	General: 518-473-6110	General: 518-474-8090	Fax request only. plus reason for info
North Carolina	MEDICAL: 919-855-4100	General: 919-715-5457	Phone or Fax request.
North Dakota	General: 701-328-2332	General: 701-328-1060	Phone or Fax request.
Ohio	N/A	N/A	out_of_state_inquiries@jfs.ohio.gov
Oklahoma	General: 405-521-2779		Phone request only.
Oregon	General: 503-945-5601 General: 610-821-6711	General: 503-373-7032 General: 610-821-6514	Fax request only. Phone or Fax request.
Pennsylvania	General: 787-289-7600 x 2613 MEDICAL: 787-765-1230 x 5811	General: 787-289-7614 MEDICAL: 787-250-0900	Phone or Fax request.
Rhode Island	General: 401-222-7000		Phone request.
South Carolina	General: 803-898-0996 MEDICAL: 888-549-0820	General: 803-898-7156	General: Phone or Fax request. MEDICAL: Phone request only.
South Dakota	General: 605-773-3493 MEDICAL: 605-773-4678	General: 605-773-7183	Phone or Fax request.
Tennessee	General: 615-313-5652	General: 866-876-7552	Fax request only.
Texas	General: 877-787-8999	General: 512-491-1967	Phone or Fax request.
Utah	General: 801-313-4600 Option 3	General: 801-526-9500	Phone or Fax request.
Vermont	General: 800-287-0589 MEDICAL: 800-250-8427		Phone request only.
Virgin Islands	General: 340-773-2323 General: 340-773-5060	General: 340-773-6121	Phone or Fax request.
Virginia	General: 703-324-7500	General: 703-324-3896	Phone request only. Request to speak to supervisor.
Washington	General: 360-725-4763	General: 360-725-4904	Phone or Fax request.
West Virginia	General: 877-716-1212	General: 304-558-1869	Phone request only.

<u>State</u>	<u>Phone Numbers</u>	<u>Fax Numbers</u>	<u>Additional Information</u>
Wisconsin	General: 608-261-6378 Option 3 TANF: 608-261-6317 Option 2		Phone request only.
Wyoming	General: 307-777-6079		Phone request only.

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Worker Guide
Combined Standards and Federal Poverty Level Figures

This worker guide lists the standards for ERDC, FS, MAA, MAF, OHP and TANF all in one place. It includes standards for need groups that contain adults and those that do not contain adults. This guide also includes the federal poverty level figures on which many income standards are based.

2009 Federal Poverty Level

<u>Number</u> <u>in Family</u>	<u>Gross</u> <u>Monthly Income</u>	<u>Gross</u> <u>Yearly Income</u>
1	\$ 903	\$ 10,830
2	1,215	14,570
3	1,526	18,310
4	1,838	22,050
5	2,150	25,790
6	2,461	29,530
7	2,773	33,270
8	3,085	37,010
9	3,396	40,750
10	3,708	44,490
+ 1	\$ 312	\$48,230

One or More Adult Standards - for MAA/MAF/OHP/TANF/Post-TANF

Persons in Need Group	TANF Payment + Coop. Incentive	Adjusted Income/ Payment Standard	Countable Income Limit	MAA/MAF/TANF Minimum Contributions (amt. each nonrecipient pays)		OHP Countable Income Standard				OHP Premium Exempt 10% FPL	Post-TANF 250% FPL
				1	Each of 2	100% FPL OPC/OPU	133% FPL OP6	185% FPL OPP	201% FPL CHP		
1	\$352	\$326	\$345	\$214	\$152	\$903	\$1,201	\$1,670	\$1,815	\$90.25	2,257
2	448	416	499	164	146	1,215	1,615	2,247	2,441	121.42	3,036
3	528	485	616	146	130	1,526	2,030	2,823	3,067	152.58	3,815
4	647	595	795	130	124	1,838	2,444	3,400	3,694	183.75	4,594
5	747	695	932	124	121	2,150	2,859	3,976	4,320	214.92	5,373
6	871	796	1,060	121	118	2,461	3,273	4,553	4,947	246.08	6,153
7	961	886	1,206	118	109	2,773	3,688	5,130	5,573	277.25	6,932
8	1085	976	1,346	109	105	3,085	4,102	5,706	6,200	308.42	7,711
9	1148	1039	1,450	105	102	3,396	4,517	6,283	6,826	339.58	8,490
10	1259	1150	1,622	105	102	3,708	4,931	6,859	7,453	370.75	9,269
+1	+107	+110	+172	* Use \$98 for each nonrecipient over 2		+312	+415	+577	+627	+1 10% of FPL	+780

TANF Payment + Cooperation Incentive - This is the TANF payment standard plus the Cooperation Incentive special need for clients who are cooperating with their case plan.

Adjusted Income/Payment Standard - This is countable income minus deductions.

Countable Income Limit - This is the amount of countable income remaining after allowable exclusions.

Minimum Contributions - This column is used to determine the amount excluded from lodger self-employment income for MAA, MAF, and TANF clients.

OHP - The 201% standard is only for OHP-CHP clients, the 185% standard is only for and OHP-OPP ; the 133% standard is for OHP-OP6 clients. The 100% standard covers OHP-OPC and OHP-OPU clients.

Food Stamp Standards					
Persons in Filing Group	Categorical Eligibility Limit (185%)	Persons in Need Group	Countable Income Limit	Adjusted Income Limit	FS Payment Standard (TFP)
1	\$1,670	1	\$1,174	\$ 903	\$200
2	2,247	2	1,579	1,215	367
3	2,823	3	1,984	1,526	526
4	3,400	4	2,389	1,838	668
5	3,976	5	2,794	2,150	793
6	4,553	6	3,200	2,461	952
7	5,130	7	3,605	2,773	1052
8	5,706	8	4,010	3,085	1202
+1	+577	+1	+406	+312	+150

FS Utility Standards
 Full Utility Allowance (FUA) = \$385
 Limited Utility Allowance (LUA) = \$272
 Individual Utility Allowance (IUA) = \$45
 Telephone Utility Allowance (TUA) = \$46

Non-needy Caretaker Relative Countable Income Limit Standard

No. in Filing Group	2	3	4	5	6	7	8	9	10	+ 1
NNCR Countable Income Group	\$2247	2823	3400	3976	4553	5130	5706	6283	6859	577

TANF No-Adult Standards

Adjusted No. in Household	2	3	4	5	6	7	8	9	10	No. in Need Group
TANF Payment + Coop. Incentive	\$236	187	173	161	156	148	147	139	137	1
TANF Adj. Income/Payment Std.	220	173	160	151	144	138	134	127	127	
TANF Countable Income Limit	249	205	198	186	176	172	168	161	162	
TANF Payment + Coop. Incentive		362	334	310	300	284	282	266	262	2
TANF Adj. Income/Payment Std.		334	308	290	276	264	256	242	242	
TANF Countable Income Limit		410	396	372	352	344	336	322	324	
TANF Payment + Coop. Incentive			495	459	444	420	417	393	387	3
TANF Adj. Income/Payment Std.			456	429	408	390	378	357	357	
TANF Countable Income Limit			594	558	528	516	504	483	486	
TANF Payment + Coop. Incentive				608	588	556	552	520	512	4
TANF Adj. Income/Payment Std.				568	540	516	500	472	472	
TANF Countable Income Limit				744	704	688	672	644	648	
TANF Payment + Coop. Incentive					732	692	687	647	637	5
TANF Adj. Income/Payment Std.					672	642	622	587	587	
TANF Countable Income Limit					880	860	840	805	810	
TANF Payment + Coop. Incentive						828	822	774	762	6
TANF Adj. Income/Payment Std.						768	744	702	702	
TANF Countable Income Limit						1,032	1,008	966	972	
TANF Payment + Coop. Incentive							957	901	887	7
TANF Adj. Income/Payment Std.							866	817	817	
TANF Countable Income Limit							1,176	1,127	1,134	
TANF Payment + Coop. Incentive								1028	1012	8
TANF Adj. Income/Payment Std.								932	932	
TANF Countable Income Limit								1,288	1,296	
TANF Payment + Coop. Incentive									1137	9
TANF Adj. Income/Payment Std.									1047	
TANF Countable Income Limit									1,458	

Use the no-adult standard for the TANF program if there is no adult in the need group. Refer to the One or More Adult Standards chart for minimum contribution amounts.

EXT/GAM/MAA/MAF/OHP-OPC,OHP-OP6, OHP-OPP/REFM/SAC HIP STANDARDS	
# in Benefit Group covered by insurance	Cost-effective premium amount (Employee cost)
1	\$82
2	\$164
3	\$246
4	\$328
5	\$410
6	\$492
7	\$574
8	\$656
9+	\$738

ERDC Income Limit	
Number in ERDC Group	Gross Income Limit (185% of 2009 FPL)
2	\$2,247
3	\$2,823
4	\$3,400
5	\$3,976
6	\$4,553
7	\$5,130
8 or more	\$5,706

B. Subject Index

Key

CA: Counting Client Assets	IN: Introduction
CC: Child Care Assistance	IND: Subject Index and Acronyms
CM: Case Management	MA: Medical Assistance Programs
CS: Child Support Program	MP WG: Multiple Program Worker Guides
DV: Domestic Violence Survivors (TA-DVS)	NC: Noncitizens
EA: Emergency Assistance	PR: Prevention Resources
ES: Employment and Self-Sufficiency Services	PRT: Pre-TANF
FS: Food Stamp Program (FS)	PSS: State Family Pre-SSI/SSDI (SFPSS)
GP: Generic Program Information	RF: Refugee Program (REF)
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A. Overview

Case Management Opportunity

For documented noncitizens, discuss plans for U.S. citizenship and offer referral to citizenship classes in their local community. For undocumented noncitizens, discuss plans for becoming legalized, and offer referral to immigration counseling and legal service, and other local support services offered in the client's primary language.

DHS provides Food Stamp, TANF cash and medical benefits to all persons who meet the citizen/alien status as specified in rule 461-120-0125, if they meet all other eligibility requirements. With the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), better known as the Welfare Reform Act, on August 22, 1996, noncitizens were divided into two categories: unqualified noncitizens and qualified noncitizens.

Unqualified noncitizens are individuals who may be admitted lawfully into the United States but do not have immigrant status, i.e., they may stay here for a specific period of time but cannot stay in the country for longer than their travel visa allows them. Foreign students, tourists, diplomats, performers, artists, entertainers, certain private company employers, etc., are included in this category.

Qualified noncitizens are individuals who are admitted to the United States with a lawful immigrant status. The person who is granted that status either enters the United States as a lawful permanent resident or will be eligible to become a lawful permanent resident in the future. A lawful permanent resident is eligible to be naturalized as a U.S. citizen usually after five years of lawful permanent residency in the U.S.

The following is the list of qualified noncitizens:

- A person who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA);
- A person who is admitted to the United States as a refugee under section 207 of the INA;
- A person who is granted asylum under section 208 of the INA;
- A person whose deportation is being withheld under section 243(h) of the INA;
- A person who is paroled into the United States under section 212(d)(5) of the INA;
- Battered immigrant spouse, battered immigrant child, immigrant parent of a battered child or an immigrant child of a battered parent, with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the INA; or

- A person who is a Cuban/Haitian entrant of the Refugee Education Assistance Act of 1980.

All lawfully admitted noncitizens are given an immigration document by USCIS. Individuals who come to the United States without an USCIS document or stay without a valid visa are considered undocumented noncitizens. They do not have immigrant status and can be subject to deportation.

For ERDC and TANF, noncitizens at risk of victimization of domestic violence do not need to meet the alien status requirement. For all other programs, undocumented noncitizens are ineligible for benefits. The Noncitizen Chart helps DHS staff determine if the holder of the USCIS document meets the alien status requirement for the program.

Alien Status; Not REF or REFM: 461-120-0125

1. Verifying Alien Status

The immigration document of each qualified noncitizen in the benefit group must be verified before eligibility is established. It is not necessary to verify the document of the noncitizen if the document has already been verified once. Verify the noncitizen's USCIS document when the client produces a different document.

Applicants sometimes present expired immigration documents. If a noncitizen presents expired documents, the worker should:

- Accept them for one certification/redetermination period; and
- Complete a form (*Federal Document Verification Request (SAVE) Dept of Justice - Immigration & Naturalization* (MSC 0845S) to validate alien status. This form can be found through the DHS form server by searching for 845. The server will link you to the USCIS website. Page down to find the form.

If USCIS validates the document, it can be used to verify alien status at the next recertification. If they do not, the noncitizen must present current documents at recertification to continue receiving benefits.

Encourage the applicant to contact USCIS to renew their status. There is a fee for renewal, but it may be waived due to destitution. Although DHS cannot help with the cost, some advocacy agencies may have funds available.

Note: *For workload savings, workers do not need to verify immigration documents through SAVE when a refugee has been in the U.S. for less than eight months.*

Verify immigration documents on-line via SAVE (WebOne).

To get access to SAVE/WEB1, contact your local subadministrator (RACF security guardian). The subadministrator will set up rights using your RACF ID and give you the initial password.

The first time you use SAVE/WEB1, you will be required to change your password. The new password must meet all the posted requirements of the website or you will be prompted to try again. Three of the following character types must be used: upper case, lower case, numeral and special character. The password is case-sensitive and must be exact.

Access SAVE/WEB1 by clicking on the link below or through the *Staff tools* on the DHS home page:

<https://www.vis-dhs.com/WebOne>

To verify immigration status/documents through SAVE/WEB1, enter the nine-digit alien registration number from the immigration document, dropping the A. Add a zero (0) to the front of the number if it is less than nine characters. Select the programs for which you are checking status. The system immediately responds with a screen containing the person's name, country of origin, DOB, date of entry and code of admission (COA).

Case workers may choose to simply narrate the information on the screen, including the verification number, or to print out a copy of the screen for the case file in addition to narrating. DHS is charged for each use of WEB1, so staff are asked to use the system only when necessary.

After getting the requested information, move the scroll bar to the right and click on "Complete and close." This ends the individual transaction. At this point, the worker may select to enter another alien number for verification or click on Exit to leave the system. If secondary verification is required, the system will prompt the user for follow-up. The secondary verification will appear on SAVE/WEB1 within 48 hours of the request. If awaiting secondary verification, exit without first selecting "Complete and close," to allow the system to work on securing the secondary data.

***Note:** It is important to click on Exit when your transactions are completed. Failing to do so will slow response time.*

The USCIS Help Desk is available during Federal business hours, weekdays from 7:00am to 9:00pm, Eastern Time. This Help Desk can assist with connectivity questions or problems, password resets and centralized problem management. This Help Desk's number is 1-800-741-5023.

Use USCIS Form G-845 when an Alien Registration Number is not available.

Before submitting the G-845S to USCIS, remember to do the following:

- Complete all items. The G-845S is a legal document for USCIS. USCIS will keep it in record for five years. Some of these forms have been used in hearings for

deportation and other immigration proceedings. It is important that all items are filled out. Do not forget your name and return address. The bottom half of the front and the back of the G-845S are for USCIS use only. Attach a speedy note or a memo if you have specific questions or information for them.

- Use one G-845S for each individual you want USCIS to verify.
- Attach to the G-845S only a copy of the document(s) for that particular individual. Do not send any other person's documents with it.
- Copy the noncitizen's document(s) on regular letter-size paper. Do not cut the paper into half-size or the size of the document(s).
- Copy both sides of the noncitizen's USCIS document(s).
- If you are sending copies of a noncitizen's passport, be sure to include the history, photo and visa pages. USCIS can identify if the noncitizen is using another person's passport if these pages are included.
- Copies of Social Security card, driver's license and other IDs are not necessary unless you think they may help USCIS. Do not include pay stubs.
- The I-797 is an USCIS correspondence document; it does not verify a noncitizen's legal status in the U.S. A person who is lawfully admitted into the country will have their very own USCIS document such as I-94, I-551 or a visa in the noncitizen's passport. So do not send the I-797 with the G-845S.
- Give your own telephone number to the verifier in case he or she needs further information from you or needs to give you additional information. It is impossible for the verifier to leave a message with the 800 number.
- Staple the G-845S and copies of the alien document(s) together once at one corner of the forms. Do not staple all four corners of the documents.
- Do not enclose a DHS self-addressed stamped envelope. USCIS has their own and they simply throw ours away.

Verification of "continuously present": For some legal entrants, such as Canadian and Mexican border crossers, for whom the USCIS does not maintain an arrival and departure record, as well as for illegal entrants, proof of continuous presence can be shown through such items as a letter from an employer, a series of pay stubs and utility bills or rental agreements in the immigrant's name spanning the period of time in question. For most legal entrants, the USCIS maintains a record of arrivals to and departures from the country. Verification of continuous presence for these entrants can be completed by filing the G-845 and the G-845S.

2. Eligibility Pending Secondary Verification

When instructed to institute secondary verification by SAVE, do not delay or deny benefits while waiting for a reply from USCIS if all of the following are true:

- The client would have met the alien status requirement if no secondary verification were required.
- Information provided by SAVE matches the information on the client’s USCIS document.
- The client meets all other eligibility requirements.

Wait 48 hours, then check SAVE/WEB1. Document the findings in the case record. If the information from USCIS adversely affects the client’s eligibility, e.g., the submitted document is not valid, send a timely continuing benefit decision notice to the client and end cash, FS, and medical eligibility for the client. Do not write an overpayment in this situation. However, an administrative overpayment exists if the worker fails to send the notice and end benefits when USCIS has verified that the document is invalid.

3. Receipt of Benefits and Public Charge

Many noncitizens are reluctant to apply for benefits for themselves or their dependents for fear that they will be deemed a public charge; i.e., dependent on government support. In very limited circumstances, receipt of long-term cash or medical benefits may cause a person to be deemed a public charge and affect a noncitizen’s ability to renew their status or pursue U.S. citizenship.

Following are the USCIS guidelines on receipt of food, cash and medical assistance.

(A) Persons applying to become Lawful Permanent Residents (LPRs)

- (1) A noncitizen will **not** be considered a “public charge” for using:
 - Health Care Benefits, including programs such as Medicaid, CHIP, prenatal care or other free or low-cost medical care at clinics, health centers or other settings (other than long-term care in a nursing home or similar institution).
 - Food Programs, such as Food Stamps, WIC, school meals or other food assistance.
 - Other Programs That Do Not Give Cash, such as public housing, child care, energy assistance, disaster relief, Head Start, job training or counseling.
- (2) USCIS **may consider** a noncitizen’s use of the following in deciding whether to grant LPR status:

- Cash Welfare, such as GA, SSI, and TANF.
- Institutionalization for long-term care, such as residing in a nursing home or mental health facility at government expense.

*Note: USCIS will **not** consider cash welfare or noncash programs received by a noncitizen's children or other family members for public charge purposes, unless the cash welfare is the family's only means of support.*

(B) LPRs cannot lose their status if they, their children or other family members use:

- Health care, food programs or other noncash programs.
- Cash welfare (*see notes below for exception).
- Long-term care (*see notes below for exception).

*Note: * LPRs who leave the country for more than six months at a time can be questioned about whether they are “public charges” when they return, and the use of cash welfare or long-term care may be considered.*

*Note: * In very rare circumstances, LPRs who use cash welfare or long-term care within their first five years in the United States could be considered deportable as a public charge.*

- (C) Refugees and people granted asylum can use any public benefits, including cash welfare, health care, food programs and other noncash programs without hurting their chances of getting LPR status.
- (D) Sponsoring Relatives - Using benefits, including cash welfare, health care, food programs and other noncash benefits, does not prevent citizens and LPRs from sponsoring relatives. However, sponsors must submit an Affidavit of Support showing that they have enough money (alone or with a co-sponsor) to support their relatives at 125% of the poverty level.
- (E) Becoming a naturalized U.S. citizen - LPRs cannot be turned down for U.S. citizenship for lawfully receiving any public benefits for which they are eligible.

4. Who Is a Sponsored Alien?

A sponsored alien is a noncitizen who is admitted into the United States as a lawful permanent resident with the help of a sponsor. Most of these noncitizens enter the U.S. with a foreign passport and/or I-94 that bears the endorsement “Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence.” The noncitizens are usually given the Permanent Resident Card (I-551) within six months from the date of their entry into the U.S. Examples of some of the most common status codes for sponsored aliens include IR, F11, F31, FX1, LB1, and P26.

5. Definition of an Alien Sponsor

A sponsor is a person who has signed an affidavit of support (known as 213A affidavits, Form I-864 or I-864A) on behalf of the noncitizen as a condition of entry into the United States as a Lawful Permanent Resident. *The affidavit is normally signed within six months prior to the sponsored alien's entry.*

Deemed Assets; Noncitizen's Sponsor: 461-145-0820 |

6. Responsibility of a Sponsor

A sponsor and their spouse are financially responsible for the noncitizen for the period of time specified in the signed affidavit of support, or until the noncitizen becomes a naturalized citizen or the noncitizen has worked or been credited for 40 qualifying quarters of work.

Deemed Assets; Noncitizen's Sponsor: 461-145-0820 |

7. Obtaining a Sponsor's Information (Use of USCIS Form G-845 Supplement)

To obtain more detailed information on immigration status, citizenship and sponsorship, use the Form G-845 Supplement. Requests for verification on Form G-845S (*Federal Document Verification Request (SAVE) Dept of Justice - Immigration & Naturalization (MSC 0845S)*) may be mailed to:

US Citizenship and Immigration Services
300 N. Los Angeles Street, Suite B120
Los Angeles, CA 90012
Attn: Immigration Status Verification Unit

8. Overview of Deeming

Because the sponsor and their spouse are financially responsible for the sponsored noncitizen, their assets are deemed to the financial group containing the sponsored noncitizen. *Deeming* means that although the sponsor and their spouse are not applying for benefits, their assets will be used in determining the eligibility for the noncitizen. Therefore, noncitizens with sponsors must provide verification of their sponsor's assets.

The deeming requirements apply only to noncitizens whose sponsor has signed a legally binding affidavit of support (known as 213A affidavits, Form I-864 or I-864A) on or after December 19, 1997. Workers may ask for a copy of the affidavit when they institute secondary verification via SAVE.

The following noncitizens are exempt from the deeming requirements:

- (1) Noncitizen whose sponsor has not signed the I-864 or I-864A.
- (2) The sponsor receives Food Stamp, TANF or SSI benefits.
- (3) The sponsor is deceased.
- (4) Noncitizen without a sponsor. Noncitizens who enter the U.S. under provisions of law other than the family-sponsored categories generally do not have sponsors that incur a liability when they apply for our program benefits. Some of these noncitizens include refugees, asylees, deportees and parolees.
- (5) Noncitizen who is a battered immigrant spouse, battered immigrant child, immigrant parent of a battered child or an immigrant child of a battered parent, so long as the battered noncitizen does not live in the same household as the person responsible for the battery. No deeming will be applied for a 12-month period and can be extended if the noncitizen demonstrates that the battery is recognized in a court or administrative order. It can also be extended if it is determined by the District that the battery has a substantial connection to the need for benefits.
- (6) The noncitizen is not an eligible person because of their alien status. The sponsor's income is not deemed to other eligible members in the household.
- (7) Noncitizens who have worked or can be credited with 40 qualifying quarters of work.
- (8) The noncitizen becomes a United States citizen.
- (9) Indigent noncitizen. A noncitizen is considered indigent if the income of the noncitizen, plus any cash, food, housing or other assistance provided by other individuals including the sponsor, is not enough for the noncitizen to obtain food and shelter without program benefits, i.e., the noncitizen household's total income including in-kind income is under 130 percent of the federal poverty level for FS, or under the Countable Income Standard for TANF/MAA and OHP. Each indigence determination is effective for 12 months and may be renewed for additional 12-month periods. Workers must notify the U.S. Attorney General when a sponsored noncitizen claims indigence. Use *Declaration of Indigency* (DHS 1058) for clients to declare indigence and send the original copy to the Food Stamp program analyst at:

500 Summer Street NE, E-47
Salem, OR 97301-1066

Deemed Assets; Overview: 461-145-0810
Deemed Assets; Noncitizen's Sponsor: 461-145-0820
When to Deem the Assets of a Sponsor of a Noncitizen: 461-145-0830

9. Deeming Income

Treat all the countable income minus earned income deductions plus the unearned income of the sponsor and the sponsor's spouse as if it were the sponsored noncitizen's income. Use the *Deeming Income From Sponsor Worksheet* (DHS 1058A) to calculate the deemed income for FS, OHP and TANF/MAA. See the sponsored noncitizens section for each program.

☞ FOR FOOD STAMPS SEE NC B.5; FOR MEDICAL SEE NC C.5; FOR TANF SEE NC D.5.

10. Deeming Resources

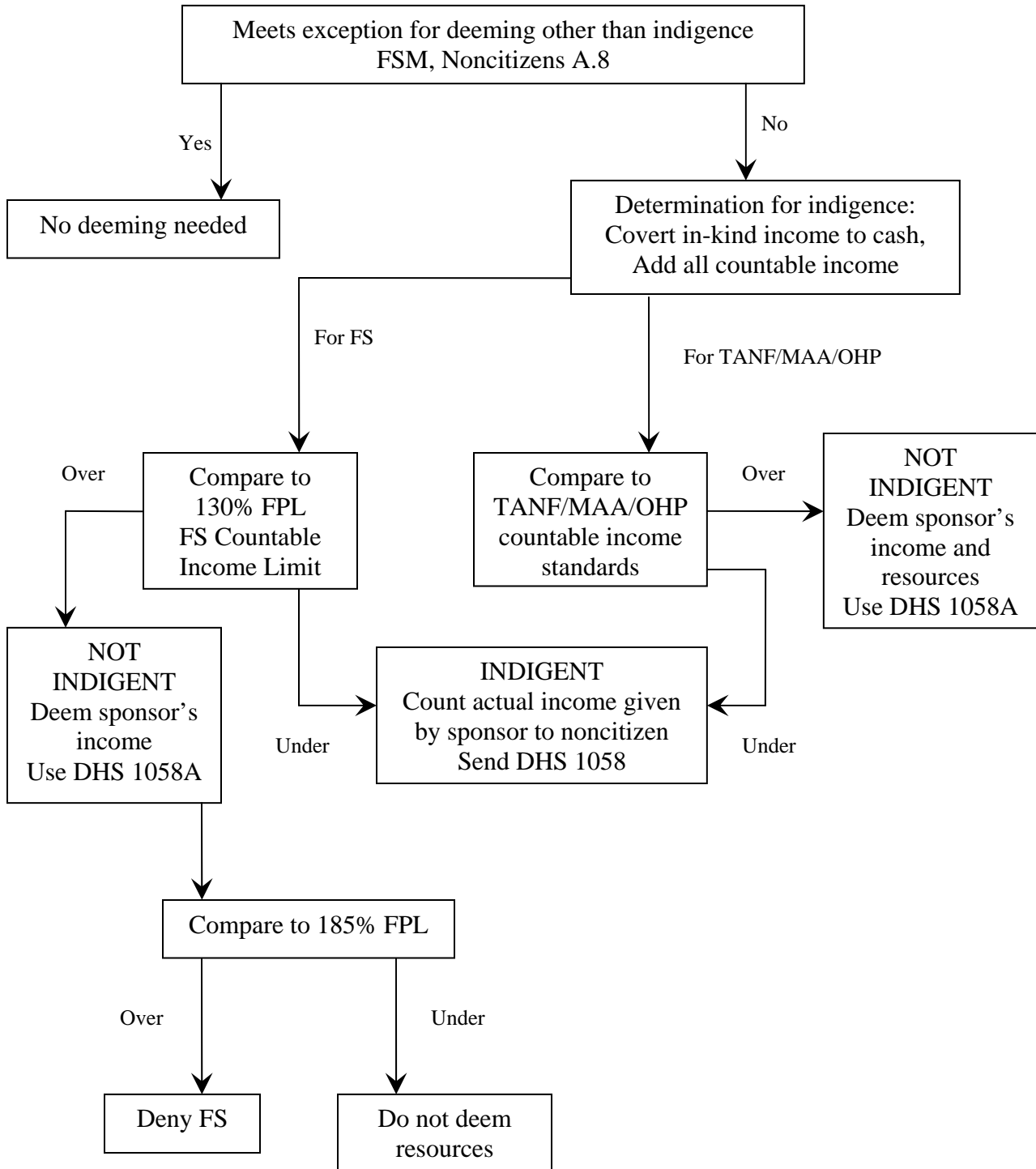
For deeming resources, see the sponsored noncitizens section for each program.

☞ FOR FS SEE NC B.6; FOR MEDICAL SEE NC C.6; FOR TANF SEE NC D.6.

11. “Opting Out”

Opting out means removing one's self from applying for benefits. A sponsored noncitizen can opt out of applying for benefits if he or she either does not want his or her sponsor being reported to USCIS as in the case of an indigent client, or does not want to obtain the information from their sponsor for DHS to determine their deemed assets. Noncitizens who opt out of the reporting to USCIS or the deeming process are considered not having their alien status requirement met. They remain as an NC2 for FS and an IA for OHP and TANF/MAA.

Deeming Sponsor's Assets



C. Noncitizens Eligibility for EXT, MAA, MAF, OHP and SAC

1. Alien Status Requirement

Many noncitizens became ineligible for medical assistance with the enactment of Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) on August 22, 1996. However, some qualified aliens continued to meet the alien status requirement.

A qualified noncitizen meets the alien status requirement for EXT, MAA, MAF, OHP and SAC if the individual is one of the following:

- (A) Under age 19.

Note: Applies to OSIPM and QMB programs, too.

- (B) A person who was admitted as a qualified noncitizen on or before August 22, 1996. A person who entered the U.S. on or after August 22, 1996, and it has been five years since he or she became a qualified noncitizen.

- (C) A person who has obtained their qualified noncitizen status less than five years ago but entered the U.S. prior to August 22, 1996, and was continuously present until receiving qualified status. The noncitizen must show that he or she has been living in the U.S. continuously from a date prior to August 22, 1996, to the date the noncitizen obtained their qualified status.

- (D) Regardless when they were admitted, a person with one of the following designated statuses:

- A person who is admitted as a refugee under section 207 of the INA or who has been identified as a victim of severe trafficking via an I-914 marked "T Visa";
- A person who is granted asylum under section 208 of the INA;
- A person whose deportation is being withheld under section 243(h) of the INA;
- A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;
- A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988.

- (E) Regardless of when they were admitted, a qualified noncitizen who is:

- A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or
- On active duty in the U.S. Armed Forces (other than active duty for training); or
- The spouse or unmarried dependent child of the veteran or person on active duty described above.

Note: There was no minimum active-duty service requirement for individuals who joined the Armed Forces prior to September 7, 1980. Individuals who joined after September 7, 1980, must serve a minimum of two years or a duration they were called or ordered to active duty.

As the result of the Balanced Budget Act of 1997, a person meets the alien status requirements for MAA, MAF, OHP, and SAC if the individual is one of the following:

- (A) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or
- (B) A member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e))).

Victims of a severe form of trafficking also meet the alien status requirement for MAA, MAF, OHP and SAC.

As the result of the Consolidated Appropriations Act, 2008, the National Defense Authorization Act, 2008, and the Omnibus Appropriations Act, 2009, a person meets the alien status requirements of MAA, MAF, OHP and SAC if the individual is:

An Iraqi or Afghan special immigrant admitted under section 101(a)(27) of the INA and has been in the country for less than eight months. The eight months starts with the month the special immigrant was admitted to the U.S. or was granted special immigrant status after already being admitted in the U.S. with a different status.

Once the eight-month time limit has been reached, the special immigrant should be treated as a Lawful Permanent Resident (LPR).

☞ PLEASE SEE THE NONCITIZEN WORKER GUIDE #1 (NC-WG #1) ON TREATMENT OF LPRS.

2. **Determining Financial Eligibility for Households with Ineligible Noncitizens**

For MAA, the filing and need group includes all noncitizens if they are required to be in the group for determining eligibility. Their income and resources will be counted in the same manner as other MAA filing groups. If they pass the financial eligibility requirements and are otherwise eligible, only the members who meet the alien status requirement are in the MAA benefit group. Those who do not meet the alien status requirement are potentially eligible for CAWEM.

For MAF, if the need group is not eligible for MAA because of the change in the budgeting method since July 1996, determine if the benefit group is eligible using the following budgeting process.

- (A) Determine the countable gross income for the ineligible noncitizens in the financial group.
- (B) Apply up to \$90 earned income deduction manually for each ineligible noncitizen's earned income.
- (C) Deduct the TANF Adjusted Income/Payment Standard for the number of ineligible noncitizens in the financial group. Combine with countable income from any need group members. Compare this to the Countable Income Standard for the number of people in the need group without including the needs of the ineligible noncitizens.
- (D) Allow up to \$50 deduction for child support, if applicable.
- (E) Compare the income to the Adjusted Income/Payment Standard for the number of members in the need group without including the needs of those ineligible noncitizens who are not in the MAF need group because their income put the MAA filing group over the income standard. If the income does not exceed the standard, the members in the MAF need group are eligible for MAF or CAWEM MAF. The MAF need group may include those ineligible noncitizens who do not have income that puts the need group over the income standard.

For SAC, the financial determination process is the same for filing groups with noncitizens who meet the alien status requirement and those who do not. Those who do not meet the alien status requirement are potentially eligible for CAWEM.

For OHP, the financial group includes all noncitizens so long as they are required to be in the group for determining eligibility. Their income and resources will be counted in similar manner as other OHP financial groups. If they pass the financial eligibility requirements and are otherwise eligible, only the members who meet the alien status requirement are in the benefit group. Those who do not meet the alien status requirement are potentially eligible for CAWEM.

3. Eligibility for CAWEM

Noncitizens who do not meet the alien status requirement for EXT, MAA, MAF, OHP, and SAC may be eligible for CAWEM. The CAWEM program covers immediate medical treatment due to the sudden onset of a medical condition and the absence of treatment could reasonably be expected to result in any of the following:

- (A) Placing the patient's health in serious jeopardy.
- (B) Serious impairment to bodily functions.
- (C) Serious dysfunction of any bodily organ or part.
- (D) The patient requires medical services for childbirth (labor and delivery).

It is not necessary for workers to determine if the noncitizens meet any of the above-mentioned criteria for CAWEM. If the group meets the eligibility requirements for EXT, MAA, MAF, OHP and SAC, their medical card will include the names of the noncitizens who do not meet the alien status requirement. An identifier CWM in the case descriptor indicates the noncitizens are eligible for CAWEM only. DMAP will reimburse medical providers when the treatments are for the above-mentioned conditions. Sixty-day postpartum care is not an automatic coverage for CAWEM females unless an emergent medical treatment is required during the 60 days. A new application is not needed when this happens. A child born to a CAWEM mother is an assumed eligible newborn.

☞ SEE MEDICAL ASSISTANCE PROGRAMS C.1.

Some examples of individuals who do not meet alien status requirements but who could be eligible for CAWEM are:

- Tourists;
- Students;
- Visitors;
- Temporary workers;
- Investors and treaty traders;
- Dignitaries from a foreign government;
- Crewman on shore leave; and
- Members of foreign press, radio, etc.

The individual must be a resident of Oregon with the intent to remain in Oregon. There is no minimum amount of time a person must live in Oregon to be a resident.

Pre-Natal Expansion Pilot Program

A pilot expanding medical services for pregnant CAWEM clients who reside in Multnomah County and Deschutes County was implemented April 1, 2008. The pilot expanded to Benton, Clackamas, Hood River, Jackson and Lincoln counties effective October 1, 2009.

The pilot uses OHP-CHP funding to pay for pre-natal care. OHP-CHP funds are permitted for the pilot because the medical services are limited to pre-natal services and benefit the unborn child who will be a U.S. citizen at birth.

- Any pregnant CAWEM client is eligible who resides in the pilot counties, regardless of the Medicaid program used to determine CAWEM eligibility, including MAA CWM, MAF CWM, OPP CWM, etc.
- Only pilot county residents who are pregnant CAWEM clients are eligible for the enhanced benefit package. If the client moves from Multnomah, Deschutes, Benton, Clackamas, Hood River, Jackson or Lincoln counties to a county not included in the pilot area, a timely continuing (10-day) notice of reduction is required.
- The enhanced benefit package is a limited version of the OHP Plus benefit package. Only necessary pre-natal services included in the OHP Plus benefit package will be covered.
- Eligibility is tied to the unborn child who will be a U.S. citizen. The mother's eligibility for the enhanced benefit package ends when the pregnancy ends.
- The pregnant CAWEM client remains a CAWEM eligible during her pregnancy and for the protected two-month post-partum period. She may receive emergent need benefits for herself during the pregnancy and for the two months following the end of her pregnancy.
- The newborn is an AEN Medicaid eligible child and may receive up to 12 months protected Medicaid as long as the AEN remains with the mother.
- CM system coding has been added to identify pregnant CAWEM clients in the pilot area. Pregnant CAWEM clients moving into the pilot counties will have the new CM system coding added to their cases by staff at the OHP Statewide Processing Center (branch 5503). Sending branch offices do not need to add the pilot coding.

Specific Requirements; Citizen/Alien-Waived Emergent Medical (CAWEM): 461-135-1070

4. Sponsored Noncitizens

Prior to December 1997, sponsors of noncitizens were required to sign affidavits of support that reflected their financial responsibility for the sponsored noncitizen.

However, those affidavits were effective for three years. As a result, those early affidavits have expired and the deeming process no longer applies to those sponsored noncitizens. Since the enactment of PRWORA, a legally enforceable affidavit of support is required to be signed by a sponsor for most noncitizens seeking admission into the U.S. The federal law requires the income and resources of the sponsor and the sponsor's spouse be deemed to the sponsored noncitizen in determining eligibility for Medicaid, such as MAA, MAF, OHP and SAC.

☞ SEE NONCITIZENS A.4 FOR EXAMPLES OF THE COMMON STATUS CODES FOR SPONSORED NONCITIZEN AND NONCITIZENS A.8 TO DETERMINE IF THE DEEMING REQUIREMENTS APPLY.

Do not deem income and resources to a sponsored noncitizen who is only eligible for CAWEM.

Deemed Assets; Noncitizen's Sponsor: 461-145-0820
When to Deem the Assets of a Sponsor of a Noncitizen: 461-145-0830

5. Deeming Income

If deeming applies, treat all the countable income (earned and unearned) of the sponsor and sponsor's spouse as if it were the sponsored noncitizen's. Allow the appropriate deductions. The remaining income is the countable income deemed to the sponsored noncitizen. Do not divide this income among the sponsored noncitizens.

When to Deem the Assets of a Sponsor of a Noncitizen: 461-145-0830

6. Deeming Resources

To determine the amount of resources deemed from the sponsor and their spouse (if living together), total all of their countable resources. This is the countable deemed resource for each sponsored noncitizen.

Deemed Assets; Overview: 461-145-0810
Deemed Assets; Noncitizen's Sponsor: 461-145-0820

Worker Guide Noncitizen Chart

This Worker Guide is intended to assist workers in determining which documents are required to verify alien status for the department's programs.

How to Use the Chart

The chart is set up to show you what programs applicants may qualify for, based on their alien status.

Key for the chart

YES = Meets the alien status requirement for the program

NO = Does not meet the alien status requirement for the program

Noncitizens are admitted into the United States under different provisions of immigration laws. They may be admitted under one provision but later adjust their status under another. The first column indicates the initial immigration status of the noncitizen. The Department of Human Services (DHS) considers their initial qualified status to determine if the alien status requirement is met.

Example 1: A noncitizen was granted political asylum and was given an I-94 or an I-688B/I-766 annotated "274a.12(a)(5)." A few years later, he applied to become a lawful permanent resident and was granted the status and given an I-551 with a status code "AS1." This noncitizen is now an LPR but his initial immigration status was an asylee (ASY).

Example 2: A noncitizen from Laos was given refugee status in 1978. His initial immigration document was an I-94 marked section 207. He became an LPR in 1980 with an IC6. His initial immigration status was a refugee (REF).

Example 3: A U.S. citizen married a noncitizen from Brazil three years ago. She arrived in the U.S. with a Brazilian passport. The visa in the passport indicated that she has been granted lawful permanent resident with an IR1 status code. Her initial immigration status was a lawful permanent resident (LPR).

The immigration status of all adult noncitizens must be verified. This is done using SAVE to verify the validity of the noncitizen's U.S. Citizenship and Immigration Service (USCIS) document and instituting secondary verification as instructed.

☞ SEE SPD WORKER GUIDE D.1 FOR NONCITIZEN ELIGIBILITY RELATED TO GA, GAM, OSIP, OSIPM, AND SSI.

☞ SEE WORKER GUIDE #2 (NC WG#2) OF THE NONCITIZENS CHAPTER FOR EXAMPLES OF CITIZENSHIP DOCUMENTATION.

Noncitizen Chart

THIS CHART IS FOR THE NONCITIZENS ONLY AND DOES NOT REFLECT THE ENTIRE FAMILY'S ELIGIBILITY. UNLESS STATED OTHERWISE, THESE NONCITIZENS ARE AUTHORIZED TO WORK.

CONSIDER EACH INDIVIDUAL SEPARATELY

	USCIS FORM OR STATUS	ERDC, TANF/EA	MAA, MAF, OHP	FS	REF
LPR	I-551. Use for all I-551 cards unless the following codes appear: See ASY if marked AS1 thru AS8, GA6, GA7, GA8; REF if marked AM1, AM2, AM3, CH6, CNP, CU1, CU6 thru CU9, IC6, IC7, RE, RE1 thru RE8; and DBW if marked Z11, Z13, Z56, or Z75	Yes	2	1	No
ASY	I-94 marked section "208" or marked "Visa 92" with the inscription "section 208" I-551 marked AS1 thru AS8, GA6, GA7, GA8 I-688B/I-766 annotated "274a.12(a)(5)."	Yes	Yes	Yes	3
REF	I-94 marked section "207" or "584(a)" or marked "Visa 93" with the inscription "section 207" I-551 marked AM1, AM2, AM3, CH6, CNP, CU0, CU6 thru CU9, IC6, IC7, RE, RE1 thru RE8	Yes	Yes	Yes	3
CUH	I-94 marked "Cuban/Haitian entrants parolees" 212(d)(5) paroled for at least one year. I-551 marked NC6 thru NC9, HA6 thru HA9, HB6 thru HB9, HC6 thru HC9, HD6 thru HD9	Yes	Yes	Yes	3
DBW	I-551 marked Z11, Z13, Z56, or Z75 I-688B/I-766 annotated "274a.12(a)(10)."	Yes	Yes	Yes	No

	USCIS FORM OR STATUS	ERDC, TANF/EA	MAA, MAF, OHP	FS	REF
HHL	Hmong and Highland Laotian; I-94 marked section 207; I-551 marked IC6, IC7, RE, RE6, RE7, and RE8	Yes	Yes	Yes*	4
CBI	Canadian-born Indians; see 10 for more info.	Yes	Yes	Yes	No
PAR	I-94 marked “Visa 91”	Yes	2	5	6
NON	I-94 marked “EWI”	No	CAWEM ⁷	No	6
PAR	I-94 marked section “212(d)(5)” paroled for at least one year except for Cuban/Haitian parolees	Yes	2	1	8
	I -688A, I-688B/I-766 (except noted above)	These are work authorization documents only.			
COL	Permanently Residing Under Color of Law including citizens of the Marshall Islands and Federated States of Micronesia. I-94 marked CFA/MIS, CFA/FSM	No	CAWEM ⁷	No	No
NON	I-94 marked “K Visa” I-130 or I-129	No	CAWEM	No	No
NON	I-130 marked “V Visa”	No	CAWEM	No	No
NON	I-854 marked “S Visa”	No	CAWEM	No	No
REF	I-914 marked “T Visa,” “T-2 Visa,” “T-3 Visa,” “T-4 Visa,” or “T-5 Visa,” or an I-914A	Yes ¹¹	Yes ¹¹	Yes ¹¹	Yes ¹¹
BAT	I-130, I-360 marked “U Visa”	Yes	2	1	No
LPR	I-151 ⁹	Yes	Yes	1	No
SIV	Iraqi or Afghan immigrant visa stamp admitted under IV (immigrant visa) Category SI1, SI2, or SI3, SQ1, SQ2, or SQ3, and I-94 showing date of entry; or I-551 showing Iraqi or Afghan nationality with IV (immigrant visa) with SI6, SI7, SI9, SQ6, SQ7, or SQ9	Yes	3	Yes ¹²	3

1 Meet alien status if they meet FS definition of disability or children under age 18. Also meet alien status if they: (a) have been a qualified noncitizen for five or more years; (b) are LPR and have worked or can be credited with 40 qualifying quarters of work; (c) are a veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the

- minimum active-duty service requirement; (d) are on active duty in the U.S. Armed Forces; or (e) are the spouse or unmarried dependent child(ren) of an individual described in (c) or (d).
- 2 Meet alien status if they: (a) granted qualified status and under age 19, regardless of the length of time in the U.S.; (b) were a qualified noncitizen before 8/22/96; (c) entered the U.S. before 8/22/96, but did not receive their qualified status until after 8/22/96, and have been residing continuously in the U.S. between August 22, 1996, and the date their qualified status was granted; (d) entered the U.S. and received their qualified status after 8/22/96, but have been living in the U.S. for five years from the date their status was granted; or (e) are a veteran of the U.S. Armed Forces who was honorably discharged not on account of alien status and who fulfills the minimum active duty service requirement; (f) on active duty in the U.S. Armed Forces; or (g) the spouse or unmarried dependent child(ren) of an individual described in (e) or (f).
- 3 Meet alien status requirement for the first 8 months from the date their immigration status was granted. For refugees, the first month is the month the refugee arrived in the U.S. For asylees, the first month is the month they receive their asylum status.
- 4 If the refugee has not been in the U.S. for more than 8 months.
- 5 Do not meet alien status if they are paroled into the U.S. for less than one year. See 1 if they are paroled for at least one year.
- 6 Yes, for Cuban and Haitian national only.
- 7 The applicants must meet all eligibility requirements for MAA, MAF, OHP (except OHP-CHP), or OSIPM except citizen/alien status in order to receive Citizen/Alien-Waived Emergent Medical (CAWEM). CAWEM clients are not eligible for OHP-CHP.
- 8 Only when the document shows they were admitted or paroled as a refugee or asylee.
- 9 Card expired in 3/96; refer to USCIS for renewal. Do not delay or deny benefits if otherwise eligible.
- 10 INS documents showing status “S13” or Canadian birth certificate, with a letter, card, or other birth record issued by the tribe that indicates the person is at least “one-half American Indian blood.” Also, members of tribes that are recognized and eligible to receive services from the U.S. Bureau of Indian Affairs.
- 11 Call the toll-free trafficking verification line at 1-866-401-5510 to notify the Office of Refugee Resettlement (ORR) of the benefits for which the individual has applied. (Note: At this time, the DHS Systematic Alien Verification for Entitlements (SAVE) system does not contain information about victims of severe forms of trafficking or nonimmigrant alien family members.)
- 12 Special Immigrant Visa (SIV) – meets alien status. Eligible for only eight months (if Iraqi) or six months (if Afghan) from date of entry or from date status was granted (if admitted under a different status and then was granted new special immigrant status). For Iraqi SIVs, Food Stamps cannot be issued beyond September 30, 2008. For Afghan SIVs, Food Stamps cannot be issued beyond September 30, 2009, even if eight- or six-month limit has not been reached. After initial period of eligibility ends (see 12 above), special immigrants are considered LPRs.
- * If the individual was not admitted as a refugee, the person meets alien status if he or she was a member, the spouse, or dependent child of the member, of the tribe that took part in a military or rescue operation during the Vietnam War era. See this section, pages 4-5 for more information.

Note: *There was no minimum active-duty service requirement for individuals who joined the Armed Forces prior to 9/7/80. Individuals who joined after 9/7/80 must serve a minimum of two years or a duration they were called or ordered to active duty.*

LPR = Lawful Permanent Residents; ASY = People granted asylum; REF = Refugees; DBW = Deportation Being Withheld; CBI = Canadian Born Indians; PAR = Parolees; NON = Non-qualifying noncitizens; CUH = Cuban/Haitian parolees; BAT = Battered spouse or children of an LPR or a U.S. Citizen; COL = Permanently residing under the Color of Law; SIV = Special Immigrant Visa

Use the following procedures to determine if a Hmong or a Highland Laotian meet alien status requirement only if the person is not a U.S. citizen or is not eligible under any other noncitizen category.

- (A) Identify if each household member is a tribal member, spouse, unmarried dependent child, or an unmarried surviving spouse. A household can have several, one, or no tribal members.
- (B) Check the birth date of the tribal member. If the DOB is before May 8, 1975, call the Program Analyst on noncitizen policies to check if the person is on the Refugee Data Center (RDC) list. If the DOB is after May 7, 1975, the person is ineligible as a tribal member. Determine if he/she can qualify as a spouse, an unmarried dependent child, or an unremarried surviving spouse of a tribal member.
- (C) If the tribal member does not appear on the RDC list, do the following:
- (1) Check the country of birth (COB) on the USCIS document of the tribal member. Most eligible tribal members will be coded as “203” for Laos. A small percentage of tribal members were born in other countries such as:

“263” (Thailand)	“245” (China)
“260” (Philippines)	“201” (Cambodia)
“266” (Vietnam)	“248” (Indonesia)
 - (2) Check the code on the USCIS document. Most eligible tribal members entered the U.S. as refugees and will be coded as one of the following:

“RE1”	“RE2”	“RE3”
“RE6”	“RE7”	“RE8”
“R86”	“IC6”	“IC7”
 - (3) If the code is listed above, check the entry date of the USCIS document. If the entry date is before April 1975, ask the tribal member if he/she explain how he/she came to enter the U.S. prior to April 1975. Then follow (6) below.
 - (4) If the code is not one of the listed above, ask the tribal member about his or her migration to the U.S. Ask the tribal member to provide evidence of his or her account of entry into the U.S. Check the entry date of the USCIS document. Follow the procedures in (3) above if the entry date is before April 1975. Then follow (6) below.
 - (5) If entry date is after April 1975, follow (6) below.
 - (6) Ask the tribal member if he or she can provide any other document that could establish his/her membership in a Hmong or Highland Laotian tribe. The person is ineligible until verification is submitted. He or she may contact a local Hmong/Asian nonprofit organization to help him or her in obtaining the necessary documentation.
 - (7) If the tribal member was born before 5/8/75 and the information and documentation appears to show that the tribal member was part of a

Hmong/Highland Laotian tribe during the Vietnam era (defined as 8/5/64-5/7/75), the tribal member is an eligible noncitizen for FS.

To qualify as a spouse of a tribal member, the spouse must be married to, not divorced from, an eligible tribal member.

To qualify as an unremarried surviving spouse, the marriage of the unremarried surviving spouse to the tribal member must have ended by death, not by divorce and the unremarried surviving spouse must have never remarried.

To qualify as an unmarried dependent child, the unmarried dependent child must be unmarried and be dependent upon the tribal member parent and under the age of 18.

Combined Standards

One or More Adult Standards - for MAA/MAF/OHP/TANF/Post-TANF

Persons in Need Group	TANF Payment + Coop. Incentive	Adjusted Income/ Payment Standard	Countable Income Limit	MAA/MAF/TANF Minimum Contributions (amt. each nonrecipient pays) 1 Each of 2		OHP Countable Income Standard				OHP Premium Exempt 10% FPL	Post-TANF 250% FPL
						100% FPL OPC/OPU	133% FPL OP6	185% FPL OPP	201% FPL CHP		
1	\$352	\$326	\$345	\$214	\$152	\$903	\$1,201	\$1,670	\$1,815	\$90.25	2,257
2	448	416	499	164	146	1,215	1,615	2,247	2,441	121.42	3,036
3	528	485	616	146	130	1,526	2,030	2,823	3,067	152.58	3,815
4	647	595	795	130	124	1,838	2,444	3,400	3,694	183.75	4,594
5	747	695	932	124	121	2,150	2,859	3,976	4,320	214.92	5,373
6	871	796	1,060	121	118	2,461	3,273	4,553	4,947	246.08	6,153
7	961	886	1,206	118	109	2,773	3,688	5,130	5,573	277.25	6,932
8	1085	976	1,346	109	105	3,085	4,102	5,706	6,200	308.42	7,711
9	1148	1039	1,450	105	102	3,396	4,517	6,283	6,826	339.58	8,490
10	1259	1150	1,622	105	102	3,708	4,931	6,859	7,453	370.75	9,269
+1	+107	+110	+172	* Use \$98 for each nonrecipient over 2		+312	+415	+577	+627	+1 10% of FPL	+780

TANF Payment + Cooperation Incentive - This is the TANF payment standard plus the Cooperation Incentive special need for clients who are cooperating with their case plan.

Adjusted Income/Payment Standard - This is countable income minus deductions.

Countable Income Limit - This is the amount of countable income remaining after allowable exclusions.

Minimum Contributions - This column is used to determine the amount excluded from lodger self-employment income for MAA, MAF, and TANF clients.

OHP - The 201% is only for OHP- CHP clients; the 185% standard is only for OHP-OPP; the 133% standard is for OHP-OP6 clients. The 100% standard covers OHP-OPC and OHP-OPU clients.

Food Stamp Standards					
Persons in Filing Group	Categorical Eligibility Limit (185%)	Persons in Need Group	Countable Income Limit	Adjusted Income Limit	FS Payment Standard (TFP)
1	\$1,670	1	\$1,174	\$ 903	\$200
2	2,247	2	1,579	1,215	367
3	2,823	3	1,984	1,526	526
4	3,400	4	2,389	1,838	668
5	3,976	5	2,794	2,150	793
6	4,553	6	3,200	2,461	952
7	5,130	7	3,605	2,773	1052
8	5,706	8	4,010	3,085	1202
+1	+577	+1	+406	+312	+150
FS Utility Standards Full Utility Allowance (FUA) = \$385 Limited Utility Allowance (LUA) = \$272 Individual Utility Allowance (IUA) = \$45 Telephone Utility Allowance (TUA) = \$46					

Non-needy Caretaker Relative Countable Income Limit Standard

No. in Filing Group	2	3	4	5	6	7	8	9	10	+ 1
NOCR Countable Income Group	\$2247	2823	3400	3976	4553	5130	5706	6283	6859	577

TANF No-Adult Standards

Adjusted No. in Household	2	3	4	5	6	7	8	9	10	No. in Need Group
TANF Payment + Coop. Incentive	\$236	187	173	161	156	148	147	139	137	
TANF Adj. Income/Payment Std.	220	173	160	151	144	138	134	127	127	
TANF Countable Income Limit	249	205	198	186	176	172	168	161	162	1
TANF Payment + Coop. Incentive		362	334	310	300	284	282	266	262	
TANF Adj. Income/Payment Std.		334	308	290	276	264	256	242	242	
TANF Countable Income Limit		410	396	372	352	344	336	322	324	2
TANF Payment + Coop. Incentive			495	459	444	420	417	393	387	
TANF Adj. Income/Payment Std.			456	429	408	390	378	357	357	
TANF Countable Income Limit			594	558	528	516	504	483	486	3
TANF Payment + Coop. Incentive				608	588	556	552	520	512	
TANF Adj. Income/Payment Std.				568	540	516	500	472	472	
TANF Countable Income Limit				744	704	688	672	644	648	4
TANF Payment + Coop. Incentive					732	692	687	647	637	
TANF Adj. Income/Payment Std.					672	642	622	587	587	
TANF Countable Income Limit					880	860	840	805	810	5
TANF Payment + Coop. Incentive						828	822	774	762	
TANF Adj. Income/Payment Std.						768	744	702	702	
TANF Countable Income Limit						1,032	1,008	966	972	6
TANF Payment + Coop. Incentive							957	901	887	
TANF Adj. Income/Payment Std.							866	817	817	
TANF Countable Income Limit							1,176	1,127	1,134	7
TANF Payment + Coop. Incentive								1028	1012	
TANF Adj. Income/Payment Std.								932	932	
TANF Countable Income Limit								1,288	1,296	8
TANF Payment + Coop. Incentive									1137	
TANF Adj. Income/Payment Std.									1047	
TANF Countable Income Limit									1,458	9

Use the no-adult standard for the TANF program if there is no adult in the need group.
Refer to the One or More Adult Standards chart for minimum contribution amounts.

EXT/GAM/MAA/MAF/OHP-OPC,OHP-OP6, OHP-OPP/REFM/SAC HIP STANDARDS	
# in Benefit Group covered by insurance	Cost-effective premium amount (Employee cost)
1	\$82
2	\$164
3	\$246
4	\$328
5	\$410
6	\$492
7	\$574
8	\$656
9+	\$738

ERDC Income Limit	
Number in ERDC Group	Gross Income Limit (185% of 2008 FPL)
2	\$2,159
3	\$2,714
4	\$3,269
5	\$3,824
6	\$4,379
7	\$4,934
8 or more	\$5,489

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