

ESA POLICY MANUAL

Government of the District of Columbia
Department of Human Services
64 New York Avenue, NE, Washington, DC

ESA Policy Manual

The Department of Human Services' **Economic Security Administration (ESA)** Policy Manual provides official instructions and the guiding principles for the implementation of ESA (formerly IMA) programs. The Manual provides front-line operations staff with clear, consistent policy standards for providing services.

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Part I

Chapter 1 - Overview of Manual

PURPOSE OF MANUAL 1.1

The purpose of the Department of Human Services (Department) Policy Manual (Manual) is to provide official instructions and guiding principles for the implementation of Income Maintenance Administration (ESA) programs. The Manual is also designed to provide front-line operations staff with clear, consistent policy standards for providing services. This Manual is the definitive policy reference for all Department program operations pertaining to:

- Medical Assistance (MA),
- Temporary Assistance to Needy Families (TANF),
- General Assistance for Children (GC),
- Interim Disability Assistance (IDA), and
- Food Stamps (FS)

In addition, this manual is the policy reference for the Burial Assistance Program.

It is the primary reference for any persons, organizations, or agencies officially acting for the Department. The Manual does not encompass procedures which have been developed for carrying out these policies except in instances where procedures are, in fact, policies.

For purposes of this Manual, policies are defined as statements of fact, principles, standards, or conditions which guide and determine present and future actions.

The Manual does not provide policy guidance or responses for every possible situation. However, the policy explanations that are contained herein specify guidelines on which staff can reliably base decisions.

MANUAL FORMAT 1.2

Organization 1.2.1

This Manual is organized as follows:

- Part I: Introduction,
- Part II: Basic Rights and Responsibilities,
- Part III: Application Processing,
- Part IV: Non-Financial Eligibility,
- Part V: Program Requirements and Sanctions,
- Part VI: Financial Eligibility,
- Part VII: Special MA Processing,
- Part VIII: Case Maintenance,
- Part IX: Special Local Programs,
- Appendix A: Acronyms,
- Appendix B: Glossary of Terms,
- Appendix C1: Commonly Used Forms,
- Appendix C2: Case Record Organization,
- Appendix C3: Checklist for Case Actions,
- Appendix C4: Fact Sheets,

- Appendix D1: The Medicaid Program Codes,
- Appendix D2: Active Medicaid Program Codes, and
- Appendix E; Important Links

Format 1.2.2

The contents of the Manual are arranged by part which identifies the overall subject area for chapters. Sections identify principal items covered within a chapter, and subsections are used to break down sections that cover complex topics. The appendices provide supporting information.

Most parts within the Manual contain more than one chapter. There is a table of contents for the part as a whole and for each chapter, as well as a table of contents for the entire Manual. The footer on each page identifies the part number, the chapter number, the chapter title, and the page number. The Manual's pages are numbered consecutively from page one through to the end.

For each chapter within the Manual, sections and subsections are numbered consecutively.

Section headings are uppercase as illustrated in the following example.

Example
SECTION HEADING 1.4

Only the initial letter of each word in a subsection heading is capitalized as in the following example.

Example
Section Heading 1.4.1

Embedded throughout the Manual are examples that illustrate some of the more difficult concepts that are involved in ensuring that applicants/recipients are being served correctly. Below is an illustration of an example taken from the text.

Example
Ms. Lindsay applies for Medicaid benefits on October 1 and is enrolled in Medicare Part A. Her eligibility is effective October 1 (or up to three months retroactively if all eligibility criteria are met).

Where exhibits are cited, they can be found at the conclusion of the chapter in which they are mentioned.

Where applicable within each section and subsection, policies for ESA programs are always listed in the following order: MA, TANF, GC, and FS. This order reflects the requirement to focus on determining MA eligibility first. The program to which the policy applies is noted in bold on the left side of the page. If a policy applies to all four programs in the exact same manner, the word ALL is used; if a policy does not apply to a specific program, N/A is written.

Example
ALL A land contract is an agreement for the sale of real property on installments (usually monthly). The contract holder (seller of the property) retains title to the property until the entire purchase price is paid.

MA	When a member of the asset group is a land contract holder (not the purchaser), count his/her equity in the contract. The equity is the amount for which the contract can be sold (usually at a commercial discount rate) minus the amount of any lien on the property (see also Section 1.22: Non-Saleable Assets in this Chapter).
TANF	Installment contracts for the sale of land or buildings are excluded as an asset if the contract or agreement is producing income consistent with its fair market value. The money received is counted as income. The exclusion also applies to the value of the property sold under the installment contract or held as security in exchange for a purchase price consistent with the fair market value of the property.
GC	See TANF
FS	See TANF

In addition, where applicable within each section and subsection, MA policy is specified for the following four categories:

- AR,
- AX,
- SR, and
- QM

When MA policy depends on whether a group uses the D.C. Healthy Families application or the Combined Application, the policy explanations are designated by AR/AX D.C. Healthy Families Application Users and AR/AX Combined Application Users are written. Also, there are instances when policy varies within a category. When this occurs, the manual specifies the variation in policy by eligibility criteria.

If an MA policy applies to all four categories in the exact same manner, no category is specified; if an MA policy does not apply to a specific category, N/A is written. See Section 2.2.2: ACEDS MA Program Types and Section 2.2.7: Policy Categories in this Part for a description of each category.

With respect to the former Medical Charities (or “MC”) program type, SSRs use this category to process applications for the 1115 (50-64) Demonstrations for District residents age 50 to 64 who meet the Medically Needy income and resource eligibility criteria. Additionally, 50-64 enrollees must be qualified aliens or U.S. citizens (see Part IV). SSRs should refer to the SR sections in order to evaluate eligibility for the 1115 (50-64) Demonstration even though the cases are processed on the MC screens in ACEDS.

Example	
MA	<p>Age is an eligibility factor for certain MA categories. A person remains eligible with respect to age for the entire month in which s/he reaches the maximum age even if the birthday is the first of the month.</p> <p>AR: A child in an AR unit must be under the age of 21. Children ages 19 and 20 are only eligible for Medicaid if they meet the MNIL eligibility criteria.</p> <p>AX: A child in an AX unit must be under the age of 19.</p> <p>SR: An individual must be age 65 or older to meet SR eligibility on the basis of age. There is no age requirement for an individual who is statutorily blind or permanently and totally disabled. However, if the disabled person is under age 21 or the individual is a parent or caretaker relative, his/her Medicaid eligibility should be evaluated under the AR and AX program types first. If the individual is</p>

	eligible based on the AR or AX program types, the individual's Medicaid application should be approved.
	QM: Age does not need to be verified, though eligibility for Medicare, an age-related benefit itself, must be verified.

Some chapters have a Legal Authority section for policies discussed within the chapter. The Legal Authority section is always located second in each chapter (e.g., 1.2, 2.2, 3.2). The Legal Authority sections are organized in chart form. The charts identify the major policy areas discussed in the chapter and the applicable federal and District regulations governing those policies.

There are few District regulations governing the administration of MA and FS. This means that unless otherwise stated within the legal authority section, policy for these two programs reflects only federal statute and regulations and the District's state plans. Also, there are no federal regulations for GC. This means that policy for GC is based on District law and regulations.

Most chapters address all four programs. However, some chapters do not. The introduction to the Chapter specifies which programs are addressed.

Use of Language 1.2.3

The language in this Manual has two objectives:

- provide specific and accurate wording of policies, and
- ensure that the policies are as clear and simple as possible.

However, in many instances, simple language cannot describe technically complex policy with accuracy or specificity. In these cases, the language is often taken directly from the legislation.

LAWS GOVERNING FEDERAL AND DISTRICT REGULATIONS 1.3

Federal and District policies have been developed to carry out the legislative mandates of the United States (U.S.) Congress and the District of Columbia. Exhibit I-1: Federal Legislation Related to ESA Programs and Exhibit I-2: District Legislation Related to ESA Programs provide a comprehensive list of public laws (P.L.) and District laws on which District MA, TANF, GC, and FS policies are based.

MAINTENANCE OF MANUAL 1.4

This Manual must be easily accessible to all Department staff since it serves as the Department's primary policy reference document.

The Department will conduct periodic reviews and revisions of the Manual. Between reviews, the Department will issue policy directives and instructions for insertion into the Manual. All policy directives shall be approved and signed by the Director or his/her designee before they become effective. The Policy Manual insertions should be logged into the Insert Documentation Form at the front of the Manual. Please note that inserted pages will be noted as such in the footers at the bottom of the pages.

EXHIBIT I-1: FEDERAL LEGISLATION RELATED TO ESA PROGRAM

TITLE OF LEGISLATION	PUBLIC LAW (P.L.)
Abandoned Infants Assistance Act of 1988	P.L. 100-105 P.L. 102-236
Adoption and Safe Families Act of 1997	P.L. 105-89
Age Discrimination Act of 1975	P.L. 94-135
Agent Orange Act of 1991	P.L. 102-4 P.L. 98-479
Agricultural Act of 1949	P.L. 98-181 P.L. 97-35
Agriculture Research, Extension and Education Act of 1998	P.L. 105-185
Alaska Native Claims Settlement Act of 1971	P.L. 92-203
Balanced Budget Act of 1997	P.L. 105-33
Child Abuse Prevention and Treatment Act (CAPTA) of 1996 and as amended.	P.L. 93-247 P.L. 104-235
Child Nutrition Act of 1995	42 USC 1771
Child Support Performance and Incentive Act of 1998	P.L. 105-200
Civil Liberties Act and Aleutian and Pribilof Islands Restitution Act of 1988	P.L. 100-383
Civil Rights Act of 1964	P.L. 102-166
Debt Collection Improvement Act of 1996	P.L. 104-134
Domestic Volunteer Services Act of 1973	P.L. 93-113
Farm Security and Rural Investment Act of 2002	P.L. 107 171
Food Stamp Act of 1977, as amended	P.L. 95-400
Health Insurance Portability and Accountability Act of 1996	P.L. 104-192
Housing and Urban Development Act of 1965	P.L. 105-244
Illegal Immigration Reform and Immigrant Responsibility Act of 1996	P.L. 104-208
Indian Judgment Funds Distribution Act of 1973	P.L. 93-134 P.L. 92-254
Judgment funds to the Grand River Band of Ottawa Indians of 1976	P.L. 94-540
Low-Income Home Energy Assistance Act of 1981, and as amended.	P.L. 104-193
National Housing Act of 1949	P.L. 97-25 P.L. 98-181 P.L. 98-479
National School Lunch Act of 1946	P.L.-396
Older Americans Act of 1965	P.L. 89-73
Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation, or the Apache Tribe of the Mescalero Reservation of 1978	P.L. 95-433
Payments received under the Sac and Fox Indian Agreements of 1975	P.L. 94-189
Payments to the Passamaquoddy Tribe and the Penobscot Nation, or any of their members pursuant to the	P.L. 94-420

Main Indian Claims Settlement Act of 1980	
Perkins Vocational and Applied Technology Education Act of 1998	P.L. 105-332
Personal Responsibility and Work Opportunity Reconciliation Act of 1996	P.L. 104-193
Radiation Exposure Compensation Act of 1990	P.L. 101-425
Receipts Distributed to Members of Certain Indian Tribes Act of 1975	P.L. 94-114
Relocation Payments to the Hopi and Navajo Tribes of 1974	P.L. 93-531
Revenue Act of 1978	P.L. 95-600
Single Audit Act of 1984	P.L. 98-502
Social Security Act of 1935	P.L. 74-271
Stewart B. McKinney Homeless Assistance Act	P.L. 100-77
Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1992	P.L. 102-295
Ticket to Work and Work Incentives Improvement Act of 1999	P. L. 106 170
Trade U.S. Housing Act of 1937	P.L. 93-383
Transportation Equity Act for the 21st Century	P.L. 105-178
Uniform Relocation Assistance and Real Property Acquisition Act of 1970	P.L. 91-646
Veterans' Disability Compensation and Survivor Benefits Act of 1976	P.L. 94-433
Victims of Trafficking and Violence Protection Act of 2000	P.L. 106-386

EXHIBIT I-2: DISTRICT LEGISLATION RELATED TO ESA PROGRAMS

Title of legislation	DC Act
Burial Assistance Program Reestablishment Emergency Amendment Act of 1999	D.C. Act 13-180
District of Columbia Child Support Enforcement Amendment Act of 1985	D.C. Act 6-212
District of Columbia Public Assistance Act of 1982, as amended	D.C. Act 4-101
District of Columbia Public Assistance Act of 1982 Conforming Amendments	D.C. Act 8-102
District of Columbia Family Support Act of 1990	D.C. Act 8-200
Fiscal Year 1998 Revised Budget Support Congressional Review Act of 1997	D.C. Act 12-239
Fiscal Year 1998 Revised Budget Support Emergency Act of 1997	D.C. Act 12-152
General Public Assistance Program Termination Emergency Amendment Act of 1997	D.C. Act 12-72
Interim Disability Assistance Act of 2000	D.C. Act 13-252
Interim Disability Assistance Emergency Amendment Act of 2003	D.C. Act 15-2
Multiyear Budget Spending Reduction and Support Emergency Act of 1994	D.C. Act 10-389
Omnibus Budget Support Congressional Recess Emergency Act of 1991	D.C. Act 9-69
Public Assistance Act of 1982 Budget Conformity Amendment of 1991	D.C. Act 9-54
Public Assistance and Day Care Policy Temporary Amendment Act of 1994	D.C. Act 10-208
Public Assistance Emergency Amendment Act of 1997	D.C. Act 12-25
Public Assistance Emergency Amendment Act of 1998 Public Assistance Legislative Review	D.C. Act 12-372
Emergency Amendment Act of 1997	D.C. Act 12-77

Self-Sufficiency Promotion Congressional Review Emergency Amendment Act of 1998	D.C. Act 12-425
Self-Sufficiency Promotion Congressional Review Emergency Amendment Act of 1999	D.C. Act 13-19
Supplemental Assistance Income Payment Second Congressional Review Emergency Amendment Act of 1997	D.C. Act

Chapter 2- Overview of Applicable Programs

INTRODUCTION 2.1

This chapter provides an overview of the benefits programs operated by ESA which are addressed in this Manual.

ESA determines eligibility for five major benefits programs in the District of Columbia:

- Medical Assistance (MA) ,
- Temporary Assistance for Needy Families (TANF),
- General Assistance for Children (GC),
- Interim Disability Assistance (IDA), and
- Food Stamps (FS)

ESA administers all of these programs except for MA. MA is administered by the Department of Health.

These benefits are available to District residents based on income and other eligibility requirements. Each program operates under different federal and District legislative authority and has its own eligibility requirements, income limits, benefit determination, benefit levels, fair hearing and administrative review procedures, and other provisions.

District residents apply for program benefits at one of the ESA service centers. Following an initial screening interview with ESA staff, applicants can be referred to other agencies or for other benefits and services, including referrals to employment opportunities.

The Department uses a Combined Application (CA) form for MA, TANF, GC, IDA, and FS benefits which collects eligibility information and documentation for all five ESA programs. In addition, an MA-specific application form, the D.C. Healthy Families Application, can be completed by certain applicants. Further, customers wishing to apply only for Food Stamps may use the Food Stamp only application form. Residents have the right to receive and file a benefits application form within the same business day they request an application. Additional rights and responsibilities are held by the applicant, recipient, and Department and are described in detail in Part II: Basic Rights and Responsibilities.

In addition to these five main programs, ESA also offers two programs for refugees: Refugee-Related MA and Refugee Cash Assistance. These programs draw on the policies used by the four main programs. Consequently, the Manual does not highlight the refugee programs in every section. Section 7.5: Refugee-Related Cash and Medical Assistance in Part IV describes the refugee programs and their relationship to the five main ESA programs.

ESA also administers the Burial Assistance Program. This program is discussed in detail in Part IX: Special Local Programs.

The following sections describe each of the five major ESA programs and provide a summary of each program's legislative authority, eligibility criteria, and benefits. More detailed explanations of policies, eligibility, and benefits are provided in later chapters of this Manual.

MEDICAL ASSISTANCE (MA) 2.2

District residents are eligible for MA through the Medicaid program if they fall into one of the categories of people listed in Section 2.2.1: MA Program Types provided they also meet all financial and non-financial criteria (see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility).

The Medicaid program is authorized by Title XIX of the Social Security Act which provides for federal grants to the states and the District for the medical assistance program. Specifically, Title XIX enables the District to provide medical assistance, rehabilitation, and other health-related services to those who have insufficient incomes and resources to meet the costs of necessary medical services.

Note regarding the COBRA Coverage Program: This program is now administered by the HIV/AIDS Administration within the Department of Health. The program pays the health care premiums for low and moderate-income individuals who are Human Immunodeficiency Virus (HIV)-positive and eligible for COBRA health insurance coverage from a former employer. Persons may apply by calling the HIV/AIDS Administration on (202) 727-2500.

MA Program Eligibility Criteria 2.2.1

The following groups of people are eligible for MA through Medicaid:

- **Families with Children:** Children and their parents, step-parents or caretakers can be eligible for Medicaid if they meet one of the following criteria (individuals receiving TANF are categorically eligible for Medicaid; see Chapter 12: Categorical Eligibility in Part IV).
 - *TANF Standard:* Individuals receiving TANF or children under age 19, their parents, step-parents, or caretakers who meet the TANF income and asset standards but are not receiving TANF;
 - *Foster Care/Department Ward/Adoption Assistance Recipient :* Children under age 18 placed in foster care (but not in institutions) and children receiving IV-E foster care payments or IV-E adoption assistance benefits are categorically eligible for Medicaid (see Chapter 12: Categorical Eligible in Part IV);
 - *Medically Needy Families & Children:* Children under the age of 21 and parents, and/or caretaker relatives with incomes below the MNIL;
 - *Poverty Level Children and Pregnant Women:* Pregnant women and infants (children under age one) with net incomes below 185 percent of the federal poverty level (FPL), children under age six with net incomes below 133 1/3 percent of the FPL, children ages six and over provided they were born after September 30, 1983 with net incomes below 100 percent of the FPL, and children 19 and 20 with net incomes under 200% of the FPL. When determining if the pregnant woman's income is below 185 percent of the FPL, the unborn child is included as a group member (i.e., if the applicant is a pregnant woman with no other children, the poverty level for a group of two is used).

Pregnant women with net incomes below 185 percent of the FPL and a medically-verified pregnancy are eligible for prenatal care during a presumptive eligibility period while their ongoing eligibility for medical services is determined.
 - *Children with Other Health Insurance:* Pregnant women and children under 19 who have other health insurance are eligible for Medicaid if their incomes are below 300 percent of the FPL;
 - *DC Healthy Families Expansion Group for Pregnant Women and Children :* Pregnant women and children under age 19 whose gross income is below 300 percent of the FPL, have no other health insurance, and are ineligible for Medicaid under the TANF Standard, Poverty Level Families and Children, and Medically Needy Families and Children criteria described above (the federal government will pay a larger share of the cost of providing health care coverage to these children because extending Medicaid to this group was done as part of the Child Health Insurance Program (CHIP));

- *DC Healthy Families Expansion Group for Parents/Caretaker Relatives* : Parents except for pregnant women, and/or caretaker relatives of a child(ren) eligible for Medicaid whose income is below 200 percent of the FPL and who is ineligible for Medicaid under the TANF Standard and Medically Needy Families & Children Criteria; and
- *Transitional Medicaid*: Parents, caretakers, pregnant women, and/or children under 19 who become ineligible for Medicaid under any category listed above because of an increase in earnings or child support are eligible for Transitional Medicaid Assistance (TMA). TMA is only available if increased earnings or child support cause persons in the group to exceed the income standard of 200 percent of FPL for parents and caretakers, and 300 percent of FPL for pregnant women and children under 19. Persons ineligible due to an increase in earnings are eligible for six months of TMA. Persons ineligible due to an increase in child support are eligible for four months of TMA
- **Elderly/Disabled:** The elderly or disabled can be eligible for full coverage if they meet one of the following criteria:
 - *SSI Recipient*: Supplemental Security Income (SSI) recipients (individuals receiving SSI are categorically eligible for Medicaid; see Chapter 12: Categorical Eligibility in Part IV);
 - *Aged/Disabled*: Individuals who are age 65 or older, blind, or disabled whose income is below 100 percent of the FPL and whose assets do not exceed twice the SSI standard (see Section 12.3: Who is Categorically Eligible in Part IV, and Section 1.6: Pickle Amendment, Section 1.7: Disabled Widow(er)s, and Section 1.8: Early Widowers in Part VII for a more extensive discussion); and
 - *Individuals in a Long-Term Care (LTC) Facility*: Medicaid pays some or all of the cost of a LTC facility for some low-income individuals.
- **Childless Adults:** Effective May 1, 2010, adults from ages 21 through 64 were eligible for full Medicaid coverage if they had incomes below 133% of the FPL, and are **NOT**:
 - age 65 or older,
 - under age 21,
 - pregnant,
 - entitled to or enrolled in Medicare Part A, or
 - enrolled in Medicare Part B

Effective December 1, 2010, that income limit increased to 200% of the FPL.

There is no resource test for these childless adults.

Individuals who are over-income for Childless Adult Medicaid may not spend-down their income to become eligible for Childless Adult Medicaid. Disabled persons who are over-income for Childless Adult Medicaid may spend-down their income to become eligible for SR Medicaid.

- **Medicare Beneficiaries:** Some low-income Medicare beneficiaries, including persons receiving Title II benefits (Social Security), can receive assistance paying for some or all of their Medicare premiums, etc. Medicare beneficiaries eligible for this type of assistance are often referred to as participating in the 'Buy In' program, i.e. the Medicaid program is helping the individual 'buy into' the Medicare program. If not otherwise eligible for Medicaid (such as through the Aged/Disabled criteria above or based on their serving as a caretaker relative for a child), these individuals do not receive other Medicaid benefits or services.

- QMB: A Medicare beneficiary whose income does not exceed 300 percent of the Federal Poverty Level is called a Qualified Medicare Beneficiary (QMB). For an individual eligible for Medicaid in the QMB category, the Medicaid program pays the following:
 - Medicare Part A deductible*,
 - Medicare Part B premium,
 - Annual Part B deductible*, and
 - Annual Part B Copayments*

* The District's policy restricts reimbursement to those infrequent situations where the total Medicare payment is less than the Medicaid fee schedule. Consequently, Medicaid rarely if ever pays these amounts.

Note that effective November 1, 2008, there is no asset limit for QMB.

- SLIMB: A Medicare beneficiary whose income is at least 100 percent of the FPL and less than 300 percent of the Federal Poverty Level is called a Special Low-Income Medicare Beneficiary (SLIMB). For an individual eligible for Medicaid in the SLIMB category, the Medicaid program pays the Medicare Part B premium. (Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application, since the QMB income limit has been increased to include these customers for the period beginning with the month following the month of application.)

Note that effective November 1, 2008, there is no asset limit for SLIMB.

- QI-1: A Medicare beneficiary whose income is at least 120 percent of the FPL and less than 135 percent of the FPL and whose resources are no more than twice the SSI resource standard is called a QI-1. For an individual eligible for Medicaid in the QI-1 category, the Medicaid program pays the Medicare Part B premium. (Note that effective July 1, 2005, there are no QI-1 eligible customers, since the QMB and SLMB income limits have been increased to include these customers.)
- QDWI: A Qualified Disabled Working Individual (QDWI) is a disabled individual who lost his/her free Medicare Part A benefits due to his/her return to work and:
 - is receiving or is eligible to receive Medicare Part A,
 - has income that does not exceed 200 percent of the Federal Poverty Level,
 - has assets that do not exceed twice the SSI standard, and
 - is not eligible for MA under any under standard.

For an individual eligible for MA as a QDWI, the Medicaid program pays the Medicare Part A premium.

A Medicare beneficiary who is eligible under one of the above categories and is also eligible for Medicaid based on another eligibility criteria, such as an individual who is 65 years of age or older and has income below the poverty line, will receive assistance paying for Medicare premiums, etc. and will also receive Medicaid-provided services not covered under the Medicare program.

- **Immigrants:** Depending on their status, immigrants may be eligible for full-coverage Medicaid or emergency Medicaid services.
 - *Refugee-Related Medicaid:* Refugees, asylees, and certain other immigrants in their first eight months in the country are eligible for Medicaid if their income and assets are below

the Medically Needy income and resource scales. ESA first determines eligibility under the AR/AX or SR programs and, if necessary, considers such persons under the Refugee-Related Medicaid program. Also, all persons receiving Refugee cash assistance are eligible for Refugee-Related Medicaid if they are not eligible for the AR/AX or SR programs.

- *Non-Qualified Immigrants:* Immigrants ineligible for Medicaid due only to their immigration status are eligible for emergency Medicaid services. These services are described in Section 2.2.4: Benefit Provision in this Chapter.

Individuals who meet all non-financial Medicaid requirements and asset limits, if applicable, but whose income exceeds the Medicaid income eligibility limit may qualify for partial coverage of medical bills if they have unpaid medical bills. Such individuals are eligible through the 'spend down' Medicaid provisions (see Chapter 7: Spend-Down in Part VI).

ACEDS MA Program Types 2.2.2

Within the Automated Client Eligibility Determination System (ACEDS), there are six MA program types. These program types can be thought of as groupings of the eligibility criteria described in Section 2.2.1: MA Program Types in this Chapter. The following table shows how the eligibility criteria correspond to the MA program types.

MA Program Types	Eligibility Criteria
AR (This code was not changed when Aid to Families with Dependent Children (AFDC) was replaced by TANF.)	<ul style="list-style-type: none"> • TANF Standard • Foster Care/Department Ward/Adoption Assistance Recipient • Medically Needy Families and Children • Poverty Level Families and Children • Transitional Medicaid
AX	<ul style="list-style-type: none"> • Children with Other Health Insurance • D.C. Healthy Families Expansion Group for Children (CHIP) • D.C. Healthy Families Expansion Group for Parents/Caretaker Relatives <p>MA eligibility for non-elderly parents, caretakers, and children must be tested under AR criteria before being tested under AX criteria. If a child, parent, or caretaker relative is ineligible for MA under any AR criteria except Transitional Medicaid, the Department must then determine if they meet AX eligibility.</p>
SR	<ul style="list-style-type: none"> • SSI Recipients • Aged/Disabled
QM	<ul style="list-style-type: none"> • QMB (Most QMBs are also eligible for Medicaid based on the Aged/Disabled category. Individuals eligible for Medicaid under the Aged/Disabled category and Medicare Buy-In are processed under the SR program type.) • SLIMB (Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application, since the QMB income limit has been increased to include these customers for the period beginning with the month following the month of application.)

	<ul style="list-style-type: none"> • QI-1 (Note that effective July 1, 2005, there are no QI-1 eligible customers, since the QMB and SLIMB income limits have been increased to include these customers) • QDWI
RR	<ul style="list-style-type: none"> • Refugees, asylees, and certain other immigrants in their first eight months in the country
LT	<ul style="list-style-type: none"> • Individuals in a LTC facility
MC	<ul style="list-style-type: none"> • Effective May 1, 2010, this program type is used for both the DC HealthCare Alliance and for Medicaid for Childless Adults

Individuals eligible for emergency Medicaid services only are assigned the program type that they would have been in had they not been ineligible due to immigration status. These individuals receive a separate code that indicates they are eligible for emergency services only.

The SSR should encourage individuals applying for and/or qualifying for MA under SR to apply for SSI at a Social Security Office. The SSR should explain that since SR MA uses the same income, asset, and disability standards as SSI, individuals eligible under SR are likely to be SSI-eligible. The SSR should inform individuals qualifying for SR of the benefits of receiving SSI (i.e., cash assistance to meet basic needs and no need to recertify Medicaid eligibility as long as they continue to receive SSI).

Determining MA Eligibility 2.2.3

The SSR must determine the ACEDS MA program type, using the following guidelines, under which each applicant may be potentially eligible for MA:

- SSI recipients are always in an SR unit.
- TANF recipients are always in an AR unit.
- MA eligibility for parents, children, and caretaker relatives is always tested under the AR program type before the AX program type.
- Parents, caretaker relatives, and children ineligible for MA through the AR or SR types should be tested under the AX type.
- If a child is not receiving SSI but could qualify as either an SR or AR/AX case, the SSR should initially evaluate the child as an AR/AX case because this does not require a disability determination.
- If a parent or caretaker relative is not receiving SSI but could qualify as either AR/AX or SR, the SSR should:
 - initially evaluate the parent/caretaker relative as an AR or AX (whichever is appropriate given his/her income), and
 - explain that if s/he returns the completed medical evaluation form, and is determined to be disabled by the Medical Review Team, s/he will not be placed in managed care.

While SSRs must select the ACEDS MA program type under which MA eligibility will be tested, ACEDS will determine the income category in which an individual fits if the individual is eligible for MA within the SSR-selected program type.

Example

Ms. Lee and her two pre-school children (under the age of 6) apply for MA. The family does not receive TANF. The family's net income is 130 percent of the FPL. The SSR should put all three individuals in the assistance group and select program type AR. After the family's income and other information have been entered, ACEDS will determine that the children are eligible for MA under the Poverty Level Children and Pregnant Women criteria. Ms. Lee, however, is ineligible for MA as part of an AR unit because her income is too high. The SSR should now create an AX unit that includes Ms. Lee and includes provisionally the two children (the children will remain in the AR unit, but they must be included provisionally in the new AX unit so the income eligibility limit for Ms. Lee will reflect 200 percent of the FPL for a family of three). Since the AX unit meets the D.C. Healthy Families Expansion Group for Parent/Caretaker Relatives eligibility criteria, ACEDS will find Ms. Lee eligible for MA as an AX unit.

Benefit Provision 2.2.4

Medicaid recipients (other than those in the QM group who are eligible only for assistance in paying Medicare-related premiums, etc.; see Section 2.2.1: MA Program Types in this Chapter) can access preventative, primary, acute, and chronic care services such as:

- clinic services;
- clinical psychologist services;
- dental care;
- drug and alcohol treatment;
- durable medical equipment;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for children and adolescents;
- emergency care;
- family planning services;
- immunizations;
- in-patient/out-patient hospital care;
- inpatient psychiatric hospital care for children and adolescents;
- labor and delivery;
- laboratory and x-ray services;
- nursing home and home health care;
- physical and occupational therapy;
- physician services;
- prenatal care;
- prescription drugs;
- school physicals; and
- vision care.

Most AR/AX Medicaid recipients are required to enroll in one of the managed care organizations that the District has contracted with to provide care to Medicaid recipients. There are a few exceptions, including Foster Care/Department Ward/Adoption Assistance Recipients and HIV-infected persons. Shortly after someone is determined Medicaid eligible under AR/AX, s/he will normally be contacted by the District's Medicaid Managed Care 'Enrollment Broker.' The 'Enrollment Broker' is responsible for educating Medicaid recipients about their managed care provider options, including:

- how to make a managed care provider selection, and
- how to obtain services under a managed care delivery system.

Recipients can obtain the above listed services by visiting a managed care plan provider. However, some types of mental health services can be obtained by seeing any provider who is certified as meeting the applicable Medicaid program provider requirements and is willing to accept Medicaid payment.

Individuals eligible for emergency Medicaid services are only eligible for medical services for a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Retroactive Eligibility 2.2.5

When a person applies for Medicaid, s/he can also apply for three months of retroactive eligibility. If s/he meets the financial and non-financial eligibility criteria during the three months prior to application, Medicaid will pay his/her outstanding bills from that three-month period.

Salazar Court Order 2.2.6

The Salazar court order governs how Medicaid applications filed on behalf of groups who are not categorically eligible (i.e., groups composed of TANF recipients, GC recipients, SSI recipients, children in foster care, department wards, or children receiving IV-E foster care payments or IV-E adoption assistance benefits, see Chapter 12: Categorical Eligibility in Part IV) and groups who are not applying based on disability are to be processed. It requires the following:

- covered Medicaid applications are to be processed within 45 days;
- if an application is not processed within 45 days, the Department will automatically deem it eligible for not less than three months; and
- all recertifications must be registered in ACEDS as soon as they are received, if they are signed.

Policy Categories 2.2.7

The bulk of the Manual relating to MA pertains to the following ACEDS MA program types: AR, AX, SR, and QM. Information specific to Refugee-Related Medicaid (RR program type) is located in Chapter 7: Citizenship/Alienage in Part IV and Section 1.4: Refugee Medical Assistance in Part VII). Issues related specifically to emergency Medicaid are also found in Chapter 7: Citizenship Alienage in Part IV. Policies relating to LTC Recipients (LT program type) are found in Chapter 2: Long-Term Care/Impoverished Spouse in Part VII.

Most policies relating to non-financial and financial eligibility requirements are consistent within the ACEDS program types (AR, AX, SR, and QM). Therefore, when describing MA policies that are not consistent between these program types (that is, the policy for the AR program differs from the policy in the SR program), the policies for each program type will be described.

Sometimes, MA policy is not divided between the AR and AX program types. This is because application processing rules for children, parents, and caretaker relatives do not depend on whether the family will ultimately be found eligible under the AR or AX program type but rather depend on the type of application submitted (see Part III: Application Processing). Families applying only for Medicaid can fill out the D.C. Healthy Families Application. Families applying for Medicaid in addition to TANF and/or FS must

fill out the Combined Application (CA). The D.C. Healthy Families application is shorter, and families applying for Medicaid using this form are required to verify less information provided on the application. Many children and parents applying for Medicaid using the D.C. Healthy Families Application are found eligible for Medicaid under the AR program type.

In cases where the policies differ for families with children based on the type of application filed rather than on the program type under which their eligibility will be determined, the Manual uses the following groupings to distinguish between families filing a D.C. Healthy Families Application and families filing a CA: AR/AX D.C. Healthy Families Application Users, AR/AX Combined Application Users, and the other groups will remain as described above (SR and QM).

EPSDT/Health Check 2.2.8

Federal Medicaid rules require that the District's Medicaid program provide Early Periodic Screening Diagnosis and Treatment (EPSDT) services to children receiving Medicaid. EPSDT services – called Health Check in the District – include medical, dental, vision, and hearing screening and all medical services deemed necessary to treat to prevent health problems in these areas. Immunizations are also considered an EPSDT service.

MAA is responsible for ensuring that Medicaid providers offer these services to children under age 21, or under age 22 in the case of a child receiving SSI due to a disabling medical condition.

ESA is responsible for informing Medicaid applicants and recipients, including those who are deaf, blind, non-English speaking, and/or functionally illiterate of the Health Check services and of the assistance MAA can provide in scheduling EPSDT appointments and assisting with transportation to and from EPSDT appointments. ESA must inform all Medicaid applicants and recipients of these services in writing and orally, at application, recertification, and when adding a child to the group.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) 2.3

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 ended the federal entitlement of individuals to cash assistance under the Aid to Families with Dependent Children Program (AFDC), formerly authorized under Title IV-A of the Social Security Act. This law replaced AFDC with the Temporary Assistance Needy Families (TANF) block grant. The District uses this block grant to operate a cash assistance program for poor families with children. The District calls this program 'TANF.' The District's TANF program includes requirements for recipients to participate in work or other activities that will lead to paid employment. The program is intended to reduce dependence on public assistance and enhance individual and family economic self-sufficiency.

PRWORA and District law impose a lifetime limit of 60 months on receipt of cash benefits funded with federal TANF funds. Subject to some exceptions, federal TANF funds cannot be used to provide cash assistance to a family that has received assistance for 60 months. In addition, in order to receive TANF cash benefits, an adult recipient, unless exempt, must be engaged in work-related activities, including work experience, job training, and subsidized and unsubsidized employment for a defined number of hours each week (see Chapter 1: Work Requirements in Part V). Failure to participate in work activities can lead to a reduction in the family's TANF grant. Individuals are exempt from work requirements only in special circumstances, such as disability, incapacity or illness, lack of appropriate child care, caring for a disabled child, or advanced age. Additional exemptions, exclusions, and restrictions apply (see Section 1.6: Exemptions from Work Requirements in Part V).

Effective April 1, 2011, a Reduced Payment Level will be used to determine eligibility for assistance groups that have received TANF for more than 60 months, if the group includes as one of its mandatory or

optional members an adult who has received TANF for more than 60 months (for mandatory and optional members, see Part IV, Sections 1.3: Mandatory Group Members and 1.4: Optional Group Members.)

The Reduced Payment Level for a given family size is 80% of the Full Payment Level (see Exhibit VI-4: Standard of Assistance and Payment Levels in Part VI.)

Benefit Provision 2.3.1

TANF benefits include a cash grant provided electronically through electronic benefits transfer (EBT) cards. EBT allows beneficiaries to use a magnetic-stripped plastic card, similar to an automated teller machine (ATM) or debit card, to withdraw their benefits electronically at an ATM. Recipients can also access benefits at stores equipped to accept EBT benefits as payment. When a TANF recipient uses an EBT card, the TANF benefits are deducted automatically from the beneficiary's account. The District's EBT card is called the Capital Access card, and it also allows eligible beneficiaries to access FS benefits electronically at grocery stores and markets equipped to accept EBT benefits as payment.

Cash benefits provided are calculated based on the number of eligible individuals in the group, group income with certain allowed deductions, and other benefits received. In order to be eligible for TANF, countable assets held by the group must be less than the applicable asset limit.

Non-exempt TANF recipients are required to participate in work activities which generally include job readiness training, job placement, subsidized employment, vocational education, and work experience programs. Participants in such programs as well as recipients combining work and welfare receipt are eligible for child care subsidies for children younger than age 13. These subsidies are provided by the Office of Early Childhood Development (OECD).

A head of household who is applying for TANF may be provided with cash assistance under the Diversion Payment Program (DPP) (see Section 3.7: Diversion Payment Program (DPP) in Part VIII) instead of receiving a TANF grant. DPP is used to resolve an immediate short-term financial need which, if resolved, will allow the applicant to continue in current employment or accept already offered new employment. During the intake, the SSR should assess whether an applicant is an appropriate candidate for DPP.

If the applicant indicates during the initial interview or subsequent discussions, but prior to TANF approval, that employment could be retained or obtained if a work-related crisis can be quickly resolved, then the SSR should inform the applicant of the program and encourage the use of DPP rather than TANF. A month for which DPP is received does not count toward the TANF 60-month time limit.

An individual may not apply for DPP. It is the responsibility of the SSR to consider if DPP is appropriate, discuss it with the applicant, and, if appropriate, recommend DPP over TANF.

The District's state-only program, POWER, is also available for TANF customers unable to meet TANF work requirements due to a physical or mental incapacity. POWER provides locally-funded cash assistance to these families.

Eligibility Criteria 2.3.2

TANF benefits are available to District families with a minor child or pregnant women when the group income is below the income-eligibility standard which varies by group size. Federal and District law deny assistance to the following individuals:

- certain groups of immigrants;

- individuals convicted in the last ten years of receiving benefits in two or more states; and
- unmarried teen parents not living in an approved adult-supervised setting and who have not been given an exemption from this requirement.

General Assistance for Children (GC) 2.4

The General Assistance for Children (GC) program provides direct financial support to children living in households without a parent or caretaker relative. The program is intended to provide assistance to households caring for unrelated children whose parents and other relatives are absent from the household and who do not or cannot provide financial support for the care of the child. ESA may assist eligible children to apply for and obtain other benefits and services available through other programs.

Benefit Provision 2.4.1

A monthly GC cash grant is provided by EBT to a responsible adult in the household. The amount of cash benefits is calculated according to TANF rules except that the adult caretaker's income and assets are not counted and their needs cannot be included in the grant.

Eligibility Criteria 2.4.2

To be eligible for GC, children must reside in a District household absent of their parent or an adult relative and absent of financial support, or adequate financial support, from their parents or relative. A child must be ineligible for TANF solely because his/her caretaker is not of acceptable degree of relationship (see Section 5.4: Who is A Relative in Part IV).

When an individual applies for cash assistance for a GC child, the SSR must first determine if the child is eligible for TANF by using the following criteria:

- Presence in the home of a relative of acceptable degree of relationship: If a parent is in the home, the child is automatically ineligible for GC if that relationship can be established. If another relative is in the home, that relative will be considered the caretaker unless s/he is mentally or physically unable to assume at least partial responsibility for the care of the child;
- Pregnancy of GC child: If a GC child is pregnant and is expected to deliver within the next four months, she is eligible for TANF. The pregnancy must be medically verified; or
- Presence of minor related child: If a GC child is an eligible TANF caretaker (that is, the applicant is a minor parent), the child may not receive GC but may qualify for TANF.

An adult in the household may apply for GC benefits for the child. The caretaker must accept the child as a member of the family and have responsibility for the supervision and care of the child. The home setting must be evaluated, including a visit to the home made by the Department, to determine that this requirement is met.

In order to be eligible for GC, the child's caretaker must produce authorization from the child's legally responsible relative or a court of competent jurisdiction designating the caretaker as the temporary or permanent caretaker of the child to the extent such authorization is obtainable by the caretaker. When such authorization is not obtainable by the caretaker, the caretaker may offer other proof of custodial relationship between the caretaker and the child. Proof may include, but is not limited to, leases indicating that the child lives with the caretaker; medical records or school records bearing the caretaker's signature; or affidavits from teachers, social workers, medical staff, or other professionals involved in the family's life.

FOOD STAMPS (FS) 2.5

The Food Stamp Program (FS) is administered at the federal level by the U.S. Department of Agriculture, Food and Nutrition Service (FNS). The program is intended to provide monthly benefits to low-income households to assist them in purchasing food needed to maintain adequate nutrition. Congress established the Food Stamp Program in 1964, and later enacted the Food Stamp Act of 1977. In 1996, Congress passed PRWORA which, along with creating TANF and eliminating AFDC, implemented major changes in FS, including a limit on the number of months that an able-bodied, non-elderly, unemployed adult without children can receive FS. The District currently has a waiver of this provision and thus does not impose time limits on able-bodied, non-elderly, unemployed adults with no children.

In the District, paper 'food stamps' or coupons have been replaced by EBT. EBT allows beneficiaries to use a magnetic-striped plastic card, similar to an ATM or debit card, to withdraw their benefits electronically at participating grocery stores and market. No coupons or cash are disbursed and nothing is exchanged. When a FS recipient uses an EBT card at the food store, the FS benefits are deducted automatically from the beneficiary's FS account and transferred to the food vendor electronically. The District's EBT card is called the Capital Access card, and it also allows eligible beneficiaries to access TANF benefits electronically at ATM machines and certain other retail stores. Grocery stores that display the QUEST logo have been FNS certified and their checkout terminals are setup to process Capital Access transactions.

In order to receive FS benefits, all non-exempt adults in the household must participate, in an employment search, work, or related activities (see Chapter 1: Work Requirements in Part V). Each applicant household member who is not exempt will register for the Food Stamp Employment and Training (FSET) program at the time of application and every 12 months after initial registration.

Benefit Provision 2.5.1

The amount of FS benefits that eligible individuals and households can receive is based on USDA's Thrifty Food Plan budget, household income, and the number of eligible members in the household. Eligible households can receive FS benefits of up to a maximum of the USDA's Thrifty Food Plan budget. Certain income is not counted when determining eligibility and benefits. Certain households must also pass an 'asset test' to be eligible for Food Stamps.

FS benefits, unlike TANF or GC benefits, can only be used for the specific purchase of food staples, limited to the following:

- any staple foods, including meat, poultry, fish, bread, cereals, vegetables, fruits, and dairy products. Staple foods do not include accessory food items, such as coffee, tea, carbonated or non-carbonated drinks, candy, condiments, spices, alcoholic beverages, tobacco, hot foods, or hot food products for immediate consumption;
- seeds and plants for use in home gardens to produce food for the personal consumption of eligible individuals;
- in the case of eligible individuals over sixty years of age or those receiving SSI, disability, or blindness benefits, meals prepared by and served in eligible federally subsidized centers and residences;
- In the case of eligible individuals over sixty years of age or who are physically or mentally handicapped, meals prepared and delivered to them at home by a public or private nonprofit agency or through a contract with the Department.
- in the case of drug and/or alcohol dependent eligible individuals, meals served in drug and alcohol treatment programs or residential facilities;
- in the case of women and children residing in domestic violence shelters, meals prepared by and served in the domestic violence shelters; and

- in the case of homeless eligible individuals, meals prepared and served by a public or private nonprofit agency or through a contract with the Department.

Recipients of FS benefits who live in an institutional setting, including residential drug and alcohol treatment facilities, may receive their FS benefits indirectly. ESA issues FS benefits directly to the residential institution providing nutritious meals to eligible recipients (see Chapter 10: Institutional Status in Part IV).

Eligibility Criteria 2.5.2

All FS recipients must be District residents and must be either a U.S. citizens or must fall within certain categories of immigrants (see Chapter 7: Citizenship/Alienage in Part IV). Generally, a household's gross income must be below 130 percent of the FPL and a household's net income must be below 100 percent of the FPL to be eligible for FS. Certain households, however, are not required to meet the gross income test (see Section 8.4: Determining Benefit Level/Amount of Assistance in Part VI).

Part II

Chapter 1 - Rights of Applicants and Recipients

INTRODUCTION 1.1

All applicants and recipients have rights under various District and federal laws. These rights include the right to fair treatment, to privacy and confidentiality, to information about the programs and client's responsibilities, and to appeal certain actions and decisions. The Department and its staff should inform applicants and recipients verbally and in writing about their rights.

'Recipients' are defined as persons to whom or on whose behalf public assistance is granted. 'Applicants' are defined as adults who do not receive benefits under these programs but who apply for benefits for themselves or other children or adults.

This chapter details and explains the rights of recipients and applicants under these benefit programs; however, applicants, recipients, and the Department may have other rights as determined by current statute and case law. Department staff should refer specific legal questions to the Office of General Counsel (OGC).

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Rights of Applicants and Recipients	TANF: D.C. Code 4-205.55, 4-205.56, 4-205.59, 4-205.64, 4-205.66, 4-208.1, 4-208.3; 29 DCMR 1708, 5803, 5805, 5817 GC: D.C. Code: 4-205-5a, 4-205.55, 4-205.56, 4-205.59, 4-208.1, 4-208.3	MA: 42 USC 1396a(a)(3), (4), (7), (8), (43); 42 CFR 431.200-206, 431.210-214, 431.220-231, 431.241-246, 431.300-306, 435.905, 435.906, 435.911, 435.912, 435.913, 435.919, 435.955 FS: 7 USC 2020; 7 CFR 272.1, 273.13, 273.14, 273.15
Non-discrimination	TANF: D.C. Code 4-205.19(i) GC: See TANF.	TANF: 45 CFR 260.35 FS: 7 USC 2020, 7 CFR 272.6, 7 CFR 273.6; Title VI of the Civil Rights Act of 1964

GENERAL RIGHTS OF APPLICANTS AND RECIPIENTS 1.3

ALL	<p>The following rights are held by applicants and recipients of all benefit programs and apply starting from the time an individual requests an application for assistance through termination of benefits. (As stated in Section 1.1: Introduction in this Chapter, each individual may have additional rights and/or limitations on these rights based on current statute and case law.)</p> <ul style="list-style-type: none">No applicant/recipient shall be discriminated against in the application or recertification process, the provision of services, the receipt of benefits, or the fair hearings and grievance process on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, disability, source of income or place of residence or business.
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Chapter 2 - Responsibilities of Applicants and Recipients

INTRODUCTION 2.1

Individuals applying for and/or receiving IMA benefits under the MA, TANF, GC, and/or FS programs are required to fulfill certain responsibilities in order to remain eligible for benefits. The Department and its staff shall inform applicants/recipients verbally and in writing about their responsibilities and what actions will result if they fail to carry them out.

'Recipients' are defined as persons to whom or on whose behalf public assistance is granted. 'Applicants' are defined as adults who do not receive benefits under these programs but who apply for benefits for themselves or other recipients (children or adults).

The following responsibilities are held by recipients/applicants of all benefit programs. (Each individual may have responsibilities and/or additions to these responsibilities based on current statute and case law in the District of Columbia). Failure to fulfill any or all of these responsibilities may result in ineligibility for benefits, ineligibility for future benefits, reduction of benefits, suspension of benefits, and/or termination of benefits. In addition, an individual's failure to comply with District and federal laws and regulations regarding the administration of IMA programs may result in prosecution for fraud, fines, and/or imprisonment.

Part V: Program Requirements provides more detail on certain non-procedural program requirements such as work requirements and child support cooperation requirements.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Responsibilities of Applicants and Recipients	TANF: D.C. Code 4-205; 29 DCMR 5800-5802, 5804, 5806 GC: D.C. Code 4-205, 4-205.5a	MA: 42 USC 1396a(a)(25); 42 CFR 435.610, 42 CFR 435.910 TANF: 45 CFR 261.10-261.14 FS: 7 USC 2015; 7 CFR 273.2, 273.12
Cooperation with CSED Requirements	TANF: D.C. Code 4-205.19; 4-217.8-10, 29 DCMR 1707	MA: 42 USC 1396a(a)(45), 42 USC 1396k; 42 CFR 433.145-148, 42 CFR 435.610 TANF: 45 CFR 264.30 - 264.31

GENERAL RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS 2.3

ALL	<p>The following are general responsibilities of the applicants/recipients of all benefit programs.</p> <ul style="list-style-type: none">• Each applicant/recipient shall answer all questions and requests for information completely and honestly. Each applicant/recipient will provide legitimate proof of statements made in the application or interview when it is required and/or requested by the Department.• Each applicant will provide needed verification within program designated time frames. Each recipient will provide needed verification within ten days after the Department asks for it.• Each applicant/recipient shall abide by all program rules. By signing the application for benefits, the applicant/recipient indicates that s/he and all recipients s/he represents will abide by all program rules. Otherwise, s/he will be subject to the penalties explained on the
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Chapter 3 - Rights and Responsibilities of the Department

INTRODUCTION 3.1

The Department is responsible for ensuring that applicant/recipient rights and responsibilities are respected and enforced. In addition, the Department has many additional rights and responsibilities in administering federal and local programs. This chapter does not detail all the rights and responsibilities of the Department, however, major program responsibilities of the Department are provided herein. Additional Department rights and responsibilities are detailed in the federal and local legislation governing IMA-administered programs and in the policies set forth in this Manual.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Responsibilities of the Department	ALL: D.C. Code 4-201.01-.04 TANF: D.C. Code 4-205; 3-209.4, 4-210 GC: See TANF and D.C. Code 4-205-5a	ALL: 42 USC 1320d; 45 CFR 164.500-534 MA: 42 USC 1396a(a)(3), (4), (7), (8), (43); 42 CFR 431.200-206, 431.210-214, 431.220-231, 431.241-246, 431.300-306, 435.905, 435.906, 435.907, 435.910-919 TANF: 45 CFR 260.35 FS: 7 CFR 272.1; 272.6; 273.2; 273.11; 273.13
Data Collection		MA: 42 CFR 435.960 TANF: 45 CFR 265 FS: 7 USC 2020, 7 CFR 272.6

GENERAL RIGHTS OF THE DEPARTMENT 3.3

The Department has the right to use and assign volunteers, community workers, and/or contractors to assist the Department in administering all aspects of IMA programs. However, only Department staff may determine eligibility for IMA programs.

In addition, the Department has the right to recoup TANF and FS benefits erroneously provided, even if the Department bears responsibility for the overpayment (see Section 6.3: Overpayments and Section 6.4: Recovery in Part VIII).

GENERAL RESPONSIBILITIES OF THE DEPARTMENT 3.4

ALL	<p>The Department has certain responsibilities to protect the individual and civil rights of applicants/Recipients in the operation and administration of IMA programs. They are as follows:</p> <ul style="list-style-type: none">The Department shall not discriminate against any applicant/recipient in the application or recertification process, the provision of services, the receipt of benefits or services, or the fair hearings or grievance process on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, disability, source of income or place of residence or business.
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	<p>Discrimination will not be tolerated, and persons engaging in such will be subject to disciplinary action.</p> <p>The Department is required to inform applicants and recipients of the offices where complaints of discrimination can be filed (complaints based on discrimination on the basis of marital status, personal appearance, sexual orientation, family responsibilities, source of income, matriculation, or place of residence or business must be filed with one of the D.C. agencies listed below):</p>		
	Agency	Address	Phone Number
	D.C. Office of Investigations and Compliance	2146 Georgia Avenue, NW Washington, D.C. 20001	202-673-6964 202-673-4464 (anonymous calls for fraud)
	D.C. Department of Human Services, Customer Service	645 H Street, NE Washington, D.C. 20002	202-724-5506
	D.C. Department of Human Services, IMA Administration Office	645 H Street, NE Washington, D.C. 20002	202-698-3900
	D.C. Office of the Public Advocate	2000 14th Street, NW Washington, D.C. 20009	202-673-4413
	U.S. Department of Agriculture, Office of Civil Rights	1400 Independence Ave., SW Room 326-W Washington, DC 20050	202-720-5964 (voice and TDD)
	U.S. Department of Health and Human Services, Office of Civil Rights	200 Independence Avenue, SW Room 506F Washington, D.C. 20201	202-619-0403 (voice) 202-619-3257 (TDD)
ALL	<ul style="list-style-type: none"> The Department is required to inform all applicants/recipients of IMA programs of the scope, conditions of eligibility, requirements, opportunity to register to vote, rights and responsibilities, and potential risks, fines, and consequences if program rules are violated. The Department is required to inform applicants/recipients that some but not all information provided by applicants/recipients and information about eligibility and benefits will be matched regularly with information from various employment databases, including but not limited to those maintained by the D.C. Department of Employment Services(DOES), U.S. Internal Revenue Service (IRS), Social Security Administration (SSA), and other states. The Department is required to inform applicants/recipients of the program provisions regarding fleeing felons and parole violators. The Department is also required to comply and respond to requests for information from law enforcement agencies on fleeing felons, parole violators, and those for whom there is a warrant for arrest. The Department must also disclose information to law enforcement and related authorities consistent with the National Security Act of 1947 and the "Uniting and Strengthening America Act by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT)" Act of 2001. The Department shall inform applicants/recipients of the Department's legal responsibility to respond to such requests for information (see Section 3.5: Confidentiality and Disclosure of Information in this Chapter). The Department is required to request data on the race and ethnicity of the households of applicants/recipients, but provision by the customer is voluntary. Although household race and 		

	<p>ethnicity will be self-determined, the Department is required to classify household race and ethnicity according to federally defined categories. The applicant's race and ethnicity will represent the race and ethnicity of the entire household.</p> <ul style="list-style-type: none"> • The Department must determine an applicant's eligibility for program benefits in accordance with timeliness standards (see Chapter 2: Processing Timeframes in Part III). Applicants must be notified in writing of the Department's eligibility determination. If an applicant is denied benefits, the applicant must be informed of the reason for the denial and the right to appeal the determination (see Section 3.4: Denied in Part III and Chapter 10: Notice of Adverse Action in Part VIII). • The Department is required to give timely and adequate notice to all recipients if the Department has determined a change in benefits including a plan to: <ul style="list-style-type: none"> ○ discontinue, ○ terminate, ○ suspend, ○ reduce benefits, or ○ change the manner or form of benefits • The Department is required to give notice to applicants/recipients of any reduction in or termination of benefits. The notice must contain the following: <ul style="list-style-type: none"> ○ the specific reasons and legal authority for the intended action or decision, ○ the conditions under which benefits and assistance are continued, ○ his/her right to a fair hearing on the proposed action, ○ the method for obtaining a fair hearing, ○ the right to representation, and ○ the availability of free legal counsel. • The Department is required to make the case record available to an applicant, recipient, an authorized representative of the household, or the legal representative of the household for examination during normal business hours upon request of the applicant/recipient or his/her authorized representative. However, the Department may withhold confidential information provided about the household without the household's knowledge, and the Department may withhold information concerning the nature or status of an ongoing criminal investigation or prosecution. However, the Department may not withhold information that forms the basis of an adverse action. • The Department will publicize the procedures for handling civil rights complaints, the Department's policies of non-discrimination, the procedures for reporting a civil rights violation, and the policies and procedures regarding fair hearings and agency conferences.
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CONFIDENTIALITY OF CUSTOMER INFORMATION 3.5

ALL	<p>All information regarding applicants/recipients will be held confidential by the Department and will not be disclosed to anyone without the prior notification and authorization of the individual or the individual's authorized representative. However, the Department is mandated to disclose certain information, with or without prior authorization or notification of the individual, under the following circumstances:</p> <ul style="list-style-type: none"> • The Department, its staff, and official agents are required to report suspected child abuse or neglect to the Department's Children and Family Services Agency (CFSA) and/or the District hotline for child abuse and neglect. In addition, the Department must share information with CFSA upon request. • The Department, its staff, and official agents are required to report on suspected crimes and
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	<p>illegal activity to local and federal law enforcement authorities. Additionally, the Department must report on individuals for whom there is a warrant for arrest.</p> <ul style="list-style-type: none"> • The Department, its staff, and official agents are required to report to the CSED and/or the U.S. Department of Health and Human Services (DHHS) information necessary to assist in establishing or verifying eligibility or benefits concerning parental child support. However, an individual has the right to claim good cause for refusing to cooperate with the Department in establishing paternity or obtaining child support (see Section 2.3: The Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with Child Support Enforcement Part V). • The Department is required to provide certain information to the Department of Homeland Security, Citizenship and Immigration Services (USCIS, formerly known as the Immigration and Naturalization Service or INS) and District, state, and federal law enforcement officials. All such requests are to be directed to the Administrator's Office. If an SSR, supervisor, or center manager receives a request from the USCIS or a law enforcement entity, no information can be released without approval from the Administrator. • The Department, its staff, and official agents are required to report to the U.S. Office of the Comptroller General, DHHS Office of the Inspector General, D.C. Office of the Inspector General and other appropriate Inspectors General information for audit examinations authorized by provisions of law. • The Department, its staff, and official agents are required to report through appropriate administrative channels some individual employment, income, and benefits information to the IRS, SSA, DHHS, USDA, and other state and federal authorities as authorized or required by law. <p>All customer information shall be used for official IMA functions. The use of customer information for any purpose not directly related to IMA business is strictly prohibited. Supervisory staff shall make reasonable efforts to limit access to and use of protected health information by staff to the minimum necessary to perform their duties.</p> <p>Staff who violate IMA's privacy policies or other applicable federal or state law are subject to adverse action in accordance with Chapter 16 of the District Personnel Manual and respective collective bargaining agreements. Staff are required to report any violations of IMA's privacy policies and should contact the Policy Unit, which will refer the matter to the DHS Privacy Officer. Reports can be made anonymously. Retaliation for reporting of violations or cooperation with investigations is prohibited and grounds for adverse action.</p>
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Informing the Applicant of His/Her Privacy Rights 3.5.1

ALL	The Department has a responsibility to inform the customer about the protection of their personal information, which includes any protected health information that they may disclose as part of the application process. SSRs should distribute the "Notice of Privacy Practices" when they give a Medical Examination Form (DHS Form 856) to an applicant who alleges that they are disabled or unable to participate in program activities because of their medical condition. The customer should then sign the "Acknowledgement of Receipt of Privacy Practices" (DHS Form 856-A), which the SSR should file in the customer's case record.
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Protecting the Confidentiality of Customer Records 3.5.2

ALL	All staff have a responsibility to protect the confidentiality of all customer information, including that within the case record. Within each Service Center, the case records are stored in a secure, employees-only area. SSRs may not leave any customer information within public view. Security personnel at IMA ensure that unauthorized persons do not enter these areas without an escort. This requirement applies to all visitors, even federal auditors.
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<p>For customers who submit Medical Forms but who are not determined to be blind or disabled, the Medical Review Team (MRT) maintains the Medical Form within the MRT suite, which is a secure, employees-only area at 645 H St, NE. During business hours, the suite is staffed with a dedicated receptionist who controls access to the single entrance to the work area. After hours, the suite is locked, and non MRT staff members are not able to access that work area until the following morning when the MRT re opens.</p>
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ROUTINE DISCLOSURES OF CUSTOMER INFORMATION 3.6

Disclosing Customer Information to the Customer or Authorized Representative 3.6.1

ALL	<p>Customers or their authorized representative(s) may request to review their own personal case record. SSRs should record any and all such disclosures in the case narrative (see below). However, SSRs shall under no circumstances disclose any customer information to an unidentified individual or to an unauthorized person. Please see Section 1.3: “General Rights of Applicants and Recipients” in this Part.</p> <p>To disclose such information to the customer, the SSR must first conclusively identify the customer by asking them to provide their correctly spelled name, date of birth, Social Security Number, and other information as appropriate. If the request is in writing, the SSR must compare the customer’s signature with that on the application and/or recertification forms contained in the case record.</p> <p>To disclose such information to an authorized representative, the SSR must conclusively identify the representative as an individual listed as an authorized representative on:</p> <ul style="list-style-type: none"> • the Authorization for Release of Information form (DHS Form 495-ARI); • the most recent application/recertification form; • an authorization or release, which is signed by the customer, from an attorney, legal advocate or other representative; or • the ADD2 screen in ACEDS. <p>If the request from the customer is in writing, the SSR may need to contact the authorized representative in order to confirm the identity of the person requesting the customer’s information. At the time of any disclosure, the SSR should note in the case narrative the following information:</p> <ol style="list-style-type: none"> 1. the date of the disclosure 2. the name of the entity or person who received the information and, if known, the address of such entity or person; 3. a brief description of the information disclosed; and 4. a brief statement of the purpose of the disclosure that reasonably documents the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure, if any. <p>In all circumstances, the SSR should release only the minimum necessary information to accomplish the purpose of the disclosure or request. The SSR should not disclose information that is peripheral, incidental or unrelated to the specific request or inquiry. If an SSR has questions about the appropriateness of releasing information, they should contact the IMA Policy Unit for further guidance.</p> <p>If the requestor is not listed on any of the documents above or on the ADD2 screen in ACEDS, the representative must produce a signed request by the customer asking that the information be released to the representative. Again, the SSR should compare the customer’s signature with that on the application and/or recertification forms contained in the case record. In the event that the customer is</p>
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	<p>deceased, the SSR should refer the requestor to the IMA Policy Unit for assistance.</p> <p>IMA will not disclose information to any authorized representative who is abusive or in any way disruptive to staff in the performance of their duties.</p> <p>If the request is less than 100 pages, the SSR should not assess any fees for the cost of copying the disclosed material. Requests in excess of 100 pages should be referred to the IMA Policy Unit.</p> <p>Any request by a customer for an accounting of all disclosures should be forwarded to the IMA Policy Unit, which will refer the matter to the DHS Privacy Officer as appropriate.</p>
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Requests for Information from All Other Parties 3.6.2

Should an SSR receive a request to review a customer's case record from a person other than the customer or their authorized representative, the SSR should refer the requestor to the Administrator. An SSR should never disclose information to such persons in the absence of a signed, verified request from the customer. Please see Section 3.7: Non-Routine Disclosures of Customer Information in this Part.

NON-ROUTINE DISCLOSURES OF CUSTOMER INFORMATION 3.7

Exclusive Role of the Administrator/Designee in Non-Routine Disclosures 3.7.1

ALL	<p>Only the Administrator or the Administrator's explicit designee may authorize the disclosure of customer information to a requestor who is not an authorized representative of a customer. For this reason, SSRs should refer all non-routine requests for customer information to the Administrator. This would include all requests from law enforcement officials, unauthorized neighbors, subpoenas, etc.</p> <p>The Office of the Administrator shall maintain a log of all such requests and maintain copies of the correspondence between the Administrator and the requestor(s). The log shall include the following information:</p> <ul style="list-style-type: none"> • the date of the disclosure; • the name of the entity or person who received the information and, if known, the address of such entity or person; • a brief description of the information disclosed; and • a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure, if any. <p>As a matter of practice, the Administrator shall deny all such requests unless the requestor can provide verification that s/he is an authorized representative of the customer. If the request is in the form of an administrative or judicial subpoena, the Administrator shall immediately contact the Office of the General Counsel. Except in rare circumstances allowed under federal and District law, the General Counsel shall seek to quash all such subpoenas. In the event that the subpoena is upheld, the Administrator shall provide only that information delineated in the subpoena. To the extent allowed by federal and District law and the judicial order, the disclosure will be noted in the case record.</p>
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Customer Service Unit Disclosures to Qualified Medical Providers 3.7.2

ALL	Because qualified medical providers have signed a provider agreement with the Medical Assistance
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	<p>Administration, the disclosure of customer eligibility information is considered “routine.” Accordingly, the Administrator has authorized the Customer Service Unit (CSU) to provide qualified medical providers with current eligibility information for their patients. Except in exigent circumstances, providers should access eligibility information via the ACEDS system or through the Eligibility Verification System (EVS) dial-up. CSU staff should refer providers to these systems because of both (a) work volume issues and (b) only EVS maintains information on a customer’s Medicaid managed care status.</p> <p>In the event that the EVS system is unavailable and a qualified medical provider cannot access ACEDS, CSU staff may verify a customer’s eligibility status. Disclosures by CSU staff are strictly limited to Medicaid eligibility information. CSU staff may disclose only the customer’s eligibility information for the current period and recent past. CSU staff may never disclose any other customer information (e.g., date of birth, address, Social Security number, Medicare number, disability status, ACEDS program code, etc.) to any other provider or unauthorized requestor.</p> <p>In the event that CSU staff members need to disclose information to a qualified medical provider, they must first conclusively identify the caller or requestor. Once the requestor is positively identified, the SSR may provide eligibility information for a customer with the exact spelling provided by the medical provider. If the identity information (e.g., spelling of names, date of birth, or Social Security number) does not match the customer’s record, the CSU may not provide any information.</p>
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THE PRIVACY OF HEALTH INFORMATION 3.8

ALL	<p>Recent legislation known as the Health Insurance Portability and Accountability Act (HIPAA) establishes uniform standards for the protection of health information in the context of medical treatment, payment, and health care operations. With respect to HIPAA, the District regards IMA as a “hybrid” entity, one that is not a health care organization but nonetheless maintains some limited amount of health information. This “hybrid” designation does not in any way dilute the pre-existing confidentiality protections that IMA had in place under the more stringent Medicaid, Food Stamps, and TANF (formerly AFDC) statutes; rather, it reinforces those procedures that have been used within those programs.</p> <p>The relevance of HIPAA to IMA is largely limited to the protection of health information. The confidentiality policies detailed above satisfy HIPAA’s requirements around the disclosure of customer information. Described below are IMA’s policies regarding the other HIPAA components that are germane to this agency. Please note that the terms used below are borrowed from the HIPAA text; thus, some of the information may not immediately appear relevant to an organization such as IMA, which is only indirectly involved with the provision or payment of health care services.</p>
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Amending Information on a Medical Examination Form 3.8.1

ALL	<p>Neither customers nor their authorized representatives may amend submitted Medical Examination Forms (DHS Form 856), which their clinician originally completed and they themselves provided to IMA. Likewise, IMA staff cannot amend in any way the Medical Examination Forms. Because IMA did not generate the information, the agency does not have the clinical or legal capacity to amend it.</p> <p>However, customers or their authorized representative(s) may request to append information to their Medical Examination Forms and/or case record. To do so, customers can submit supplemental information from a clinician or they can submit another Medical Examination Form. Alternatively, a</p>
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	customer may request a Fair Hearing. Outside of these options, customers may not amend a submitted Medical Examination Form or other information in their case record in any other way.
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Maintenance of Customer Records 3.8.2

ALL	IMA shall retain all information in a customer's record for at least three (3) years after the case is closed. A log of the disclosures of customer information shall be kept for at least six (6) years and shall be disclosed to an applicant, recipient or individual's representative upon written request in a manner consistent with the policy and procedures outlined above.
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SAFEGUARDING INFORMATION AND TRAINING ON SAFEGUARDING INFORMATION 3.9

ALL	<p>Pursuant to Publication 1075 from the National Institute of Standards and Technology (NIST) in furtherance of its statutory responsibilities under the Federal Information Security Management Act (FISMA) of 2002, Public Law 107-347, this policy is established in order to maintain and safeguard privileged and private government and customer information obtained from other agencies. As such, the District of Columbia Access System/Automated Client Eligibility Determination System (herein after, "DCAS /ACEDS") personnel/users are required to participate in an initial training class for current users and when newly hired, and an annual training requirement thereafter, which emphasizes the safeguarding of privileged information. They must also sign a security disclosure statement at the conclusion of the training that indicates their cooperation and compliance with this policy. Any DCAS/ACEDS personnel/user that does not satisfactorily complete the training class, and submit a signed disclosure statement, will not have access to DCAS /ACEDS until these requirements are met. A signed disclosure statement for all DCAS/ACEDS personnel/users must be on file with the Division of Program Development and Training ("DPDT") before access to the DCAS/ACEDS system is granted.</p> <p>Internal Procedures for Disclosure Statement(s):</p> <ul style="list-style-type: none"> • New DCAS/ACEDS personnel/users that complete the training will not have access to the system until they submit their disclosure statement to the DPDT training staff. • Current DCAS/ACEDS personnel/users will have fifteen (15) calendar days from the completion of their training to submit a signed disclosure statement. If the statement is not submitted within the fifteen (15) days, then on the 16th day their user access will be denied until the signed statement is submitted to the DPDT training staff. • Each DCAS/ACEDS personnel/user will receive a disclosure statement at the beginning of the Safeguards & Awareness Training. • The disclosure document will be reviewed during the training. • The DPDT Trainer must notify Program Managers/Deputies whenever a new or current DCAS/ACEDS user has not satisfactorily completed the test and submitted a disclosure statement at the conclusion of their training. • Program Managers/Deputies must follow-up with users to ensure the signed disclosure statement is submitted, and, if not, take the appropriate personnel action for that user. <p>Training and Implementation Procedures:</p> <ul style="list-style-type: none"> • All levels of personnel, including, but not limited to, management, administration, technical personnel, design/developer personnel, and program personnel involved in the DCAS/ACEDS workflow will be required to participate in an initial and on-going annual training class for Safeguarding and Awareness of privileged and private vital government and customer information. • A test will be administered at the conclusion of each offered training class in order to determine each user's comprehension of the information. • DCAS/CEDS personnel/users will have to repeat the training class if they score less than 75%
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on the test.

- DCAS/ACEDS personnel/users will have the opportunity to make up the training, if they miss the scheduled training, or fail the test at the conclusion of the training, within 15 days from the initial training offer date.
- This training will be offered every year, and a review of the training materials and information will be conducted annually to determine if changes to materials and information presented are warranted.
- An evaluation of the training will be done by each DCAS/ACEDS user to determine the need for additional training and/or other desired training needs each year.
- An outline of the initial training will consist of the following components:
 - Purpose,
 - Introduction,
 - Objectives,
 - IRS information,
 - SSA and NDNH information,
 - IRS, SSA, and NDNH roles,
 - ESA responsibility for confidentiality,
 - Exception to print IRS screen,
 - Penalty for unauthorized disclosure,
 - Need to know disclosure, and
 - Summary.

Coordination and compliance amongst organizational entities: DPDT on behalf of DCAS/ACEDS will coordinate Safeguarding Awareness Training Classes for appropriate agencies, facilities, clinics, contractors, and/or outreach centers that have access to privileged and vital customer information.

Non-disclosure and Authorized Official Usage: DCAS/ACEDS personnel/users must not disclose, or cause to be disclosed, verbally or in writing, and/ or engage in unauthorized use or disclosure of privileged government/customer information pursuant to regulations under the Internal Revenue Service (IRS), Personally Identifiable Information (PII), and/or Health Information Portability and Accountability Act (HIPAA), but not limited to these regulations.

DCAS/ACEDS personnel/users must protect personal information of customers by safeguarding the information, and not leaving documentation unsecured in their workstation for anyone to see, obtain, or take from the work area. DCAS/ACEDS personnel/users must only share sensitive information with those who need it to perform their duties in conducting official business pertaining to the determination of eligibility for public benefits in the District of Columbia. (Note: DCAS/ACEDS will be monitored and tracked on a regular basis to ensure appropriate usage of the system, i.e., authorized, official case review/action).

For Example: Molly & Sue are friends. Molly is a DCAS personnel/user. Sue calls Molly and asks her to verify or look up information regarding her estranged husband's income status. Molly, willing to help her friend, Sue, looks up the husband's information since she has access to it at her center. By following through on Sue's request, Molly is engaging in unauthorized and unofficial case review/action. Thus, Molly can be subjected to penalties, including loss of wages, loss of job, imposed fines, and she can be held personally liable in a civil action for her unauthorized use and disclosure of privileged information.

Non-reproduction Requirements: Additionally, DCAS/ACEDS Data where identified in the system(s) must remain strictly confidential, and must not be printed as a hard copy under any circumstances. The specific screen will say "Do not print".

Handling of Federal Tax Information ("FTI"): DCAS/ACEDS personnel/users must not include or cause

	<p>to be copied, transmitted via means including, but not limited to, e-mail and facsimile (See <i>Policy on the Prohibition of FTI via email and fax</i>), or transcribed any federal tax information received into the customer's file, or the case narrative. Despite the format of the document received, anything from IRS, New Hires and BEERS must be treated as confidential. DCAS/ACEDS personnel/users can only use information that is independently verified to effect case action. Additionally, DCAS/ACEDS personnel/users must not identify FTI, BEERS or NDNH as data sources when requesting additional information from the customer or a third party to verify the information.</p> <p>Need to Know Disclosure: Federal Tax information, SSA, PII, HIPAA and/or NDNH information is permissible to disclose to other DCAS/ACEDS personnel/user when there is collaboration in a case and the information is needed to perform official job duties. Disclosure of privileged information is on a need-to-know basis between DCAS/ACEDS personnel/users.</p> <p>Penalties Imposed for Non-compliance: Pursuant to Title 26 U.S. Code IRC Sections 7431, 7213(a) and 7213A, unauthorized disclosure means to make tax return, SSA and/or NDNH information known to anyone in any unauthorized manner. DCAS/ACEDS personnel/users, current or former, will be penalized for disclosure of information related to confidential tax information, Social Security Administration (SSA), PII, HIPAA, or National Directory of New Hires ("NDNH") information to anyone who is not entitled to and/or authorized to the information. Pursuant to local and federal law, penalties may include monetary fines up to \$5,000.00, and (5) years imprisonment. Additionally, the penalty for unauthorized disclosure of HIPAA information is from \$100.00 to \$50,000.00. Also, under IRC Section 7431, a tax payer can sue a person in a civil action case and they can be held personally liable for unauthorized use and disclosure of a customer's information and/or inappropriate disclosure of the information.</p>
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PROHIBITION OF TRANSMITTING FEDERAL TAX INFORMATION VIA EMAIL OR BY FACSIMILE 3.10

ALL	<p>Handling of Federal Tax Information ("FTI"): If and when FTI, BEERS or NDNH data is received or held in paper form and/or in an electronic format, DCAS/ACEDS personnel/users are prohibited from transmitting or causing to be transmitted FTI for any reason via means including, but not limited to, e-mail and/or facsimile, including federal tax information related to Hearings and Appeals. Despite the format of the document received, anything from IRS, New Hires and BEERS must be treated as confidential.</p>
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	<p>application such as removal of needs, fines, imprisonment, or disqualification from receiving future assistance payments.</p> <ul style="list-style-type: none"> • Each applicant/recipient household member will cooperate in any subsequent review or certification of program eligibility. • Each applicant/recipient will cooperate with the Department in determining and recertifying eligibility and benefits and will cooperate with Department and federal staff conducting quality control reviews or audits of IMA programs. • Each applicant/recipient will not alter, sell, trade, or transfer any IMA benefits or privileges, including EBT cards, MA identification cards, or other documents or cards which remain the property of the Department. Individuals will immediately surrender any cards or documentation remaining the property of the Department following written notice by the Department. • Each applicant/recipient must provide financial and non-financial information, and report circumstance changes in a timely manner as required by the relevant program.
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SPECIFIC PROGRAM RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS 2.4

In addition to the above general responsibilities, applicants/recipients also have the following program-specific responsibilities:

MA	<ul style="list-style-type: none"> • Each applicant/recipient will report changes in financial and non-financial eligibility information within 10 days of the change. • Each applicant/recipient, before using MA benefits, will use all other available medical insurance, including other medical insurance coverage, veterans' benefits, and veterans' facilities. • Each applicant/recipient will agree to assign to the Department and DOH the right to third-party payment (such as other health insurance that will cover the cost of services received) for care, treatment, and services provided under the MA program. • Each applicant/recipient, unless exempt, will be required to enroll with one of the managed care organizations that the District has contracted with to provide care to Medicaid recipients. People exempt from this requirement include the elderly, people with disabilities (SR), and people living with HIV. • Each applicant/recipient receiving MA coverage or benefits who institutes a legal proceeding against or enters into settlement negotiations with a third party regarding medical claims must provide written notice of the action to the Medical Assistance Administration (MAA) within 20 calendar days. • Parents and caretakers with children receiving MA will cooperate with the Child Support Enforcement Division (CSED) of the Office of Corporation Counsel in the determination of a child's biological and/or legal parent and in the establishment of a medical support order. However, applicants completing the DC Healthy Families Application may request quick referral for CSED services. The adult applicant/recipient's cooperation is a condition for receipt of MA benefits by the adult, unless the applicant/recipient has good cause for failing to cooperate (see Section 2.6: Good Cause for Non-Cooperation in Part V). An applicant/recipient's cooperation may include: <ul style="list-style-type: none"> ○ naming the absent parent of any child applying for or receiving MA; ○ providing information to assist the Department in locating the absent parent; ○ assisting in the establishment of legal paternity or parental status; ○ agreeing to submit to blood tests, if needed to identify a beneficiary child's biological parents; and
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	<ul style="list-style-type: none"> o providing information on additional medical insurance available to the child receiving MA benefits. <p>If an adult fails to cooperate with CSED requirements, the adult is ineligible for MA, but the child's eligibility is not affected.</p>
TANF	<ul style="list-style-type: none"> • Each applicant/recipient will report changes in non-financial eligibility information within 10 days of the change. Each applicant/recipient will report changes in financial information within 10 days of the change, unless notified of Simplified change reporting requirements. • Each applicant/recipient household member will repay assistance erroneously received, even when due to Department error (see Chapter 6: Overpayment and Underpayment in Part VIII). • Each applicant/recipient household member will provide the proof required to determine composition of the household. • Each applicant/recipient, unless exempt, will participate in mandatory employment, education, and/or training activities as a requirement for receiving benefits (see Chapter 1: Work Requirements in Part V). • Each applicant/recipient who is not exempt from work or work-related activity must report in a timely fashion on hours worked in each activity to the Department or its representative. • Each applicant/recipient will cooperate with the Department and CSED in the determination of a child's biological and/or legal parent and in the determination and collection of child and medical support. Failure to cooperate with CSED requirements without good cause will result in a 25 percent reduction in the group's TANF grant (see Section 2.3: The Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with Child Support Enforcement in Part V). An applicant/recipient's cooperation may include: <ul style="list-style-type: none"> o naming the absent parent of any child applying for or receiving TANF; o providing information to assist the Department in locating the absent parent; o assisting in the establishment of legal paternity or parental status; o agreeing to submit to blood tests, if needed to identify a beneficiary child's biological parents; and o providing information on additional medical insurance available to the child receiving TANF benefits.
GC	See TANF, except there are no child support or work requirements associated with the GC program and the caretaker/payee does not need to report changes of the non-GC household members.
FS	<ul style="list-style-type: none"> • Each applicant/recipient will report to the Department changes in unearned income of more than \$50, except changes in TANF or GC grants, and changes in earned income of more than \$100, unless notified of Simplified change reporting requirements. • Each applicant/recipient will use FS benefits to purchase only allowable food items (see-Section 2.5.1: Benefits Provision in Part I). • Each applicant/recipient household member will repay assistance erroneously received, even when due to Department error (see Section 6.3: Overpayments and Section 6.4: Recovery in Part VIII). • Each applicant/recipient household member will provide the proof required to determine composition of the household, when questionable. • Each applicant/recipient household member will cooperate with a Quality Control Review (QCR) of eligibility. • Each applicant/recipient, unless exempt, will participate in the FSET or a program component for education, and/or training activities as a requirement for receiving benefits (see Chapter 1: Work Requirements in Part V).

An applicant/recipient who believes that s/he has been discriminated against may file a complaint with the offices listed in the following table (complaints based on discrimination on the basis of marital status, personal appearance, sexual orientation, family responsibilities, source of income, matriculation, or place of residence or business must be filed with one of the D.C. agencies listed below):

Agency	Address	Phone Number
D.C. Department of Human Services, Customer Service	645 H Street, NE Washington, D.C. 20002	202-724-5506
D.C. Office of Human Rights and Local Business Development	441 4th Street, NW Suite 970N Washington, D.C. 20001	202-724-1385
D.C. Office of Investigations and Compliance	2146 Georgia Avenue, NW Washington, D.C. 20001	202-673-6964 202-673-4464 (anonymous calls for fraud)
D.C. Office of the Public Advocate	2000 14th Street, NW Washington, D.C. 20009	202-673-4413
U.S. Department of Agriculture, Office of Civil Rights	1400 Independence Ave., SW, Room 326-W Washington, DC 20050	202-720-5964 (voice and TDD)
U.S. Department of Health and Human Services, Office of Civil Rights	200 Independence Avenue, SW Room 506F Washington, D.C. 20201	202-619-0403 (voice) 202-619-3257 (TDD)

- Each applicant/recipient has the right to be informed verbally and in writing of his/her rights, obligations, responsibilities, potential risks, and penalties under these benefit programs.
- Each applicant/recipient has a right to privacy. Information unrelated to the eligibility process cannot be requested by the Agency.
- All information regarding an applicant/recipient shall be used only for determining and administering benefits and shall be safeguarded against disclosure without prior authorization by the applicant/recipient or his/her legal representative, except as noted in Section 3.5: Confidentiality and Disclosure of Information in this Part.
- Each applicant/recipient has a right to have information collected kept private by the Department. Data collected and maintained by District agencies is private, unless specifically classified otherwise by law. Although this data is considered private, applicants/recipients or representatives may review private records which contain data or information on them. Private or public data must actually be shown to the subject of the data and not summarized. Data on two or more people maintained in a common file because of family relationships are 'joint records'. Delete material in joint records about the person not requesting the review to protect that person's privacy. Parents may view records of their minor children, unless the agency decides that the request is not in the best interests of the children. Provide copies of original documents when requested by the subject of the data or the subject's authorized representative.

	<ul style="list-style-type: none"> • Each applicant/recipient has the right to examine his/her case record. The Department will provide his/her case record for examination by the applicant/recipient during normal business hours, or the Department will make copies available at the cost of reproduction. The Department may withhold confidential information about the applicant/recipient obtained without his/her knowledge, confidential information about other individuals contained within the household's shared case record, or information on the nature and status of pending criminal prosecutions. However, all information that forms the basis of an adverse action must be released. • The public has the right to examine handbooks, manuals, and supplemental instructions issued by the Department concerning the administration of IMA programs and policies. The Department will make these documents available within ten days of the date of request for examination by the public during normal business hours. • Each applicant/recipient has the right to be represented by or accompanied and assisted by an individual of his/her choice in all contacts with the Department, including during application, eligibility determination, recertification/redetermination, administrative review, and fair hearing. • Each applicant/recipient has the right to appeal any action or decision made by the Department, and each individual has the right to have an administrative review or a fair hearing regarding any action or decision made by the Department. • Each applicant/recipient who has received an adverse fair hearing decision regarding the receipt of benefits has the right to request a judicial review. • An individual does not forfeit or compromise any of these rights by applying for benefits, receiving benefits, requesting a fair hearing or administrative review, requesting a judicial review, or reporting discriminatory or unfair practices.
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SPECIFIC PROGRAM RIGHTS OF RECIPIENTS 1.4

ALL	<p>Each recipient has the following rights:</p> <ul style="list-style-type: none"> • to timely and adequate notice by the Department when it intends to: <ul style="list-style-type: none"> ○ discontinue, ○ terminate, ○ suspend, ○ reduce benefits, or ○ change the manner or form of benefits. • to receive notice of a change in or termination of benefits including: <ul style="list-style-type: none"> ○ the specific reasons and legal authority for the intended action or decision, ○ the conditions under which benefits and assistance are continued, ○ his or her right to a fair hearing on the proposed action, ○ the method for obtaining a fair hearing, and ○ the right to representation. • to be afforded a reasonable opportunity to resolve the discrepancy before a determination of eligibility can be made when unverified information from a source other than the household contradicts statements made by the household. • to timely notice during which assistance shall not be suspended, reduced, or terminated, or the manner of payment changed until: <ul style="list-style-type: none"> ○ the advance notice period has expired and the applicant/recipient has not requested a hearing, or ○ a hearing decision is reached. • to request, verbally or in writing, a fair hearing within 90 days following the effective date of a notice of adverse action. If the request for a fair hearing is made before the effective date of the adverse action, the benefit will continue to be provided (unless the customer
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	requests not to have benefits paid pending appeal). TANF and FS benefits paid pending a hearing decision will be considered overpayments if the Department's proposed action is upheld.
MA	MA recipients must be notified of and afforded the right to free legal counsel.
TANF	See MA. In addition, each adult recipient has the right to exercise personal decisions regarding the use of the TANF cash grant except in cases in which a protective payee or involuntary rental vendor payment has been established (see Chapter 11: Restricting TANF Payments in Part VIII).
GC	See MA
FS	See MA Information on the loss of an EBT card has been moved to Section 5.7: Loss of Benefits in Part VIII.

SPECIFIC PROGRAM RIGHTS OF APPLICANTS 1.5

ALL	<p>The following rights are held by applicants who apply for benefits for themselves or on behalf of other adults or children:</p> <ul style="list-style-type: none"> • Each applicant has the right to apply for assistance without delay, including the rights to: <ul style="list-style-type: none"> ○ receive and file an application for benefits the same day s/he contacts the Department if s/he contacts the agency during office hours; ○ receive assistance in completing the application in person within the same day if requested; ○ have an application mailed on the same business day to individuals requesting an application by mail or telephone. 'Mail' refers to the transmittal of all written communications and documents and may include, but is not limited to, the U.S. Postal Service, other commercial delivery services, and electronic communications or document transmission technology, such as electronic mail or the Internet; and ○ apply for benefits at any time, including while a fair hearing request is pending or after a hearing decision has been made. • Each applicant has the right to an initial application interview in the home or on the telephone if an adult representative is unable to go to the service center because of one of the following circumstances: <ul style="list-style-type: none"> ○ the applicant or adult representative has a mental or physical medical condition that prevents visiting a Department office or service center; ○ the applicant is over age sixty-five (over age sixty under the FS program); or ○ the authorized program manager (center manager) determines on a case-by-case basis the need to conduct an in-home or telephone interview <p>'Telephone' refers to any mode of real-time, person-to-person telecommunications, including but not limited to the telephone, telecommunications device for the deaf (TDD), teletypewriter (TTY), videophone, teleconferencing, or other electronic telecommunications device.</p> • Each applicant has the right to adequate written notice that his/her application for benefits has been approved or denied. If the application is approved, the applicant shall receive a written notice stating what benefits are granted. If the application is denied, the written notice shall include the following: <ul style="list-style-type: none"> ○ a statement of the reason for denial; ○ the specific regulation supporting such action; and ○ an explanation of the applicant's right to request a fair hearing, to be represented at the hearing, and the availability of low or no cost legal services from public and
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	private sources.
MA	<ul style="list-style-type: none"> Each applicant shall have a timely disposition. For non-disability-related MA applicants, 'timely disposition' means the right to receive a determination of MA eligibility within 45 days after filing an application, provided that the Department received the required information in a timely manner (see Section 2.3: Time Standards in Part III for a full discussion of application processing timeframes, including a discussion of circumstances under which the timeframes can be extended). <p>For disability-related MA cases (SR), the Department has 90 days to make an eligibility determination. If after 45 days the disability determination has not yet been made, the Department must assess the individual's eligibility for MA for all non-financial and financial criteria except disability. Within 90 days, the full MA eligibility determination must be made. If found eligible for disability-related MA, eligibility is retroactive to the date of application.</p> <p>If an individual establishes eligibility for Medicaid under a non-disability related Medicaid category (such as a disabled parent who has income of less than 200 percent of the FPL) prior to establishing disability, the individual's Medicaid application must be approved under the non-disability related program type (AR or AX). However, the applicant maintains the right to be considered for SR Medicaid. Persons on SR Medicaid are not placed in managed care. If disabled caretakers wish to receive services in the fee-for-service system, they must complete the medical evaluation form or provide proof of a Social Security Administration (SSA) determination of disability. Since the SSA shares eligibility information with IMA through computer matching (BENDEX and SDX interfaces), the SSR must use any verification of disability status that is available through these sources. If the applicant/recipient wishes to receive services through the fee-for-service system, the case should be converted to SR Medicaid after disability is confirmed.</p> <ul style="list-style-type: none"> Each applicant has the right, verbally or in writing, to request a fair hearing within 90 days following the denial of eligibility. If this occurs, no benefits will be paid until and unless a decision is made in favor of the applicant. Each applicant enrolled in and served by a health benefits plan as part of his/her MA benefits has additional rights to grievance procedures under D.C. Law 12-274, Health Benefits Plan Members Bill of Rights Act of 1998.
TANF	<ul style="list-style-type: none"> Each applicant shall have the right to a timely disposition, including the right to receive a determination of TANF eligibility within 45 days after filing an application, provided that the Department received the required information in a timely manner (see Section 2.3.1: Household-Caused Delays in Benefits Processing in Part III). Each applicant has the right, verbally or in writing, to request a fair hearing within 90 days following the denial of eligibility. If this occurs no benefits will be paid until and unless a decision is made in favor of the applicant. Each applicant has the right to refuse to admit any representative of the Department into his/her home for an inspection of the premises.
GC	<ul style="list-style-type: none"> See TANF, except there is no right to refuse access to a Home Review investigator.
FS	<ul style="list-style-type: none"> Each applicant shall have a timely disposition, including the right to receive a determination of FS eligibility within 30 days of application, provided the Department received the information in a timely manner.

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| | <ul style="list-style-type: none">• Each applicant has the right to be screened for expedited FS. If the applicant is eligible for expedited FS, the benefits, and an EBT card to access them, must be made available within seven days.• Each applicant has the right to file an FS complaint which is forwarded to the United States Department of Agriculture.• Each applicant has the right to request a fair hearing within 90 days following an adverse action.• Each applicant has the right to request a waiver of the eligibility or recertification interview in an office of the Department because the individual has or is involved in one of the following:<ul style="list-style-type: none">○ illness,○ dependent care responsibilities,○ mental or physical handicap,○ inclement weather,○ transportation difficulties,○ age sixty or older, or○ work schedule prevents individual from going to the service center. |
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The Department will determine on a case-by-case basis whether to reschedule an in-office interview or schedule a telephone or in-home interview.

Part II

Chapter 1 - Rights of Applicants and Recipients

INTRODUCTION 1.1

All applicants and recipients have rights under various District and federal laws. These rights include the right to fair treatment, to privacy and confidentiality, to information about the programs and client's responsibilities, and to appeal certain actions and decisions. The Department and its staff should inform applicants and recipients verbally and in writing about their rights.

'Recipients' are defined as persons to whom or on whose behalf public assistance is granted. 'Applicants' are defined as adults who do not receive benefits under these programs but who apply for benefits for themselves or other children or adults.

This chapter details and explains the rights of recipients and applicants under these benefit programs; however, applicants, recipients, and the Department may have other rights as determined by current statute and case law. Department staff should refer specific legal questions to the Office of General Counsel (OGC).

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Rights of Applicants and Recipients	TANF: D.C. Code 4-205.55, 4-205.56, 4-205.59, 4-205.64, 4-205.66, 4-208.1, 4-208.3; 29 DCMR 1708, 5803, 5805, 5817 GC: D.C. Code: 4-205-5a, 4-205.55, 4-205.56, 4-205.59, 4-208.1, 4-208.3	MA: 42 USC 1396a(a)(3), (4), (7), (8), (43); 42 CFR 431.200-206, 431.210-214, 431.220-231, 431.241-246, 431.300-306, 435.905, 435.906, 435.911, 435.912, 435.913, 435.919, 435.955 FS: 7 USC 2020; 7 CFR 272.1, 273.13, 273.14, 273.15
Non-discrimination	TANF: D.C. Code 4-205.19(i) GC: See TANF.	TANF: 45 CFR 260.35 FS: 7 USC 2020, 7 CFR 272.6, 7 CFR 273.6; Title VI of the Civil Rights Act of 1964

GENERAL RIGHTS OF APPLICANTS AND RECIPIENTS 1.3

ALL	<p>The following rights are held by applicants and recipients of all benefit programs and apply starting from the time an individual requests an application for assistance through termination of benefits. (As stated in Section 1.1: Introduction in this Chapter, each individual may have additional rights and/or limitations on these rights based on current statute and case law.)</p> <ul style="list-style-type: none">No applicant/recipient shall be discriminated against in the application or recertification process, the provision of services, the receipt of benefits, or the fair hearings and grievance process on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, disability, source of income or place of residence or business.
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Chapter 2 - Responsibilities of Applicants and Recipients

INTRODUCTION 2.1

Individuals applying for and/or receiving IMA benefits under the MA, TANF, GC, and/or FS programs are required to fulfill certain responsibilities in order to remain eligible for benefits. The Department and its staff shall inform applicants/recipients verbally and in writing about their responsibilities and what actions will result if they fail to carry them out.

'Recipients' are defined as persons to whom or on whose behalf public assistance is granted. 'Applicants' are defined as adults who do not receive benefits under these programs but who apply for benefits for themselves or other recipients (children or adults).

The following responsibilities are held by recipients/applicants of all benefit programs. (Each individual may have responsibilities and/or additions to these responsibilities based on current statute and case law in the District of Columbia). Failure to fulfill any or all of these responsibilities may result in ineligibility for benefits, ineligibility for future benefits, reduction of benefits, suspension of benefits, and/or termination of benefits. In addition, an individual's failure to comply with District and federal laws and regulations regarding the administration of IMA programs may result in prosecution for fraud, fines, and/or imprisonment.

Part V: Program Requirements provides more detail on certain non-procedural program requirements such as work requirements and child support cooperation requirements.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Responsibilities of Applicants and Recipients	TANF: D.C. Code 4-205; 29 DCMR 5800-5802, 5804, 5806 GC: D.C. Code 4-205, 4-205.5a	MA: 42 USC 1396a(a)(25); 42 CFR 435.610, 42 CFR 435.910 TANF: 45 CFR 261.10-261.14 FS: 7 USC 2015; 7 CFR 273.2, 273.12
Cooperation with CSED Requirements	TANF: D.C. Code 4-205.19; 4-217.8-10, 29 DCMR 1707	MA: 42 USC 1396a(a)(45), 42 USC 1396k; 42 CFR 433.145-148, 42 CFR 435.610 TANF: 45 CFR 264.30 - 264.31

GENERAL RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS 2.3

ALL	<p>The following are general responsibilities of the applicants/recipients of all benefit programs.</p> <ul style="list-style-type: none">• Each applicant/recipient shall answer all questions and requests for information completely and honestly. Each applicant/recipient will provide legitimate proof of statements made in the application or interview when it is required and/or requested by the Department.• Each applicant will provide needed verification within program designated time frames. Each recipient will provide needed verification within ten days after the Department asks for it.• Each applicant/recipient shall abide by all program rules. By signing the application for benefits, the applicant/recipient indicates that s/he and all recipients s/he represents will abide by all program rules. Otherwise, s/he will be subject to the penalties explained on the
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Chapter 3 - Rights and Responsibilities of the Department

INTRODUCTION 3.1

The Department is responsible for ensuring that applicant/recipient rights and responsibilities are respected and enforced. In addition, the Department has many additional rights and responsibilities in administering federal and local programs. This chapter does not detail all the rights and responsibilities of the Department, however, major program responsibilities of the Department are provided herein. Additional Department rights and responsibilities are detailed in the federal and local legislation governing IMA-administered programs and in the policies set forth in this Manual.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Responsibilities of the Department	ALL: D.C. Code 4-201.01-.04 TANF: D.C. Code 4-205; 3-209.4, 4-210 GC: See TANF and D.C. Code 4-205-5a	ALL: 42 USC 1320d; 45 CFR 164.500-534 MA: 42 USC 1396a(a)(3), (4), (7), (8), (43); 42 CFR 431.200-206, 431.210-214, 431.220-231, 431.241-246, 431.300-306, 435.905, 435.906, 435.907, 435.910-919 TANF: 45 CFR 260.35 FS: 7 CFR 272.1; 272.6; 273.2; 273.11; 273.13
Data Collection		MA: 42 CFR 435.960 TANF: 45 CFR 265 FS: 7 USC 2020, 7 CFR 272.6

GENERAL RIGHTS OF THE DEPARTMENT 3.3

The Department has the right to use and assign volunteers, community workers, and/or contractors to assist the Department in administering all aspects of IMA programs. However, only Department staff may determine eligibility for IMA programs.

In addition, the Department has the right to recoup TANF and FS benefits erroneously provided, even if the Department bears responsibility for the overpayment (see Section 6.3: Overpayments and Section 6.4: Recovery in Part VIII).

GENERAL RESPONSIBILITIES OF THE DEPARTMENT 3.4

ALL	<p>The Department has certain responsibilities to protect the individual and civil rights of applicants/Recipients in the operation and administration of IMA programs. They are as follows:</p> <ul style="list-style-type: none">The Department shall not discriminate against any applicant/recipient in the application or recertification process, the provision of services, the receipt of benefits or services, or the fair hearings or grievance process on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, disability, source of income or place of residence or business.
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	<p>Discrimination will not be tolerated, and persons engaging in such will be subject to disciplinary action.</p> <p>The Department is required to inform applicants and recipients of the offices where complaints of discrimination can be filed (complaints based on discrimination on the basis of marital status, personal appearance, sexual orientation, family responsibilities, source of income, matriculation, or place of residence or business must be filed with one of the D.C. agencies listed below):</p>		
	Agency	Address	Phone Number
	D.C. Office of Investigations and Compliance	2146 Georgia Avenue, NW Washington, D.C. 20001	202-673-6964 202-673-4464 (anonymous calls for fraud)
	D.C. Department of Human Services, Customer Service	645 H Street, NE Washington, D.C. 20002	202-724-5506
	D.C. Department of Human Services, IMA Administration Office	645 H Street, NE Washington, D.C. 20002	202-698-3900
	D.C. Office of the Public Advocate	2000 14th Street, NW Washington, D.C. 20009	202-673-4413
	U.S. Department of Agriculture, Office of Civil Rights	1400 Independence Ave., SW Room 326-W Washington, DC 20050	202-720-5964 (voice and TDD)
	U.S. Department of Health and Human Services, Office of Civil Rights	200 Independence Avenue, SW Room 506F Washington, D.C. 20201	202-619-0403 (voice) 202-619-3257 (TDD)
ALL	<ul style="list-style-type: none"> The Department is required to inform all applicants/recipients of IMA programs of the scope, conditions of eligibility, requirements, opportunity to register to vote, rights and responsibilities, and potential risks, fines, and consequences if program rules are violated. The Department is required to inform applicants/recipients that some but not all information provided by applicants/recipients and information about eligibility and benefits will be matched regularly with information from various employment databases, including but not limited to those maintained by the D.C. Department of Employment Services(DOES), U.S. Internal Revenue Service (IRS), Social Security Administration (SSA), and other states. The Department is required to inform applicants/recipients of the program provisions regarding fleeing felons and parole violators. The Department is also required to comply and respond to requests for information from law enforcement agencies on fleeing felons, parole violators, and those for whom there is a warrant for arrest. The Department must also disclose information to law enforcement and related authorities consistent with the National Security Act of 1947 and the "Uniting and Strengthening America Act by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT)" Act of 2001. The Department shall inform applicants/recipients of the Department's legal responsibility to respond to such requests for information (see Section 3.5: Confidentiality and Disclosure of Information in this Chapter). The Department is required to request data on the race and ethnicity of the households of applicants/recipients, but provision by the customer is voluntary. Although household race and 		

	<p>ethnicity will be self-determined, the Department is required to classify household race and ethnicity according to federally defined categories. The applicant's race and ethnicity will represent the race and ethnicity of the entire household.</p> <ul style="list-style-type: none"> • The Department must determine an applicant's eligibility for program benefits in accordance with timeliness standards (see Chapter 2: Processing Timeframes in Part III). Applicants must be notified in writing of the Department's eligibility determination. If an applicant is denied benefits, the applicant must be informed of the reason for the denial and the right to appeal the determination (see Section 3.4: Denied in Part III and Chapter 10: Notice of Adverse Action in Part VIII). • The Department is required to give timely and adequate notice to all recipients if the Department has determined a change in benefits including a plan to: <ul style="list-style-type: none"> ○ discontinue, ○ terminate, ○ suspend, ○ reduce benefits, or ○ change the manner or form of benefits • The Department is required to give notice to applicants/recipients of any reduction in or termination of benefits. The notice must contain the following: <ul style="list-style-type: none"> ○ the specific reasons and legal authority for the intended action or decision, ○ the conditions under which benefits and assistance are continued, ○ his/her right to a fair hearing on the proposed action, ○ the method for obtaining a fair hearing, ○ the right to representation, and ○ the availability of free legal counsel. • The Department is required to make the case record available to an applicant, recipient, an authorized representative of the household, or the legal representative of the household for examination during normal business hours upon request of the applicant/recipient or his/her authorized representative. However, the Department may withhold confidential information provided about the household without the household's knowledge, and the Department may withhold information concerning the nature or status of an ongoing criminal investigation or prosecution. However, the Department may not withhold information that forms the basis of an adverse action. • The Department will publicize the procedures for handling civil rights complaints, the Department's policies of non-discrimination, the procedures for reporting a civil rights violation, and the policies and procedures regarding fair hearings and agency conferences.
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CONFIDENTIALITY OF CUSTOMER INFORMATION 3.5

ALL	<p>All information regarding applicants/recipients will be held confidential by the Department and will not be disclosed to anyone without the prior notification and authorization of the individual or the individual's authorized representative. However, the Department is mandated to disclose certain information, with or without prior authorization or notification of the individual, under the following circumstances:</p> <ul style="list-style-type: none"> • The Department, its staff, and official agents are required to report suspected child abuse or neglect to the Department's Children and Family Services Agency (CFSA) and/or the District hotline for child abuse and neglect. In addition, the Department must share information with CFSA upon request. • The Department, its staff, and official agents are required to report on suspected crimes and
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	<p>illegal activity to local and federal law enforcement authorities. Additionally, the Department must report on individuals for whom there is a warrant for arrest.</p> <ul style="list-style-type: none"> • The Department, its staff, and official agents are required to report to the CSED and/or the U.S. Department of Health and Human Services (DHHS) information necessary to assist in establishing or verifying eligibility or benefits concerning parental child support. However, an individual has the right to claim good cause for refusing to cooperate with the Department in establishing paternity or obtaining child support (see Section 2.3: The Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with Child Support Enforcement Part V). • The Department is required to provide certain information to the Department of Homeland Security, Citizenship and Immigration Services (USCIS, formerly known as the Immigration and Naturalization Service or INS) and District, state, and federal law enforcement officials. All such requests are to be directed to the Administrator's Office. If an SSR, supervisor, or center manager receives a request from the USCIS or a law enforcement entity, no information can be released without approval from the Administrator. • The Department, its staff, and official agents are required to report to the U.S. Office of the Comptroller General, DHHS Office of the Inspector General, D.C. Office of the Inspector General and other appropriate Inspectors General information for audit examinations authorized by provisions of law. • The Department, its staff, and official agents are required to report through appropriate administrative channels some individual employment, income, and benefits information to the IRS, SSA, DHHS, USDA, and other state and federal authorities as authorized or required by law. <p>All customer information shall be used for official IMA functions. The use of customer information for any purpose not directly related to IMA business is strictly prohibited. Supervisory staff shall make reasonable efforts to limit access to and use of protected health information by staff to the minimum necessary to perform their duties.</p> <p>Staff who violate IMA's privacy policies or other applicable federal or state law are subject to adverse action in accordance with Chapter 16 of the District Personnel Manual and respective collective bargaining agreements. Staff are required to report any violations of IMA's privacy policies and should contact the Policy Unit, which will refer the matter to the DHS Privacy Officer. Reports can be made anonymously. Retaliation for reporting of violations or cooperation with investigations is prohibited and grounds for adverse action.</p>
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Informing the Applicant of His/Her Privacy Rights 3.5.1

ALL	The Department has a responsibility to inform the customer about the protection of their personal information, which includes any protected health information that they may disclose as part of the application process. SSRs should distribute the "Notice of Privacy Practices" when they give a Medical Examination Form (DHS Form 856) to an applicant who alleges that they are disabled or unable to participate in program activities because of their medical condition. The customer should then sign the "Acknowledgement of Receipt of Privacy Practices" (DHS Form 856-A), which the SSR should file in the customer's case record.
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Protecting the Confidentiality of Customer Records 3.5.2

ALL	All staff have a responsibility to protect the confidentiality of all customer information, including that within the case record. Within each Service Center, the case records are stored in a secure, employees-only area. SSRs may not leave any customer information within public view. Security personnel at IMA ensure that unauthorized persons do not enter these areas without an escort. This requirement applies to all visitors, even federal auditors.
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<p>For customers who submit Medical Forms but who are not determined to be blind or disabled, the Medical Review Team (MRT) maintains the Medical Form within the MRT suite, which is a secure, employees-only area at 645 H St, NE. During business hours, the suite is staffed with a dedicated receptionist who controls access to the single entrance to the work area. After hours, the suite is locked, and non MRT staff members are not able to access that work area until the following morning when the MRT re opens.</p>
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ROUTINE DISCLOSURES OF CUSTOMER INFORMATION 3.6

Disclosing Customer Information to the Customer or Authorized Representative 3.6.1

ALL	<p>Customers or their authorized representative(s) may request to review their own personal case record. SSRs should record any and all such disclosures in the case narrative (see below). However, SSRs shall under no circumstances disclose any customer information to an unidentified individual or to an unauthorized person. Please see Section 1.3: “General Rights of Applicants and Recipients” in this Part.</p> <p>To disclose such information to the customer, the SSR must first conclusively identify the customer by asking them to provide their correctly spelled name, date of birth, Social Security Number, and other information as appropriate. If the request is in writing, the SSR must compare the customer’s signature with that on the application and/or recertification forms contained in the case record.</p> <p>To disclose such information to an authorized representative, the SSR must conclusively identify the representative as an individual listed as an authorized representative on:</p> <ul style="list-style-type: none"> • the Authorization for Release of Information form (DHS Form 495-ARI); • the most recent application/recertification form; • an authorization or release, which is signed by the customer, from an attorney, legal advocate or other representative; or • the ADD2 screen in ACEDS. <p>If the request from the customer is in writing, the SSR may need to contact the authorized representative in order to confirm the identity of the person requesting the customer’s information. At the time of any disclosure, the SSR should note in the case narrative the following information:</p> <ol style="list-style-type: none"> 1. the date of the disclosure 2. the name of the entity or person who received the information and, if known, the address of such entity or person; 3. a brief description of the information disclosed; and 4. a brief statement of the purpose of the disclosure that reasonably documents the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure, if any. <p>In all circumstances, the SSR should release only the minimum necessary information to accomplish the purpose of the disclosure or request. The SSR should not disclose information that is peripheral, incidental or unrelated to the specific request or inquiry. If an SSR has questions about the appropriateness of releasing information, they should contact the IMA Policy Unit for further guidance.</p> <p>If the requestor is not listed on any of the documents above or on the ADD2 screen in ACEDS, the representative must produce a signed request by the customer asking that the information be released to the representative. Again, the SSR should compare the customer’s signature with that on the application and/or recertification forms contained in the case record. In the event that the customer is</p>
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	<p>deceased, the SSR should refer the requestor to the IMA Policy Unit for assistance.</p> <p>IMA will not disclose information to any authorized representative who is abusive or in any way disruptive to staff in the performance of their duties.</p> <p>If the request is less than 100 pages, the SSR should not assess any fees for the cost of copying the disclosed material. Requests in excess of 100 pages should be referred to the IMA Policy Unit.</p> <p>Any request by a customer for an accounting of all disclosures should be forwarded to the IMA Policy Unit, which will refer the matter to the DHS Privacy Officer as appropriate.</p>
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Requests for Information from All Other Parties 3.6.2

Should an SSR receive a request to review a customer's case record from a person other than the customer or their authorized representative, the SSR should refer the requestor to the Administrator. An SSR should never disclose information to such persons in the absence of a signed, verified request from the customer. Please see Section 3.7: Non-Routine Disclosures of Customer Information in this Part.

NON-ROUTINE DISCLOSURES OF CUSTOMER INFORMATION 3.7

Exclusive Role of the Administrator/Designee in Non-Routine Disclosures 3.7.1

ALL	<p>Only the Administrator or the Administrator's explicit designee may authorize the disclosure of customer information to a requestor who is not an authorized representative of a customer. For this reason, SSRs should refer all non-routine requests for customer information to the Administrator. This would include all requests from law enforcement officials, unauthorized neighbors, subpoenas, etc.</p> <p>The Office of the Administrator shall maintain a log of all such requests and maintain copies of the correspondence between the Administrator and the requestor(s). The log shall include the following information:</p> <ul style="list-style-type: none"> • the date of the disclosure; • the name of the entity or person who received the information and, if known, the address of such entity or person; • a brief description of the information disclosed; and • a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure, if any. <p>As a matter of practice, the Administrator shall deny all such requests unless the requestor can provide verification that s/he is an authorized representative of the customer. If the request is in the form of an administrative or judicial subpoena, the Administrator shall immediately contact the Office of the General Counsel. Except in rare circumstances allowed under federal and District law, the General Counsel shall seek to quash all such subpoenas. In the event that the subpoena is upheld, the Administrator shall provide only that information delineated in the subpoena. To the extent allowed by federal and District law and the judicial order, the disclosure will be noted in the case record.</p>
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Customer Service Unit Disclosures to Qualified Medical Providers 3.7.2

ALL	Because qualified medical providers have signed a provider agreement with the Medical Assistance
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	<p>Administration, the disclosure of customer eligibility information is considered “routine.” Accordingly, the Administrator has authorized the Customer Service Unit (CSU) to provide qualified medical providers with current eligibility information for their patients. Except in exigent circumstances, providers should access eligibility information via the ACEDS system or through the Eligibility Verification System (EVS) dial-up. CSU staff should refer providers to these systems because of both (a) work volume issues and (b) only EVS maintains information on a customer’s Medicaid managed care status.</p> <p>In the event that the EVS system is unavailable and a qualified medical provider cannot access ACEDS, CSU staff may verify a customer’s eligibility status. Disclosures by CSU staff are strictly limited to Medicaid eligibility information. CSU staff may disclose only the customer’s eligibility information for the current period and recent past. CSU staff may never disclose any other customer information (e.g., date of birth, address, Social Security number, Medicare number, disability status, ACEDS program code, etc.) to any other provider or unauthorized requestor.</p> <p>In the event that CSU staff members need to disclose information to a qualified medical provider, they must first conclusively identify the caller or requestor. Once the requestor is positively identified, the SSR may provide eligibility information for a customer with the exact spelling provided by the medical provider. If the identity information (e.g., spelling of names, date of birth, or Social Security number) does not match the customer’s record, the CSU may not provide any information.</p>
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THE PRIVACY OF HEALTH INFORMATION 3.8

ALL	<p>Recent legislation known as the Health Insurance Portability and Accountability Act (HIPAA) establishes uniform standards for the protection of health information in the context of medical treatment, payment, and health care operations. With respect to HIPAA, the District regards IMA as a “hybrid” entity, one that is not a health care organization but nonetheless maintains some limited amount of health information. This “hybrid” designation does not in any way dilute the pre-existing confidentiality protections that IMA had in place under the more stringent Medicaid, Food Stamps, and TANF (formerly AFDC) statutes; rather, it reinforces those procedures that have been used within those programs.</p> <p>The relevance of HIPAA to IMA is largely limited to the protection of health information. The confidentiality policies detailed above satisfy HIPAA’s requirements around the disclosure of customer information. Described below are IMA’s policies regarding the other HIPAA components that are germane to this agency. Please note that the terms used below are borrowed from the HIPAA text; thus, some of the information may not immediately appear relevant to an organization such as IMA, which is only indirectly involved with the provision or payment of health care services.</p>
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Amending Information on a Medical Examination Form 3.8.1

ALL	<p>Neither customers nor their authorized representatives may amend submitted Medical Examination Forms (DHS Form 856), which their clinician originally completed and they themselves provided to IMA. Likewise, IMA staff cannot amend in any way the Medical Examination Forms. Because IMA did not generate the information, the agency does not have the clinical or legal capacity to amend it.</p> <p>However, customers or their authorized representative(s) may request to append information to their Medical Examination Forms and/or case record. To do so, customers can submit supplemental information from a clinician or they can submit another Medical Examination Form. Alternatively, a</p>
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	customer may request a Fair Hearing. Outside of these options, customers may not amend a submitted Medical Examination Form or other information in their case record in any other way.
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Maintenance of Customer Records 3.8.2

ALL	IMA shall retain all information in a customer's record for at least three (3) years after the case is closed. A log of the disclosures of customer information shall be kept for at least six (6) years and shall be disclosed to an applicant, recipient or individual's representative upon written request in a manner consistent with the policy and procedures outlined above.
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SAFEGUARDING INFORMATION AND TRAINING ON SAFEGUARDING INFORMATION 3.9

ALL	<p>Pursuant to Publication 1075 from the National Institute of Standards and Technology (NIST) in furtherance of its statutory responsibilities under the Federal Information Security Management Act (FISMA) of 2002, Public Law 107-347, this policy is established in order to maintain and safeguard privileged and private government and customer information obtained from other agencies. As such, the District of Columbia Access System/Automated Client Eligibility Determination System (herein after, "DCAS /ACEDS") personnel/users are required to participate in an initial training class for current users and when newly hired, and an annual training requirement thereafter, which emphasizes the safeguarding of privileged information. They must also sign a security disclosure statement at the conclusion of the training that indicates their cooperation and compliance with this policy. Any DCAS/ACEDS personnel/user that does not satisfactorily complete the training class, and submit a signed disclosure statement, will not have access to DCAS /ACEDS until these requirements are met. A signed disclosure statement for all DCAS/ACEDS personnel/users must be on file with the Division of Program Development and Training ("DPDT") before access to the DCAS/ACEDS system is granted.</p> <p>Internal Procedures for Disclosure Statement(s):</p> <ul style="list-style-type: none"> • New DCAS/ACEDS personnel/users that complete the training will not have access to the system until they submit their disclosure statement to the DPDT training staff. • Current DCAS/ACEDS personnel/users will have fifteen (15) calendar days from the completion of their training to submit a signed disclosure statement. If the statement is not submitted within the fifteen (15) days, then on the 16th day their user access will be denied until the signed statement is submitted to the DPDT training staff. • Each DCAS/ACEDS personnel/user will receive a disclosure statement at the beginning of the Safeguards & Awareness Training. • The disclosure document will be reviewed during the training. • The DPDT Trainer must notify Program Managers/Deputies whenever a new or current DCAS/ACEDS user has not satisfactorily completed the test and submitted a disclosure statement at the conclusion of their training. • Program Managers/Deputies must follow-up with users to ensure the signed disclosure statement is submitted, and, if not, take the appropriate personnel action for that user. <p>Training and Implementation Procedures:</p> <ul style="list-style-type: none"> • All levels of personnel, including, but not limited to, management, administration, technical personnel, design/developer personnel, and program personnel involved in the DCAS/ACEDS workflow will be required to participate in an initial and on-going annual training class for Safeguarding and Awareness of privileged and private vital government and customer information. • A test will be administered at the conclusion of each offered training class in order to determine each user's comprehension of the information. • DCAS/CEDS personnel/users will have to repeat the training class if they score less than 75%
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on the test.

- DCAS/ACEDS personnel/users will have the opportunity to make up the training, if they miss the scheduled training, or fail the test at the conclusion of the training, within 15 days from the initial training offer date.
- This training will be offered every year, and a review of the training materials and information will be conducted annually to determine if changes to materials and information presented are warranted.
- An evaluation of the training will be done by each DCAS/ACEDS user to determine the need for additional training and/or other desired training needs each year.
- An outline of the initial training will consist of the following components:
 - Purpose,
 - Introduction,
 - Objectives,
 - IRS information,
 - SSA and NDNH information,
 - IRS, SSA, and NDNH roles,
 - ESA responsibility for confidentiality,
 - Exception to print IRS screen,
 - Penalty for unauthorized disclosure,
 - Need to know disclosure, and
 - Summary.

Coordination and compliance amongst organizational entities: DPDT on behalf of DCAS/ACEDS will coordinate Safeguarding Awareness Training Classes for appropriate agencies, facilities, clinics, contractors, and/or outreach centers that have access to privileged and vital customer information.

Non-disclosure and Authorized Official Usage: DCAS/ACEDS personnel/users must not disclose, or cause to be disclosed, verbally or in writing, and/ or engage in unauthorized use or disclosure of privileged government/customer information pursuant to regulations under the Internal Revenue Service (IRS), Personally Identifiable Information (PII), and/or Health Information Portability and Accountability Act (HIPAA), but not limited to these regulations.

DCAS/ACEDS personnel/users must protect personal information of customers by safeguarding the information, and not leaving documentation unsecured in their workstation for anyone to see, obtain, or take from the work area. DCAS/ACEDS personnel/users must only share sensitive information with those who need it to perform their duties in conducting official business pertaining to the determination of eligibility for public benefits in the District of Columbia. (Note: DCAS/ACEDS will be monitored and tracked on a regular basis to ensure appropriate usage of the system, i.e., authorized, official case review/action).

For Example: Molly & Sue are friends. Molly is a DCAS personnel/user. Sue calls Molly and asks her to verify or look up information regarding her estranged husband's income status. Molly, willing to help her friend, Sue, looks up the husband's information since she has access to it at her center. By following through on Sue's request, Molly is engaging in unauthorized and unofficial case review/action. Thus, Molly can be subjected to penalties, including loss of wages, loss of job, imposed fines, and she can be held personally liable in a civil action for her unauthorized use and disclosure of privileged information.

Non-reproduction Requirements: Additionally, DCAS/ACEDS Data where identified in the system(s) must remain strictly confidential, and must not be printed as a hard copy under any circumstances. The specific screen will say "Do not print".

Handling of Federal Tax Information ("FTI"): DCAS/ACEDS personnel/users must not include or cause

	<p>to be copied, transmitted via means including, but not limited to, e-mail and facsimile (See <i>Policy on the Prohibition of FTI via email and fax</i>), or transcribed any federal tax information received into the customer's file, or the case narrative. Despite the format of the document received, anything from IRS, New Hires and BEERS must be treated as confidential. DCAS/ACEDS personnel/users can only use information that is independently verified to effect case action. Additionally, DCAS/ACEDS personnel/users must not identify FTI, BEERS or NDNH as data sources when requesting additional information from the customer or a third party to verify the information.</p> <p>Need to Know Disclosure: Federal Tax information, SSA, PII, HIPAA and/or NDNH information is permissible to disclose to other DCAS/ACEDS personnel/user when there is collaboration in a case and the information is needed to perform official job duties. Disclosure of privileged information is on a need-to-know basis between DCAS/ACEDS personnel/users.</p> <p>Penalties Imposed for Non-compliance: Pursuant to Title 26 U.S. Code IRC Sections 7431, 7213(a) and 7213A, unauthorized disclosure means to make tax return, SSA and/or NDNH information known to anyone in any unauthorized manner. DCAS/ACEDS personnel/users, current or former, will be penalized for disclosure of information related to confidential tax information, Social Security Administration (SSA), PII, HIPAA, or National Directory of New Hires ("NDNH") information to anyone who is not entitled to and/or authorized to the information. Pursuant to local and federal law, penalties may include monetary fines up to \$5,000.00, and (5) years imprisonment. Additionally, the penalty for unauthorized disclosure of HIPAA information is from \$100.00 to \$50,000.00. Also, under IRC Section 7431, a tax payer can sue a person in a civil action case and they can be held personally liable for unauthorized use and disclosure of a customer's information and/or inappropriate disclosure of the information.</p>
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PROHIBITION OF TRANSMITTING FEDERAL TAX INFORMATION VIA EMAIL OR BY FACSIMILE 3.10

ALL	<p>Handling of Federal Tax Information ("FTI"): If and when FTI, BEERS or NDNH data is received or held in paper form and/or in an electronic format, DCAS/ACEDS personnel/users are prohibited from transmitting or causing to be transmitted FTI for any reason via means including, but not limited to, e-mail and/or facsimile, including federal tax information related to Hearings and Appeals. Despite the format of the document received, anything from IRS, New Hires and BEERS must be treated as confidential.</p>
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	<p>application such as removal of needs, fines, imprisonment, or disqualification from receiving future assistance payments.</p> <ul style="list-style-type: none"> • Each applicant/recipient household member will cooperate in any subsequent review or certification of program eligibility. • Each applicant/recipient will cooperate with the Department in determining and recertifying eligibility and benefits and will cooperate with Department and federal staff conducting quality control reviews or audits of IMA programs. • Each applicant/recipient will not alter, sell, trade, or transfer any IMA benefits or privileges, including EBT cards, MA identification cards, or other documents or cards which remain the property of the Department. Individuals will immediately surrender any cards or documentation remaining the property of the Department following written notice by the Department. • Each applicant/recipient must provide financial and non-financial information, and report circumstance changes in a timely manner as required by the relevant program.
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SPECIFIC PROGRAM RESPONSIBILITIES OF APPLICANTS AND RECIPIENTS 2.4

In addition to the above general responsibilities, applicants/recipients also have the following program-specific responsibilities:

MA	<ul style="list-style-type: none"> • Each applicant/recipient will report changes in financial and non-financial eligibility information within 10 days of the change. • Each applicant/recipient, before using MA benefits, will use all other available medical insurance, including other medical insurance coverage, veterans' benefits, and veterans' facilities. • Each applicant/recipient will agree to assign to the Department and DOH the right to third-party payment (such as other health insurance that will cover the cost of services received) for care, treatment, and services provided under the MA program. • Each applicant/recipient, unless exempt, will be required to enroll with one of the managed care organizations that the District has contracted with to provide care to Medicaid recipients. People exempt from this requirement include the elderly, people with disabilities (SR), and people living with HIV. • Each applicant/recipient receiving MA coverage or benefits who institutes a legal proceeding against or enters into settlement negotiations with a third party regarding medical claims must provide written notice of the action to the Medical Assistance Administration (MAA) within 20 calendar days. • Parents and caretakers with children receiving MA will cooperate with the Child Support Enforcement Division (CSED) of the Office of Corporation Counsel in the determination of a child's biological and/or legal parent and in the establishment of a medical support order. However, applicants completing the DC Healthy Families Application may request quick referral for CSED services. The adult applicant/recipient's cooperation is a condition for receipt of MA benefits by the adult, unless the applicant/recipient has good cause for failing to cooperate (see Section 2.6: Good Cause for Non-Cooperation in Part V). An applicant/recipient's cooperation may include: <ul style="list-style-type: none"> ○ naming the absent parent of any child applying for or receiving MA; ○ providing information to assist the Department in locating the absent parent; ○ assisting in the establishment of legal paternity or parental status; ○ agreeing to submit to blood tests, if needed to identify a beneficiary child's biological parents; and
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	<ul style="list-style-type: none"> o providing information on additional medical insurance available to the child receiving MA benefits. <p>If an adult fails to cooperate with CSED requirements, the adult is ineligible for MA, but the child's eligibility is not affected.</p>
TANF	<ul style="list-style-type: none"> • Each applicant/recipient will report changes in non-financial eligibility information within 10 days of the change. Each applicant/recipient will report changes in financial information within 10 days of the change, unless notified of Simplified change reporting requirements. • Each applicant/recipient household member will repay assistance erroneously received, even when due to Department error (see Chapter 6: Overpayment and Underpayment in Part VIII). • Each applicant/recipient household member will provide the proof required to determine composition of the household. • Each applicant/recipient, unless exempt, will participate in mandatory employment, education, and/or training activities as a requirement for receiving benefits (see Chapter 1: Work Requirements in Part V). • Each applicant/recipient who is not exempt from work or work-related activity must report in a timely fashion on hours worked in each activity to the Department or its representative. • Each applicant/recipient will cooperate with the Department and CSED in the determination of a child's biological and/or legal parent and in the determination and collection of child and medical support. Failure to cooperate with CSED requirements without good cause will result in a 25 percent reduction in the group's TANF grant (see Section 2.3: The Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate with Child Support Enforcement in Part V). An applicant/recipient's cooperation may include: <ul style="list-style-type: none"> o naming the absent parent of any child applying for or receiving TANF; o providing information to assist the Department in locating the absent parent; o assisting in the establishment of legal paternity or parental status; o agreeing to submit to blood tests, if needed to identify a beneficiary child's biological parents; and o providing information on additional medical insurance available to the child receiving TANF benefits.
GC	See TANF, except there are no child support or work requirements associated with the GC program and the caretaker/payee does not need to report changes of the non-GC household members.
FS	<ul style="list-style-type: none"> • Each applicant/recipient will report to the Department changes in unearned income of more than \$50, except changes in TANF or GC grants, and changes in earned income of more than \$100, unless notified of Simplified change reporting requirements. • Each applicant/recipient will use FS benefits to purchase only allowable food items (see-Section 2.5.1: Benefits Provision in Part I). • Each applicant/recipient household member will repay assistance erroneously received, even when due to Department error (see Section 6.3: Overpayments and Section 6.4: Recovery in Part VIII). • Each applicant/recipient household member will provide the proof required to determine composition of the household, when questionable. • Each applicant/recipient household member will cooperate with a Quality Control Review (QCR) of eligibility. • Each applicant/recipient, unless exempt, will participate in the FSET or a program component for education, and/or training activities as a requirement for receiving benefits (see Chapter 1: Work Requirements in Part V).

An applicant/recipient who believes that s/he has been discriminated against may file a complaint with the offices listed in the following table (complaints based on discrimination on the basis of marital status, personal appearance, sexual orientation, family responsibilities, source of income, matriculation, or place of residence or business must be filed with one of the D.C. agencies listed below):

Agency	Address	Phone Number
D.C. Department of Human Services, Customer Service	645 H Street, NE Washington, D.C. 20002	202-724-5506
D.C. Office of Human Rights and Local Business Development	441 4th Street, NW Suite 970N Washington, D.C. 20001	202-724-1385
D.C. Office of Investigations and Compliance	2146 Georgia Avenue, NW Washington, D.C. 20001	202-673-6964 202-673-4464 (anonymous calls for fraud)
D.C. Office of the Public Advocate	2000 14th Street, NW Washington, D.C. 20009	202-673-4413
U.S. Department of Agriculture, Office of Civil Rights	1400 Independence Ave., SW, Room 326-W Washington, DC 20050	202-720-5964 (voice and TDD)
U.S. Department of Health and Human Services, Office of Civil Rights	200 Independence Avenue, SW Room 506F Washington, D.C. 20201	202-619-0403 (voice) 202-619-3257 (TDD)

- Each applicant/recipient has the right to be informed verbally and in writing of his/her rights, obligations, responsibilities, potential risks, and penalties under these benefit programs.
- Each applicant/recipient has a right to privacy. Information unrelated to the eligibility process cannot be requested by the Agency.
- All information regarding an applicant/recipient shall be used only for determining and administering benefits and shall be safeguarded against disclosure without prior authorization by the applicant/recipient or his/her legal representative, except as noted in Section 3.5: Confidentiality and Disclosure of Information in this Part.
- Each applicant/recipient has a right to have information collected kept private by the Department. Data collected and maintained by District agencies is private, unless specifically classified otherwise by law. Although this data is considered private, applicants/recipients or representatives may review private records which contain data or information on them. Private or public data must actually be shown to the subject of the data and not summarized. Data on two or more people maintained in a common file because of family relationships are 'joint records'. Delete material in joint records about the person not requesting the review to protect that person's privacy. Parents may view records of their minor children, unless the agency decides that the request is not in the best interests of the children. Provide copies of original documents when requested by the subject of the data or the subject's authorized representative.

	<ul style="list-style-type: none"> • Each applicant/recipient has the right to examine his/her case record. The Department will provide his/her case record for examination by the applicant/recipient during normal business hours, or the Department will make copies available at the cost of reproduction. The Department may withhold confidential information about the applicant/recipient obtained without his/her knowledge, confidential information about other individuals contained within the household's shared case record, or information on the nature and status of pending criminal prosecutions. However, all information that forms the basis of an adverse action must be released. • The public has the right to examine handbooks, manuals, and supplemental instructions issued by the Department concerning the administration of IMA programs and policies. The Department will make these documents available within ten days of the date of request for examination by the public during normal business hours. • Each applicant/recipient has the right to be represented by or accompanied and assisted by an individual of his/her choice in all contacts with the Department, including during application, eligibility determination, recertification/redetermination, administrative review, and fair hearing. • Each applicant/recipient has the right to appeal any action or decision made by the Department, and each individual has the right to have an administrative review or a fair hearing regarding any action or decision made by the Department. • Each applicant/recipient who has received an adverse fair hearing decision regarding the receipt of benefits has the right to request a judicial review. • An individual does not forfeit or compromise any of these rights by applying for benefits, receiving benefits, requesting a fair hearing or administrative review, requesting a judicial review, or reporting discriminatory or unfair practices.
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SPECIFIC PROGRAM RIGHTS OF RECIPIENTS 1.4

ALL	<p>Each recipient has the following rights:</p> <ul style="list-style-type: none"> • to timely and adequate notice by the Department when it intends to: <ul style="list-style-type: none"> ○ discontinue, ○ terminate, ○ suspend, ○ reduce benefits, or ○ change the manner or form of benefits. • to receive notice of a change in or termination of benefits including: <ul style="list-style-type: none"> ○ the specific reasons and legal authority for the intended action or decision, ○ the conditions under which benefits and assistance are continued, ○ his or her right to a fair hearing on the proposed action, ○ the method for obtaining a fair hearing, and ○ the right to representation. • to be afforded a reasonable opportunity to resolve the discrepancy before a determination of eligibility can be made when unverified information from a source other than the household contradicts statements made by the household. • to timely notice during which assistance shall not be suspended, reduced, or terminated, or the manner of payment changed until: <ul style="list-style-type: none"> ○ the advance notice period has expired and the applicant/recipient has not requested a hearing, or ○ a hearing decision is reached. • to request, verbally or in writing, a fair hearing within 90 days following the effective date of a notice of adverse action. If the request for a fair hearing is made before the effective date of the adverse action, the benefit will continue to be provided (unless the customer
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	requests not to have benefits paid pending appeal). TANF and FS benefits paid pending a hearing decision will be considered overpayments if the Department's proposed action is upheld.
MA	MA recipients must be notified of and afforded the right to free legal counsel.
TANF	See MA. In addition, each adult recipient has the right to exercise personal decisions regarding the use of the TANF cash grant except in cases in which a protective payee or involuntary rental vendor payment has been established (see Chapter 11: Restricting TANF Payments in Part VIII).
GC	See MA
FS	See MA Information on the loss of an EBT card has been moved to Section 5.7: Loss of Benefits in Part VIII.

SPECIFIC PROGRAM RIGHTS OF APPLICANTS 1.5

ALL	<p>The following rights are held by applicants who apply for benefits for themselves or on behalf of other adults or children:</p> <ul style="list-style-type: none"> • Each applicant has the right to apply for assistance without delay, including the rights to: <ul style="list-style-type: none"> ○ receive and file an application for benefits the same day s/he contacts the Department if s/he contacts the agency during office hours; ○ receive assistance in completing the application in person within the same day if requested; ○ have an application mailed on the same business day to individuals requesting an application by mail or telephone. 'Mail' refers to the transmittal of all written communications and documents and may include, but is not limited to, the U.S. Postal Service, other commercial delivery services, and electronic communications or document transmission technology, such as electronic mail or the Internet; and ○ apply for benefits at any time, including while a fair hearing request is pending or after a hearing decision has been made. • Each applicant has the right to an initial application interview in the home or on the telephone if an adult representative is unable to go to the service center because of one of the following circumstances: <ul style="list-style-type: none"> ○ the applicant or adult representative has a mental or physical medical condition that prevents visiting a Department office or service center; ○ the applicant is over age sixty-five (over age sixty under the FS program); or ○ the authorized program manager (center manager) determines on a case-by-case basis the need to conduct an in-home or telephone interview <p>'Telephone' refers to any mode of real-time, person-to-person telecommunications, including but not limited to the telephone, telecommunications device for the deaf (TDD), teletypewriter (TTY), videophone, teleconferencing, or other electronic telecommunications device.</p> • Each applicant has the right to adequate written notice that his/her application for benefits has been approved or denied. If the application is approved, the applicant shall receive a written notice stating what benefits are granted. If the application is denied, the written notice shall include the following: <ul style="list-style-type: none"> ○ a statement of the reason for denial; ○ the specific regulation supporting such action; and ○ an explanation of the applicant's right to request a fair hearing, to be represented at the hearing, and the availability of low or no cost legal services from public and
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	private sources.
MA	<ul style="list-style-type: none"> Each applicant shall have a timely disposition. For non-disability-related MA applicants, 'timely disposition' means the right to receive a determination of MA eligibility within 45 days after filing an application, provided that the Department received the required information in a timely manner (see Section 2.3: Time Standards in Part III for a full discussion of application processing timeframes, including a discussion of circumstances under which the timeframes can be extended). <p>For disability-related MA cases (SR), the Department has 90 days to make an eligibility determination. If after 45 days the disability determination has not yet been made, the Department must assess the individual's eligibility for MA for all non-financial and financial criteria except disability. Within 90 days, the full MA eligibility determination must be made. If found eligible for disability-related MA, eligibility is retroactive to the date of application.</p> <p>If an individual establishes eligibility for Medicaid under a non-disability related Medicaid category (such as a disabled parent who has income of less than 200 percent of the FPL) prior to establishing disability, the individual's Medicaid application must be approved under the non-disability related program type (AR or AX). However, the applicant maintains the right to be considered for SR Medicaid. Persons on SR Medicaid are not placed in managed care. If disabled caretakers wish to receive services in the fee-for-service system, they must complete the medical evaluation form or provide proof of a Social Security Administration (SSA) determination of disability. Since the SSA shares eligibility information with IMA through computer matching (BENDEX and SDX interfaces), the SSR must use any verification of disability status that is available through these sources. If the applicant/recipient wishes to receive services through the fee-for-service system, the case should be converted to SR Medicaid after disability is confirmed.</p> <ul style="list-style-type: none"> Each applicant has the right, verbally or in writing, to request a fair hearing within 90 days following the denial of eligibility. If this occurs, no benefits will be paid until and unless a decision is made in favor of the applicant. Each applicant enrolled in and served by a health benefits plan as part of his/her MA benefits has additional rights to grievance procedures under D.C. Law 12-274, Health Benefits Plan Members Bill of Rights Act of 1998.
TANF	<ul style="list-style-type: none"> Each applicant shall have the right to a timely disposition, including the right to receive a determination of TANF eligibility within 45 days after filing an application, provided that the Department received the required information in a timely manner (see Section 2.3.1: Household-Caused Delays in Benefits Processing in Part III). Each applicant has the right, verbally or in writing, to request a fair hearing within 90 days following the denial of eligibility. If this occurs no benefits will be paid until and unless a decision is made in favor of the applicant. Each applicant has the right to refuse to admit any representative of the Department into his/her home for an inspection of the premises.
GC	<ul style="list-style-type: none"> See TANF, except there is no right to refuse access to a Home Review investigator.
FS	<ul style="list-style-type: none"> Each applicant shall have a timely disposition, including the right to receive a determination of FS eligibility within 30 days of application, provided the Department received the information in a timely manner.

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| | <ul style="list-style-type: none">• Each applicant has the right to be screened for expedited FS. If the applicant is eligible for expedited FS, the benefits, and an EBT card to access them, must be made available within seven days.• Each applicant has the right to file an FS complaint which is forwarded to the United States Department of Agriculture.• Each applicant has the right to request a fair hearing within 90 days following an adverse action.• Each applicant has the right to request a waiver of the eligibility or recertification interview in an office of the Department because the individual has or is involved in one of the following:<ul style="list-style-type: none">○ illness,○ dependent care responsibilities,○ mental or physical handicap,○ inclement weather,○ transportation difficulties,○ age sixty or older, or○ work schedule prevents individual from going to the service center. |
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The Department will determine on a case-by-case basis whether to reschedule an in-office interview or schedule a telephone or in-home interview.

PART III APPLICATION PROCESSING

CHAPTER 1: FILING AN APPLICATION

INTRODUCTION 1.1

ALL	<p>No individual or group may receive benefits without filing an application either in person, by fax or through a home visit by the SSR. The information provided on the application and the verification documentation are used for three important purposes:</p> <ul style="list-style-type: none">• as the Department's basis for approving or denying benefits,• to determine the amount of benefits, and• as the primary instrument in the Department's initiation of a fraud case or claim against a group. <p>ESA staff will not alter the group's application in any way. IMA staff shall use dictation and additional information sheets to add information relevant to the group's application. IMA staff must, however, assist individuals who are unable to read, write, and understand the application to complete the necessary forms (see Section 1.5: Assisting Applicants Unable to Read or Write in Submitting an Application in this Chapter).</p> <p>All interactions between the Department and the applicant, including the intake interview, phone conversations, and any other meetings, shall be conducted in a manner that respects the dignity and privacy of the applicant.</p>
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LEGAL AUTHORITY 1.2

AREA / TOPIC	DISTRICT	FEDERAL
Application Processing	TANF: D.C. Code 4-205.15; 4-205.19; 4-205.23; 4-205.26; 4-205.31	MA: 42 CFR 435.904-435.914; 435.930
	GC: See TANF and D.C. Code 4-205-5a	FS: 7 USC 2020; 7 CFR 273.2; 273.10

RESPONDING TO INQUIRIES 1.3

ALL	<p>An inquiry is a face to face, telephone, or written request by a person for information about ESA programs and benefits.</p> <p>When a face to face inquiry is made and the individual expresses interest in filing an application, the SSR shall encourage the group to file an application the same day the group contacts him/her.</p> <p>When a telephone inquiry is received, the SSR shall do the following:</p> <ul style="list-style-type: none">• inform the caller that s/he can apply for benefits at the nearest Service Center on the day of the telephone call, and
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	<ul style="list-style-type: none"> • if the caller does not wish to come to the office in person, inform the caller that the Department can mail them the application. The SSR shall mail an application and related forms on the day the request is received. <p>When a written inquiry for assistance is received, the SSR shall mail the application and related forms, including information about expedited Food Stamps, the same day the request is received.</p>
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ALL	<p>Every person has the right to file an application on the same day that s/he contacts IMA. An application is considered filed if it:</p> <ul style="list-style-type: none"> • is on the prescribed form; • contains a name and address (unless homeless); • has a signature; and • is received by any IMA Service Center by mail or in person at any IMA center (except for IDA. See below for that program). <p>The Combined Application (CA) allows individuals to apply for multiple assistance programs. The CA covers the following five programs:</p> <ul style="list-style-type: none"> • MA • TANF • GC • IDA , and • FS <p>Persons applying for multiple program benefits, such as TANF and FS, should complete the pertinent sections of the CA as outlined in the instructions. IMA staff must accept all applications presented at a Service Center during regular business hours. If the application has been sent to the incorrect Service Center, center staff should inform the applicant of the correct Service Center and give the applicant the choice of taking the application to the correct center or permitting the Service Center to forward the application to the correct center.</p>
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MA	<p>Children under the age of 19, pregnant women, and parents and/or caretaker relatives of children under the age of 19 may use the D.C. Healthy Families application (which is shorter than the CA) if they are not also applying for TANF and/or FS. If they are also applying for TANF and/or FS, they should complete the CA.</p> <p>All other MA applicants should complete a CA, filling out the pertinent sections.</p>
TANF	All applicants should complete a CA, filling out the pertinent sections.
GC	See TANF
FS	See TANF
IDA	Applicants should complete a CA. An application for IDA is considered filed when it is received at the designated IMA service center and a face-to-face interview is completed.

Who Must Sign the Application 1.4.1

MA	<p>A parent or the caretaker of a child under the age of 21 must sign the application. A child under the age of 21 may sign their own application if they are a pregnant, parenting, or emancipated minor.</p> <p>For adult MA applicants, either the adult applicant or his/her spouse must sign the application.</p> <p>An authorized representative is also permitted to sign an MA application for a group (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of Another Individual or Group in this Chapter).</p>
TANF	The parent/caretaker relative or payee of the child must sign the application.
GC	An adult who exercises parental control over the child and also lives with the child must sign the application.
FS	The application must be signed by an adult group member or the authorized representative (see section 1.6.2: Filing an Application/Accessing Benefits on Behalf of an Individual or Group in this Chapter).

ALL	<p>The date that an application is filed is relevant for determining the time standard for processing the application and the amount of the initial benefit. Except for IDA, an application is considered filed the date that any Service Center receives a signed application containing the applicant's name and address (unless homeless); (see Section 1.7: Where to File in this Chapter).</p> <p>On the application, ESA staff must document receipt of the application by date-stamping or manually recording the date the Department receives the application.</p>
FS	<p>If an application for an SSI applicant/recipient was forwarded from an SSA Office, then the application will be considered filed for normal processing purposes when the signed application is received by SSA. For purposes of determining the expedited processing timeframes, the date IMA receives the application is used (see Section 1.7: Where to File in this Chapter).</p> <p>For a resident of a public institution who applies for benefits prior to his/her release from the institution and is entitled to expedited service, the date of filing of his/her FS application is the date of release of the applicant from the institution.</p>
IDA	<p>An application is considered filed on the date that a signed application containing the applicant's name and address (unless homeless) is received at the designated IMA service center and a face-to-face interview is completed.</p>

ASSISTING APPLICANTS UNABLE TO READ OR WRITE IN SUBMITTING AN APPLICATION

1.5

ALL	<p>If an applicant cannot read or write and the applicant does not wish to have another family member or acquaintance assist him/her with the application process, ESA staff are to fill out the application for the individual. The SSR should explain to the applicant that s/he can have another individual such as a friend or family member assist with the application process or the individual can let the SSR help him/her fill out the application. The choice should be left to the applicant.</p> <p>If the SSR fills out the application for the applicant, the contents of the completed application must be read aloud to and reviewed with the applicant in the presence of a second IMA staff person, preferably a supervisor or center manager. The second ESA staff person must then sign the application indicating that the applicant agrees with the information provided on the application form.</p>
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WHO MAY FILE AN APPLICATION 1.6

Head of Household 1.6.1

ALL	<p>Generally, the head of the group (the primary informant (PI)) files the application for benefits and is the person to whom the Department directs correspondence and notices. The head of the group must sign the application and is responsible for the validity of the information provided on the application. The three exceptions to this are:</p> <ul style="list-style-type: none">• the case of the authorized representative for FS (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of an Individual or Group in this Chapter);• the case of a protective payee for TANF (see Section 11.3: Protective Payments in Part VIII; and• the case in which a Medicaid applicant is unable to file the application on his/her own behalf.
MA	<p>In cases in which a child is receiving MA, the head of household is the parent or caretaker of the child (regardless of whether the parent or caretaker is receiving MA for him/herself). In the case of a two-parent family, either parent may be designated as the head. In cases in which no child is receiving MA, an adult recipient is designated as the head of the unit. A child under the age of 21 may be the head of household if they are a pregnant, parenting, or an emancipated minor.</p>
TANF	<p>A parent or caretaker relative of the child(ren) receiving TANF must be designated as the head of the household. The caretaker relative is designated as the head even if s/he is not included in the grant. In the case of an eligible two-parent family, the principal wage earner (see below for definition) shall be designated as head of household. In cases in which both parents meet the principal wage earner test, the household may choose who is to be designated as the head of household.</p> <p>The Principal Wage Earner (PWE) is the parent who earned the greater amount of money during the 24-month period preceding the month of application or transfer from another deprivation factor. The SSR should not consider any circumstance (such as whether the parents lived together during the entire period) except the amount each one earned during the period. If both parents earned an identical amount during the 24-month period, the SSR should designate the PWE according to the choice of the parents. The parent who is the PWE at application remains the PWE for as long as the family receives TANF.</p> <p>A minor parent can be the head of a unit only if the following two conditions are met:</p> <ul style="list-style-type: none">• The minor's parent's parent or caretaker relative is not already receiving TANF and is not requesting TANF for him/herself; and• The minor parent does not live with a sibling who is receiving TANF <p>If the minor parent's parent or caretaker relative is receiving TANF or requests TANF for him/herself, the minor parent must be included in the same group as his/her parent or caretaker relative (see Section 1.11: Multiple Generations in the Home in Part IV). Similarly, if the minor parent lives with a sibling also receiving TANF, the minor parent and his/her children must be included in the same group with the minor parent's sibling (and any children s/he may have).</p>
GC	<p>The adult in the household that exercises parental control over the child receiving GC must be designated as the head of the unit.</p>

FS	<p>The person designated as the head of household will be authorized to access FS benefits and will be issued an EBT card. The head of household does not have to be the only adult issued an EBT card or permitted to access FS benefits. Households are permitted to select an adult to serve as the head of the household. If all adults agree with the selection, the Department will accept the household's selection. If, however, the adults do not agree, the Department shall select the head of the household. If a child (either a minor child or an adult child) resides in the household, the SSR should generally select the parent to serve as the head unless the parent is incapacitated and unable to provide information. If there is no child in the household and the household adults cannot agree on who should serve as the head, the SSR should select an adult s/he deems most able to provide needed information to the agency.</p> <p>The adult that the household (or SSR) selects as the head should be designated as the PI in ACEDS. If an adult other than the head needs an EBT card, the SSR should designate that additional adult as the authorized representative for issuance purposes. If the household also wants mail addressed to the adult designated as the authorized representative for issuance purposes, that adult should also be listed as the authorized representative for application purposes.</p>
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Filing an Application/Accessing Benefits on Behalf of Another Individual or Group 1.6.2

MA	<p>A person may file an application on behalf of another person if:</p> <ul style="list-style-type: none"> • the applicant is unable to come into the office, • the applicant signs the application, (unless the applicant is unable to sign the application), and • the individual acting on the applicant's behalf has sufficient knowledge of the applicant's circumstances to present them factually and completely.
TANF	A protective payee can apply for benefits on behalf of a group (see Chapter 11: Restricting TANF Payments in Part VIII).
GC	All GC applications are filed by an unrelated individual exercising parental control over the child.
FS	<p>In cases in which the head of the household, spouse, or other responsible household member cannot apply for the household, an adult non-member of the household may be designated by any responsible member of the household as the 'authorized representative' to act on behalf of the household in applying for program benefits. In addition to filing an application for a household, an authorized representative may be given access to the household's FS benefits for the purpose of purchasing food for the household, provided the authorized representative has the consent of the household. The person who serves as an authorized representative to file an application, however, does not have to be the same person who is authorized to purchase food for the household. A private, nonprofit organization or institution managing a drug addiction or alcoholic treatment and rehabilitation center may also serve in this capacity.</p> <p>When an authorized representative applies on behalf of the household, the SSR must verify the identity of the authorized representative and the head of the household.</p> <p>It is important that the head of the household, or the spouse prepare or review the application whenever possible, even though another household member or the authorized representative will actually be interviewed. The SSR must emphasize to the household that it will be held liable for any overpayment which results from erroneous information given by the authorized representative.</p> <p>If an individual does not have sufficient information i.e. knowledge of SSN, date of birth, residence address, etc., she/he cannot act as an authorized representative.</p>

	<p>Both an authorized representative authorized to purchase food for the household and the head of the household will be issued an EBT card. The name of the authorized representative and the head of the household will appear on both EBT cards.</p> <p>The following persons cannot serve as authorized representatives.</p> <ul style="list-style-type: none"> • Department employees who are involved in the certification and/or issuance processes and retailers authorized to accept FS benefits unless they have the specific written approval of the FS Certification Office after it has been determined that no one else is available to serve, • entities that provide meals for homeless recipients, or • individuals disqualified for intentional program violations (IPV) during the period of disqualification unless the SSR has determined that no one else is available to obtain benefits and/or purchase food regularly with the benefits.
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Filing an Application/Accessing Benefits on Behalf of Another Individual or Group 1.6.2

MA	<p>An application may be filed by an authorized representative on behalf of a deceased individual within three months of his/her death. Eligibility covers the month of application and three months prior.</p> <p>If death occurred during the month of application and before the date of application or if death occurs during the period of pending disposition, eligibility is determined for the prospective period. Eligibility begins on the first day of the month of application and ends in the month of death. Eligibility is processed for a retroactive period if a need has been indicated on the application form.</p> <p>If an individual dies before completing the application process, the application may be denied as an abandoned application if no authorized representative completes the application. The deceased individual's authorized representative may complete the application process or withdraw the application.</p>
TANF	<p>If the head of the household dies before completing the application process and there is no other parent in the household, deny the application and inform the family members when possible that another family member may file a new application for the surviving household member(s).</p> <p>If a surviving spouse is in the home and that spouse agrees to continue with the application, continue to process the application. Similarly, if a group member other than the head dies while the application is pending, continue processing the application.</p> <p>To determine eligibility and benefits for the month of application, include the deceased person in the unit if s/he was in the unit at least one day from the date of application to the end of the application month. For the month following the month of application, consider the person in the unit if s/he was in the unit at least one day of the month following the month of application.</p>
GC	<p>If the adult caretaker of a child applying for GC dies and there is another adult in the household who intends to continue to care for the child, continue processing the application (see Section 5.6: Caretaker in Part IV). If another adult caretaker is not willing to continue the application, or the child is not going to remain in the home, deny the application.</p>

	<p>If a child in a GC unit dies and there are no other children in the unit, deny the application. If there are other children in the unit, continue processing the application.</p> <p>To determine eligibility and benefits for the month of application, include the deceased person in the unit if s/he was in the unit at least one day from the date of the application to the end of the application month. For the month following the month of application, consider the person in the unit if s/he was in the unit at least one day of the month following the month of application.</p>
FS	<p>If a person in a one-person unit dies prior to completing the application process, deny the application.</p> <p>If a person in an assistance unit of more than one dies, continue processing the application. To determine eligibility and benefits for the month of application, include the deceased person in the unit if s/he was in the unit at least one day from the date of application to the end of the application month. For the month following the month of application, consider the person in the unit if s/he was in the unit at least one day of the month following the month of application. Certify the household for ongoing benefits based on the unit not including the deceased individual.</p> <p>Example The Johnsons, an elderly couple, apply for FS on January 15th. Mrs. Johnson dies on January 25th. When determining eligibility and benefits for January, include Mrs. Johnson in the assistance unit. When determining eligibility and benefits for February, do not include her in the unit.</p>

WHERE TO FILE 1.7

MA	<p>The application may be filed at any ESA office that serves the program.</p> <p>If the application is filed at an ESA office that does not serve the applicant's address, then the SSR shall forward the application to the appropriate office on the same day it is received.</p>
TANF	See MA.
GC	See MA
FS	See MA. In addition to submitting FS applications to any ESA Service Center, SSI applicants/recipients may apply for FS benefits at SSA Offices even though the SSA does not determine FS eligibility and level of benefits (see Section 1.7.1: Applying for Food Stamps Benefits through the SSA in this Chapter).
IDA	The application must be filed at an ESA center designated to accept IDA applications.

Applying for Food Stamp Benefits through the SSA 1.7.1

In accordance with a special agreement, whenever a member of a household consisting only of SSI applicants/recipients transacts business at the SSA Office, SSA will inform the household member of:

- his/her right to apply for FS benefits at the SSA Office without going to an IMA service center, and
- his/her right to apply at an IMA service center if s/he chooses.

If a member of a household consisting only of SSI recipients/applicant chooses to apply for FS at the SSA Office, then the following will occur.

- The SSA will accept and assist the customer in completing the FS application and forward it within one working day after receipt of a signed application to the ESA SSI Processing Unit.
- ESA must make an eligibility determination and issue FS benefits to eligible SSI households within 30 days following the date the signed application was received by SSA for normal processing. The expedited processing time standard begins on the date IMA receives a FS application. FS applications and supporting documentation sent to an incorrect service center will be sent to the correct service center within one working day of receipt.
- An SSR shall not contact the household further in order to obtain information for certification for FS benefits unless:
 - the application is improperly completed,
 - mandatory verification requirements were not supplied by SSA, or
 - certain information on the application is questionable.

In no event would the applicant be required to appear at the service center to finalize the eligibility determination. Households in which all members are applying for or participating in SSI are not required to see an SSR or otherwise be subject to an additional IMA interview.

- SSA pre-screens all applications for entitlement to expedited service on the day the applications are received at the SSA Office and marks 'Expedited Processing' on the first page of all applications that appear to be entitled to such processing. SSA informs households that appear to meet the criteria for expedited service that benefits may be issued a few days sooner if the household applies directly at the service center.
- ESA must pre-screen all applications received from SSA for entitlement of expedited service. All SSI households entitled to expedited service are certified in accordance with expedited service standards. (See Chapter 4: Expedited Food Stamp Services in this Part).
- ESA determines if members of SSI households whose applications are forwarded by the SSA are already participating in the Department's FS program by matching the households with available records.
- ESA will provide and SSA will distribute an information sheet and a FNS 1226 brochure to all households processed under the SSI and FS Joint Application provision. This material must inform the household of the following:
 - the address and telephone number of the household's correct service center;
 - the remaining actions to be taken in the application process;
 - a statement that a household must be notified of FS eligibility within 30 days;
 - a description of the client's rights and responsibilities, including administrative reviews, fair hearings, authorized representatives, out of office interviews, reporting changes, and timely reapplication; and
 - information on how and where to use and obtain benefits, including the commodities clients may purchase with benefits.
- Upon receipt of an application from SSA, ESA staff must do the following:
 - review the application to ensure completeness;
 - determine if any household member is currently receiving FS;
 - determine sufficiency and adequacy of documentation and verification material;

- contact the household, if necessary, for additional information for determining FS eligibility;
- determine whether the household is entitled to expedited service and if so meet the expedited timeframes; and
- not request or require the household to come into an ESA service center.

If SSA takes an SSI application or redetermination on the telephone from a member of a household in which all members are SSI recipients, an FS application will also be completed during the telephone interview. In these cases, the FS application is mailed to the claimant for signature for return to the SSA Office. SSA will then forward any FS applications it receives to the ESA FS Branch, SSI Processing Unit.

INTAKE INTERVIEW 1.8

MA	<p><i>AR/AX Combined Application Users:</i> A face to face interview with the applicant, any responsible group member, or authorized representative is generally required for mailed, in-person, and forwarded applications.</p> <p>The purposes of the interview are the following:</p> <ul style="list-style-type: none"> • to inform the applicant of his/her rights and responsibilities (see Chapter 1: Rights of Applicants and Recipients and Chapter 2: Responsibilities of Applicants and Recipients in Part II); • to explain the programs and related services; • to outline the conditions of eligibility and what information and verification are necessary to determine eligibility; • to advise the applicant of the opportunity to register to vote if s/he desires; • to inform the applicant of the availability of EPSDT services for children under 21 (see Section 2.2.8: EPSDT/Health Check in Part I); • to notify the applicant of the requirement that information provided by the applicant be regularly matched by computer with information from DOES, IRS, SSA, and other states; and • to explore and resolve unclear and incomplete information. <p><i>AR/AX D.C. Healthy Families Application Users:</i> An interview is not required.</p> <p><i>SR:</i> See AR/AX Combined Application Users. However, LTC applicants are exempt from the face-to-face interview requirement even if an authorized representative is available.</p> <p><i>QM:</i> See SR. However, persons applying for the QM program with the Buy-In mail-in application are exempt from the interview requirement.</p>
TANF	<p>See AR/AX Combined Application Users. The SSR also shall inform the applicant of the following requirements:</p> <ul style="list-style-type: none"> • read or have read to and sign the Acknowledgment of TANF Program Requirements; • read or have read to and sign the Customer Agency Agreement as a condition of eligibility; and • read or have read to and sign the CSED Partnership Agreement. <p>In addition the TANF applicant is required to complete with the SSR the Preliminary Assessment Form for TANF Applicants. The Preliminary Assessment is used only with TANF new applicants. The form records background information, barriers to employment, and reasons the applicant may be exempt from participating in work activities.</p>

GC	See AR/AX Combined Application Users.
FS	See AR/AX Combined Application Users with the exception of the EPSDT information (unless the group includes children also applying for Medicaid). The SSR shall also inform the applicant that as a condition of eligibility, unless exempt, all household members must register for employment with the Department at the time of application and once every twelve months after initial registration and participate in the FSET program. In addition, the SSR shall give the applicant a Change Report Form.

Scheduling the Interview 1.8.1

ALL	<p>For in person applications, interview the applicant or authorized representative on the day the application is filed. If this is not possible, schedule the interview for the next working day.</p> <p>For mail in and forwarded applications, schedule the interview as soon as possible after the filing of the application in order to ensure that the eligible group receives an opportunity to participate in a timely manner (see Chapter 2: Processing Timeframes in this Part).</p> <p>If a group fails to appear for the first interview, the interview will be rescheduled without requiring the group to provide good cause for failing to appear. If the group does not appear for the rescheduled interview, the Department need not schedule any further interviews unless the group requests another interview.</p>
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MA	<p>Substitute a telephone interview for the face to face interview (if such an interview is generally required) when:</p> <ul style="list-style-type: none"> • the applicant cannot come into the office due to medical condition, • an authorized representative is not available, and • the center manager or designee approves the waiver on a case by case basis. <p>Waiver of the face to face interview does not exempt the household from the verification requirements discussed in Part IV: Non-Financial Eligibility, Part V: Program Requirements and Sanctions, and Part VI: Financial Eligibility). IMA staff may use alternative verification procedures to assure timely receipt of benefits in these cases. Applicants may substitute a collateral contact in lieu of documentary verification.</p> <p>Waiver of the face to face interview will not affect the length of the household's certification period.</p>
TANF	See MA.

GC	See MA.
FS	<p>The face to face interview is waived upon request by any household which is unable to appoint an authorized representative and which has no household member able to come into the service center because they are 60 years of age or older or are mentally or physically handicapped. The Department may also waive the face to face interview on a case by case basis for any household which is unable to come to a service center because of transportation difficulties or similar hardships which the Department determines warrant a waiver of the office interview. Hardship conditions include, but are not limited to:</p> <ul style="list-style-type: none"> • illness, • care of an ill or incapacitated household member, • hardship due to prolonged severe weather, or • work or training hours which preclude an in office interview. (Note, however, that such customers should be encouraged to use extended hours services available at specific service centers.) <p>The Department determines if the transportation difficulty or hardship reported by a household warrants a waiver of the office interview and documents in the case file why a request for a waiver was granted or denied. Waiver of the face-to face interview is considered only after the exhaustion of all other measures such as rescheduling the interview. Households for whom the face to face interview is waived will receive a telephone interview.</p> <p>Waiver of the face to face interview does not exempt the household from the verification requirements discussed in Part IV: Non-Financial Eligibility, Part V: Program Requirements and Sanctions, and Part VI: Financial Eligibility). IMA staff may use alternative verification procedures to assure timely receipt of benefits in these cases. Applicants may substitute a collateral contact in lieu of documentary verification.</p> <p>Waiver of the face to face interview will not affect the length of the household's certification period.</p>

SCREENING FOR THE PROGRAM ON WORK, EMPLOYMENT, AND RESPONSIBILITY 1.9

MA	N/A
TANF	<p>At the point of TANF application, the Preliminary Assessment form should be used by the SSR to identify heads of households who face physical and/or mental incapacities that interfere with their ability to participate in countable work activities. If the head of household in a single-parent unit or if either parent in a two-parent family appears to have incapacities that preclude work, the first step is to request a medical evaluation. MA eligibility should be established or verified as soon as possible so that a medical evaluation can be completed quickly. Neither TANF applicants nor recipients can apply directly for POWER. Eligibility is based on the SSR's identification of a possible incapacity and subsequent referral of the individual for a medical evaluation.</p> <p>The TANF application should be processed following normal application processing procedures while the individual completes (or decides not to complete) the medical evaluation form and the MRT's decision is pending. If the individual is found eligible for POWER, the case will be converted at that point.</p> <p>Individuals should be exempted from work participation pending a POWER eligibility decision. If</p>

	<p>POWER eligibility is denied but the individual still meets exemption criteria, exemption status should continue.</p> <p>It is the recipient's responsibility to return the medical evaluation to the SSR for a determination by the MRT. The recipient has 90 days from the date the SSR issues the medical evaluation to submit the completed evaluation to the SSR to receive consideration under POWER. The SSR then submits the medical evaluation to the MRT for a determination of incapacity or disability. The MRT must specify the period of incapacity/disability which cannot exceed 12 months at one time, but there is no limit on the total months a case can be covered under POWER. Recipients of POWER are not subject to the TANF 60-month lifetime limit.</p> <p>If the MRT determines that the head of household is eligible for POWER, the eligibility date for placement into a POWER unit will be the first day of the month in which the medical evaluation was issued to the recipient (see Section 3.10: Program on Work, Employment, and Responsibility (POWER) in Part VIII for a further discussion of POWER).</p> <p>POWER recipients will receive a referral to APRA or RSA as appropriate. POWER recipients who fail to comply with APRA or RSA program requirements will be placed back in the TANF program.</p>
GC	N/A
FS	N/A
MA	<p>Outstation locations have been established at all disproportionate share hospitals (DSH) and federally qualified health centers (FQHCs) that participate in the Medicaid program and provide services to Medicaid eligible pregnant women and children.</p> <p>Each outstation location is responsible for receiving and the initial processing of Medicaid applications. Initial processing means taking applications, assisting applicants in completing the applications, providing information and referrals, obtaining required documentation, assuring the information contained on the application is complete, and conducting any necessary interviews. It does not include making a determination of eligibility or ineligibility.</p> <p>The Medicaid applications shall be delivered by each outstation location within five days to the IMA Medicaid Branch, Office of the Branch Chief, 645 H Street, N.E., Third Floor. The applications are logged in and distributed to the appropriate service center for registration and processing.</p> <p>The Medicaid program will reimburse the hospital and health centers for the reasonable cost of outstation workers.</p>
TANF	N/A
GC	N/A
FS	N/A

Chapter 2 – Processing Timeframes

INTRODUCTION 2.1

Decisions on eligibility or ineligibility shall be made and eligible applicants shall receive benefits as soon as possible and within certain time standards.

The time standards should not be used as a waiting period or as a basis for denying an application.

In some cases, the time standards may be extended due to circumstances beyond the Department's control such as:

- information is beyond the applicant's ability to obtain,
- circumstances beyond the applicant's control such as hospitalization, or
- an administrative or other emergency such as a mass program change that could not be reasonably controlled by the Department.

In no instance may the time standards be extended due to the applicant's failure to provide verifications which are:

- within the applicant's control, or
- not required to determine eligibility or, if applicable, the amount of benefits.

A verification checklist issued through ACEDS must be given to the applicant at the time the application is filed. The checklist and the date the application was filed are essential for the timely issuance of all application notices and timely disposition of the application.

LEGAL AUTHORITY 2.2

AREA / TOPIC	DISTRICT	FEDERAL
Time Standards	MA: Salazar Court Order TANF: D.C. Code; 4-205.11-a; 205.26 GC: See TANF and D.C. Code 4-205.5a	MA: 42 CFR 435.911-914 FS: USC 2020(e); 7 CFR 273.2
Household-Caused Delays		FS: 7 CFR 273.2
Department-Caused Delays		FS: 7 CFR 273.2

TIME STANDARDS 2.3

ALL	<p>It is IMA's goal that eligibility determinations should be made within ten days from the date that all information necessary to determine eligibility has been submitted. IMA is not legally obligated to meet this timeframe, though it is generally expected that SSRs do so.</p>
MA	<p>AR: If an applicant fails to provide the necessary verification by the tenth day following the application filing date, ACEDS generates a Ten-Day Notice, Form 804, (Application Reminder) on the tenth day or the next available work day. The Ten-Day Notice lists all of the information outstanding on the checklist which was issued at the time the application was filed.</p> <p>If the applicant fails to provide the necessary verification before the 30th day, then an ACEDS-generated 30-Day Notice Application Follow-Up is sent to the applicant on the 30th day following the application filing date or the next available workday).</p> <p>The applicant has 15 days from the date the 30-Day Notice was sent to provide the information necessary to establish eligibility. If the necessary information is not provided by the 15th day after the 30-Day Notice was sent, a denial notice is sent on the 15th day following the date the 30-Day Notice was sent. If, however, verification is received from the applicant within the last five days of the 15-day period after the 30-Day Notice was sent, but eligibility cannot be determined by the 15th day after the 30-Day Notice was sent, then the SSR has an additional day for each day within the last five days that verification was not received to determine eligibility.</p> <div><p>Example</p><p>Ms. Scott was unable to return information verifying her status to receive MA until the 13th day after the 30-Day Notice was sent. Since the verification information was received within the 15-day period, the application should not be denied for failure to provide needed information. However, the SSR might not be able to determine eligibility within the 45-day timeframe because the information was not provided until the 13th day following the date the 30-Day Notice was sent. The SSR has three additional days to determine eligibility and still be considered to have met the timeliness standard; in other words, the SSR has 18 days after the 30-Day Notice was sent in order to determine eligibility.</p></div> <p>An eligibility determination notice must be mailed no later than 45 days from the date of application or 15 days after the 30-Day Notice (Form 803) was sent, if that is later than 45 days from the application date.</p> <p>AX: See AR.</p> <p>SR: See AR. In addition, for disability-related MA cases, the timeframe for application disposition is different than for other MA cases. The Department has 90 days to make a final eligibility determination in disability-related cases. Within 45 days, however, the Department must assess the individual's eligibility for MA for all non-financial and financial criteria except disability.</p> <p>If the individual would be eligible for MA even if the MRT does not determine the individual disabled because, for example, the individual is a parent or caretaker of minor children, the individual's Medicaid application must be approved within 45 days under the appropriate program type (AR or AX). (In this circumstance, the individual should be encouraged to complete the medical evaluation form because a disability finding will affect whether the individual is placed in a managed care organization.) Additionally, to the extent that the customer is eligible for a special Demonstration program such as the 1115 (50-64) program, s/he should be processed under that program type (please see Part III, Chapter 6: Medicaid Demonstration and</p>

	<p>Waiver Programs).</p> <p>Within 90 days, the full MA eligibility determination, including the disability determination, must be made. If found eligible for disability-related MA, eligibility is retroactive to date of application.</p> <p>QM: See AR.</p>
TANF	See AR
GC	See AR
FS	<p>IMA must determine eligibility and provide the applicant an opportunity to participate (i.e. provide an EBT card and have issuance facilities open and available for the household to obtain benefits) within 30 calendar days following the date the application was filed.</p> <p>For households applying prior to their release from an institution, the 30 day timeliness standard begins on the date of their release.</p> <p>For households applying at an SSA office, the timeliness standard begins on the date the application is filed with SSA (see Section 1.7.1: Applying for Food Stamp Benefits through the SSA in Part III).</p> <p>For households entitled to expedited service, the timeliness standard requires that households have the opportunity to receive their EBT cards within seven calendar days from the date the application is filed (see Section 4.5: Time Standards in this Part). For individuals who apply at SSA, this timeliness standard begins on the date the application was received at an IMA service center.</p> <p>If the SSR cannot make an eligibility determination within 30 days from the date of filing, the cause of the delay must be determined. Delays are either household caused or Department caused (see Section 2.3.1: Household-Caused Delays in Benefits Processing and Section 2.3.2: Department-Caused Delays in Benefit Processing in this Chapter).</p>

Household-Caused Delays in Benefits Processing 2.3.1

MA	N/A
TANF	N/A
GC	N/A
FS	<p>The following actions or situations lead to household-caused delays:</p> <ul style="list-style-type: none"> • The household fails to complete the application form and the SSR has offered or attempted to offer assistance in its completion; • One or more members of the household has failed to register for work (see Chapter 1: Work Requirements in Part V) and the SSR has informed the household of the need to register for work and has given the household at least 10 days from the date of notification to register these members; • Verification is incomplete, and the SSR has provided the household with 'A Statement of Required Verification,' offered to assist the household in obtaining required verification,

	<p>and allowed the household at least ten days from the date of the SSR's initial request for missing verification to comply; or</p> <ul style="list-style-type: none"> The household failed to appear for an interview and the SSR has attempted to reschedule the initial interview within 30 days following the date the application was filed. <p>However, if the household has failed to appear for the first interview, and a subsequent interview is postponed at the household's request or cannot otherwise be rescheduled until after the 20th day but before the 30th day following the date the application was filed, the household must appear for the interview, bring verification, and be referred for the FSET program by the 30th day. Otherwise, the delay is the fault of the household. If the household has missed two scheduled interviews and requests another interview, any delay is the fault of the household.</p> <p>If by the 30th day the SSR cannot take further action on the application due to household delays, the household loses its entitlement to benefits for the month of application. Send a notice of denial to the household. Inform the household that they have an additional 30 days to take the required action without filing another application and if found eligible during that time, benefits will begin from the date that the required information is provided. No further action by the SSR is required after the notice of denial is sent, if the household fails to take the required action within 60 days following the date the application was initially filed.</p>
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Department-Caused Delays in Benefits Processing 2.3.2

MA	N/A
TANF	N/A
GC	N/A
FS	<p>The following actions or situations constitute a Department-caused delay:</p> <ul style="list-style-type: none"> The SSR fails to notify the household of any action it must take to complete the application process; The SSR fails to schedule the required interviews in a timely manner; or The SSR fails to determine household recertification or initial eligibility in sufficient time to provide for issuance of benefits by the household's next normal issuance and the household provided all required information in a timely manner. <p>If the household is determined eligible and the Department was at fault for the delay in the initial 30 days, immediate corrective action shall be taken by the Department. If the Department caused the delay, the application will not be denied. The household will be notified by the 30th day following the date the application was filed that it is being held pending and will be notified of any action it must take to complete the application process. If verification is lacking, the Department must hold the application pending for 10 days following the date of the initial request for the missing item of verification.</p> <p>If the Department is at fault for not completing the application process by the end of the second 30 day period and the case file is otherwise complete, continue to process the original application until an eligibility determination is reached. If the household is determined eligible and the Department was at fault for the delay in the initial 30 days, the household shall receive</p>

benefits retroactive to the month of application. Lost benefits are always provided to the household for the period in which the delay was Department caused.

If the case is denied based on circumstances that changed since the original application date, advise the household of its possible entitlement to benefits lost as a result of a Department-caused delay.

Example

Mr. Jones applies for FS benefits on April 15. The Department did not make an eligibility determination until July 1 due to a Department-caused error. In July, the application was denied because Mr. Jones was over-income for the program. Mr. Jones, however, had no income when he initially applied for benefits. He found a job in June and became over-income for benefits in June. Mr. Jones is eligible for back-benefits for the April and May benefits he should have received based on his circumstances in those months.

CHAPTER 3: APPLICATION DISPOSITION

INTRODUCTION 3.1

There are two application dispositions: **approved** and **denied**. This chapter addresses both types of dispositions, but the majority of the chapter concentrates on denied applications.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Application Withdrawal		FS: 7 CFR 273.2
Application Denial	TANF: D.C. Code 4-205.26; 4-205.27; 4-205.51; 4-210 GC: See TANF and D.C. Code 4-205.5a	MA: 42 CFR 431.206; 431.220; 435.911-912 FS: 7 CFR 273.2

APPROVED 3.3

MA	<p>If all non-financial and financial conditions of eligibility (see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility) are met, the SSR shall notify the applicant of eligibility via letter within 45 days of the date of application.</p> <p>ESA shall inform DOH about the applicant's eligibility. DOH will inform the applicant if s/he must enroll in a managed care program.</p> <p>The applicant will receive his/her MA card through the mail.</p> <p>If the applicant is ineligible during the month of application but becomes eligible before the application is denied, the SSR shall approve the application for the month in which the applicant meets the eligibility requirements.</p> <p>Example</p> <p>Ms. Parks, age 67, applies on January 3 for Medicaid based on age and income. At the time she applies, she fails to meet the asset test, but on January 15, she calls to say that her assets have been depleted below the asset limit because she paid a past due credit card bill. The SSR has not yet denied her application for Medicaid. Ms. Parks will now be approved for Medicaid effective January 1.</p>
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TANF	<p>If all non-financial and financial conditions of eligibility (see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility) are met, the SSR shall approve the application and notify the applicant of the approval, the amount of assistance, and eligibility for MA (See Chapter 12: Categorical Eligibility in Part IV). If the applicant is eligible for FS a separate notice will be sent.</p> <p>If the applicant is ineligible during the month of application but becomes eligible before the application is denied, the SSR shall approve the application for the first month in which the applicant meets all eligibility requirements.</p>
GC	See TANF
FS	<p>If all financial and non-financial eligibility conditions are met (see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility), the SSR must notify the household in writing of its eligibility and the level of benefits the household will receive. All applications must be screened for expedited services (see Section 4.4: Screening Applications in this Part).</p> <p>The SSR must also send eligible households written notice of their requirement to report changes. For households under Simplified Reporting rules, the SSR shall send ACEDS notice F722: "Notice of Simplified Reporting." For households under Standard Reporting rules, the SSR shall send ACEDS notice F723: "Standard Reporting Notice." (See Part VII, Section 5.3.1: Standard Reporting and Section 5.3.2: Simplified Reporting.)</p>

DENIED 3.4

ALL	<p>The application shall be denied if:</p> <ul style="list-style-type: none"> the applicant does not cooperate with IMA in providing the information needed to determine eligibility, conditions of non-financial eligibility have not been met (see Part IV: Non-Financial Eligibility), income and/or assets exceed established limits (see Part VI: Financial Eligibility), or the application has been voluntarily withdrawn or abandoned. <p>The applicant shall be notified of the denial, reason for the denial, and right to a fair hearing (see Chapter 10: Notice of Adverse Action in Part VIII).</p>
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MA	<p>To determine eligibility, the information on the application must be completed and signed, the group or its authorized representative must be interviewed, and certain information on the application must be verified.</p> <p>If the group refuses to cooperate with the SSR in completing this process, the application will be denied on the basis of the refusal. For such a determination to be made, the group must be able to cooperate but clearly demonstrate that it chooses not to take the actions that are required to complete the application process. A refusal to be interviewed will result in a denial; failure to keep an appointment for an interview will not. If there is any question as to whether the group has failed to cooperate or is unable to cooperate, the group will not be denied. However, if information needed to determine eligibility is still missing by the end of the applicable timeframes, the application will be denied at that point.</p> <p>The SSR shall not determine the group to be ineligible when a person outside of the group</p>
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	fails to cooperate with a request for verification. Additionally, the SSR shall not consider individuals living in the home identified as 'group' members as individuals outside of the group.
TANF	See MA.
GC	See MA.
FS	See MA. In addition, households entitled to expedited service shall not be required to provide verification other than verification of identity, for the purposes of determining eligibility for expedited benefits (see Chapter 4: Expedited Food Stamp Service in Part III).

Voluntary Withdrawal 3.4.2

ALL	When an application is voluntarily withdrawn, an eligibility determination is not made. However, if an applicant does withdraw the application, the SSR shall document in the case file the reason for withdrawal, if any was stated by the household, and send a denial notice on that basis (see Section 1.6.3: Filing an Application for the Deceased/Death of a Group Member in this Part). When notified by an applicant that s/he wishes to withdraw the application, the SSR must ask the individual why s/he wishes to withdraw the application. The withdrawn application and accompanying materials remain the property of ESA
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Abandonment 3.4.3

MA	<p>An application is considered to be abandoned if the applicant has not responded to requests for information.</p> <p>An application is considered abandoned when:</p> <ul style="list-style-type: none"> • a 30 day letter has been sent. • 15 days have elapsed since the letter was sent, and • there has been no more than one contact between the SSR and the applicant. <p>If the application meets the conditions for being abandoned, deny it based on the abandonment and send a denial notice.</p> <p>If an applicant should die before an eligibility determination, an individual may establish him/herself as an authorized representative and complete or withdraw the application (see Section 1.6.3: Filing an Application for the Deceased/Death of a Group Member and Section 3.4.2: Voluntary Withdrawal in this Part).</p>
TANF	See MA, with the exception of when an applicant dies before an eligibility determination.

GC	See TANF
FS	<p>Consider the application abandoned 30 days from the date of application and send a denial notice if the household fails to:</p> <ul style="list-style-type: none"> • keep the first scheduled appointment and does not schedule a second, or • keep two scheduled interview appointments and made no subsequent contact.

MA	<p>If all necessary requested verification has not been submitted within 15 days of the date the 30-Day Notice was sent, the application must be denied based on the applicant's failure to provide needed information. Non-disability-related MA applications may not be pending for more than 45 days or 15 days after the date the 30-Day Notice was sent, whichever is later. If all necessary information has not been submitted at this time, the application must be denied for failure to provide needed information.</p>
TANF	<p>If all necessary requested verification has not been submitted within 15 days of the date the 30-Day Notice was sent, the application must be denied based on the applicant's failure to provide needed information unless the applicant has contacted the SSR within the 15 day period and indicates that s/he is trying to comply with the verification requirements. If contact has been made, the application may pend beyond the 45 days.</p>
GC	See TANF
FS	<p>FS If the applicant has failed to provide the needed verification within 30 days of the date of application, the application should be denied based on failure to provide needed information, provided that the SSR:</p> <ul style="list-style-type: none"> • conducted the intake interview, • requested all necessary verification on the same day the interview was held, and • provided any required assistance in obtaining verification.

Cases Meeting Income Tests But Not Eligible for Benefits 3.4.5

FS	<p>Households of more than two persons who meet the gross and net income tests may not be eligible for an ongoing monthly allotment after the calculation (see Part IV, Chapter 8, Section 8.5: Determining Benefits Level/Amount of Assistance.) Deny applications when a household of three or more persons is not eligible for any ongoing FS benefit. Do not deny applications when the total ongoing monthly benefit is held back for recoupment of an overpayment claim.</p>
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CHAPTER 4: EXPEDITED FOOD STAMP SERVICES

INTRODUCTION 4.1

Expedited service is an essential part of the FS program and does not apply to any other IMA-Operated Program. It seeks to aid the neediest households which, because of their circumstances, may not be able to wait to receive benefits issued in the normal 30 day processing time standard. The Department must screen all FS applicants/recipients and groups recertifying eligibility using the Expedited Screening Form to identify those entitled to expedited benefits. (It is necessary to screen recertifying customers because some individuals indicate that they are recertifying for FS benefits when, in fact, they are re-applying after a lapse of benefits. Recipients who are timely recertifying their FS benefits are ineligible for expedited processing.)

The Expedited Screening Form provides all the necessary information to determine eligibility for expedited service. Expedited processing does not override program eligibility requirements, although certain processing requirements and actions may be postponed due to the expedited service time standard.

Any FS household which meets expedited service criteria at initial application or recertification and is found eligible to participate in the FS program must receive and have an opportunity to transact its initial EBT allotment with the Capital Access Card no later than the seventh calendar day after the date the application was filed.

LEGAL AUTHORITY 4.2

Area / Topic	District	Federal
Expedited Services		FS: USC 2020(e)(9); 7 CFR 273.2(i)

EXPEDITED SERVICE CRITERIA 4.3

Applicants are entitled to expedited service if:

- they have less than \$150 in countable monthly gross income (see Chapter 5: Whose Income is Counted in Part VI) and \$100 or less in total liquid assets (see Section 1.4.1: Liquid Assets (Cash Value) in Part VI);
- they are destitute migrant or seasonal farm workers with less than \$100 in liquid assets; or
- the household's combined monthly gross income and liquid assets are less than its monthly shelter expenses (shelter expenses include rent and/or mortgage payments, homeowners insurance, or property taxes) plus heat and utilities (standard utility allowance (SUA) may be used instead of actual utility cost if the household is entitled to SUA) (see Section 6.3: Income Disregards and Deductions in Part VI).

Residents of a certified shelter for battered women and children who meet one of these criteria are eligible for expedited services even if they may already have been included in another household which contained the alleged abuser.

SCREENING APPLICATIONS 4.4

The Department must screen all FS applicants, including those requesting additional programs, to identify those entitled to expedited service. The CA and the Expedited Screening Form provide the information needed to identify expedited service cases. The household does not have to request expedited service. A household cannot waive its right to expedited service. Do not deny an applicant the right to apply or to be screened for expedited service.

All applications must be reviewed and accepted for expedited service on the same day an individual applies, even if there is inadequate staffing or an unexpected influx of applications.

When the application is filed, the SSR must screen all applications to determine if the applicant is entitled to expedited service.

Households determined entitled to expedited services must be designated in ACEDS to ensure timely issuance of benefits.

TIME STANDARDS 4.5

Households entitled to expedited service must have their applications processed such that they have an opportunity to pick up their Capital Access Card at one of the two EBT training centers (located at 611 H Street, NE and 2041 Martin Luther King Jr. Avenue, SE) in time to draw the initial issuance of FS no later than the seventh calendar day following the date of application.

If the preliminary review fails to identify that a household is entitled to expedited service and the SSR subsequently discovers that the household is entitled, the time standard for issuing the Capital Access Card begins with the date the SSR discovers the entitlement. The discovery date must be documented in the case record. If the delay in issuance of expedited benefits is the result of an agency error in screening or processing the application for expedited service, IMA is still accountable for failing to provide expedited benefits timely.

If a household is ineligible to participate for the month of application but the SSR determines that it meets expedited criteria for the following month, the time standard for issuing the Capital Access Card begins on the first day of the month the household is eligible. A new application is not required.

Do not delay the processing of expedited benefits because of pending verification which is needed to determine eligibility for another program for which the household may be applying.

If a telephone interview is conducted and the application is incomplete, the time standard begins on the day the signed, completed application is received by an ESA office (see Section 1.8.2: Waiver of Face-To-Face Interview in this Part).

Example

Ms. Jones submits an application for FS at the end of the day on Monday, January 10. The application is not complete because Ms. Jones did not provide any information on her assets. Ms. Jones is elderly and ill (but does not receive SSI) and a telephone interview is substituted for a face-to-face intake interview. During the telephone interview, Ms. Jones still cannot provide any information about her assets, indicating that her adult son who does not live with her keeps track of all her finances for her. Ms. Jones appears to be eligible for expedited service, but eligibility cannot be determined until the information about assets is filled out on her application. The time standard for expedited service does not begin until the application, including the information on assets, is completed.

If an SSI applicant/recipient applying for FS benefits at an SSA Office meets the expedited criteria, benefits must be made available within seven days from the date that the application is received at ESA.

INTERVIEWS 4.6

Households entitled to expedited service must participate in an office or telephone interview (see Section 1.8: Intake Interview in this Part for specific interview policy). If the application is filed in person, the interview must be held the same day the application is filed, unless the applicant/recipient requests a postponement. If s/he qualifies for a telephone interview, it must be conducted no later than the first working day following the application submittal.

If the household applied by mail and/or could not be contacted within one day to be interviewed, this fact must be documented in the case record. ESA must offer the applicant the opportunity to be interviewed no later than one working day after contact is made.

Provide any necessary help in completing the application during the interview.

Expedited service will not be provided until the face-to-face or telephone interview is completed. If the interview is completed within six days of the application submittal, adhere to the seven day deadline for making expedited services available. If the interview is completed on the seventh day or thereafter, consider the date of the interview the "discovery date" and make expedited benefits available within seven days of the date of discovery (see Section 4.5: Time Standards in this Part.)

TREATMENT OF ASSETS 4.7

When determining entitlement to expedited service, only liquid assets are counted (see Section 4.3: Expedited Service Criteria in this Chapter).

When determining eligibility for allotment, both liquid and non liquid assets are counted (see Section 1.4: Liquid and Non-Liquid Assets in Part VI).

TREATMENT OF INCOME 4.8

All income requirements, including deeming the income of ineligible household members, apply when determining benefits provided under expedited service (see Chapters 4-8 in Part VI: Financial Eligibility).

While past income may be used as an indicator of future income, only income which can reasonably be expected to be received is counted. If the date of receipt or amount is uncertain, the income is not used.

HOUSEHOLD-CAUSED DELAYS IN PROCESSING EXPEDITED BENEFITS 4.9

If the household does not provide the information needed to determine eligibility for expedited service within seven days but provides the information within 30 days from the date of application, the SSR has seven days from the date of discovery to determine eligibility for expedited service.

If the information necessary to determine eligibility for expedited service has not been received, the SSR should indicate a pending status on the Expedited FS form. See Section 4.4: Screening Applications in this Chapter.

WORK REGISTRATION 4.10

All household members, unless exempt, must work or register for work with the Department at the time of application and once every twelve months after initial registration as a condition of eligibility (see Section 1.3: Work Requirements in Part V). Work registration does not need to take place before expedited benefits are issued.

The SSR may request the applicant or authorized representative to register household members by completing the required forms on their behalf, or the SSR may accomplish work registration through other means, such as calling the household. The Department may attempt to verify questionable work registration exemptions, but such verifications should not delay the processing of a household's application when the household is entitled to expedited service.

SIMULTANEOUS BENEFITS 4.11

If a household applies for initial benefits on or after the 16th of the month and meets expedited service criteria, they will receive a combined prorated allotment for the initial month of application plus the next full month's allotment within the expedited timeframe. This does not apply to expedited service recipients who are migrant or seasonal farm workers receiving full initial month benefits despite applying after the first of the month.

SUBSEQUENT BENEFITS AFTER POSTPONED VERIFICATION 4.12

Groups who apply for FS prior to the 16th of the month and who are entitled to expedited service, receive benefits prorated from the date of application to the end of the month of application under the waived verification requirements. Benefits for the month following the month of application cannot be issued unless all verification requirements are met.

Groups who apply for FS on or after the 16th of the month and who are entitled to expedited services receive FS benefits simultaneously for the month of application (prorated based on the date of application) and the following month. Benefits for the third month cannot be issued unless all verification is provided.

Once during a season, a migrant household is entitled to a postponement in securing out of state verifications during the second month's issuance. They must provide the postponed out of state verifications before they are given a third month's issuance. If the migrant household reapplies for expedited service again during the same season, they will be entitled to a postponement only during the month of application.

NO LIMITS ON EXPEDITED SERVICES 4.13

There is no limit to the number of times a household can be approved under expedited procedures. However, prior to the next expedited approval, the household must either:

- complete the verification requirements that were postponed at the last expedited approval (regardless of the amount of time that has expired), or
- be processed under normal application processing standards after expedited benefits were last issued.

APPROVAL OF EXPEDITED SERVICES 4.14

If the household is entitled to expedited benefits, the SSR has to create an Expedited Food Stamp-Postponed Verification Notice (F 609) to be sent through ACEDS. The form tells the household what information is needed before additional benefits can be issued.

DENIAL OF EXPEDITED SERVICES 4.15

If the household is not entitled to expedited service, the SSR will:

- advise the household of ineligibility for expedited service and document that fact on the screening form (written notice to the household is not required);
- inform the household of the right to a Department conference with a supervisor within two business days after the determination of ineligibility for expedited service, an administrative conference, or a fair hearing on any action by the Department which occurred in the prior 90 days;
- pre-screen the application and schedule an interview according to normal application processing procedures; and
- record in the case record the reason for denial, any attempts to verify identity through collateral contacts (if this is the reason for the denial of expedited service), and that the household was advised of the right to a Department conference.

VERIFICATION 4.16

Reasonable efforts should be taken to verify all information within the expedited processing time standard. In all expedited cases, however, identity is the only item requiring verification before benefits are issued. Identity can be verified through readily available documentary evidence or a collateral contact which is an oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made in person or over the telephone.

Expedited benefits cannot be delayed if assets, income, and other facts needed to determine FS eligibility or benefit level cannot be verified within the time requirement.

Part IV

Chapter 1 - Group Composition

INTRODUCTION 1.1

There are several non-financial factors of eligibility (such as citizenship/alienage or disability) which must be met for someone to receive assistance. Non-financial eligibility factors are combined with financial eligibility requirements (see Part VI: Financial Eligibility) to determine eligibility. Before non-financial and financial eligibility factors can be applied, the SSR must first determine who is in the group.

This chapter discusses how to compose a group. The term 'group' and 'assistance unit' mean the same thing. A group consists of either one person or several people who live together whose needs, assets, and income are combined to determine eligibility and the amount of benefits, if eligible. All group members receive benefits if the group is found eligible. There may be people not in the group whose income and assets must be considered when determining financial eligibility and benefits (see Chapter 2: Whose Assets are Counted and Chapter 5: Whose Income is Counted in Part VI).

Each program has its own rules to determine who is in a group (e.g., MA does not 'pull' people into a group the way TANF, GC, and FS do; see Section 1.3: Mandatory Group Members in this Chapter).

No person may be included in more than one group, but a group member may be the payee for another group (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of Another Individual or Group in Part III).

Some household members must be in the group (see Section 1.3: Mandatory Group Members in this Chapter) while other people may choose whether or not to be in the group (see Section 1.4: Optional Group Members in this Chapter). Certain people cannot be in the group (see Section 1.5: Excluded Persons in this Chapter).

Some people may be members of the group while they temporarily live apart from the rest of the group (see Section 1.14: Temporary Absence in this Chapter). Apart from a temporary absence, the SSR should establish separate groups for people who do not live together, regardless of relationship. In some circumstances, people living together may not have to be included in the same group.

Each program requires that all individuals in the group have certain characteristics or circumstances. The required characteristics or circumstances vary by program. All members of the group must meet each non-financial eligibility requirement. In some instances, one person's failure to meet a requirement will make the whole group ineligible. In other instances, one person's characteristic or circumstance will disqualify only him/herself.

LEGAL AUTHORITY 1.2

AREA / TOPIC	DISTRICT	FEDERAL
Group Composition	TANF: D.C. Code 4-205.15; 4-205.19; 4-205.23; 4-205.24; 4-205.43; 4-205.53; 4-205.65; 4-205.66; 4-205.69; 4-205.70	MA: 42 USC 1396a(l),(m); 42 USC 1396d(a),(n), (p),(s); 42 USC 1396u-1; 42 CFR 435.4; 435.110; 435.115, 435.116; 435.120; 435.145; 435.170; 435.201; 435.301; 435.310; 435.602
	GC: See TANF and D.C. Code 4-205.5a	TANF: 42 USC 608 (a)(1), 42 USC 608 (a)(4); 42 USC 608 (a)(8); 42 USC 608 (a)(9); 45 CFR 260.30;
		FS: 7 USC 2012(i); 7 CFR 273.1; 7 CFR 273.12
Requirement that Minor Parent Live in An Adult Supervised Setting	TANF: D.C. Code 4-205.63-.64	TANF: 42 USC 608 (a)(5)
Temporary Absences; Living With and Together; Living Situations	TANF: D.C. Code 4-205.15; 4-205.18	TANF: 42 USC 608(a)(10); 45 CFR 260.20
	GC: See TANF and D.C. Code 4-205.5a.	FS: 7 USC 2012(i); 7 CFR 273.1

MANDATORY GROUP MEMBERS 1.3

ALL	<p>Certain people must be included in the group. Although group composition rules vary by program, all programs consider the parental and marital relationships of people who live together when determining who must be considered in the group. Some programs also consider sibling relationships when determining group composition.</p> <p>Some programs require the presence of certain individuals only if they also apply for assistance. Other programs require the presence of certain people even if they do not request assistance for themselves.</p>
MA	<p>The MA assistance group must consist of the person requesting assistance and certain relatives and caretakers of children (including unrelated caretakers) who live with the person; if these individuals also wish to receive assistance. Relatives/caretakers who do not want to apply for benefits for themselves are never required to be included in the MA assistance unit, though their income and/or resources may be considered when determining the applicant's eligibility for MA (see Chapter 2: Whose Assets are Counted and Chapter 5: Whose Income is Counted in Part VI). Some relatives/caretakers also applying for MA may be included in the same MA unit, but they do not have to be. In fact, individuals living in the same household may be eligible under different MA program types (such as AR, AX, SR, or QM) or different eligibility categories within a program type (that is, one child may be eligible for MA based on the Poverty Level Families and Children criteria while a child age 20 may be eligible based on the Medically Needy Families and Children criteria). The SSR must explore all categories for each person who requests assistance (see Section 2.2.1: MA Program Eligibility Criteria in Part I for a discussion of categories of people who are eligible for MA). The SSR should designate the group(s) in the manner most beneficial to the applicants (that is, in the manner that allows as many applicants, related or not, to be determined eligible; see Section 1.4: Optional</p>

Group Members in this Chapter for an example).

Combination assistance units arise in households where some members are one type of unit and other members are a different type of unit. The SSR must determine all potential program types under which each individual applicant may be eligible for Medicaid and test each individual against each potential eligibility criteria.

AR: An AR assistance unit includes at least one child under age 21 (including an unborn child).

Non-disabled children ages 19 and 20 who are not themselves parents or caretakers can only be eligible for Medicaid based on the TANF Standard or the Medically Needy Families and Children category. Children under the age of 19 can be eligible for Medicaid based on the TANF Standard, Foster Care/Department Ward/Adoption Assistance Recipient category, the Medically Needy Families and Children category, or the Poverty Level Families and Children category. (Children under 19 whose incomes exceed the various AR standards may be eligible under the AX type.)

While parents residing in the home with a dependent child do not have to be included in the assistance unit, parents living in the home with a dependent child are provisionally included for purposes of determining financial eligibility (see Chapter 5: Whose Income is Counted and Chapter 2: Whose Assets are Counted in Part VI). Caretaker relatives and unrelated caretakers of minor children are not required to be in the group and are not included provisionally if they choose not to apply for benefits on their own behalf as a caretaker of a child.

Foster Care/Department Ward/Adoption Assistance Recipient

Department wards are automatically eligible for MA if they are not in penal institutions. A Department ward is any child who:

- has been committed to, or placed with, CFSA by a court order due to abuse or neglect, and
- has been placed in either a foster care home or a licensed child-care institution by the Department.

No other individuals are included in a unit with a Department ward.

Foster parents may apply on behalf of foster care children (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of Another Individual or Group). They do not have the option of being included in the group with the foster care child but could otherwise be eligible.

Current MA eligibility for Department wards begins with the first day of the month the court order was received by the Department. Applications are not required for Department wards, (including those eligible for IV-E), for current MA, but applications are required for retroactive MA.

Any child for whom foster care maintenance payments are made is eligible for MA. The child is eligible for MA in the state where s/he is physically present even if the foster care payments are made by another state.

A foster child committed by the court to a juvenile penal facility can only receive Medicaid during an inpatient hospital stay.

Any child under age 21 for whom there is an adoption assistance agreement in effect under Title IV-E of the Social Security Act is eligible for MA. The child is eligible for MA in the state where s/he is physically present even if the adoption assistance agreement is with another state. The adoption assistance agreement need not provide for an actual adoption assistance payment.

AX: An AX unit always contains a child under the age of 19, a parent or a caretaker (related or unrelated) of a child under the age of 19 who is eligible for Medicaid, or a pregnant woman. All parents, caretakers, pregnant women and children under the age of 19 must first be evaluated to determine if they are eligible under the AR program type. If the individual is aged, disabled and/or an SSI recipient, s/he must be evaluated under the SR program type before determining eligibility as part of an AX unit.

There are no mandatory group members for this type of unit.

SR: A person eligible for MA in an SR unit must be:

- age 65 or older,
- blind, or
- permanently and totally disabled.

A person who is blind or permanently and totally disabled can be any age from newborn to age 65. After age 65, the person's medical condition is no longer relevant because the person meets the age criteria.

The only mandatory group member is a spouse if s/he is also aged, blind, or disabled. If only one spouse is aged, blind, or disabled, then the other spouse is not included in the SR unit.

There are never more than two people in an SR unit. The only time there are two in the unit is when the two people are married to each other, are living together, and are aged, blind, or disabled. An SR unit always consists of either a married couple who are living together or an individual. An SR unit will never consist of a disabled parent and a disabled child. If a parent and a child are both disabled, they are considered two separate SR units.

Example

Mr. and Mrs. Drew have one daughter, Rebecca, who is 14. Mrs. Drew is blind. All three family members apply for MA. Mrs. Drew has the option of being included in her own SR unit or in a unit with Rebecca. Mr. Drew should be included in a unit with Rebecca and, if she chooses, Mrs. Drew.

Suppose Mrs. Drew and Rebecca have no income, Mr. Drew earns \$1,000 per month, and the family incurs no child care costs. If all three are included in the same assistance unit and tested under the AR category, Rebecca will be found eligible (since the family's income is below 100 percent of the FPL for a family of three). If both Mr. and Mrs. Drew chose to be in the same unit with Rebecca, both would be tested under the AX criteria. Rebecca would be included provisionally in the AX unit, and Mr. and Mrs. Drew would be found eligible for Medicaid (since their family's income is below 200 percent of the FPL).

Mrs. Drew could choose to be in her own SR unit. By doing so, she would not be placed in managed care because disabled Medicaid recipients are not required to enroll in the managed care system. Because the general managed care organizations may not meet the needs of disabled individuals, individuals with disabilities should be strongly encouraged to complete the medical evaluation form. If the MRT determines the individual disabled, the individual can be switched from an AR or AX unit to an SR unit.

Couple status ceases for spouses who are no longer living together the month after the month of separation. The reason for the separation does not matter. (See Chapter 2, Part VII for information on the treatment of spouses in LTC cases).

An SSI recipient is always in an SR unit.

QM: Only Medicare beneficiaries can be included in a QM unit. Spouses who are both applying for assistance with Medicare premiums, deductibles, and co-payments must be included in the same QM unit.

TANF	<p>To determine the TANF mandatory group members, SSRs should start the group formation with the child for whom assistance is requested. If no step-parent is in the home, the child's parent(s) who lives in the home and meets each non-financial eligibility requirement must then be included. Then the SSR should add the child's siblings and half-siblings who live in the home and meet each non-financial eligibility requirement. Eligible siblings and half-siblings of TANF children must be included. Adoptive siblings receiving an adoption subsidy must be excluded. The SSR should then add the sibling's parent(s) who live in the home and meet each non-financial eligibility requirement.</p> <p>If a step-parent is living in the home, and the parent is not, the step-parent can choose to be included in the group with his/her step-children. In this situation, the step-parent is treated as a caretaker relative.</p> <p>When any member of a couple that has a child in common applies for TANF, the group must consist of all of the following:</p> <ul style="list-style-type: none">• both members of the couple, whether or not they are married,• the child in common, and• all of the dependent siblings and half-siblings of the child in common who are in the home and who meet TANF eligibility criteria. <p>When a married couple does not have a child in common, and one member of the couple applies for TANF for his/her child(ren), the only mandatory members are that parent's child(ren). However, the children's parent may choose to be included in the assistance unit (See Section 1.4: Optional Group Members in this Chapter.) If the parent chooses to include his/her needs in the group, the group must consist of all of the following:</p> <ul style="list-style-type: none">• the applicant's child(ren),• the applicant,• the applicant's spouse (the step-parent), and• all dependent children of the step-parent. <p>When an unmarried couple does not have a child in common, and one member of the couple applies for TANF for his/her child(ren), the group must consist of all of the following:</p> <ul style="list-style-type: none">• the applicant, and• the applicant's dependent children. <p>Children without a common parent are not drawn into a group together unless a married applicant chooses to include his/her needs in the group. If the parent is included, the step-parent and the step-parents' children must be included in the group. Also see Section 1.11: Multiple Generations in this Chapter.</p>
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	<p>Example</p> <p>Mr. Richey and Ms. Haymond are an unmarried couple. Mr. Richey is employed. They are living with her children from a previous relationship (Erwin and Imogene), his children from a previous relationship (Cedric and Sheldon), and their "child in common" (Mabel). Ms. Hammond applies for assistance for her children. Establish a group consisting of Ms. Haymond, Mr. Richey, and all of the children.</p> <p>If there was no child in common, the group would be established as Ms. Hammond and her children Erwin and Imogene. Mr. Richey is not married to Ms. Hammond, so he is not a step-parent to Erwin and Imogene.</p> <p>Example</p> <p>Mr. and Mrs. James have no child in common. Mrs. James has one child from a previous marriage, Ralph, and Mr. James has one child from a previous marriage, Edna. Mr. James applies for TANF for Edna. If Mr. James wants to be included in the TANF group himself, Mrs. James and her child must be part of the group. If Mr. James chooses not to be included, Mrs. James and Ralph cannot be included. Mrs. James can apply for Ralph and a separate group consisting of only Ralph will be established. However, if Mrs. James wants to be included with Ralph, Mr. James, and Edna must also be included.</p> <p>Example</p> <p>Mr. and Mrs. Johnson have two children in common, Jackie and Isaac. Mrs. Johnson has one child from a previous relationship, Andre. Mrs. Johnson applies for TANF for Andre. Since there are children in common, the group must consist of Mr. and Mrs. Johnson, Jackie, Isaac, and Andre.</p>
GC	<p>Mandatory group members are all siblings and half-siblings who live in the same home and meet all non financial eligibility factors.</p> <p>Caretakers cannot be included in a GC assistance unit.</p> <p>Example</p> <p>A household consists of Ms. Stein, her daughter's child (Susan), and another child (Mary) who has the same father as Susan but a different mother. The GC case would only include Mary since, although she is a half sibling of a TANF child, she is not related to Mrs. Smith and, thus, does not meet the "relationship" requirement (see Section 5.4: Who is a Relative in this Part). The TANF case would include Ms. Stein if she elects to receive assistance, and her grandchild, Susan.</p>

FS	<p>In general, all household members who purchase and prepare food together who are not disqualified from participating in the FS Program because they fail to meet a financial or non-financial eligibility requirement are mandatory group members.</p> <p>The phrase "purchase and prepare food together" is meant to describe persons who customarily share food in common. Persons customarily share food in common if:</p> <ul style="list-style-type: none"> • they each contribute to the purchase of food; • they share the preparation of food, regardless of who paid for it; or • they eat from the same food supply, regardless of who paid for it. <p>Persons who normally purchase and prepare food separately maintain that distinction even when they are temporarily sharing food with others. A person is temporarily sharing food if s/he had previously purchased and prepared food separately and others are sharing his/her food until the person:</p> <ul style="list-style-type: none"> • is approved for Food Stamps, • qualifies for other cash assistance, or • secures some other source of income. <p>Some household members must be included in the same group even if they are not purchasing and preparing food together. The relationships of the people who live together affect whether they must be included or excluded from the group.</p> <ul style="list-style-type: none"> • Spouses: Spouses are members of legally married or unmarried couples who tell others they are married or otherwise represent themselves as married (that is, use the same last name). Spouses who live together must be in the same group. • Parents and Children: Parent(s) and child(ren) who live together must be in the same group unless the child is age 22 or over and cooks and eats separately from the group. If this exception is met, either group may apply for and receive separate status. Parenting children (age 21 or under) who live at home with their parent(s) must be included in the same group with their parent(s). If the parenting minor is married, his/her spouse must also be included in the same group (if the spouse resides in the home).
	<p>Example</p>
	<p>Ms. Day (age 54) lives with her brother Mr. Earl (age 53) who receives SSI. Ms. Day purchases and prepares food separately from Mr. Earl. Ms. Day and Mr. Earl are separate FS groups. Either may apply for separate group status.</p>
	<ul style="list-style-type: none"> • Foster Child: The FS group may choose to include or exclude a foster child whose foster parent is a group member. If excluded, this foster child is not eligible for FS as a separate group and the foster care payment is not income to the group. • Children Not Living with a Parent: Generally, a child under 18 years of age must be included with an adult if the adult exercises parental control (care and supervision). The adult does not have to be related. However, the SSR should form separate groups if the child and adult eat separately and: <ul style="list-style-type: none"> ○ The child has his/her own child who lives with the group, or ○ The child is married and living with his/her spouse. • Siblings: Siblings (natural, adopted, half, or stepbrothers and sisters) who eat separately may form separate groups unless one sibling provides parental guidance over the other. The SSR should establish separate groups for parental guidance siblings if one sibling is a senior (age

	60 or over) disabled individual, or veteran or has a child under 18 who lives with the group.
	<p>Example</p> <p>Ms. Day (age 54) lives with her brother Mr. Earl (age 53) who receives SSI. Ms. Day purchases and prepares food separately from Mr. Earl. Ms. Day and Mr. Earl are separate FS groups. Either may apply for separate group status.</p>
	<p>Generally, a person must not participate as a member of more than one FS group in any given month. If the person is a mandatory group member, action must be taken as soon as possible to remove him/her from his/her former group and add him/her to the new group. Residents of shelters for battered women and children, however, may be a member of more than one group (see Section 10.10: Shelter Facilities for Battered Women and Children in this Part).</p> <p>The group may reside in a house, apartment, rooming house, certain institutional settings such as a group living arrangement, or a shelter for battered women, or it may be homeless.</p> <p>Households must list on their application individuals residing with the group who may not be eligible to be included in the FS group. These include the following persons:</p> <ul style="list-style-type: none"> • ineligible aliens (see Chapter 7: Citizenship/Alienage in this Part), • roomers (see Section 1.13: Living Situations in this Chapter), • boarders (see Section 1.13: Living Situations in this Chapter), • strikers (see Chapter 11: Strikers in this Part), • ineligible students (see Section 4.4: School Attendance and Student Status in this Part), and • disqualified persons <p>The following are considered groups:</p> <ul style="list-style-type: none"> • a person living alone who purchases food and prepares meals, • a person or group of people living with others but who purchases and prepares meals separately from the others,
	<p>Example</p> <p>Ms. Grant and her two children move in with Ms. Mason, Ms. Grant's friend. Ms. Mason purchases and prepares food separately from Ms. Grant and her two children. They are two groups for FS purposes.</p>
	<ul style="list-style-type: none"> • a group of people who live together and who purchase food and prepare meals together, and • a person at least 60 years old, his/her spouse, and their children under 22 may choose to be a separate group from those they live with even if they purchase and prepare food together if: <ul style="list-style-type: none"> ○ the person age 60 or over cannot purchase and prepare meals due to a permanent disability as determined by SSA or a non disease related permanent disability, and ○ the countable income of all the other people with whom the impaired senior lives does not exceed 165 percent of the FPL.

OPTIONAL GROUP MEMBERS 1.4

MA	The SSR should designate or create the group(s) in the manner most beneficial to the applicants (that
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	<p>is, in the manner that allows as many applicants as possible to be eligible), including optional members where helpful.</p>
	<p>Example</p> <p>Mrs. Payne lives with her two children, Robert and Mary, and her husband. Mr. Payne is neither Robert nor Mary's father. Mr. Payne works and earns \$45,000 per year. Mrs. Payne works and earns \$15,000 per year, and neither Robert nor Mary receives any child support or other benefits.</p> <p>Create an assistance unit consisting of Robert and Mary and evaluate their Medicaid eligibility based on the AR program type. If they are ineligible, evaluate their Medicaid eligibility based on the AX program type. Do not include Mrs. Payne in the assistance unit (but code her as "IP", so her own income is counted). If she is included, Mr. Payne's income will be deemed available to the assistance unit because spousal income is always deemed available to a spouse applying for Medicaid for him/herself. Step-parent income, however, is not deemed to step-children if the natural/adoptive parent is not in the assistance unit. Therefore, when determining the children's Medicaid eligibility, only Mrs. Payne's income will be deemed available to Robert and Mary if Mrs. Payne chooses not to be included in the assistance unit.</p> <p>AR: Children under 21, parents and/or step-parents living with children under 21, and caretakers of children under 21 (in households in which the parents are absent) may be included in the assistance unit with the child. Related and unrelated caretakers of minor children may be included in the group.</p> <p>If a child lives in a joint or shared custody situation (that is, child lives with his/her mother two weeks each month and his/her father the other two weeks), only one parent may be in the group. The income and resources of the parent included in the group (or applying on behalf of the child) is included. Only actual income received by the child from the other parent is counted.</p> <p>Foster care parents are not included in the assistance unit. Step-siblings and children-in-common may be included in the group if they so elect.</p> <p>The parent(s) of a parenting minor may be included in the group if it is to the benefit of the household. Similarly, the parent(s) of a pregnant minor may be included in the group. However, SSR shall exclude the parent(s) of a pregnant or parenting minor at their own request or at the request of the minor. If the parents are excluded, their income and resources are not counted, even provisionally.</p> <p>An essential person (see Section 1.6: Essential Person in this Chapter) of a dependent child has the option of being included in the assistance unit. Also, a caretaker relative has the option of being included in the assistance unit, but s/he may only be included if a parent is not in the home.</p> <p>AX: See AR. Note that although the AR program serves children until they turn 21, the AX program serves children only until they turn 19. Children under 19, parents and/or step-parents living with children under 19, and caretakers of children under 19 eligible for Medicaid (in households in which the parents are absent) who are otherwise eligible may be included in the assistance unit. Other types of persons that can be included in the AR group can likewise be included in an AX group.</p> <p>SR: There are no optional group members.</p> <p>QM: See SR.</p>
TANF	There are four (4) types of optional group members:

	<ul style="list-style-type: none"> • a caretaker relative (see Section 5.6: Caretaker in this Part). • a child of a TANF child. • an 18 year old TANF child who is enrolled as a full-time student in a secondary school or the equivalent level of a vocational or technical training program prior to their 19th birthday, and. • a married person who does not have children in common with his/her spouse. <p>These individuals may be included or excluded from the group depending on whichever is advantageous to the group. The caretaker relative must request that s/he be included in the group.</p> <p>The 18 year old TANF child who is enrolled as a full-time student in a secondary school or the equivalent a vocational or technical training program will be removed from the group when s/he reaches the age of 19.</p>
GC	There are no optional group members, though a caretaker can be included in the MA unit as is described above.
FS	N/A

EXCLUDED PERSONS 1.5

Fugitive Felon and Probation or Parole Violators 1.5.1

ALL	<p>Assistance will be denied to any person who is fleeing to avoid prosecution, custody, or confinement after conviction under the laws of the place from which the individual flees for a crime or an attempt to commit a crime which is a felony under the laws of the jurisdiction from which the individual flees; or who is violating a condition of probation or parole imposed under federal, state, or D.C. law. A fleeing felon is usually determined by the existence of an outstanding warrant for the individual's arrest; the individual is assumed to be fleeing as of the date the warrant is issued.</p> <p>For an individual to be considered fleeing, that individual must be acting with the intent to avoid prosecution. For cases where a warrant has been issued, the individual must have knowledge that a warrant has been issued for his arrest in order to be considered "fleeing". Once an individual has knowledge of the warrant, either by having received the warrant personally, or by being advised of its existence by the SSR, s/he is technically at that time, "fleeing". In the case where the SSR determines during the application processing time frame that an applicant has a warrant out for his/her arrests, the SSR must verify with the applicant whether s/he has knowledge of the warrant. The applicant should also be given an opportunity to submit documentation that the warrant has been satisfied. This policy does not apply to individuals who have been granted a pardon from the President of the United States with respect to the above conduct.</p> <p>In compliance with the District's existing policy on safeguarding customer confidentiality, the Department is required to cooperate with federal, state, and D.C. law enforcement authorities by honoring their request for information on persons who are believed to have committed a felony.</p> <p>At each application and review, the SSR must inform the customer of the program provisions regarding fleeing felons and probation and parole violators.</p>
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Intentional Program Violation (IPV) 1.5.2

MA	N/A
TANF	A person may permanently or temporarily be ineligible if s/he has been found by a

	<p>federal, state, or D.C. court to have committed an IPV, which is an action by an individual that leads intentionally to the following:</p> <ul style="list-style-type: none"> • a false or misleading statement; • a misrepresentation, concealment, or withholding of facts; or • any act intended to mislead, misrepresent, conceal, or withhold facts. <p>The action must be for the purpose of receiving TANF or FS benefits for which the family is not eligible.</p> <p>This ineligibility is in addition to and cannot be substituted for any other sanction or penalties which may be imposed by law for the same offenses.</p> <p>The Disqualified Customer System Coordinator will send a Program Disqualification Notice to the SSR who is responsible for handling case activity for an individual who is to be disqualified. The terms of the disqualification will be noted on the form.</p> <p>If there is an IPV disqualification, the SSR shall do the following:</p> <ul style="list-style-type: none"> • delete the needs of the individual from the group, • deem his/her assets and income according to Chapter 2: Whose Assets are Counted and Chapter 5: Whose Income is Counted in Part VI, and • provide assistance to other eligible members of the group. <p>Also, an individual found to have committed an IPV is ineligible for:</p> <ul style="list-style-type: none"> • six months for the first offense, • 12 months for the second offense, and • permanently for the third offense. <p>The disqualification periods for the first and second offense do not expire until they have actually been imposed and may not run concurrently with other disqualifications.</p>
GC	N/A
FS	<p>See TANF for the definition of an IPV. In addition, an administrative disqualification hearing decision may substitute for a court decision. The disqualified individual is not counted when determining the household size, asset limit, allotment level, or the gross and net income eligibility limits. Deem the individual's assets and income according to Chapter 2: Whose Assets are Counted and Chapter 5: Whose Income is Counted in Part VI. An individual found to have committed an IPV is ineligible for:</p> <ul style="list-style-type: none"> • a period of twelve months for the first offense; • a period of twenty-four months for the second offense; and • permanently for the third offense. <p>In addition, an individual found to have committed an IPV is ineligible for:</p> <ul style="list-style-type: none"> • a period of twenty-four months for the first finding by a federal, state, or DC court of trading a controlled substance for benefits; • permanently for the second finding by a federal, state, or DC court of trading a controlled substance for benefits; • permanently for the first occasion of a finding by a federal, state, or D.C. court for trading firearms, ammunition, or explosives for benefits; and • permanently for having trafficked benefits for an aggregate value of \$500 or more.

	Finally, an IPV disqualification follows individuals from one jurisdiction to another.
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Misrepresented Residence in order to Receive Assistance in Two or More States 1.5.3

ALL	<p>Assistance will be denied for a period of ten years to any person convicted in a federal, state, or D.C. court after August 22, 1996 of making a fraudulent statement or misrepresentation with respect to residence in order to receive TANF, FS, SSI, or Medicaid simultaneously in two or more states. The ten-year period will begin on the date of the conviction in federal, state, or D.C. court of having made such a statement or misrepresentation. This policy does not apply to individuals who have been granted a pardon from the President of the United States with respect to the above conduct.</p> <p>The individual must be denied or terminated from federally funded assistance programs at the earliest possible date.</p>
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Other Excluded Persons 1.5.4

MA	<p>AR: An individual is excluded from the AR assistance unit if:</p> <ul style="list-style-type: none"> • she/he refuses to provide information needed to determine his/her eligibility; • she/he is a parent or caretaker who refused without good cause to cooperate with child support cooperation or medical support assignment requirements (see Chapter 2: Child Support Requirements in Part V); • she/he is a member of another public assistance unit receiving TANF; • she/he is a child and the applicant/recipient has requested that the child be excluded from the assistance unit (such as in the case of a child who has significant income that, if included, will make other family members ineligible for Medicaid); • he is the expecting father of an unborn child, there are no other children in the assistance unit until the month in which the child is born, and the expecting father is not married to the mother (if the expecting parents are married, then the expecting father's needs are included provisionally, but he is ineligible for MA benefits with this group until the child is born); • she/he is a foster parent and the ward is included in the unit; • she/he is a parent whose needs are met by his/her spouse who is not a natural or adoptive parent of the dependent child, and the parent has chosen to be excluded; or • she/he is a parent under age 21, his/her needs are met by his/her parent(s) living in the home, and the parent under 21 has chosen to be excluded. <p>If a natural or adoptive parent of a child applying for MA chooses to exclude him/herself from the unit, the parent is included in the unit provisionally when determining the child's eligibility for MA. A step-parent may be included in an AR unit at his/her option. If s/he chooses to be excluded from the unit, his/her income and resources are not counted unless his/her spouse is in the unit.</p> <p>AX: An individual is excluded from the AX assistance unit if:</p> <ul style="list-style-type: none"> • s/he refuses to provide information needed to determine his/her eligibility; • s/he is a parent or caretaker who refused without good cause to cooperate with child support cooperation or medical support assignment requirements (see Chapter 2: Child Support Requirements in Part V); • s/he is a child and the applicant/recipient has requested that the child be excluded from the assistance unit; • he is the expecting father of an unborn child, there are no other children in the assistance unit until the month in which the child is born, and the expecting father is not married to the mother (if the expecting parents are married, then the expecting father's needs are included provisionally, but he is ineligible for MA benefits with this group until the child is born); • s/he is a parent whose needs are met by his/her spouse who is not a natural or adoptive parent of the dependent child, and the parent has chosen to be excluded; or • s/he is a parent under age 21, his/her needs are met by his/her parent(s) living in the home, and the parent under 21 has chosen to be excluded. <p>If a natural or adoptive parent of a child applying for MA chooses to exclude him/herself from the unit, the parent is included in the unit provisionally when determining the child's eligibility for Medicaid.</p> <p>A step-parent may be included in an AR unit at his/her option. If s/he chooses to be excluded from the unit, his/her income and resources are not counted unless his/her spouse is in the unit.</p> <p>SR: A group member is excluded if s/he refuses to provide information necessary to determine</p>
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	<p>eligibility such as their Social Security Number, etc.</p> <p>Resources and income of excluded persons may be considered in determining eligibility (see Chapter 2: Whose Assets are Counted and Chapter 5: Whose Income is Counted in Part VI).</p> <p>QM: See SR.</p>
TANF	<p>The following persons cannot be included in the assistance unit:</p> <ul style="list-style-type: none"> • non-qualified immigrants and certain categories of qualified immigrants (see Chapter 7: Citizenship/Alienage in this Part); • a step-parent whose needs are excluded from the grant because s/he does not have a child in common with the parent of a child in the assistance unit; • foster children and children receiving adoption assistance. Such children, however, may qualify the caretaker for TANF assistance (see Section 4.3: Adoption Subsidy and Section 4.16: Foster Care Payments in Part VI); • unless exempt, an adult who failed to sign the Customer/Agency Agreement. Persons exempt from this requirement are those who are working at least 30 hours per week or who are subject to the school attendance requirement; • individuals who failed to cooperate with IMA at the application stage (see Section 3.4.1: Failure to Cooperate with IMA at the Application Stage in Part III); and • SSI recipients. An SSI recipient may be the caretaker of a child but shall not be included in the TANF grant). <p>A child receiving SSI shall not be included in the TANF grant but may qualify the caretaker. Two parents may be included in the grant if the SSI child is deprived due to incapacity or unemployment of a parent (see Chapter 8: TANF Child Deprivation in this Part).</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Example</p> <p>Ms. Roberts lives with her daughter, Sara, who receives SSI. Ms. Roberts has no source of income. Ms. Roberts can qualify for a TANF grant based on a group size of one. Sara would not be included in the grant.</p> </div> <p>The SSR should never deem the income and/or assets of an SSI recipient to the group. The SSR should not compute an overpayment (see Chapter 6: Overpayment and Underpayment) for the dual receipt of TANF and SSI unless:</p> <ul style="list-style-type: none"> • ESA informed SSA that a person would be removed from the grant on a specific date, and • the person was not removed from the grant on that date. <p>If the SSI check was not reduced due to TANF benefit, the SSR should notify SSA of the dual receipt. SSA will process an SSI overpayment.</p> <p>Individuals who are sanctioned as a result of failing to comply with a program requirement after eligibility has been determined and a grant of assistance is made (see Part V: Program Requirements and Sanctions for more information) may have their needs removed from the grant.</p>
GC	Caretakers cannot be included in a GC assistance unit.
FS	<p>Any individual convicted of trafficking FS benefits of \$500 or more is permanently disqualified from receiving FS benefits.</p> <p>In addition, individuals who failed to cooperate with IMA at the application stage (see Section 3.4.1: Failure to Cooperate with IMA at the Application Stage in Part III) are excluded.</p>

ESSENTIAL PERSON 1.6

MA	<p>AR: An essential person is an individual who lives in the home with a dependent child (other than an unborn child) and is recognized as essential to the child's well-being by the applicant/recipient. There are two ways someone may be an essential person:</p> <ul style="list-style-type: none">• applicant/recipient declares that a related individual is essential to the child's well-being, or• competent medical testimony maintains that a non-related individual is essential to the child's well-being. <p>An essential person has the option of being included in the assistance unit.</p> <p>AX: See AR.</p> <p>SR: N/A</p> <p>QM: N/A</p>
TANF	N/A
GC	N/A
FS	<p>SSI recipients receive a higher SSI payment level when an essential person lives in the home. To be considered an essential person for purposes of SSI, the essential person must live in the home of the recipient and his/her needs must have been considered in determining the grant of the eligible individual. The essential person must not be eligible for SSI in his/her own right.</p> <p>In the case of a household consisting of one SSI recipient and an essential person, the maximum SSI payment is increased from the single person entitlement to the entitlement for a couple. For FS purposes, this would be considered a two person household. If an eligible couple has an essential person, the SSI entitlement is increased to include the difference between the single-person entitlement and that for a couple. This is considered a normal three person household for FS program purposes, and all income received is considered. The FS program purchase and prepare requirements and household composition provisions must be considered when determining household size (see Section 1.3: Mandatory Group Members in this Chapter).</p>

ADDING A NEWBORN 1.7

This section has been moved to Part VIII, Chapter 5, Section 5.6: Adding a Newborn.

ADDING A CARETAKER IF PARENT IS NOT IN THE HOME 1.8

MA	<p>AR: Add caretakers to the group if:</p> <ul style="list-style-type: none">• the biological or adoptive parent is not in the home,• the caretakers elect to be in the group, and• the caretakers meet all non financial eligibility requirements. <p>AX: See AR.</p> <p>SR: N/A</p> <p>QM: N/A</p>
TANF	See AR, except caretakers must be related in order to be included in the TANF grant or for children in their care to be eligible for TANF.

GC	N/A
FS	N/A
GC CUSTODIAL RELATIONSHIP 1.9	
MA	N/A
TANF	N/A
GC	In order to be eligible for GC, the child's caretaker must produce authorization from the child's legally responsible relative or a court of competent jurisdiction designating the caretaker as the temporary or permanent caretaker for the child, to the extent such authorization is obtainable by the caretaker. When such authorization is not obtainable by the caretaker, the caretaker may offer other proof of a custodial relationship between the caretaker and the child. Proof may include, but is not limited to, leases indicating that the child lives with the caretaker, medical records, a school record bearing the caretaker's signature or affidavits from teachers, social workers, medical staff, or other professionals involved in the family's life.
FS	N/A

GROUPS WITH NO CHILDREN 1.10

MA	<p>There are seven situations in which a group with no children may receive MA benefits. These situations arise if the group consists only of the following or some combination of the following:</p> <ul style="list-style-type: none"> • individuals who are disabled or who are at least 65; • individuals who are 19 or 20; • parents or caretakers who live with children who are age 19 or 20 whose income meets the MNIL; • parents, caretakers, or step-parents whose income is less than 200 percent of the FPL whose children or step-children are included in a separate group; (Note: The children or step-children must receive Medicaid in order for a parent, step-parent or caretaker to qualify under the AR or AX program types on the basis of being a parent, step-parent, or caretaker.) • a pregnant woman whose income is less than 200 percent of the FPL and who is not living with any other children; or • Medicare beneficiaries in QM units.
TANF	<p>There are five situations which allow a group with no children to receive benefits. These five situations arise if the group consists only of a:</p> <ul style="list-style-type: none"> • pregnant woman who meets all financial and non-financial eligibility requirements (except being the parent of a minor child; see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility) and: <ul style="list-style-type: none"> ○ she is expected to deliver the child within four months; and ○ the child, if born, would be eligible for TANF. <p>The SSR should not add the expecting father of the unborn to the group prior to the birth of the child. After the birth, the father must be part of the group if he lives in the same home as the child.</p> • parent or caretaker of an SSI child when the dependent child would be eligible except for the receipt of SSI; • parent or caretaker of a child disqualified due to TANF school attendance requirements

	<p>when the dependent child would be eligible except for disqualification for failure to meet TANF school attendance requirements (see Section 4.5.2: School Attendance in this Part);</p> <ul style="list-style-type: none"> • caretaker relative of a foster child when the dependent child would be eligible except that the child is receiving foster care payments (most foster parents are not related to the foster child and are therefore ineligible); or • parent or caretaker of child receiving adoption assistance when the dependent child is not in the group due to receipt of adoption assistance.
GC	N/A
FS	Eligibility for FS does not require the presence of children, thus many FS households do not include children.

LIVING WITH AND LIVING TOGETHER 1.11

ALL	<p>'Living together' or 'living with' means sharing a home except for temporary absences. A temporarily absent person is considered in the home (see Section 1.14: Temporary Absence in this Chapter). In order to receive assistance as part of a group, an individual must live with the group.</p> <p>Individuals are considered to be living together if they share any common living quarters such as a kitchen, bathroom, bedroom, or living room. Persons who share only an access area (that is, entrance or hallway) or non living area (that is, laundry room) are not considered to be living together.</p>
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MULTIPLE GENERATIONS IN THE HOME 1.12

MA	See Section 1.4: Optional Group Members for information regarding the option to include parents of pregnant or parenting minors.
TANF	<p>The child of a minor receiving TANF assistance is not a mandatory group member. However, if assistance is requested for the child of the minor, s/he must be included in the group with his/her parent. If the minor parent's parent or caretaker relative is receiving assistance or applies for assistance, the minor parent must be included in the same unit as his/her parent or caretaker relative. Similarly, if the minor parent's sibling who lives in the same household as the minor parent is receiving assistance, the minor parent must be included in the same unit as his/her sibling. If the minor parent does not live with a parent, caretaker relative, or sibling who is also receiving TANF, the minor parent can be the head of his/her own unit.</p> <p>If the minor parent does not meet all non-financial eligibility requirements (as in the case of the minor parent receiving SSI), a separate group should be established for the minor parent's child. The child should not be included in the assistance group with the minor parent's parent/caretaker relative or the minor's parent's sibling. However, if the minor parent is disqualified from receiving TANF because s/he fails to comply with program requirements, the minor parent's child should be included in the unit with the minor parent's parent, caretaker relative, or sibling if the child would have been included in the unit if the minor parent was not disqualified.</p> <p>Example 1</p> <p>Ms. Smith lives with her teenage daughter, Jane who is 17. Ms. Smith and her teenager receive TANF. Jane has a baby. The baby's father pays child support. The baby does not have to be included in the group with Jane and Jane's mother if the group chooses to exclude the baby.</p>

	<p>Example 2</p> <p>Ms. Thomas lives with her teenage daughter Amy who is 16. Ms. Thomas works and does not receive TANF. Amy has a baby and applies for TANF. The TANF group can consist of just Amy and the baby, if Ms. Thomas does not want to be included. Because Ms. Thomas is legally responsible for her teenage daughter, Ms. Thomas' income is deemed, using the deemed parent formula, to the group that includes Amy.</p>
	<p>Example 3</p> <p>Ms. Krohn lives with her teenage daughter Julia who receives SSI. Julia, age 16, has a baby. The baby must be in her own group since her mother, Julia, is ineligible for TANF due to her receipt of SSI. Because the baby's grandmother, Ms. Krohn, is not legally responsible for her granddaughter, no income is deemed from Ms. Krohn to the baby.</p>
	<p>Example 4</p> <p>A household consists of a mother, Ms. Fisher, and her two teenage daughters (Alisha and Kim); Kim receives SSI. The TANF group consists of Ms. Fisher and Alisha. Both Alisha and Kim have babies and request assistance for them. Add Alisha's baby to the existing TANF group. Establish a separate group for Kim's baby. Since Kim receives SSI, she does not meet the non-financial eligibility requirements.</p>
	<p>Example 5</p> <p>Ms. Waxman lives with her daughter (Denise, age 17) and her granddaughter, Amy. Ms. Waxman receives TANF for herself, Denise, and Amy. Denise fails to comply with the school attendance requirement and is removed from the grant. Amy must remain in the unit with Ms. Waxman. A separate unit is not established for Amy.</p>
GC	N/A
FS	N/A

REQUIREMENT THAT MINOR PARENT LIVE IN AN ADULT SUPERVISED SETTING 1.13

MA	N/A
TANF	<p>To receive TANF benefits, a minor custodial parent (male or female) or a pregnant teen expecting to give birth within four months who is younger than 18 years of age must reside in his/her parent's home or, if that option is unavailable, in the home of another adult relative or guardian. This requirement does not apply if the teen parent is married, regardless of whether the teen parent is residing with his/her spouse.</p> <p>If the applicant refuses to comply (without claiming one of the good cause exceptions listed below) or does not provide a 'living with' (see Section 1.10: Living With and Living Together in this Chapter) statement from the adult with whom the teen parent lives, the SSR should approve the TANF assistance grant for the child or children only and exclude the minor parent when determining the payment amount. This sanction will continue until the minor parent complies with the requirement to live in an adult-supervised setting or reaches his/her 18th birthday, whichever occurs first. The SSR must explain the requirement that a minor parent live in an adult-supervised setting to a teen parent applicant.</p> <p>A minor parent is considered to have good cause for failing to live in an adult-supervised setting and shall not be subject to the requirement if:</p> <ul style="list-style-type: none"> • There is no parent, guardian, or other adult relative living or his/her whereabouts are

	<p>unknown;</p> <ul style="list-style-type: none"> • There is no parent, legal guardian, or other adult relative willing to allow the minor parent to reside in his/her home; or • There exists in the parent's, guardian's, or relative's home a situation which, if the minor parent lived there, would jeopardize the physical or emotional health or safety of the minor parent or child. <p>In the event a minor parent claims to fall into one of the excepted categories, assistance is to be approved or continued while the Office of Child and Family Services (OCFS) investigates the minor parent's claim. If the claim is substantiated, OCFS will assist the minor parent in locating a suitable, adult-supervised living arrangement (e.g., second-chance home, maternity home, or other appropriate adult-supervised supportive living arrangement) in order to create an allowable living arrangement that will enable the applicant/recipient to obtain TANF benefits. The results of the investigation will be made available to the SSR within 45 days. The case shall be approved within the normal processing standards while the OCFS is finding an appropriate living arrangement if the group is otherwise eligible.</p>
GC	N/A
FS	If a minor parent applying for FS is also receiving TANF and fails to meet the requirement to live in an adult-supervised setting, the FS amount must be based on the full TANF grant amount (that is, including the minor parent's needs) even though the household is not receiving the full TANF grant.

LIVING SITUATIONS 1.14

MA	N/A
TANF	N/A
GC	N/A
FS	<p>The following policies describe living situations which must meet specific requirements to allow eligibility.</p> <ul style="list-style-type: none"> • A boarder is a person residing in a licensed commercial boarding house who pays a fee to a person or group of people for housing and meals. Boarders are ineligible for FS as a separate group. If the boarder does not pay a reasonable amount for meals provided, the boarder must be included in the FS group consisting of the household that provides the boarder services. If the boarder pays a reasonable amount for meals provided, the group that provides the boarder services can choose whether or not to include the boarder in its FS group. Boarder status shall not be granted to individuals otherwise required to be included in the FS unit. If the boarder is excluded from the FS unit, the amount paid to the household providing boarder services less reasonable expenses is treated as self-employment income (see Section 4.40: Self-Employment in Part VI). • A live in attendant who lives in the group's home to provide housekeeping, medical or child care, or similar personal services may form a separate group if s/he purchases and prepares food separately from other household members. Persons who take someone into their own home to provide such services are not considered live in attendants. Spouses, parents, children, and siblings cannot be live in attendants for one another, regardless of the actual situation. • A roomer is a person to whom the group furnishes lodging, but not meals, for compensation. A roomer may apply for FS as a separate group if s/he purchases and prepares meals separately.

TEMPORARY ABSENSE 1.15

ALL	The SSR should determine if someone has left the group permanently or is only temporarily absent. If the person has left the group permanently, then the SSR should remove the person from the group and adjust the benefit level when appropriate. If the individual who left the group wishes to apply for assistance as his/her own group, s/he must re-apply for program benefits.
MA	<p>A person's absence is temporary if:</p> <ul style="list-style-type: none"> the individual's location is known, there is a definite plan to return home when the purpose of the absence has been accomplished, s/he continues to make his/her home in D.C., and s/he does not establish residency in another state; or the absence is for vacations, medical conditions, business trips, school attendance, or family commitments. An absence outside the United States may also be a temporary absence. <p>A person who is in and out of the home is considered to be living in the home provided another residence has not been established and his/her possessions remain in the home.</p> <p>A newborn who remains in the hospital is considered to be living with the mother unless the hospital certifies that the baby will never be released to the home, the baby is made a ward of the District, or someone else obtains legal custody.</p> <p>Verification of absences of more than 30 days is mandatory to determine if the individual is returning to the home.</p>
TANF	<p>See MA. In addition, the 'living with' requirement (see Section 1.10: Living With and Living Together in this Chapter) continues to be met when either the child or caretaker is temporarily absent if:</p> <ul style="list-style-type: none"> the caretaker continues to exercise responsibility for care and control of the child; the family has definite plans to unite; and the caretaker or child's absence has lasted, or is expected to last, 90 days or less. <p>Assistance will be denied to any minor child who is absent from the home or is expected by the parent or caretaker relative to be absent from the home without good cause in excess of 90 days.</p> <p>A parent or caretaker relative who fails to notify the Department on a timely basis of the absence or the expected absence of a minor child from the home for a period in excess of 90 days shall be disqualified from program participation for three consecutive payment months (the child now absent from the group must also be removed from the group) effective the first month the change can be made (adequate and timely notice is required). Notification of an absence expected to last more than 90 days must be provided to the Department within a five-day period, which begins on the date that it becomes clear to the parent or caretaker relative that the minor child will be absent in excess of 90 days.</p> <p>The absent child remains eligible if an absence of more than 90 days is due to good cause. Good cause is defined as:</p> <ul style="list-style-type: none"> training, including the Job Corps; schooling, including schools which also provide medical care; treatment in a residential center for drug/alcohol addiction; hospitalization, including newborns who remain in the hospital after the mother is discharged, unless: <ul style="list-style-type: none"> the hospital indicates that it is unlikely that the baby will ever be released to the

	<ul style="list-style-type: none"> home, ○ the baby is made a ward of the District, or ○ someone else obtains legal custody of the baby; and • a situation in which joint or shared custody or a visitation order exists which requires the child to be out of the home for more than 90 days, but the applicant/customer is expected to maintain a home for the child. This exception applies as long as the child is not in an assistance unit with the other parent in D.C. or any other jurisdiction.
GC	GC See TANF
FS	FS A member of a FS group must be in the household at least one day during the month to be considered part of the FS stamp unit.

VERIFICATION 1.16

ALL	MA, TANF, GC, and FS all require certain aspects of group composition to be verified. The following sections detail which aspects of group composition must be verified.
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Boarder Status 1.16.1

MA	N/A
TANF	N/A
GC	N/A
FS	If the person claims boarder status, the SSR must obtain a written statement from the board provider that indicates the amount paid for board.

Identity 1.16.2

MA	<p><i>AR/AX D.C. Healthy Families Application Users:</i> D.C. Healthy Families applications must be accompanied by proof of each applicant's social security number or proof that a social security number has been applied for. Examples of acceptable proof include:</p> <ul style="list-style-type: none"> • a social security card; • an application for an SSN; • a Social Security benefits document; or • other state, local, or federal document (such as a driver's license) indicating the SSN. <p><i>AR/AX Combined Application Users:</i> The person applying for assistance must present evidence of his/her identity (only the identity of the PI must be verified).</p> <p>If documentary evidence is not readily available, a collateral contact must be used. A collateral contact is an oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made in person or over the phone. No specific document can be required as verification and photo identification cannot be required.</p> <p>Acceptable verification may include, but cannot be limited to, any one of the following:</p> <ul style="list-style-type: none"> • driver's license; • D.C. issued non-drivers I.D.; • school I.D.; • documents which indicate a client's receipt of benefits under another program which requires verification of identity, such as SSI or SSDI; • birth certificate; • Social Security card; • pay-stubs;
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	<ul style="list-style-type: none"> • voter registration card; • employee identification card; • library card; • passport; • I.D. issued by the Public Housing Authority; • I.D. card, issued from previous eligibility, including a copy of the photo I.D. card in the applicant's previous case record; and • contact with a third party agreeable to the SSR and applicant who can identify the client. <p>SR: See AR/AX Combined Application Users.</p> <p>QM: See AR/AX Combined Application Users.</p>
TANF	See AR/AX Combined Application Users.
GC	See AR/AX Combined Application Users.
FS	See AR/AX Combined Application Users. Also, if a person filing an application or accessing benefits applies on behalf of a group, the identity of both the person filing the application and the head of the household must be verified.

Inability to Purchase/Prepare Food 1.16.3

MA	N/A
TANF	N/A
GC	N/A
FS	When an individual age 60 and over seeks to establish a separate Food Stamp unit based on an inability to purchase and prepare food on their own, the SSR must obtain a statement from a physician or licensed or certified psychologist if it is not obvious that the individual is not able to purchase and/or prepare food separately because s/he suffers from a physical or mental disability. Verification is not required if it is obvious that the individual is unable to purchase and/or prepare meals separately due to a physical or mental disability.

Chapter 2 - Residency

INTRODUCTION 2.1

To be eligible for program benefits, a person must be a resident of the District of Columbia. However, no durational residency requirement may be imposed.

A person must not be denied program benefits because s/he does not reside in a permanent dwelling or does not have a fixed mailing address.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Residency	TANF: 4-205.2-4;4-205.69 GC: See TANF and DC Code 4-205.5a	MA: 42 CFR 435.403 TANF: 42 USC 608 (a)(8); 42 USC 608 (a)(10) FS: 7 CFR 273.3

DETERMINING RESIDENCY 2.3

MA	<p>A person is generally considered a resident if s/he is presently living in DC voluntarily and not for a temporary purpose and has no current intention of moving out of DC. In some cases, Medicaid applicants may be considered residents when they move to DC to work or seek employment, even if this is for a temporary period. Staff should contact the policy office in reference to applicants who report they have a temporary purpose for staying in DC.</p> <p><i>Temporary Non-Immigrants</i></p> <p>Persons who are in this country for temporary purposes and who remain under the jurisdiction of another country, such as embassy employees and their families, are not residents of the District of Columbia. This includes children born to such employees in the US. Unless they change their immigration status or become naturalized citizens, they are not under the jurisdiction of the United States and are not residents of the District of Columbia.</p>
TANF	See MA.
GC	See MA.
FS	<p>A FS applicant/recipient is considered a resident of DC if s/he is physically present in the city, and intends to remain in the city permanently, temporarily or indefinitely for any purpose other than vacation. Students who return home during school breaks and elderly individuals who spend a portion of the year with friends or relatives are not considered vacationers; these individuals are considered residents for the time they spend in DC. Persons who are working in DC or seeking employment and students who are here attending school are considered residents while here. The fact that a group may be living in informal arrangements, such as camping or in a vehicle, does not affect resident status.</p>

INSTITUTIONALIZED PERSONS 2.4

MA	<p>A person is a resident of DC if a DC agency (that is, Social Services, juvenile court, and so on) places the person in an institution located in another state. Generally, a person is not a resident of DC if another state's agency places the person in an institution in DC. However, Title IV-E foster children, children who receive adoption subsidies under IV-E, and other foster children and adoptive foster homes are in DC are residents of DC. Adopted and foster children receiving IV-E assistance from DC but who live outside DC are not residents of DC for purposes of MA eligibility. Such children receive MA from the state where they are physically located.</p> <p>With the exception of a person who is in an out-of-state placement and one who is under age 21 and unmarried, the residency status of an institutionalized person is dependent on a determination of his/her capability to indicate intent. A person is considered to be capable of indicating intent unless evidence establishes that s/he is incapable.</p> <p>When it is verified that a person meets any one of the following criteria, s/he is considered to be incapable of indicating intent:</p> <ul style="list-style-type: none"> • has an IQ less than 50, • has a mental age of less than eight, • is judged incompetent by a court, • is in a psychiatric facility by order of a court, or • the MRT based on medical evidence has determined s/he is incapable. <p>For an institutionalized person who became incapable of indicating intent before age 21 or is under age 18 and unmarried, the state of residence is DC if:</p> <ul style="list-style-type: none"> • The person is institutionalized in DC and: <ul style="list-style-type: none"> ○ s/he was abandoned by his/her parents, s/he does not have a court-appointed legal guardian, and the person who completed the most recent application for the person lives in DC; ○ the parental rights of the person's parents have been terminated; the court has appointed a legal guardian for the person, and the legal guardian lives in DC; or ○ one of his/her legal parents lives in DC; or • at the time s/he was institutionalized: <ul style="list-style-type: none"> ○ the parental rights of the person's parents were terminated, and the person had a court-appointed legal guardian who lived in DC; or ○ one of the person's legal parents lived in DC. <p>An institutionalized person who became incapable at or after age 21 is a resident of DC if s/he is physically present in DC, and the placement was not made by an out-of-state agency.</p> <p>An institutionalized but capable person who is at least age 18 or married is a resident of DC when s/he is living in DC and intends to remain permanently or for an indefinite period.</p>
TANF	N/A
GC	N/A
FS	<p>Individuals shall be considered residents of an institution when the institution provides them with the majority (over 50 percent of three meals daily) of their meals as part of the institution's normal services. Residents of an institution are considered residents of the state in which the institution is located.</p>

	<p>Persons in certain living situations are exempt from this limitation. The following persons can receive Food Stamps even if they are provided most of their meals by the institution:</p> <ul style="list-style-type: none"> • residents of private or public shelters for the homeless; • residents of federally-subsidized housing for the elderly; • residents of a facility or treatment center that is providing them regular treatment or rehabilitation for alcohol or drug addiction; <ul style="list-style-type: none"> ○ This includes children who are living with a person receiving treatment in a drug or alcohol facility but it does not include the spouse of a person receiving drug or alcohol treatment; • persons who are disabled or blind and are residents in a group living facility; and • women or women and their children who are temporarily living in a shelter for battered women and children.
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HOMELESS PERSONS 2.5

ALL	<p>A homeless person is an individual who lacks a fixed and regular nighttime residence or whose nighttime residence is:</p> <ul style="list-style-type: none"> • a supervised private or public shelter designed to provide temporary accommodations for the homeless; • an accommodation which provides temporary residence for individuals released from institutions; • a temporary accommodation in the residence of another; or • a place not designed or ordinarily used as a residence such as a public hallway, bus station, park, building entrance, and so on. <p>A homeless person who generally resides within District borders is considered a resident of the District. Homeless persons should be encouraged to give a mailing address so that they can receive notices from IMA. However, a mailing address is not a requirement to receive benefits</p>
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CHANGING RESIDENCY 2.6

ALL	<p>No individual may participate in more than one state's program in any month unless that individual is a resident of a shelter for battered women and children and was a member of a household containing the person who had abused him/her (see Section 10.10: Shelter Facilities for Battered Women & Children in this Part).</p> <p>If the applicant household indicates that they either did not receive or did not redeem benefits from the other state in that month, the SSR may accept their declaration, request verification from the other state, and if the group is otherwise eligible, issue benefits for the month of application.</p> <p>If the applicant acknowledges receiving benefits, the application may be used to establish eligibility for the first month for which benefits were not received from the other state.</p>
MA	<p>Assistance must terminate at the end of the month in which a person moves to another state.</p>
TANF	<p>Assistance shall continue for the two months following the month in which a person moves to another state provided the group continues to meet all other financial and non-financial eligibility requirements (see Part IV: Non-Financial Eligibility and Part VI: Financial Eligibility) and the group verifies that it has applied for assistance in the other state. The group is not permitted, however, to receive benefits in two states for the same benefit month.</p>

GC	See MA.
FS	See MA.

VERIFICATION 2.7

ALL	<p><i>The following applies to all programs except for the DC HealthCare Alliance. See below for verification requirements relating to the Alliance.</i></p> <p>Residence shall be verified, subject to the following provisions:</p> <ul style="list-style-type: none"> • There is a difference between verifying that someone is a DC resident and verifying his/her current address. A customer may be able to establish that he/she is a resident of DC without providing documentation of his/her exact address, such as a homeless person. Also, a person may provide proof that he/she is staying at a particular address in DC and yet not be a DC resident, such as a vacationer or a diplomat. • A person's statements regarding his/her intent to remain a resident of the District of Columbia are acceptable verification unless they are inconsistent or in conflict with known facts. • A client who has just arrived in DC, an immigrant, or a homeless person who does not have a permanent address cannot be denied benefits solely for lack of verification of residency. The SSR should note the lack of verification and the reason it is unavailable in the case record. The SSR should inquire as to exactly where the client sleeps and annotate the case record accordingly. <p>Verification sources include but are not limited, to the following:</p> <ul style="list-style-type: none"> • Residence <ul style="list-style-type: none"> ○ driver's license, ○ other types of I.D. which provide both a name and address, ○ mortgage or rent receipt, ○ utility bills, ○ lease or statement from the landlord or shelter, or ○ collateral contact • Intent to return to D.C. <ul style="list-style-type: none"> ○ evidence that possessions remain in D.C., ○ evidence that a local job is being held for return., or ○ evidence that the reason for the absence implies intent to remain a DC resident. <p>Applicants/recipients are not required to verify a reported mailing address.</p>
MA	<p><i>DC HealthCare Alliance</i></p> <p>Effective September 15, 2009, the following are the only allowable verifications of DC residence for the DC HealthCare Alliance:</p> <ul style="list-style-type: none"> • a current DC driver's license or current Non-Driver ID issued by the DC Department of Motor Vehicles; • a voter registration card with an address in the District of Columbia; • an unexpired lease, rental agreement, or rent receipt for a residence in the District of Columbia; • a deed, settlement agreement, or mortgage statement for a residence in the District of Columbia; • a DC Property Tax bill issued within the last 60 days for a residence in the District of

	<p>Columbia;</p> <ul style="list-style-type: none"> • an unexpired homeowner's or renter's insurance policy for a residence in the District of Columbia; • a utility bill (water, gas, electric, oil, cable, or landline telephone) for a residence in the District of Columbia, issued in the last 60 days; • a pay stub indicating a DC address and DC withholding taxes, for pay received in the last 30 days; or • a letter from a verifiable source confirming that the applicant resides in the District. Such a letter must meet the following criteria: <ul style="list-style-type: none"> ○ The letter is signed by a DC resident or a DC social service provider, with the signer's name, DC address, and telephone number; ○ The letter states that the applicant is a DC resident; and ○ If signed by a DC resident, the signer must provide a document from the items above establishing the signer's DC residency. <ul style="list-style-type: none"> ▪ Applicants may use the "Proof of D.C. Residency Form" as the letter. This form may be completed by either of the following; <ul style="list-style-type: none"> ▪ a DC resident who provides one of the documents listed above as proof of their own DC residence; or ▪ a non-profit social service provider, such as a community health provider*, a shelter, a religious organization, a legal clinic, or an immigrant services provider <p>*"Community health provider" does not include a hospital or a contractor working for a hospital.</p>
FS	<p>Documents provided for other areas of eligibility such as shelter costs and identification should be used as much as possible to verify residence. If such documentation is not sufficient, use a collateral contact or other readily available documents as verification. Any reasonable document or collateral contact is sufficient to establish residence.</p>

Chapter 3 - Social Security Number

INTRODUCTION 3.1

Applicants/recipients must:

- furnish an SSN (or numbers if more than one has been issued) for each member of the group, or
- apply for a number (either because a number has not been issued or is not known) and furnish the number when it is received from SSA, except that:
 - applicants/recipients of the DC HealthCare Alliance are not required to apply for an SSN if they do not have one, and
 - applicants/recipients of Medical Assistance under Emergency Medicaid and the Immigrant Children's Program are exempt from this requirement.

The SSR shall notify the applicant/recipient that the SSN will be used in administering the program, including the use of computer matches with other data sources such as Social Security and DOES data.

A person with more than one SSN must reveal all numbers. The SSR should record each number provided.

Individuals who fail, without good cause, to provide an SSN are ineligible for program benefits. There are exceptions to this rule (see Section 3.3: Exceptions/Good Cause for a discussion of exceptions and good cause in this Chapter).

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Social Security Number (SSN)	TANF: 4-217.7 GC: See TANF and DC Code 4-205.5a	MA: 42 CFR 435.910; 435.920 FS: 7 CFR 273.6

EXCEPTIONS/GOOD CAUSE 3.3

ALL	<p>A group member who has not complied with SSN requirements may be allowed to continue to participate if good cause exists as determined by the SSR. The good cause determination must be noted in the case record. An example of a good cause reason for failing to provide an SSN is the case of an individual who cannot apply for an SSN because s/he cannot secure a needed out-of-state birth certificate.</p> <p>Good cause for not complying in a timely fashion does not include delays due to illness, lack of transportation, or temporary absences.</p> <p>In cases not involving expedited Food Stamp service, if good cause exists for not applying for and/or providing an SSN, the person is allowed to participate for the month of application and one additional month. Good cause must be shown monthly thereafter. The SSR should assist a person who is unable to obtain the verification needed to apply for an SSN.</p>
MA	<p>The SSR should exempt aliens eligible only for emergency services and children eligible for the Immigrant Children's Program from the SSN requirement. Adults and children in the DC HealthCare Alliance must provide their SSN if they have one, but they are not required to apply for an SSN if they do not have one.</p>
GC	<p>The SSR should exempt a child from the SSN requirement if:</p> <ul style="list-style-type: none">• the child is too young to apply for a number, or• the SSA will not honor the caretaker's application for the child's number.

FS	<p>The SSR should advise the group that an SSN or proof of application for an SSN must be provided for each member prior to certification except for households entitled to expedited service or categorically eligible groups (see Chapter 4: Expedited Services in Part III and Chapter 12: Categorical Eligibility in this Part).</p> <p>FS groups entitled to expedited service are not required to provide or apply for a SSN prior to receiving their initial benefit. They must do so prior to the issuance of benefits subsequent to the issuance of expedited benefits.</p> <p>A categorically eligible group is not required to provide proof of SSNs for Food Stamp purposes.</p> <p>In addition, a newborn may be added to an open case without provision of an SSN or proof of application for an SSN (see Adding a Newborn in Section 1.7 of this Part).</p>
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VERIFICATION 3.4

All SSNs must be verified unless the person is exempt from the requirement. Once an applicant/recipient has furnished an SSN, the primary means of verification is by submission of the SSN to SSA for verification through the ACEDS system.

The SSR should not delay the issuance of benefits pending receipt of a number when application for an SSN has been verified.

Acceptable verification of application for an SSN includes:

- a receipt from SSA,
- notices from hospitals with enumeration agreements, or
- vital records for those enumerated at birth.

Chapter 4 - Age/School Attendance

INTRODUCTION 4.1

Age and school attendance are eligibility factors for some programs. In some cases, age may not be an eligibility factor, but it may impact what disregards and deductions the individual receives. For some programs, school attendance can make an individual ineligible while, for others, school attendance is required in order for an individual to be eligible.

LEGAL AUTHORITY 4.2

AREA/TOPIC	DISTRICT	FEDERAL
Age	TANF: DC Code 4-205.15 GC: See TANF and DC Code 4-205.5a.	MA: 42 USC 1396a(a)(10); 42 USC 1396a(l); 42 USC 1396d(a); 42 USC 1396u-1; 42 USC 1396a(m); 42 CFR 435.4, 435.520 TANF: 45 CFR 260.30 FS: 7 USC 2012 (f); 2014 (c); 2014 (e); 2014 (g); 7 CFR 273.8(b); 273.9(a); 273.9(d)
School Attendance and Student Status	TANF: DC Code 4-205.15, 4-205.65-.66 GC: DC Code 4-205.5a; 34205.15	TANF: 42 USC 608 (a)(4); 45 CFR 261.33 FS: 7 USC 2015 (e); 7 CFR 273.5(

AGE 4.3

MA	<p>Age is an eligibility factor for certain MA categories. A person remains eligible with respect to age for the entire month in which s/he reaches the maximum age even if the birthday is the first of the month.</p> <p>AR: A child in an AR unit must be under the age of 21. Children ages 19 and 20 are eligible for Medicaid if they have incomes under 200% of the FPL.</p> <p>AX: A child in an AX unit must be under the age of 19.</p> <p>SR: An individual must be age 65 or older to meet SR eligibility on the basis of age. There is no age requirement for an individual who is statutorily blind or permanently and totally disabled. However, if the disabled person is under age 21 or the individual is a parent or caretaker relative, his/her Medicaid eligibility should be evaluated under the AR and AX program types first. If the individual is eligible based on the AR or AX program types, the individual's Medicaid application should be approved. The individual should be strongly encouraged to complete the medical evaluation form because if the MRT determines the individual disabled, and the case is converted to an SR case, the individual will not be placed in the same managed care system that serves non-disabled Medicaid participants. This system may not be appropriate for individuals with disabilities. (If the individual's income - after the appropriate deductions - exceeds the SR standard for a household of one, the individual does not need to complete a medical evaluation form.)</p> <p>QM: Age does not need to be verified, though eligibility for Medicare, an age-related benefit itself,</p>
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	must be verified.
TANF	<p>Age is an eligibility factor for the child(ren) in the group. However, there is no age requirement for the parent/caretaker relative.</p> <p>In general, a child must be under age 18. In certain circumstances, an 18-year-old child may be included in the group if the 18-year-old child:</p> <ul style="list-style-type: none"> Is enrolled as a full-time student in a secondary school or in the equivalent level of vocational or technical training program before s/he reaches 19 years of age. See Section 4.4: School Enrollment and Student Status in this Chapter. <p>The inclusion of the 18 year old child into the group, who is enrolled as a full-time student in a secondary school or in the equivalent level of vocational or technical training program before s/he reaches 19 years of age, as described above, is optional.</p>
GC	See TANF
FS	<p>Age is not an eligibility factor for FS but must be considered in certain situations. FS groups that include a person who is 60 or older are:</p> <ul style="list-style-type: none"> not required to meet the gross income test (see Section 8.4: Determining Income-Eligibility in Part VI); entitled, under some circumstances, to a higher shelter deduction (see Section 6.3: Income Disregards and Deductions in Part VI); subject to a higher resource limit (see Exhibit VI-2); and entitled to an Excess Medical Deduction if the elderly individual's medical expenses exceed \$35 per month (see Section 6.3: Income Disregards and Deductions in Part VI).

SCHOOL ATTENDANCE AND STUDENT STATUS 4.4

MA	N/A
TANF	<p>Dependent 16- and 17-year-old children who do not have a high school diploma or a General Education Development (GED) certificate must be enrolled in an elementary or secondary school, vocational, or technical training program in order to be eligible for TANF.</p> <p>A child is a full-time student if s/he is enrolled in:</p> <ul style="list-style-type: none"> a public school or a licensed private school and the program calls for at least twenty (20) hours of classroom or vocational training a week; a junior college, college, or university and is carrying at least eight (8) semester or quarter hours; or a training program which: <ul style="list-style-type: none"> is designed to prepare the student for gainful employment, issues a certificate or diploma upon successful completion of the program, and calls for attendance of at least 20 hours per week. <p>The Job Corps is a program that qualifies as a training program.</p> <p>The child must be enrolled in school full-time unless one (1) of the following exemptions apply:</p> <ul style="list-style-type: none"> only part-time attendance is necessary to receive a diploma, the remaining portion of the day is spent in a work study or similar program, or the child completed secondary school or received a GED certificate.

If a dependent 16 or 17-year-old fails to comply with this requirement, his/her needs will be removed from the grant.

A child is a part-time student if s/he is enrolled in:

- a public school or a licensed private school and the program calls for at least six (6) but less than twenty (20) hours of classroom instruction or vocational/technical training per week;
- a junior college, college, or university and is carrying at least four (4) but less than eight (8) semester or quarter hours; or
- a training program which:
 - is designed to prepare the student for gainful employment,
 - issues a certificate or diploma upon successful completion of the program, and
 - requires for attendance of at least six (6) but less than twenty 20 hours per week.

If the child already has a high school diploma or a GED certificate, s/he is eligible for TANF as long as s/he is under age 18.

'Enrolled in' means that the particular school or training program considers the child to be a current student. The enrollment status continues:

- during the summer months (through September) if the child was enrolled when school was dismissed for the summer break, and
- until the ESA worker verifies or receives notification that a child is no longer enrolled.

Example

A school drops a child from its enrollment list in November due to non-attendance. The ESA Social Service Representative (SSR) is notified in January that the child is no longer enrolled. The ESA Worker should consider the child to be a student through January because it was in January when ESA received notification that the child was no longer enrolled. No overpayment is charged against the TANF grant.

Dependent 18-year-old children

Dependent 18-year-olds included in the TANF group must be enrolled in secondary school or an equivalent training program. An 18-year-old who has already graduated from high school is ineligible for TANF assistance as a dependent child. The 18-year-old must be enrolled full-time unless at least one (1) of the exemptions apply:

- only part-time attendance is necessary to receive a diploma, or
- the remaining portion of the day is spent in a work study or similar program.

Full-time enrollment is defined in the same manner as for Dependent 16 and 17-year-olds above.

The 18-year-old student becomes ineligible for TANF assistance as a dependent child if s/he is no longer physically attending unless s/he is not attending but:

- has definite plans to resume his/her attendance within 30 days, or
- is not currently attending due to:
 - illness of limited duration,
 - family emergency of limited duration,

	<ul style="list-style-type: none"> ○ school suspension, or ○ house arrest.
GC	See TANF
FS	<p>Attending 'institutions of higher education' (see definition below) may affect a person's eligibility. Students who are enrolled at least half-time in an institution of higher education must meet at least one of the following criteria to be eligible:</p> <ul style="list-style-type: none"> • receiving TANF benefits; • under age 18 or over age 49; • physically or mentally unable to work; • employed and paid for at least 20 hours per week or self-employed for a minimum of 20 hours per week and paid the equivalent of working at least 20 hours per week at the federal minimum hourly wage (this includes on-the-job training, internships, and apprenticeships); • participating in a state or federally financed work study program (the exemption begins the date the person is approved for work study or the beginning of the school year, whichever is later, and continues over the period the work study is intended to cover, unless the student rejects or refuses a work study assignment); • responsible for the physical care of a dependent household member under age six; • responsible for the physical care of a dependent household member ages six through 11 when adequate child care is not available; • a single parent attending an institution of higher education full-time with responsibility for a child under 12; or • assigned to an institution of higher education through a program under the JTPA, Trade Adjustment Assistance (TAA), Trade Readjustment Assistance (TRA), or FSET. <p>If a person is enrolled in a post-secondary program which contains both a classroom and a training component, the person is not considered a student when participating in the training component. When the person is attending classes, however, s/he is considered a student and is ineligible for the program unless one of the exemption criteria is met.</p> <p>All other students are ineligible for FS unless they receive TANF and/or SSI. TANF and SSI recipients may attend post-secondary institutions even if they are part of a Food Stamp unit that includes individuals who do not receive TANF or SSI.</p> <p>'Institution of higher education' means any institution which normally requires a high school diploma or equivalency certificate for enrollment, including but not limited to colleges, universities, and vocational or technical schools at the post-high school level.</p> <p>The enrollment status of a student will begin on the first day of the school term of the institution of higher education. Such enrollment will be deemed to continue through normal periods of class attendance, vacation, and recess unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term (excluding summer school). Residents of institutions are not eligible for program participation. Dormitories are considered institutions if they provide students the majority of their meals, and the dormitory is not authorized to accept EBT cards.</p> <p>If a student can demonstrate that the dormitory does not provide him/her a majority of his/her meals, the student may participate if otherwise eligible; if the dormitory has separate room/board contracts, and the student only enters into a 'room' contract, the student would not be considered a resident of an institution.</p>

SCHOOL ATTENDANCE AND STUDENT STATUS 4.4

Teen Parent School Attendance Requirement 4.4.1

MA	N/A
TANF	<p>To receive TANF benefits as a pregnant teen or parenting teen (male or female) who is younger than 20 years of age, he/she must attend high school or an equivalent educational, training, or other similar program approved by the Department. This requirement does not apply if:</p> <ul style="list-style-type: none">• the teen parent is married, whether or not the teen parent is residing with his/her spouse;• the teen parent has already obtained a high school diploma or a GED certificate; or• the teen parent is a dependent child living with a parent or caretaker relative who is applying for or receiving TANF for the teen parent. <p>The teen parent cannot be required to attend school or an equivalent training/educational program if her/his child is less than 12 weeks of age (this differs from the standard TANF work exemption which exempts parents of children under age one from work requirements). The teen parent also cannot be required to attend school or a training/educational program if the reason for the lack of attendance is that appropriate child care within a reasonable distance from school is unavailable, unaffordable, or unsuitable, and the child for whom care is sought is less than six years of age. A teen parent who fails without good cause to comply with the school attendance requirement is ineligible for assistance (the children remain eligible).</p> <p>Good cause reasons for not complying with school attendance requirements shall include circumstances beyond the individual's control such as, but not limited to, the following:</p> <ul style="list-style-type: none">• illness of the individual,• illness of another household member requiring the presence of the individual,• a household emergency (including domestic violence),• unavailability of transportation,• lack of adequate or affordable child care for children who are six and under, and• discrimination by a school in violation of District or federal law
GC	N/A
FS	N/A

VERIFICATION 4.5

Age 4.5.1

MA	<p>AR: No verification of age is required.</p> <p>AX: See AR.</p> <p>SR: If age is an eligibility factor (that is, the applicant is applying based on age not disability), age should be verified if questionable. Sources of verification include:</p> <ul style="list-style-type: none">• physician's statement,• insurance policy,• court documents,• Census records,• social service agency records,
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	<ul style="list-style-type: none"> • birth certificate, • adoption papers, • hospital or birth records, • baptismal records, • church birth records, • U.S. passport, • family bible, • Indian Census records, • INS records, • military records, and • SSA records or documents. <p>QM: N/A</p>
TANF	<p>The age of children should be verified if questionable (even if the child is excluded from the unit but is the basis of a parent/caretaker relative's eligibility). See SR for sources of verification. Two of the following may be substituted if the sources listed in SR are not available:</p> <ul style="list-style-type: none"> • school records, • court support order, • juvenile court records, • child welfare records, • insurance policy, and • affidavit from an individual other than the caretaker relative who has knowledge of the birth.
GC	See TANF
FS	<p>If age is questionable and needed to determine eligibility or benefit levels (that is, if a person claims to be entitled to a medical deduction based on his/her being at least 60 years of age, but the SSR finds the declared age questionable), the SSR must obtain verification (see SR for sources of verification).</p>

School Attendance 4.5.2

MA	N/A
TANF	<p>School enrollment must be verified for each dependent child age 16 and older. School enrollment, as well as attendance, must be verified for teen parents.</p> <p>A Verification of School Attendance Form is used to verify enrollment. The form is completed by a school official and a school stamp must be affixed to the form. Other verification sources for school enrollment and student status include school records such as:</p> <ul style="list-style-type: none"> • most recent issued report card for current school year, • correspondence from school authorities, • correspondence from scholarship boards or other similar organizations, or • information from school records obtained through data sharing agreements and exchanges with schools.

	Teen parents required to attend school are referred to the New Heights program operated by the DC. Public Schools. This program monitors expectant and teen parent enrollment and attendance in school.
GC	See TANF
FS	The SSR should verify school enrollment and school attendance only if questionable.

Chapter 5 - Living with a Relative

INTRODUCTION 5.1

Requirements regarding living with a relative vary by program. For FS, a child does not have to live with a relative. For GC, living with a relative makes a child ineligible for GC assistance. For TANF, a child must live with a relative who is responsible for his/her day-to-day care in order to be eligible. There is no requirement that a child live with a relative in order to receive MA. Unrelated caretakers may be included in the MA group with a child in their care. This chapter outlines the program requirements, defines who is a relative, describes the circumstances under which paternity must be established, and discusses who is a caretaker. This chapter applies only to MA and TANF.

LEGAL AUTHORITY 5.2

AREA/TOPIC	DISTRICT	FEDERAL
Living with a Relative	TANF: D.C. Code 4-205.15; 4-205.18 GC: See TANF and D.C. Code 4-205.5a.	MA: N/A TANF: 45 CFR 263.2 (b)(2); 260.20 (a)

LIVING WITH A RELATIVE 5.3

MA	AR: A caretaker relative of a child may be included, at his/her option, in the AR assistance unit. (See Section 5.6: Caretaker in this Chapter.) An unrelated caretaker may also be included in the unit at his/her option. AX: See AR. SR: N/A QM: N/A
TANF	In order to be eligible for TANF, a child must live with a relative who has responsibility for the day-to-day care of the child. A child who is not living with a relative may be eligible for a temporary period (not to exceed three months) if: <ul style="list-style-type: none">the child had been receiving TANF;an emergency situation occurs which deprives the child of the care of the relative with whom s/he has been receiving assistance, andanother person acts for the relative. Do not include the other person in the group. For information about a child or caretaker's temporary absence from the home, see Section 1.14: Temporary Absence in this Part . If the TANF application is denied because relationship between the child and caretaker could not be established, the case should be considered for the GC program.

WHO IS A RELATIVE 5.4

MA	AR: The SSR should consider the following people relatives: <ul style="list-style-type: none">any relative, including one of half-blood, who is within the sixth degree of relationship:<ul style="list-style-type: none">grandparent, great-grandparent, great-great-grandparent, great-great-great-grandparent, or great-great-great-great-grandparent;sister or brother;half-sister or half-brother;step-sister or step-brother;uncle, great-uncle, great-great-uncle, great-great-great-uncle, or great-great-great-great-uncle;aunt, great-aunt, great-great-aunt, great-great-great-aunt, or great-great-great-great-aunt;first cousin or first cousin once removed;
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	<ul style="list-style-type: none"> ○ second cousin; or ○ niece or nephew; • stepfather or stepmother; and • spouse of any person named above even after the marriage is ended by death or divorce. <p>The above people include relationships established by adoption.</p> <p>A court termination of parental rights negates that parent as an eligible relative, but the relationship between the child and other relatives (such as a grandmother) remains intact.</p> <p>Legal custody has no effect on relationship. Unrelated caretakers -- including legal guardians -- can, however, be included in the group at their option.</p> <p>AX: See AR.</p> <p>SR: N/A</p> <p>QM: N/A</p>
TANF	See AR, except that an unrelated caretaker cannot be included in the group.

PATERNITY 5.5

MA	N/A
TANF	<p>Paternity must be established for a father before he can qualify for TANF based on being a child's father.</p> <p>The SSR should accept the following circumstances as proof that paternity has been established:</p> <ul style="list-style-type: none"> • mother and father were married either when the child was born or conceived; • judicial determination; • father's name on a D.C. birth certificate issued after October 8, 1981; • written acknowledgment by the father; or • genetic test indicating at least 99 percent probability of paternity. <p>The SSR may establish paternity in additional ways if:</p> <ul style="list-style-type: none"> • the child ever lived in another state; and • during that time, circumstances existed which established paternity according to the state's laws. <p>In Maryland, additional ways are:</p> <ul style="list-style-type: none"> • marriage after the birth and the father verbally acknowledged being the father, or • father openly acknowledges the child to be his. <p>In Virginia, additional ways are:</p> <ul style="list-style-type: none"> • father's name on a Virginia birth certificate issued after July 1, 1991; • father openly cohabitated with the mother during all of the 10 months prior to the child's birth; or • father claimed the child on any statement, tax return, or other document filed with any local, state, or federal agency.

	For other states, contact the CSED for guidelines on how paternity is established.
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CARETAKER 5.6

MA	<p>AR: In order to be eligible for MA as a caretaker of a child, the adult must be responsible for the day-to-day care of the child. This includes physical care, supervision, and making decisions about the child.</p> <p>The SSR should consider a parent in the home to be the caretaker of the child unless:</p> <ul style="list-style-type: none"> • the parent states that another relative is the principal caretaker, • another relative presents convincing evidence that s/he is the actual caretaker, or • the parent states that the child is independent, and the child is: <ul style="list-style-type: none"> ◦ married, or ◦ previously lived apart from the parent and received TANF as a caretaker during that time. <p>A person retains caretaker status if the child and caretaker live together even if the child is:</p> <ul style="list-style-type: none"> • under the jurisdiction of a court (such as on probation or under protective supervision), or • in the legal custody of an agency. <p>AX: See AR.</p> <p>SR: N/A</p> <p>QM: N/A</p>
TANF	See AR, except the caretaker, must be related within a specified degree of relationship.

STEP-PARENTS 5.7

MA	<p>AR: Step-parents can, at their option, be included in an AR group with their step-children. If they choose to be out of the unit, and the stepparent's spouse is included in the unit, the stepparent's income is deemed to the group. If the step-parent chooses not to be in the group, and the stepparent's spouse also chooses not to be in the group, no income is deemed from the step-parent to the children in the group.</p> <p>AX: See AR</p> <p>SR: N/A</p> <p>QM: N/A</p>
TANF	When a step-parent is in the home, and the parent and step-parent have no children in common, both the step-parent and the parent are out of the unit and the child receives a child-only grant. In this circumstance, no income is deemed from the step-parent to the group. If the step-parent is in the home but the parent is not, the step-parent can be in the unit with his/her step-children or choose to be out of the unit at his/her option. In this situation, the step-parent is treated as any other caretaker relative.

VERIFICATION 5.8

Relationship 5.8.1

MA	<p>AR: No verification of relationship is required.</p> <p>AX: See AR.</p> <p>SR: For individuals applying for LTC, spousal relationships must be verified. The following pieces of verification are acceptable:</p> <ul style="list-style-type: none">• marriage license/certificate,• SSA records indicating relationship,• divorce papers, and• vital statistics records <p>If the above sources are not available, use two of the following:</p> <ul style="list-style-type: none">• statement from a priest, minister, or rabbi;• family bible;• health records maintained by a hospital, clinic, or physician;• social service agency records;• insurance records; and• Census records. <p>QM: No verification of relationship is required unless questionable.</p>
TANF	<p>Relationship must be verified initially and when a child is added; no verification is required at recertification.</p> <p>The following pieces of verification are acceptable:</p> <ul style="list-style-type: none">• birth certificates,• adoption records,• marriage license/certificate,• divorce papers,• hospital records of birth,• vital statistics records,• court records of parentage,• baptismal records,• juvenile court records,• child support records, and• SSA records indicating relationship. <p>If the above sources are not available, use two of the following:</p> <ul style="list-style-type: none">• statement from a priest, minister, or rabbi;• family bible;• health records maintained by a hospital, clinic, or physician;• child care records;• social service agency records;• insurance records;• school records;• Census records; and• CSED records

Living With 5.8.2

MA	No 'living with' verification is required unless information provided appears questionable.
TANF	<p>'Living with' must be verified at application and when adding a child to the assistance unit. School records (for school age children) or at least two of the following is acceptable:</p> <ul style="list-style-type: none">• hospital, clinic, or health department records;• statement from child care provider;• court support order;• juvenile court records;• child welfare agency records;• statement from clergy;• statement from non-relative; and• statement from a non-relative landlord.

Chapter 6 - Pregnancy

INTRODUCTION 6.1

Pregnancy can affect what benefits an individual may receive or what program requirements they must follow. For example, if a minor is pregnant and is expected to deliver within the next four months she is ineligible for GC; instead, the SSR should determine if she is eligible under TANF. In addition, pregnant women may face different income tests in Medicaid. This chapter details the adjustments that must be made for a pregnant applicant. Pregnancy does not affect eligibility determinations for FS. This chapter only applies to MA, TANF, and GC.

LEGAL AUTHORITY 6.2

AREA/TOPIC	DISTRICT	FEDERAL
Pregnant Women	D.C. Code: 4-205.43	MA: 42 USC 1396a(e)(4)-(6); 42 USC 1396a(1); 42 USC 1396d(a) (10); 42 USC 1396r-1; 42 USC 1396u-1; 42 CFR 435.116; 42 CFR 435.117; 42 CFR 435.170 TANF: 42 USC 608 (a)(1)

ELIGIBILITY 6.3

MA	<p>A woman is eligible for Medicaid under the AR/AX program types once pregnancy has been confirmed.</p> <p>When determining the eligibility of a pregnant woman or a group that includes a pregnant woman, take into account the needs, income, and resources of:</p> <ul style="list-style-type: none">• the pregnant woman,• the unborn child (or children when it is medically verified that there is more than one fetus),• the unborn child's father if he is living in the home (the father cannot be in the group until the child is born), and• eligible siblings. <p>The needs, income, and resources of the unborn child are considered as though the child (or children) were born and living with the mother (see Section 6.5: Presumptive Eligibility for Pregnant Women for information on presumptive Medicaid eligibility for pregnant women).</p> <p>Example Ms. Brady is pregnant. She has no other children and does not live with the unborn child's father. When assessing program eligibility for Ms. Brady, her income will be compared to the income eligibility standard for a family of two.</p>
TANF	<p>A woman who is pregnant and presents medical certification that she is expected to deliver within the next four months is eligible for TANF benefits, even if she has no other children in her household.</p>
GC	<p>If a non-related caretaker applies for financial benefits for a pregnant minor who is not expected to deliver within 4 months, the application should be processed under the GC program. When a pregnant minor is expected to deliver within 4 months, she is eligible for TANF provided she meets all other financial and non-financial eligibility requirements for TANF. In this case, no GC application should be taken.</p>

PROGRAM REQUIREMENTS 6.4

MA	<p>Pregnant women are not required to cooperate in establishing paternity and obtaining medical support for either their unborn child or other children in their families.</p> <p>All other non-financial eligibility factors applicable to the MA program must be met by pregnant women, including:</p> <ul style="list-style-type: none">• residence• citizenship or alienage• SSNs• assignment of third-party liability rights• utilization of potential benefits.
TANF	<p>In order to receive benefits, a pregnant minor (under age 18) expected to deliver within the next four months must reside in her parent's home or, if that option is unavailable, in the home of another adult relative or responsible adult (unless the Department determines that no appropriate such living arrangement exists). If the pregnant teen is married, then s/he is not required to live in an adult-supervised setting, even if the teen is not residing with her spouse. This requirement also applies to minor custodial parents (see Section 1.12: Requirement that Minor Parent Live in an Adult-Supervised Setting in this Part for more information).</p> <p>In addition, an unmarried pregnant teen must attend high school or an equivalent educational, training, or other similar program approved by the Department unless she has good cause for failing to meet the requirement. This requirement does not apply if she is married, even if she is not living with her spouse, or if she has already obtained a high school diploma or GED certificate. Unmarried parenting teens are also subject to this requirement (see Section 4.4.1: Teen Parent School Attendance Requirement in this Part for more information).</p>
GC	N/A

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN 6.5

MA	<p>Presumptive eligibility is available to pregnant women whose family income does not exceed 200 percent of FPL while ongoing eligibility for MA is determined. Selected qualified medical providers (QMP) are authorized to make a presumptive eligibility determination based on preliminary information. Eligibility is established on the basis of pregnancy, family income, and family size (with the unborn child treated as a group member). The pregnancy must be medically verified. The pregnant woman's family income must not exceed 200 percent of the FPL.</p> <p>The presumptive eligibility period begins on the day the QMP makes the presumptive eligibility determination. The pregnant woman is presumptively eligible until the last day of the month following the month she became presumptively eligible.</p> <p>During the presumptive eligibility period, the pregnant woman is eligible for ambulatory prenatal services only. The services must be provided by a Medicaid provider. Delivery and hospitalization costs are not covered unless the woman is subsequently determined eligible for MA.</p> <p>A presumptive eligibility period is limited to one presumptive determination per pregnancy. Individuals ineligible for MA due to immigration status are not eligible for a presumptive eligibility determination (see Chapter 7: Citizenship/Alienage in this Part).</p>
TANF	N/A

GC	N/A
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EXTENDED COVERAGE OF PREGNANT WOMEN 6.6

MA	<p>Continue to provide all pregnancy-related and postpartum services to any woman (except non-qualified aliens) who was eligible for, applied for, and received MA while pregnant. The services continue for 60 days after the pregnancy ends beginning on the last day of pregnancy and ending on the last day of the month in which the 60th day falls.</p>
	<p>Example Ms. Bennett gives birth on May 20. Extended coverage begins on May 20 and ends on July 31.</p>
	<p>Re-determine eligibility for an individual whose eligibility ends after the extended coverage period to determine if she and her family are eligible for continued services.</p> <p>Individuals ineligible for MA due to immigration status are not eligible for extended benefits. Postpartum services are provided, however, as part of emergency pregnancy-related services for such immigrants.</p> <p>The newborn is deemed eligible for one year (see Section 1.7: Adding a Newborn in this Part).</p>
TANF	N/A
GC	N/A

VERIFICATION 6.7

MA	<p>AR/AX D.C. Healthy Families Application Users: No verification of pregnancy is required.</p> <p>AR/AX Combined Application Users: Pregnancy should be verified, particularly in early months. Also, pregnancy must be verified for presumptive eligibility.</p>
TANF	Pregnancy must be verified prior to providing benefits to a woman based on her pregnancy.
GC	N/A

Chapter 7 - Citizenship / Alienage

INTRODUCTION 7.1

PRWORA narrowed the groups of immigrants eligible for various types of assistance. Several pieces of subsequent legislation further refined the groups of immigrants eligible and ineligible for TANF, Medicaid, and FS. Under federal law prior to 1996, most immigrants in the country lawfully were eligible for cash assistance, FS, and Medicaid on the same basis as U.S. citizens. Undocumented immigrants were eligible for emergency Medicaid services only. Under current law, some lawfully present immigrants are ineligible for these forms of aid. Immigrants ineligible for Medicaid based only on their immigration status, including both those here lawfully and unlawfully, are eligible for emergency Medicaid services.

With only three exceptions (which are unlikely to arise frequently in DC), an immigrant must have one of the immigration statuses that makes him or her a 'qualified immigrant' to be eligible for any form of assistance administered by IMA other than emergency Medicaid. Many immigrants in the country lawfully, as well as undocumented immigrants, do not meet the criteria to be 'qualified immigrants.' While non-qualified immigrants are ineligible for TANF, Medicaid (except emergency Medicaid), and FS, it is also the case that some 'qualified immigrants' are ineligible for one or more programs administered by the Department due to their immigration status. However, because an immigrant generally must be 'qualified' to be eligible for any forms of assistance, SSRs should first determine whether the individual's immigration status makes him/her 'qualified' when determining program eligibility.

The presence of a person who does not meet the citizenship/alien status factor does not prohibit other persons in the home from applying for and receiving program benefits. However, the income and assets of such disqualified persons may have to be considered in determining the eligibility for and amount of benefits of other persons in the home (see [Chapter 2: Whose Assets Are Counted](#) and [Chapter 5: Whose Income is Counted](#) in [Part VI](#)).

LEGAL AUTHORITY 7.2

AREA/TOPIC	DISTRICT	FEDERAL
Citizenship/Alienage Eligibility	TANF: D.C. Code 4-205.15 (2) and (3); 4-205.24 GC: See TANF and D.C. Code 4-205.5a	ALL: 8 USC Chapter 14 et. seq. Department of Justice Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [AG Order No. 2129-97]; Guidelines for Making Determinations Using SSA's Quarters of Coverage History System, June 1998, Social Security Administration
Refugee Cash and Medical Program		45 CFR 400

QUALIFIED ALIENS 7.3

ALL	PRWORA created a new eligibility category for aliens, called 'qualified aliens.' The following table provides a description of qualified aliens by immigration category.	
	Immigration Category	Description
	Lawful Permanent Resident (LPR)	Person granted LPR status (green card holders)
	Refugee	Person admitted as a refugee
	Asylee	Person granted asylum
	Granted Withholding of Removal (formerly called	Person granted withholding of removal

'Withholding of Deportation')	
Parolee for a year or more	Person who has been paroled into the U.S. for at least one year
Cuban and Haitian Entrant	Person paroled into the U.S. as a Cuban or Haitian Entrant or any other national from Cuba or Haiti who is the subject of exclusion or removal proceedings or who has an application for asylum pending
Domestic Violence Victims and their parents or children	Regardless of the individual's immigration status, a victim of domestic violence or his/her parent or child is 'qualified' if: <ul style="list-style-type: none"> immigrant has been battered or subjected to extreme cruelty, or immigrant's child or parent has been battered, by a spouse, parent, or member of the household; immigrant has a pending or approved spousal petition or a petition pending for relief under the Violence Against Women Act; immigrant's need for assistance has a substantial connection to the battery or cruelty; and immigrant does not currently live with the abuser.
Victim of a Severe Form of Trafficking in Persons	Regardless of the individual's immigration status, an immigrant is considered 'qualified' if designated by the Office of Refugee Resettlement as a victim of a severe form of trafficking in persons.

Exceptions 7.3.1

ALL	<p>There are three exceptions to the requirement that an immigrant be qualified in order to be eligible for benefits.</p> <ul style="list-style-type: none"> Native American Exception: American Indians born in Canada and certain other tribal members born outside the U.S. are eligible for FS, Medicaid, and SSI even if they do not otherwise meet the criteria to be a 'qualified' immigrant. If they do not otherwise meet the definition of 'qualified,' they are not eligible for TANF or GC. Hmong and Laotian Exception: This exception only affects FS eligibility. Some lawfully present immigrants who would otherwise be ineligible for FS are eligible if they were a member of a Hmong or Laotian tribe when the tribe rendered assistance to U.S. military personnel during the Vietnam era. The spouse, unmarried dependent child, and the surviving spouse (who has not remarried) of such an immigrant also are eligible for FS. To be eligible for FS under this exception, the immigrant must be lawfully present but does not have to meet the 'qualified' criteria. Non-Qualified Immigrants Who Were Receiving SSI on August 22, 1996: Non-qualified immigrants who were receiving SSI on August 22, 1996 are eligible for SSI. If they receive SSI, they are also eligible for Medicaid
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Lawfully Present but Not Qualified Aliens 7.3.2

ALL	<p>As noted, many aliens in the United States lawfully are not considered 'qualified.' Examples of such lawfully present immigrants include:</p> <ul style="list-style-type: none"> immigrants paroled into the country for less than one year, those who hold temporary resident status, immigrants granted temporary protected status, family unity beneficiary under IRCA amnesty program, immigrant granted Deferred Enforced Departure or Deferred Action Status, immigrant who is the spouse or child of a U.S. citizen who has a pending application for
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	<p>adjustment of status, and</p> <ul style="list-style-type: none"> • applicant for asylum or cancelation of removal who has been granted employment authorization.
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ELIGIBILITY FOR BENEFITS 7.4

ALL	<p>Some groups of qualified immigrants are ineligible for some or all Department-administered assistance programs. The following program-specific tables describe the groups of qualified immigrants eligible for FS, TANF, GC, IDA, and MA (see Section 7.4.2: Eligibility Charts in this Chapter). In addition, a chart showing the immigrant eligibility rules for SSI is also included even though the Department does not administer this program.</p> <p>When determining whether an immigrant meets the immigration-related criteria for various programs, it is important to note that an immigrant may fit into more than one immigration status for purposes of benefit determination. The immigrant is eligible if anyone of his/her immigration categories is one for which benefits are provided.</p> <p>Example</p> <p>Mr. Soto entered the country as a refugee three years ago and has converted to LPR status (most refugees and asylees convert to LPR status within two years of entering the country). Mr. Soto would be eligible for FS based on having entered as a refugee within the last seven years, even though he would not be eligible for FS based on being an LPR.</p>
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Common Terms 7.4.1

ALL	<p>The following are terms used frequently in this chapter. They are defined here to make the chapter, particularly the eligibility charts, easier to read.</p> <ul style="list-style-type: none"> • Veteran Exemption: Many groups of otherwise ineligible immigrants are eligible for program benefits if they are veterans or on active U.S. military duty or are the spouse or unmarried dependent of a veteran or person on active duty. • Entered the Country on or Before August 22, 1996: In some cases, qualified immigrants who entered the country on or before August 22, 1996 are treated differently than immigrants who entered after this date. When eligibility hinges on whether an individual entered the country on or before August 22, 1996, the immigrant's immigration status on or before August 22, 1996 is irrelevant. For example, immigrants who currently fall into a 'qualified' category and who entered the country on or before August 22, 1996 are eligible for TANF, regardless of their immigration status when they entered the country on or before August 22, 1996. • 40-Quarters Exemption: Some LPRs otherwise ineligible for program benefits are eligible for assistance if they have 40 countable quarters of employment. The quarters of a spouse or parent can be counted when determining an individual immigrant's countable quarters. The concept of countable quarters used here is generally equivalent to that used by the SSA which determines the number of countable quarters each employee 'earns' based on his/her annual earnings (see Section 8.3.2: Work History in this Chapter). This calculation of countable quarters is needed to determine citizens' and immigrants' eligibility for Social Security retirement, disability, and survivors' benefits. Under SSA rules, no employee can earn more than four quarters each year based on his/her own earnings, although more than four quarters per year can be counted when determining whether an immigrant meets the 40-quarter exemption criteria if the immigrant's spouse or parent (during years in which the immigrant is a minor) also worked. (This exemption is only available to LPRs who have 40 countable quarters. It is not available to other qualified immigrants who do not have LPR status.)
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	<p>Example Mr. and Mrs. Mehta emigrated from India and both worked in 1997. Each earned enough to be credited with four countable quarters based on their own earnings. Because the quarters of spouses can be added together when determining immigrant eligibility for benefits, both Mr. and Mrs. Mehta are credited with eight countable quarters for purposes of determining if they meet the 40-quarter exemption.</p> <ul style="list-style-type: none"> • Hmong/Laotian Exemption: Some lawfully present immigrants (these immigrants do not have to be 'qualified') who would otherwise be ineligible for FS are eligible if they were a member of a Hmong or Laotian tribe when the tribe rendered assistance to US personnel during the Vietnam era. The spouse, unmarried dependent child, or the surviving spouse (who has not remarried) of such an immigrant also are considered part of this category. • Native American Exemption: Some otherwise ineligible American Indians born in Canada and certain other tribal members born outside the US (including non-qualified immigrants) are eligible for Medicaid, FS, and SSI. These immigrants do not receive special treatment under TANF but may be eligible if they otherwise fit into an eligible immigrant category. • Lawfully Present: Individuals who have INS authorization to be in the country. • Lawfully Residing: Individuals who have INS authorization to be in the country and who are not in the country on a temporary basis such as a student or tourist. • Disability-Related Benefits: These include SSI, SSDI, railroad retirement disability, veteran's disability, Federal retirement disability, Interim Disability Assistance (IDA), and disability-related Medicaid (SR for disabled). • Amerasian: Child fathered by a US citizen in certain Southeast Asian countries during the years of conflict in that region. These immigrants have been granted LPR status. • Refugee: Person who has left their country of origin and is unable or unwilling to return because of persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group. • Asylee: Person already admitted to the US, who requests permission to stay because of persecution or fear of persecution in their country of origin. • Parolee: Person admitted to the US or permitted to stay in the US based upon a decision of the Department of Justice that this serves the public interest. Parole may be granted for humanitarian, legal or medical reasons.
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Eligibility Charts 7.4.2

ALL	<p>The following charts describe the immigration-related eligibility requirements for MA, TANF/GC, and FS. In addition, a chart showing SSI/IDA eligibility has been included to assist SSRs who get questions from customers about SSI eligibility rules.</p> <p>When using these charts, it is important to note that many immigrants will fall into more than one immigrant category. In such cases, the immigrant is eligible for the program benefit if s/he falls into at least one eligible category.</p>	
MA	Immigration Category	<p>Circumstances Under Which Immigrant Is Eligible for MEDICAID OR D.C. MEDICAL CHARITIES (other than Emergency Medicaid)</p>
	Immigrants Receiving SSI Eligible	See the SSI table for information on immigrant eligibility for SSI.
	Qualified Immigrant	<p>Eligible if:</p> <ul style="list-style-type: none"> • entered the country before August 22, 1996; • meets veteran exemption; • meets Native American exception; or • entered the country on or after August 22, 1996 and has been in the U.S. in a 'qualified status' for more than 5 years (no one qualified under this category until August

	23, 2001).
Immigrant Category Entered the country as a Refugee (or was granted refugee status)	All immigrants in these categories are eligible for Medicaid
Granted Asylee Status	
Granted Withholding of Removal	
Cuban/Haitian Entrant	
Amerasian Immigrant	
Victim of Severe Form of Trafficking in Persons	
Non-Qualified Immigrant	Eligible if meets Native American exception

Emergency Medicaid

Individuals who would be eligible for Medicaid except for their immigration status are eligible for Emergency Medicaid services. Medical services covered are for medical conditions (including emergency labor and delivery) manifesting themselves by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

DC Healthy Families Expansion Coverage

In addition to Emergency Medicaid Services, non-qualified immigrant children may qualify for locally-funded Medical assistance through “DC Healthy Families Expansion Coverage,” a funding-capped program that can serve approximately 800 children. Children eligible for “Expansion Coverage” must be ineligible for standard Medicaid because of their immigration status. They must meet all other non-financial requirements in the AX Medicaid program, except provision of a Social Security Number. Their income must be below 200 percent of Federal Poverty Level.

Children eligible for “Expansion Coverage” must enroll in managed care and are eligible for standard Medicaid services. However, they cannot receive Medicaid services on a fee-for-service basis prior to enrolling in managed care. Children eligible for “Expansion Coverage” are not eligible for retroactive eligibility and cannot qualify for benefits by spending down their income with medical bills.

ESA currently runs a waiting list when requests for the program exceed the program's capacity.

TANF/GC	Immigration Category	Circumstances Under Which Immigrant Is Eligible for TANF/GC
	Qualified Immigrant	Eligible if: <ul style="list-style-type: none"> entered the country before August 22, 1996; meets veteran exemption; or entered the country on or after August 22, 1996 and has been in the U.S. in a 'qualified' status for more than 5 years (no one qualified under this category until August 23, 2001).
	Entered the country as a Refugee (or was granted refugee status) Granted Asylee Status Granted Withholding of Removal Cuban/Haitian Entrant Amerasian Immigrant Victim of Severe Form of Trafficking in Persons	All immigrants in these categories are eligible for TANF/GC.
	Non-Qualified Immigrant	Non-Qualified Immigrants are ineligible for TANF/GC

FS	Immigration Category	Circumstances Under Which Immigrant Is Eligible for FS
	Qualified Immigrant	Eligible if: <ul style="list-style-type: none"> meets veteran exemption meets Hmong/Laotian exemption meets Native American exemption currently receives disability-related benefits is currently under age 18, or was lawfully residing in U.S. on August 22, 1996 and <ul style="list-style-type: none"> was 65 years or older on August 22, 1996
	LPR	Eligible if: <ul style="list-style-type: none"> meets 40-quarters exemption, or has been in the country at least 5 years in a 'qualified' status <p>See also 'Qualified Immigrant' eligibility categories above.</p>
	Entered the country as a Refugee (or was granted refugee status) Granted Asylee Status Granted Withholding of Removal Cuban/Haitian Entrant	Eligible if entered the country or granted status in the last seven years See also 'Qualified Immigrant' eligibility categories and, if applicable, the 'LPR' categories above. The seven-year 'clock' begins to run at the time the immigrant was granted one of these statuses. For example, asylees are eligible for FS for the first seven years after they were granted asylee status, not seven years after they first entered the U.S. Similarly,

	Amerasian Immigrant	those granted cancellation of removal are eligible for FS for the first seven years after they were granted cancellation of removal.
	Victim of Severe Form of Trafficking in Persons	
	Non-Qualified Immigrant	Eligible if: <ul style="list-style-type: none"> • meets Hmong/Laotian Exception, or • meets Native American Exception.

SSI/IDA	Immigration Category	Circumstances Under Which Immigrant Is Eligible for SSI
	Qualified Immigrant	Eligible if: <ul style="list-style-type: none"> • was receiving SSI on August 22, 1996; • was lawfully residing in the country on August 22, 1996 and is currently Blind or disabled; • meets veteran exemption; or • meets Native American exception.
	LPRs	Eligible if: <ul style="list-style-type: none"> • entered the country before August 22, 1996 and meets 40-quarters exemption; or • entered the country on or after August 22, 1996, has been in the country at least 5 years, and meets the 40-quarter exemption (no one qualified under these criteria until August 23, 2001). See also 'Qualified Immigrant' eligibility categories above.
	Entered the country as a Refugee (or was granted refugee status)	Eligible if entered the country or granted status in the last seven years. See also 'Qualified Immigrant' eligibility categories and, if applicable, the 'LPR' eligibility categories above.
	Granted Asylee Status	The seven-year 'clock' begins to run at the time the immigrant was granted one of these statuses. For example, asylees are eligible for SSI for the first seven years after they were granted asylee status, not seven years after they first entered the U.S. Similarly, those granted cancellation of removal are eligible for SSI for the first seven years after they were granted cancellation of removal.
	Granted Withholding of Removal	
	Cuban/Haitian Entrant	
	Victim of Severe Form of Trafficking in Persons	
	Amerasian Immigrant	Eligible if entered the country or granted status in the last seven years. See also 'Qualified Immigrant' and 'LPR' eligibility categories above.
	Non-Qualified Immigrant	Eligible if meets Native American exception.

REFUGEE-RELATED CASH AND MEDICAL ASSISTANCE 7.5

Eligible Immigrants 7.5.1

Immigrants ineligible for TANF, Medicaid, and SSI who fall into one of the following four categories can apply for Refugee Cash Assistance and/or Refugee Medical Assistance:

- those who were paroled as a refugee or asylee under section 212(d)(5) of the Immigration and Nationality Act (INA);
- those admitted as a conditional entrant under section 203(a)(7) of the INA;
- those admitted as a refugee under section 207 of the INA;
- those granted asylum under section 208 of the INA ; and
- those admitted for permanent residence, provided the individual previously held one of the statuses identified above.

Eligibility for Refugee Cash Assistance and Refugee Medical Assistance are limited to the first eight months the immigrant is in the United States, except in the case of an asylee who is eligible for the eight-month period beginning on the date s/he is granted asylee status, with the month in which the status is granted counting as the first month. For non-asylee cases, the month of entry is considered the first month in the United States

Example

Ms. Xhoa entered the United States on a tourist visa on January 18, 1999. She applied for asylee status after entering the United States and was granted asylum August 14, 1999. Ms. Xhoa is eligible for Refugee Cash and Refugee Medical Assistance for the period August 14, 1999 - March 30, 2000.

Refugee Cash Assistance 7.5.2

Refugee Cash Assistance provides cash assistance benefits to eligible immigrants who meet the financial eligibility requirements and are ineligible for TANF due to the non-financial eligibility requirements of TANF. The RCA benefit levels and methodologies for determining financial eligibility are identical to those in the TANF program. The TANF non-financial eligibility requirements do not apply, however, to RCA. Thus, single individuals and married couples without children as well as two-parent families ineligible for TANF under the 'unemployed parent' requirements are eligible for RCA.

Before an RCA application can be approved, the applicant must demonstrate that s/he has registered for employment services funded by the District of Columbia Office of Refugee Resettlement (DCORR). The refugee must show an employment registration form from a specified service provider.

RCA recipients must report changes in income, resources, and household composition that affect eligibility and benefits under the same rules as TANF customers.

Refugee Medical Assistance (RMA) 7.5.3

The Refugee Medical Assistance (RMA) program provides health insurance comparable to Medicaid to eligible immigrants who do not qualify for Medicaid due to non-financial eligibility requirements. Thus, single, non-disabled individuals and couples without children who would otherwise be ineligible for Medicaid can qualify for RMA. The RMA program uses the Medically Needy Income Level and budgeting methodologies.

Immigrants eligible for RCA are categorically eligible for RMA.

Once an immigrant has been found eligible for RMA, s/he is not required to recertify his/her eligibility nor is s/he required to report any changes in income or resources. That is, once eligible for RMA, the immigrant remains eligible through the eight-month period beginning on the date of entry, or, in the case of an asylee, on the date asylee status was granted.

Example

Mr. Rhoe entered the country on April 3, 1999. He was found eligible for RMA on May 15. He is eligible for RMA through November 30, 1999, regardless of whether his income increases above the Medically Needy Income Level before November 30.

TANF and Medicaid Eligibility Must Be Considered First 7.5.4

Immigrants in the categories listed above who are eligible for TANF or Medicaid under the rules of those programs are ineligible for Refugee Cash and Refugee Medical Assistance.

Example 1

Ms. Suarez and her two children arrive in the United States as refugees on March 14, 1999. The family has no income and comes to an IMA service center to apply for assistance. Because refugees are eligible for TANF and Medicaid and Ms. Suarez and her children meet the non-financial eligibility requirements for TANF and Medicaid, Ms. Suarez and her children should be considered for standard TANF and Medicaid eligibility.

Example 2

Mr. Poks enters the United States as a refugee. He has no other family in the United States and applies for assistance. As a non-disabled single individual with no children, Mr. Poks is ineligible for TANF and Medicaid. Thus, he should be considered under the RCA and RMA programs.

CITIZEN/ALIENAGE DECLARATION FORMS 7.6

ALL	<p>There are two forms which must be filled out by all groups using the Combined Application. The first form, the Immigration and Citizenship Initial Declaration Form (see Exhibit IV-1), provides a list of the immigration categories in which non-citizens must fall in order to be eligible for TANF, FS, GC, IDA, or Medicaid (except emergency services). That is, the form lists all 'qualified' immigration categories as well as the three immigration categories described in Section 7.3.1: Exceptions in this Chapter. The PI must fill out this form and attest to which of the following groups each household member belongs:</p> <ul style="list-style-type: none">• U.S. citizen or national;• not a U.S. citizen or national and individual's immigration status falls into one of the categories listed on the form (which means that s/he is potentially eligible for benefits); or• not a U.S. citizen or national and individual's immigration status does not fall into one of the categories listed on the form (which means that s/he is not eligible for TANF, FS, GC IDA, or Medicaid, except emergency Medicaid services). <p>For TANF and FS applicants, each household member that generally would be required to be in the assistance unit must be listed on the form and his/her citizenship/immigration status attested to. For Medicaid applicants, only those household members applying for Medicaid must be listed on the form.</p> <p>If at least one person was listed on the Immigration and Citizenship Initial Declaration form as an immigrant whose status matched one of those listed on that form, a second form, the Citizen/Alienage Declaration (CAD) form, must be completed by the PI. This form requires additional information, such as an individual's SSN and alien number.</p>
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Example 1

Ms. Hernandez and her two children, Maria (14) and Jose (4), apply for TANF, FS, and Medicaid. Mrs. Hernandez must fill out an Immigration and Citizenship Initial Declaration Form listing herself and her two children. On the form, she indicates that she and Maria are not citizens or nationals and their immigration status does not match any of the categories listed on the form. On the form, she indicates that Jose is a U.S. citizen. Based on this information, Ms. Hernandez does not need to fill out a CAD form. Jose, who is a

citizen, is the only member of the family that meets the immigration-related requirements of the three programs, other than Emergency Medicaid. The SSR should not ask Ms. Hernandez any further questions about her immigration status or that of Maria.

Example 2

Mr. Pak, his daughter, and his severely disabled sister apply for Medicaid and FS. Mr. Pak must fill out an Immigration and Citizenship Initial Declaration Form that lists all three members of the household since under FS rules they would generally all be included in the FS unit since they all purchase and prepare food together. Mr. Pak indicates that he and his daughter are not citizens or nationals and that their immigration status matches one of those listed on the form. He indicates that his sister's immigration status does not match one of those listed on the form. The CAD form he fills out should list only himself and his daughter, not his sister.

SPONSORED ALIENS 7.7

ALL When PRWORA created categories of immigrants who could qualify for Federal means-tested public benefits, such as TANF, Medicaid, and Food Stamps, it also imposed requirements that restricted the eligibility of those qualified immigrants. Among those mandates is a requirement to deem a sponsor's income and resources to some non-citizens when determining their eligibility for and amount of their benefits. A sponsor is anyone who executed an affidavit of support on behalf of an immigrant as a condition of the immigrant's entry into the U.S. Because courts had held that the affidavits of support in use at the time PRWORA was enacted were not legally binding contracts between the sponsor and the U.S. government, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 and the Balanced Budget Act of 1997, amended PRWORA requiring creation of a new affidavit of support for sponsors of certain lawful immigrants and new rules for deeming income and resources from the sponsor to the sponsored immigrant. A new legally enforceable affidavit of support, INS Form I-864, Affidavit of Support Under Section 213A of the (Immigration and Nationality) Act, otherwise known as, an I-864 Affidavit, was instituted and took effect on December 19, 1997.

Who is Subject to Sponsor to Immigrant Deeming 7.7.1

The responsibility of an alien sponsor to support a sponsored immigrant depends upon the relationship of the sponsor to the immigrant and the immigration status of the immigrant. The only immigrants whose sponsors have signed legally binding I-864 Affidavits are family-based Lawful Permanent Residents (LPRs) and a few employment-based LPRs. Most family-based immigrants, including immediate relatives, family preference immigrants and some orphans, must submit an I-864 Affidavit when they file a visa application or apply for an adjustment to LPR status on or after December 19, 1997. In addition, an employment-based immigrant who is coming to work for a relative or work for a company in which a relative holds at least five percent ownership must file an I-864 Affidavit.

Exceptions to Sponsor to Immigrant Deeming 7.7.2

The following groups are not subject to sponsor to immigrant deeming:

- immigrants who became LPRs before December 19, 1997, or filed for LPR status before December 19, 1997;
- immigrants whose sponsors signed affidavits of support before December 19, 1997;
- immigrants without sponsors;
- immigrants sponsored by organizations;
- immigrants who are a battered spouse, battered child or parent, or child of a battered person providing the battered alien lives in a separate household from the person responsible for the battery;
- immigrants who are included in the same assistance unit as their sponsor;

- immigrants who are ineligible because of their immigration status, for example, an LPR without five years of qualified residency;
- immigrants who become naturalized citizens;
- immigrants who can be credited with 40 qualifying quarters of work;
- immigrants whose sponsors have died; or
- immigrants who are found to be indigent.

Determining if a Immigrant is Indigent 7.7.3

ALL	An indigent immigrant is an LPR whose sponsor signed an I-864 Affidavit, but the sponsored immigrant would, in the absence of the assistance provided by IMA, be unable to obtain food and shelter taking into account the alien's own income plus any cash, food, housing or other assistance provided by other individuals, including the sponsor.
MA	N/A
TANF	Pending
GC	There is no requirement to deem income from an alien sponsor to the immigrant.
IDA	There is no requirement to deem income from an alien sponsor to the immigrant.
FS	<p>An immigrant is considered indigent if the sum of the immigrant's household's own income and any cash or in-kind assistance provided by the sponsor or others is less than 130 percent of the Federal Poverty Level (FPL) in effect at the start of the fiscal year. If an immigrant is indigent, only the actual support received from his/her sponsor is countable. Each indigence determination is effective for 12 months and may be renewed for additional 12-month periods. Since the gross monthly income limit for most households is 130 percent of FPL, most sponsored immigrants should qualify for an indigent exemption.</p> <p>Households that include sponsored immigrants who have been determined as indigent may opt into sponsor deeming and have their benefits determined based upon the income and resources that would be deemed if the immigrant was not indigent</p>

Determining if an Immigrant's Sponsor Signed a Binding Affidavit 7.7.4

ALL	Persons requesting Federally-funded means-tested benefits for immigrants are expected to cooperate in determining if the immigrant has a sponsor who is legally bound to provide support. Applicants who indicate in their applications and/or on their Immigration and Citizenship Initial Declaration Form that their household includes an LPR for whom they want assistance should complete a "Declaration of Sponsorship" (see Exhibit IV-10). The Declaration of Sponsorship poses a series of questions that should lead to a determination of whether the LPR has a sponsor who signed a legally binding I-864 Affidavit. If the applicant provides incomplete or questionable information about the sponsorship of a non-exempt LPR granted status on or after December 19, 1997, IMA must request verification of sponsorship status from INS.
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Verifying Whether an Immigrant Has a Sponsor who Signed a Binding Affidavit 7.7.5

ESA must ask INS to verify sponsorship of an LPR when:

- the immigrant's LPR status was granted on or after December 19, 1997,
- no sponsor was declared,
- the LPR has no evidence of converting from a immigration status, such as refugee, exempt from sponsor deeming rules, and
- the LPR does not qualify for any exception to sponsor deeming.

Requests to verify whether an immigrant has a sponsor who signed an I-864 Affidavit must be submitted to INS on INS Forms G-845 and G-845 Supplement (see Exhibits IV-6 and IV-7 at the end of this chapter). Pending verification from INS, IMA cannot delay, deny, reduce, or terminate the LPR's benefits based on the LPR's immigration status.

Sponsor Liability 7.7.6

ALL	<p>Sponsors who signed legally binding I-864 Affidavits are liable for the value of the means-tested benefits received by the sponsored immigrant, if those benefits were received during the period of time that the affidavit of support is in effect.</p> <p>An affidavit of support remains in effect until:</p> <ul style="list-style-type: none">• the sponsored immigrant becomes a naturalized citizen,• the sponsored immigrant can be credited with 40 qualifying quarters of work,• the sponsored immigrant permanently leaves the U.S., or• the sponsor or sponsored immigrant dies. <p>ESA must request reimbursement from sponsors who have signed I-864 Affidavits for the value of any benefits received by the sponsored immigrant during the period the affidavit is in effect. It is not required to pursue legal action, however, if the amount of the liability is not paid.</p> <p>ESA must notify households that contain immigrants who are subject to deeming that the sponsored immigrant's sponsor may be liable for the amount of benefits the sponsored immigrant receives while the affidavit of support is in effect.</p>
FS	<p>ESA cannot request reimbursement from the sponsor for any period that the sponsor received food stamps. If the sponsor stops receiving food stamps, the sponsor is still not liable for the benefits received by the sponsored immigrant during the period the sponsor also received food stamps.</p>

Requirement to Report Information on Indigent Immigrants 7.7.7

ALL	<p>ESA must notify the U.S. Attorney General if a sponsored immigrant is approved for means-tested federal benefits because s/he was determined to be indigent. ESA must provide the names and addresses of the sponsored immigrant and his or her sponsor to the INS Statistics Branch.</p> <p>ESA must notify households that include sponsored immigrants that the names and addresses of the sponsored immigrants and their sponsors will be provided to the U.S. Attorney General.</p>
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DETERMINING WHETHER AN ALIEN 'ENTERED' THE U.S. BEFORE AUGUST 22, 1996 7.8

ALL	<p>Some qualified immigrants are eligible for benefits only if they 'entered' the country before August 22, 1996. For example, all qualified immigrants who entered the country before August 22, 1996 are eligible for TANF and Medicaid while some qualified immigrants who entered after this date are ineligible for these benefits during their first five years in the country.</p> <p>Determining whether an immigrant 'entered' the U.S. prior to August 22, 1996 can be difficult. Use the following steps.</p>
Step 1:	<p>Determine whether the qualified alien entered the U.S. before August 22, 1996, by reviewing immigration documents and printouts obtained through the Systematic Alien Verification of Entitlements computer system. If these documents do not indicate whether the alien entered before August 22, 1996, submit a G-845 and G-845 Supplement to INS (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement) and request that the individual provide additional documentation that can establish whether s/he was physically present in the country prior to August 22, 1996.</p>
Step 2:	<p>Determine whether the qualified alien obtained qualified alien status prior to August 22, 1996. If the immigrant obtained qualified alien status prior to August 22, 1996, s/he is considered to have 'entered' the U.S. prior to this date. If s/he did not obtain qualified alien status prior to this date, go to Step 3.</p>

	<table border="1"> <tr> <td data-bbox="235 226 300 394">Step 3:</td><td data-bbox="300 226 1432 394">If the applicant entered the U.S. before August 22, 1996, but obtained qualified alien status after that date, the alien is only considered to have 'entered' the U.S. before August 22, 1996 if the individual entered the country and was continuously present from the latest date of entry to the date that s/he obtained qualified alien status (see Section 7.8.2: Determining 'Continuous Presence' in this Chapter).</td></tr> </table>	Step 3:	If the applicant entered the U.S. before August 22, 1996, but obtained qualified alien status after that date, the alien is only considered to have 'entered' the U.S. before August 22, 1996 if the individual entered the country and was continuously present from the latest date of entry to the date that s/he obtained qualified alien status (see Section 7.8.2: Determining 'Continuous Presence' in this Chapter).
Step 3:	If the applicant entered the U.S. before August 22, 1996, but obtained qualified alien status after that date, the alien is only considered to have 'entered' the U.S. before August 22, 1996 if the individual entered the country and was continuously present from the latest date of entry to the date that s/he obtained qualified alien status (see Section 7.8.2: Determining 'Continuous Presence' in this Chapter).		

Methods of Determining Date of Entry 7.8.1

ALL	<p>There are several types of documentation which can demonstrate that an individual entered the country prior to August 22, 1996.</p> <ul style="list-style-type: none"> • Immigration Documents: Many immigration documents include date stamps that indicate either the date the individual entered the country or the date the document was issued (see Section 7.11: Verification of Citizenship/Alienage in this Chapter for a description of some of the date stamps that may be found on immigration documents). • SAVE System: In addition, the SAVE system provides printouts that include an entry called 'Date of Entry.' Unfortunately, INS has informed the Department that this line on the printout does not always refer to the date the individual entered the U.S., but sometimes it indicates the date the individual adjusted his/her immigration status. Thus, if the SAVE printout indicates a 'Date of Entry' that is before August 22, 1996, this can be taken as proof that the individual entered the country prior to this date. However, if the printout indicates a 'Date of Entry' that is on or after August 22, 1996, this cannot be taken as proof the individual entered the U.S. after this date. In such cases, the SSR should submit a G-845 form and the G-845 Supplement form to INS (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement). When it receives these forms, INS attempts to locate the alien's case file and looks through the file to determine date of entry, immigration status, etc. In some cases, the case file may provide a different date of entry than has been entered into the SAVE system. However, even if the INS returns the forms and indicates a date of entry that is on or after August 22, 1996, and the individual continues to claim that s/he was here prior to that date, the SSR must give the individual an opportunity to present evidence that s/he was in the U.S. prior to August 22, 1996. • Additional Documentation Provided by Customer: If immigration documents and the SAVE system do not provide evidence that an individual entered the country prior to August 22, 1996, but the customer contends that s/he did enter the country prior to this date, the customer must be given an opportunity to provide additional evidence demonstrating that s/he did enter the country prior to August 22, 1996. Examples of additional information that would demonstrate that the individual had entered the country prior to August 22, 1996, include: <ul style="list-style-type: none"> ○ canceled checks or bank statements from a period before August 22, 1996; ○ a rent receipt, lease, mortgage, or other document indicating that the individual maintained a residence in the U.S. prior to August 22, 1996; ○ a written statement from an employer, landlord, or social service agency describing the relationship the applicant/recipient had with the statement writer prior to August 22, 1996; ○ drivers license issued prior to August 22, 1996; ○ written documentation (including a letter from the principal, report card, and so on) from a school showing that a member of the family attended the school prior to August 22, 1996; or ○ other reasonable evidence that demonstrates the individual resided in the U.S. prior to August 22, 1996.
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Example

Mr. Sanchez and his two children apply for TANF and Medicaid. Mr. Sanchez and his two children are currently LPRs. Their 'green cards' were issued in 1997. The SAVE system verifies that Mr. Sanchez and his two children are LPRs, but it indicates a 'Date of Entry' of December 1996. However, Mr. Sanchez says that he and his children were in the U.S. prior to August 22, 1996, though they were not yet LPRs. The SSR should file a G-845 form and the G-845 Supplement form with INS. In the meantime, the SSR should encourage Mr. Sanchez to gather any evidence he has that indicates he resided in the U.S. prior to August 22, 1996. Mr. Sanchez brings the SSR a bank statement that covers July 1996 and one of his children's report cards that covered the 1995-1996 school year. Regardless of the date of entry the INS reports back in response to the G-845 forms submitted, the SSR should accept Mr. Sanchez's bank statement and school record as proof that the family had entered the U.S. prior to August 22, 1996.

Determining 'Continuous Presence' 7.8.2

ALL	<p>Some individuals, such as those on tourist visas, may have entered the country prior to August 22, 1996, but they were not continuously present in the United States. If an alien who currently meets the definition of a 'qualified alien' did not obtain their 'qualified' status prior to August 22, 1996 and traveled to and from the United States but did not establish a continuous presence until after August 22, 1996, the alien is not eligible for benefits on the basis of having entered the U.S. prior to August 22, 1996.</p> <p>To determine if a person was continuously present prior to August 22, 1996, complete the following steps.</p>
Step 1:	Determine the latest date the person entered the country prior to August 22, 1996.
Step 2:	Determine whether the alien had a single absence from the U.S. of more than 30 days between the date of latest entry (prior to August 22, 1996), and the date the individual became a 'qualified' alien. If 'Yes,' the person is generally not considered to have 'entered the U.S.' prior to August 22, 1996, for purposes of eligibility determinations.
Step 3:	Determine whether the alien had cumulative absences from the U.S. of more than 90 days between the date of latest entry (prior to August 22, 1996) and the date the individual became a 'qualified' alien. If 'Yes,' the person is generally not considered to have 'entered the U.S.' prior to August 22, 1996.
	<p>If an individual provides evidence that s/he had established residency (legal or not) in the U.S. but was absent for longer than the standards described in Steps 2 and 3 above for a legitimate reason, such as caring for an ill family member in the individual's country of origin, the SSR should ask the Office of the Administrator to review the case and make a determination of whether the individual should be considered to have been 'continuously present' prior to August 22, 1996.</p> <p>If the individual has a passport that shows that s/he left the U.S. and reentered the United States after August 22, 1996, the date stamps in the passport should be used to determine whether the individual was 'continuously present' in the United States. Because of the difficulty in verifying periods of absence from the U.S., if the individual does not have a passport, the agency will accept the attestation of the applicant/recipient as to the amount of time s/he was absent from the country between the latest date of entry prior to August 22, 1996, and the date s/he obtained 'qualified' status. Once the SSR has established that the individual was physically present prior to August 22, 1996 (see Section 7.8.1: Methods of Determining Date of Entry in this Chapter) and the date the customer achieved 'qualified status,' the SSR should ask the customer:</p>

	<ul style="list-style-type: none"> • for the latest date the individual entered the country prior to August 22, 1996; and • whether the customer left the country between that date and the date s/he achieved 'qualified' status, and if so, how long the individual was absent from the U.S. on those trips. <p>The SSR should document the answers to these questions in the case file.</p>
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DETERMINING QUALIFYING QUARTERS 7.9

MA	N/A
TANF	N/A
GC	N/A
FS	<p>In some instances, an alien will only be eligible for FS benefits if s/he has '40 qualifying quarters' of work history. In other cases, an immigrant who is sponsored may qualify for an exemption to deeming his/her sponsor's income and resources, if s/he has "40 qualifying quarters" of work history. The term 'qualifying quarter' (QQ) originated in the Social Security Program. In order for anyone, citizen or alien, to be eligible for Social Security benefits, the individual must have a specified number of qualifying quarters. An individual can earn up to four qualifying quarters per year based on his/her earnings. For example, in 1998, an individual must earn \$700 to earn a single qualifying quarter in a year. If an individual earns less than \$700 in 1998, no quarters are earned. If an individual earns at least \$2,800 in 1998, four quarters are earned. When determining qualifying quarters, the actual dates an individual earned the income does not matter. If an individual earns \$10,000 in 1998, s/he would earn four qualifying quarters for that year, even if s/he only worked one month during the year.</p> <p>When determining whether an alien has 40 qualifying quarters, the applicant's own qualifying quarters based on his/her own earnings and quarters earned by his/her parents and/or spouse (with certain exceptions) can be combined. For example, if an applicant has earned 25 qualifying quarters, and his/her spouse has earned 15, the applicant meets the 40-quarter criteria. Thus, when interviewing an applicant who is an alien and who may qualify for FS based on the 40-qualifying quarters criteria, the SSR must determine whether the applicant's parent(s) worked in the United States while the applicant was a minor and whether the applicant's current or former spouse (if the marriage ended due to the death of the spouse) worked in the United States while they were married.</p>

Determining Whose Qualifying Quarters Can Count Toward the 40-Quarters Criteria 7.9.1

MA	N/A
TANF	N/A
GC	N/A
FS	<p>The qualifying quarters of the following individuals can be added to those of the applicant when determining whether an applicant has 40 qualifying quarters for the purposes of FS eligibility:</p> <ul style="list-style-type: none"> • applicant's Natural Parents (unless the child has been adopted): Use only the quarters earned while the applicant was under age 18; • applicant's Adoptive Parents: Use only the quarters earned while the applicant was under age 18; • applicant's Step-parent (provided the step-relationship still exists unless terminated by the

	<p>death of step-parent): Use only the quarters earned while the relationship was in existence and the applicant was under age 18. The stepparent's relationship to the child is based on the marital relationship to the child's parent. If the marital relationship ends other than by death, the relationship also ends;</p> <ul style="list-style-type: none"> • applicant's Current Spouse: Use only the quarters earned during the marital relationship; and • applicant's Former Spouse (but only if the marriage ended by death): Use only the quarters earned during the marriage.
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Determining Whether Applicant Could Have Met 40-Quarter Requirement 7.9.2

MA	N/A				
TANF	N/A				
GC	N/A				
FS	<p>In some cases, the applicant will not have been in the U.S. long enough to have met the 40 qualifying quarter requirement. To determine if it is possible that the applicant could meet the 40 qualifying quarter criteria, the SSR should complete the following two steps.</p> <table> <tr> <td>Step 1:</td><td>Ask how many years the applicant and each of the relevant individuals (those individuals whose qualifying quarters may count toward the applicant's 40-quarter requirement) has lived in this country.</td></tr> <tr> <td>Step 2:</td><td> <p>Add the number of years for each together.</p> <ul style="list-style-type: none"> • If the totals equal at least ten years, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. • If the total is less than ten years, ask whether the applicant, his/her parents, or his/her spouse ever commuted to work in the U.S. from another country (e.g., Canada or Mexico) before coming here to live or, if a legal resident of the U.S., worked for a U.S. company overseas or in self-employment. <ul style="list-style-type: none"> ○ If 'Yes,' determine the number of years and add them to the total. ○ If the total is at least ten, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. ○ If the total is less than ten, do not proceed any further. The applicant cannot meet the 40-quarter requirement. </td></tr> </table>	Step 1:	Ask how many years the applicant and each of the relevant individuals (those individuals whose qualifying quarters may count toward the applicant's 40-quarter requirement) has lived in this country.	Step 2:	<p>Add the number of years for each together.</p> <ul style="list-style-type: none"> • If the totals equal at least ten years, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. • If the total is less than ten years, ask whether the applicant, his/her parents, or his/her spouse ever commuted to work in the U.S. from another country (e.g., Canada or Mexico) before coming here to live or, if a legal resident of the U.S., worked for a U.S. company overseas or in self-employment. <ul style="list-style-type: none"> ○ If 'Yes,' determine the number of years and add them to the total. ○ If the total is at least ten, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. ○ If the total is less than ten, do not proceed any further. The applicant cannot meet the 40-quarter requirement.
Step 1:	Ask how many years the applicant and each of the relevant individuals (those individuals whose qualifying quarters may count toward the applicant's 40-quarter requirement) has lived in this country.				
Step 2:	<p>Add the number of years for each together.</p> <ul style="list-style-type: none"> • If the totals equal at least ten years, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. • If the total is less than ten years, ask whether the applicant, his/her parents, or his/her spouse ever commuted to work in the U.S. from another country (e.g., Canada or Mexico) before coming here to live or, if a legal resident of the U.S., worked for a U.S. company overseas or in self-employment. <ul style="list-style-type: none"> ○ If 'Yes,' determine the number of years and add them to the total. ○ If the total is at least ten, the individual could meet the 40-quarter requirement and the SSR should proceed to verify his/her qualifying quarters. ○ If the total is less than ten, do not proceed any further. The applicant cannot meet the 40-quarter requirement. 				

Determining Qualifying Quarters (QQ) 7.9.3

MA	N/A
TANF	N/A
GC	N/A
FS	<p>Four quarters in each year can be credited to the applicant based on his/her own work history. In addition, up to four years can also be credited to the applicant based on the work history from each parent and spouse.</p>

	<p>Example</p> <p>Mr. Ling is applying for FS. He is a 22-year-old LPR, who has lived in the United States since he was ten. Both of his parents worked when he was a child. In addition to the quarters he accrued based on his own earnings (up to four per year), Mr. Ling can earn up to four quarters in any year that his father worked and an additional four quarters in any year that his mother worked while Mr. Ling was a minor. In 1985, both of Mr. Ling's parents worked. Mr. Ling's father earned 4 quarters in 1985. Mr. Ling's mother earned 3 quarters. Mr. Ling himself did not work in 1985. Thus, Mr. Ling is credited with 7 qualifying quarters in 1985.</p>
	<p>In general, the SSR will receive information about qualifying quarters through the ACEDS interface with the SSA's Quarters of Coverage History System (QCHS). This system will provide an array by year, beginning in 1937, of all qualifying quarters derived from work covered by the Social Security Act and, beginning in 1978, all creditable non-covered earnings. Beginning in 1978, the number of quarters an individual earns is based on annual earnings, not on the number of quarters within the calendar year in which the individual actually was employed.</p>
Step 1:	<p>The SSR should always credit the applicant's own quarters first. This will simplify verification because many applicants will have sufficient quarters from their own record, and it will not be necessary to request a QQ History for other relatives.</p> <ul style="list-style-type: none"> • If the interview process clearly shows that the applicant meets the 40-quarters exception, request verification using the 40 QQ History ACEDS interface. • If the interview process shows the applicant may meet the 40-quarters exception, request verification using the 40 QQ History ACEDS interface. • If the interview process shows that the applicant will not meet the 40-quarters exception, but the applicant still believes s/he meets this requirement, request verification using the 40 QQ History ACEDS interface.
Step 2:	<p>If the applicant does not have 40 qualifying quarters based on his/her earnings alone, the SSR must determine if the applicant's parent(s) or spouse have qualifying quarters that can be credited to the applicant. If the applicant has a parent(s) that lived and worked in the United States while the applicant was a minor or if the applicant is married or has a former spouse (and the marriage ended by death) who lived and worked in the U.S. while the applicant was married to the individual, additional quarters based on these individuals' earnings may be credited toward the applicant.</p> <ul style="list-style-type: none"> • Establish the necessary relationship to the applicant. Relationship must be established before the SSR may request a QQ History through the ACEDS interface. • Obtain a complete Consent for Release of Information, Form SSA-3288 (see Exhibit IV-3: SSA-3288), from the parent(s) or spouse of the applicant. The Consent for Release of Information must be completed and signed by the parent or spouse of the applicant (unless the individual is deceased) even if they are difficult to contact. <p>The parent/spouse must indicate on the Form SSA-3288 that the request authorizes release of his/her SSN, identifying information, information about benefit payments, and other QCHS. Additionally, the parent/spouse must state his/her relationship to the applicant and sign and date the form.</p> <p>This form is necessary because these records are protected by the Privacy Act. The SSR should indicate that the information can be released to both the Department and the</p>

	<p>applicant.</p> <p>The signed consent form must be retained in the case file. SSA may need to review this documentation as part of a Quality Control Review or if a question is raised.</p> <p>If an individual refuses to cooperate and will not complete Form SSA-3288 or the individual cannot be located to complete the form the SSR cannot use the automated system. However, the SSA will provide information about such individuals to the Department. See Step 4 below.</p>
Step 3:	<p>If the consent form has been signed, request a QQ History through the ACEDS interface. If the consent form has not been signed, submit the SSA-513 to SSA (see Exhibit IV-5: SSA-513).</p>
Step 4:	<p>If a consent form cannot be obtained from a spouse or parent of an applicant, the SSR should fill out the SSA-513 'Request for Quarters of Coverage (QC) History Based on Relationship' Form (see Exhibit IV-5: SSA-513). This form must indicate the individual on which information is being requested (that is, the spouse or parent of the applicant), that individual's SSN, date of birth, and relationship to the applicant. In addition, the SSR must indicate on the form the years (and quarters) for which the individual's work history can count toward the applicant's 40-quarter requirement. SSA will return the form with information about the QQ the individual earned during the relevant period.</p> <p>Example</p> <p>Mrs. Santos and her two children are applying for FS. Mrs. Santos is a LPR who came to the United States in 1988. Mrs. Santos' children are U.S. citizens. Mrs. Santos has 20 qualifying quarters based on her own earnings. Mrs. Santos is currently married, but her estranged husband who does not live with her refuses to sign a consent form. (The couple is not, however, divorced.) Mrs. Santos was married in June 1990. The SSR should complete an SSA-513 form to submit to the SSA. On the form, the SSR must indicate the years in which Mr. Santos' earnings can be credited toward Mrs. Santos' 40 quarters requirement. Since they were married in the 2nd quarter of 1990, the SSR should indicate that SSA should provide information from the 2nd quarter of 1990 to the most recent quarter for which data are available.</p>
Step 5:	<p>Determine whether any quarters earned by the applicant or his/her parent or spouse must be excluded because the quarter was earned in 1997 or after and the individual received a federal means-tested public benefit during the quarter.</p> <ul style="list-style-type: none"> • Information about SSI receipt will be provided by SSA as part of the query. • The SSR should check whether the applicant or the applicant's parent or spouse received FS, TANF, or Medicaid (excluding emergency Medicaid) in the District of Columbia in any quarter counted toward the applicant's 40-quarter requirement that was earned in 1997 or after. If the individual did receive such benefits (excluding emergency Medicaid) in D.C., the quarter must be excluded. • For any quarters earned in or after 1997, the SSR should ask the applicant and, if possible, the other individuals whose quarters are being credited to the applicant, whether any of the following were received by the individuals in any part of the U.S.: <ul style="list-style-type: none"> ○ Medicaid, other than emergency Medicaid; ○ TANF cash assistance; ○ FS; or ○ Housing assistance (living in public housing or receiving a federal rental subsidy such as through the Section 8 or Section 202 housing programs)

		The SSR shall accept the attestation of the applicant and, if applicable, the applicant's spouse or parent (when these individuals' quarters are being credited to the applicant). If the SSR is unable to contact the applicant's spouse or parent and quarters earned in or after 1997 are being credited to the applicant, the SSR should ask the applicant if s/he knows whether the parent or spouse received any such benefits. If the applicant does not know or indicates that such benefits were not received, the SSR should credit the quarters toward the applicant.
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Using the Query Output 7.9.4

MA	N/A
TANF	N/A
GC	N/A
FS	<p>QQ History should not be used to verify earnings or employment history for the purposes of determining grant or allotment amounts. The output received from SSA may only be used to determine qualifying quarters that can be credited toward an alien applying for benefits. The SSA output will include:</p> <ul style="list-style-type: none"> • verified SSN, • SSN submitted to the SSA, • last name, • first name, • middle initial, • date of birth, • minimum number of Qualified Quarters 1937-1950, • maximum number of Qualified Quarters 1937-1950, • railroad service months (1937-1946), • condition code, and • QQ pattern. <p>If the QQ Pattern is blank, there will be a condition code which will either explain the reason or indicate a problem with the system. The condition code values are:</p> <ul style="list-style-type: none"> • 01 - Earnings record not found (if the individual still believes that earnings exist on this record, s/he should contact SSA for an earnings investigation); • 02 - System error, please resubmit request; and • 99 - Record not processable. This can be caused by SSA system edits. If this message appears, the SSR must contact Jeffrey Borkman and explain that s/he has a condition 99 and ask that they contact the SSA regional office.

Quarters of Coverage Pattern Values 7.9.5

MA	N/A
TANF	N/A
GC	N/A

FS	<p>Each of the following codes, which will appear in the QC pattern indicates a potential qualifying quarter. All codes represent a QQ from covered earnings (QC) except codes 'F, U, and W' which indicate QQ from non-covered earnings. This information is relevant when determining how to handle discrepancies.</p> <ul style="list-style-type: none"> • A - Agricultural QC; • C - Wage QC (most common quarter code the SSR will see); • D - Military QC; • F - Federal, state, or local government wage QQ; • G - Gift QC; • J - Japanese Internment QC; • M - Military QC; • R - Railroad QC; • S - Self-Employment QC; • X - Wage QC which occurs for 1951 or 1952; and • * - A covered QC. <p>The following code will also appear in the QQ display but cannot be counted as a QQ: N - Quarter with no earnings, a non-QQ.</p> <p>Sometimes there is not enough information on the SSA record to determine whether there is a potential QQ. When this happens, the SSR will see the following codes:</p> <ul style="list-style-type: none"> • # - Questionable QC that can occur 1952 through 1977, and • Z - Questionable QC that can occur 1952 through present. <p>If these codes (# or Z) appear in a quarter, and the applicant does not meet the 40-quarter requirement without them, contact SSA. SSA will investigate the earnings and either confirm or deny the quarter.</p> <p>The Minimum Number QCs 1937-1950 field and Maximum Number QCs 1937 - 1950 field provide information on QCs for individuals whose earnings records do not contain specific breakouts for quarters of coverage from 1937 to 1950. The Minimum Number QCs field will contain the result of dividing total earnings in this period by \$400, and the Maximum Number QCs field will contain the result of dividing total earnings over the period by \$50. There should not be entries in the QQ pattern for 1937-1950 if there are entries in the Minimum and Maximum Numbers QCs fields.</p> <p>The record the SSR receives will not show current year earning or possibly last year's earnings, depending on when the SSR makes the request. SSA processes earnings reports on a flow basis, but because of the volume, SSA generally does not complete the processing until mid to late summer of the year following the year of earnings. Earnings for this period are called 'lag' earnings. SSA will not develop these earnings because they will appear on SSA records when they are processed. See Section 7.9.7: Reconciliation in this Chapter for guidelines on how to develop the existence of lag earnings if such earnings are needed to establish the 40-quarters exception. If these quarters represent recent work activity, the applicant should have acceptable evidence readily available.</p>

Making the Determination 7.9.6

MA	N/A
TANF	N/A
GC	N/A

FS	<p>The SSR cannot count any QQ after December 31, 1996, if the applicant or the person whose SSN is being used received a federal means-tested public benefit during the quarter.</p> <p>The SSR should take the following three steps:</p>
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Step 1:	<p>The SSR should review the applicant's record. Do these codes which represent QQs add up to 40?</p> <ul style="list-style-type: none"> • If 'Yes,' the applicant meets the exception requirement. • If 'No,' are there current or prior years' earnings which are not shown in the QQ pattern? • If 'Yes,' develop as described in Section 7.9.7: Reconciliation in this Chapter. • If the total now equals 40 or more, the applicant meets the exemption requirement.
Step 2:	<p>The SSR reviews other records for the periods which can be used (during the marriage for a spouse and under age 18 for a parent). The SSR should add the codes which represent a QQ on these records to the applicant's record to see if they equal 40.</p> <ul style="list-style-type: none"> • If 'Yes,' the applicant meets the exception requirement. • If 'No,' consider current and prior taxable year earnings as in Step 1. • If the total when these are added equals 40, the applicant meets the exception requirement. • If 'No,' go to Step 3.
Step 3:	<p>On all records, the SSR should review the Minimum Number QCs 1937-1950 field.</p> <ul style="list-style-type: none"> • If these can be used (see Step 2), add them to the total. Does the total equal 40? • If 'Yes,' the applicant meets the exception requirement. • If 'No,' continue. <p>Review the Maximum Number of QCs 1937-1950 field and look at the QC patterns for codes # and Z.</p> <ul style="list-style-type: none"> • If the maximum number and/or the code # and Z will equal 40 when added to the total, refer the case to SSA as described in Section 7.9.7: Reconciliation in this Chapter. • If the total still does not equal 40, continue. <p>Review the QQ pattern with the applicant.</p> <ul style="list-style-type: none"> • If the applicant believes that quarters are missing, refer the case to SSA as described in Section 7.9.7: Reconciliation in this Chapter. • If the applicant believes the records are correct, s/he cannot meet the exception requirements.

The following chart will assist the SSR in determining whether the individual has the level of earnings to produce a QQ.

For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of credible QQs is obtained by dividing the individual's total earned income by the increment amount for the year. The maximum number of quarters per year is 4. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The Credit of Qualifying Quarters Chart presented below outlines the amount of earnings needed for each credit for 1979 through 2012.

Year	Amount of Needed Earnings	Year	Amount of Needed Earnings
1979	\$260	1996	\$640
1980	\$290	1997	\$670
1981	\$310	1998	\$700
1982	\$340	1999	\$740
1983	\$370	2000	\$780
1984	\$390	2001	\$830
1985	\$410	2002	\$870
1986	\$440	2003	\$890
1987	\$460	2004	\$900
1988	\$470	2005	\$920
1989	\$500	2006	\$970
1990	\$520	2007	\$1,000
1991	\$540	2008	\$1,050
1992	\$570	2009	\$1,090
1993	\$590	2010	\$1,120
1994	\$620	2011	\$1,120
1995	\$630	2012	\$1,130

A current year quarter and a quarter earned in the immediately preceding year may be included in the 40-quarter computation even if SSA does not have information about those earnings on the automated system. The SSR should use the individual's earnings (earned to date) as the numerator to determine the number of quarters earned in a current year for which SSA does not yet have data on the automated system. IMA has elected to allow credit for a quarter even if the year is not yet complete.

Example

The applicant entered the U.S. in 1986. The applicant's spouse entered prior to that time. They married in June 1991. The SSR determined that a QQ history for both SSNs would be needed for the applicant to meet the 40-quarters exception. The SSR obtained a Consent for Release of Information from the spouse and requested information on their quarters of work through the automated ACEDS interface. The QQ History received is shown below. The quarter display begins on the left with the first quarter and ends on the right with the fourth quarter (see Section 7.9.5: Quarters of Coverage Pattern Values in this Chapter). If the SSR receives data in a format different than what is presented below, it will be clearly labeled.

	Applicant	Applicant's Spouse
1986	NNNN	CCCC
1987	NAAC	CCCC
1988	NNNN	ZZCC
1989	NNAA	CCCC
1990	AAAA	CCCC
1991	AAAA	CCCC
1992	AANN	CCCC
1993	CCCC	CCCC
1994	CCCC	CNNC
1995	CCCC	CCCC
1996	NNNN	NNNN
1997	NNNN	NNNN

The applicant has a combination of wage and agricultural quarters totaling 27. The spouse's quarters earned during the marriage must be added to the applicant's Qualifying Quarters. The spouse has 17 quarters during the marriage. When added to the applicant's quarters, the total exceeds the 40-quarter requirement.

In this case, the SSR does not need to reconcile the Z quarters with SSA because they are outside of the marriage period. Also, lag quarters do not need to be developed because they are not needed to reach the 40-quarter requirement.

Reconciliation 7.9.7

MA	N/A
TANF	N/A
GC	N/A
FS	<p>LAG QUARTERS</p> <p>When the applicant or other individual does not agree with the QC pattern provided by the query and the problem is missing quarters in the current year, do the following.</p> <ul style="list-style-type: none"> For current year earnings, accept a current employer-prepared wage statement as proof of earnings and credit a quarter for each increment as outlined in the Credit of Qualified Quarters chart in Section 7.9.6: Making the Determination in this Chapter. The SSR should assume the earnings are covered employment if the wage statement shows FICA

withholding.

- QQ information for a particular calendar year will not show up on the automated system until September of the following year. For example, information about 1998 earnings was not available on the automated system until September 1999. For quarters in the prior calendar/taxable year which do not show up on the SSA automated system because the information is requested prior to September of the following year, accept forms such as W-2 and/or W-2 C, employer-prepared wage statements, or an IRS copy of the individuals' tax return. Credit QQ as outlined in the Credit of Qualified Quarters chart in Section 7.9.6: Making the Determination in this Chapter. Assume the earnings are covered if the proof submitted indicates FICA taxes were withheld. If the request is made on or after September 1 for the prior calendar year and the information does not match the applicant's claim that s/he worked during the year, do not treat the discrepancy as a lag quarter issue. See Non-Lag Quarters below.

NON-LAG QUARTERS

Whenever the applicant or any other individual does not agree with the QC patterns provided by the query, it will be necessary to reconcile the discrepancy. When the individual believes that the work s/he performed was in covered employment or Medicare-only federal, state, or local wage, and the earnings do not fall within the lag period, SSA is responsible for investigating the discrepancy and correcting the record.

Refer all covered employment or Medicare-only federal, state, or local wage cases to SSA as follows.

- If the individual indicates that s/he used more than one SSN or allowed others to use his/her SSN, then the individual will need to contact his/her local SSA office to resolve the issue or call 1-800-772-1213 to setup an appointment. The individual should take a copy of the QC pattern, identifying information, and any proof of earnings that s/he may have to the SSA office with him/her.
- If the SSR needs to develop a Z indicator for 1977 or earlier or a # sign indicator from the QC pattern, then refer the case to SSA Office of Central Records Operations for Investigation. Send a written request containing the following information.
 - Name
 - SSN
 - Date of birth
 - Year(s) in question
 - Return address
 - Copy of the output from the query

A separate request is needed for each SSN to be investigated. The SSR must mail the request along with the copy of the output from the query to:

SSA, OCRO
POB 17750
Baltimore, MD 21235-0001

If you need to follow-up on the status of your request, then the SSR should request another QQ History query 45 days after the original request. If the entry has been updated, the # or Z will be overlaid with N or C. If the QQ pattern has not been updated after 60 days, call 1-800-

	<p>775-7802 (SSA-OCRO, Earning Discrepancy).</p> <p>If the individual indicates that there are missing quarters, or the code Z is 1978 or later, then have the applicant, if s/he is the number holder of the SSN, complete an SSA-7008 Request for Correction of Earnings. Proof of earnings such as W-2s, pay stubs, tax return, or statement from the employer should be provided. On top of the SSA-7008, the SSR should write 'Welfare Reform.'</p> <p>If the applicant is not the number holder, tell the applicant that the number holder must complete the SSA-7008 and provide proof of earnings as shown above. All SSA-7008s along with the documentation should be mailed to:</p> <p>SSA, OCRO POB 17752 Baltimore, MD 21235-0001</p> <p>If the applicant has no documentation, s/he should contact the local SSA office or call 1-800-775-7802 to arrange for an appointment.</p>
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Non-Covered Employment 7.9.8

MA	N/A
TANF	N/A
GC	N/A
FS	<p>Any claim of non-covered quarters should be discussed with the Administration's office at (202) 698-3900.</p> <p>When an applicant cannot meet the 40-quarters exception using covered earnings or Medicare-only federal, state, or local wages but alleges that s/he had additional work that is not documented by the SVES query of the QCHS, follow the outline below to establish the existence of the earnings and convert them to QQs. The two steps that should be followed are:</p>

Step 1:	<p>The SSR should review the QCHS response with the applicant to determine whether QQs are missing from the record.</p> <ul style="list-style-type: none"> • If QQs are not missing from the response, make your determination based on the information already obtained. • If QQs are missing from the response, obtain sufficient information from the individual so that the SSR can use the Credit of Qualifying Quarters Chart in Section 7.9.6: Making the Determination in this Chapter to determine whether the alleged earnings are covered or non-covered. Some examples of questions the SSR might ask are: <ul style="list-style-type: none"> ○ Name and address of employer ○ Dates of employment ○ Amount of earnings ○ Type of business or self-employment ○ Rate of pay ○ Work performed
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	<p>The Covered Employment Chart should be used as a guide. The Social Security Act provisions are complex and the chart may not cover exceptions in the SSA.</p> <p>It is important to note that 97 percent of all employment is now covered under the Social Security Act.</p> <ul style="list-style-type: none"> • If the SSR determines the earnings are from covered employment or federal, state, or local Medicare-only wages, then refer to development guidelines in Section 7.9.3: Determining Qualifying Quarters (QQ) in this Chapter. • If the SSR determines the earnings are from other non-covered employment, then you must obtain satisfactory evidence that the earnings exist before using the earnings to credit QQs. For acceptable means by which evidence necessary to credit QQs might be obtained see Section 7.9.3: Determining Qualifying Quarters (QQ) in this Chapter.
Step 2:	<p>If the SSR is satisfied that the non-covered earnings exist, use the Credit of Qualifying Quarters Chart in Section 7.9.6: Making the Determination in this Chapter to determine the number of QQs that can be credited. Covered and non-covered earning can be combined for a year. The dollar amount indicates the amount needed to credit one QQ beginning with 1979.</p> <p>A current year quarter may be included in the 40-quarter computation. The SSR should use the current year amount as the divisor to determine the number of quarters available. A quarter may be counted once it has started, even if it is not yet complete.</p>

If the SSR needs to credit quarters from 1937 through 1977, use the following guidelines:

- A credit was earned for each calendar quarter in which an individual was paid \$50 or more in wages (including agricultural wages for 1951-1954).
- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were \$400 or more.
- A credit was earned for each \$100 (limit to a total of four) for agricultural wages paid during the year for the years 1955-1977.

A QQ cannot be credited before 1937.

VICTIMS OF SEVERE FORMS OF TRAFFICKING OR DOMESTIC VIOLENCE 7.10

ALL	Certain abused immigrants are considered 'qualified immigrants,' even if, in the absence of the abuse, they would not be considered 'qualified.' These victims of battery, extreme cruelty or trafficking in persons are provided special exceptions from the general restrictions on non-citizens' eligibility for benefits.
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Victims of Severe Form of Trafficking 7.10.1

ALL	<p>Immigrants who are found to be victims of severe forms of trafficking in persons are considered qualified immigrants and are eligible for benefits to the same extent as refugees.</p> <p>"Severe forms of trafficking in persons" means:</p> <ul style="list-style-type: none"> • sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or • the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to
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	involuntary servitude, peonage, debt bondage, or slavery.
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Determining if an Immigrant is a Victim of Severe Forms of Trafficking 7.10.2

ALL	<p>The Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Services must determine if an immigrant is a victim of severe forms of trafficking. Adult victims of trafficking receive certification letters from ORR confirming their status. Children under 18 are not certified by ORR, but receive letters similar to the adult certification letter, stating that they are victims of trafficking.</p> <p>Certifications of trafficking are valid for eight months from the date of issuance and are subject to renewal thereafter.</p> <p>Since ORR is the only entity that can determine if an immigrant is a trafficking victim, no verification of immigration status is needed from INS to establish eligibility for these persons.</p>
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Victims of Domestic Violence 7.10.3

ALL	<p>To be a 'qualified immigrant' based on domestic violence-related criteria, an individual must meet each of the following requirements:</p> <ul style="list-style-type: none"> • be abused or be the parent or child of an abused individual; • have an approved or pending petition for a family based immigrant visa, self-petition for an immigrant visa, or application for cancelation of removal/suspension of deportation filed on the basis of abuse; • have a need for assistance that has substantial connection to the abuse; and • not currently live with the abuser <p>Remember: Not all qualified immigrants are eligible for program benefits. If an immigrant is determined 'qualified' based on the above domestic violence-related criteria, the SSR must still determine whether s/he meets the immigration-related requirements of the particular program for which the individual is applying.</p> <p>Because of the difficulty determining eligibility under these criteria, the Administrator's office should be contacted when an immigrant-related domestic violence claim is made.</p>
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Example

Mrs. Sanchez and her daughter apply for Medicaid. She and her daughter are determined to be qualified immigrants based on their status as victims of domestic violence. Mrs. Sanchez and her daughter entered the U.S. in 1997 and, thus, are subject to the "five-year-bar." That is, Mrs. Sanchez and her daughter are ineligible for Medicaid because they are in their first five years in the United States. Despite being a qualified immigrant, they are ineligible for program benefits.

Determining Whether an Immigrant Has Been Abused or Is the Child or Parent of an Abused Individual 7.10.4

ALL	<p>To be a 'qualified immigrant,' a victim of abuse must demonstrate one of the following:</p> <ul style="list-style-type: none"> • that s/he was abused by a parent, spouse, or member of the spouse's or parent's family living in the same household; • that s/he is a child whose parent was abused by the parent's spouse or a member of the spouse's family living in the same household. (In this situation, the child does not have to have been abused); or
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- that s/he is a parent whose child was abused by the applicant's spouse or parent, or a member of the spouse's or parent's family living in the same household. (In this situation, the parent does not have to have been abused. Also, the applicant must not have participated in the abuse of the child.)

The abuse suffered by the applicant may be physical, sexual, emotional, or mental. Abuse could include, for example, being the victim of any act or threatened act of violence, including any forceful detention, which results in physical or mental injury. Psychological or sexual abuse or exploitation, including intimidation, threats, rape or forced prostitution, shall be considered acts of violence. Other abusive actions may also be acts of violence. Acts or threats that may not initially appear abusive may be part of an overall pattern of abuse.

Applicants may submit any credible evidence of abuse. Examples of acceptable documentation include, but are not limited to, any of the following: a signed and sworn affidavit testifying to the abuse, reports and affidavits from witnesses, family members, judges, police, social workers, counselors, clergy, and school officials. In the absence of any other documentation, a signed and sworn affidavit testifying to the abuse is sufficient.

Establishing abuse is a prerequisite to qualify for certain immigration remedies such as a self-petition for an immigrant visa filed on the basis of abuse or cancelation of removal/suspension of deportation filed on the basis of abuse. (These remedies are discussed below). Therefore, immigrants who have approved or pending prima facie cases for these particular immigration remedies should be presumed to have established abuse. (The term 'prima facie' means that, on its face, the document appears to establish eligibility for the relief sought.)

Determining Whether the Immigrant Has Filed Necessary Petitions 7.10.5

To be a 'qualified immigrant' based on domestic violence criteria, the immigrant must have an approved application or petition, or a pending application or petition that sets forth a prima facie case, for one of the following:

- an I-130 petition for an immigrant visa filed by the applicant's U.S. citizen or Legal Permanent Resident (LPR) spouse or parent;

The I-130 petition is the form used by U.S. citizens and LPRs to assist family members, including spouses and certain offspring, to become LPRs. Only I-130 petitions describing the following relationships are relevant to establishing 'qualified immigrant' status: husbands or wives of U.S. citizens or LPRs, unmarried children under 21 years old of U.S. citizens or LPRs, or the unmarried sons or daughters age 21 or older of LPRs. An unmarried child under 21 years old whose parent is married to a LPR may be included in the parent's I-130 petition as a derivative beneficiary. In such case, the child may not have a separate I-130 or approval notice. Nonetheless, as a derivative beneficiary, the child is eligible to be classified as a 'qualified immigrant.'

- an I-360 self-petition for an immigrant visa filed on the basis of abuse; Spouses and unmarried children under 21 years old who are abused by their U.S. citizen or LPR spouse or parent, may file self-petitions (Form I-360) for LPR status, without the knowledge or consent of their abusive spouse or parent. Also, a parent whose child is abused by the parent's U.S. citizen or LPR spouse can self-petition, even if the parent has not been abused. These self-petitions are commonly known as VAWA petitions. *An unmarried child under 21 years old may be included in the parent's I-360 petition as a derivative beneficiary, and the I-360 will reflect this. In such case, the child may not have a separate I-360, Notice of Prima Facie Eligibility or Approval Notice. Nonetheless, as a derivative beneficiary, the child is eligible to be classified as a 'qualified immigrant.'*
- an I-360 self-petition for an immigrant visa filed as a widow/er (and the widow/er's children) of a deceased U.S. citizen. An un-remarried widow/er of a U.S. citizen, who was married to the citizen for at least two years, may file a self-petition to become an LPR. The petition has to be filed within two years of the death of the citizen. The widow/er's unmarried children under 21 years old may file as well; or
- an application for cancellation of removal (Form EOIR-42B) or suspension of deportation (Form EOIR-40) filed on the basis of abuse.

An immigrant who has been continuously present in the U.S. for three years, and meets other requirements, may file for cancellation of removal/suspension of deportation before an Immigration Judge if the immigrant has been abused by a U.S. citizen or LPR spouse or parent. Also, an immigrant whose child is abused by the child's U.S. citizen or LPR parent can file for cancellation of removal/suspension of deportation, even if the immigrant has not been abused and has not married the child's abusive parent. A successful application stops the immigrant's deportation from the U.S. and results in LPR status for the immigrant.

Determining Whether the Immigrant No Longer Lives with the Abuser 7.10.6

To be a 'qualified immigrant,' the immigrant cannot currently live with the abuser.

Applicants may submit any credible evidence of non-residency with the abuser. Examples of acceptable documentation include, but are not limited to, any of the following: a letter from friends, family members, other third parties; a civil protection order requiring the batterer to stay away from the applicant or the applicant's children or parent; a notice or order evicting the batterer from the applicant's residence;

employment records; utility receipts; school records; hospital or medical records; rental records or records from a building or property manager; other records establishing that the applicant or his or her child or parent no longer resides with the abusive spouse, parent, or family member.

In some circumstances, abused immigrants who are financially dependent on their abusers may be unable or hesitant to leave their abusers unless they have resources to assist them pending flight or separation. In such instances, the SSR should provide the customer with information about domestic violence shelters and service providers. In addition, the SSR should explain to the individual that s/he will only qualify for assistance after s/he no longer resides with the abuser.

Follow the procedures outlined below to verify the immigration status of applicants who allege eligibility as abused immigrants.

TIMELINESS 7.11

ALL	If an applicant who is not a citizen has provided required verification to establish his/her alien status, but IMA cannot verify his/her status with INS or verify whether the alien meets the 40-quarters requirement with SSA within relevant application processing timeframes (see Chapter 2: Processing Timeframes in Part III), the application must be approved if the alien meets all other financial and non-financial eligibility requirements. This applies only in cases in which the documentation provided by the applicant and the alien's attestations indicate the alien is eligible for assistance.
	Example 1 Mr. Gull applies for FS. He can only be eligible if he meets the 40-quarter criteria. The SSA interface indicates that he has 35 QQs, but there are six quarters with a Z indicator. Mr. Gull attests that he worked during those years and earned enough to earn QQs. The SSR submitted a request for information to the SSA Office of Central Records Operations for Investigation, but the office did not resolve the issue prior to the end of the 30-day application processing time period. The SSR must approve the FS application. If SSA subsequently finds that Mr. Gull did not have sufficient QQs, and he cannot provide further evidence that he did earn sufficient quarters, his benefits would be terminated and the benefits received in error would be charged as a household-caused overpayment.
	Example 2 An SSR has requested additional information from INS using the G-845 and the G-845 Supplement form because information in SAVE and the immigration documents presented by the applicant do not match. INS has not responded by the end of the application processing timeframe. The SSR must accept the documentation provided by the customer. If INS subsequently provides additional information indicating that the documentation provided by the applicant does not establish eligibility, the individual's benefits will be terminated and, if applicable, the case can be referred for investigation if the mistake appears fraudulent.

VERIFICATION OF CITIZENSHIP/ALIENAGE STATUS 7.12

ALL	Copies of the following documents will, when combined with satisfactory proof of identity (which will come from the document itself if it bears a photograph of the person to whom it relates) and, in some cases, verification with the INS, demonstrate that a person is a U.S. citizen, non-citizen national, or qualified alien for purposes of determining eligibility for TANF, GC, IDA, FS, and Medicaid.
	It is important to note that immigration documents are numerous and subject to change. If an individual presents a document that is not included in this list, the SSR should not assume the document is illegitimate or that it does not adequately verify immigration status. If the nature of the document is

unclear, INS should be contacted for assistance.

Qualified Aliens 7.12.1

ALL	<p>The following documents can demonstrate that an individual falls into various 'qualified' immigration categories. Regardless of the apparent legitimacy of documents presented, the immigration information provided by applicants, including these forms, must be further verified through the Systematic Alien Verification of Entitlements computer system. Each service center has access to SAVE computer terminals which allow SSRs to verify immigration information provided by customers with the INS (see Section 7.11.4: INS Verification in this Chapter).</p> <ul style="list-style-type: none">• Alien lawfully admitted for permanent residence:<ul style="list-style-type: none">○ INS Form I-551 (Alien Registration Receipt Card), or○ Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94.• Amerasian:<ul style="list-style-type: none">○ INS Form I-94 with codes AM1, AM2, or AM3;○ I-551 Form with codes AM6, AM7, or AM8; or○ A Vietnamese Exit Visa or Vietnamese or U.S. Passport if stamped by INS with codes of AM1, AM2, or AM3. <p>The date on INS Form I-551 or the date of inspection on the stamp on INS Form I-94 will indicate the date of admission. If the date is missing on Form I-94, file INS form G-845 and the G-845 Supplement along with a copy of the documents indicating asylee status with the local INS office to verify the date of admission (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement).</p> <ul style="list-style-type: none">• Asylee:<ul style="list-style-type: none">○ INS Form I-94 annotated with stamp showing grant of asylum under Section 208 of the INA;○ INS Form I-688B (Employment Authorization Card) annotated '274a.12(a)(5);○ INS Form I-766 (Employment Authorization Document) annotated 'A5';○ Grant letter from the Asylum Office of INS;○ Order of an immigration judge granting asylum; or○ INS form I-571 (the form is called the Refugee Travel Document but is also given to asylees). <p>INS Form I-94, the INS grant letter, and the court order will each include the date asylee status was granted. If the applicant cannot provide any of these documents, file INS form G-845 and the G-845 Supplement along with a copy of the documents indicating asylee status with the local INS office to verify the date the status was granted (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement).</p> <ul style="list-style-type: none">• Refugee:<ul style="list-style-type: none">○ INS Form I-94 annotated with stamp showing admission under Section 207 of the INA,○ INS Form I-688B (Employment Authorization Card) annotated '274a.12(a)(3)',○ INS Form I-766 (Employment Authorization Document) annotated 'A3', or○ INS Form I-571 (Refugee Travel Document). <p>Refugees usually adjust to LPR status after 12 months in the U.S. For purposes of determining eligibility, individuals who enter as a refugee are considered refugees for the first seven years in the country. Therefore, you must check the coding on Form I-551 for codes RE-6, RE-7, RE-8, or RE-9 to determine whether a LPR entered the country as a refugee.</p>
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	<p>The date of inspection on the refugee stamp on INS Form I-94 will indicate the date of admission as a refugee. If the date is missing or if the applicant cannot present an I-94, file INS Form G-845, and the G-845 Supplement along with a copy of the pertinent documents with the local INS office to verify the date of admission as a refugee (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement).</p>
ALL	<ul style="list-style-type: none"> • Alien paroled into the U.S. for at least one year: <ul style="list-style-type: none"> ○ INS Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA. An applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement. • Alien granted Withholding of Removal (formerly called Granted Withholding of Deportation): <ul style="list-style-type: none"> ○ INS Form 1-688B (Employment Authorization Card) annotated '274a.12(a)(10)' ; or ○ Order from an immigration judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997 or removal withheld under Section 241(b)(30) of the INA. <p>The court order will include the date deportation was withheld, or removal was canceled. If the applicant does not present a court order, file INS Form G-845, and the G-845 Supplement along with a copy of the pertinent documents with the local INS office to verify the date of deportation was canceled or withheld (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement).</p> • Aliens granted conditional entry: <ul style="list-style-type: none"> ○ INS Form I-94 with stamp showing admission under Section 203(a)(7) of the INA, ○ INS Form 1-688B (Employment Authorization Card) annotated '274a.12(a)(3)', or ○ INS Form 1-766 (Employment Authorization Document) annotated 'A3.' • Cuban/Haitian entrant: <ul style="list-style-type: none"> ○ INS Form I-551 (Alien Registration Receipt Card, commonly known as a 'green card' with the code CU6, CU7, or CH6); ○ Unexpired temporary I-551 stamp showing parole as 'Cuban/Haitian Entrant' under Section 212(d)(5) of the INA; or ○ INS Form I-94 with stamp showing parole as 'Cuban/Haitian Entrant' under Section 212(d)(5) of the INA <p>The date on the INS Form I-551 or the date of inspection stamp on the INS Form I-94 will indicate the date the status was granted. If the applicant does not present a court order, file INS Form G-845, and the G-845 Supplement along with a copy of the pertinent documents with the local INS office to verify the status was granted (see Exhibit IV-6: G-845 and Exhibit IV-7: G-845 Supplement).</p> • Domestic violence victims and their parents or children (see Section 7.11.6: Domestic Violence Criteria in this Chapter) • Native American exception: <ul style="list-style-type: none"> ○ INS Form I-551 with code S-13; ○ Unexpired temporary I-551 stamp in a Canadian passport or on INS Form I-94 with the code S-13; ○ A letter or other tribal document certifying at least 50 percent American Indian blood, as required by INA Section 289, combined with a birth certificate or other satisfactory evidence of birth in Canada; or ○ Membership card or other tribal document demonstrating membership in a federally-recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act. <p>If the individual has no document evidencing tribal membership, the appropriate tribal government must be contacted to confirm the individual's membership. In such a case, staff in the Administrator's</p>

office should be contacted.

- Alien qualifying for Veteran exemption;

To qualify for the veteran exemption, an individual must be one of the following:

- a veteran with an Honorable Discharge who fulfills a minimum active-duty service requirement; the following can be used to verify that an individual has a honorable discharge.
 - A discharge certificate, DD Form 214 or equivalent that shows active duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard and character of discharge 'Honorable' indicates the individual has an Honorable Discharge.
 - If veteran status is claimed, but the individual cannot provide papers showing service and discharge, the local VA office should be contacted.
- an active duty United States Armed Forces service member (other than active duty for training); the following can be used to determine if an individual satisfied the 'Minimum Active-Duty Service Requirement.'
 - If the discharge certificate, DD Form 214 or equivalent, shows an original enlistment before September 7, 1980, and the documents demonstrate an Honorable Discharge, the individual meets the minimum active-duty service requirement.
 - If the discharge certificate, DD Form 214 or equivalent, shows an original enlistment after September 7, 1980 and the forms show at least two years of continuous active-duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard, the individual meets the minimum active-duty requirement.
 - If the discharge certificate, DD Form 214 or equivalent, shows an original enlistment after September 7, 1980 and the forms show less than two years active duty, contact the local VA office to determine whether the individual satisfies the minimum active-duty requirement.

The following can be used to verify that an individual is on active-duty.

- A current Military Identification Card (DD Form 2 (Active)) that lists an expiration date of more than one year from the date of application.
- If the Military Identification Card is due to expire within one year, the service member shall verify active duty status by showing a copy of his or her current military orders.
- If the individual cannot produce either of the documents discussed above, active-duty may be verified by a letter from his/her commanding officer or by contacting DEERS Support Office, ATTN: Research and Analysis, 400 Gigling Road, Seaside, CA 93955-6771, fax: 408-655-8317 and requesting verification that the individual is on active-duty.

Active-duty for training is temporary full-time duty in the Armed Forces performed by members of the Reserve, Army National Guard, or Air National Guard for training purposes. Active-duty for training does not establish eligible status, but a discharge from active-duty for training may establish veteran status and should be referred to the local VA office for a determination.

- A spouse, unmarried dependent, or un-remarried surviving spouse of a veteran with an Honorable Discharge who fulfills a minimum active-duty service requirement or an active duty United States Armed Forces service member (other than active duty for training). An individual claiming to be the un-remarried spouse of a veteran or active duty personnel must demonstrate that s/he has not remarried, that his/her former spouse meets the veteran or active-duty criteria, and:

	<ul style="list-style-type: none"> ○ The surviving spouse was married to the veteran or active duty personnel for at least one year, ○ A child was born of the relationship between the surviving spouse and the veteran/active duty personnel either during or before the marriage, or ○ The surviving spouse was married to the veteran or active-duty individual within 15 years of the veteran/active duty personnel leaving the service and the veteran/active duty personnel must have died of a condition incurred or aggravated while s/he was in the service. <p>If an individual demonstrates that s/he was married to a veteran or active duty personnel who meets the criteria for the Veteran Exemption, IMA will accept a self-declaration that the surviving spouse has not remarried and that s/he meets one of the three conditions listed above.</p> <p>The following demonstrate that an individual is a surviving spouse of a veteran or active duty personnel:</p> <ul style="list-style-type: none"> • the Military Identification Card of the deceased spouse or the surviving spouse or child with an expiration date of more than one year from the date of application; • the military orders of the deceased spouse; or • a discharge certificate, DD Form 214 or equivalent that shows active duty in the Army, Navy, Air Force, Marine Corps, or Coast Guard and character of discharge 'Honorable.' <p>If the individual cannot produce these documents, the SSR should contact the local VA office in cases in which the individual claims to be the surviving spouse of a veteran and the DEERS office in cases in which the individual claims to be the surviving spouse of an active-duty personnel.</p>
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Expired or Absent Documentation 7.12.2

ALL	If an applicant presents expired documents or is unable to present any documentation evidencing his or her immigration status, refer the applicant to the local INS office to obtain documentation. In unusual cases involving applicants who are hospitalized, are medically disabled, or can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute an undue hardship, if the applicant can provide an alien registration number, the SSR may file INS Form G 845 and Supplement, along with the alien registration number and a copy of any expired INS document presented, with the local INS office to verify status. As with any documentation of immigration status, the SSR should confirm that the status information received back from INS pertains to the applicant for whom identity verification was sought.
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Receipt for Replacement Document 7.12.3

ALL	If an applicant presents a receipt indicating that s/he has applied to the INS for a replacement document for one of the documents identified above, file INS Form G 845 and Supplement along with a copy of the receipt with the local INS office to verify status. Upon return receipt of information from INS, confirm that it pertains to the applicant whose identity you have verified. The SSR should ask to see the replacement document at a later date.
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Immigration and Naturalization Service (INS) Verification 7.12.4

ALL	After a customer has provided his/her alien number and other documents indicating his/her alien status, the SSR must attempt to verify this information with INS. The first step to verifying information with INS is through the Systematic Alien Verification of Entitlements system. The SAVE computer terminal allows the Department to enter a customer's alien number and then provides the worker information about the individual's immigration status.
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	<p><i>Reasonable Opportunity Period</i></p> <p>If a non-citizen applicant reports his immigration status and that status that makes him/her a qualified alien and by his/her statements he/she meets the immigration requirements for Medicaid, do not pend eligibility determination for verification of immigration status. Accept any verification provided by the applicant, such as a “green card” and/or the nine-digit alien card and conduct a SAVE inquiry if possible.</p>
MA	<p>If the applicant is otherwise eligible for Medicaid, approve Medicaid for a full certification period. If a nine-digit Alien Number is not available, or the results of a SAVE inquiry do not support the recipient’s reported status, give the recipient a ninety-day “reasonable opportunity period” to provide verification of current immigration status. During this period, the recipient is eligible for Medicaid. If the recipient fails to provide verification of immigration status during the reasonable opportunity period, terminate Medicaid after timely and adequate notice. Persons terminated from Medicaid, for this reason, are not eligible for the DC HealthCare Alliance.</p> <p>A recipient who contacts the agency and states that he/she is having difficulty obtaining the information may be given an additional 90 days to provide the needed documentation.</p>

US Citizen or National 7.12.5

ALL	<p>ESA does not generally verify citizenship status of applicants for financial assistance (TANF, IDA or GC) or Food Stamps. That is, if an individual attests on his/her application that s/he is a citizen (or that other household members are citizens), the SSRs are not permitted to require the individual to provide documentation that proves his/her U.S. citizenship status. Furthermore, SSRs are not permitted to require individuals who declare they are US citizens to provide proof based on suspicions arising from the individual’s race, language or accent, ethnicity or religion.</p>
MA	<p>Documentation of US citizenship is required by all applicants and recipients of federally-funded Medicaid, except that the following persons are exempt from the requirement:</p> <ul style="list-style-type: none"> • persons who are not US citizens or nationals, • persons receiving Supplemental Security Income (SSI), • persons receiving Social Security Disability Income (RSDI), • persons eligible for any Part of Medicare, • children in Foster Care, • children receiving Adoption Subsidy Assistance, and • children born to mothers where the mother is a Medicaid recipient at the time of the child's birth. <p>At the time of application, US citizens who are not exempt must provide a valid and verifiable Social Security Number. Once provided, that SSN initially fulfills the citizenship documentation requirement. If otherwise eligible, approve the applicant for a full certification period. Once eligible, ESA conducts a computer match with the Social Security Administration. If SSA verifies US citizenship, the citizenship documentation requirement is fulfilled.</p> <p><i>Reasonable Opportunity Period</i></p> <p>If the computer match with SSA does not result in verification of US citizenship, the recipient must be notified of their responsibility to provide documentation of citizenship. The recipient has a ninety-day “reasonable opportunity period” to provide documentation. During this period, the recipient remains eligible for Medicaid. If no documentation is provided, terminate Medicaid after timely and</p>

	<p>adequate notice. Persons who are terminated from Medicaid for failure to provide citizenship documentation are not eligible for the DC HealthCare Alliance.</p> <p>A recipient who contacts the agency and states that he/she is having difficulty obtaining the information may be given an additional 90 days to provide the needed documentation.</p> <p><i>Acceptable Documentation</i></p> <p>To establish US citizenship in cases where the computer match with SSA does not verify citizenship, the documentation must show:</p> <ul style="list-style-type: none"> • a US place of birth, or • that the person is a US citizen. <p>Unless the document showing citizenship includes proof of identity, a document showing identity is also required.</p> <p>To establish identity the document must show:</p> <ul style="list-style-type: none"> • evidence that provides identifying information that relates to the person named on the document <p>Proof of citizenship with identity is required for all members of an MA group, with the exception of the exempted person listed above.</p> <p>All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted. Faxed copies of documents may not be accepted. A copy of the document must be maintained in the case record.</p> <p><i>Documents Establishing US Citizenship and Identity</i></p> <p>The following charts list the acceptable evidence of US citizenship and/or identity. Charts 1 through 4 cover evidence of citizenship. Charts 1 and 5 cover evidence of identity. If an individual presents documents from Chart 1, no other information is required, since these documents verify citizenship and identity. If an individual presents documents from Charts 2 through 4 to verify citizenship, then an identity document listed in Chart 5 must also be presented. Charts 1 through 4 establish a hierarchy of reliability of citizenship documents. The applicant/recipients must provide the most reliable document that is available. The following instructions specify when a document of lesser reliability may be accepted.</p> <p><i>Primary Documents to Establish Both US Citizenship and Identity (Chart 1)</i></p> <p>Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a US citizen. In general, obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in this chart as primary evidence of both US citizenship and identity if the document meets the criteria listed under “Explanations and Notes” and there is nothing indicating the person is not a US citizen (e.g. lost US citizenship).</p> <p>Note: Persons born in American Samoa (including Swain’s Island) are usually US non-citizen nationals. References in these instructions to “citizens” should be read as references to non-citizen nationals with</p>
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	<p>respect to these persons. There is no difference in terms of their Medicaid eligibility.</p> <p>Note: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by US Citizenship and Immigration service (USCIS) within DHS. However, even documents issued after this date may bear INS legends.</p> <p>Applicants or recipients born outside the US who were not citizens at birth must submit a document listed under primary evidence of US citizenship.</p> <table border="1" data-bbox="261 562 1430 1255"> <tr> <th colspan="2">Chart 1 – Primary Evidence of Citizenship</th></tr> <tr> <th>Primary Documents</th><th>Explanations and Notes on Documentation</th></tr> <tr> <td>US passport</td><td> <p>The Department of State issues this. A US passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation.</p> <p>Note: Spouses and children were sometimes included on one passport through 1980. US passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</p> <p>Exception: Do not accept any passport as evidence of US citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p> </td></tr> <tr> <td>Certificate of Naturalization (N-550 or N-570)</td><td>Department of Homeland Security issues for naturalization.</td></tr> <tr> <td>Certificate of Citizenship (N-560 or N-561)</td><td>Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.</td></tr> </table>	Chart 1 – Primary Evidence of Citizenship		Primary Documents	Explanations and Notes on Documentation	US passport	<p>The Department of State issues this. A US passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation.</p> <p>Note: Spouses and children were sometimes included on one passport through 1980. US passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</p> <p>Exception: Do not accept any passport as evidence of US citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p>	Certificate of Naturalization (N-550 or N-570)	Department of Homeland Security issues for naturalization.	Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
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MA	<p><i>Secondary Documents to Establish US Citizenship (Chart 2)</i></p> <p>Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. In addition, a second document establishing identity MUST also be presented as described in Chart 5, Evidence of Identity.</p> <p>Available evidence is evidence that exists and can be obtained during the normal application period of 45 days for AR/AX applicants/recipients or 90 days for SR/QM applicants/recipients.</p> <p>Accept any of the documents listed in this Chart as secondary evidence of US citizenship if the document meets the criteria listed under “Explanations and Notes” and there is nothing indicating the person is not a US citizen (e.g. lost US citizenship).</p> <table border="1" data-bbox="261 1696 1430 1894"> <tr> <th colspan="2">Chart 2 – Secondary Evidence of Citizenship</th></tr> <tr> <th>Secondary Documents</th><th>Explanations and Notes on Documentation</th></tr> <tr> <td> <p>A US public birth record showing birth in:</p> <ul style="list-style-type: none"> one of the 50 US </td><td> <p>The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age.</p> </td></tr> </table>	Chart 2 – Secondary Evidence of Citizenship		Secondary Documents	Explanations and Notes on Documentation	<p>A US public birth record showing birth in:</p> <ul style="list-style-type: none"> one of the 50 US 	<p>The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age.</p>				
Chart 2 – Secondary Evidence of Citizenship											
Secondary Documents	Explanations and Notes on Documentation										
<p>A US public birth record showing birth in:</p> <ul style="list-style-type: none"> one of the 50 US 	<p>The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age.</p>										

<p>States;</p> <ul style="list-style-type: none"> • District of Columbia; • American Samoa • Swain's Island • *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the US (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time)); or • Guam (on or after April 10, 1899) 	<p>An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.</p> <p>Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the US, or the Northern Mariana Islands before these areas became part of the US, the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. *See additional requirements for Collective Naturalization.</p>
Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to US citizens in the US who were born outside the US and acquired US citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth (FS-240). The DS-1350 is not issued outside the US
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the US to US military personnel usually have one of these.
Certification of Birth Abroad (FS-545)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, US consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
United States Citizen Identification Card (I-197) or the prior version (I-179)	INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized US citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
American Indian Card (I-872)	DHS issues this card to identify a member of the Texas Band of Kickapoos living near the US/Mexican border. A classification code "KIC" and a statement on the back denote US citizenship.
Northern Mariana Card (I-873)	INS issued the I-873 to a collectively naturalized citizen of the US who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
Final adoption decree	The adoption decree must show the child's name and US place of birth. In situations where an adoption is not finalized and the State in which the

	child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and US place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.						
Evidence of civil service employment by the US government	The document must show employment by the US government before June 1, 1976.						
Official Military record of service	The document must show a US place of birth (for example a DD-214 or similar official document showing a US place of birth).						
<p><i>Third Level Documents to Establish US Citizenship (Chart 3)</i></p> <p>Third level evidence of US citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used ONLY when primary evidence cannot be obtained within 45 days for AR/AX or 90 days for SR/QM, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the US In addition, a second document establishing identity MUST be presented as described in Chart 5, Evidence of Identity.</p> <p>Accept any of the documents listed in Chart 3 as third level evidence of US citizenship if the document meets the criteria listed under "Explanations and Notes", the applicant alleges birth in the US, and there is nothing indicating the person is not a US citizen (e.g., lost US citizenship).</p> <p>Third level evidence is generally a non-government document established for a reason other than to establish US citizenship and to show a US place of birth. The place of birth on the non-government document and the Medicaid application must agree.</p>							
<p align="center">Chart 3 – Third Level Evidence of Citizenship</p> <table border="1"> <thead> <tr> <th>Third Level Documents</th><th>Explanations and Notes on Documentation</th></tr> </thead> <tbody> <tr> <td>Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a US place of birth</td><td>Do not accept a souvenir "birth certificate" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application</td></tr> <tr> <td>Life or health or other insurance record showing a US place of birth and was created at least 5 years before the initial application date</td><td>Life or health insurance may show biographical information for the person including place of birth; the record can be used to establish US citizenship when it shows a US place of birth.</td></tr> </tbody> </table>		Third Level Documents	Explanations and Notes on Documentation	Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a US place of birth	Do not accept a souvenir "birth certificate" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application	Life or health or other insurance record showing a US place of birth and was created at least 5 years before the initial application date	Life or health insurance may show biographical information for the person including place of birth; the record can be used to establish US citizenship when it shows a US place of birth.
Third Level Documents	Explanations and Notes on Documentation						
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Life or health or other insurance record showing a US place of birth and was created at least 5 years before the initial application date	Life or health insurance may show biographical information for the person including place of birth; the record can be used to establish US citizenship when it shows a US place of birth.						
<p><i>Fourth Level Documents to Establish US Citizenship (Chart 4)</i></p> <p>Fourth level evidence of US citizenship is documentary evidence of the lowest reliability. Fourth level evidence should ONLY be used in the rarest of circumstances. This level of evidence is used ONLY when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within 45 days for AR/AX or 90 days for SR/QM, and the applicant or recipient alleges being born in the US In addition, a second document establishing identity MUST be presented as described in Chart 5, Evidence of Identity. Available evidence is evidence that can be obtained within 45 days.</p>							

Accept any of the documents listed in Chart 4 as fourth level evidence of US citizenship if the document meets the criteria listed under “Explanations and Notes”, the applicant alleges birth in the US, and there is nothing indicating the person is not a US citizen (e.g. lost US citizenship). In addition, a second document establishing identity must be presented.

Fourth level evidence, as described below, consists of documents established for a reason other than to establish US citizenship and to show a US place of birth. The place of birth on the document and the application must agree. The written affidavit described in this chart may be used only when the State is unable to secure evidence of citizenship listed in any other chart.

Chart 4 – Fourth Level Evidence of Citizenship

Fourth Level Documents	Explanations and Notes on Documentation
Federal or State census record showing US citizenship or a US place of birth (Generally for persons born 1900 through 1950).	<p>The census record must also show the applicant’s age.</p> <p>Note: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC-600, Application for Search of Census Records for Proof Age. Add in the remarks portion “US citizenship data requested.” Also, add that the purpose is for Medicaid eligibility. This form requires a fee.</p>
Other documentation as listed in the explanation that was created at least 5 years before the application for Medicaid	<p>This document must be one of the following and show a US place of birth:</p> <ul style="list-style-type: none"> • Seneca Indian tribal census record • Bureau of Indian Affairs tribal census records of the Navaho Indians • US State Vital Statistics official notification of birth registration • An amended US public birth record that is amended more than 5 years after the person’s birth • Statement signed by the physician or midwife who was in attendance at the time of birth.
Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a US place of birth	<p>Admission papers generally show biographical information for the person including place of birth; the record can be used to establish US citizenship when it shows a US place of birth.</p>
Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a US place of birth	<p>Medical records generally show biographical information for the person including place of birth; the record can be used to establish US citizenship when it shows a US place of birth.</p> <p>Note: An immunization record is not considered a medical record for purposes of establishing US citizenship.</p> <p>Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.</p>
Written Affidavits	<p>Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits,</p>

		<p>the following rules apply:</p> <ul style="list-style-type: none"> • There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit). • At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient. • In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity. • If the individual making the affidavit has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. • IMA must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained. • The affidavits must be signed under penalty of perjury.
<p><i>Evidence of Identity (Chart 5)</i></p> <p>When primary evidence of citizenship described in Chart 1 is not available, a document from charts 2 through 4 may be presented when accompanied by an identity document from this chart.</p>		
<p align="center">Chart 5 – Evidence of Identity</p>		
<p>Documents to Establish Identity</p>	<p>Explanations and Notes on Documentation</p>	
<p>Certificate of Degree of Indian Blood, or other US American Indian/Alaska Native tribal document.</p>	<p>Acceptable if the document carries a photograph of the applicant or recipient or has other personal identifying information relating to the individual.</p>	
<p>Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act</p>	<p>Use 8 CFR 274a.2(b)(1)(v)(B)(1). This section includes the following acceptable documents for Medicaid purposes:</p> <ul style="list-style-type: none"> • driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color • School identification card with a photograph of the individual • US military card or draft record • Identification card issued by the Federal, State, or local government with the same information included on driver's licenses • Military dependent's identification card • Native American Tribal document 	

	<ul style="list-style-type: none"> • US Coast Guard Merchant Mariner card • data matches with other federal or state agencies if the agencies establish and certify true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle or child protective services. <p>Children who are age 16 or younger and cannot provide one of the documents listed above may present one of the following documents:</p> <ul style="list-style-type: none"> • School record that shows a date and place of birth and parent(s) name • Clinic, doctor or hospital record showing date of birth • Daycare or nursery school record showing date and place of birth, or • If none of the documents listed previously are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. <p>Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1).</p>
	<p><i>Collective Naturalization</i></p> <p>The following will establish US citizenship for collectively naturalized individuals:</p> <ul style="list-style-type: none"> • Puerto Rico <ul style="list-style-type: none"> ○ Evidence of birth in Puerto Rico on or after April 11, 1899, and the applicant's statement that s/he was residing in the US, a US possession, or Puerto Rico on January 13, 1941; or ○ Evidence that the applicant was a Puerto Rican citizen and the statement that s/he was residing in Puerto Rico on March 1, 1917 and that s/he did not take an oath of allegiance to Spain. • US Virgin Islands <ul style="list-style-type: none"> ○ Evidence of birth in the US Virgin Islands and the applicant's statement of residence in the US, a US possession, or the US Virgin Islands on February 25, 1927; ○ The applicant's statement indicating residence in the US Virgin Islands as a Danish citizen on January 17, 1917; residence in the US, a US possession, or the US Virgin Islands on February 25, 1927; and that s/he did not make a declaration to maintain Danish citizenship; or ○ Evidence of birth in the US Virgin Islands and the applicant's statement indicating residence in the US, a US possession or territory, or the Canal Zone on June 28, 1932. • Northern Mariana Island (NMI) was formerly part of the Trust Territory of the Pacific Islands (TTPI) <ul style="list-style-type: none"> ○ Evidence of TTPI citizenship; residence in NMI, the US, or a US territory or possession on November 3, 1986 (NMI local time); and the applicant's statement that s/he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); ○ Evidence of TTPI citizenship, continuous residence in the NMI since before November

	<p>3, 1981, voter registration prior to January 1, 1975, and the applicant's statement that s/he did not owe allegiance to a foreign state on November 4, 1986 ; or</p> <ul style="list-style-type: none"> ○ Evidence of continuous domicile in the NMI since before January 1, 1974, and the applicant's statement that s/he did not owe allegiance to a foreign state on November 4, 1986. If a person entered the NMI as a nonimmigrant and lived in the NMI before January 1, 1974, this does not constitute continuous domicile and the individual is not a US citizen.
TANF	<p>Although TANF applicants and recipients are not required to provide documentation of citizenship, any document that is acceptable verification of citizenship for MA, will verify citizenship for TANF also. In addition TANF, applicants and recipients can show citizenship based on the parentage or marriage of a US citizen. The following will establish US citizenship that is derived from a parental or spousal relationship to a US citizen:</p> <p><i>Derivative Citizenship</i></p> <ul style="list-style-type: none"> • Applicant Born Abroad to Two US Citizen Parents <ul style="list-style-type: none"> ○ Evidence of the US citizenship of the parents, the relationship of the applicant to the parents, and that at least one parent resided in the US or an outlying possession prior to the applicant's birth. • Applicant Born Abroad to a US Citizen Parent and a US Non-Citizen National Parent. <ul style="list-style-type: none"> ○ Evidence that one parent is a US citizens and that the other is a US non-citizen national, evidence of the relationship of the applicant to the US, citizen parent, and evidence that the US citizen parent resided in the US, a US possession, American Samoa, or Swain's Island for a period of at least one year prior to the applicant's birth. • Applicant Born Out-of-Wedlock Abroad to a US Citizen Mother <ul style="list-style-type: none"> ○ Evidence of the US citizenship of the mother, evidence of the relationship to the applicant and, for births on or before December 24, 1952, evidence that the mother resided in the US prior to the applicant's birth or, for births after December 24, 1952, evidence that the mother had resided, prior to the child's birth, in the US or a US possession for a period of one year. • Applicant Born in the Canal Zone or the Republic of Panama <ul style="list-style-type: none"> ○ A birth certificate showing birth in the Canal Zone on or after February 26, 1904 and before October 1, 1979 and evidence that one parent was a US citizen at the time of the applicant's birth or one parent was a US citizen and employed by the US government or the Panama Railroad Company or its successor in title. <p>For all other situations where an applicant claims to have a US citizen parent and an alien parent, or claims to fall within one of the categories, refer him/her to the local INS office for determination of the US citizenship. If the applicant is outside the US, refer him/her to the State Department for a US citizenship determination.</p> <ul style="list-style-type: none"> • Adoption of Foreign-Born Child by a US Citizen <ul style="list-style-type: none"> ○ If the birth certificate shows a foreign place of birth and the applicant cannot be determined to be a naturalized citizen under any of the above criteria, obtain other evidence of US citizenship; or ○ Since foreign-born adopted children do not automatically acquire US citizenship by virtue of adoption by US citizens, refer the applicant to the local INS office for a determination of US citizenship if the applicant provides no evidence of US citizenship.

	<ul style="list-style-type: none"> US Citizenship by Marriage <p>A woman who acquired US citizenship through marriage to a US citizen before September 22, 1922, requires evidence of US citizenship of the husband and evidence showing the marriage occurred before September 22, 1922.</p> <p>If the husband was an alien at the time of the marriage and became naturalized before September 22, 1922, the wife also acquired naturalized citizenship. If the marriage terminated, the wife maintained her US citizenship if she was residing in the US at the time and continued to reside in the United States.</p>
GC	See TANF
FS	See TANF, except proof of US citizenship, may be requested when questionable. An applicant/recipient's inability to provide proof of citizenship for Medicaid does NOT mean his/her citizenship is automatically questionable.

Documentation to Confirm Domestic Violence Qualification 7.12.6

ALL	<p>The following is a list of common immigration documents that are generated as a result of family-based immigrant visa petitions, self-petitions for immigrant visas, and applications for cancellation of removal/suspension of deportation. This list is not exclusive, and additional documents not listed here may also corroborate a relevant immigration status.</p>
A.	<p>Approved or pending I-360 self-petition for an immigrant visa</p> <ul style="list-style-type: none"> INS Form I-797 or I-797C indicating approval or prima facie validity of an I-360 petition (only I-360s based on status as a widow/widower of a U.S. citizen or as a self-petitioning spouse or child of an abusive U.S. citizen or LPR may be accepted). An I-360 petition with proof of filing such as a file-stamped copy of the petition, an INS Form I-797 or I-797C, or a signed certified return receipt or cash register or computer generated receipt (only I-360s based on status as a widow/widower of a U.S. citizen or as a self-petitioning spouse or child of an abusive U.S. citizen or LPR are relevant).
B.	<p>Approved or pending I-130 petition for an immigrant visa</p> <ul style="list-style-type: none"> INS Form I-797 indicating filing or approval of an I-130 petition (only I-130 petitions describing the following relationships are relevant: husbands or wives of U.S. citizens or LPRs, unmarried children under 21 years old of U.S. citizens or LPRs, or the unmarried sons or daughters age 21 or older of LPRs). An I-130 petition with proof of filing such as a file-stamped copy of the petition, or another document demonstrating filing such as a signed certified return receipt, cash register or computer generated receipt (only I-130 petitions describing the following relationships are relevant: husbands or wives of U.S. citizens or LPRs, unmarried children under 21 years old of U.S. citizens or LPRs, or the unmarried sons or daughters age 21 or older of LPRs).
C.	<p>Approved or pending application for cancellation of removal or suspension of deportation</p> <ul style="list-style-type: none"> An order or document from the Immigration Court or Board of Immigration Appeals granting suspension of deportation under INA section 244(a)(3) as in effect prior to April 1, 1997, or cancellation of removal under INA section 240A(b)(2). An application for cancellation of removal (Form EOIR-42B) or suspension of deportation

	<p>(Form EOIR-40) with proof of filing such as a file-stamped copy of the application, or another document demonstrating filing such as a signed certified return receipt or a cash register or computer generated receipt (only applications for suspension of deportation under INA section 244(a)(3) as in effect prior to April 1, 1997, or cancellation of removal under INA section 240A(b)(2).</p> <ul style="list-style-type: none"> • A document from the Immigration Court or Board of Immigration Appeals indicating that the applicant has established a prima facie case for suspension of deportation under INA Section 244(a)(3) as in effect prior to April 1, 1997, or cancellation of removal under INA Section 240A(b)(2).
	<p>Document Verification Procedures</p> <p>Follow the procedures outlined below to verify the immigration status of applicants who allege eligibility as abused immigrants.</p> <p>If the applicant filed a self-petition as a victim of abuse (Form I-360) or a family-based immigrant visa petition (Form I-130), complete the form in Exhibit IV-6. Fax the form to the INS Vermont Service Center: fax 802-527-3159 or 802-527-3252.</p> <p>If the applicant filed for cancelation of removal or suspension of deportation as a victim of abuse, complete the form in Exhibit IV-7. Fax the form to the immigration court where the application was filed. You may locate the current fax numbers for the immigration courts on the list in Exhibit IV-8.</p> <p>If an immigrant has provided the agency with all required documentation and that documentation indicates that s/he is a qualified immigrant based on the domestic violence criteria, but the Immigration and Naturalization Service or immigration court has not returned the verification forms within the applicable application processing timeframes, the SSR should:</p> <ul style="list-style-type: none"> • Determine the individual's eligibility for benefits assuming that s/he is a qualified immigrant • Approve or deny the application within the applicable application time frame.

Verification of Status as Victims of Severe Forms of Trafficking 7.12.7

ALL	<p>Victims of severe forms of trafficking must provide proof of their status. Adult victims should provide a certification letter from the Office of Refugee Resettlement (ORR) to verify they are trafficking victims. Child victims do not receive certification letters but should have a letter that verifies that they are eligible for benefits pursuant to section 107(b) of the Trafficking Victims Protection Act of 2000.</p> <p>Letters issued to victims of trafficking should be verified by calling ORR's trafficking verification line. The case worker should call the trafficking verification line at (202) 401-5510 to verify the validity of the letter and to inform ORR of the benefits for which the immigrant has applied. The letters will list a nine-digit tracking number that will be needed to verify its validity.</p>
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Chapter 8 - TANF Child Deprivation

This chapter has been repealed. The definition of a Principal Wager Earner (PWE) has been moved to Section 1.6: Exemptions from Work Requirements in [Part V: Program Requirements and Sanctions](#).

Chapter 9 - Disability/Blindness

INTRODUCTION 9.1

This chapter pertains to MA and FS only. Some applicants qualify for program benefits or special consideration when determining benefits on the basis of disability or blindness. This chapter discusses the definition of disability and blindness and how to establish disability or blindness for eligibility purposes. (See Section 1.6: Exemptions from Work Requirements in Part V for information on exemptions to TANF work requirements based on incapacity. See Section 3.10: POWER in Part VIII for information on the POWER program -- an alternative to TANF for incapacitated individuals.)

Disability or blindness affects eligibility for two programs, MA, and FS. Individuals not otherwise eligible for Medicaid can qualify based on their disability or blindness if they also meet other non-financial and financial eligibility requirements (see Part VI: Financial Eligibility Requirements). FS households that include a disabled or blind household member are also entitled to special considerations. Such households are not required to meet the gross income test (see Chapter 8: Determining Income Eligibility in Part VI), can receive a larger shelter deduction under some circumstances, and can deduct certain medical expenses from their income (see Chapter 6: Income Disregards and Deductions in Part VI).

LEGAL AUTHORITY 9.2

AREA/TOPIC	DISTRICT	FEDERAL
Disability/Blindness		MA: 42 USC 1396a(m); 42 CFR 435.530-531, .540-541 FS: 7 USC 2012 (r); 7 USC 2014 (c); 7 USC 2014 (e); 7 USC 2014 (g); 7 CFR 271.2; 273.9 (a); 273.9 (d)(3); 273.9 (d)(5)(ii)

DEFINITION 9.3

MA	<p>AR: N/A</p> <p>AX: N/A</p> <p>SR: A person is permanently and totally disabled when:</p> <ul style="list-style-type: none">• s/he has a medically determined physical or mental impairment,• his/her impairment prevents him/her from engaging in any substantial gainful activity, and• his/her impairment:<ul style="list-style-type: none">○ can be expected to result in imminent death,○ has lasted at least 12 consecutive months, or○ is expected to last at least 12 consecutive months; <p>or s/he:</p> <ul style="list-style-type: none">○ meets the District of Columbia's October 1972 definition of disability, and○ received assistance under the Aid to the Permanently and Totally Disabled Program for December 1973.
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	<p>The October 1972 definition of disability is as follows:</p> <ul style="list-style-type: none"> An individual is "permanently and totally disabled" if that individual has some permanent physical or mental impairment, disease, or combination thereof that substantially precludes him or her from holding a job or engaging in a useful occupation within his or her competence. <p>A person is determined to be blind when:</p> <ul style="list-style-type: none"> the visual acuity in his better eye can only be corrected to 20/200 or less, the widest diameter of the visual field in his/her better eye is limited to an angle 20 degrees or less, conditions that constitute severe visual handicaps exist, or s/he: <ul style="list-style-type: none"> meets the District of Columbia's October 1972 definition of blindness, and received assistance under the Aid to the Blind Program for December 1973. <p>Under the 1972 definition of blindness, an individual is considered to be blind when he or she has</p> <ul style="list-style-type: none"> vision in the better eye of no more than 20/200 while wearing corrective glasses; a loss of 80 percent or more of his or her peripheral vision; or certain other conditions which constitute a severe visual handicap. <p>QM: N/A</p>
<p>FS</p>	<p>Disabled group member means a member of a household who meets any of the following requirements:</p> <ul style="list-style-type: none"> receives SSI benefits under Title XVI of the Social Security Act or disability or blindness payments under Titles I, II, X, XIV, or XVI of the Social Security Act; receives federally or state-administered supplemental benefits under Section 212(a) of Public Law 93-6; receives disability retirement benefits from a governmental agency because of a disability considered permanent under Section 221(l) of the Social Security Act; is a veteran with a service-connected or non-service connected disability rated by VA as total or paid as total by VA under Title 38 of the U.S. Code; is a veteran considered by VA to be in need of regular aid and attendance or permanently housebound under Title 38 of the U.S. Code; is a surviving spouse of a veteran and considered by VA to be in need of regular aid and attendance or permanently housebound or a surviving child of a veteran considered by VA to be permanently incapable of self-support under Title 38 of the U.S. Code; is a surviving spouse or child of a veteran and considered by VA to be entitled to compensation for a service-connected death or pension benefits of a non-service connected death under Title 38 of the U.S. Code and has a disability

	<p>considered permanent under Section 221(l) of the Social Security Act ('entitled' as used in this definition refers to the veteran's surviving spouse and children who are receiving the compensation or pension benefits stated or have been approved for such payments but are not yet receiving them); or</p> <ul style="list-style-type: none"> receives an annuity payment under Section 2(a)(l)(iv) of the Railroad Retirement Act of 1974, is determined to be eligible to receive Medicare by the Railroad Retirement Board or Section 2(a)(l)(iv) of the Railroad Retirement Act of 1974, and is determined to be disabled based upon the criteria used under Title XVI of the Social Security Act.
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DISABILITY/BLINDNESS DETERMINATIONS 9.4

MA	<p>AR: N/A</p> <p>AX: N/A</p> <p>SR: Disability/blindness determinations are made by the SSA, the Department's eye specialist, or MRT. Individuals receiving SSI are categorically eligible for Medicaid, and no further disability determination is required (see Chapter 12: Categorical Eligibility in this Part). Individuals receiving SSDI based on their own disability have met the disability requirement for disability-related Medicaid. The MRT does not make a separate disability determination in this case. If the SSDI recipient meets the other non-financial and financial eligibility requirements (see Part VI: Financial Eligibility), s/he will qualify for Medicaid.</p> <p>The disability determination for those individuals who do not receive SSI or SSDI (based on their own disability) who are applying for Medicaid based on disability will be made by the MRT unless the SSA has already made a disability determination and found that the individual does not meet the SSA disability standard (and no changes in the individual's medical condition have occurred).</p> <p>Individuals for whom a final SSA disability/blindness determination has not been made are entitled to a disability/blindness determination by the MRT. An SSI/SSA determination that disability or blindness does not exist for SSI purposes is considered final for MA purposes if:</p> <ul style="list-style-type: none"> no further appeals may be made at SSA (see Exhibit IV-6: General Information About the SSA Appeals Process) or the applicant/recipient failed to file an appeal at any step within SSA's 60-day limit, and the applicant/recipient is not claiming: <ul style="list-style-type: none"> a totally different disabling condition than the condition SSA based its determination on, or an additional impairment(s) or change of deterioration in his/her condition on which SSI has not made a determination. <p>Once SSA's determination of ineligibility is final, eligibility for Medicaid based on disability or blindness does not exist, even if the MRT had determined the individual to be disabled or blind.</p>
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	<p>Individuals denied SSI eligibility because of a refusal to meet an SSI program requirement not applicable under Medicaid should be granted Medicaid coverage if they meet non-financial and financial eligibility requirements (see Part VI: Financial Eligibility). These individuals include:</p> <ul style="list-style-type: none"> • disabled or blind individuals over age 15 and under 65 who refuse to meet the SSI program requirement for vocational rehabilitation, and • individuals who refuse to meet the SSI program requirements for: <ul style="list-style-type: none"> ○ alcoholism treatment, ○ drug treatment, or ○ corrective surgery. <p>QM: N/A</p>
FS	N/A

PENDING DETERMINATIONS 9.5

MA	<p>AR: N/A</p> <p>AX: N/A</p> <p>SR: Applicants who qualify for Medicaid based on non-disability-related eligibility criteria, such as applicants age 65 or over, children, or parents/caretaker relatives caring for minor children, do not have to rely on a disability/blindness determination and their eligibility should be determined under the appropriate non-disability-related category. Disabled parents should be strongly encouraged, however, to complete the medical evaluation form because if the MRT determines the individual disabled, and the case is converted to an SR case, the individual will not be placed in the same managed care system that serves non-disabled Medicaid participants. This system may not be as appropriate for individuals with disabilities as for those without disabilities. If however, the individual would not meet the SR financial eligibility criteria, the individual should not be given a medical evaluation form.</p> <p>QM: N/A</p>
FS	N/A

VERIFICATION 9.6

MA	<p>AR: N/A</p> <p>AX: N/A</p> <p>SR: The disability standard used in Medicaid for individuals applying for Medicaid based on disability is the same as that used by the SSA when administering SSI and SSDI. Recipients of SSI are categorically eligible for Medicaid, and no further verification of disability is required.</p> <p>Recipients of SSDI benefits based on an individual's own disability are considered to meet the disability standard applied in Medicaid. This includes a person whose entire SSDI benefit is being withheld for recoupment. Applicants receiving SSDI must provide verification that they receive SSDI benefits (that is, a document from the SSA verifying receipt of SSDI based on disability or blindness), and those benefits are based on their own disability. No further</p>
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	<p>medical information must be verified.</p> <p>Individuals applying for Medicaid based on disability who do not receive either SSI or SSDI must submit the results of a medical examination within 45 days of filing an application. The MRT reviews this form and issues a disability determination within 90 days from the date of application.</p> <p>If an individual applies for Medicaid based on disability, but the individual would be eligible based on a non-disability eligibility category, the SSR should determine eligibility based on the non-disability-related standard since this will reduce burden on the applicant (s/he will not be required to submit a medical evaluation form) and will speed the eligibility determination process. The individual should be strongly encouraged to complete the medical evaluation form because if the MRT determines the individual disabled, and the case is converted to an SR case, the individual will not be placed in the same managed care system that serves non-disabled Medicaid participants.</p> <p>QM: N/A</p>
FS	<p>The following table shows what verification is required for an individual claiming to be disabled for FS purposes by category of disability:</p>

Category of Disability (from Section 9.3: Definition)	Verification Required
<p>An individual who:</p> <ul style="list-style-type: none"> • Receives SSI benefits based on disability or disability or blindness payments under Titles I, II, X, XIV, or XVI of the Social Security Act • Receives federally or state-administered supplemental benefits under Section 212(a) of Public Law 93-66. 	<p>The household must provide proof that the disabled individual is receiving benefits under Titles I, II, X, XIV, or XVI of the Social Security Act (that is, a statement from the SSA).</p>
<p>A veteran with a service-connected or non-service connected disability rated by VA as total or paid as total by VA under Title 38 of the U.S. Code.</p>	<p>The household must present a statement from the VA which clearly indicates that the disabled individual is receiving VA disability benefits for a service-connected or non-service connected disability and that the disability is rated total or paid at that total rate by VA.</p>
<p>An individual who:</p> <ul style="list-style-type: none"> • Is a veteran considered by VA to be in need of regular aid and attendance or permanently housebound under Title 38 of the U.S. Code. • Is a surviving spouse of a veteran and considered by VA to be in need of regular aid and attendance or permanently housebound or a surviving child of a 	<p>The household must prove that the disabled individual is receiving VA disability benefits (that is, a statement from the VA).</p>

<p>veteran and considered by VA to be permanently incapable of self-support under Title 38 of the U.S. Code.</p>	
<p>An individual who:</p> <ul style="list-style-type: none"> • Receives disability retirement benefits from a governmental agency because of a disability considered permanent under Section 221(l) of the Social Security Act. • Is a surviving spouse or child of a veteran and considered by VA to be entitled to compensation for a service-connected death or pension benefits of a non-service connected death under Title 38 of the U.S. Code and has a disability considered permanent under Section 221(l) of the Social Security Act. 	<p>If it is obvious to the SSR that the individual has one of the disabilities listed on SSA's most current list of disabilities considered permanent under the Social Security Act, the household is considered to have a verified disability.</p> <p>If the disability is not obvious to the SSR, the household must provide a statement from a physician or licensed or certified psychologist certifying that the individual either has one of the disabilities listed or is unable to purchase meals because s/he suffers from some other severe permanent physical or mental disease or non-disease-related disability. This medical statement is reviewed by the MRT, which decides whether the individual meets the required disability standard.</p>
<p>An individual who receives an annuity payment under Section 2(a)(l)(iv) of the Railroad Retirement Act of 1974 is determined to be eligible to receive Medicare by the Railroad Retirement Board or Section 2(a)(l)(iv) of the Railroad Retirement Act of 1974, and is determined to be disabled based upon the criteria used under Title XVI of the Social Security Act.</p>	<p>The household must provide proof that the individual receives a Railroad Retirement Disability annuity from the Railroad Retirement Board and has been determined to qualify for Medicare.</p>

The following is a partial list of disabilities considered permanent under the SSA:

- permanent loss of the use of both hands, both feet, or one hand and one foot;
- amputation of a leg at a hip;
- amputation of a leg or foot because of diabetes mellitus or a peripheral vascular disease;
- total deafness not correctable by surgery or a hearing aid;
- statutory (that is, legal) blindness, except if due to cataracts or a detached retina.
- IQ of 59 or less established after age 16;
- paraplegia or quadriplegia;
- multiple sclerosis that is severe and recurring and includes muscle weakness, paralysis, or interference of vision or speech;
- muscular dystrophy with a significant effect on the use of the arms or legs; and
- chronic renal disease (documented by persistent, adverse objective findings) resulting in severely reduced kidney function.

As discussed in Section 1.3: Mandatory Group Members in this Part, a person at least 60 years old, his/her spouse, and their children under 18 may choose to be a separate group from those

they live with even if they purchase and prepare food together if:

- the person age 60 or over cannot purchase and prepare meals due to a permanent disability as determined by SSA or a non-disease related permanent disability, and
- the countable income of all the other people with whom the senior impaired group lives does not exceed 165 percent of the FPL.

For disability determinations which must be made relevant to this provision, the individual must be unable to purchase and prepare meals because s/he suffers from a severe physical or mental disability, even if the individual's disability is not specifically mentioned on the SSA list.

The elderly and disabled individual (or his/her authorized representative) is responsible for obtaining the cooperation of the individuals with whom s/he resides in providing the necessary income information about the others to the SSR for purposes of this provision.

Exhibit IV-10 General Information about the SSA Appeals Process

When the SSA determines that a client is not disabled/blind for SSI purposes, the client may appeal that determination at SSA.

The SSA appeals process consists of three steps:

- reconsideration,
- hearing, and
- appeals council.

SSA has no time limits for making decisions on appeals.

The client, however, has 60 days from the date s/he receives notice to appeal each of the following SSA actions:

- determinations,
- reconsideration decisions, and
- hearing decisions.

Reconsideration is completed at the SSA. An SSA employee other than the one who decided the client was not disabled/blind reviews the determination. Most considerations uphold the original decision.

Hearings are conducted by an administrative law judge (ALJ). The ALJ renders a new decision based on a review of the material; questions asked at the hearing, testimony of witnesses, and new evidence submitted. Approximately 60 percent of all SSA disability denials are overturned at the hearing level.

The Appeals Council can deny or dismiss an appeal from the hearing level or grant the request by issuing a new decision or remanding the case back to an ALJ. Most appeals are denied or dismissed at this step.

If the Appeals Council upholds the ALJ's decision, there are no further appeals at SSA. The client may contest SSA's decision at the appropriate federal district court.

Chapter 10 - Institutional Status

INTRODUCTION 10.1

Certain individuals are not eligible for program benefits when living in an institution. This chapter explains how institutional status affects a person's eligibility.

'Entire calendar month' means a period that begins any time on the first day of a calendar month and ends any time on the last day of the same month.

A person residing in a facility which provides its residents more than 50 percent of their meals is not eligible for FS unless the person:

- is a resident of private or public shelters for the homeless;
- is a resident of federally-subsidized housing for the elderly;
- is a resident of a facility or treatment center that is providing him/her regular treatment or rehabilitation for alcohol or drug addiction;
 - This includes children who are living with a person receiving treatment in a drug or alcohol facility but it does not include the spouse of a person receiving drug or alcohol treatment;
- is disabled or blind and is a resident in a group living facility; or
- is a woman or woman and her child(ren) who are temporarily living in a shelter for battered women and children.

LEGAL AUTHORITY 10.2

AREA/TOPIC	DISTRICT	FEDERAL
Institutional Status		MA: 42 USC 1396a(a)(10); 42 USC 1396r-5 TANF: 45 CFR 260.20(b); 45 CFR 263(b)(2) FS: 7 USC 2012(i); 7 CFR 273.1(c)(6); 273.1(e); 273.11(e); 273.11(f); 273.11(g); 273.11(i)

ADOPTION ASSISTANCE 10.3

MA	Children receiving adoption assistance payments are categorically eligible for Medicaid (see Chapter 12: Categorical Eligibility in this Part).
TANF	Children receiving adoption assistance payments are ineligible for benefits. When determining the eligibility and benefits of other household members, none of the child's income or assets (including the adoption assistance payment) is considered available to the group.
GC	See TANF
FS	Children receiving adoption assistance payments are included like any other child. If the child is included in the unit, all income and assets of the child (including the adoption assistance payments) are counted when determining the group's eligibility and benefits.

DRUG AND ALCOHOL TREATMENT FACILITIES 10.4

MA	Residence in a drug and/or alcohol treatment facility does not affect an individual's eligibility for MA
TANF	<p>A parent, caretaker relative, or child who expects to be in a non-penal treatment facility for less than 90 days and then expects to return to the group meets the definition of a 'temporarily absent' parent, caretaker relative, or child (see Section 1.15: Temporary Absence in this Part). In this situation, the individual can remain a part of the TANF group even though s/he lives apart from the group while in the facility.</p> <p>Some treatment facilities allow children to live in the facility with a parent or caretaker relative. In such a situation, the parent/caretaker relative and the child could form a TANF group if the child(ren) and the parent or caretaker relative meet all financial and non-financial eligibility requirements (see Part VI: Financial Eligibility).</p>
GC	A child 'temporarily absent' from his/her caretaker's home because s/he resides in a drug or alcohol treatment facility remains eligible for GC during the temporary absence.
FS	<p>Members of eligible groups, including single person groups, who are narcotics addicts or alcoholics who regularly participate in a licensed chemical dependency treatment, rehabilitation facility, or facilities eligible for funding under Part B of Title XIX to provide such treatment may voluntarily elect to participate in the FS program but must do so through an authorized representative.</p> <p>Residents of treatment centers must have their eligibility determined and be certified as one-person groups through the use of an authorized representative. The authorized representative must be an employee of and designated by the private, nonprofit organization or institution and must apply on behalf of the addict or alcoholic and receive and spend the EBT allotment for food prepared by and/or served to the addict or alcoholic. Narcotics addicts or alcoholics who for the purpose of regular participation in drug or alcoholic treatment and rehabilitation program reside at a facility or treatment center are not considered residents of institutions.</p> <p>Residents of addict/alcoholic treatment centers must be certified using the same provisions that apply to all other applicant groups except that certification is completed through use of the authorized representative as described in Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of Another Individual or Group.</p> <p>Prior to certifying any residents for FS benefits, the SSR must verify that the treatment center is authorized by the FNS program as a retailer (if the center wishes to redeem benefits through a wholesaler), is certified by the Department of Licensing and Inspection including a determination by that office that the center is a nonprofit organization, or is funded under Part B or Title XIX of the Public Health Service Act (42 U.S. Code 300 x et. seq.).</p> <p>For residents of drug addiction or alcoholic treatment and rehabilitation centers and residents of group living arrangement who are entitled to expedited service, the SSR must have the EBT card available for pick-up no later than seven calendar days following the date the application was filed.</p> <p>Regular participants in a drug addiction or alcoholic treatment and rehabilitation program are exempt from FSET work program requirements. The regular participation of an addict or alcoholic in a treatment program may be verified through the organization or institution</p>

	<p>operating the program before granting the exemption if the information is questionable.</p> <p>Because of the substantial likelihood of frequent and significant changes and the inability to predict circumstances in the near future, residents of treatment centers may be certified for as little as one or two months. However, if a longer period is warranted it must be assigned. If the group is certified after the 15th and the group's circumstances warrant it, the certification period is increased by one month. Treatment center residents provided service are assigned certification periods in accordance with Chapter 4: Recertification in Part VIII.</p> <p>When the participant leaves the center, the center will provide him/her with any un-transacted EBT cards that were received for them. The departing participant will also receive his/her full allotment if already issued and if no benefits have been spent on behalf of that individual. These procedures are applicable anytime during the month.</p> <p>However, if the benefits already have been issued, any portion has been spent on behalf of the individual, and the individual leaves the treatment and rehabilitation program prior to the 16th day of the month, the treatment center will provide him/her with one-half of his/her monthly benefit allotment. If the participant leaves on or after the 16th day of the month and the benefits have already been issued and used, the individual does not receive any benefits.</p> <p>Once the participant leaves the treatment center, the center is no longer allowed to act as that individual's authorized representative.</p> <p>The treatment center provides the individual with a change report form. The participant is to use the form to report his/her new address and other circumstances after leaving the center. The center must advise the individual to return the form to the appropriate FS office within ten days. The treatment center must notify the Department FS branch of the changes in the participant's circumstances. The treatment center must also inform the FS branch when the addict or alcoholic leaves the center.</p> <p>The Department will establish a claim against the treatment center for overpayments (see Section 6.3: Reporting of Overpayments in Part VIII) for FS benefits held on behalf of resident clients if any overpayments are discovered during an investigation or hearing procedures for redemption violations.</p> <p>If FNS disqualifies an organization or institution as an authorized retail store, the Department will suspend its authorized representative status for the same period. If the treatment center loses its authorization from FNS to accept and redeem coupons or is no longer certified, its residents are no longer entitled to a notice of adverse action but will be provided written notice explaining the termination of the center's involvement in their participation process and when it will become effective.</p>
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FOSTER CARE CHILDREN 10.5

MA	Children receiving foster care payments are categorically eligible for Medicaid (see Chapter 12: Categorical Eligibility in this Part).
TANF	Children receiving foster care payments are ineligible for benefits. When determining the eligibility and benefits of other household members, none of the foster child's income or assets (including the foster care payment) is considered available to the group.
GC	See TANF

FS	Children receiving foster care payments can be included or excluded from the group. If a foster child is included in the unit, all income and assets of the foster child are counted when determining the group's eligibility and benefits. If the foster child is excluded from the unit, none of the child's income or assets is considered.
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GROUP LIVING FACILITIES (WHICH RECEIVE BENEFITS UNDER TITLE II OR TITLE VII OF THE SOCIAL SECURITY ACT) 10.6

MA	N/A
TANF	N/A
GC	N/A
FS	<p>Disabled or blind residents of a group living arrangement who receive benefits under Title II or Title XVI of the Social Security Act may voluntarily apply for the FS program. If these residents apply through use of the facility's authorized representative, their eligibility will be determined as one-person groups. If the residents apply on their own behalf, the group size will be in accordance with the required characteristics outlined in Chapter 1: Group Composition in this Part.</p> <p>The SSR will certify these residents using the same provisions that apply to all other groups. Prior to certifying any residents for FS, the SSR must verify that the group living arrangement is authorized by FNS or is certified by the D.C. Department of Consumer and Regulatory Affairs, Service Facility Regulation Administration, Social Services Facility Division, including a determination by that office that the center is a non-profit organization.</p> <p>The SSR must have the EBT card available for pick-up no later than seven calendar days following the date the application was filed for blind or disabled residents of group living arrangements receiving benefits under Title II or Title XVI of the Social Security Act when the facility acts as the resident's authorized representative and the resident is entitled to expedited service.</p> <p>If a resident who is having his/her group living arrangement act as an authorized representative is entitled to expedited service, the SSR must have the EBT card available for pick-up no later than seven calendar days following the date the application was filed. A resident applying on his/her behalf is responsible for overpayments (see Section 6.3: Reporting of Overpayments in Part VIII), as would any other group.</p> <p>The group living arrangement may purchase and prepare food to be consumed by eligible residents on a group basis if residents normally obtain their meals at a central location as part of the group living arrangement services or if meals are prepared at a central location for delivery to the individual residents. If residents purchase and/or prepare food for home consumption, as opposed to communal dining, the group living arrangement must ensure that each resident's food stamps are used for meals intended for that resident.</p> <p>If the resident retains use of his/her own allotment, s/he may either use the benefits to purchase meals prepared for him/her by the facility or to purchase food to prepare meals for his/her own consumption.</p>

LONG-TERM CARE FACILITIES 10.7

ALL	LTC facilities are licensed: <ul style="list-style-type: none">• skilled nursing facilities (SNF),• skilled nursing units (SNU),• intermediate care facilities (ICF),• intermediate care facilities for the mentally retarded (ICF-MR), and• psychiatric institutions.
MA	Applicants residing in LTC facilities are eligible for assistance (see Chapter 2: Long-Term Care/Impoverished Spouse in Part VII).
TANF	A person who is in a LTC facility for the entire calendar month is ineligible for assistance for that month.
GC	See TANF
FS	Individuals in a LTC facility are ineligible for FS unless the facility is authorized by the FNS to accept FS.

PENAL INSTITUTIONS 10.8

ALL	<p>A person is considered an inmate of a penal institution until s/he is released:</p> <ul style="list-style-type: none">• on bail,• as not guilty,• on parole,• on pardon, or• upon completing his/her sentence. <p>Individuals involuntarily residing in a halfway house are considered inmates.</p>
MA	<p>Adult inmates who would be eligible for Medicaid if they were not incarcerated are eligible for Medicaid coverage for in-patient procedures including, but not limited to, labor and delivery. Such individuals are not eligible for outpatient or ambulatory care services through Medicaid.</p> <p>If individuals under age 21 in penal facilities require inpatient medical care, they are eligible for Medicaid coverage for the period of the inpatient hospital stay.</p>
TANF	Inmates are not eligible for TANF
GC	See TANF
FS	See TANF

PSYCHIATRIC FACILITIES 10.9

MA	<p>Individuals at psychiatric facilities such as the Psychiatric Institute and St. Elizabeth's Hospital are eligible for MA under the same rules as if they were not in an institution. Such facilities do not, however, qualify as LTC facilities.</p> <p>After an individual has resided in a psychiatric facility for 30 days, his/her parents' or spouses' income/resources are no longer considered available to the individual in the institution.</p>
TANF	Individuals residing in a psychiatric facility are treated like other individuals absent from

	the home. See Section 1.15: Temporary Absences in Part IV.
GC	See TANF
FS	N/A

SHELTER FACILITIES FOR BATTERED WOMEN AND CHILDREN 10.10

MA	N/A
TANF	N/A
GC	N/A
FS	<p>If a shelter has authorization to redeem FS as wholesalers, shelter residents may apply for and receive FS benefits.</p> <p>Many shelter residents have recently left households that received FS. These shelter residents were generally part of the FS group in their former household. A woman (and her children) who left a household receiving FS may apply for and receive FS as a separate group, even if the woman (and her children) has not yet been removed from the other FS group, provided her former FS group included the individual who abused her or her children. The SSR should ensure that the woman (and her children, if applicable) is removed from the former FS group such that these individuals are not included in two FS groups for more than one month.</p> <p>Shelter residents who apply as separate groups are certified solely on the basis of their income, resources, and the expenses for which they are responsible. They are certified without regard to the income, resources, and expenses of their former group. Jointly held resources are considered inaccessible in accordance with Section 1.16.1: Unavailable Jointly Owned Assets in Part VI. Room payments to the shelter are considered expenses.</p> <p>Any shelter residents eligible for expedited service will be handled in accordance with Chapter 4: Expedited Food Stamps in Part III. The SSR must take prompt action to ensure that the former group's eligibility or allotment reflects the change in the group's composition. Such action will include either shortening the certification period by issuing a notice of expiration to the former group or acting on the reported change by issuing a notice of adverse action</p>

Chapter 11 - Strikers

INTRODUCTION 11.1

This chapter applies only to FS. Households with a striking member are ineligible for FS unless the assistance unit was eligible to receive benefits the day prior to the strike and is otherwise eligible at the time of application. Striker status does not affect TANF or MA eligibility.

LEGAL AUTHORITY 11.2

AREA/TOPIC	DISTRICT	FEDERAL
Strikers		FS: 7 USC 2015 (d)(1)(D) (iii)(3); 7 CFR 273.1(g); 7 CFR 273.7(i)

DEFINITION 11.3

A strike is defined as a planned stoppage of work by employees (including a stoppage by reason of the expiration of a collective bargaining agreement), any planned slowdown, or other planned interruption of operations by employees. A striker is anyone participating in a strike. A person on strike is not considered to have quit his/her job. Participating in a strike means an individual has agreed in cooperation with others to stop work. Participation in a strike does not constitute good cause to refuse to seek or accept employment.

There are several situations in which an individual may appear to be a striker but is not considered a striker:

- employees whose workplace is closed by an employer in order to resist demands of employees (e.g., a lockout);
- employees unable to work as a result of striking employees (e.g., truck drivers who are not working because striking newspaper pressmen prevent newspapers from being printed); or
- employees who are not part of the bargaining unit on strike who do not want to cross a picket line due to fear of personal injury or death.

When determining the eligibility of a group that includes a striker, the applicant's circumstances on the day prior to the strike must be considered.

Eligibility at the time of application shall be determined by comparing the striking member's income before the strike to the striker's current income and adding the higher of the two to the current income of non-striking members during the month of application. To determine eligibility and benefits, deductions shall be calculated for the month of application as for any other household. Whether the striker's pre strike earnings are used or his current income is used, the earnings deduction shall be allowed if appropriate (see Chapter 6: Income Disregards and Deductions in Part VI).

Strikers whose households are eligible to participate will be subject to the work registration requirements unless otherwise exempt (see Section 1.3: Work Requirements in [Part V](#)).

A Food Stamp recipient who goes on strike who meets a work registration exemption criterion the day prior to the strike -- other than those exempt solely on the grounds that they are employed -- shall not be deemed to be a striker. This applies even if the group was not receiving Food Stamps on the day prior to the strike.

Chapter 12 - Categorical Eligibility

INTRODUCTION 12.1

Some groups are categorically eligible for FS or MA.

In MA, being categorically eligible means that the group does not have to be tested against asset and income limits. Since the group is categorically eligible, it automatically meets financial eligibility criteria. Individuals receiving TANF, GC, IV-E foster care or adoption assistance, department wards placed in foster care, etc. (though not in penal institutions), and SSI recipients are categorically eligible for MA.

In FS, a group that is categorically eligible does not have to meet the FS asset limit or the net income limit. Effective November 1, 2013, categorically eligible households of one or two persons are automatically eligible for \$15 in benefits. Households in which all members receive TANF or SSI are categorically eligible for FS and do not need to meet the gross income test. Other households that receive a non-cash TANF-funded service are categorically eligible, but must have gross income at or below 200% of the Federal Poverty Level. These **households** meet expanded categorical eligibility requirements.

If there are changes in group composition or the circumstances of group members, the SSR must assess whether or not the group remains categorically eligible. If the group is no longer categorically eligible for MA, the SSR must determine whether the groups, or individuals within the group, qualify for MA based on other eligibility categories. Similarly, if a household is no longer categorically eligible for FS, the SSR must determine whether the group remains eligible for FS and categorically eligible under expanded categorical eligibility rules.

LEGAL AUTHORITY 12.2

AREA/TOPIC	DISTRICT	FEDERAL
Categorical Eligibility		MA: 42 USC 1383c; 42 USC 1396u-1; 42 CFR 435.4; 435.909; 435.916 FS: 7 USC 2014(a); 7 CFR 273.2 (j)

WHO IS CATEGORICALLY ELIGIBLE 12.3

MA	Individuals receiving TANF, GC, SSI (see Section 12.3.1: SSI in this Chapter), IV-E foster care or adoption assistance are categorically eligible for Medicaid. Individuals under 21 who are Department wards, except those in penal facilities, are also categorically eligible for Medicaid. Department wards under 21 in penal facilities are eligible for Medicaid only for an inpatient hospital stay. Example Sharon, age 13, receives SSI and lives with her parents who do not receive SSI or TANF. Sharon is categorically eligible for Medicaid, but her parents are not. Her parents may still qualify for Medicaid under standard eligibility rules.
FS	Categorical eligibility for FS benefits may be conveyed in one of two ways. The following households are categorically eligible for FS benefits:

- any household (except those specifically excluded below) in which all members receive or are authorized to receive TANF cash assistance and/, or SSI benefits are categorically eligible for FS, or
- any household that receives a TANF-funded brochure on Domestic Violence Services, and whose monthly income is at or below 200% of Federal Poverty Level

Households in Which all Members Receive TANF or SSI

Categorical eligibility for FS may be granted to households whose members are ALL current TANF and/or SSI recipients.

A recipient is a person who is:

- receiving TANF and/or SSI;
- authorized for such benefits but who has not received payment. (Residents of public institutions who apply jointly for SSI and FS benefits prior to their release from the institution are not categorically eligible based upon a finding by SSA of potential SSI eligibility prior to such release. The individuals are considered categorically eligible when a final SSI eligibility determination has been made, and the individual has been released from the institution);
- eligible for such benefits, but benefits are suspended or recouped; or
- eligible for TANF benefits of less than \$10 monthly and therefore not receiving a payment.

To be included in the FS group, a TANF or SSI recipient must meet the citizenship/alienage requirements of the Food Stamp Program. The citizenship/alienage requirements for TANF and SSI differ from those of the Food Stamp program. TANF and SSI recipients who do not meet the citizenship/alienage requirements of the Food Stamp Program cannot get FS even though they meet the requirement for categorical eligibility.

In addition, the limitations on student eligibility (see Section 4.5.2: School Attendance in this Part) for FS do not apply since all TANF and SSI recipients qualify for exemption from student eligibility requirements.

Households Who Receive a TANF-Funded Brochure

Food Stamp regulations allow the expansion of categorical eligibility to households that receive TANF-funded services. In order to convey expanded categorical eligibility to households that include persons who do not get TANF or SSI, the SSR will distribute a TANF-funded brochure notifying Food Stamp applicants and recipients about the availability of Domestic Violence services. The Domestic Violence Brochure must be given to all households applying or recertifying for FS benefits. The SSR must record in the dictation that the Domestic Violence brochure was given to the household.

ESA will provide the Domestic Violence brochure to all households applying or recertifying for FS benefits in person, through the mail, on-line, or by any other electronic means. However, only households whose gross income is at or below 200% of the Federal Poverty Level (FPL) will qualify for expanded categorical eligibility, based on the provision of the TANF-funded brochure.

Exceptions to Categorical Eligibility

	<p>Regardless of the basis used to establish that a household may be categorically eligible, such eligibility may not be given in some situations. The entire household cannot be categorically eligible for FS benefits if one of the following conditions apply:</p> <ul style="list-style-type: none"> any member of the household is disqualified for an Intentional Program Violation (IPV); or the head of the household is disqualified for failure to comply with Food Stamp work requirements. <p>The following individuals cannot be considered members of a categorically eligible household:</p> <ul style="list-style-type: none"> ineligible aliens, ineligible students, residents of an institution, or persons, other than the head of household, who are ineligible because of failure to comply with Food Stamp work requirements. <p>In these cases, the ineligible household members are excluded, but the remaining household members may be categorically eligible.</p>
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SSI 12.3.1

MA	<p>The SSI program provides financial assistance to needy persons who are at least age 65, blind, or disabled. SSA determines initial eligibility for SSI, and the Department is responsible for administering the MA program for SSI recipients; this includes determining continued MA eligibility when SSI benefits terminate. Recipients of SSI and/or state supplement payments (SSP) are categorically eligible for MA.</p> <p>The SSI program provides basic federal payment levels. The District provides an SSI supplement to SSI recipients and some non-SSI recipients in community residential facilities (CRFs).</p> <p>SSA provides the Department with information on the District's SSA recipients through SDX. The SDX tapes list SSI applications, openings, re-openings, closures, denials, addresses, and other changes. This information is used to open, close, and update MA cases for SSI recipients.</p> <p>The following persons qualify categorically for MA:</p> <ul style="list-style-type: none"> persons currently receiving SSI and/or SSP, persons receiving SSI pending a final determination of blindness or disability, persons receiving SSI under an agreement with SSA to dispose of assets that exceed the SSI asset limitation, and persons granted 'special SSI eligibility status.' <p>The SSA gives 'special SSI eligibility status' to certain individuals who are blind or have disabling impairments and who are engaged in 'substantial gainful activity' (SGA) which disqualifies them for standard SSI benefits.</p> <p>The following persons also qualify categorically for MA on the basis of SSI program requirements (these individuals meet the applicable SSI program requirements but are not</p>
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	<p>recipients of the program):</p> <ul style="list-style-type: none"> • persons who are ineligible for SSI because of failure to meet SSI program requirements that are not applicable under the Medicaid program, such as the requirement that an applicant suffering drug addiction accept a referral for treatment; • former SSI recipients who receive Title II benefits and would be currently eligible for SSI if the Title II COLAs received since SSI eligibility ended were excluded (see Section 1.6: Pickle Amendment in Part VII); • certain disabled widow(er)s who lost SSI eligibility due to a 1983 change in Title II benefits and who applied for MA prior to July 1988 (see Section 1.7: Disabled Widow(er)s in Part VII); • certain widow(er)s age 60-64 who are or become ineligible for SSI due to Title II benefits (see Section 1.8: Early Widow(er)s in Part VII); • certain disabled adult children who received SSI on the basis of a disability or blindness that began before age 22 and who subsequently became ineligible for SSI due to Title II benefits (see Section 1.9: Disabled Adult Children in Part VII); • individuals eligible for MA in December 1973 based on disability, blindness, status as an essential person, or institutionalization continue to be categorically eligible provided they have continued to meet the December 1973 criteria; • individuals who would be eligible for SSI except for the 20 percent increase in Social Security benefits that occurred in August 1972 are eligible for Medicaid provided the individual would have been entitled to and receiving both Social Security benefits and cash assistance benefits; and • persons who were receiving OAA, AB, APTD, or AABD benefits in August 1972 (or would have been eligible to receive such benefits except they had not applied for them or would have been eligible if they had not been residing in a LTC facility) and: <ul style="list-style-type: none"> ○ became ineligible for those benefits solely because of the OASDI cost of living adjustment (COLA) effective October 1, 1972; and ○ would be currently eligible for SSI if the amount of the OASDI COLA effective October 1, 1972, was deducted from their income.
FS	N/A

APPLICATION PROCESSING 12.4

MA	<p>The SSR must evaluate the group for categorical eligibility upon receipt of information that a group member has begun receiving SSI, TANF, or GC.</p> <p>The categorically eligible group is certified in accordance with all of the non-financial eligibility requirements for any other MA household. The group will be certified in accordance with notice, procedural, and timeliness requirements of the MA regulations.</p> <p>Groups applying simultaneously for SSI, TANF, or GC and MA shall be subject to MA program requirements. Benefits shall be based solely on MA eligibility criteria, including financial criteria, until the group is considered categorically eligible (that is, authorized to receive SSI, TANF, or GC). In sum, SSRs shall process the MA eligibility as soon as possible without waiting for verifications, etc. that are required only for FS, TANF, GC, etc.</p>
FS	<p>To facilitate their participation in the FS program, households in which all members are applying for public assistance must be allowed to apply for FS benefits at the same time. The household will be certified in accordance with notice, procedural, and timeliness requirements</p>

	<p>of the FS regulations.</p> <p>SSI recipients/applicants may apply for FS at a Department facility or an SSA facility as indicated in Section 1.7: Where to File in Part III. If the SSI applicants/recipients applied for FS benefits in the 30 preceding days and/or have a FS application pending, process the current application instead.</p> <p>Groups applying simultaneously for SSI and FS shall be subject to FS program requirements until the group is considered categorically eligible. The SSR should contact the applicant and provide a copy of the TANF-funded brochure in order to convey expanded categorical eligibility to the group while they are applying for SSI. It should be recorded in case dictation that the flyer was provided. Groups denied FS that have an SSI application pending shall be informed on the notice of denial of the possibility of categorical eligibility if they become SSI recipients. ESA will make an eligibility determination based on information provided by SSA and/or the group.</p> <p>Effective November 1, 2013, one and two member categorical FS households that exceed the net income limit are eligible for a \$15 FS benefit amount.</p> <p>Three or more member categorical FS households that exceed the net income limit may be eligible for benefits as low as \$2 or ineligible for benefits altogether as determined by the FS income standards table (see Exhibit VI-5: FS Income Standards in Part VI).</p>
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POSTPONING DENIAL 12.5

MA	N/A
FS	Postpone the denial of benefits for a potential categorically eligible household until the 30th day if it is likely that every household member is eligible for TANF and/or SSI.
	Example
	A group consisting of an elderly couple applies for FS. The couple also has a pending application for SSI, which appears likely to be disposed prior to the date the FS application must be either approved or denied. The couple's assets exceed the asset limit. The SSR should postpone denying the application until the 30th day to see if the couple's SSI application is approved. If it is approved, the couple will be categorically eligible for SSI and will not be required to meet the FS asset limit.
	If eligibility for the other program(s) is still pending on the 30th day, ESA shall:
	<ul style="list-style-type: none">determine eligibility for FS on the 30th day, andensure that a denied FS application is easily retrievable should TANF and/or SSI benefits be approved later.

TERMINATION OF CATEGORICAL ELIGIBILITY 12.6

MA	If TANF or GC benefits are terminated during the benefit period (to the entire group or to a member of the group), review all MA eligibility requirements to determine whether the group
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	<p>or individuals within the group remain eligible. If TANF benefits were terminated due to an increase in earnings or child support do not certify the group as eligible for TMA unless all group members do not continue to qualify for Medicaid under other eligibility categories (see Section 1.3: Transitional Medicaid in Part VII.) Send a notice to inform the group members of any change in eligibility.</p> <p>When TANF benefits are terminated, and the SSR does not have enough information to re-determine MA eligibility, the SSR must set the Medicaid certification end date to the end of the third month following the month in which the TANF termination notice was sent. Medicaid benefits must be continued until the newly set certification period expires (unless the group provides information or the Department otherwise obtains information prior to the end of the certification period that shows the group to ineligible for MA). If the group returns the mail-in Medicaid recertification form, the Department must re-determine MA eligibility. If the form is not returned, MA eligibility will terminate.</p>
	<p>Example</p> <p>Ms. Carmaly's TANF grant is being terminated effective November 1 because Ms. Carmaly failed to provide the information necessary to re-determine the group's TANF eligibility. The Notice of Adverse Action for the TANF termination is sent in October. The SSR must set the Medicaid certification end date to January -- three months after the month in which the TANF termination notice was sent. ACEDS will generate a Medicaid recertification form to Ms. Carmaly. If she returns the form, ESA will re-determine the group's Medicaid eligibility. If the form is not returned, the group's Medicaid eligibility will end January 31.</p>
	<p>If SSI benefits are terminated, and the Department has no application on file, MA benefits are terminated. The SSR should send a termination notice and advise the group that an MA application must be submitted in order to receive benefits. If SSI benefits are terminated, and an MA application is on file (that is, group applied for MA prior to SSI approval), the SSR should set a recertification date in ACEDS. ACEDS will then generate a recertification notice for the group.</p>
FS	<p>When TANF or SSI benefits are terminated to the household or to an individual within a household or when a household adds a member that does not receive TANF or SSI during the benefit period, the household is no longer categorically eligible, unless a TANF-funded brochure was provided at the most recent application or recertification, or a TANF-funded brochure is provided to the customer when the loss of TANF or SSI benefits is determined. All FS eligibility requirements must be reviewed to determine whether the household remains eligible. A notice must be sent to inform the customer of any change in eligibility or benefit level. If still eligible, FS benefits should be continued through the existing certification period.</p>

VERIFICATION 12.7

MA	<p>If questionable, the SSR must verify that the presumed categorically eligible individual:</p> <ul style="list-style-type: none"> • receives SSI, GC or TANF, and • includes no persons who have been disqualified (see Section 1.5: Excluded Persons in this Part). <p>Do not independently verify the following items as they have already been verified under SSI, GC, or TANF:</p>
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	<ul style="list-style-type: none"> • assets, • income, • SSNs, • alienage or citizenship status, or • residency
FS	<p>If questionable, the SSR must verify that the household:</p> <ul style="list-style-type: none"> • meets all of the household composition requirements of Chapter 1: Group Composition in this Part, • includes all persons who purchase and prepare food together in one FS household whether or not they are separate cases for TANF and/or SSI purposes, and • includes no persons who have been disqualified (see Section 1.5: Excluded Persons in this Part). <p>The SSR should confirm through ACEDS or SSA records that the household contains only members that are TANF and/or SSI recipients or confirm through case dictation that the household has received the TANF-funded brochure.</p> <p>If the household is categorically eligible because all household members are receiving TANF or SSI, do not independently verify the following items for FS purposes as they have already been verified under the other programs:</p> <ul style="list-style-type: none"> • income, • SSNs, or • residency <p>If the household qualifies for FS under expanded categorical eligibility, you must independently verify:</p> <ul style="list-style-type: none"> • income, • SSNs, and • residency <p>Since no asset test is applied to categorically eligible FS households, you do not need to verify assets.</p>

Chapter 13 - Lifetime Limits

13.1 INTRODUCTION

This chapter only applies to the TANF program. Since its beginning in 1997, federal regulations have set a lifetime limit of 60 months for receipt of TANF benefits, but allowed for a percentage of a state's TANF caseload to exceed that limit.

Up through March, 2011, the District of Columbia has maintained families on TANF beyond the 60 month limit in excess of federal law.

Effective April 1, 2011, District law requires that TANF eligibility for groups including adult recipients of TANF will be determined using a Reduced Payment Level, once the adult member(s) receive TANF for more than a cumulative total of 60 months in the District of Columbia, not necessarily consecutive. Effective October 1, 2013, the Reduced Payment Level is 60% of the Full Payment Level (See Exhibit VI-4: Standard of Assistance and Payment Levels in [Part VI](#).)

13.2 LEGAL AUTHORITY

AREA/TOPIC	DISTRICT	FEDERAL
Lifetime Limits	TANF: D.C. Code 4-205.11a, 4-205-11b, and 4-205.52	TANF: 42 USC 608(a)(7)

13.3 GROUPS COVERED BY LIFETIME LIMITS

Any TANF group that includes a mandatory or optional adult member who has received TANF benefits for more than 60 months is subject to the lifetime limit provision.

The 60 month lifetime limit is applied to:

- adults who are mandatory members of a TANF assistance unit. This includes adults who are mandatory members but who are disqualified from receiving benefits (such as persons sanctioned for non-participation in work efforts and persons who are unqualified aliens); and
- adults who are optional members of a TANF group and have opted to be included in the group.

Example

Joyce Esthers has received TANF for herself and her children for every month since July, 2005. The TANF group consists of Joyce and the children. As of April 1, 2011, she has received TANF benefits for 68 months. As the children's mother, she is a mandatory member of the TANF group. Effective April, 2011, determine the group's eligibility using the Reduced Payment Level.

Example

Ralph Justice has received TANF intermittently for himself and his child since May, 2003. In June, 2011, he receives the 60th TANF payment. As his child's father, he is a mandatory member of the TANF group. Effective July 1, 2011, determine the group's eligibility using the Reduced Payment Level.

Example

Elizabeth Patterson has received TANF for herself and her two grandchildren continuously since June 2000. As of April 1, 2011, she has received TANF for a total of 129 months. Although an optional member, Ms. Patterson has chosen to be part of the group for the entire time period. Effective April 1, 2011, determine the group's eligibility using the Reduced Payment Level.

13.4 COUNTING MONTHS TOWARDS THE LIFETIME LIMIT

The following months count towards the 60 month lifetime limit:

- any month for which a TANF payment is made that includes a mandatory or optional adult member;
- any month for which a prorated TANF payment is made based on the date of application and the payment includes the needs of a mandatory or optional adult member; and
- any month for which a TANF payment is made to the group and an adult member's needs are excluded because the adult is disqualified but otherwise mandatory.

The following months do not count towards the 60 month lifetime limit:

- any month for which a TANF payment is issued for a child or children that does not include the needs of an adult and there is NO mandatory adult member who is in the home but disqualified from receiving TANF;
- any month for which a TANF payment is issued to a recipient of SSI for his/her child(ren); and
- any month for which a POWER payment is issued.

Example

Lydia Johnson has received TANF for herself and her children off and on since January, 2002. As of April 1, 2011, she has received TANF for a total of 63 months. During four of those months, her needs were not included in the grant because she was disqualified due to a TANF work sanction.

The four months that Ms. Johnson was disqualified do count towards the 60 month lifetime limit. Effective April 1, 2011, determine the group's eligibility using the Reduced Payment Level.

Example

Alfred Johnson started receiving TANF for himself and his children in October, 2003. Mr. Johnson was found to be disabled and eligible for SSI effective August, 2006 and his needs were removed from the TANF grant effective August, 2006. Only the months of October, 2003 through July, 2006 count towards the 60 month lifetime limit. The countable months add up to 34 months. If otherwise eligible, continue to calculate the TANF grant using the Full Payment Level

Example

Julio Garcia has received TANF benefits for his nephew Antoine since April, 2001. Mr. Garcia has never opted to be included in the TANF grant. There are no countable months against the 60 month lifetime limit. If Mr. Garcia is otherwise eligible, continue to determine the group's TANF grant using the Full Payment Level.

Example

Daniella N'Gansi has received TANF for her children since February, 2002. Ms. N'Gansi's needs have never been included in the grant because she is disqualified as an unqualified alien. Since she is otherwise a mandatory member of the group as the mother of the children, all of the months of TANF receipt count towards the 60 month lifetime limit. As of April 1, 2011, she has received TANF for 109 months. Effective April 1, 2011, determine the group's eligibility using the Reduced Payment Level.

Example

April Reed has received TANF benefits for herself and her children off and on since December, 2002. She last received TANF in October, 2010, and that was her 70th month countable towards the lifetime limit. Ms. Reed was incarcerated in November, 2010. Her brother, James Reed, applies for TANF for the children in May, 2011. Since Ms. Reed is no longer in the TANF grant,

there are no months countable towards the 60 month limit. If Mr. Reed opts to have his needs included in the TANF grant, and has never received TANF before, countable months will begin with the first TANF payment for him and the children. Until countable months exceed 60 months, determine eligibility using the Full Payment Level.

Part V

Chapter 1 - Work Requirements

INTRODUCTION 1.1

This chapter applies only to TANF and FS. It details federal and District regulations for work and work-related activities that applicants/recipients must meet to be eligible for TANF and FS programs. This chapter also describes the consequences of an applicant/recipient voluntarily quitting a job without good cause.

Applicants/recipients who do not meet the work requirements will be sanctioned. Individuals who voluntarily quit a job without good cause are sanctioned differently from those who fail to comply with work activity requirements.

District and/or federal TANF and FS rules place work-related requirements on applicants/recipients. In addition, federal TANF law mandates that the Department meet specified work participation rates. That is, federal law mandates that a certain proportion of adult TANF recipients participate in certain work activities.

Where appropriate, this chapter provides information on applicant, recipient, and Department requirements within each section. Under both TANF and FS, applicants/recipients may be exempted from work and work-related activities or may establish that they have a good cause reason for failing to participate. Individuals who are exempt are not required to participate in work activities, and, thus, are not subject to work-related sanctions. Individuals who fail to participate with *good cause* are not sanctioned for failing to comply with work requirements.

In TANF, the head of household who is non-exempt is subject to work requirements. In a TANF two-parent household, both parents are subject to work requirements if neither qualifies for an exemption.

In FS, all adults in the household who are non-exempt are subject to work activity requirements.

A Preliminary Assessment for TANF Applicants must be completed along with the Combined Application (CA). The purpose of the Preliminary Assessment is to assist IMA staff in determining whether the individual should be exempt from work activities, recommended for the Program on Work, Employment, and Responsibility (POWER) or mandated to participate in TANF work activities.

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Work Requirements	D.C. Code 4-205.19 and 19a-19e, 4-250.50, 4-250.65; 29 DCMR 5804 - 5809, 5811, 5813	45 CFR 261, Subparts A, B, C FS: 7 USC 2015(d); 7 CFR 273.7
Sanctions	D.C. Code 4-205.19f; 29 DCMR 5810, 5811, 5812	TANF: 45 CFR 261.13-16; 261.56 FS: 7 USC 2015(d); 7 CFR 273.7

WORK REQUIREMENTS 1.3

TANF	<u>Applicant Requirements</u> TANF applicants who are single-parent heads of household or parents in a two-parent
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household shall be required to participate in work activities as a condition of eligibility (see Section 1.6: Exemptions from Work Requirements in this Chapter).

Effective March 1, 2013, TANF applicants, who would be included in the TANF grant if approved, shall complete an Online Work Readiness Assessment, orientation, and Individual Responsibility Plan as a condition of eligibility. Herein after, these three components are collectively referred to as an "assessment" unless otherwise noted.

Failure to complete the assessment will result in denial of TANF benefits for the family.

Effective March 1, 2013, applicants must sign and comply with an Individual Responsibility Plan as a condition of eligibility. Failure to sign the IRP will result in denial of TANF benefits for the family.

Recipient Requirements

Non-exempt TANF recipients must participate in work activities. Most non-exempt TANF recipients will fulfill their work requirement by participating in work programs operated by private entities referred to as "vendors." These organizations have the contractual responsibility for assisting recipients to prepare for, find, and retain unsubsidized employment.

Some TANF recipients are engaged with other agencies and organizations that satisfy the requirements for allowable work activities (See Section 1.5: Work Activities below.) These groups may also be used by TANF recipients to fulfill their work activity requirements.

Once assigned to a vendor or service provider, the TANF recipient must cooperate in developing and signing a Detailed Individual Responsibility Plan that sets out how the recipient will meet his or her TANF participation hours requirement by engaging in allowable activities.

Effective February 1, 2013, adult TANF recipients, who are included in the TANF grant, shall complete a work assessment at the time of TANF review as a condition of TANF eligibility. Failure to complete the assessment will result in termination of TANF benefits for the family.

Effective February 1, 2013, recipients who complete the assessment and are determined to be required to participate in work activities shall complete a group orientation as a condition of eligibility. Failure to complete the orientation will result in termination of TANF benefits for the family.

Effective February 1, 2013, recipients who complete the assessment shall sign and comply with an agreement to participate in work activities (initial Individual Responsibility Plan) as a condition of eligibility. Failure to sign the IRP will result in termination of TANF benefits for the family.

Each TANF recipient who is referred to a vendor to participate in countable work activities shall be required by the vendor to sign a Detailed Individual Responsibility Plan (DIRP) which sets forth both recipient and Department/vendor responsibilities for assisting the recipient in attaining unsubsidized employment. Some TANF recipients will be assigned or permitted to participate in alternate work-related activities including:

- the Paving Access to Higher Security (PATHS) program run by the University of the District of Columbia (UDC),
- the Project Empowerment program run by the Department of Employment Services (DOES)
- self-initiated training activities,

	<ul style="list-style-type: none"> • post-secondary education with scholarships funded by the Department Tuition Assistance Program in TANF (TAPIT program), and • adult basic education programs funded in whole or part through the Department. <p>All hours spent in work activities must be documented and the documentation submitted to the Department for verification.</p> <p><u>Department Requirements</u></p> <p>The Department has certain obligations for carrying out the work activity portion of the TANF program. They include:</p> <ul style="list-style-type: none"> • providing oversight of vendors who hold contracts with the District to assist recipients prepare for, find, and retain employment; • determining who is required to participate in activities; • referring customers to work programs; • making final determinations about when sanctions should be applied for failure to comply with work activities; • providing notice of case actions; and • performing fair hearings and administrative review <p>In addition, the Department has the obligation to meet the following federally-mandated work participation standards. Each state and the District must meet two separate work participation rates. One is the overall rate based on the number of adults participating in work activities, and the other is the two-parent rate based on the number of adults in two-parent families who participate in work activities. Following are the mandated work participation rates:</p> <ul style="list-style-type: none"> • Work Participation Rates for All Families: <ul style="list-style-type: none"> ○ FY 2000 - 40% ○ FY 2001 - 45% ○ FY 2002 and beyond - 50% • Work Participation Rates for Two-Parent Families: <ul style="list-style-type: none"> ○ FY 1999 and beyond - 90%
FS	<p><u>Applicant Requirements</u></p> <p>Each applicant household member who is not exempt will register for FSET at the time of application and every 12 months after initial registration as a condition of eligibility (see Section 1.6: Exemptions from Work Requirements in this Chapter). The registration form can be completed by someone other than the recipient. Applicants who report a condition that indicates they are exempt such as medical unfitness, but fail to verify, when required, their exempt status, must register for FSET.</p> <p>Strikers who are applying for assistance and whose households are eligible will be subject to work registration unless exempt on the day of application (see Chapter 11: Strikers in Part IV).</p> <p><u>Recipient Requirements</u></p> <p>Non-exempt recipients must work register annually. At each 12-month recertification, the SSR must determine which group members are required to participate in FSET and which are exempt.</p> <p>Recipients who are not exempt must register for FSET which can include job search, work experience, and programs to improve employability of household members (see Section 1.6: Exemptions from Work Requirements in this Chapter for a full listing of exemptions).</p>

	<p>To comply with FSET work registration requirements, recipients must commit to the following activities:</p> <ul style="list-style-type: none"> • respond to requests from the employment and training component for information regarding employment status or availability for work; • participate in work activities upon notification to do so by the Department; • report to an employer, to whom they are referred, if the potential employment is at a wage equal to or greater than the applicable minimum wage; and • accept a bona fide offer of suitable employment at a wage equal to or greater than the applicable minimum wage
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WORK PARTICIPATION ALLOWANCE 1.4

TANF	The mandatory work program to which an applicant/recipient is assigned shall reimburse him/her in the form of a work participation allowance not to exceed \$10 per day of participation. This allowance is designed to reimburse the participant for employment or training-related expenses such as travel, meals away from home, and transportation to and from the employment or training site. These are excludable reimbursements which shall not be considered income (see Section 4.50.2: Training Expense Allowances/Stipends in Part VI).
FS	Mandatory recipients who participate in work or work-related activities shall be reimbursed by the FSET program for the actual costs of transportation and other costs (excluding dependent care costs) that are necessary and directly related to participation in FSET up to \$25 per participant per month. These are excludable reimbursements which shall not be considered income (see Section 4.50.2: Training Expense Allowances/Stipends in Part VI).

WORK ACTIVITIES 1.5

TANF	One and two-parent households are required to participate in an allowable work activity as follows:						
	Effective October 1, 1999	Single-Parent Caretaker Group No Children Under 6		Two-Parent Household		Single-Parent/ Caretaker Group w/ a Child Under Six**	
	Year	Weekly	Monthly	Weekly	Monthly	Year	Monthly
	2000+	30	120	35/55*	140/220*	20	80

*The second figure applies only to a two-parent household where the family receives federally-funded child care and no parent in the family is disabled or caring for a child with a disability.

**Federal law requires single parents with children under six to participate in work or a work-related activity 20 hours per week. While a work program could require additional hours of participation, a single-parent with a child under six participating at least 20 hours per week is not subject to sanction.

In order to meet the federal work participation rates (see Section 1.3: Work Requirements in this Chapter), TANF recipients must participate in 'countable' work activities. In some limited cases however, the Department may permit recipients to fulfill their work requirements by participating in activities that do not meet the federal definition of a 'countable' activity. For example, some individuals participating in Department-approved adult basic education classes may fulfill their work requirement even if they are not participating in a federally-recognized 'countable' activity.

The following activities shall be countable toward the first 20 of the 30 hours of work activities required for a single-parent/caretaker non-exempt household and the first 30 of the 35 hours of work activities required for a two-parent household:

- unsubsidized employment, meaning full or part-time employment in the public or Private sector that is not subsidized by TANF or any other public program;
- subsidized private sector employment, meaning employment in the private sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing an individual (Note that the District does not currently administer this activity) ;
- subsidized public sector employment, meaning employment in the public sector for which the employer receives a subsidy from TANF or other public funds to offset some or all of the wages and costs of employing an individual (Note that the District does not currently administer this activity);
- work experience, if sufficient private-sector employment is not available, meaning a work activity performed in return for welfare that provides an individual with an opportunity to acquire the general skills, knowledge, and work habits necessary to obtain employment, including work associated with the refurbishing of publicly-assisted housing;
- on-the-job training, meaning training in the public or private sector that is given to a paid employee while he or she is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job;
- job search and job readiness assistance for up to six weeks (no more than four weeks may be consecutive), meaning the act of seeking or obtaining employment or preparation to seek or obtain employment, including;
 - life skills strategies and soft skills training,
 - budget and credit counseling,
 - substance abuse treatment,
 - domestic violence support or services, or
 - mental health activities or rehabilitative activities for individuals who are otherwise employable;
- community service programs, meaning structured programs and activities in which individuals perform work for the direct benefit of the community under the auspices of public or nonprofit organizations;
- vocational education training (up to 12 months per individual), meaning education programs that are directly related to the preparation of individuals for employment in current or emerging occupations that are provided by an accredited education or training organization such as a vocational-technical school, community college, post secondary

institution, or proprietary school. Courses offered by such programs can include;

- adult basic education,
- English as a Second Language (“ESL”), and
- literacy courses; provided,
 - that the courses are part of the vocational training curriculum and are directly related to the preparation of individuals for employment in occupations that require training; or
- provision of child care services to an individual who is participating in a community service program, meaning providing child care to enable another TANF or state supplementary payment recipient to participate in a community service program.

The following work-related activities also shall count as work participation provided the individual also participates in one of the above activities for at least 20 hours per week for a single parent/caretaker family and 30 hours per week for a two-parent family:

- job skills training directly related to employment, meaning training or education for-job skills required by an employer to provide an individual with the ability to obtain employment or to advance or adapt to the changing demands of the workplace, including;
 - post-secondary education at an accredited university or college that leads to a bachelor's or advanced degree that is directly related to employment;
- education related to employment, in the case of a recipient who has not received a high school diploma or general educational development certificate (“GED”) and needs specific employment training, means education directly related to a specific job or job offer, including;
 - adult basic education,
 - literacy, GED, and ESL activities; and
- satisfactory attendance in a secondary school or in a general equivalence program, meaning regular attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate.

A recipient under 20 years of age can count education as a work activity if s/he:

- maintains satisfactory attendance at a secondary school or equivalent during the month, or
- participates in education directly related to employment for an average of 20 hours per week during the month (see Section 4.4: School Attendance and Student Status in [Part IV](#))

No more than 30 percent of the individuals that count toward the federal work participation rate may be in vocational education training. For the purpose of this limitation, teen parents attending school are counted as participants in vocational education training.

The District will also count documented hours spent in Barrier Remediation, although these hours are not reportable under federal rules. Barrier Remediation is defined as follows:

Barrier Remediation are supportive activities that are designed to assist the customer overcome his or her barriers to employment and have an **indirect** connection to improving employability or finding employment. They exclude all activities that are deemed to have a **direct** connection to improving employability or finding employment such as substance abuse treatment, mental health treatment, and rehabilitation activities that can be coded to job search and job readiness assistance activity. To be considered a barrier remediation activity, the activity must require the

	customer to take one or more active steps (e.g. the act of looking for a home).
FS	<p>Mandatory participants must participate in the FSET program and accept any bona fide offer of a suitable job (see Section 1.9.4: Suitable Employment in this Chapter).</p> <p>FSET participants required to search for a job must submit a form indicating that they have made 12 job contacts each month. If they participate in work experience, they can only be required to participate for the number of hours equal to their FS benefits divided by the minimum wage.</p> <p>Work activities under FS can include:</p> <ul style="list-style-type: none"> • job search programs, • job search training programs, • work experience programs, • programs designed to improve the employability of household members and assist them in moving promptly into public or private employment, • supported work programs, • educational programs to improve basic skills or employability, or • programs that promote self-employment.

EXEMPTIONS FROM WORK REQUIREMENTS 1.6

BOTH	If an individual repeatedly has good cause for failing to participate in work activities, a determination should be made to see if the individual meets an exemption criterion.
TANF	<p>The following TANF applicants/recipients are exempt from work participation:</p> <ul style="list-style-type: none"> • a minor who is not the head of an assistance unit or is not a parent of a child receiving TANF; • a single custodial parent or caretaker who personally provides care for a child under six who cannot obtain needed appropriate child care because it is unaffordable or not within reasonable distance of the parent or caretaker's home or work activity; • a single custodial parent with a child under 12 months; • a recipient 60 years old or older; • a parent or caretaker in a two-parent or caretaker household who is not a principal wage earner (PWE) (if the household is eligible for TANF because of PWE's unemployment) and who is personally taking care of a child under six, if the parent or caretaker cannot obtain needed child care because it is unaffordable or not within reasonable distance of the parent or caretaker's home (See Section 1.6.1: Head of Household in Part III for definition of PWE); • a person who is ill, injured, or incapacitated as determined by competent medical evidence (and his/her condition is expected to last longer than four weeks); • a person who is needed at home because another household member requires the individual's presence due to illness or injury; • a person in a one-parent/caretaker household who is working for an average of 30 hours per week; • persons in a two-parent household who are working for a combined total average of at least 35 hours per week, or persons in a two-parent household where the family receives federally-funded child care and no parent in the family is disabled or caring for a child with a disability who are working a combined total of at least 55 hours per week; • a full-time VISTA or AmeriCorps volunteer; • a person who is granted a domestic violence waiver because complying with the work requirement would put the applicant/recipient at further risk of violence (see Section 3.8.3: Waiver of Work Requirement in Part VIII); or • a teen parent who can provide proof of school attendance or who can demonstrate that there is

	<p>either a lack of needed child care for a child under six that prevents the teen parent's school attendance or that a child's verified special health needs prevent the child's regular attendance at school (see Section 4.4.1: Teen Parent School Attendance Requirement in Part IV and Section 3.12: Teen Parent Program in Part VIII).</p> <p>Any applicant/recipient who is exempt from work participation may voluntarily participate. If s/he volunteers and then fails to participate without good cause and for a reason unrelated to his/her qualification for an exemption, the individual is subject to sanction.</p> <p>Families in which the parent has a physical or mental incapacity that prevents them from working and/or participating in TANF work activities are eligible for POWER -- a District-funded program that provides cash assistance in lieu of TANF (see Section 1.9: Screening for the Program on Work, Employment, and Responsibility in Part III and Section 3.10: Program on Work, Employment, and Responsibility (POWER) in Part VIII).</p>
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FS	<p>The following people are exempt from FSET participation:</p> <ul style="list-style-type: none"> • homeless persons; • individuals receiving TANF; • persons younger than 16 years of age or a person 60 years of age or older. If a child has his/her 16th birthday within a certification period, the child will be work registered as part of the next scheduled recertification process unless the child qualifies for another exemption; • persons physically or mentally unfit for employment; this includes but is not limited to persons who have applied for SSI or persons who currently receive IDA, SSI, SSDI or other disability-related benefits; • a person receiving unemployment insurance benefits (UIB) or who has a pending UIB application as long as s/he is registered for work and actively looking; • a parent or other household member responsible for the care of a dependent child under six or an incapacitated person; • a regular participant in a drug or alcohol addiction program, which prohibits participation in FSET work activities during normal business hours; such drug and alcohol programs would include but not be limited to residential treatment, but would not include participation in after-hours meetings of recovery support groups, etc.; • persons who are employed or self-employed and working a minimum of 30 hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours (this includes migrant and seasonal farm workers who are under contract or have an agreement with an employer or an employer representative to begin employment within 30 days); • a student 16- or 17-years-old who is enrolled and attends regular classes at least half-time, as defined by the learning institution, in any appropriate school, training program, or institution of higher education; and • other persons granted an individual exemption by FSET staff
	<p>Example</p> <p>Susan is a 17-year-old with a GED who wants to attend Clarkson Computer Learning Center to earn a certificate of competence in Software Testing. Susan is eligible for FS benefits, but she needs an exemption from participation in the FSET program so she can attend Clarkson. Susan tells her SSR of her plans and shows proof of enrollment. Susan is granted her exemption from FSET as long as she provides the SSR with regular proof of attendance at Clarkson.</p>

	<p>Persons engaged in hobbies or volunteer work or any other activity which cannot be considered gainful employment (because of the minimal amount of monies received from such activity) are not exempt from work registration regardless of the amount of time spent in such activity.</p> <p>Persons losing exemption status due to any change in circumstances (such as departure from the household of the sole dependent child for whom an otherwise non-exempt household member was caring) must be work registered when the change is reported.</p> <p>Mandatory FSET participants may be exempted from FSET participation if monthly expenses that are reasonable, necessary and directly related to participation exceed the allowable reimbursement amount (see Section 1.4: Work Participation Allowance in this Chapter).</p> <p>Group members who are applying for SSI and for FS (see Section 1.7.1: Applying for Food Stamp Benefits through the SSA in Part III) will have the requirement for work registration waived until their eligibility for SSI is determined. Failure to complete the work registration form is not grounds to delay processing. If they are determined ineligible for SSI, a determination of their work registration status must be made.</p> <p>Adult members of a group entitled to Expedited Food Stamp Processing (see Chapter 4: Expedited Food Stamp Services in Part III) are referred to FSET but cannot be sanctioned until a determination of standard FS eligibility is made. In addition, non-exempt group members do not have to work register prior to being determined eligible for expedited Food Stamp benefits.</p>

GOOD CAUSE FOR NONCOMPLIANCE WITH WORK ACTIVITIES 1.7

BOTH	An applicant/recipient will be sanctioned if s/he does not have good cause for failing to comply with work requirements. Good cause generally can be thought of as a short-term reason an employer might excuse an employee from work. If a recipient repeatedly has good cause, such as a recurring illness, the Department should determine whether the individual meets an exemption criteria (see Section 1.6: Exemptions from Work Requirements in this Chapter) or should be referred to POWER. Specific good cause reasons for both TANF and FS programs are listed below.
TANF	Determinations of good cause may be made by the vendor to whom the TANF recipient is assigned, the Office of Work Opportunity, and the ESA Vendor Monitoring unit.
FS	Determinations of good cause may be made by staff of the Food Stamp Employment and Training program.
BOTH	To determine whether or not good cause exists, the responsible party must consider the facts and circumstances, including information submitted by the group member who is involved, the employer, or the work-site supervisor.
TANF	<p>When a non-exempt individual fails to participate in work activities, a sanction will be imposed, unless it is determined that the individual had good cause for not participating (see Section 3.10:6: Sanctions and Good Cause in Part VIII for a discussion of good cause in the POWER program).</p> <p>Good cause for failure to participate in work activities, assessment, and POWER program requirements or to sign the IRP include the following:</p>

	<ul style="list-style-type: none"> • a properly verified illness or medical condition of the recipient or a member of the recipient's household prevents the recipient from meeting requirements, • appropriate and affordable child care is not available within a reasonable distance from the recipient's home or work site and the applicant/recipient has a need for child care (need for child care for TANF purposes means that the applicant/recipient is caring for a child under six or for a child with a special health need as verified by medical evidence that prevents regular attendance at school), • participant is a parent or caretaker who personally provides child care for a child under six and already participates in work activities for at least 20 hours per week, • an extraordinary and unforeseen circumstance beyond the recipient's control prevents compliance with meeting work requirements, • accepting work or participating in a work activity may result in an act of domestic violence against the applicant/recipient or other in his/her family or household (see Section 3.8: Domestic Violence in Part VIII), • an individual has met an exemption criteria but has not been exempted from requirements because the exemption-related circumstance was undetected, and • a household emergency occurs such as a death in the family.
FS	<p>Noncompliance with work requirements with good cause includes circumstances beyond the applicant/recipient's control, such as, but not limited to the following:</p> <ul style="list-style-type: none"> • personal illness, • illness of another group member requiring presence of or care by the applicant/recipient, • lack of adequate child care for children who have reached age six but are under age 12 • lack of available transportation, and • a household emergency such as a death in the family. <p>All circumstances that constitute good cause for non-participation in work activities must be verified.</p>

SANCTIONS FOR NONCOMPLIANCE WITH WORK ACTIVITIES WITHOUT GOOD CAUSE 1.8

TANF	<p>A non-exempt TANF recipient who fails to comply with work requirements, including applicant job search/job clubs (see Section 3.9: Job Clubs in Part VIII), without good cause will be sanctioned. The noncompliant applicant/recipient will be disqualified from the unit resulting in a reduced grant being provided to the group. The sanction will remain in place for a minimum sanction period or until s/he complies with program requirements, whichever is later. If an applicant fails to comply, the application will continue to be processed but the noncompliant individual will be disqualified from the unit.</p> <p>If the SSR receives a request for sanction, but has evidence that the recipient is exempt, no sanction should be imposed. If the recipient reports prior to the effective date of sanction that a medical condition expected to last more than one month prevented participation in work activities, the sanction should not be imposed. The recipient should be told to submit a medical report for determination of eligibility for POWER, and granted a 90-day exemption.</p> <p>If a noncompliant recipient becomes exempt, the SSR must lift the sanction for the month after the exemption is confirmed. If confirmation of the exemption is delayed due to timely provision of verifications from the recipient, or untimely action by the agency, an underpayment should be</p>
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	<p>given for the period beginning the month after the agency received information about the exemption, and ending the date the sanction was lifted.</p> <p>The noncompliant individual is disqualified from the unit for the following periods of time:</p> <table> <tr> <th>Violation</th><th>Period for Removal of Needs</th></tr> <tr> <td>1st</td><td>1 month or until compliance, whichever is later</td></tr> <tr> <td>2nd</td><td>3 months or until compliance, whichever is later</td></tr> <tr> <td>3rd and subsequent violations</td><td>6 months or until compliance, whichever is later</td></tr> </table>	Violation	Period for Removal of Needs	1st	1 month or until compliance, whichever is later	2nd	3 months or until compliance, whichever is later	3 rd and subsequent violations	6 months or until compliance, whichever is later
Violation	Period for Removal of Needs								
1st	1 month or until compliance, whichever is later								
2nd	3 months or until compliance, whichever is later								
3 rd and subsequent violations	6 months or until compliance, whichever is later								
	<p>Compliance is evidenced by the applicant/recipient engaging in the required activity. Applicant/recipients must meet the weekly participation requirement for one week to be considered in compliance. If a sanction ends because the applicant/recipient complies with the program requirements, the applicant/recipient shall not receive TANF benefits for the remainder of the month in which the individual began complying with program requirements. Provided the minimum sanction period has expired, s/he shall begin receiving benefits (that is, will be included in the unit) in the following month and shall receive benefits in subsequent months as long as the applicant/recipient remains in compliance.</p> <p>If an applicant/recipient is found to be exempt from initial job readiness and job search requirements, s/he shall not be sanctioned for failure to comply.</p> <p>If an applicant/recipient failed to comply with work requirements during a prior period of benefit receipt, that sanction "counts" when determining whether a future act of noncompliance constitutes a 1st, 2nd or 3rd sanction (i.e., a subsequent act of noncompliance).</p> <p>If a TANF case under sanction is closed for any reason and the group subsequently reapplies, the previous sanction will not be applied at re-application. If the applicant group is otherwise determined eligible to receive benefits, they will be approved and no sanction will be applied. However, if the group subsequently fails to comply without good cause, it will be sanctioned again. Since the sanction periods increase for subsequent acts of noncompliance with work requirements, this new noncompliance will result in the imposition of a longer penalty, unless the sanctioned person has already reached the highest level of sanction which is 6 months or until compliance, whichever is later.</p> <p>Example Ms. Sayer and her two children receive TANF. In January, Ms. Sayer is disqualified for failing to comply with work requirements. This was her first sanction. In June, the Sayer's case is closed. If Ms. Sayer reapplies and is eligible, she will not be disqualified unless she fails to comply with a requirement subsequent to her new application being filed. Suppose she is found eligible in October and in November she fails to comply with work requirements. Ms. Sayer would again be disqualified and the minimum sanction period would be three months.</p>								

	<p>The dollar amount of the TANF sanction is treated as unearned income in the Food Stamp Program to ensure that Food Stamp benefits do not increase as a result of a TANF sanction.</p> <p>If a TANF case is terminated for failing to comply with a TANF work requirement, the entire TANF grant must continue to be counted as unearned income for the Food Stamp program to ensure that Food Stamp benefits do not increase as the result of the TANF termination. This income must be counted until any of the following occurs:</p> <ul style="list-style-type: none"> the sanctioned person reapplies for TANF and is approved, since a previous TANF sanction cannot be applied at re-application (See Part V, Section 1.8: Sanctions for Non-Compliance with Work Activities Without Good Cause), the agency becomes aware that the PI has become ineligible for TANF for a reason unrelated to the sanction, or the TANF income has been counted for one year as unearned income for Food Stamps. <p>Example 1</p> <p>Mr. Lawrence receives TANF for herself only and Food Stamps for herself and her child. Her only child receives SSI. Ms. Lawrence is not needed in the home to care for her child. She does not comply with work requirements and a TANF sanction is recommended. Her TANF benefits are terminated for this reason. The amount of the TANF grant must continue to be counted as unearned income for the Food Stamp Program. Unless Ms. Lawrence reapplies for TANF and is approved, or the agency determines that she later becomes ineligible for TANF for a reason other than the TANF sanction, the TANF benefit will continue to be counted as income for Food Stamps for one year following the termination of the TANF benefit.</p> <p>Example 2</p> <p>Ms. Capel receives TANF for herself only, and Food Stamps for herself and one child. Her only child receives SSI. Ms. Capel is sanctioned for not participating in required work activities and her TANF is terminated effective April 1. The amount of her TANF benefit continues to be counted towards Food Stamps. Ms. Capel recertifies for Food Stamps in July. The caseworker notes that Ms. Capel's SSI child turned 18 in June and will not graduate before the child turns 19. Since Ms. Capel would no longer qualify for TANF, the amount of her TANF sanction is no longer countable for Food Stamps. The caseworker deletes the TANF sanction income for the new certification period.</p> <p>Any applicant/recipient who is exempt from work participation may voluntarily participate. If s/he volunteers and then fails to participate without good cause and for a reason unrelated to his/her qualification for an exemption, the individual is subject to sanction.</p>	
FS	<p>If an individual member of the group or the head of the group refuses to work register, fails to comply with FSET requirements, or fails to accept a bona fide offer of employment, the noncompliant person is made ineligible for FS until s/he completes the appropriate disqualification period. The disqualification periods are listed in the table below. The sanction is lifted at the end of the disqualification period, regardless of whether the individual is complying with program requirements.</p>	
	Violation	Period for Removal of Needs
	1st	2 months

	2nd	3 months
	3rd	6 months
	<p>All otherwise countable income and assets of the sanctioned member are considered available to the remaining group, but the size of the group is reduced when determining the group's benefit level.</p> <p>In cases in which the FS case closes when an individual fails to comply with FSET requirements -- such as will occur when a person in a one-person FS household fails to comply with FSET -- the individual must reapply for FS in order to begin receiving benefits after the sanction period has ended. In cases in which the case is not closed because the noncompliant individual is part of a larger FS group, the SSR must add the disqualified individual back into the FS unit when the sanction period ends.</p> <p>If any group member who failed to comply joins another group, s/he is ineligible for the remainder of his/her disqualification period.</p> <p>If the non-compliant person is found to be exempt, the sanction may be lifted during the disqualification period. If the group continued to receive benefits during the disqualification period, the newly exempt group member should be added to the group for the month after s/he was found exempt. If the FS case was closed when the sanction was imposed, the newly exempt individual must re-apply. If otherwise eligible, benefits will begin effective the date of re-application.</p>	

Notice of Adverse Action for Non-Compliance with Work Requirements Without Good Cause

1.8.1

TANF	<p>If an applicant/recipient is noncompliant without good cause a notice of adverse action is sent (see Chapter 10: Notice of Adverse Action in Part VIII). No adverse action can be applied in fewer than 15 days. If the applicant/recipient complies before the effective date of the adverse action, no sanction is imposed. If the notice is sent when at least 15 days remain in the month and the applicant/recipient does not come into compliance prior to the end of the month, the sanction will begin the first day of the next month. If the notice is sent when there are fewer than 15 days remaining in the month and the individual does not come into compliance, full benefits will continue to be paid for the next month, and the sanction will be applied in the second month following the month in which the notice was sent (see Section 10.3: Time Standard for Issuance of Notice of Adverse Action in Part VIII).</p> <p>Example On April 3rd, Mr. Dewey refused to participate in a TANF job search activity. Upon receipt of this information, the SSR sent out a TANF notice of adverse action dated April 5th. Mr. Dewey did not come into compliance before April 30. Mr. Dewey's needs were removed for the May 1 issuance</p> <p>Example On September 20th, Ms. Colton refused a bona fide job offer. Since Ms. Colton offered no good reason for refusing the job, the SSR sent Ms. Colton a notice of adverse action which was dated September 25th. Because there were fewer than 15 days left in September from the date of the adverse action notification, full benefits continued to be paid to Ms. Colton in October. Ms. Colton did not come into compliance by the end of October. Her sanction period, therefore, began on November 1st. Since this is Ms. Colton's second sanction, it will last three months, or until compliance</p>
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	with program activities, whichever is later.
FS	<p>Within 15 days of determination by the FSET program that a group member is noncompliant with work requirements, the FSET will provide the group with notification of the unapproved absence or noncompliance and the requirement that the group contact FSET within the following ten days. If there is no contact or the individual neither establishes good cause nor comes into compliance, the FSET program will forward notification of noncompliance to the SSR.</p> <p>Upon receipt of notification that an act of noncompliance has occurred without good cause, the group will be provided with a notice of adverse action. The notice of adverse action must be specific to the applicant/recipient and include the particular act of noncompliance committed, the proposed period of ineligibility, and the action(s) which must be taken to end or avoid disqualification or other sanctions.</p> <p>The notice of adverse action must be sent even if the case was closed for other reasons. If the case was closed for other reasons and the group reapplies within the sanction period, the sanction will be imposed. The start date of the sanction period cannot begin prior to 15 days from the date the adverse action notice was sent.</p> <p>.</p>

VOLUNTARY QUIT 1.9

Both	<p>In both TANF and FS, an individual who voluntarily quits without good cause a suitable job of 30 or more hours per week, or which paid the equivalent of 30 hours per week at federal minimum wage, is disqualified from receipt of benefits. An individual, who voluntarily reduces work effort without good cause and, after the reduction, is working less than 30 hours a week is disqualified from receipt of benefits. However no sanction should be imposed if the individual is exempt from work requirements.</p> <p>If an <i>applicant</i> for TANF and/or FS voluntarily quits a suitable job or reduces work effort in a suitable job without good cause in the 60-day period preceding the date of application, the individual is disqualified from receipt of benefits for 90 days from the date of the voluntary quit (or the date that work effort was reduced).</p> <p>If a <i>recipient</i> of TANF and/or FS voluntarily quits a suitable job or reduced work effort in a suitable job without good cause while receiving program benefits, the individual is disqualified from benefit receipt for three consecutive months, beginning with the first month in which benefits can be reduced after timely and adequate notice has been provided.</p> <p>In both programs, only the individual who voluntarily quits or reduces work effort without good cause is removed from the unit.</p> <p>The sanction can be lifted prior to the end of the sanction period if the individual secures 'comparable employment' (see Section 1.9.3: Comparable Employment in this Part) or begins to meet a work exemption criteria of the relevant program. The sanction is lifted effective the first issuance after the date the individual secures comparable employment or meets the exemption criteria provided the change was reported timely. If there is insufficient time to</p>
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	<p>adjust the monthly issuance cycle, a benefit adjustment should be made such that the benefits received in the month equal the total amount for which the group is eligible. If the change is not reported timely, the Department must adjust benefits effective the first issuance after the reported change.</p> <p>If the disqualified person joins another group or otherwise reapplies prior to the end of the sanction period, the disqualification will 'follow' the individual, unless s/he has found comparable employment or now meets an exemption criterion.</p> <p>Example 1</p> <p>On June 26, the SSR learns that Mr. Garcia, a FS recipient, voluntarily quit a job without good cause in May. Mr. Garcia and his son are included in the FS unit. The SSR sends a notice of adverse action on June 29 indicating that Mr. Garcia will be removed from the unit effective August 1 (the sanction cannot be imposed in July because of the 15-day timeliness requirement for notices of adverse action). Mr. Garcia is disqualified and does not receive August benefits, though his son remains eligible for FS benefits. In September, Mr. Garcia informs the SSR that he has found a job with similar hours and wages. His disqualification is lifted effective for the October issuance. The SSR must send a notice to Mr. Garcia informing him that his sanction will be lifted effective October 1.</p> <p>Example 2</p> <p>Ms. Hopkins is currently disqualified from TANF because she voluntarily quit a job without good cause. The disqualification period is from September to November. In October, Ms. Hopkins falls ill and meets the exemption criteria based on illness and/or incapacity. Ms. Hopkins' voluntary quit sanction should be lifted effective November 1. If the SSR does not have time to affect the November issuance, the SSR should issue a supplemental benefit for November.</p>
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Voluntarily Reducing Work Effort 1.9.1

BOTH	An applicant/recipient is considered to have voluntarily reduced his/her work effort if s/he reduces the number of hours s/he works and, after the reduction, the individual is working less than 30 hours per week.
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Good Cause 1.9.2

TANF	<p>Good cause reasons for voluntarily quitting a job or reducing hours include circumstances beyond the individual's control such as, but not limited to, the following:</p> <ul style="list-style-type: none"> • illness of the individual, • illness of another household member requiring the presence of the individual, • a household emergency (including domestic violence), • unavailability of transportation, • lack of adequate or affordable child care for children who are under six, • discrimination by an employer in violation of District or federal law, • work demands or conditions that render such continued employment unreasonable, such as working without being paid on schedule, • resignations by persons age 60 years or more which are recognized by the employer as retirement, and • job no longer meets the definition of 'suitable' (see Section 1.9.4: Suitable Employment in this Chapter).
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FS	<p>Good cause reasons for voluntarily quitting a job or reducing hours include circumstances beyond the individual's control such as, but not limited to, the following:</p> <ul style="list-style-type: none"> • discrimination by an employer based on age, race, gender, color, handicap, religious beliefs, national origin, or political beliefs; • unreasonable work demands or conditions; • acceptance by the head of the group of new employment; • enrollment by the head of the group of at least half-time in any recognized school, training program, or institution of higher education that requires the head of the group to leave employment; • acceptance of employment by any other group member or enrollment at least half-time in any recognized school, training program, or institution of higher education in another jurisdiction which requires the group to move and thereby requires the head of the group to leave employment; • resignations by persons under the age of 60 who are recognized by the employer as retired • wage offered is less than the highest of applicable federal minimum wage, District minimum wage, or 80 percent of the federal minimum wage if neither the federal nor District wage is applicable; • acceptance of a bona fide offer of employment of more than 20 hours per week, or in which the weekly earnings are equivalent to or greater than the federal minimum wage multiplied by 20 hours, which either does not materialize or results in employment of less than 20 hours a week or weekly earnings of less than the federal minimum wage multiplied by 20 hours; • leaving a job with patterns of employment in which workers are frequently moving such as migrant farm labor or construction work; • individual had to quit a job because s/he experienced one of the good cause situations related to failing to participate in work activities such as illness, incapacity, inability to secure child care, or s/he met one of the exemption criteria; and • job no longer meets the definition of 'suitable' (see Section 1.9.4: Suitable Employment in this Chapter).
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Comparable Employment 1.9.3

BOTH	Any employment that pays at least applicable minimum wage and provides at least 20 hours per week of employment is deemed to be comparable.
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Suitable Employment 1.9.4

BOTH	<p>Unsuitable employment can be refused (or quit) without penalty. Employment is considered unsuitable if it meets any one of the following criteria:</p> <ul style="list-style-type: none"> • the wage offered is less than the highest of: <ul style="list-style-type: none"> ○ the applicable federal minimum wage, ○ the applicable District minimum wage, or ○ 80 percent of the federal minimum wage if neither the federal nor the District minimum wage is applicable; • employment is offered on a piece-rate basis and the average hourly wage the employee can reasonably expect to earn is less than the applicable hourly minimum wage; • the household member is required to join, resign from, or refrain from joining any
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	<p>legitimate labor organization in order to be hired or to continue working ;</p> <ul style="list-style-type: none"> the work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (Taft-Hartley) or unless an injunction has been issued under Section 10 of the Railway Labor Act there is a reasonable risk to health and safety ; the member is physically or mentally unfit to perform the employment as documented by medical evidence or by reliable information from other sources; the employment offered within the first 30 days of FSET work program participation is not in the group member's field of experience; or the distance from the group member's home to the place of employment is unreasonable based on the expected wage and the time and cost of commuting; <p>Daily commuting time must not exceed two hours per day, not including the transportation of a child to and from the child care facility. Employment also will not be considered suitable if the distance to the place of employment prohibits walking to the job site and both public and private transportation are unavailable for getting to the job site.</p> <ul style="list-style-type: none"> the working hours or nature of the employment interferes with the member's religious observance, convictions, or beliefs; and accepting work may result in domestic violence (see Section 3.8: Domestic Violence in Part VIII) <p>Example Mr. Taylor is a Sabbatarian and refuses to work on Saturday. His religious observance will not affect his eligibility, and he is not required to accept a job with Saturday hours.</p>
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Notice of Adverse Action for Voluntary Quit/Reducing Work Effort without Good Cause 1.9.5

BOTH	If a determination of voluntary quit without good cause is made, a notice of adverse action shall be sent (see Chapter 10: Notice of Adverse Action in Part VIII). The sanction cannot be effective until at least 15 days after the date of the notice.
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VERIFICATION 1.10

Verification of Exemption from Work Activities 1.10.1

BOTH	<p>The exemption categories discussed in Section 1.6: Exemptions from Work Requirements in this Chapter require the following types of verification.</p> <ul style="list-style-type: none"> If a person claims to be exempt by reason of employment or self-employment for at least 30 hours per week, verification of the amount of income received from such employment is sufficient to establish the exemption, provided the amount of income appears to be consistent with employment for 30 hours a week under the general conditions prevailing in the community. <p>However, if the individual does not meet this test but still claims to be self-employed, then s/he must cooperate with the SSR in establishing that the income received from the self-employment</p>
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	<p>enterprise is at least sufficient to be considered gainful employment and the volume of work claimed justifies a determination that the self-employment enterprise is a full-time job for the purpose of this exemption. Factors to be considered, while not all inclusive, are:</p> <ul style="list-style-type: none"> • Does the wage meet the DC or federal minimum wage? • Have deductions of required mandatory amounts for federal and/or state income taxes, Social Security tax, and so on been made by the employer or individual? • Does the employer or individual pay Unemployment Insurance premiums on behalf of the individual? • If a parent and another member of the group both claim to be the responsible caretaker for the care of the same dependent child or incapacitated adult, the actual responsibility should be determined by discussion with the applicant. The SSR should require documentation of the incapacity of the person requiring the caretaker. • Individuals claiming unfitness for work requirements for physical, mental or addiction reasons who do not currently receive disability-related benefits must receive a medical examination to verify their condition. If the person is requesting exemption from TANF work requirements, the MRT will make the final determination of fitness and determine whether an exemption should be granted or whether the case should be converted to POWER. If the person is requesting exemption from Food Stamp work requirements, the SSR or FSET program staff may grant an exemption if the person's medical provider indicates inability to work. • A VISTA or Americorps volunteer must provide a copy of his/her contract for verification
TANF	Monitoring of teen parent school attendance is handled by the Teen Parent Unit which is run by the DC Public Schools. Proof of school attendance should be provided to the Unit within 45 days after application/recertification.
FS	<p>Eligibility for and receipt of benefits from SSI is evidence of unemployability. In the case of an SSI household containing an 'essential person,' (see Section 1.6: Essential Person in Part IV), individual situations must be examined to determine whether the essential person should be work registered. In addition, receipt of disability payments under the Social Security Program, Veterans Benefits, or OASDI will be considered proof of unfitness for employment for purposes of this exemption.</p> <p>Other individuals claiming an unfitness exemption should, in the absence of physical evidence, furnish verification which can substantiate such unfitness or documentary evidence which supports the claim. Appropriate verification may consist of receipt of temporary or permanent disability benefits issued by governmental or private sources or a completed medical evaluation form from a physician or licensed or certified psychologist that must be submitted to the MRT. Adequate documentation should appear in the case file to support the granting of this exemption. Receipt of Worker's Compensation may indicate temporary disability.</p> <p>If an addiction exemption is questionable, the regular participation of an addict or alcoholic in a drug or alcoholic treatment and rehabilitation program will be verified through the organization or institution operating the program. If collateral contact or verification is completed by means other than in writing, a notation of how and with whom participation was verified should be entered into the case file.</p>

Verification of Questionable Information 1.10.2

BOTH	<p>When information on past or current employment provided by a group is questionable, the SSR must request verification of work status. The primary responsibility for providing verification rests with the group. If the group has difficulty in obtaining documentary evidence in a timely manner, the SSR should offer assistance to obtain the needed verification. Acceptable sources of verification include but are not limited to:</p> <ul style="list-style-type: none"> • the current employer, • the previous employer, • employee associations, or • union representatives and grievance committees or organizations.
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Verification of a Voluntary Quit for Good Cause 1.10.3

BOTH	<p>When documentary evidence is not available for a voluntary quit, the SSR should obtain verification from acceptable collateral contacts provided by the individual or the group. If verification cannot be obtained because the cause for the quit resulted from circumstances that for good reason cannot be verified, the SSR should not deny benefits if otherwise eligible and verification efforts should be terminated.</p>
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Chapter 2 - Child Support Requirements

INTRODUCTION 2.1

This chapter applies to MA, TANF, and POWER assistance units that include a dependent child who has an absent parent. In the case of MA, the head of the unit must assign the right to medical support for a dependent child while in the case of TANF and POWER, the head of the unit must assign the right to both medical and child support. Medical support is defined as the absent parent's voluntary or court-ordered agreement to be responsible for the payment of his/her child's medical expenses. A signed Combined Application (CA) serves as the assignment of child and/or medical support rights. If a dependent child subsequently becomes part of another assistance unit, the head of the new unit is subject to the child/medical support assignment requirement.

The medical support cooperation requirement applies only to AR and AX program types. It does not apply, however, to pregnant women.

The SSR will send Form 1288/1288A "Notice to Child Support Agency" to the Child Support Enforcement Division (CSED) for each MA*, TANF, and POWER applicant/recipient who will be required to cooperate with paternity and child support establishment, child support enforcement, medical support enforcement, and collection. In addition, the Department will send CSED Form 886 Information Exchange for each TANF and MA applicant/recipient who has self-identified a past, present, or future risk of domestic violence. CSED will place the form in the case file of the applicant/recipient and will refer to this in making its good cause determination. An SSR may learn of domestic violence issues through the preliminary assessment, information provided by the vendor, or other collateral contacts.

*Customers applying for MA using the D.C. Healthy Families mail-in application will be referred to CSED on a "volunteers first" basis. Those customers that indicate that they would like CSED assistance quickly will be referred immediately. IMA will maintain information on other customers, but not refer them to CSED until CSED requests this information. In this way, IMA and CSED will prioritize those cases in which CSED assistance would most likely result in the collection of child support.

The SSR should refer assistance units required to assign medical and/or child support rights to CSED. These assistance units must cooperate with CSED unless there is good cause for non-cooperation. Cooperation may include any of the following:

- identifying and locating the absent parent,
- establishing the paternity of a child born out-of-wedlock,
- securing a court order for medical and/or child support of the child, and
- enforcing and/or modifying the support order.

If the assistance unit claims good cause for non-cooperation, CSED will evaluate the claim and inform IMA of its finding.

To validate a claim of good cause, CSED may:

- decide the claim based on information provided by the applicant/recipient, or
- decide to conduct a further investigation to verify the claim

CSED will not contact the non-custodial parent without informing the applicant/recipient and will not contact the non-custodial parent at all if it will put the applicant/recipient in danger. CSED will not attempt to establish third party liability (see Section 3.2: Third Party Liability for Payment of Medical Expenses in this Part) for medical services in situations in which it determines that the applicant/recipient has good cause for refusing to cooperate. If CSED does not determine that there is good cause, the individual can continue to fail to cooperate (making CSED contact impossible) and suffer the associated sanction.

If CSED does not find good cause or the assistance unit does not cooperate, IMA then applies a sanction to the assistance unit. The sanction for non-cooperation differs by program. If a TANF/POWER recipient fails to cooperate, the family's TANF/POWER grant is reduced by 25 percent. In MA, the adult who failed to cooperate is disqualified from MA.

This chapter relates only to those MA, TANF, and POWER assistance units which are subject to the medical/child support requirement. Thus, when the term 'ALL' is used in this chapter, it refers only to those programs and categories which impose this requirement.

POWER policy follows TANF policy, therefore the policies listed under 'TANF' also relate to POWER.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Child Support Requirements	TANF: D.C. Code 4-205.19, 4-217.8-10; 29 DCMR 1707 and 1715	MA: 42 USC 1396a(a)(45), 1396k; 42 CFR 433.145-.148, 435.610 TANF: 45 CFR 264.30-3

THE NOTICE OF REQUIREMENT TO COOPERATE AND RIGHT TO CLAIM GOOD CAUSE FOR REFUSAL TO COOPERATE WITH CHILD SUPPORT EFFORTS 2.3

ALL	<p>Every applicant/recipient who is a parent or caretaker of a child for whom benefits are paid or sought must be given a copy of the Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Enforcement. The SSR should explain the purpose of the notice, the penalties for not cooperating with CSED, and the reasons that the applicant/recipient may be exempt from the requirement to cooperate (i.e., good cause).</p> <p>The SSR must make sure the applicant/recipient reads, understands, and signs the Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Enforcement. The SSR must also sign the notice and place a signed and dated copy in the case file of the applicant/recipient and provide an additional copy to the applicant/or recipient at the time of signing. The applicant/recipient must be given an opportunity to express his/her intent to claim a good cause reason not to comply with child support requirements at the time s/he signs the notice. If s/he expresses intent to claim good cause, this information must be registered in ACEDS. The recipient can also claim good cause at the point s/he meets with CSED or at any future date. After the SSR signs the notice, the SSR will refer the assistance unit to the CSED which will begin the process of establishing paternity (if required) and collecting support from the absent parent.</p>
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	<p>The SSR must provide a copy of the Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Enforcement form to the recipient at least once per year.</p> <p>If an applicant/recipient informs ESA of his/her intent to claim good cause for not cooperating with child support requirements, the SSR must inform CSED of this fact within five days of the claim of good cause if the claim arose during a redetermination or within five days of application approval.</p>
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REFERRAL TO CSED 2.4

ALL	<p>Upon receipt of a referral from ESA, CSED will contact the applicant/recipient for a meeting with CSED. At this meeting, CSED will inform the applicant/recipient again verbally and in writing of the right to claim good cause and the requirements applicable to good cause determinations.</p> <p>During this meeting, CSED will make a finding as to whether the applicant/recipient could reasonably be expected to provide information with regard to the non-custodial parent. In making the finding, CSED will consider:</p> <ul style="list-style-type: none"> • the age of the child for whom support is sought, • the circumstances surrounding the conception of the child, • the age and/or mental capacity of the applicant/recipient, • the time that has elapsed since the customer last had contact with the alleged non-custodial parent, and • whether the applicant/recipient is the parent of the child for whom support is sought. <p>CSED has the responsibility to make a final determination of non-cooperation in all situations and informs IMA of the results. IMA applies sanctions based on the CSED findings.</p> <p>CSED will make a determination of good cause no later than 180 days from the date the applicant/recipient makes the claim. The determination period may exceed 180 days only if verification of required information will take longer and the applicant/recipient did not provide corroborative evidence within the period required.</p>
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COOPERATION ESTABLISHING PATERNITY AND SUPPORT 2.5

ALL	<p>As a condition of eligibility, each applicant has the responsibility to cooperate with CSED by:</p> <ul style="list-style-type: none"> • providing the name of the non-custodial parent of the child for whom assistance is sought; • providing all relevant information about the absent parent to CSED such as: <ul style="list-style-type: none"> ○ age or date of birth; ○ last known home address; ○ SSN; ○ home and work telephone numbers; ○ last known employer name and address ○ occupation; ○ union or trade association affiliation; ○ schooling;
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	<ul style="list-style-type: none"> ○ names and addresses of relatives or associates; ○ date and place of any arrest; ○ make, model, or license plate number of car; ○ driver's license number; ○ bank account or credit card information; or ○ any additional information necessary to establish paternity for the child or to establish, modify, or enforce a child support order; <ul style="list-style-type: none"> • appearing at interviews, hearings, and legal and administrative proceedings regarding the support of the child with respect to whom assistance is sought; • submitting to genetic testing as required by a judicial or administrative order; and • submitting the child for whom assistance is sought to genetic testing as required by a judicial or administrative order. • paying to the District any support payments received directly from the non-custodial parent that are subject to assignment • attesting to lack of information under penalty of perjury if the applicant/recipient is, in good faith, unable to identify or assist in locating the non-custodial parent (see Section 2.6: Good Cause For Non-Cooperation in this Chapter)
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GOOD CAUSE FOR NON-COOPERATION 2.6

ALL	<p>CSED determines non-cooperation for all situations of non-cooperation with child and medical support requirements and informs IMA which then applies the appropriate sanction, if the recipient is determined to have failed to cooperate without good cause. An applicant/recipient may, at any time, claim good cause for non-cooperation with CSED with respect to determining paternity and obtaining medical/child support from the absent parent of a dependent child. CSED will determine good cause for non-cooperation, bearing in mind the best interests of the child, which include minimizing the child's exposure to family violence.</p> <p>The custodial parent is considered to have good cause for not cooperating with child and medical support requirements when:</p> <ul style="list-style-type: none"> • efforts to cooperate are reasonably anticipated to result in physical, sexual, or emotional harm to: <ul style="list-style-type: none"> ○ The child for whom assistance is sought; ○ The applicant/recipient; ○ A household member of the applicant/recipient; or ○ An immediate family member of the applicant/recipient (i.e., spouse, parent, sibling, child); • circumstances are identified that would make cooperation or actions resulting from cooperation detrimental to the child for whom assistance is claimed including one or more of the following: <ul style="list-style-type: none"> ○ the child was conceived as a result of rape or incest, ○ legal proceedings for the adoption of the child are pending before a court, or ○ the applicant/recipient is receiving counseling from a public or licensed private social agency to decide if the child should be released for adoption.
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	<p>Good cause may not be claimed for failure to turn in support payments to CSED.</p> <p>If CSED determines that the applicant/recipient has good cause for non-cooperation, all action on paternity and child/medical support will be suspended until the applicant/recipient requests resumption or CSED determines good cause no longer exists, whichever is sooner.</p> <p>Until CSED makes a finding concerning an applicant/recipient's good cause claim, the applicant/recipient's eligibility will be determined without regards to the child/medical support cooperation requirement and no sanctions will be imposed provided that:</p> <ul style="list-style-type: none"> • the applicant/recipient has made timely corroboration of the good cause claim, and • CSED has failed to determine whether good cause exists within the time period permitted to process TANF applications and redetermination. <p>If the claim for good cause is denied for paternity and child support, the applicant/recipient must be given notice in writing and must then comply with the requirement or face sanctions imposed by ESA.</p>
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SANCTIONS 2.7

ALL	CSED determines when an individual has failed to comply with child support requirements without good cause. If a parent receiving both TANF and MA fails to comply with child support requirements without good cause, both the TANF and MA sanctions are imposed.
MA	<p>If it is determined that the head of the unit refuses to cooperate with CSED without good cause, then s/he is ineligible for MA. The dependent child's MA benefits are not affected. If, however, the noncompliant adult is eligible for MA based on age or disability (as opposed to being eligible for MA because of his/her status as caretaker of the dependent child), then MA eligibility continues, but the designation of the adult's case must change to SR. QM is not affected by the child support requirement.</p> <p>Once the adult cooperates, benefits are restored effective the first month following the date of cooperation.</p>
TANF	<p>If it is determined that a parent refuses to cooperate with child support enforcement without good cause, the group's TANF benefits shall be reduced by 25 percent. Sanctions for failing to cooperate with child support requirements cannot be imposed on caretakers other than parents, even if the caretaker is included in the assistance unit. Child support sanctions also cannot be imposed on cases in which the parent is "out" of the unit (such as an SSI parent) or disqualified due to alienage.</p> <p>Once the parent cooperates, benefits are restored effective the first month following the date of cooperation.</p> <p>If an adult recipient fails to comply with both TANF work and child support requirements, the larger of the two sanctions is imposed. If the adult complies with one of the requirements, the other sanction should be imposed.</p> <p>The benefit reduction amount counts as unearned income in the Food Stamp Program. This ensures that FS benefits do not increase when a TANF sanction is imposed.</p>

SUPPORT COLLECTED 2.8

MA	If a group is ineligible for MA in the AR or AX program types due to an increase in child support, the group is eligible for four months of TMA. If the group's income still exceeds 200 percent of the FPL after the four-month period the group is no longer eligible for MA (see Section 1.3: Transitional Medicaid Assistance (TMA) in Part VII). If the group's income is below 200 percent of the FPL after the four-month period, the group should be recertified for MA. The group would no longer be eligible for TMA, but rather would be eligible for Medicaid under the AR or AX program types.				
TANF	<p>If support is collected and is less than the grant, it is retained by CSED to defray the costs of providing assistance to the group. After two consecutive months of collections that are greater than the current TANF grant, the TANF case is closed, and the child support is sent directly to the family. All support collected by CSED in excess of the TANF grant must be returned to the family and counted as unearned income (see Section 4.9: Child Support in Part VI).</p> <table><tr><td>Example 1</td></tr><tr><td>Ms. Watkins has two children by the same father, Sam Cole. Ms. Watkins has assisted CSED in locating Mr. Cole who allowed a paternity test to be administered which proved him to be the father of both children. Mr. Cole pays \$75 per month in child support for both children. Since this is less than the current TANF grant provided to Ms. Watkins, CSED retains the entire \$75 paid by Mr. Cole.</td></tr><tr><td>Example 2</td></tr><tr><td>Ms. Minton has one child, Samantha. CSED located John Wright; the man who Ms. Minton claimed was the father. When he was contacted by CSED, Mr. Wright agreed to take a blood test to determine paternity. The test showed that Mr. Wright was in fact Samantha's father, and he was ordered by the court to pay child support. After several months of erratic support payments, Mr. Wright got a new, better paying job, and in May, he began to pay the proper amount of child support. After full payment was made for two consecutive months (May and June), it was determined by CSED that the child support paid by Mr. Wright exceeded Ms. Minton's TANF grant. At this point, Ms. Minton's TANF case was closed, and child support paid by Mr. Wright is sent from CSED to Ms. Minton.</td></tr></table>	Example 1	Ms. Watkins has two children by the same father, Sam Cole. Ms. Watkins has assisted CSED in locating Mr. Cole who allowed a paternity test to be administered which proved him to be the father of both children. Mr. Cole pays \$75 per month in child support for both children. Since this is less than the current TANF grant provided to Ms. Watkins, CSED retains the entire \$75 paid by Mr. Cole.	Example 2	Ms. Minton has one child, Samantha. CSED located John Wright; the man who Ms. Minton claimed was the father. When he was contacted by CSED, Mr. Wright agreed to take a blood test to determine paternity. The test showed that Mr. Wright was in fact Samantha's father, and he was ordered by the court to pay child support. After several months of erratic support payments, Mr. Wright got a new, better paying job, and in May, he began to pay the proper amount of child support. After full payment was made for two consecutive months (May and June), it was determined by CSED that the child support paid by Mr. Wright exceeded Ms. Minton's TANF grant. At this point, Ms. Minton's TANF case was closed, and child support paid by Mr. Wright is sent from CSED to Ms. Minton.
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VERIFICATION 2.9

ALL	<p>Within 20 days after claiming good cause, the applicant/recipient must provide CSED with information needed to determine good cause. CSED will allow more time for the applicant/recipient to provide the requested information only if it is determined that more than 20 days is needed.</p> <p>An applicant/recipient who claims good cause for non-cooperation in establishing paternity, child support, or medical support has the burden of establishing good cause by:</p> <ul style="list-style-type: none"> • specifying the circumstances that the applicant/recipient believes establishes good cause for not cooperating, • providing sufficient information to establish the claim, and • corroborating at least one good cause circumstance with: <ul style="list-style-type: none"> ○ a birth certificate or medical, mental health, or law enforcement record which indicates the child was conceived as a result of rape or incest; ○ a court document or other record which indicates that legal proceedings for adoption are pending in court; ○ physical evidence or court, medical, criminal, CSFA, social services, psychological, law enforcement, or clerical records which indicate that the alleged father might inflict physical, mental, sexual, or emotional harm on the child, applicant/recipient, household member, or immediate family member;
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| | <ul style="list-style-type: none">○ a written statement from a medical health professional concerning the emotional health of the child, applicant/recipient, household member, or immediate family member;○ a medical record that indicates the emotional health history and reflects the emotional health status of the applicant/recipient or child;○ a written statement from CSFA or a licensed private social service agency that the customer is being assisted to resolve the issue of placing the child for adoption; or○ a sworn written statement from an individual, including the applicant/recipient, whose knowledge can provide the basis for a good cause claim. |
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The applicant/recipient may request assistance obtaining verification from CSED.

Chapter 3 - Third Party Requirements

INTRODUCTION 3.1

This chapter applies only to MA. As a condition of MA eligibility, each individual who is legally able must assign to the Department rights to third party resources, unless s/he has good cause for not cooperating.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Third Party Liability Requirements		MA: 42 USC 1396k; 42 CFR 433.145-.148, 435.610

THIRD PARTY LIABILITY FOR PAYMENT OF MEDICAL EXPENSES 3.3

A third party resource is a person (such as a non-custodial parent), entitlement, or program that is liable for payment of all or part of an individual's medical expenses. In most instances, the third party is an insurance company. A third party resource may exist in the following situations:

- an individual has private health insurance;
- there is a court decree, such as a judgment of divorce or a child support order which includes a provision regarding medical support;
- an individual has an employment-related or school-related illness or injury;
- an individual is injured in a motor vehicle accident and car insurance is liable to cover part or all of the accident-related expenses;
- an individual is age 65 or over or disabled and is covered by Medicare (Note: these individuals may have private health insurance in addition to Medicare);
- an individual is a member of a union and receives health insurance through the union or employer;
- retired persons may have health insurance through their former employer;
- military personnel and their dependents may have medical coverage through Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Civilian Health and Medical Program of the Veterans' Administration (CHAMPVA); or
- an individual has an injury-related accident/incident such as medical malpractice, slip and fall, faulty products, etc. and insurance or a court settlement is covering health care costs related to the accident.

The Third Party Liability Unit is responsible for making recoveries from liable third parties. Good cause for not assigning the Department rights to third party resources from a non-custodial parent are detailed in Section 2.6: Good Cause for Non-Cooperation in this Part.

VERIFICATION 3.4

Existing Health Coverage 3.4.1

Verification of information about existing health coverage is mandatory. The preferred source of verification is a document or statement from the insurance company or organization indicating the family members who are covered and their account or claim numbers.

Assignment of Rights to Third Party Payments 3.4.2

Verification of the assignment of rights to third party payments is mandatory. The only acceptable source of verification is the signature of the applicant/recipient or his/her authorized representative on the application or recertification form.

Part VI

CHAPTER 1 - DETERMINING COUNTABLE ASSETS

INTRODUCTION 1.1

The TANF and GC programs place a limit on the level of assets a group can own (and have access to) and still be eligible for assistance. The FS program places a similar asset limit on all assistance groups except those which are categorically eligible (i.e., all household members receive TANF and/or SSI or the household has received a prescribed TANF-funded service (see Chapter 12: Categorical Eligibility Part IV). The rules for which assets are countable toward the asset limit, how to value assets and the overall level of countable assets allowed are almost always the same for TANF, GC, and FS. The asset rules are governed by federal FS regulations which outline how assets are to be treated. If a customer reports assets that are not defined in the IMA Policy manual, contact the IMA Policy Office for guidance. Please note that some publications use the terms "asset" and "resource" interchangeably.

To be eligible for MA under some eligibility categories, groups must have countable assets below a specified level. Some categories do not, however, impose an asset test. Specifically, children and pregnant women who meet the non-financial and income-eligibility criteria under 'Poverty Level Families and Children' within the AR program type and children, parents, and caretaker relatives eligible under the AX program type do not have to meet an asset test (see Section 2.2.2: ACEDS MA Program Types in [Part I](#)). Also, groups which are categorically eligible do not have to meet an asset test (see Chapter 12: Categorical Eligibility in [Part IV](#)).

This chapter relates only to the treatment of assets for programs or eligibility groups within programs that impose an asset test on applicants and recipients. Thus, in this chapter when the term 'ALL' is used to indicate the programs to which a particular policy apply, the term only includes those programs and eligibility categories within programs that apply an asset test. Similarly, in this chapter the term 'MA' only includes the DC Healthcare Alliance and those Medicaid eligibility categories that impose an asset test. For clarity, when MA is broken into subgroups in this chapter, a notation will be made to indicate that the asset-related discussion does not apply to certain categories.

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Countable Assets	TANF: 3-205.10-.11; 3-205.15; 3-217.5	MA: 42 USC 1396 a(l), 1396 u-1; 42 CFR 435.601, 435.840-845
	GC: See TANF and D.C. Code 3-205.5a	FS: 7 USC 2014(g), 2014(j); 7 CFR 273.8

GENERAL PRINCIPLES 1.3

ALL	<p>The value of all assets that are available and not explicitly excluded are counted. Assets are available if an applicant/recipient has both legal authority and actual ability to use the assets for self-support. When an asset is owned, in whole or in part, presume the asset is wholly available unless the applicant/recipient proves it is not available. An applicant/recipient may prove unavailability by verifying a legal or other actual barrier to disposal of the asset that cannot reasonably be overcome.</p> <p>Certain overall principles apply when considering a client's assets:</p> <ul style="list-style-type: none">An asset will not be considered available for purposes of charging an overpayment if all members of the group were unaware of the asset and had no reason to be aware of it (see Chapter 6: Overpayment and Underpayment in Part VIII). An asset can be excluded from the
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	<p>asset limit for the period of time the client is unable to sell it.</p> <ul style="list-style-type: none"> • An asset which the client owns jointly with another person may be available (see Section 1.16: Jointly Owned Assets in this Chapter). • Customers are responsible for providing information and verifications regarding countable assets at initial application and assets acquired during the certification period or in-between eligibility redeterminations. • Countable assets have either cash value or equity value. Cash value is the amount of money that can be generated if the asset were sold. Equity value is fair market value minus encumbrances or any amount legally owed on the asset. Countable cash value and equity value will be measured against the asset limit in the eligibility determination process.
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Excluded Assets 1.3.1

ALL	<p>An asset may be excluded in whole or in part depending upon its type or its source. It may also be excluded for a set period of time. Different programs may have different rules regarding whether an asset may be excluded, the amount of the exclusion, or the period during which it may be excluded.</p> <p>Liquid assets that can be excluded should be kept separate and apart from countable assets.</p>
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LIQUID AND NON-LIQUID ASSETS 1.4

ALL	<p>Assets are either liquid or non-liquid. If assets are liquid, they have a cash value. If assets are non-liquid, they have an equity value. Fair market value is the wholesale value of an asset, regardless of the amount the group owes on it. Equity value is the fair market value minus encumbrances or any amount legally owed on the asset. An asset that is converted from one type to another (i.e., an item is sold for cash) continues to be considered an asset.</p>
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Liquid Assets (Cash Value) 1.4.1

ALL	<p>For the following liquid assets, the value of the asset is the amount in the applicant's possession or in the account:</p> <ul style="list-style-type: none"> • cash on hand, including uncashed checks, drafts, and warrants; • savings account; • checking account; • credit union share or draft account; • LTC patient trust fund; and • Personal Needs Allowance (PNA) account administered by a LTC facility or authorized representative on behalf of a MA recipient. <p>The value of the following types of liquid assets is the amount if it were converted to cash:</p> <ul style="list-style-type: none"> • certificate of deposit (CD); • life insurance; • U.S. savings bond, except that it will not be counted as long as it cannot be cashed in; • lump sum payments such as lottery winnings and inheritances; • trusts; • stocks, bonds, securities, and mutual funds; and • income tax refunds.
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Non-Liquid Assets (Equity Value) 1.4.2

ALL	<p>The following are examples of non-liquid assets:</p> <ul style="list-style-type: none">• real property (land and building), mortgages, land contracts, life estates, and life leases;• licensed and unlicensed boats, aircraft, campers and trailers; and• tools and machinery for education, training, or employment of the household. <p>Exclude non-liquid assets against which a lien has been placed as a result of taking out a business loan and the household is prohibited by the security or lien agreement with the lien holder/creditor from selling the assets.</p> <p>For all moveable assets, such as boats, aircraft, and campers, and for real property, the lien, if it exists, must be filed with the appropriate agency (i.e. Department of Motor Vehicles (DMV) or Recorder of Deeds) in order for the lien amount to be subtracted from the fair market value.</p> <p>Land contracts and mortgages are excluded. This exclusion applies to installment contracts for the sale of land or buildings and to the value of property sold under installment contract or held as security in exchange for a purchase price consistent with the fair market value of that property.</p>
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BURIAL FUNDS 1.5

ALL	<p>Exclude all funds in a pre-paid burial account, burial plan, or burial trust. Exclude all other funds clearly designated for burial expenses, including funeral agreements, burial contracts, burial trusts, or other burial arrangements. In addition, financial accounts (checking, savings, or other types of accounts), and the cash surrender value of life insurance may also be excluded if set aside for burial expenses. To be excluded, burial funds cannot be commingled with any assets except excluded burial space assets. If a savings account is designated for burial funds, all subsequent deposits must also be designated for burial funds.</p> <p>If excluded burial funds are used for purposes other than the burial of the person for whom the funds were set aside, the amount not used becomes unearned income.</p>
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BURIAL SPACE 1.6

ALL	<p>A burial space includes customary items for a deceased's bodily remains such as a:</p> <ul style="list-style-type: none">• grave site (burial plot);• mausoleum, crypt, or niche; or• casket or urn. <p>Also included are necessary improvements such as a:</p> <ul style="list-style-type: none">• vault, outside receptacle, or rough box;• headstone, marker, and/or plaque;• burial container;• opening and closing of the grave site; and• care and maintenance of the grave site (endowment care). <p>Exclude the value of burial space items, provided the items are identified separately from the value of non-burial space items.</p> <p>Exclude one burial space for each person for whom assets are counted (see Chapter 2: Whose Assets</p>
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	are Counted in this Part).
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BUSINESS ASSETS 1.6A

ALL	Exclude all accounts receivable, promissory notes, and loan-related assets.
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CASH EXCLUSION 1.7

ALL	<p>Cash that is countable as income is not an asset in the month received (see Section 1.12: Income in this Chapter). Current assistance payments (TANF, GC, IDA, SSI, and so on) are not an asset in the month received. See Section 1.21: Non-recurring Lump Sums and Accrued Benefits in this Chapter for information on the treatment of lump sum cash awards including retroactive benefit payments.</p> <p>Unless otherwise excluded based on the origin of the cash, cash-on-hand is considered an asset.</p>
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EARNED INCOME TAX CREDIT (EITC) 1.8

ALL	Exclude all EITC payments.
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ENERGY ASSISTANCE 1.9

ALL	Exclude all energy assistance payments, including payments made in a prior month that were intended to cover expenses in a previous month but were not spent.
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HIGHER EDUCATION SAVINGS PLANS 1.9A

ALL	<p>Section 529 College Savings Plans are higher education savings plan trusts established under Section 529(b) of the Internal Revenue Code as "qualified tuition programs." Through these plans, individuals may make investments for the purpose of accumulating savings for qualifying higher education costs of beneficiaries.</p> <p>Exclude all Section 529 College Savings Plans.</p>
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HOUSEHOLD AND PERSONAL GOODS 1.10

ALL	<p>Exclude household goods customarily found in the home and intended for its maintenance, use, or occupancy such as:</p> <ul style="list-style-type: none"> • furniture and furnishings, • appliances, • carpets, • dishes and utensils, • televisions and audio equipment, and • household tools and equipment. <p>Exclude personal goods (incidental items for personal use) such as:</p> <ul style="list-style-type: none"> • clothing, • watches and jewelry, • exercise equipment, and
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	<ul style="list-style-type: none"> • musical instruments.
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INACCESSIBLE ASSETS 1.11

ALL	<p>Inaccessible assets, also known as 'unavailable assets,' are assets which the group can neither use for ongoing support nor sell. Examples of unavailable assets include but are not limited to irrevocable trust funds, security deposits on rental property or utilities, property in probate, and real property which the household is making a good faith effort to sell at a reasonable price and which has not been sold or is unlikely to produce any 'significant return' or any 'significant amount of funds' for the support of the group.</p> <p>Significant return means any return, after taking into account estimated costs of sale or disposition and the ownership interest of the household that is estimated to be one-half or more of the applicable asset limit for the household. 'Any significant amount of funds' means any funds amounting to one-half or more of the applicable asset limit for the household.</p> <p>Assets having cash value which are not accessible to the group are exempt.</p>
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INCOME 1.12

ALL	Countable income (see Chapter 4: Determining Countable Income in this Part) is not an asset in the month received.
	Example
	A May 10th bank deposit of Mr. Carreon's paycheck is not an asset for May, but funds remaining in the account in June will be considered assets.
	The amount of the paycheck is considered income, not assets, for May.
	When income must be averaged or prorated (such as self-employment, or farm and rental income), exclude the resulting assets for the months of proration.

INCOME-PRODUCING ASSETS/ESSENTIAL TO SELF-SUPPORT 1.13

ALL	<p>Exclude the portion of a non-cash asset (such as a separate parcel of land) necessary to maintain and use a vehicle for producing income for someone whose assets are counted (see Chapter 2: Whose Assets are Counted in this Part). This exclusion applies even if the group can convert the asset to cash or a parcel of property is in effect subdivided contrary to an ordinance or law.</p> <p>Income-producing assets are excluded as long as they produce a return consistent with their value. In addition, for self-employed farmers, exclude assets, including land, equipment, and supplies, essential to self-employment of a unit member engaged in farming. Upon terminating farming as self-employment, continue to exclude essential self-support farming assets for one year.</p>
MA	<p>SR (excluding SSI Recipients): In addition, the assets of a blind or disabled individual that are essential to the fulfillment of a Department-approved self-support plan are non-countable for as long as the self-support plan remains in effect. Such assets must be specified in the plan for self-support in accordance with the policies governing the deductions for achieving self-support (see Section 6.4: Income Disregards and Deductions in this Part.)</p> <p>QM: See SR.</p>

INCOME TAX REFUNDS 1.14

ALL	Exclude income tax refunds not consisting of an EITC. See Section 1.8: Earned Income Tax Credit (EITC) in this Chapter for a description of the treatment of the EITC.
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INDIAN LAND 1.15

ALL	Exclude Indian lands jointly held with a tribe and land that can only be sold with the approval of the Department of Interior, Bureau of Indian Affairs.
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JOINTLY OWNED ASSETS 1.16

ALL	Jointly owned assets are those that have more than one owner. The amount which is counted depends on whether the asset is available to the owner in the asset group and on whether the asset has cash or equity value.
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Unavailable Jointly Owned Assets 1.16.1

ALL	<p>The asset is unavailable if:</p> <ul style="list-style-type: none">• an owner cannot legally sell his/her share without the other owner's consent, and• the owner verifies that the joint owner does not agree to the sale. <p>In addition, any asset owned by residents of shelters for battered women and children is unavailable when:</p> <ul style="list-style-type: none">• the asset is jointly owned with a member of the former group, or• access to the asset is dependent on the cooperation of the joint owner who still resides in the former group. <p>Exclude all unavailable assets.</p>
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Available Jointly Owned Assets 1.16.2

MA	AR N/A AX: N/A SR (excluding SSI Recipients): Count the entire amount of an asset to which the income group has access. QM: See SR. MC: See AR.
TANF	Prorate the value of the asset according to the number of owners.
GC	See TANF
FS	Count assets owned jointly by separate households in their entirety to each household. If the household can demonstrate that it has access to only a portion of the asset, the value of that portion of the asset shall be counted toward the household's asset level.

LAND CONTRACT 1.17

ALL	A land contract is an agreement for the sale of real property on installments (usually monthly). The
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	contract holder (seller of the property) retains title to the property until the entire purchase price is paid.
	Exclude the value of the property for both the contract holder and the purchaser.

LIFE INSURANCE 1.18

ALL	<p>A life insurance policy is a contract between the policy owner and the company that provides the insurance which is also referred to as the insurer. The company agrees to pay money to a designated beneficiary upon the death of the insured which is the person whose life the policy insures.</p> <p>The policyholder (or owner) is usually the person who pays the premiums and is the person who has the right to change the policy. However, the policyholder and the insured may be different people. A policy is an asset of the policyholder.</p> <p>The amount of basic death benefit contracted for the time the policy is purchased is referred to as the face amount, face value, amount of insurance, amount of policy, or sum insured. It does not include dividends or additional amounts payable because of accidental death or other special provisions.</p> <p>The amount of money the policy owner can get by canceling the policy before it matures or the insured dies is referred to as the cash surrender value (CSV) or cash value. A life insurance policy is an asset if it generates a CSV. Generally, term insurance does not have a CSV. A whole or straight life policy generates a CSV. The CSV usually increases over time. A loan against a policy reduces its CSV. A policy may be able to generate a CSV but have a CSV of zero (i.e., a person recently purchased a policy). Such a policy is an asset with zero value.</p> <p>It is important to remember that the CSV and the face value are not the same.</p> <p>A life insurance policy may be assigned to pay funeral/burial expenses (see Section 1.19: Life Insurance Funded Funerals in this Chapter).</p>
MA	There is no exclusion. Count the CSV of all life insurance policies owned by the asset group.
TANF	The entire CSV is excluded.
GC	See TANF.
FS	See TANF.

LIFE INSURANCE FUNDED FUNERALS 1.19

ALL	<p>A prearranged funeral contract may be funded using life insurance if a person purchases a life insurance policy and assigns (i.e., directs) the proceeds to be used for his/her funeral expenses.</p> <p>In addition to assigning the proceeds, a person may transfer ownership of the insurance policy to a trust, funeral director, or other third party.</p> <p>A person who purchases a life insurance policy marketed and designed to fund funerals will usually do the following:</p> <ul style="list-style-type: none"> • assign the proceeds to fund his/her prearranged funeral, or • irrevocably/permanently transfer ownership of the insurance policy to a trust. <p>Exclude the value of life insurance funded funerals.</p>
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LOAN-RELATED ASSETS 1.20

ALL	<p>Exclude non-cash assets, either business or non-business, used to secure a loan for business purposes if:</p> <ul style="list-style-type: none">• the borrower is a household member, ineligible alien, or disqualified person whose assets are counted as part of the household's assets (see Chapter 2: Whose Assets are Counted in this Part); and• a security or lien agreement makes the asset inaccessible (i.e., the group cannot sell it or convert its value to cash) <p>If the above conditions are not met, count the asset's cash/equity value.</p>
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NON-RECURRING LUMP SUMS AND ACCRUED BENEFITS 1.21

ALL	<p>A lump sum is cash received on a non-recurring or irregular basis that cannot reasonably be anticipated.</p> <p>Some lump sums payments may be excluded in their entirety or in part. Funds received from excludable lump sum payments must not be commingled with countable assets.</p> <p>The following lump sum payments are excluded in their entirety by law or federal statute:</p> <ul style="list-style-type: none">• payments received under PL 100-383 to US citizens of Japanese ancestry, resident Japanese aliens and Aleuts who were interned or relocated during World War II;• payments received under the Radiation Exposure Compensation Act of 1990, PL 101-325, as compensation for exposure to radiation from nuclear testing and uranium mining;• Agent Orange settlement fund payments or payments from any other fund established because of the settlement in the in re: Agent Orange product liability litigation, MDL No. 381 (EDNY); and• payments received under Section 401 of the Veterans Benefits and Health Care Improvement Act of 2000, PL 106-419.
MA	<p>To the extent that lump sums are countable, they are considered an asset beginning the month after payment was received.</p> <p>The following lump sum payments are excluded entirely:</p> <ul style="list-style-type: none">• payments made by the District government related to judgments or settlement agreements made on behalf of customers of District government agencies including the following:<ul style="list-style-type: none">◦ Evans v Williams,◦ Dixon v Williams,◦ Brady v Williams, and◦ Salazar v Williams;• accrued retroactive benefits from the following:<ul style="list-style-type: none">◦ TANF,◦ TANF Diversion payments,◦ Supplemental Security Income (SSI),◦ Medicare Buy-In and related reimbursements, and◦ Social Security (OASDI). <p>The first \$12,000 in accrued retroactive benefits is excluded for twelve months from the month of</p>

	<p>receipt for the following:</p> <ul style="list-style-type: none"> • Unemployment Compensation Benefits (UCB), • Railroad Retirement Benefits, and • Veteran's Benefits. <p>The amount of the lump sum exceeding \$12,000 is countable as an asset in the month following the month that the payment is received. The amount of any remaining cash is countable effective the first day of the 13th month.</p> <p>Also, exclude for twelve months payments from any source for the planned repair or replacement of a non-countable asset that was lost, stolen, damaged, or destroyed. Any remaining cash becomes countable effective the first day of the 13th month.</p> <p>Unless otherwise state the proceeds from the sale of assets are countable in the month following the sale.</p>
	<p>Example 1</p> <p>If Mr. Martin inherits a sum of money, the money received is treated as income in the month received. Any money remaining after the first of the next month would be treated as an asset.</p>
	<p>Example 2</p> <p>Ms. Morris and her eight-year-old son receive MA but no longer receive TANF assistance. Ms. Morris works, and her income equals 185 percent of the FPL. Both are part of an AX group. IMA discovers that Ms. Morris is due a TANF underpayment. The underpayment is not counted as an asset or income when determining the group's MA eligibility.</p>
TANF	<p>Lump sums and accrued benefits not listed below or otherwise excluded by law are not treated as assets but rather as windfall income (see Section 4.26: Lump Sums and Accrued Benefits and Section 8.4.1: Future Ineligibility Based on Receipt of a Lump Sum or Accrued Benefit in this Part).</p> <p>Retroactive SSI benefits are not treated as assets or windfall income.</p> <p>Retroactive Social Security (OASDI) benefits are not counted as windfall income and are excluded as assets for six months following the month of payment. Any remaining cash becomes countable as a cash asset on the first day of the seventh month.</p> <p>Proceeds from the sale of other assets are not countable as windfall income, but are countable as a cash asset on the first day of the month following the month of the sale.</p>
	<p>Example</p> <p>Mrs. Skuble, a disabled mother, and her two children receive TANF. Mrs. Skuble applied for SSI on February 1, 1998. In January 1999, SSA determines her SSI-eligible and issues her a retroactive benefit that reflects the benefits she was entitled to since the date she applied for SSI. Once Mrs. Skuble is made eligible for SSI, she becomes ineligible for TANF, but her children remain eligible for TANF. The retroactive benefit is not counted as an asset or as income when determining her children's TANF benefit. In addition, no overpayment is charged for the TANF benefits Mrs. Skuble received between February 1998 and January 1999.</p>
GC	See TANF.

FS	<p>Non-recurring lump sums are countable against the asset limit in the month the lump sum is received.</p> <p>Lump sums and accrued benefits which are to be treated as assets and not income include the following:</p> <ul style="list-style-type: none"> • lottery winnings, • income tax refunds, • inheritances, • lawsuit settlements, • insurance settlements, • refunds of security deposits for rent or utilities, • retroactive unemployment compensation benefits, • retroactive TANF benefits, • retroactive SSI benefits, • retroactive OASDI (Social Security) benefits, • retroactive railroad retirement benefit, and • retroactive veteran's benefits. <p>Retroactive OASDI (Social Security) benefits are excluded assets for 6 months.</p> <p>While retroactive TANF and SSI benefits are considered assets, the assets of individuals receiving TANF or SSI are not considered when determining countable assets for the household. If all household members receive TANF or SSI, the household is categorically eligible for FS and does not have to meet the asset test. If some members of the household do not receive TANF or SSI, the assets of those members who do are excluded so the receipt of retroactive TANF or SSI will not affect their eligibility (see Section 1.27: SSI and Public Assistance Benefits in this Part).</p> <p>Annuities and lottery winnings that are paid on an annual basis must be averaged as income over a 12-month period.</p> <div data-bbox="261 1199 1437 1894"> <p>Example 1</p> <p>Ms. Williams and her two children receive TANF and FS. Between January and August, she received a TANF benefit of \$200. IMA discovers that her TANF benefits were miscalculated for the eight-month period and that she should have received \$275 each month. In September, she receives a payment of \$600 to offset her underpayment for the eight-month period in addition to her \$275 regular TANF benefits.</p> <p>The group's FS benefits were calculated correctly between January and August based on the income Ms. Williams actually received (that is, based on a TANF benefit of \$200). The \$600 underpayment is treated as an asset, not as income, in the month received. The group receives TANF and is categorically eligible for FS; therefore, the additional assets cannot make her ineligible for FS. The group's FS benefits are not adjusted for the January-August period, and the group is not charged with an overpayment.</p> <p>Example 2</p> <p>Ms. Johnson and her two children received TANF and FS from January through April. She found a job in April and stopped receiving TANF. She continues receiving FS. In June, Ms. Johnson is awarded a \$300 TANF underpayment based on a prior Department error. The \$300 is considered an asset in June - but the family is also considered to be a TANF recipient in June and, therefore, categorically eligible for FS. Thus, in June, the family is not required to meet the FS asset test.</p> </div>
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NON-SALEABLE ASSETS 1.22

ALL	<p>An asset is not saleable and thus is unavailable when it has no current market value as shown by one of the following:</p> <ul style="list-style-type: none">• statements from two knowledgeable sources (such as realtors, bankers, stock brokers) in a geographic area that say the asset is not saleable due to a specific condition; or• an actual sale attempt at or below fair market value in the geographic area that results in no reasonable offer to purchase an asset for which a fair market value is determined. This applies only to real property, mortgages, land contracts, life estates, and life leases. The asset becomes saleable when a reasonable offer is received. <p>Non-saleable assets are excluded from countable assets.</p>
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PENDING SALE OF PROPERTY 1.23

ALL	<p>Count as an asset any income that is generated from sale of real estate property, other than the group's primary residence (See also Section 1.24.2: Home Sales in this Part.)</p> <p>Exclude property the group is making a good faith effort to sell. This means:</p> <ul style="list-style-type: none">• an actual attempt has been made to sell it at a price no higher than fair market value, confirmed by a listing with a real estate company or advertising the property in a major newspaper;• no reasonable purchase offer has been made; and• for active cases, the property is continuously up for sale. <p>There is no time limit on the exclusion if the above conditions are met.</p> <p>If the above conditions are not met, count the group equity in the property as an asset.</p>		
MA	<p>Exclude real estate and personal property that by itself or in combination with other assets would make the individual ineligible provided the person:</p> <ul style="list-style-type: none">• signs an agreement to sell the property and to repay the amount of assistance received up to the amount but not to exceed the proceeds of the sale (any proceeds remaining after the repayment are a countable resource); and• makes a good faith effort to sell the property. <p>When the property is sold, the net proceeds are counted as an asset to the group. If this makes the group ineligible for Medicaid (based on exceeding the asset limit), the DOH will recover Medicaid expenditures made on the group's behalf out of the proceeds from the sold asset. To enable the DOH to recover these expenditures, the SSR must notify DOH upon learning that an asset is for sale. Only the initial nine months of conditional benefits (or six months in the case of personal property) are subject to recovery.</p> <table><tr><td>Example</td></tr><tr><td>Ms. James and her 19-year-old child receive MA under the AR standard, Medically Needy Families and Children. Ms. James inherits a second home which she places on the market for sale. The value of the house would make the group's assets exceed the asset limit for the Medically Needy standard. The house is sold 13 months after she inherited the property. Based on her good faith efforts to sell the property, her MA eligibility continued past the initial nine-month period. Her net</td></tr></table>	Example	Ms. James and her 19-year-old child receive MA under the AR standard, Medically Needy Families and Children. Ms. James inherits a second home which she places on the market for sale. The value of the house would make the group's assets exceed the asset limit for the Medically Needy standard. The house is sold 13 months after she inherited the property. Based on her good faith efforts to sell the property, her MA eligibility continued past the initial nine-month period. Her net
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	proceeds from the sale equal \$50,000. The group now exceeds the resource limit and is ineligible for MA. Over the first nine months that the group owned the second home, Medicaid paid \$2,000 in medical expenses for the group. The DOH will seek to recover that \$2,000 from the group.
	Do not count real estate property that is jointly owned if the sale of the property would cause the other owner undue hardship due to loss of housing and no other housing is readily available. (Note: The home in which a group member resides is always excluded; see Section 1.24: Real Estate in this Chapter.)

REAL ESTATE 1.24

Home 1.24.1

ALL	Except for LT, exclude the principal residence owned and occupied by the group. Principal residence is the place where the group usually lives. It includes the home, all adjoining land, and any other buildings on the land. Adjoining land may be separated by roads, rivers, and so on, but it may not be land owned by someone else. Count all other residences.
	For LT, see Section 2.12a: Limitation on Home Equity for Long Term Care Assistance in Part VII .

Home Sales 1.24.2

MA	Exclude any income generated from the sale of a home as an asset, if the group purchases or intends to purchase a new home within the next twelve month. The cash from the sale must be kept in a separate account from countable assets. If the person buys another home within the twelve month period, count as an asset any cash that remains from the earlier sale. If the group does not intend to purchase a new home within twelve month, or fails to purchase a new home within twelve months, count the cash that remains from the sale as an asset.
TANF	See MA.
GC	See AR.
FS	Count as an asset any income generated from the sale of a home.

Income-Producing Real Property 1.24.3

ALL	Property which annually produces income consistent with its fair market value, even if it only produces income on a seasonal basis, is not counted as a resource (though the income produced from the asset would be treated as income). The minimum annual rate of return is six percent of either assessed or fair market value, whichever is less.
MA	SR: Some SR Medicaid recipients may also qualify for the "PASS" program under which some assets are not countable. Contact the IMA Policy Unit, if an SR Medicaid recipient reports such assets.

Probate Property 1.24.4

ALL	Exclude property held in probate.
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Property Lot 1.24.5

ALL	Exclude a lot (including a partially built home) in the District of Columbia if the person intends it to become his/her home and does not own another home.
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Temporary Absence from Home 1.24.6

MA	Exclude a home the person formerly lived in if the absence is due to care in a hospital or LTC facility and the person intends to return to the home. Also exclude a home a person formerly lived in if the person is temporarily absent (see Section 1.15: Temporary Absence in Part IV).
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TANF	Exclude the home that a person formerly lived in if the person is 'temporarily absent' from that home (see Section 1.15: Temporary Absence in Part IV).
GC	See TANF.
FS	Exclude a home the person formerly lived in if the absence is for one of the following: <ul style="list-style-type: none"> • vocational rehabilitation training; • inability to live at home due to a verified health condition; • migratory farm worker with the intent to return to the home; or • employment, training for future employment, illness, casualty (such as fire), or natural disaster. The group must intend to return.

RENT PAYMENTS WITHHELD 1.25

ALL	Rental payments withheld for a rent strike and given to a third party such as the Landlord Tenant Court or Neighborhood Legal Service are excluded.
MA	Exclude also rental payments that are withheld due to a rent strike but remain in the possession of the group.
TANF	See MA
GC	See MA
FS	Count rental payments that are withheld due to a rent strike but remain in the possession of the group.

RETIREMENT PLANS 1.26

ALL	Exclude the cash value of all retirement plans for all group members, including the following: <ul style="list-style-type: none"> • Individual Retirement Accounts (IRAs); • Keogh accounts; • 401(k), 403(b), and 457 accounts; and • all other pension and retirement funds as long as the funds remain in the retirement plan. <p>Any funds removed or disbursed from a retirement plan shall be treated as income in the month withdrawn and countable as a cash asset thereafter.</p>
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SSI AND TANF BENEFITS 1.27

MA	The assets of an SSI recipient, including assets from sources other than SSI benefits, are never considered when determining the eligibility of other family members.
	Example
	Mr. Kelly, a 19-year-old, lives with his disabled mother who receives SSI. Mr. Kelly is applying for MA under the Medically Needy (AR) standard. When determining Mr. Kelly's eligibility, none of his mother's assets are deemed to him.
TANF	See MA
GC	See MA
FS	Exclude the assets of a group member who receives SSI or TANF benefits.
	Example

A household consists of a mother (Ms. Munoz), her two children, and the children's disabled grandmother receiving SSI (the grandmother is under age 60 and purchases and prepares food with the rest of the family). Ms. Munoz works and does not receive TANF but applies for FS. Ms. Munoz and her two children have \$1,500 in countable assets. The grandmother, who receives SSI, has \$1,000 in countable assets. When determining whether the household meets the asset limit, the grandmother's \$1,000 in assets is not included because she receives SSI. Thus, the household has countable assets of \$1,500 and is below the \$2,000 asset limit.

TRANSFER OF ASSETS 1.28

MA	<p>AR: The assets of the group are determined at the point of application. Assets transferred prior to application are not considered.</p> <p>AX: See AR.</p> <p>AZ: <i>Elderly and Physically Disabled Home-And-Community-Based Services Waiver</i></p> <p>Persons who transfer assets for less than full market value may be subject to a penalty period. During this period, they are not eligible for Medicaid reimbursement for the following services:</p> <ul style="list-style-type: none"> • home health services; • home and community care for functionally disabled and elderly adults; • personal care services provided to persons who are not inpatients in medical institutions; and • any other long-term care services for which Medicaid payment may be withheld by law. <p>The penalty period is the lesser of the following:</p> <ul style="list-style-type: none"> • thirty months, or • the number of months obtained by dividing the uncompensated full market value of the transferred assets by the average monthly cost of nursing facility services in the District of Columbia. The penalty period shall include partial months that result from this calculation. <p>The average monthly cost of nursing home care in DC is \$7,149.</p> <p>The date of the transfer is used to determine the penalty period:</p> <ul style="list-style-type: none"> • Transfers before February 8, 2006 are used to determine a penalty period if they occurred during or after the 36th month preceding the first month for which the person was determined to be eligible for Medicaid. In this situation, the penalty period begins on the first day of the month in which the asset was transferred, even when this month is prior to the month of application for Medicaid. • Transfers on or after February 8, 2006 are used to determine a penalty period if they occurred during or after the 60th month preceding the first month for which the person was determined to be eligible for Medicaid. In this situation, the penalty period begins on the first day of whichever of these months is later: <ul style="list-style-type: none"> ○ the month during which the transfer took place, or ○ the first month for which the person was determined to be eligible for Medicaid. <p>When multiple assets are transferred for less than full market value on different dates, contact the ESA Policy Unit for instructions.</p>
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Example

Mr. Jones owns a parcel of land that has a full market value of \$40,000. On January 10, 2006, he sells the parcel of land to his son for \$2,000. He applies for Medicaid on September 15, 2006 under the Community Based Care Waiver program and is determined eligible effective September 1, 2006. If the average cost of private-pay nursing facility care in DC is \$3,000 per month, the penalty period is determined as follows:

- Full Market Value of Transferred Asset = \$40,000
- minus Compensation Received - \$2,000
- Uncompensated Value of Transferred Asset = \$38,000
- Uncompensated Value \$38,000
- divided by Monthly Private-Pay Nursing Cost ÷ \$3,000
- Penalty Period = 12 and 2/3 months

Mr. Jones is subject to a penalty period of twelve and 2/3 months that begins on January 1, 2006 and ends on in January, 2007. Therefore he is subject to restricted Medicaid reimbursement for the period September 1, 2006 into January, 2007. If the transfer had occurred on or after February 8, 2006, the penalty period would start on September 1, 2006 and end in September, 2007.

If a spouse transfers a countable asset for less than market value, the penalty period will be divided in half and equally apportioned to the spouses, if both spouses are eligible for Medicaid. If the status of one spouse changes and he/she is no longer subject to a penalty period, the remaining full penalty period must be served by the remaining spouse.

Penalties due to transfers of income streams will be handled as follows:

- for lump sum transfers, the lump sum value will be used to determine the penalty period;
- for transfers of individual payments from an income stream, separate penalties will be imposed for each payment, including partial months; and
- for transfers of the right to an income stream, the actuarial value of all payments transferred will be used to calculate the penalty period.

Transfers of assets or income streams between spouses are not subject to these penalties and should be handled under the provisions in Chapter 2: Impoverished Spouse in this Part.

Notification of Penalty Period and Undue Hardship Determination

When a person is subject to a penalty period of restricted Medicaid reimbursement, ESA will notify the applicant/recipient in writing.

The notice of the penalty period will also inform the individual of his/her opportunity to claim that the penalty would result in undue hardship and to present evidence backing that claim. The agency will determine that an undue hardship exists if:

- the individual has been threatened with eviction from a long-term care facility or other medical institution and has exhausted all legal methods to prevent the eviction, or the individual's medical provider has threatened to terminate home and community-based services based on a waiver; and
- the transferee is no longer in possession of the transferred asset, has no other assets of comparable value with which to pay the cost of care, and there is no organization, family member, or other individual able and willing to provide care.

Penalty periods will not be imposed if it creates undue hardship to the individual.

	<ul style="list-style-type: none"> SR (excluding SSI Recipients): See AR. For individuals in LTC facilities, however, the rules differ. See AZ: <i>Elderly and Physically Disabled Home-And-Community-Based Services Waiver</i> above and Section 2.13: Transfer of Assets Before and After MA Eligibility Determination in Part VII. <p>QM: See AR.</p> <p>MC: For both the 50-64 Demonstration Program and the DC HealthCare Alliance, assets are determined at the point of application. Transfers prior to the date of application are not considered.</p>
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TANF	Assets are determined at the point of application. Transfers prior to the date of application are not considered.												
GC	See TANF.												
FS	<p>At the time of application, the applicant household must provide information regarding any resources which any group member (or ineligible alien or disqualified person whose assets are being considered available to the group; see Chapter 2: Whose Assets are Counted in this Part) had transferred within the three-month period immediately preceding the date of application.</p> <p>Eligibility for the program will not be affected by a transfer of assets if:</p> <ul style="list-style-type: none"> the transfer would not otherwise affect eligibility (for example, excluded personal property such as furniture or money that when added to other non-exempt resources was less than allowable limits at the time of the transfer); assets sold or traded at, or near, fair market value do not result in disqualification; assets are transferred between members of the same group (including ineligible aliens or disqualified persons whose assets are being considered available to the group); or assets are transferred for reasons other than for qualifying or attempting to qualify for FS benefits such as, a parent placing funds in an inaccessible educational trust fund. <p>Groups which have transferred assets knowingly for the purpose of qualifying or attempting to qualify for FS are disqualified from participation in the program for up to one year from the date of the discovery of the transfer. This disqualification period will be applied if the assets are transferred knowingly in the three-month period prior to application or if they are transferred knowingly after the group is determined eligible for benefits. An example of the latter would be assets which the group acquires after being certified for benefits which are then transferred to prevent the group from exceeding the maximum asset limit.</p> <p>The length of the disqualification period is based on the amount by which the transferred resources, when added to other countable assets, exceed the allowable asset limits. The following table shows the period of disqualification by excess amount:</p> <table border="1"> <thead> <tr> <th>Amount in Excess of the Limit</th><th>Period of Disqualification</th></tr> </thead> <tbody> <tr> <td>\$0.00 - \$249.99</td><td>1 month</td></tr> <tr> <td>\$250.00 - \$999.99</td><td>3 months</td></tr> <tr> <td>\$1,000.00 - \$2,999.99</td><td>6 months</td></tr> <tr> <td>\$3,000.00 - \$4,999.99</td><td>9 months</td></tr> <tr> <td>\$5,000.00 and higher</td><td>12 months</td></tr> </tbody> </table> <p>In the event the SSR established that the applicant group knowingly transferred assets for the</p>	Amount in Excess of the Limit	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 and higher	12 months
Amount in Excess of the Limit	Period of Disqualification												
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\$1,000.00 - \$2,999.99	6 months												
\$3,000.00 - \$4,999.99	9 months												
\$5,000.00 and higher	12 months												

	purpose of qualifying or attempting to qualify for FS, the SSR will send the group a notice of denial explaining the reason for and length of the disqualification. The period of disqualification will begin in the month of application. If the group is participating at the time of the discovery of the transfer, the SSR will send the recipient Form F713: Disqualification which explains the reason for and length of the disqualification. The period of disqualification is effective with the first allotment issued after the adverse notice period has expired unless the group requested a fair hearing and continued benefits.
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TRUSTS 1.29

ALL	<p>A trust is a right of property created by one or more persons for the benefit of themselves or another person(s).</p> <p>The grantor is the person(s) who creates the trust, and the beneficiary is the person(s) for whose benefit the trust is created.</p> <p>The trustee is the person(s) to whom the grantor transfers the asset. The trustee has legal title to the asset and is responsible for managing the trust for the benefit of the beneficiary.</p> <p>The assets in the trust are the principal, which may be real property (such as a house, furniture, or land) or personal property (such as stocks, bonds, life insurance policies, or savings accounts).</p> <p>Divestment might result when the client (or, for MA, a client's spouse) uses his/her own assets to establish a trust in order to qualify for, remain eligible for, or increase the amount of program benefits.</p> <p>When a trust established by an asset group member is determined to be irrevocable, it is excluded. Irrevocable trusts and any funds in a trust or transferred to a trust are excluded from resources if they are inaccessible to the household.</p> <p>Excluded assets placed in a revocable trust are excluded. If an applicant placed assets, including a home, in a revocable trust, the value of the property in trust is excluded. The value of any non-excluded assets in the revocable trust is countable for the grantor.</p> <p>Any funds in a trust (including income produced by the trust) or funds transferred to a trust are considered unavailable if all of the following conditions apply:</p> <ul style="list-style-type: none"> • the trust arrangement is not likely to end during the benefit period; • no asset group member has the power to revoke the trust or change the name of the beneficiary during the benefit period; • the trustee administering the funds is; <ul style="list-style-type: none"> ○ a court or an institution, corporation, or organization not under the direction or ownership of any asset group member, or ○ an individual appointed by the court who is restricted by the court to use the funds solely for the benefit of the beneficiary; and • investments made on behalf of the trust do not directly involve or benefit any business or corporation under the control or direction of an asset group member; and • the funds in the irrevocable trust are; <ul style="list-style-type: none"> ○ established from the asset group's own funds and the trustee uses the funds solely to make investments on behalf of the trust or to pay the educational or medical
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	<p>expenses of the beneficiary, or</p> <ul style="list-style-type: none"> ○ established from funds of a person who is not a member of the asset group. <p>If a determination can be made that assets in a trust are totally available, the trust is a countable asset. If a determination of availability cannot be made by examining the trust document(s) or talking with the trustee, proceed as follows.</p> <ul style="list-style-type: none"> • If the trust is administered by Probate Court, the asset group must petition the court to make the trust available. The court decides availability. • Otherwise, refer the trust to the Office of the General Counsel to decide on availability.
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UNDERWOOD VS. HARRIS (HUD REIMBURSEMENTS) 1.30

ALL	Exclude retroactive tax and utility cost subsidy payments issued by the Department of Housing and Urban Development as a result of Underwood vs. Harris in the month received and the following month.
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VEHICLES 1.31

ALL	<p>A vehicle is any motorized vehicle reasonably associated with the function of transporting persons or goods. Common vehicles are passenger cars, trucks, motorcycles, motorbikes, jeeps, recreational vehicles (RVs), vans, and sports utility vehicles (SUVs). A boat may be considered as a vehicle if it is the group's primary means of transportation.</p> <p>Exclude entirely the value of all vehicles owned by or registered to members of the group, regardless of the number of vehicles the group has, the total value of the vehicles, the purpose for which the vehicles are used, or any encumbrances that may be in effect.</p> <p>A boat used for recreational purposes is not considered as a vehicle, or its value is countable as a non-liquid asset. Non-motorized or towable conveyances, such as trailers or campers are not considered vehicle. Their values are countable as non-liquid assets. See Section 1.4.2: Non-Liquid Assets (Equity Value) in this Chapter for information on determining the value of non-liquid assets.</p>
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CHAPTER 2 - WHOSE ASSETS ARE COUNTED

INTRODUCTION 2.1

Countable assets of all group members must be considered except when determining countable assets in FS. In the FS program, assets of individuals receiving SSI or TANF are not considered. In addition, in MA, TANF, GC, and FS, assets of certain people who are outside of the group, such as some relatives and/or disqualified group members, must be considered.

As noted in Chapter 1: Determining Countable Assets in this Part, some eligibility categories within MA do not impose an asset test. Specifically, children and pregnant women who meet the non-financial and income-eligibility criteria under 'Poverty Level Families and Children' within the AR program type and children, parents, and caretaker relatives eligible under the categories within the AX program type do not have to meet an asset test (see Section 2.2.2: ACEDS MA Program Types in Part I). In addition, groups categorically eligible for MA or FS do not have to meet the asset tests in those programs (see Chapter 12: Categorical Eligibility in [Part IV](#)).

This chapter relates only to the treatment of assets for programs or eligibility groups within programs that impose an asset test on applicants and recipients. Thus, in this chapter when the term 'ALL' is used to indicate the programs to which a particular policy apply, the term only includes those programs and eligibility categories within programs that apply an asset test. Similarly, in this chapter, the term 'MA' only includes those eligibility categories within Medicaid and D.C. Medical Charities that impose an asset test. For clarity, when MA is broken into subgroups in this chapter, a notation is made to indicate that the asset-related discussion does not apply to certain Medicaid categories.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Asset Groups	TANF: D.C. Code 3-205.10-11; 3-205.15; 3-205.19-19a; GC: See TANF and D.C. Code 3-205.5a	MA: 42 USC 1396a(a)(17), 1396 a(r)(2), 1396a(l); 42 CFR 435.601, 435.602, 435.840-.845 FS: 7 USC 2014(g), (i); 7 CFR 273.8; 273.11(c)
Deeming Assets	TANF: D.C. Code 3-205.22 GC: See TANF and D.C. Code 3-205-5a	FS: 7 CFR 273.11(c)

ASSET GROUPS 2.3

MA	Combine the assets of all group members. In addition, see Section 2.4: Deeming Assets in this Chapter.
TANF	Combine the assets of the following people to determine the group's countable assets: <ul style="list-style-type: none">• all members of the group, and• mandatory group members who are disqualified for:<ul style="list-style-type: none">○ alien status○ alien sponsorship status○ failure to comply with SSN requirements

	<ul style="list-style-type: none"> ○ IPV, or ○ failure to comply with third party liability requirements, and • a parent excluded from the group because s/he is married to an individual who is not related to the children in the group (see Section 5.7: Step-Parents in Part IV). <p>Do not consider the assets for any other person, including a step-parent.</p>
GC	Consider the assets of the group members only.
FS	<p>The asset group includes the following:</p> <ul style="list-style-type: none"> • FS group members, and • persons disqualified due to: <ul style="list-style-type: none"> ○ IPV ○ refusal to provide a SSN ○ alien status, or ○ TANF work program noncompliance.

DEEMING ASSETS 2.4

ALL	All or part of the assets of certain people outside an assistance unit is counted toward the asset limit. Those assets are 'deemed' available to a unit. Count assets deemed available to a unit even if the unit does not actually have access to the assets.
MA	<p>AR (excluding Poverty Level Families and Children and Foster Care/Department Wards/Adoption Assistance Recipients): If a child is in the AR unit, the parents' assets are deemed available to the child even if the parent is not in the unit. If an adult is in an AR unit, the assets of the adult's spouse are deemed available to the unit even if the spouse is not in the unit.</p> <p>If a parent is not in the assistance unit (that is, the parent will not receive MA if the group is found eligible), then the assets of the parent's spouse who is not also the parent of a child in the unit (that is, a step-parent) are not deemed available to the unit. A stepparent's assets are only considered when the children's parent is included in the unit. A stepparent's assets are not included even if the parent is included provisionally in the unit for purposes of determining eligibility of actual assistance group members.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Example</p> <p>Mrs. Belden applies for MA for her daughter, Tara. Mrs. Belden is included provisionally in the unit. However, no income from Mr. Belden, who is Tara's step-father, is deemed to Tara.</p> <p>If Mrs. Belden was also applying for MA, then Mr. Belden's income would be deemed to her and Tara.</p> </div> <p>AX: N/A</p> <p>SR (excluding SSI Recipients): The assets of relatives who have financial responsibility for members of an SR assistance unit are deemed available to the SR group. The following is a list of individuals</p>

	<p>considered to be financially responsible for SR group members:</p> <ul style="list-style-type: none"> • Spouse for his/her spouse when they are living in the same home, • Spouse for his/her spouse when both are applicants for or recipients of SSI and cease to live together, <p>(Note: If spouses cease to live together because of the institutionalization or hospitalization of one spouse, their assets are considered as available to each for the first 30 days of hospitalization/institutionalization. After this 30-day period, only the assets that are actually contributed by one spouse to the other are considered.)</p> <ul style="list-style-type: none"> • Parent for his/her unmarried child under age 21 when they are living in the same home. <p>If a child is separated from his/her parent(s) due to institutionalization or hospitalization, the parents' assets are considered available to the child for the first 30 days of the separation. After this period, only assets actually contributed by the parent(s) are considered.</p> <p>The deemed amounts of the spouse's assets are considered available to the assistance unit whether or not the assistance unit actually receives them.</p> <p>The amount of assets to be deemed is the spouse's total countable assets, determined in accordance with the SR policies governing countable and non-countable assets. If any assets are deemed, the size of the assistance unit is increased by one for the comparison of the assistance unit's total countable assets to the appropriate asset limitation. Assets are deemed whether or not any income is deemed.</p> <p>When a financially responsible parent is not a member of the SR assistance unit, the parent's assets must be deemed to the assistance unit. The deemed amounts of the parent's assets are considered available to the assistance unit whether or not the assistance unit actually receives them. The amount of assets to be deemed is the parent's total countable assets in excess of the SSI asset limitation for the number of parents involved. The parent's total countable assets are determined in accordance with the SR policies governing countable and non-countable assets. Assets are deemed whether or not any income is deemed.</p> <p>QM: See SR</p> <p>MC: See AR.</p>
TANF	Include all countable assets of a parent living in the home (except parents receiving SSI), whether or not the parent is in the unit, and all assets of an otherwise mandatory group member who is disqualified from receiving TANF. Disqualified individuals include those individuals excluded due to immigration status, failure to comply with program requirements, or an IPV.
GC	Do not deem any assets from non-group members.
FS	<p>Persons may live with the FS group or applicant group who are not group members. The resources of a non-group member are counted in their entirety if the non-group member purchases and prepares food with the FS household and has been disqualified or determined ineligible because of:</p> <ul style="list-style-type: none"> • an IPV • failure to participate in FSET • failure to provide an SSN, or

	<ul style="list-style-type: none"> immigration status <p>If the above persons do not purchase and prepare food with the FS household, the SSR should not include their resources.</p> <p>The SSR should not consider the resources of all other non-group members including an ineligible student, boarder, or individual disqualified for failure to comply with TANF work program requirements.</p>
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SPONSORED ALIEN ASSETS 2.5

ALL The assets of alien sponsors who have signed legally binding affidavits of support must be counted when determining the eligibility for federal means-tested benefits of households that contain immigrants that they sponsored. Only immigrants whose sponsors signed I-864 Affidavits on or after December 19, 1997 are subject to deeming of their sponsors' assets. If the sponsor signed an I-864 Affidavit, his or her assets and the assets of his or her current spouse must be deemed. Assistance units that include sponsored immigrants must still meet regular asset limits.

Determining the Amount of Deemable Assets 2.5.1

ALL	Any type of asset that is countable when determining an applicant's eligibility for a specific program is countable when controlled by the sponsor of a sponsored immigrant included in the applicant's assistance unit. When determining the value of a specific type of asset owned by the sponsor, use the regular rules for valuation of assets for the programs involved. The net value of the sponsor's assets minus program specific disregards is countable and should be added to the applicant's own assets when determining asset eligibility.
MA	N/A
TANF	Pending
GC	There is no requirement to deem assets from an alien sponsor to the immigrant.
IDA	There is no requirement to deem assets from an alien sponsor to the immigrant.
FS	Exclude up to \$1500 of the alien sponsor's total net assets. The value of assets exceeding \$1500 is deemed to the assistance unit that includes the sponsored immigrant. The value of the alien sponsor's assets is not affected by the size of the sponsor's family or their sponsorship of additional immigrants.

Chapter 3 - Determining Asset Eligibility

INTRODUCTION 3.1

At application, use the assets available on the date of application, unless the applicant's assets change before application disposition. Assets are available if an individual has both legal authority and actual ability to use them for self-support. When an individual owns an asset in whole or in part, presume the asset is wholly available unless the individual proves it is not (see Chapter 1: Determining Countable Assets in this Part). If excess assets exist at application, deny the application.

In on-going cases, use the assets the group expects to have in the payment month. The case should be closed for the month of ineligibility.

To be eligible for MA under some eligibility categories, groups must have countable assets below a specified level. Some categories do not, however, impose an asset test. Specifically, children and pregnant women who meet the non-financial and income-eligibility criteria under 'Poverty Level Families and Children' within the AR program type and children, parents, and caretaker relatives eligible under the categories within the AX program type do not have to meet an asset test (see Section 2.2.2: ACEDS MA Program Types in [Part I](#)). Also, FS and MA groups which are categorically eligible do not have to meet an asset test (see Chapter 12: Categorical Eligibility in Part IV).

This chapter relates only to the treatment of assets for programs or eligibility groups within programs that impose an asset test on applicants and recipients. Thus, in this chapter when the term 'ALL' is used to indicate the programs to which a particular policy apply, the term only includes those programs and eligibility categories within programs that apply an asset test. Similarly, in this chapter, the term 'MA' only includes those eligibility categories within Medicaid and D.C. Medical Charities that impose an asset test. For clarity, when MA is broken into subgroups in this chapter, a notation will be made to indicate that the asset-related discussion does not apply to certain categories.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Determining Asset Eligibility	D.C. Code 3-205.10-11; 3-217.5	MA: 42 USC 1396a(l), 1396a(r)(2); 1396u-1; 42 CFR 435.601, 435.840-.845
	GC: See TANF and D.C. Code 3-205.5a.	TANF: 45 CFR 265.10
		FS: 7 USC 2014(a),(g),(i); 7 CFR 273.8

ASSET LIMITS 3.3

ALL	A group is ineligible when the total value of its countable assets exceeds the asset limit for the pertinent program. Exhibit VI-1: Asset Limits shows the asset limits for each program by ACEDS program type and group.
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DETERMINING ASSET ELIGIBILITY/ASSET BUDGETING 3.4

MA	Groups which are categorically eligible do not have to meet the asset limits listed in Exhibit VI-1: Asset Limits. A group is categorically eligible if all eligible MA group members receive or are authorized to receive TANF, GC, and/or SSI benefits (see Section 12.3: Who is Categorically Eligible in Part IV).
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	For groups subject to an asset test, asset eligibility exists when the group's countable assets are below the applicable MA asset limit for at least one day during the month being tested.
TANF	<p>Determine asset eligibility using the group's assets for the payment month. The group is ineligible if its assets exceed the applicable limit during any day of the month (see Exhibit VI-1: Asset Limits).</p> <p>Example</p> <p>A group receiving TANF exceeded the asset limit on July 8 and reported it on July 15. The group verifies it no longer had excess assets on July 19. Recoup July TANF benefits. Continue August benefits because the group's assets are within the asset limit for that month. If the group had also been receiving MA, there would have been no break in MA coverage for the group.</p>
GC	See TANF.
FS	<p>Groups which are categorically eligible do not have to meet the asset limits listed in Exhibit VI-1: Asset Limits. A group is categorically eligible (see Section 12.3: Who is Categorically Eligible in Part IV) if:</p> <ul style="list-style-type: none"> all eligible FS group members receive or are authorized to receive TANF and/or SSI benefits, and no group member is disqualified for FS because of an IPV. <p>For all other applicant groups, use the asset group's countable assets on the interview date to determine the initial eligibility of the group.</p> <p>For on-going cases, if the asset limit is exceeded at any point during the month, the group is ineligible for that month (see Sections 6.3-6.4.4 in Part VIII for rules for when an overpayment should be charged and benefits recouped). The group may reapply and be determined eligible if the assets are again below the limit.</p>

DETERMINING RETROACTIVE ELIGIBILITY 3.5

MA	<p>AR: When a person applies for Medicaid, s/he can also apply for three months of retroactive eligibility. In order to determine retroactive eligibility, consider the applicant's resources during each month of the three-month period and compare it to the appropriate standard in Exhibit VI-1: Asset Limits.</p> <p>AX: N/A.</p> <p>SR: See AR.</p> <p>QM: QMBs, Q1-1s and Q1-2s are not eligible for retroactive eligibility. For SLIMBs and QDWIs, see</p> <p>AR.</p> <p>MC: N/A</p>
TANF	N/A
GC	N/A
FS	N/A

VERIFICATION 3.6

Requirements 3.6.1

MA	<p>AR – TANF Standard: If the applicant is categorically eligible, no verification is required. Otherwise, verify assets.</p> <p>AR – Foster Care/Department Ward/Adoption Assistance Recipient: All individuals in this group are categorically eligible for MA. Thus, assets do not need to be verified.</p> <p>AR – Medically Needy Standard: Do not require verification when assets exceed the limit based on the client's statement of value.</p> <p>Otherwise, require verification of the value of countable assets at application, redetermination, or when a change in assets is reported. Require verification of the ownership of all assets at application and when a change is reported.</p> <p>AR – Poverty Level Families and Children: N/A</p> <p>AX: N/A</p> <p>SR – SSI Recipients: If the applicant receives SSI, no verification is required.</p> <p>SR – Aged/Disabled: See AR – Medically Needy Standard.</p> <p>QM: See AR – Medically Needy Standard.</p> <p>MC: See AR – Medically Needy Standard.</p>
TANF	See AR – Medically Needy Standard.
GC	See AR – Medically Needy Standard.
FS	Require verification only if the information provided would affect group eligibility and is questionable (i.e., unclear, inconsistent, or incomplete).

Sources 3.6.2

ALL	<p>The following prove ownership and/or value of assets. The SSR must assist a client unable to obtain proof.</p> <p>Items verified by telephone contact must be documented in the case record.</p> <p>The following types of assets must be verified with one of the stated sources or its equivalent:</p> <ul style="list-style-type: none">• Burial Plots:<ul style="list-style-type: none">○ right of burial certificate○ written statement from cemetery.• Checking (or Credit Union Draft) Account:<ul style="list-style-type: none">○ monthly statement (examination of checkbook is not sufficient verification)○ current credit union statement○ if necessary, telephone contact with the institution to verify the current balance• Funeral Contract:<ul style="list-style-type: none">○ copy of contract○ contact with the funeral home
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	<ul style="list-style-type: none"> • Insurance: <ul style="list-style-type: none"> ○ policy document ○ written statement from insurance company or agent • Money Held By Another Person: <ul style="list-style-type: none"> ○ written statement from the person holding the money • Other Property: <ul style="list-style-type: none"> ○ written statement from an individual or agency in a position to know the value of the type of property ○ the client's records verifying ownership and/or current value • Real Estate: <ul style="list-style-type: none"> ○ deed, mortgage, purchase agreement, or contract ○ property tax record ○ attorney or court records ○ city records ○ written statement from real estate agent or financial institution ○ telephone contact with real estate agent or financial institution to verify property as non-saleable • Retroactive SSDI or SSI Payments: <ul style="list-style-type: none"> ○ SSDI/SSI award letter • Savings (or Credit Union Share) Account: <ul style="list-style-type: none"> ○ passbook with entry posted within the last 30 days ○ current (30 days) quarterly credit union statement ○ Christmas Club coupon book ○ written statement from financial institution ○ if necessary, telephone contact with the institution to verify the current balance • Savings Certificate: <ul style="list-style-type: none"> ○ certificate itself ○ written statement from financial institution • Stocks or Saving Bonds: <ul style="list-style-type: none"> ○ certificate or bonds themselves ○ written statement from the broker or company ○ information from local brokerage firms, banks, or newspapers about the current value of stock/bonds • Temporary Illness and Ability to Return to Work: <ul style="list-style-type: none"> ○ written statement from a M.D. or D.O. indicating the nature of the illness or whether the person will likely be able to return to a type of work for which the excluded asset is essential • Trust Fund: <ul style="list-style-type: none"> ○ information from the administrator or trustee of the estate or LTC facility ○ court or attorney records • Vehicle: <ul style="list-style-type: none"> ○ DMV inquiry ○ vehicle title, registration, or proof of insurance ○ blue book or NADA book wholesale (trade-in) value ○ written statement from one auto dealer (or junk dealer if appropriate) ○ loan statement ○ payment book (only to verify ownership and not value)
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EXHIBIT VI-1 ASSET LIMITS

Policy Category	Eligibility Criteria	Group	Size	Limit
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MA	AR - TANF Standard	Families receiving TANF	All	None - Categorically Eligible
		Families with children who meet TANF payment standard but do not receive TANF (categorically needy standards)	All	None, effective July 1, 2005
	AR – Poverty Level Families and Children	Pregnant women and children	All	None
	AR - Medically Needy Families and Children	Parents, caretaker relatives, and children (including 19 and 20-year-old children)	All	None, effective July 1, 2005
	Foster Care/Dependent Ward/Adoption Assistance Recipient		All	None - Categorically Eligible
	AX	Pregnant women, parents, caretaker relatives, and children	All	None
	SR	Individuals eligible based on age or disability (SSI recipients are categorically eligible)	1 2	\$4,000 \$6,000
	QM	QMB, SLIMB QWDI	1 2 1 2	None, effective November 1, 2008 \$4,000 \$6,000
	MC	DC HealthCare Alliance Childless Adult Medicaid	1 2	\$4,000 \$6,000 No resource test
TANF		Parents, caretakers, and children – no elderly household member Parents, caretakers, and children – at least one elderly group member	All All	\$2,000 \$3,000
GC		See TANF		
FS		Household with Categorical Eligibility or Expanded Categorical Eligibility Other households with no elderly or disabled member Other households that include an elderly or disabled member	All All All	None, effective March 1, 2010 \$2,000 \$3,250, effective October 1, 2011

Chapter 4 - Determining Countable Income

INTRODUCTION 4.1

Income is either countable or excluded. If income is countable, it is considered to be either earned or unearned income.

Countable income is income that is considered in some way when determining whether a group is income-eligible for program benefits. Some or all countable income may be disregarded in some step of the eligibility determination process (see Chapter 6: Income Disregards and Deductions in this Part).

Excluded income means that it is not considered in any amount or in any step of the eligibility determination process.

Income that is paid to a person for the specific benefit of another person is considered the income of the beneficiary rather than the payee.

Countable income is the gross amount unless otherwise noted and includes garnished amounts.

Count and budget all income received that is not specifically excluded. If a customer reports income that is not defined in the IMA Policy Manual, contact the IMA Policy Office for guidance.

Exhibit VI-2: Summary of Earned/Unearned Income summarizes how different types of income are to be treated.

LEGAL AUTHORITY 4.2

AREA/TOPIC	DISTRICT	FEDERAL
Countable and Excludable Income	TANF: D.C. Code 3-205.5-5a; 3-205.10-11; 3-205.13a; 3-205.19; 3-205.22, 3-205.33; 3-205.36-37; 3-205.52; 29 DCMR 5814 GC: See TANF and D.C. Code 3-205.5a.	MA: 42 USC 1396a(l), 1396u-1, 1396a(m), 1396a(r)(2); 42 CFR 435.601-.602, 435.811, 435.831 FS: 7 USC 2014(d)-(f), 2014(h), 2014(k)-(m); 7 CFR 273.9, 273.10(c), 273.11
Child Support	D.C. Code 3-205.19; 3-217.7-8; 29 DCMR 1707-1715 See TANF and D.C. Code 3-205.5a.	TANF: 45 CFR 264.30-31 FS: 7 USC 2014(d), 2014(e)(4); 7 CFR 273.9(b)(2)(iii), (b)(5)(ii), (d)(7)

ADOPTION SUBSIDY 4.3

ALL	<p>An adoption subsidy is a payment to the adopting parent(s) of an adopted child who would remain in foster care without the subsidy incentive. There are two types of adoption subsidies:</p> <ul style="list-style-type: none">• support subsidy: a payment for ongoing care and support of the child, and• medical subsidy: a payment for medical expenses due to a physical, mental, or emotional condition of the child.
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MA	Children receiving adoption subsidies are categorically eligible for Medicaid. The adoption subsidy is not counted as income for other family members.
TANF	Children receiving adoption subsidies are ineligible for TANF cash assistance. Exclude adoption subsidies when determining the eligibility of the group (which does not include the child receiving the adoption subsidy).
GC	A child receiving adoption subsidies must be excluded from the group. Exclude all adoption subsidies.
FS	Count support and subsidies as unearned income. Exclude a medical subsidy provided that it must be used for medical expenses.

AGENT ORANGE PAYMENTS 4.4

ALL	Exclude money received from the Agent Orange settlement fund or other similar funds or government programs. Veteran's benefits for service-connected disabilities due to Agent Orange exposure are unearned income (see Section 4.56: Veteran's Benefits-Non-Educational in this Chapter).
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AMERICORPS 4.5

ALL	There are three AmeriCorps programs. AmeriCorps State and National provides grants to community-based organizations who host part-time and full-time AmeriCorps volunteers. AmeriCorps NCCC (National Civilian Community Corps) is a fulltime residential service program that focuses on environmental issues and disaster relief. AmeriCorps VISTA provides non-profit organizations and public agencies with full-time AmeriCorps volunteers who focus on relieving poverty. Exclude all payments to AmeriCorps volunteers who participate through AmeriCorps State and National and AmeriCorps NCCC.
MA	Exclude payments to volunteers who participate through AmeriCorps VISTA.
TANF	See MA
FS	Exclude all AmeriCorps-VISTA payments, if the volunteer was receiving FS, TANF, IDA, GC, or SSI before joining VISTA. If the volunteer did not receive one of the means-tested benefits listed prior to joining VISTA, the AmeriCorps-VISTA payments are countable as earned income. To determine if the customer participates through VISTA, check the District of Columbia registry on the AmeriCorps website (www.americorps.gov).

CAPITAL GAINS/INTEREST/DIVIDENDS 4.6

ALL	The term "capital gains" describes the profit from the sale or transfer of capital assets used in a self-employment enterprise. The term 'capital assets' refers to real estate property, equipment, machinery, and other items or goods expected to last at least 12 months. Count as income the proceeds (net of commissions) from the sale of capital assets in the month received. Count the full amount of the income generated from the sale less commissions paid, even if only a lesser amount is taxed for federal income tax purposes.
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CHILD NUTRITION BENEFITS 4.7

MA	Exclude benefits received under the Child Nutrition Act of 1965 or the National School Lunch Act of 1946.
TANF	See MA.

GC	See MA.
FS	<p>If a child care provider is in the FS group, count payments received under the Child Nutrition Act of 1965 or the National School Lunch Act of 1946 minus the value of meals for the provider's own child(ren) during child care hours as gross self-employment earnings (see Section 4.40: Self-Employment in this Chapter).</p> <p>Self-employment earnings equal gross earnings minus business expenditures. While child nutrition payments are counted as self-employment earnings, the amount the provider spends to purchase and prepare the meals for the children in his/her care are subtracted from these gross earnings.</p>

CHILDREN'S EARNINGS 4.8

MA	AR: Do not count the earnings of an unmarried child who is living with a person who provides care or supervision and who is under 21.
TANF	For applicants/recipients, disregard all of the monthly gross earned income of each child who is a full-time student or a part-time student provided s/he is not employed full-time (see Section 4.4: School Attendance and Student Status in Part IV).
GC	See TANF
FS	<p>Do not count the earns income of any household member:</p> <ul style="list-style-type: none"> • who is under age 18, • who is an elementary or secondary school student (or is attending GED classes), and • who lives with a natural, adoptive, or step-parent or is under the parental control of a household member other than a parent. <p>This exclusion continues to apply during temporary interruptions in school attendance due to semester or vacation breaks, provided the child's enrollment will continue following the break.</p> <p>Do not count either the earned or unearned income of ineligible students except for income that the ineligible student actually contributes to group members.</p> <p>Exclude payments from on-the-job training programs under the Workforce Investment Act (WIA) of 1998 (successor to the Job Training Partnership Act) to persons under 19 years of age who are under the parental control of another adult group member, regardless of school attendance and/or enrollment. For the purpose of this provision, earnings include monies paid by the WIA and monies paid by employers.</p> <p>If you cannot determine the portion of a FS group's earning that is the child's, prorate the total among the earners and exclude one share as attributable to the child.</p> <p>In an ongoing case, begin counting the earnings in the month after the minor reaches his/her 18th birthday.</p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p>Example</p> <p>Darlene assists her parents in a street vendor business, and the profits are shared. Prorate the net earnings and exclude one-third as attributable to Darlene.</p> <p>Darlene turns 18 in the initial application month, count what she earns on or after her birthday.</p> </div>

CHILD SUPPORT 4.9

ALL	<p>Child support is the voluntary or court-ordered payment of money by the absent parent(s) for the living expense of his/her child(ren). Medical, dental, child care, and educational expenses can also be covered.</p> <p>Child support may be paid directly to the child's caretaker, paid through the court to the caretaker, or paid to the Child Support Services Division (CSSD.)</p> <p>CSED sends the family:</p> <ul style="list-style-type: none"> • all support collected, if the family never received TANF; • support received in excess of the amount that CSSD may legally retain if the family received AFDC/TANF in the past; or • up to the first \$150 in total child support collected by CSSD for the family, if the family currently receives TANF. This is called a "pass-through" payment. Pass-through payments started in April 2006, but families' eligibility for pass-throughs is retroactive to October 1, 2005.
MA	<p>AR: Count all child support received and any payments from CSSD as unearned income but exclude the first \$150 of total child support received by the group.</p> <p>AX: See AR.</p> <p>SR: Count two-thirds of child support received by an SR child as unearned income.</p> <p>QM: N/A</p> <p>MC: See AR.</p>
TANF	<p>TANF recipients must turn in all child support received directly from the absent parent or through the court to CSSD. CSSD is responsible for collecting all child support for the group. Treat child support received by a family as follows:</p> <ul style="list-style-type: none"> • For TANF <i>applicants</i>, count voluntary child support, any CSSD "excess" payments received by the group, and any CSSD pass-through payments as unearned income in determining potential eligibility, and disregard the first \$150. Next, if the group meets the income test, determine the amount of the grant by including child support in excess of \$150 as countable income for TANF for two months. This allows CSSD time to begin retaining support (see Chapter 2: Child Support Requirements in Part V.) • For TANF recipients who begin receiving child support, count the child support as income for the first two months that can be affected, after timely and adequate notice, unless CSSD begins retaining support before the two-month period ends. During this two-month period, disregard the first \$150 in total child support received by the group. After two months, the SSR should assume that CSSD is collecting the group's child support. If the SSR learns that this is not the case, the SSR should inform CSSD that child support is being paid to the family. The SSR may continue to count the child support received after the second month only when the adult has failed to cooperate with CSSD requirements with respect to the child on whose behalf support is being received and the group is subject to a child support sanction. <p>When the non-custodial parent pays support for two consecutive months that exceeds the TANF grant by more than \$150, the TANF grant is terminated. If in a single month, CSSD provides and</p>

	excess payment (i.e., the child support payment is greater than the amount of the TANF grant), the payment is counted as unearned income.
GC	Count all child support received by the group as unearned income. If the group receives CSSD payments, count the payments as unearned income.
FS	<p>Exclude all child support payments that are required to be transferred to CSSD in accordance with an official agreement between CSSD and the assistance group or caretaker.</p> <p>Count as unearned income:</p> <ul style="list-style-type: none"> all child support payments received by the assistance group when there is no official agreement with CSSD; the first \$150 in child support payments to the assistance group that is not counted for TANF or MA; and any CSSD child support payments to the assistance group or caretaker, including pass-through payments.

Disability Benefits 4.10

ALL	<p>Refer to the specific sections in this chapter for policies regarding:</p> <ul style="list-style-type: none"> Social Security Benefits – Old Age, Survivors, Disability Insurance (OASDI) (Section 4.42). Rehabilitation Services Administration payments (Section 4.35). Railroad Retirement Board Benefits (Section 4.31). Supplemental Security Income (SSI) (Section 4.46). Worker's Compensation (Section 4.57). <p>Other disability benefits are benefits paid to workers absent from work due to illness or injury. These are usually paid through the person's or employer's insurance. Regular wages received while on sick leave are not considered disability benefits but rather are treated as earnings.</p>
MA	Count as unearned income the gross benefit minus any monthly or monthly averaged premium the person must pay to continue receiving the benefits.
TANF	See MA.
GC	See MA.
FS	Count the benefits paid through the person's or employer's insurance as earnings if the person is still considered an employee and plans to continue to work and the employer contributes part of the premium or benefit. Count the benefits as unearned income if either of these conditions is not met.

Domestic Volunteer Service Payments 4.11

ALL	<p>Payments are made to volunteers in programs under Title I, Title II, and Title III of the Domestic Volunteer Service Act of 1973 (P.L. 93-113).</p> <p>Title I programs include:</p> <ul style="list-style-type: none"> VISTA, University Year for Action, and Urban Crime Prevention Program. <p>Title II programs include:</p>
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	<ul style="list-style-type: none"> • Foster Grandparents, • Senior Companion, • Retired Senior Volunteer Program (RSVP), and • Older American Volunteer Program. <p>Title III programs include Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE).</p>
MA	Exclude payments from all Title I, II, and III programs.
TANF	See MA.
GC	See MA.
FS	<p>Count Title I payments as earnings if the person was not receiving FS, TANF, GC, or SSI (in any jurisdiction) when s/he joined the volunteer program. Deduct from the countable amount any portion that is a reimbursement.</p> <p>Exclude Title II payments.</p> <p>Count Title III payments from SCORE and ACE as earned income.</p>

DONATIONS 4.12

ALL	<p>A donation is money received from a private, nonprofit organization based on need as determined by the contributing agency. Exclude non-recurring cash gifts of \$600 or less quarterly, not to exceed \$600 per household per quarter, and small payments paid to women who receive pre-natal and well-baby care. Count any remainder as unearned income. Donations which are reimbursements may be excludable above the \$600 limit (See Section 4.36: Reimbursements in this Chapter.)</p>
	<p>Example</p> <p>Ms. Allen and her two children receive \$379 in TANF benefits each month. The family also receives FS. In September, Ms. Allen's church provided money to needy families to help buy school clothes for the new school year. The family's TANF and FS benefits are just enough for her to pay rent, buy food, and needed personal items. She does not have enough to buy school clothes each September and relies on donations and hand-me-downs from family and neighbors to clothe her children. The church gives her \$200 to buy clothes. Since this is under \$600, the income is excluded. If Ms. Allen receives other donations within a three month period that includes September, the amount of donations over \$600 would be counted as unearned income.</p>

EARNED INCOME TAX CREDIT (EITC) 4.13

ALL	Exclude EITC payments. They are not considered income (see Section 1.8: Earned Income Tax Credit (EITC) in this Part). (Note that an individual's paycheck may reflect both his/her earnings and an advance payment of the EITC. This advance payment must be excluded when determining countable earnings.)
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EDUCATIONAL BENEFITS 4.14

Department of Education - Bureau of Indian Affairs Benefits 4.14.1

ALL	Exclude in their entirety educational benefits from the Department of Education's Bureau of Indian Affairs.
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Department of Education - Perkins Vocational and Applied Technology Education Act 4.14.2

ALL	Educational benefits provided under the Perkins Vocational and Applied Technology Education Act of 1998 differs from the Perkins loans under Title IV of the Higher Education Act. Exclude all Perkins benefits.
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Department of Education - Title IV Benefits 4.14.3

ALL	Exclude in their entirety. Title IV benefits include: <ul style="list-style-type: none"> • Basic Education Opportunity Grants (BEOG or PELL Grants) • Presidential Access Scholarships (Super PELL Grants) • Supplemental Educational Opportunity Grants (SEOG) • State Student Incentives Grants (SSIG) • Stafford Loan (formerly GSL) • Supplemental Loans for Students (formerly ALAS) • PLUS Loans for parents • Bureau of Indian Affairs Grant Program • Perkins Loans (formerly NDSL) • Federal Work Study Funds (not all federal work study comes under Title IV of the Higher Education Act (see Section 4.14.5: Other Educational Benefits in this Chapter) • Upward Bound (TRIO Grants) • Robert E. McNair Post-Baccalaureate Achievement • Robert C. Byrd Honors Scholarship Program • College Assistance Migrant Program (CAMP) • High School Equivalency Program (HEP) • National Early Intervention Scholarship and Partnership Program.
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Other Department of Education Benefits 4.14.4

ALL	Exclude in their entirety any other grant or loan that is made or insured by the Department of Education (DOE).
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ENERGY ASSISTANCE 4.15

ALL	Exclude all benefits from the Low Income Home Energy Assistance Program (LIHEAP).
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FOSTER CARE PAYMENTS 4.16

MA	A child receiving foster care is categorically eligible for MA and should be his/her own group (see Section 1.3: Mandatory Group Members in Part IV). A child receiving foster care should not be part of a group consisting of members of the foster family. Exclude all payments related to foster care from the income of the group consisting of members of the foster family.
TANF	Children receiving foster care payments are ineligible for TANF cash assistance. Exclude foster care payments when determining the eligibility of group members.
GC	Children receiving foster care payments are ineligible for GC.
FS	The group may choose to include or exclude a foster child whose foster parent is a group member (see Section 1.3: Mandatory Group Members in Part IV). If the child is in the group, count all

	payments as unearned income. If the child is not in the group, exclude all payments.
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GRANDPARENTS CAREGIVERS SUBSIDY 4.16a

ALL	Effective March 1, 2006, certain relatives who care for a child may receive subsidies under the Grandparent Caregivers Pilot Program. The only relatives who qualify are grandparents, great-grandparents, great-aunts, and great-uncles, or persons who were grandparents, great-grandparents, great-aunts, or great-uncles of a child before adopting the child.
MA	Exclude Grandparent subsidies from countable income for both the child and caretaker relative.
TANF	See MA.
FS	Count Grandparent subsidies as unearned income.

GUARDIANSHIP SUBSIDY 4.16b

MA	A child whose legal guardian is receiving a guardianship subsidy is categorically eligible for MA and should be his/her own group.
TANF	Children, whose legal guardian receives a guardianship subsidy for the children, are ineligible for TANF cash assistance. Exclude guardianship subsidy payments when determining the eligibility of group members.
GC	Children, whose legal guardian receives a guardianship subsidy for the children, are ineligible for GC cash assistance.
FS	The group may choose to include or exclude a child whose caretaker is a group member who receives a Guardianship Subsidy (see Section 1.3: Mandatory Group Members in Part IV). If the child is in the group, count all payments as unearned income. If the child is not in the group, exclude all payments.

HOUSING ASSISTANCE 4.17

ALL	<p>No form of housing assistance provided by the federal or District of Columbia governments or a non-profit organization which provides assistance directly to a landlord is counted as income when determining eligibility. Exclude housing assistance provided under any of the following laws:</p> <ul style="list-style-type: none"> • Title II of the Uniform Relocation and Real Property Acquisition Act of 1970. • Experimental Housing Allowance Program made under Annual Contribution Contracts entered into prior to January 1, 1975 under Section 23 of the U.S. Housing Act of 1937, as amended. • U.S. Housing Act of 1937. • Relocation payments made to displaced persons under Section 216 of P.L. 91-6469, the Uniform Relocation Assistance, and Real Property Acquisition Policies Act of 1970. • National Housing Act of 1949. • Section 101 of the Housing and Urban Development Act of 1965. <p>Many housing programs operate under the last four laws, including the Rent Supplement (Section 8) Program, 236 Program, and 235 Program.</p>
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INCENTIVE PAYMENTS FOR PRENATAL AND WELL-BABY CARE 4.18

ALL	Exclude all payments from the Better Babies program.
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INCOME TAX REFUNDS 4.19

ALL	Exclude federal, state, and local income tax refunds, including refunds from the EITC (see Section
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	1.14: Income Tax Refunds in this Part). For information on how the EITC is treated in determining countable assets, see Section 1.8: Earned Income Tax Credit (EITC) in this Part.
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INCONSEQUENTIAL INCOME 4.20

ALL	<p>Inconsequential income is income that is unpredictable and irregular and has no appreciable effect on continuing need, such as occasional cash gifts or yard sale proceeds. If the income is a donation from a private entity, see Section 4.12: Donations in this Chapter.</p> <p>Exclude a group member's first \$50 of inconsequential income per month. If it is received by the entire group, it may be prorated among the members.</p>
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IN-KIND BENEFITS 4.21

ALL	<p>In-Kind Benefits are goods or services provided to a person, group, or family in a form other than money. This includes meals, food, clothing, shelter, etc.</p> <p>Exclude all In-Kind Benefits from countable income.</p>
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JAPANESE/ALEUT PAYMENTS 4.22

ALL	Exclude payments made under P.L. 100-383 to U.S. citizens of Japanese ancestry, resident Japanese aliens, and Andaluets.
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JURY DUTY 4.23

MA	Exclude all jury duty compensation.
TANF	See MA
FS	Exclude the amount of jury duty compensation that is a reimbursement for transportation. Count the remainder as earned income.

LEASE OF NATURAL RESOURCES 4.24

ALL	Count money received for leasing rights to natural resources as unearned income. This includes storage rights. Examples of natural resources include timber, gravel, oil, and natural gas.
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LOANS (NON-EDUCATIONAL) 4.25

ALL	<p>Exclude any loans including U.S. Repatriation Assistance if the group declares an intent to repay it. Otherwise, count it as unearned income.</p> <p>In a questionable circumstance or when private loans are recurring, the SSR may require a signed statement by the lender regarding the repayment obligation.</p>
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LUMP SUMS AND ACCRUED BENEFITS 4.26

ALL	<p>A lump sum is defined as a non-recurring one-time only payment which excludes money that applicants receive through the DPP. Some examples of lump sums are the following:</p> <ul style="list-style-type: none"> • winnings, • inheritances, • insurance settlements, and • retroactive payments of SSDI, VA benefits <p>An accrued benefit is a one-time payment intended to cover a retroactive period of time or to cover a future period of time but not the current payment period.</p>
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	Certain lump sums and accrued benefits are assets, not income (for policy on lump sums which count as assets see Section 1.21: Non-Recurring Lump Sums and Accrued Benefits in this Part).
MA	Exclude lump sum or accrued benefit payment in the month received. In future month, consider them as a resource (See Section 1.21: Non-Recurring Lump Sums and Accrued Benefits in this Part.)
TANF	<p>Lumps sums and accrued benefits not considered as assets are windfall income.</p> <p>Count a windfall, except an excluded portion, as unearned income. Exclude any lump sum or portion of a lump sum earmarked and used for the purpose for which it is paid. Examples include money for overdue medical bills resulting from accidents, funeral and burial costs, replacement or repair of damaged property, and so on.</p> <p>See Section 8.4.1: Future Ineligibility Based on Receipt of a Lump Sum or Accrued Benefit in this Part for an explanation of how to calculate a period of ineligibility due to receipt of a windfall.</p>
GC	See TANF.
FS	Count as unearned income the portion of non-recurring benefits which are not considered assets and are intended to cover needs in the current month.

MILITARY PAY AND ALLOTMENTS 4.27

ALL	<p>Pay received by active duty members of the Armed Forces is counted as earned income.</p> <p>Allotments are payments for the support of dependents of military personnel, usually initiated by the service member.</p> <p>Count the gross payment amount of an allotment as unearned income.</p> <p>It is possible to obtain an involuntary allotment if a court or administrative order for support exists and payments are past due.</p> <p>CSSD staff can provide information on involuntary allotments.</p> <p>Allotments are considered child support if paid by the parent of a child in the group (see Section 4.9: Child Support in this Chapter).</p>
FS	<p><i>Combat Duty Pay and Allotments</i></p> <p>Additional pay received by members of the Armed Forces who are deployed to a combat area is not countable income. To determine the amount of income to count, follow the following procedures:</p> <ul style="list-style-type: none"> • For FS groups that included a member of the Armed Forces prior to the member being deployed to a combat area; <ul style="list-style-type: none"> ○ Determine the member's take home military pay prior to deployment, and ○ During deployment count the lesser of these two amounts: <ul style="list-style-type: none"> ▪ The prior take-home pay, or ▪ The current allotment or direct deposit from the deployed serviceman. • For FS groups that received an allotment or direct deposit from a member of the Armed Forces prior to the serviceperson's deployment to a combat area, but the serviceperson was not a part of the FS group: <ul style="list-style-type: none"> ○ Determine how much income the absent serviceperson was making available to the FS group prior to deployment to a combat area, and ○ During deployment, count the lesser of these two amounts: <ul style="list-style-type: none"> ▪ The prior available income, or

- The current allotment/direct deposit.

“Combat areas” are defined as any of the following:

- Effective January, 1991:
 - Bahrain,
 - Gulf of Aden,
 - Gulf of Oman,
 - Iraq,
 - Kuwait,
 - Persian Gulf,
 - Qatar,
 - Oman,
 - Red Sea,
 - Saudi Arabia, and
 - United Arab Emirates.
- Effective November, 1995:
 - Bosnia,
 - Herzegovina,
 - Croatia, and
 - Macedonia
- Effective March 24, 1999:
 - The Federal Republic of Yugoslavia (Serbia/Montenegro),
 - Albania,
 - The Adriatic Sea, and
 - The Ionian Sea north of the 39th parallel
- Turkey effective January 1, 2003
- Israel from January 1 through July 31, 2003
- Eastern Mediterranean from March 19 through July 31, 2003
- Jordan effective March 19, 2003
- Egypt effective March 19 through April 20, 2003
- Afghanistan, effective September 19, 2001
- Pakistan effective September 19, 2001
- Tajikistan effective September 19, 2001
- Jordan effective September 19, 2001
- Incirlik AFB Turkey effective September 19, 2001
- Kyrgyzstan effective October 1, 2001
- Uzbekistan effective October 1, 2001
- Philippines (only troops w/orders that reference OEF) effective January 9, 2002
- Yemen effective April 10, 2002
- Djibouti effective July 1, 2002

MONEY RECEIVED BY A THIRD PARTY 4.28

ALL	Money received by a third party for a group member is counted as income only if the group member actually receives the money from the third party. If the money is not turned over to the group member, then it is not counted. The Department may require the group member to take steps to obtain money not turned over to the group.
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MONEY RECEIVED ON BEHALF OF OTHERS 4.29

ALL	Money received as a third party on behalf of others is not counted as income received if it does not
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	reflect the needs of the person receiving the money.
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NATIVE AMERICAN PAYMENTS 4.30

ALL	Exclude payments made to Native Americans under the following laws: <ul style="list-style-type: none">• P.L. 92-203: Tax exempt portions of payments under the Alaska Native Claims Settlement Act.• P.L. 92-254: Judgment funds to members of the Blackfeet Tribe of Blackfeet Reservation, Montana and Gros Ventre Tribe of the Fort Belknap Reservation, Montana• P.L. 93-134: Funds distributed to members of Indian tribes and the purchases made with such funds.• P.L. 93-531: Relocation assistance payments to members of the Hopi and Navajo Tribes• P.L. 94-114: Receipts distributed to members of certain Indian tribes.• P.L. 96-420: Payments to the Passamaquoddy Tribe and the Penobscot Nation.• P.L. 94-433: Payments received by the confederated tribes and Bands of Yakima Indian Nation Apache Tribe of the Mescalero Reservation.• P.L. 95-531: Relocation payments to the Navajo and Hopi Tribes.• P.L. 94-189: Payments received under the Sac and Fox Indian agreements.• P.L. 94-540: Judgment funds to the Grand River Band of Ottawa Indians.• 23 U.S.C.A. 460d - 460d-31: Financial assistance to Navajo and Hopi Indians.
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NUTRITION PAYMENTS 4.31

ALL	Exclude benefits issued through the following programs: <ul style="list-style-type: none">• Women, Infants, and Children (WIC)• Title VII Nutrition Program for the Elderly of the Older Americans Act of 1965• Child Nutrition Act of 1965• National School Lunch Act of 1946• Food Stamps Act of 1977• Section 32 of P.L. 94-320• Section 416 of the Agriculture Act of 1949
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PURSUIT OF POTENTIAL INCOME 4.32

ALL	Individuals or groups applying for or receiving Medical Assistance, TANF, Food Stamps, or GC cannot be required to apply for or pursue other benefits or income sources (except with respect to child support-related requirements in the TANF and Medicaid programs). IMA staff should strongly encourage customers who appear potentially eligible for other benefits such as SSI, unemployment compensation, or Social Security retirement/disability benefits to apply for these benefits. IMA must not, however, require groups to apply for these benefits as a condition of eligibility for benefits.
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RADIATION EXPOSURE 4.33

ALL	Exclude payments made under the Radiation Exposure Compensation Act of 1990, P.L. 101-425, as compensation for exposure to radiation.
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RAILROAD RETIREMENT BOARD BENEFITS 4.34

ALL	Count as unearned income the gross benefit amount before any deductions. The amount of the check may be less than the gross amount due to a Medicare deduction.
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REHABILITATION SERVICES ADMINISTRATION PAYMENTS 4.35

MA	Exclude these payments.
TANF	See MA.
GC	See MA.
FS	Count as unearned income the payment minus any portion that is a reimbursement as defined in Section 4.36: Reimbursements in this Chapter.

REIMBURSEMENTS 4.36

MA	<p>A reimbursement is money received from an organization or person outside the group to cover past, current, or future expenses.</p> <p>Exclude a reimbursement if it is:</p> <ul style="list-style-type: none">• for actual expenses,• earmarked to cover those expenses, and• paid or documented separately from any other payment such as wages. <p>Count as income any reimbursement which does not meet the three conditions above or is not listed below (see also Section 4.12: Donations in this Chapter).</p> <p>The following are examples of types of reimbursements that should be excluded:</p> <ul style="list-style-type: none">• payments to volunteers for expenses incurred in their work,;• related expense allowances (separate from wages or incentive payments) from an agency or organization to participate in the training program such as travel, per diem, uniforms, and transportation to and from the training or job site;• any payments to cover medical care from sources such as Medicare, private insurance, or government programs;• refunds of Medicare Part A or Part B premiums as a result of Department Buy-In;• Title XX payments for services other than normal living expenses such as adult chore services;• compensation awarded for a particular use such as Workers' Compensation which must be used for training expenses or disaster related loans and grants;• transportation reimbursement payments for jury duty;• stipends provided to participants of the FSET or TANF work program; and• any work-related reimbursement.
TANF	See MA.
GC	See MA.
FS	<p>See MA. In addition, count as unearned income any portion of a reimbursement that:</p> <ul style="list-style-type: none">• covers normal living expenses (rent, food eaten at home, clothing, utilities, and so on),• is not intended and used for a specifically identified expense, or• exceeds the actual expense as indicated by the provider or FS group. <p>Multiple expenses covered by a payment need not be separately identified or counted unless a normal living expense is included.</p>

RENTAL INCOME 4.37

MA	<p>Rental income is money a person (landlord) receives for allowing another person (renter) to use the landlord's property. It includes income from a lease.</p> <p>Income from real estate is earned income if the individual manages the property by collecting rental payments and by providing services to maintain the property.</p> <p>Income from real estate is unearned income if the property is managed by a rental company or other party and the individual has no specific responsibility for the management of the property.</p> <p>Expenses related to the maintenance of the property - including a mortgage payment on the property - must be subtracted from gross rental income.</p>
TANF	See MA.
GC	See MA.
FS	<p>Rental income is money a person (landlord) receives for allowing another person (renter) to use the landlord's property. It includes income from a lease.</p> <p>Treatment of rental payments as earned or unearned income depends on the amount of time the landlord actively engages in managing the rental unit(s):</p> <ul style="list-style-type: none">• Under 20 hours per week: the monthly rental payments are countable unearned income• 20 hours per week: the monthly rental payments are countable self-employment earnings and the 20 percent earned income disregard is allowed (see Section 6.3: Income Disregards and Deductions in this Part). <p>Active management of the rental unit(s) includes, but is not limited to, the following:</p> <ul style="list-style-type: none">• advertising,• showings to prospective renters,• accounting activities,• inspections, and• cleaning, repairing, and redecorating <p>Whether earned or unearned, count the gross rental income minus expenses.</p>

Room and Board 4.37.1

ALL	Income from boarders includes all direct payments to the household for the boarder's room, meals, and utilities.
MA	Count gross boarder income minus expenses as earned income (boarder income is treated as other self-employment income). Expenses deducted must be clearly associated with the rental unit (i.e., expenses the group would incur as a result of housing a boarder). Shelter expenses paid directly by the boarders to a third party are not considered income to the household.
	Example
	A boarder is charged \$100 per month and must pay the household's electric bill of \$50 per month. The boarder pays the electric company directly. The amount considered income from the boarder is \$100 per month.
TANF	See MA.
GC	See MA.

FS	A boarder is charged \$100 per month and must pay the household's electric bill of \$50 per month. The boarder pays the electric company directly. The amount considered income from the boarder is \$100 per month.
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Roomers 4.37.2

ALL	<p>A roomer is a person who is not a group member but lives with the group for lodging and does not eat with or pay the group for food. A roomer lives in someone else's home and pays rent to the owner.</p> <p>Count the gross rental payment minus expenses. Such expenses must be clearly associated with the rental unit (i.e., expenses the group would incur as a result of renting out part of its home). If expenses are greater than the gross rental payment, then reduce gross rental payment to zero.</p> <p>Roomer income is considered unearned income if no services are provided. Roomer income is considered earned if services are provided.</p>
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Roommates - Shared Living Arrangements 4.37.3

MA	<p>Shared living arrangements occur when separate households occupy the same dwelling and neither household owns the dwelling. Roommates jointly pay for the cost of housing to an outside entity. The households have an agreement to divide common costs such as rent, utilities, and so on. Payments made by one household to the other under the agreement will not be counted as income since the receiving party acts primarily as a courier in taking the payments to the landlord or utility company.</p> <p>Exclude cash payments given to the assistance group by a non-group household member for his/her share of the household expense. The household that pays the landlord does not have the money counted as income.</p>
TANF	See MA.
GC	See MA.
FS	When determining the shelter costs of a group that shares housing with a roommate, only that portion of the rent and utilities paid by the group are counted.

RETIREMENT INCOME 4.38

ALL	<p>Retirement benefits include annuities and federal, state, or local government and private pensions. Count the gross amount as unearned income except exclude any portion that is diverted to an ex-spouse as a requirement of the divorce decree or settlement.</p>
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RETROACTIVE BENEFITS 4.39

ALL	Retroactive benefits are treated as assets or lump sums (see Section 1.21: Non-Recurring Lump Sums and Accrued Benefits in this Part and Section 4.26: Lump Sums and Accrued Benefits in this Chapter).
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SELF-EMPLOYMENT 4.40

MA	<p>An employer is responsible for withholding Social Security and income taxes from an employee's earnings. To determine whether a person has an employer or is self-employed, determine whether the person is responsible for withholding taxes from his/her earnings. A person who runs his/her own business is self-employed. This includes selling goods or direct services (such as a boarding house).</p> <p>Countable earnings from self-employment equal the total proceeds minus allowable expenses of producing the income. If the allowable expenses exceed the total proceeds, the amount of the loss cannot offset any other income.</p>
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Example

Ms. Rodell operates a retail store. Total proceeds for the month are \$3,200. Allowable expenses for the mortgage interest, property tax, insurance, utilities, and goods purchased at wholesale total \$3,800. The \$600 deficit cannot be used to offset any other group income.

Deduct the following allowable expenses from the gross proceeds of self-employment income:

- identifiable expenses of labor, stock, and raw material;
- payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods;
- interest, but not the principal, on loans for equipment, real estate, or income-producing property;
- insurance premiums on equipment, real estate, and other income-producing property.
- taxes paid on income-producing property;
- transportation costs while on the job (such as fuel) but not routine transportation to and from work;
- cost of goods sold, supplies, and materials;
- advertising costs;
- accounting and legal fees;
- professional licensing fees and union dues if necessary to practice a profession or trade;
- costs of maintaining a place of business such as rent and utilities. If a business is operated in the home, only the utilities associated with the business may be allowed and not the utilities incurred by the home; and.
- any other identifiable expenses of producing self-employment income.

Do not deduct the following from self-employment income:

- depreciation on equipment, real estate, or other capital investments;
- a net loss from a previous period;
- federal, state, and local income taxes;
- personal entertainment or other personal business expenses;
- money set aside for retirement;
- the purchase of capital equipment; or
- any amount that exceeds the payment a household receives from a boarder for lodgings and meals.

While allowable expenses (which are subtracted from gross self-employment income) cannot generally exceed proceeds, allowable expenses of farming can exceed the proceeds if the actual or anticipated proceeds are \$1,000 or more for the year. This farm loss can then be deducted from other income as follows:

- Deduct the net farm loss from any other self-employment income of the group.
- If a net farming loss remains, deduct it from any other countable income of the group, after the earned income deduction has been applied, and
- The previous year's tax return is the usual basis to calculate the farming income. Prorate the loss over the year to determine a monthly amount to apply to the other income sources.

Generally, self-employment income is annualized, also known as averaged, over a 12-month period. This is done by dividing annual self-employment income by 12. This is done to "smooth" the income fluctuations of self-employed individuals.

	<p>If, however, the annualized amount does not accurately reflect the household's actual circumstances because the household has experienced a significant increase or decrease in business, the SSR shall calculate the self-employment income based on anticipated earnings.</p> <p>Self-employment income which is intended to meet the household's needs for only part of the year shall be averaged over the period of time the income is intended to cover.</p> <p>If a household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise shall be averaged over the period of time the business has been in operation and the monthly amount projected for the coming year.</p> <p>Example 1</p> <p>Ms. Davis and her two children apply for FS and MA. Ms. Davis is a self-employed caterer. Last year, she earned \$8,000 over the course of the year, though her earnings were uneven during the year. She earned more during the Christmas season and in the early summer due to catering several weddings. Ms. Davis expects her annual income to equal her earnings last year. The household's self-employment earnings should be averaged over a 12-month period. Her average monthly earnings are \$667 per month. This figure should be used as the group's monthly income to determine eligibility for FS and MA. If Ms. Davis recently got a contract to provide catering services each week to a new client and, therefore, the prior year's earnings do not reflect her current circumstances, they cannot be used to determine her eligibility or benefits. If she anticipates earning \$2,400 over the next three months, average her expected earnings over the next three months and use this figure (\$800) to determine eligibility and compute benefits.</p> <p>Example 2</p> <p>Mr. Roberts is self-employed during June, July, and August selling ice cream as a street vendor, but he intends to work at another job (not as a self-employed person) the remainder of the year. The self-employment income from the ice cream business should be averaged over the three months in which it is earned.</p>
TANF	See MA.
GC	See MA.
FS	<p>See MA. In addition, persons paying a reasonable amount for room and board, as discussed in Section 1.13: Living Situations in Part IV are excluded from the group when determining the group's eligibility and benefit level. The income from boarders includes all direct payments to the group for room and meals, including contributions to the group's shelter expenses. Shelter expenses paid directly by boarders to someone outside the group are not counted as income to the group.</p> <p>Example</p> <p>Ms. Thomas pays the group's utility bills directly to the provider. This is not considered as income to the group or as part of the group's shelter cost.</p>

SENIOR COMMUNITY SERVICE EMPLOYMENT 4.41

ALL	Income earned under this program established by Title V of the Older Americans Act of 1965 is excluded.
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SOCIAL SECURITY BENEFITS - OLD AGE, SURVIVORS, DISABILITY INSURANCE (OASDI) 4.42

ALL	OASDI benefits or Social Security benefits (also called Title II benefits) are available to retired and disabled persons, their dependents, and the survivors of deceased workers. If monies are deducted from Social Security benefits to repay a previous overpayment, the amount recouped from the
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	benefits does not count as income, and must be excluded. Monies deducted for Medicare premiums must be included as income. Social Security benefits are counted as unearned income.
MA	AR: N/A AX: N/A SR: If an applicant or recipient of Medicaid under the SR program type received Title II benefits, the amount of the Title II COLA is disregarded for the first three months of the calendar year, from January 1 - March 31. The Title II COLAs are disregarded to ensure that individuals do not become ineligible for MA based on the annual inflation adjustment to Title II benefits because this adjustment is made several months prior to the adjustment in the federal poverty level used to determine SR eligibility. QM: See SR. MC: N/A
FS	If the Social Security Administration is deducting Medicare premiums from an OASDI benefit, count the gross amount of OASDI as income. Consider the Medicare premiums as a medical expense (see Section 6.3: Income Disregards and Deductions in this Part.)

SPOUSE SUPPORT 4.43

ALL	Spouse support is a legally enforceable obligation for the financial support of a spouse or former spouse. It is usually in the form of maintenance payments during a marital separation or alimony following a divorce decree.
MA	Count as unearned income the cash amount of any spouse support received.
TANF	See MA.
GC	See MA.
FS	See MA. Also, count as unearned income spouse support that is otherwise payable to the family that is diverted to a creditor for a household expense. Do not include as unearned income support payments, whether court-ordered or voluntary, to a third-party that is not otherwise payable to the family. Example 1 A court orders Mr. Patel to pay \$400 per month to Sonali, his former spouse. Mr. Patel and Sonali agree that he will pay \$350 per month directly to Sonali's landlord. The entire \$400 counts as unearned income for Sonali. Example 2 A court orders Mr. Leigh to pay \$300 per month to Janet, his former spouse, and another \$200 per month directly to a bank to repay a car loan. Only \$300 counts as unearned income for Janet.

STRIKE BENEFITS 4.44

MA	Count the gross amount of compensation for persons on strike as unearned income.
TANF	See MA.
GC	See MA.
FS	See Chapter 11: Strikers in Part IV for the treatment of strikers in the FS Program. If the striker's income on the day before the strike is higher than the striker's income while on strike, the individual's income on the day before the strike is used to determine FS eligibility and benefits. Thus, if the individual's income was higher prior to the strike, strike benefits will be excluded in lieu of using the individual's higher pre-strike income.

	<p>Example</p> <p>Mr. Holland is part of a FS household. Mr. Holland participates in a strike and reports his loss of earnings to his SSR. Prior to the strike, Mr. Holland earned \$900 per month and had no other income. His strike benefits equal \$450, and he now has no other income. Because Mr. Holland's pre-strike income exceeds his income from strike benefits, the SSR continues to use his pre-strike income to calculate FS benefits.</p>
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SUPPLEMENTAL SECURITY INCOME (SSI) 4.45

MA	<p>Groups comprised solely of SSI and TANF recipients are categorically eligible for MA benefits and therefore do not have to meet the income or asset tests (see Section 12.3: Who is Categorically Eligible in Part IV). The SSI payments are not considered income for any other group members living with an SSI recipient.</p>
	<p>Example</p> <p>Ms. Meltzer lives with her two daughters, Lisa and Shayna. Shayna receives SSI. When determining MA eligibility for Ms. Meltzer and Lisa, Shayna's SSI income is excluded. Shayna is in her own MA group.</p>
TANF	<p>An SSI recipient cannot be included in the group.</p> <p>Exclude money given to the group by an SSI recipient who:</p> <ul style="list-style-type: none"> • Would be a mandatory group member were it not for the receipt of SSI. • Is the step-parent of a dependent child. • Is the parent of a minor caretaker relative. • Is a spouse of group member. • Is another person who is giving the money for shared living expenses. <p>Count any money actually given to the group by other SSI recipients.</p>
GC	See TANF.
FS	<p>Count as unearned income the gross amount minus any monies deposited in a 'Plan to Achieve Self Support' (PASS) account or that were deducted to repay an overpayment. Monies deducted to repay an overpayment are never countable as income. Groups comprised solely of SSI and TANF recipients are categorically eligible (see Section 12.3: Who is Categorically Eligible in Part IV) for FS benefits and, therefore, do not have to meet the gross income test or asset test.</p>

TANF BENEFITS 4.46

MA	Count as unearned income TANF benefits from another state and the District of Columbia, even if erroneously issued by the state or District of Columbia.
TANF	Count as unearned income TANF benefits from another state, even if erroneously issued by the state.
GC	A person receiving TANF from the District of Columbia must be excluded from the group. Count as unearned income benefits from another state, even if erroneously issued by that state.
FS	<p>Count as unearned income the amount of TANF benefits received. If the group's TANF benefit is reduced due to the imposition of a sanction for failing to comply with TANF program rules, include the sanctioned amount as unearned income even though it is not received by the group. For information regarding TANF recoupments, see Section 4.48: TANF Recoupments in this Chapter.</p> <p>Do not count as unearned income the amount of an initial TANF benefit intended to cover a previous month. This retroactive benefit is counted as a resource in the month received. However, FS groups in</p>

	which all members receive TANF or SSI are categorically eligible for FS (see Section 12.3: Who is Categorically Eligible in Part IV) and do not have to meet the income or asset test. Furthermore, in FS groups consisting of some TANF/SSI recipients and some non-recipients, the assets of TANF recipients are excluded when determining the group's countable assets.
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TANF RECOUPMENTS 4.47

MA	Exclude any benefits retained by an agency (such as a portion of a benefit that is retained to compensate for a prior overpayment; see Section 6.4.2: Recoupment in Part VIII) when determining countable income.
TANF	Count as unearned income TANF benefits from another state, even if erroneously issued by the state.
GC	See MA.
FS	If a group is subject to recoupment because of an overpayment, the recouped amount counts as unearned income if the TANF overpayment was the result of a fraud or intentional program violation. If the overpayment was not the result of fraud or an intentional program violation, the amount recouped does not count as income.

TANF SANCTIONED AMOUNTS 4.48

MA	N/A
TANF	N/A
GC	N/A
FS	<p>If a group is sanctioned for failing to comply with a TANF requirement (work, child support), then FS cannot increase as a result of that sanction. Thus, the sanction amount is counted as unearned income, as if it were received.</p> <p>If a TANF grant is terminated due to a sanction for failure to comply with a TANF requirement, the TANF grant must continue to be counted as income for FS until any one of the following occurs:</p> <ul style="list-style-type: none"> • The family reapplies for TANF and is approved; • The agency determines that the family is not eligible for TANF for some reason other than the work sanction. For example, the parent starts a job and the earnings would make them over-income for TANF; or • The TANF benefit counts against Food Stamps for one year following the TANF termination. Food Stamp eligibility must then be recalculated without the TANF benefit. <p>Example 1</p> <p>Adrian Taylor receives TANF for herself. Her only child, Hester, receives SSI. Ms. Taylor is not needed in the home to take care of Hester. Ms. Taylor fails to comply with TANF work requirements and a sanction is recommended. Since Ms. Taylor is the only person in the TANF grant, the entire TANF grant is terminated. The TANF grant must continue to be counted as FS income for one year, unless Ms. Taylor reapplies for TANF and is approved or it is determined that she is not eligible for TANF for some reason other than the TANF sanction.</p>

TANF UNDERPAYMENTS 4.49

ALL	Retroactive payments are excluded.
GC	N/A
FS	Retroactive TANF payments are treated as an asset, but the assets of TANF recipients do not count against a household's asset limit. An individual receiving a retroactive TANF payment is considered a TANF recipient in the month in which the payment is received (see Section 1.21: Non-Recurring Lump

	Sums and Accrued Benefits in this Part).
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TRAINING INCOME 4.50

ALL	Training income includes payments from WIA, TANF work program, Rehabilitation Services, and other programs such as the Youth Build Program and AmeriCorps.
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Workforce Investment Act (WIA) of 1998 4.50.1

ALL	<p>WIA (successor to the Job Training Partnership Act (JTPA) programs provide various training opportunities including:</p> <ul style="list-style-type: none"> • classroom training, • vocational education, • on-the-job training, • work experience, • youth programs including the Summer Youth Employment and Training Program, • programs for dislocated workers, migrant farm workers, Native Americans, and veterans, and • Job Corps <p>If an adult participant in an on-the-job training or work experience program receives wages, the wages should be counted as earned income (for treatment of children's earnings, see Section 4.8: Children's Earnings in this Chapter.) Training participants often also receive unearned income such as a training allowance. Exclude training allowances intended to defray participation-related expenses.</p>
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Training Expense Allowances/Stipends 4.50.2

ALL	<p>A training expense allowance is defined as a payment to a trainee to reimburse them for expenses which they incur solely because of their participation in a countable work activity. These expenses usually include transportation costs, dependent care costs, uniforms, minor supplies, and so on.</p> <p>These payments are excluded.</p>
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Work/Training Incentive Allowances 4.50.3

ALL	These are training allowances from vocational and rehabilitative programs recognized by federal, state, or local government such as the work incentive program.
MA	These payments are excluded.
TANF	See MA.
GC	See MA.
FS	Count these allowances as earnings to the extent that they are not reimbursements or are not intended to defray participation expenses.

TRUST FUNDS 4.51

ALL	<p>A trust is a right of property created by one or more persons for the benefit of themselves or another person(s).</p> <p>The grantor is the person(s) who creates the trust, and the beneficiary is the person(s) for whose benefit the trust is created.</p> <p>The trustee is the person(s) to whom the grantor transfers the trust. The trustee has legal title to the trust and is responsible for managing the trust for the benefit of the beneficiary.</p>
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	When a trust established by a group member is determined to be irrevocable, it is excluded. Irrevocable trusts and any funds in a trust or transferred to a trust are excluded from resources if they are inaccessible to the household.
MA	Count as unearned income any amount actually distributed to a person from a trust fund.
TANF	See MA.
GC	See MA.
FS	Count as unearned income the income available to the group from a trust fund that is not counted as a resource. "Income available" means income received by the group from the trust fund and dividend income the group has the option of receiving.

UNEMPLOYMENT COMPENSATION BENEFITS (UCB) 4.52

ALL	UCB benefits are available through the D.C. DOES and comparable agencies in other states.
	Count the gross benefits amount as unearned income.

UTILITY ALLOWANCES RECEIVED THROUGH HOUSING PROGRAMS 4.53

ALL	Exclude any utility allowance received through a housing program.
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VENDOR PAYMENTS 4.54

ALL	<p>A vendor payment is a payment directly to a creditor or service provider on behalf of the group. The vendor payment can be made by an agency, organization, or person who is not a member of the participating group.</p> <p>See also Section 4.12: Donations in this Chapter.</p> <p>Count the payment as earned or unearned if it is from income the group is legally entitled to receive; otherwise exclude it. Examples of countable payments include:</p> <ul style="list-style-type: none"> • TANF rental/vendor payments, • wages withheld and forwarded to a creditor to comply with a garnishment order, and • child support withheld from a group member's income and forwarded directly to the court (the FS program allows a group to deduct child support payments made to individuals outside the group; see Section 6.3: Income Disregards and Deductions in this Part) <p>Examples of excluded payments include:</p> <ul style="list-style-type: none"> • a rent or mortgage payment by a friend who is not in the group; • payments by a government agency directly to a child care provider; • payments by Medicare, Medicaid, or other health insurer directly to a medical provider (see also Section 4.36: Reimbursements in this Chapter); and • payments made by government programs directly to providers of services or goods.
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VETERAN'S BENEFITS - NON-EDUCATIONAL 4.55

ALL	<p>Current and former U.S. Armed Services personnel and their families receive retirement, disability, survivors, and need-based benefits.</p> <p>Count as unearned income the gross veteran's benefits, excluding the following:</p>
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	<ul style="list-style-type: none"> • reimbursements for maintenance of uniforms; and • Aid and Attendance payments (A&A). A&A payments are given separately from regular VA pensions in order to reimburse veterans for certain medical expenses. <p><i>Compensated Work Therapy (CWT)</i></p> <p>Certain veterans receive pay to do work as part of a vocational rehabilitation program. These payments are countable as earned income.</p> <p><i>Vocational Rehabilitation Subsistence Allowance</i></p> <p>Veterans who are in vocational rehabilitation may receive a subsistence allowance while they are in training programs. These payments are countable as unearned income.</p>
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WAGES 4.56

MA	<p>Wages are the pay an employee receives from another person or organization in return for work performed.</p> <p>Count an employee's wages/salary, tips, wages/salary paid during a vacation or illness, and severance pay as earnings.</p> <p>Count a wage advance as earnings when the employer actually pays it. It should not be recounted when the money is withheld to offset the advance.</p> <p>If an individual receives advance EITC payments in his/her paycheck, this amount should be subtracted from earnings (see Section 1.8: Earned Income Tax Credit (EITC) in this Part).</p>
TANF	See MA.
GC	See MA.
FS	<p>See MA. Also, count wages held at the employee's request. However, wages held as a general practice by the employer are not income until actually paid.</p> <p>If a person is on strike, count the higher of:</p> <ul style="list-style-type: none"> • his/her earnings if not on strike, or • his/her current earnings. <p>Chapter 11: Strikers in Part IV defines a striker for FS purposes and Section 4.45: Strike Benefits in this Chapter explains how to treat strike benefits.</p>

WORKER'S COMPENSATION 4.57

ALL	Worker's Compensation consists of benefits to persons with a job-related illness or injury and to survivors of a deceased worker. There are two types of workers compensation - temporary and permanent.
MA	Temporary Worker's Compensation is treated as earned income. Permanent Worker's Compensation is treated as unearned income.
TANF	See MA.
GC	N/A
FS	All Workers' Compensation - temporary and permanent - is treated as unearned income.

WORK STUDY 4.58

ALL	Exclude all payments given to students through a work-study program.
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Exhibit VI-2 Summary of Earned/Unearned Income

Type of Income	Earned	Unearned	Either Depends on Circumstance
Adoption Subsidy	X		
Agent Orange Payments		X	
AmeriCorps	not counted		
Capital Gains/Interest/Dividends		X	
Child Foster Care Payments			X
Child Nutrition Payments	X		
Child Support		X	
Children's Earnings	not generally counted		
Disability Benefits			X
Domestic Volunteer Service Act Payments	X		
Donations		X	
Earned Income Tax Credit	not counted		
Educational Benefits: DOE Bureau of Indian Affairs Benefits not counted	not counted		
Educational Benefits: DOE Title IV Benefits not counted	not counted		
Educational Benefits: DOE Perkins Vocational and Applied Technology Education Act		X	
Energy Assistance		X	
Housing Assistance not counted	not counted		
Incentive Payments for Prenatal & Well-Baby Care not counted	not counted		
In-Kind Benefits			X
Income Tax Refunds not counted	not counted		
Inconsequential Income		X	
Japanese/Andaluet Payments not counted	not counted		
Jury Duty	X		
Lease of Natural Resources		X	
Loans (Non-Educational)		X	
Lump Sums and Accrued Benefits		X	
Military Allotments		X	
Money Received By a Third Party		X	
Money Received on Behalf of Others	not counted		
Native American Payments	not counted		

Type of Income	Earned	Unearned	Either Depends on Circumstance
Nutrition Payments	not counted		
Other Education Benefits			X
Other DOE Education Benefits			X
Pursuit of Potential Income			X
Radiation Exposure not counted	not counted		
Railroad Retirement Board Benefits		X	
Rehabilitation Service Administration Payments		X	
Reimbursements	not generally counted		
Rental Income			X
Retirement Income		X	
Retroactive Benefits		X	
Returned Benefits		X	
Room and Board			X
Roomers			X
Roommates - Shared Living Arrangement	not counted		
Self-Employment	X		
Senior Community Service Employment	X		
Social Security - Old Age, Survivors, and Disability Insurance (OASDI)		X	
Spina Bifida		X	
Spouse Support		X	
Strike Benefits		X	
Supplemental Security Income (SSI)		X	
TANF Benefits		X	
TANF Recoupments	When counted, treated as unearned income		
TANF Sanctioned Amounts		X	
TANF Underpayments		X	
Training Income: Training Expense Allowances/Stipends	not counted		
Trust Funds		X	
Unemployment Compensation Benefits (UCB)		X	
Utility Allowance Received Through a Housing Program	not counted		
Vendor Payments			X
Veteran's Benefits - Non-educational		X	
Wages	X		
Work/Training Incentive Allowances	X		
Workers Compensation			X
Workforce Investment Act - Wages	X		

Chapter 5 - Whose Income is Counted

INTRODUCTION 5.1

This chapter explains whose income is counted when determining the countable income of an assistance group. See Chapter 1: Group Composition in Part IV for policy on determining who is in the assistance group.

LEGAL AUTHORITY 5.2

AREA/TOPIC	DISTRICT	FEDERAL
Deeming Income	TANF: D.C. Code 4-205.10-11; 4-205.15; 4-205.22	MA: 42 USC, 1396a(a)(17), 1396a(m), 1396a(r)(2); 1396u-1; 42 CFR 435.601, 435.602, 435.811, 435.831
	GC: See TANF and D.C. Code 4-205.5a	FS: 7 USC 2014(d)-(f),(h),(k)-(m); 7 CFR 273.11

INCOME OF GROUP MEMBERS 5.3

ALL	All countable income recorded by individuals in the assistance unit are counted when determining income eligibility and, in the case of TANF, GC, and FS, the level of benefits for which the group is eligible. As is discussed in Section 4.8: Children's Earnings in this Part, the earnings of children including in some cases, children through age 21, are generally excluded. That is, such earnings are not considered countable income. See Section 4.8: Children's Earnings in this Part for more information.
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DEEMING INCOME 5.4

ALL	Deemed income is money that is considered available to the group even though it is received by someone outside the group. Deemed income is counted as income even if the group does not receive it. Count the actual amount given if it exceeds the deemed amount. Verification requirements for individuals whose income is deemed are the same as for any other group member (see Section 8.6: Verification in this Part).
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Alien Sponsor's Income 5.4.1

ALL	The income of alien sponsors who have signed legally binding affidavits of support must be counted when determining the eligibility for federal means-tested benefits of households that contain immigrants that they sponsored. Only immigrants whose sponsors signed I-864 Affidavits on or after December 19, 1997 are subject to deeming of their sponsor's income. If the sponsor signed an I-864 Affidavit his or her income and the income of his or her current spouse must be deemed. <i>Determining the Amount of Deemable Income</i> Any kind of income that is countable when determining an applicant's eligibility for a specific program is countable when received by the sponsor of a sponsored immigrant who is included in the assistance unit. The sponsor's income for the eligibility period should be verified using standard procedures for determining gross income (see Chapter 8: Determining Income Eligibility in this Part). The sponsor's monthly income minus applicable program disregards is countable and should be added to the applicant's own income when determining the unit's income eligibility
MA	N/A

TANF	Pending
GC	There is no requirement to deem income from an alien sponsor to the immigrant.
IDA	There is no requirement to deem income from an alien sponsor to the immigrant.

Disqualified Group Members' Income 5.4.2

MA	<p>Count the earned and unearned income of a mandatory group member who is disqualified as if s/he were in the group. Individuals may be disqualified for:</p> <ul style="list-style-type: none"> • alien status, • failure to comply (without good cause) with SSN requirements, • non-cooperation (without good cause) with medical support requirements, • non-cooperation (without good cause) with third party liability (TPL) cooperation requirements, or • IPV <p>These individuals are 'included provisionally' when determining the eligibility of group members. Including the individual provisionally directs ACEDS to use the income-eligibility limit for a group size equal to the assistance unit group plus the disqualified members.</p>
TANF	<p>Count the earned and unearned income of a mandatory group member who is disqualified as if s/he were in the group. Individuals may be disqualified for:</p> <ul style="list-style-type: none"> • alien status, • failure to comply (without good cause) with SSN requirements, • failure to comply (without good cause) with work requirements, or • IPV <p>Individuals ineligible based on these reasons are coded 'DI' in ACEDS.</p>
GC	N/A
FS	<p>There are two groups of disqualified individuals:</p> <ul style="list-style-type: none"> • individuals disqualified for an IPV or sanction for failing to comply with FSET requirements, and • individuals disqualified for failing to provide an SSN or for being an ineligible alien. <p>All of the earned and unearned income of an individual disqualified from the household for an IPV or a work-related sanction is deemed in its entirety to the remaining household members. The earned and unearned income of individuals disqualified based on failing to provide an SSN or for being an ineligible alien <i>minus</i> a pro-rata share of the income is deemed to the remaining household members.</p> <p>Allowable deductions (earned income, medical, dependent care, and excess shelter; see Section 6.3: Income Disregards and Deductions in this Part) are based on the circumstances of all group members and those individuals disqualified from the group but whose income is deemed to the group.</p> <p>To compute the group's prorated share, the SSR will:</p> <ul style="list-style-type: none"> • Determine the ineligible person's monthly gross earned and unearned income (disregard all income that would be exempt for group members) • Divide the amount of the ineligible person's gross income by the number of group members,

	<p>including any ineligible person whose income can be counted</p> <ul style="list-style-type: none"> Disregard the disqualified group members' share of the prorated income.
	<p>Example 1</p> <p>Ms. Sanchez, an ineligible alien, applies for FS for her two citizen children. Ms. Sanchez earns \$300 per month and has no other income. The FS group consisting of her two children is attributed \$200 of Ms. Sanchez's earned income. The group is eligible for an earned income deduction based on having \$200 of earned income.</p>
	<p>Example 2</p> <p>The Nicholson's, a childless couple, receive FS. Both are required to participate in the FSET program. Ms. Nicholson fails to comply with the requirement and is excluded from the FS unit. She receives \$400 per month in alimony from her prior marriage. The full \$400 is counted as income to the FS unit which now consists only of Mr. Nicholson.</p>
	<p>In cases in which a pro-rata share of income is deemed to the assistance group, that portion of the household's child support payment and dependent care expenses which are either paid by or billed to the ineligible members shall be divided evenly among the household members -- including the ineligible members. All but the ineligible members' share is counted as a deductible child support payment or dependent care expense for the remaining household members. In like manner, shelter expenses shall also be divided evenly among the household members and shall be prorated for the eligible household members, except that utility allowances are not prorated.</p>
	<p>Example 1</p> <p>Ms. Jimenez lives with her two children. Ms. Jimenez is ineligible for FS based on her immigration status, but her children are eligible. The household pays \$300 per month for rent. When determining the excess shelter deduction for the FS group (consisting of the two children), the group's rent should be considered \$200 - Ms. Jimenez's pro-rata share of the rental costs is not considered a shelter cost to the FS group. If the group is eligible for a utility allowance, the group would receive the entire utility allowance without proration.</p>
	<p>Example 2</p> <p>The Jackson's and their two children apply for FS. Mrs. Jackson is an ineligible alien. The Jacksons operate a small janitorial business with gross earnings estimated at \$240 per month. Mrs. Jackson's actual share cannot be determined so two prorated share computations must be made:</p> <ol style="list-style-type: none"> Mrs. Jackson's earnings are determined by dividing \$240 by two. Her gross income is \$120. Mrs. Jackson's gross income of \$120 is prorated among all four members (\$30 each) and \$90 is deemed as earned income available to the eligible group members. Total earned income is \$90 deemed from Mrs. Jackson + \$120 earned by Mr. Jackson= \$210.

Parental Income 5.4.3

MA	AR: The income of a natural or adoptive parent who lives with the child is always considered when determining a child's eligibility for MA, unless the parent receives SSI. The way in which the income
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is considered depends on whether the child is a minor parent.

If a child who is not a minor parent is applying for MA and the parent is not applying for him/herself (or the parent is disqualified from participating in MA), the parent is 'included provisionally' in the group. By including the parent provisionally, the parent's income is treated as if the parent were also applying for MA and the income eligibility criteria used are based on a group size including the parent.

If a minor parent applies for MA for him/herself and the minor parent's child and the minor parent lives with his/her parent(s), the income of the minor parent's parent(s), that is, the child's grandparents, is deemed to the minor parent and his/her children using a deeming formula. The income of the minor parent's parent(s) is deemed if the minor parent is not in the unit because s/he is disqualified from participating from Medicaid. If, however, the minor parent is not included in the group because s/he chooses not to be in the unit (rather than having been disqualified), the minor parent is included provisionally in the unit and no income from the minor parent's parent(s) is deemed to the group.

To determine the amount of income to deem to a minor parent from the minor parent's parent(s), perform the following calculations:

- Determine net monthly income.
 - Calculate gross earned income of each deemed parent.
 - Calculate the Work Expense Deduction. The Work Expense Deduction equals the lesser of \$90 or the deemed parent's earnings. Each deemed parent receives a Work Expense Deduction.
 - Calculate net earned income by subtracting the Work Expense Deduction from gross earned income.
 - Calculate gross unearned income.
 - Calculate net monthly income by adding gross unearned income and net earned income.
- Determine allowable expenses.
 - Determine alimony and child support paid by the deemed parent(s) to individuals outside the household.
 - Determine 100 percent of the Standard of Assistance (see Exhibit VI-4: TANF Standard of Assistance & Payment Levels) for a family size that includes the deemed parent(s) and other dependents in the household not included in the MA assistance group.
 - Add the above. This equals total allowable expenses.
- Calculate Deemed Income.
 - $\text{Deemed Income} = \text{Net Monthly Income} - \text{Total Allowable Expenses}$.

Example

The Avers live with their 12-year-old son Sam, their 16-year-old daughter Sue, and Sue's baby Todd. Both Mr. and Mrs. Avery work. Mr. Avery earns \$1,200 per month, and Ms. Avery earns \$1,300 per month. They have no other income. Neither Mr. nor Mrs. Avery pay alimony or child support to individuals outside the home. Sue applies for MA for herself and her baby. A portion of the Avery's income must be deemed to the MA group consisting of Sue and her baby.

- Determine net monthly income
 - Gross earned income = \$2,500 per month
 - Work Expense Deduction (\$90 for each employed adult) = \$180
 - Net earned income = \$2,500 - \$180 = \$2,320
- Determine allowable expenses
 - Alimony and Child Support = \$0
 - 100 percent of Standard of Assistance for a family of 3 (Mr. and Mrs. Avery and Sam) = \$712
 - Total = \$712
- Calculate deemed income
 - Deemed Income = Net Monthly Income – Total Allowable Expenses \$2,320 – \$712 = \$1,608

AX: See AR.

MA

SR: Deeming applies only when the child lives with one or both parents and the parents are not receiving TANF or SSI. If a child is separated from his/her parents due to hospitalization or institutionalization, parental income is considered available for the first 30 days of the separation. After this 30-day period, consider only the income of the parent(s) that is actually contributed or provided to the child.

Both earned and unearned income of the parent(s) is deemed to the assistance unit as unearned income. When determining the amount of income to deem to the assistance unit, consider the earned and unearned income of both parents together. That is, both parents do not receive their own earned income disregard. When determining how much earnings to disregard, apply the disregards to the sum of the parents earned income. The amount of income to be deemed is determined as follows:

- Determine total gross earned and unearned income.

Include all earned and unearned income that would be countable if the income were received by an SR group member except income that is:

- received from a public assistance program such as TANF;
- used by any cash assistance program to determine the amount of that program's benefits to the spouse or someone else;
- received as a tax refund on income;
- used to fulfill an approved PASS;
- used to comply with terms of court-ordered support;
- received as income in-kind in the form of support and maintenance; or
- received through a federal, state, or local government program for purchasing chore, attendant, or homemaker services for the SR individual.

If the deemed parent(s) have no countable earned and unearned income using the above policies, no income is deemed from the parent(s) to the group and no further steps are required.

- Determine deduction based on the presence of non-SR children in the household and subtract deduction from gross unearned and earned income.

If children who are not part of the SR group and who are not in their own SR group are in the household, a portion of the deemed parent(s) income is deducted to reflect that some of the deemed parent(s) income is used to meet the needs of those other children in the household.

Deduct an amount for each child (or step-child) who is living in the home, is under age 18, or who is under 21 and a student, and is not a member of a SR assistance unit. The amount allocated for each child is the difference between the SSI benefit for a couple and for an individual. If a child has income of his/her own, the amount allocated for that child is reduced by the total countable income of the child. If a child is a member of TANF or GC unit, no amount is allocated for that child.

The amount allocated for each child is deducted first from the parents' unearned income. Any remainder is deducted from the parents' earned income.

If after subtracting the deduction based on the presence of children not in an SR group the deemed parent(s) have no remaining countable income, no further calculations are needed. No income is deemed to the assistance group. If, however, some earned and/or unearned income remains, then proceed.

Example

Ms. Daly lives with her two children, Kate and Belinda. Belinda is disabled and is applying for SR Medicaid. Ms. Daly earns \$800 per month and does not receive TANF. A portion of Ms. Daly's income must be deemed to Belinda. The amount of income deducted based on the presence of Kate, the non-disabled child, is \$257, which is the difference between the SSI benefit level for a couple and an individual.

- Deduction based on parent being an alien's sponsor.

Deduct an amount for each alien sponsored by the parent. The amount allocated for each alien is the difference between the SSI benefit level for a couple and an individual. If an alien has income of his/her own, the amount allocated for that alien is reduced by the total countable income of the alien.

The amount allocated for each alien is deducted first from the parents' unearned income. Any remainder is deducted from the parents' earned income.

- Determine the deduction for parental needs and subtract from remaining earned and unearned income.

A portion of the deemed parents' income is deducted based on the need for the income to be used to meet the parent's needs.

If the parents' remaining income (after the deduction based on the presence of children not in a SR group) is earned income only:

- Subtract \$20 from the deemed parents' earned income;
- Subtract \$65 from the deemed parents' earned income;
- Subtract one-half of all remaining earnings; and
- Subtract an amount equal to the SSI income standard for an individual if there is only one parent residing in the home, or subtract an amount equal to the SSI income standard (SSI income plus the D.C. supplement) for a couple if there are two parents residing in the home.

If the parents' remaining income is unearned income only:

- Subtract \$20 from the deemed parents' unearned income; and
- Subtract an amount equal to the SSI income standard for an individual if there is only one parent residing in the home, or subtract an amount equal to the SSI income standard for a couple if there are two parents residing in the home.

If the parents' remaining income includes both earned and unearned income:

- Subtract \$20 from the deemed parents' unearned income;
- Subtract any remaining portion of the \$20 from earned income (that is, if the deemed parents' unearned income was less than \$20 then the remainder of the \$20 deduction is then applied to earned income);
- Subtract \$65 from earned income;
- Subtract one-half of the remaining earned income;
- Add the remaining unearned income to the remaining earned income; and
- Subtract an amount equal to the SSI income standard for an individual if there is only one parent residing in the home, or subtract an amount equal to the SSI income standard for a couple if there are two parents residing in the home.

Example

Mr. Herman lives with his only child, Grace, who is disabled. Grace is applying for MA. Mr. Herman earns \$800 per month, receives \$100 per month in unearned income, and does not receive TANF. Since there are no other children in the household, his only deductions are based on parental needs. His deduction is the following:

- Countable Unearned Income = \$100 (gross unearned income) – \$20 (deduction) = \$80
- Countable Earned Income
\$800 – \$65 (earned income deduction) = \$735
Subtract 1/2 of the remainder = \$367.50
Countable Earned Income = \$367.50
- Countable Unearned Income and Countable Earned Income = \$80 + \$367.50 = \$447.50
- Subtract SSI Income Standard
SSI income standard for a group of 1 = \$564.

Since the SSI income standard exceeds countable earned income plus countable unearned income, no income is deemed.

	<p>QM: N/A</p> <p>MC: N/A</p>
TANF	<p><i>When a minor parent applies for assistance and there is not already an existing unit which s/he is required to be a member of (see Section 1.3: Mandatory Group Members and Section 1.11: Multiple Generations in the Home in Part IV), then the minor parent can form his/her own group with his/her child(ren). In this case, the income of the minor parent's parents is deemed to the group. The income of the minor parent's parent is deemed using the same deeming formula as in AR in MA.</i></p>
GC	N/A
FS	<p><i>Count the earned and unearned income if the parent(s) are in the group. If the parent(s) are disqualified, see Section 5.4.2: Disqualified Group Members' Income in this Part.</i></p>

Spousal Income 5.4.4

MA	<p>AR: A portion of the income of a spouse of a group member who is in the home but outside the group (provided the spouse is not the parent of a child in the group) is counted as unearned income to the group. The portion of income deemed to the group is calculated as described in Section 5.4.3: Parental Income for the AR group in this Chapter.</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p>Example</p> <p>Ms. Mosey lives with her two children and her husband, Mr. Herndon. Mr. Herndon is not the father of her two children. If Ms. Mosey applies for MA for herself and her children, Mr. Herndon's income is deemed to the group. If Mr. Herndon earns \$2,000 per month and has no other unearned income, then \$1,460 would be deemed to the group.</p> <ul style="list-style-type: none"> o Work Expense Deduction: $\\$2,000 - \\90 (Work Expense Deduction) = $\\$1,910$ o Deduction for Individual's Needs: $\\$1,910 - \\450 (standard of assistance for a group of 1) = $\\$1,460$ <p>If, however, Ms. Mosey does not apply for MA on her own behalf but only for her children, then Mr. Herndon's income is not deemed to the children. A stepparent's income is not deemed to a group unless the parent is included in the group.</p> <p>Mr. Herndon can choose to be included in the assistance unit as well. In that case, his entire income would be counted.</p> </div> <p>AX: See AR.</p> <p>SR: If any income is deemed, the size of the assistance unit is increased by one for the comparison of the assistance unit's net MA income to the appropriate income standards.</p> <p>The spouse's earned income is deemed to the assistance unit as earned income, and the spouse's unearned income is deemed to the assistance unit as unearned income.</p>
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To determine the amount of deemed income, determine the following:

- Determine gross earned and unearned income.

Include all earned and unearned income that would be countable if the income were received by an SR group member except income that is:

- received from a public assistance program such as TANF;
- used by any cash assistance program to determine the amount of that program's benefits to the spouse or someone else;
- received as a tax refund on income;
- used to comply with the terms of court-ordered support;
- received as income in-kind in the form of support and maintenance;
- received through a federal, state, or local government program for purchasing chore, attendant, or homemaker services for the SR individual; or
- Deduction based on the presence of children in the home.

Deduct an amount for each child (or step-child) living in the home who is under age 18 or who is under age 21 and a student. The amount to be deducted is the difference between the SSI benefit level for a couple and for an individual. If a child has income of his/her own, the amount allocated for that child is reduced by the amount of the child's income. If a child is a member of any other cash assistance unit including TANF or SSI, no amount is allocated for that child.

The amount allocated for each child is deducted first from the unearned income of the spouse. Any remainder is deducted from the earned income of the spouse.

- Deduction based on the spouse being an alien's sponsor.

Deduct an amount for each alien sponsored by the spouse. The amount allocated for each alien is one-half of the SSI income standard for an individual. If an alien has income of his/her own, the amount allocated for that alien is reduced by the total countable income of the alien.

The amount allocated for each alien is deducted first from the unearned income of the spouse. Any remainder is deducted from the earned income of the spouse.

- Calculate deemed income.

Compare the remaining monthly income to the difference between the SSI benefit level for a couple and for an individual. If the remaining income is equal to or less than this level, no income is deemed to the SR individual. If the remaining income is greater than this amount, all of the income is deemed to the SR individual. Remaining earned income deemed to the group is treated as income earned by the group member -- that is, this income is eligible for the applicable earned income disregards. Similarly, remaining unearned income is treated as income received by the group member and is eligible for the unearned income disregard.

If the spouses cease to live together, income is treated separately, beginning the month of separation. The reason for the separation does not matter.

QM: See SR.

MC: The only relative who has financial responsibility for a member of an MC assistance unit is a

	spouse for his/her spouse when they are living in the same home. The financial responsibility of a spouse who is not a member of the MC assistance unit is determined in accordance with the Spousal deeming formula used in AR.
TANF	<p>Count as unearned income a portion of the income of the following spouses (who are not the step-parent of a TANF child) who are in the home but outside the group:</p> <ul style="list-style-type: none"> • spouse of a caretaker relative other than a parent when the relative (for example, an aunt) elects to be in group, • spouse of a TANF child, or • spouse of a pregnant woman with no other children. <p>Deem the income of a spouse of a group member according to the Spousal deeming rules in AR.</p>
GC	The income of a spouse of a GC child is deemed to the GC child's group according to the Spousal deeming rules in AR.
FS	N/A

Step-Parent's Income 5.4.5

ALL	A step-parent is someone who is legally married to a person's parent but is not the person's biological or adoptive parent. The marriage may be ceremonial or common law.
MA	<p>A stepparent's income is only considered if the step-parent is in the unit or if the stepparent's spouse (i.e., the child's parent) is in the assistance unit. If the step-parent is out of the group but his/her spouse is in the unit, the stepparent's income is deemed to the spouse, following the parental deeming formula described in AR in Section 5.4.5: Parental Income in this Chapter. If neither the step-parent or his/her spouse is not included in the assistance unit, none of his/her income is deemed. Thus, if the stepparent's income would make the entire MA assistance unit ineligible for MA, the SSR should determine whether the child(ren) would be eligible for MA if his/her parent were not included in the unit.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Example</p> <p>A household consists of a mother (Ms. Hough), a step-father (Mr. Griffith), and Ms. Hough's two children (Debra and Adrienne). Ms. Hough has no income, but Mr. Griffith has significant earnings. If Ms. Hough applies for MA for herself, Debra, and Adrienne, Mr. Griffith's income would be deemed following the parental deeming formula to Ms. Hough. If Mr. Griffith's income is high enough to make Ms. Hough and the children ineligible for MA, the SSR should determine whether the children would be eligible for MA if Ms. Hough were not included in the assistance unit. If the children alone apply for MA, Ms. Hough's income would be counted when determining the children's eligibility (following the deemed parent rules), but Mr. Griffith's income would not be considered.</p> </div>
TANF	<p>Do not include the step-parent in the assistance unit unless:</p> <ul style="list-style-type: none"> • there is a child-in-common; • there is no child-in-common but the parent has chosen to have his/her needs included in the group; or • the parent is not in the home and the step-parent chooses to be in the unit (in this case, the step-parent is treated like any other caretaker relative). <p>If the step-parent is excluded, none of his/her income is considered in determining eligibility. The income of the child's(ren's) parent is deemed to the TANF assistance unit using the deemed parent formula, described in Section 5.4.3: Parental Income in this Chapter.</p>

	N/A
GC	N/A
FS	N/A

Chapter 6 - Income Disregards and Deductions

INTRODUCTION 6.1

When determining program eligibility and the level of benefits for which a group is eligible, certain deductions are made from the group's gross income. Some deductions can only be used to reduce a group's earned income while others can reduce a group's total gross income, including unearned income.

An earned income disregard is one form of an income deduction. An earned income disregard reduces the amount of a group's earned income that is considered when determining eligibility and/or benefit levels.

Some income deductions depend on the extent to which the group incurs certain costs such as child care, medical, or shelter costs.

A deduction from income can never reduce income below \$0 (i.e. if a group is eligible for a \$134 standard deduction in FS but the group only has \$100 in income, the group's income is reduced to \$0 by the standard deduction, but it is not reduced below this level).

By reducing the amount of income that is counted when determining whether a group meets the income eligibility criteria of a program or when calculating the level of benefits for which the group qualifies, income deductions allow groups to have higher incomes and still qualify for benefits. Income deductions, particularly earned income disregards, can reduce the extent to which benefits are reduced as earnings increase, thereby providing an incentive for groups to increase their earnings.

To determine the household's net income, subtract applicable deductions and disregards from gross income.

LEGAL AUTHORITY 6.2

AREA/TOPIC	DISTRICT	FEDERAL
Income Disregards and Deductions	TANF: D.C. Code 4-205.5; 4-205.11; 4-205.36-37; 4-205.52(a); 29 DCMR 5814 et seq. GC: See TANF and D.C. Code 4-205.5a	MA: 42 USC 1396a(l), 1396a(m), 1396a(r)(2), 1396u-1; 42 CFR 435.601, 435.602, 435.811, 435.831 TANF: 45 CFR 260, Subpart A FS: 7 USC 2014(e); 7 CFR 273.9(d); 273.10(e)

INCOME DISREGARDS AND DEDUCTIONS 6.3

MA	AR: Deduct the following two items from earned income in the order presented. (1) Earned Income Disregard Deduct \$90 plus \$30 and one-third of the remainder from the unit's gross earned income for expenses.
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Example

Ms. Walker lives with her two children and is applying for MA for herself and her two children. She earns \$600 per month. When determining the group's eligibility under the AR standards, the earned income disregard is applied:

Earned Income Disregard = \$90 + \$30 + 1/3 of (\$600 – \$90 – \$30) = \$280.

Her countable net earned income equals gross earnings minus her earned income disregard.

Net Earned Income = \$600 – \$280 = \$320.

(2) Dependent Care Deduction

Subtract the actual amount paid by the group out-of-pocket for the care of a dependent child or incapacitated adult living in the home up to the following maximums from earned income:

- \$175 per child (or incapacitated adult) if the child is age two or older.
- \$200 per child if the child is under age two.

The dependent care expenses must be incurred in order to allow a family member to work in order to be deductible. The dependent care expense can be for the care of a family member who is not included in the AR Medicaid group. The dependent care expense may not be paid to a member of the group.

If a group receives a child care subsidy to help it pay for child care expenses, count only the amount paid by the group when determining the Dependent Care Deduction.

Example 1

Ms. Walker's net earned income after subtracting out the earned income disregard is \$320. She spends \$200 per month on child care: \$150 for her 4-year-old and \$50 for her 10-year-old. Her net earned income is reduced by \$200 and now equals \$120.

Example 2

Ms. Ryson and her son apply for Medicaid. Ms. Ryson also has a daughter (age 10) who receives SSI and is in her own SR case. Ms. Ryson pays \$100 per month for after-school care for her son and \$200 per month for after-school care for her disabled daughter. Ms. Ryson is eligible for a \$100 dependent care deduction based on the child care expenses she pays for her son and \$175 based on the child care expenses she incurs on behalf of her daughter. (Since her daughter is over age two, the dependent care deduction is capped at \$175.)

Example 3

Ms. Ewings and her two children apply for Medicaid. The family receives a child care subsidy from the District's Office of Early Childhood Education. While the full cost of the child care for the two children is \$600 per month, Ms. Ewings only pays \$100 per month - the subsidy pays the remainder. Ms. Ewings is eligible for a \$100 dependent care deduction.

AX: Deduct the following two items from earned income in the order presented.

(1) *Earned Income Disregard*

Deduct \$100 from the unit's gross monthly earned income.

(2) *Dependent Care Deduction*

The only deduction applied is for actual out-of-pocket dependent care expenses. Deduct all out-of-pocket dependent care expenses from gross income (there is no cap on allowable dependent care expenses). Dependent care expenses include out-of-pocket costs for child care as well as care for other family members (such as elder care or care for older disabled children) incurred by the group to enable a group member to work.

SR: The following four deductions must be applied in the order in which they are presented.

(1) *Unearned Income Deduction*

Subtract \$20 from the unearned income of each assistance unit. If one spouse resides in a LTC facility, the deduction is applied only to the community spouse.

(2) *Earned Income Deduction*

If a portion of the \$20 unearned deduction was 'unused' (because unearned income was less than \$20), subtract this 'unused portion' from earned income. Next, deduct \$65 from earned income. Finally, deduct one-half of the remainder from earned income.

(3) *Work Expenses of the Blind*

Deduct work expenses reasonably attributable to the earning of income by a blind individual under age 65 in a SR assistance unit. Deduct that portion of the earned and/or unearned income of a SR blind or disabled individual that is conserved for the fulfillment of an approved PASS. This deduction is subtracted from the earned and/or unearned income of the blind or disabled individual for whom the income is conserved.

(4) *Plan to Achieve Self-Support (PASS)*

The amount of income deducted under this provision must be specified in a Department-approved plan that meets the following requirements:

- The plan must specify an occupational objective that can realistically be attained, and the amount to be conserved must be consistent with the anticipated costs of achieving the goals of the plan.
- The conserved income must be deposited in a savings or trust account, for which verification of the deposit amount and accrued balance can be obtained by the Department at any time.
- The PASS must be signed by the blind or disabled individual and a representative of the Department on the form prescribed by the Department for this purpose.

A PASS is initially limited to a period of 18 months. An extension for an additional period of 18

months may be granted when the Department determines that such an extension is required to achieve the goals of the previously approved plan. Approval of a total period of up to 48 months is possible when the plan includes an educational goal that extends beyond the initial and extension periods.

If the plan is abandoned, the amount in the savings or trust account becomes countable assets in accordance with the policies in Section 1.29: Trusts and Section 1.4.1: Liquid Assets (Cash Value) in this Part.

QM: See SR. In addition, exclude impairment-related work expenses for QMBs. Also, for both QMBs and SLIMBs, disregard the Title II COLA for the first three months of the calendar year, from January 1 through March 31. The Title II COLAs are disregarded to alleviate problems caused by the disparity between the effective dates of the COLAs and the annual adjustment made, based on inflation, to FPLs.

MC: For both the DC HealthCare Alliance and Childless Adult Medicaid, deduct \$100 from earned income.

The standard work expense deduction and the dependent child care deduction are not applied to the earnings of any individual who has terminated employment, reduced his/her earned income, or refused to accept a bona fide offer of employment without good cause during the 30 days preceding the month of application or recertification. Good cause is determined by considering the salary in relation to minimum wage and customary salary for similar work in the community, the availability of transportation, the individual's physical ability to do the work, and the hazardousness of the working conditions (see Section 1.7: Good Cause for Non-Compliance with Work Activities and Section 1.9.2: Good Cause in [Part V](#)).

TANF In determining the need of families applying for assistance, apply income disregards to applicants and recipients as detailed below.

The applicant disregards described below are used to calculate an applicant group's countable monthly income for purposes of determining whether the applicant group meets the income eligibility criteria for the program. If the applicant group's countable monthly income, using the applicant disregards described below, are below the payment standard and the group's assets are below the asset limit (see Section 3.3: Asset Limits in this Part) and all non-financial eligibility requirements are met (see [Part IV](#): Non-Financial Eligibility), the group is eligible for TANF.

Once a group is eligible for TANF, the group is eligible for the recipient disregards described below. Stated another way, when determining level of benefits, recipient disregards are always used, even for new cases. Applicant disregards are only used to determine initial eligibility for new applicants.

For purposes of this section, an applicant is a person who is not currently receiving TANF.

APPLICANT DISREGARDS

Apply the following disregards to the earned income of applicants to calculate net earned income (see Section 4.8: Children's Earnings in this Part for a discussion of the treatment of the earnings of children who are students):

Work Expense Deduction

Disregard the first \$160 of total gross earned income of each individual in the household who has earnings. If more than one non-student (see Student Disregard below) group member has earnings, then the \$160 work expense deduction is applied to each group member with earnings.

Example

Ms. Kenner, her 16-year-old daughter Julie, and Julie's daughter Kathy are all applying for TANF assistance. Both Ms. Kenner and Julie work. Ms. Kenner earns \$300 per month, and Julie earns \$250 per month. The \$160 work expense deduction is applied to both Ms. Kenner and Julie. After accounting for this disregard, Ms. Kenner's countable earned income is \$140, and Julie's is \$90.

Dependent Care Deduction

Disregard the actual amount paid for the care of each dependent child or incapacitated adult living in the home and receiving TANF up to the following maximums:

- \$175 per child (or incapacitated adult) if the child is age two or older.
- \$200 per child if the child is under age two.

The child care expense may not be paid to a member of the group. If a group's child care costs are fully paid by a subsidy program, the group receives no child care disregard.

Child care costs can only be subtracted from earned income. If the combination of the work expense deduction and child care expenses are greater than the group's earned income, the group's net earned income is \$0. No deductions to unearned income can be made based on child care or work expenses.

When determining whether an applicant group is eligible for TANF, the group's net earned income is combined with the group's countable unearned income to determine net countable income. If a group's net countable income is less than the payment level, the group meets the income-eligibility criteria for TANF. If the group's assets are below the asset limit (see Section 3.3: Asset Limits in this Part) and the group meets all non-financial eligibility requirements (see Part IV: Non-Financial Eligibility), the group is eligible for TANF. If an applicant group is determined eligible, the recipient disregards described below should be used when calculating the level of benefits for which the group is eligible.

Example

Ms. Dee lives with her two children and is applying for TANF. Ms. Dee works and earns \$400 per month. One of her children receives \$75 per month in child support. Ms. Dee pays her neighbor \$110 per month to watch her younger child while she works.

To determine if Ms. Dee and her children are eligible for TANF, her net countable income must be compared to the payment standard for a family of three which equals \$379.

The group's net earned income is calculated as follows:

\$400 (earnings)
– \$160 (work expense deduction)

– \$110 (child care expenses)
\$130 = Net Earned Income

The group's net earned income is combined with her countable unearned income (\$75) to determine net countable income. The group's net countable income equals \$205. Since the group's net countable income is less than \$379 (the payment standard), the group meets the income-eligibility criteria for TANF.

If a person is added to an existing TANF group, that applicant is considered a recipient and receives recipient disregards.

RECIPIENT DISREGARDS

Recipient disregards are applied to determine the eligibility of groups already receiving TANF and level of benefits. Applicant disregards, described above, are used to determine the eligibility of applicant groups. Once a group has been determined eligible, recipient disregards are always used when determining the level of benefits for which a group is eligible.

Apply the following disregards to the earned income of TANF recipients to calculate net earned income (see Section 4.8: Children's Earnings in this Part for a discussion of the treatment of the earnings of children who are students):

Work Expense Deduction

Disregard the first \$160 of total gross earned income of each individual in the household who has earnings. If more than one non-student (see Student Disregard below) group member has earnings, then the \$160 work expense deduction is applied to each group member with earnings (see above for an example of how to apply the Work Expense Deduction when two individuals are working.)

Earned Income Disregard

Disregard two-thirds ($\frac{2}{3}$) of the earnings not already disregarded due to the Work Expense Deduction.

Dependent Care Deduction

Disregard the actual amount paid for the care of each dependent child or incapacitated adult living in the home and receiving TANF up to the following maximums:

- \$175 per child (or incapacitated adult) if the child is age two or older.
- \$200 per child if the child is under age two.

The child care expense may not be paid to a member of the group. If a group's child care costs are paid in full by a subsidy program, the group receives no child care disregard. Child care costs can only be subtracted from earned income.

If the combination of the work expense deduction, the earned income disregard, and child care expenses are greater than the group's earned income, the group's net earned income is \$0. No deductions to unearned income can be made based on child care or work expenses.

	<p>Do not apply the recipient two-thirds (2/3) earned income disregard to the earned income of an individual for whom one of the following conditions apply:</p> <ul style="list-style-type: none"> • an individual terminated his/her employment or reduced his/her earned income without good cause within 30 days of the preceding the month, • an individual refused to accept a bona fide offer of employment without good cause within 30 days preceding the month, or • an individual failed without good cause to report his/her earnings properly. For earnings to be properly reported, one of the following conditions must be met: <ul style="list-style-type: none"> ○ the recipient reports the earnings in their entirety within ten days of receipt. (acceptable verification must accompany the report), or ○ the recipient is in the quarterly reporting system and timely reports his/her earnings on the form and provides acceptable verification. <p>Good cause for terminating or refusing employment will be determined by considering:</p> <ul style="list-style-type: none"> • salary in relationship to minimum wage requirements and customary salary for similar work in the community, • availability of transportation and appropriate and affordable child care, • person's physical ability to do the work, and • hazardous working conditions. <p>Good cause for not properly reporting earnings exists if:</p> <ul style="list-style-type: none"> • the client was hospitalized anytime within five days prior to the date the report of earnings was due; or • The verification was not provided by the due date, but <ul style="list-style-type: none"> ○ the earnings were reported by the due date, ○ verification is provided before the last day available to affect the check amount, and ○ the verification agrees with the client's report of the earnings.
GC	<p>See TANF.</p> <p>GC cases do not include adults. The earnings of students are disregarded (see Section 4.8: Children's Earnings in this Part) and to be eligible for GC, children ages 16 and 17 must be students (see Section 4.4: School Attendance and Student Status in Part IV). Therefore, it is unlikely that earnings of a GC group member will ever be counted. Earnings of a deemed individual, such as the adult spouse of a GC child, could be included when determining GC eligibility and benefits.</p>
FS	<p>When determining whether a group meets the net income test (see Section 8.4: Determining Income Eligibility in this Part) and calculating an eligible group's FS benefits, several deductions are applied:</p> <ul style="list-style-type: none"> • The Standard Deduction; • Earned Income Disregard; • Excess Medical Deduction; • Dependent Care Deduction; • Excess Shelter Deduction; and • Child Support Deduction. <p>Some groups must pass a gross income test to be eligible for FS (i.e., groups that are not categorically</p>

eligible for FS (see Section 12.3: Who is Categorically Eligible in Part IV) and groups that do not include an elderly or disabled group member). These deductions are not applied when determining whether a group's gross income is below the gross income limit (see Section 8.4: Determining Income-Eligibility in this Part).

The Standard Deduction applies to all FS households while all other deductions apply to certain groups of FS households such as households with high housing costs, households that incur dependent care costs, or certain households with excess medical expenses.

Listed below are the various FS income deductions in the order in which they are to be applied.

Earned Income Disregard

Deduct an amount equal to 20 percent of the group's gross countable earnings. Excluded earned income as defined in Chapter 4: Determining Countable Income in this Part will not be included when allowing the earned income disregard.

Example

A group has \$150 in gross countable earnings and no other income. The group is entitled to a deduction of \$30 (20 percent of \$150).

Standard Deduction

The standard deduction depends on the size of the FS household. Deduct the amount shown in the following table from the gross income of each group:

Household Size	Standard Deduction (as of October 1, 2013)
1-3	\$152
4	\$163
5	\$191
6+	\$219

Excess Medical Deduction

A household member meeting the requirements below is entitled to a deduction for medical expenses in excess of \$35 per month, excluding special diets, for an elderly or disabled member:

- a person age 60 or over;
- a disabled person (see Section 9.4: Disability/Blindness Determinations in Part IV); or
- a person who, at the time of application, did not meet the criteria for a disabled person, but later was determined eligible for SSI.

This person is entitled to retroactive deductions for excess medical expenses. The SSR will restore benefits back to the date of the FS application or the date of initial SSI eligibility, whichever is later.

A household member who is not elderly or disabled but who is receiving disability benefits as the dependent of a disabled or elderly person is not entitled to this deduction. In addition, only the medical expenses of the individual who qualifies as elderly or disabled are used as a deduction for excess medical expense.

The following are allowable medical expenses when incurred for the care of an elderly or disabled member:

- medical and dental care, including psychotherapy and rehabilitation services. These services must be provided by a licensed practitioner authorized by District law or by another qualified health professional.
- hospitalization, outpatient treatments, or nursing care. The deduction will include payments made by the household for an individual who was a household member immediately prior to entering a hospital or nursing home. The care must be provided by a District recognized facility.
- prescription drugs or over-the-counter medications, including insulin, when prescribed or approved by a licensed practitioner or another qualified health professional.
- rental or purchase of prescribed medical supplies, sick room equipment, or other prescribed equipment.
- health and hospitalization insurance policy premiums. The costs of health and accident policies such as those payable in a lump sum upon death or dismemberment of the policy holder or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled are not deductible.
- Medicare premiums.
- co-payments for MA recipients.
- dentures, hearing aids, and prostheses.
- purchase and maintenance of a seeing eye or hearing dog, including dog food and veterinarian expenses.
- eyeglasses prescribed by an optometrist or a physician skilled in eye disease.
- reasonable transportation and lodging to obtain medical treatment or services.
- maintenance of an attendant, such as a homemaker, home health aide, child care service, or housekeeper. This service must be provided by a non-household member and be necessary due to age, infirmity, or illness of the elderly or disabled household member.

In addition, if the household provides the majority of an attendant's meals, the household is eligible for a deduction equal to the coupon allotment for one person. This deduction must be updated when the standard allotment amount changes to reflect the increased maximum benefit for a one-person group.

If an elderly or disabled person has an expense that could be used for either a dependent care deduction or a medical deduction, it will be used as a medical deduction.

Example

Ms. Dodds has a 19-year-old mentally retarded son, James, who requires constant care. In order for Ms. Dodds to work, James attends an adult day care center. The cost of the adult day care services in excess of \$35 per month qualifies as a medical expense since James is disabled.

A disabled mother who works and has an expense for babysitting for her child so she can work is not entitled to a medical deduction, but she may be eligible for a dependent care deduction which is discussed below.

A fluctuating expense may be averaged to arrive at a monthly figure. An expense which is billed less often than monthly, such as every three months, may be averaged over the period of time it is expected to cover. A one-time only medical expense may be averaged over the remaining months of the certification period in which it is billed.

Dependent Care Deduction

Deduct the actual amount paid out-of-pocket for the care of each dependent child or incapacitated adult living in the home. Effective October 1, 2008, there is no cap to this deduction. The child care may not be paid to a member of the group and must be necessary for a household member:

- to accept or continue employment,
- to comply with employment and training requirements, or
- to attend training or pursue education which will help the individual prepare for employment (provided these expenses are otherwise covered by an educational benefit or program).

Unlike in TANF and MA, the dependent care deduction in FS can be used to reduce either earned or unearned income.

Expenses are not allowed if paid in goods or services (payment-in-kind).

Example

Ms. Hicks is employed and permits a neighbor to use her garage in payment for babysitting for her children. Ms. Hicks estimates the use of the garage to be valued at \$150 per month. The expense is not allowed because the payment is in-kind and is not a cash payment.

Child Support Deduction

Legally obligated child support paid by a group member to a non-group member, including payments made to third parties or to a state child support agency such as CSED (or similar agencies in other states), is deducted from the group's income. Payments made toward child support areas shall also be deducted. Alimony payments shall not be deducted from the group's income. To be deducted from the group's income, the child support must actually be paid.

Excess Shelter Deduction

An income deduction is allowed for monthly shelter costs which exceed 50 percent of the group's income after the earned income, standard, excess medical, dependent care, and child support deductions have been applied.

Shelter expenses are allowed when billed. The expenses do not have to be paid to be allowed. Shelter expenses include the costs necessary to maintain a residence including utilities.

A group containing an elderly or disabled person may receive a deduction equal to the full amount by which its shelter expenses exceed 50 percent of the group's income (net of all other deductions). All other households may receive the lesser of the difference between its shelter expenses and 50 percent of the group's income (net of all other deductions) and the Shelter Cap. Effective October 1, 2013, the shelter cap is \$478.

Allowable shelter expenses include the principal and interest charges for:

- continuous costs for the shelter occupied by the household such as rent, mortgage, or other costs leading to the ownership of the property;
- repayment of a loan to purchase a mobile home;

- repayment of a second or third mortgage;
- cost for loans involving liens or judgments when failure to make the payment results in the loss of the household's shelter property;

Example

Mr. Powell was arrested and borrowed money for bail. As collateral for the loan, he used his home. Since failure to pay the loan, including interest, would result in the loss of the household's shelter, payments on the bail loan are allowable as shelter costs.

- property taxes, state and local assessments, and insurance on the structure, but not separate charges on the contents such as furniture, clothing, and personal belongings;

If the cost of insurance includes coverage on both the structure and contents, the entire charge may be deducted.

- Charges for repair of a home which was substantially damaged or destroyed due to a natural disaster such as fire or flood;

These expenses, however, cannot be allowed if the group has been or will be reimbursed by any source, such as an insurance company.

- Shelter costs associated with an unoccupied home, including homes in another state, temporarily unoccupied by the FS group due to employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss. All shelter expenses listed in this section incurred on a temporarily unoccupied home can be counted as a shelter expense and used when calculating the group's excess shelter deduction provided:
 - the FS group intends to return to the home;
 - the current occupants of the home, if any, are not claiming shelter costs on that home for FS purposes; and
 - the home is not being leased or rented to others during the FS group's absence.

Households cannot receive credit for utility expenses for unoccupied homes, when they also receive credit for utility costs for the residence they presently occupy.

- Heating/Cooling and Other Utility Costs.

This includes the cost of heating and cooking fuel, cooling and electricity, water and sewage, garbage, and trash collecting fees (including purchase of special trash bags where required as a condition of pick-up), and fees charged by the utility providers for utility installation, excluding deposits.

Mandatory Utility Allowance

Households that are responsible for paying utilities will receive a mandatory allowance that is based on the types or number of utilities that they must pay. Households will receive one of the following utility allowances.

Heating and Cooling Standard Utility Allowance (HCSUA)

Households that are responsible for a heating or cooling cost that is separate and apart from their rent or mortgage are entitled to the HCSUA. This includes:

- households that receive energy assistance under the Low Income Energy Assistance Program (LIHEAP), even if LIHEAP has covered the full heating cost;
- households that receive direct or indirect energy assistance payments, other than LIHEAP, such as HUD utility reimbursements, that expect to pay some out-of-pocket heating or cooling expense during the certification period;
- residents of private rental housing who are billed monthly for heating or cooling costs by their landlords based on individual usage or a flat rate; and
- residents in a public or private housing unit that has a central utility meter and charges residents only for excess heating and cooling costs.

A household incurring heating or cooling costs on an intermittent basis, but otherwise eligible for the HCSUA, may continue to use it between billing periods. Air conditioning costs do not include the cost of using fans. Heating or cooling costs must be verified to receive the HCSUA. The HCSUA is \$305.00 effective October 1, 2013.

Effective January 1, 2010 all FS recipients are eligible to receive a \$1 "Heat and Eat" payment under the Low-Income Energy Assistance Program (LIHEAP) if they are not already eligible for LIHEAP under other provisions. Receipt of LIHEAP, including the \$1 "Heat and Eat" payment, makes them eligible for the HCSUA. Any active FS household is reasonably expected to receive the \$1 LIHEAP payment effective January 1, 2010, which makes them eligible for the HCSUA even if the \$1 payment has not yet been issued.

Determine initial eligibility for households who apply for FS without reference to the Heat and Eat program. If the household is otherwise eligible for the HCSUA expense, use the HCSUA in determining eligibility. If the household is not otherwise eligible for the HCSUA, first determine if the FS household is eligible for FS without the HCSUA. If the household is not eligible, deny the application. If the household is eligible for any FS benefit, including households of 2 or more members that meet gross and net income tests but are eligible for a \$0.00 benefit, the household is now receiving FS and is eligible for the Heat and Eat program. Redetermine eligibility using the HCSUA, since the household is reasonably expected to receive a LIHEAP payment.

FS households who are recertifying for FS are current recipients and are therefore eligible for the HCSUA under the Heat and Eat program.

Limited Utility Allowance (LUA)

Households that are responsible for paying at least two non-heating or non-cooling utility costs are entitled to the LUA. Non-heating and non-cooling costs include:

- electricity,
- cooking gas,
- water and sewage,
- trash removal, and
- telephone.

Households must verify that they must pay at least two non-heating and non-cooling costs to receive the LUA. The LUA is \$242.00 effective October 1, 2013.

Note that effective January 1, 2010, every active FS household is eligible for the HCSUA instead of the LUA.

One Utility Allowance (OUA)

Households that are responsible for paying only one non-heating, non-cooling, and non-phone utility are entitled to the OUA. Households must verify that they must pay one non-heating, non-cooling, and non-phone utility bill to receive the OUA. The OUA is \$62.00 effective October 1, 2013.

Note that effective January 1, 2010, every active FS household is eligible for the HCSUA instead of the OUA.

Telephone Standard

Households that are only responsible for paying for telephone costs are entitled to the Telephone Standard. This includes landline and wireless telephones. Households must verify that they are billed for telephone services. The Telephone Standard is \$55 effective October 1, 2013.

Note that effective January 1, 2010, every active FS household is eligible for the HCSUA instead of the Telephone Standard.

A FS group living with and sharing costs with another individual or group is entitled to a full utility allowance.

Case Processing When Expenses are Unverified

Effective January 1, 2010, an active FS household is not required to document utility costs, since IMA will automatically refer all FS recipients for a LIHEAP payment. A household who is applying for FS and not currently receiving FS may need to document utility costs in order to be determined eligible for FS. Once determined eligible, the customer is eligible for the HCSUA allowance.

Example

Ms. Grier applies for Food Stamps on March 31. She states she pays rent and heating/cooling costs. She brings her rent receipt, but does not have proof of her utility expense. There is no record in ACEDS of a LIHEAP payment. The worker determines her eligibility without using a utility expense and finds she is not eligible for Food Stamps for the prorated month of March, but is eligible for an allotment effective April 1. Since she is now a FS recipient, she is expected to receive a LIHEAP payment. The caseworker enters the HCSUA and redetermines her allotment for April and subsequent months.

Example

Mr. Allen is certified for FS through June 30 and comes in to recertify on June 13. Since he is currently a FS recipient, he is expected to receive a LIHEAP payment. The worker gives Mr. Allen the HCSUA when determining eligibility for the new certification period.

Example

Ms. Allawi applies for FS on August 10. She rents but does not pay separate heating/cooling costs. There is no record of a LIHEAP payment. The worker determines Ms. Allawi's eligibility without giving her the HCSUA. Ms. Allawi's income makes her ineligible for FS. The worker denies the application without redetermining eligibility using the HCSUA.

Treatment of Deductions and Disregards for Disqualified Household Members 6.3.1

MA	The income of individuals 'included provisionally' in an MA unit is treated in the same manner as if the individual were included in the unit. The income disregards and deductions apply as if the person were included in the unit.
TANF	See MA, except disqualified <u>individuals</u> are coded 'DI' not 'IP.'
GC	N/A
FS	<p>In cases in which a household member has been disqualified from the group due to an IPV or failure to comply with work requirements, the countable income of the <u>disqualified</u> member is counted as if the individual were in the unit. The group remains eligible for all disregards and deductions for which it would <u>be eligible</u> if the <u>individual</u> were not excluded.</p> <p>In cases in which <u>an individual is</u> disqualified due to failing to satisfy (without good cause) the SSN requirement or because s/he is an ineligible alien, all income on a pro rata share is deemed to the group. In such a case, the 20 percent earned income deduction is applied to the level of earnings which is actually <u>deemed</u> to be the FS group. The portion of the household's allowable child support payment and dependent care expenses which are either paid by or billed to the ineligible members shall be divided evenly among the household's members, including the <u>ineligible</u> members. All but the ineligible member's share is counted as a deductible child support payment or dependent care expenses for the remaining household members. In like manner, shelter expenses shall also be divided evenly among the household members and shall be prorated for the eligible household members, except that utility allowances are not prorated.</p>

Chapter 7 - Spend-Down

INTRODUCTION 7.1

Some individuals or groups are ineligible for MA because their countable income (after all applicable disregards) exceeds the applicable MA standard. However, they can become eligible for MA by "spending down" their excess income on eligible medical expenses. An individual (or group) that is over-income for MA, but who is otherwise eligible, can qualify for MA if allowable medical expenses exceed their spend-down "deductible." The spend-down deductible is calculated by subtracting the Medically Needy Income Level (MNIL) from the individual's (or group's) income. The MNIL is set at 50% percent of the Federal Poverty Level, except that the MNIL for one person is set at 95% of the MNIL for two persons; see Exhibit VI-3: "MA Income Standards."

After the individual or group incurs allowable medical expenses equal to their spend-down deductible, the individual or group is eligible for all MA services. The expenses used to meet the spend-down deductible are not eligible for Medicaid payment or reimbursement.

In short, the spend-down provisions described in this chapter ensure that individuals with incomes above the MA income limits who incur large medical expenses qualify for assistance in meeting their medical expenses. It is used primarily by:

- elderly and disabled persons who are slightly over-income,
- persons who have accumulated a large amount of outstanding medical debt,
- persons with a catastrophic or chronic illness (such as renal failure), and
- persons needing an expensive medical procedure in one month.

There are no spend-down provisions for QMB or SLIMB. However, individuals with incomes in excess of these eligibility limits may qualify for full Medicaid coverage, including coverage of Medicare Part B premiums, if they are over-income for Medicaid and meet their spend-down deductible.

The spend-down deductible may be established for the retroactive budget period, the prospective budget period, or both. The retroactive period consists of the three months prior to the month of application. The prospective budget period consists of the six-month period beginning with the month of application. In the case of recertification, the prospective period consists of the six-month period that begins after timely and adequate notice of the spend-down deductible is sent. When determining eligibility through the spend-down process, the applicant always has the option of applying incurred medical expenses from the retroactive spend-down period toward the prospective period. However, an incurred medical expense may only be claimed once. If there are advantages and disadvantages to each choice, advise the applicant and allow the applicant to make the decision.

LEGAL AUTHORITY 7.2

AREA/TOPIC	DISTRICT	FEDERAL
Spend-Down		MA: 42 CFR 435.831

DETERMINING SPEND-DOWN DEDUCTIBLE AMOUNT 7.3

Only groups that meet all non-financial MA requirements (Medicaid or Emergency Medicaid services) and resource limits may qualify for MA through the spend-down process.

A group's monthly spend-down deductible is equal to the amount by which the group's net countable income, after all applicable deductions, exceeds the MNIL.

Example

Ms. Weaver is age 67 and applies for Medicaid based on her age. She is otherwise eligible, but her income exceeds the SR standards. Her income is \$200 per month over the MNIL. Her spend-down deductible is \$200 per month.

Spend-Down Deductible – Retroactive Budget Period 7.3.1

If a group applies for MA and is found to be over-income, the group may qualify for MA coverage for the retroactive budget period if it meets its spend-down deductible. The three-month period prior to the month of application is called the 'retroactive budget period.' When determining whether the group meets the spend-down deductible for the retroactive budget period, the allowable medical expenses incurred in those three months (see Section 7.4: Allowable Medical Expenses in this Chapter) are compared to the spend-down deductible. If medical expenses exceed the spend-down deductible, the group will be certified eligible for some or all of the retroactive period, depending on when the medical expenses exceeded the spend-down deductible and which method was used (based on which was advantageous to the applicant) to determine eligibility (see Section 7.7: "Two Methods for Determining Eligibility through Spend-Down Process" in this Chapter). The SSR should use the method that is most advantageous to the applicant.

Spend-Down Deductible – Prospective Budget Period 7.3.2

If a group applies or is recertified for MA and is found to be over-income, the group may qualify for MA coverage for the prospective budget period if it meets its spend-down deductible. When determining whether the group meets the spend-down deductible for the prospective budget period, allowable medical expenses incurred prior to the prospective budget period plus paid and unpaid allowable medical expenses incurred during the prospective budget period are compared to the spend-down deductible. If medical expenses exceed the spend-down deductible, the group will be certified eligible for some or all of the prospective period, depending on when the medical expenses exceeded the spend-down deductible and which method was used (based on which was advantageous to the recipient) to determine eligibility (see Section 7.7: "Two Methods for Determining Eligibility through Spend-Down Process in this Chapter". The SSR should use the method that is most advantageous to the applicant.

ALLOWABLE MEDICAL EXPENSES 7.4

Allowable medical expenses are those expenses that may be applied toward meeting the spend-down deductible.

For retroactive eligibility, medical expenses must be incurred or paid during the three-month retroactive budget period to count toward the spend-down deductible. Both paid and unpaid medical expenses incurred during this period can count toward the spend-down deductible. Outstanding medical debt, no

matter how old, for which the applicant/recipient remains responsible, may be used toward the spend-down deductible as long as it has not been used towards a previous spend-down deductible.

For prospective eligibility, medical expenses may be incurred during the prospective budget period or prior to the budget period. However, only unpaid expenses incurred prior to the budget period for which the individual is still responsible may count toward the spend-down deductible, except that expenses that were paid during the three months prior to the prospective period may be used as long as they were not used to establish retroactive eligibility.

Medical expenses may not be claimed in both the retroactive and prospective budget periods.

Allowable medical expenses may be incurred by:

- the person applying to receive MA benefits (recipient),
- dependents of the person applying to receive MA benefits, and
- parents or financially responsible caretakers of children applying to receive MA benefits.

Allowable medical expenses may be incurred or anticipated during the following periods of time:

- medical expenses (paid and unpaid) incurred during the budget period,
- medical expenses incurred before the budget period but paid during the budget period (these expenses can only be used to determine prospective eligibility),
- medical expenses incurred and paid during the three months period to the prospective budget period,
- medical expenses incurred and billed before the budget period and remaining unpaid during the budget period,
- health insurance, including Medicare Part B and Medicare Drug Plan expenses, paid in the retroactive budget period or anticipated during the prospective budget period. Only expenses for which the applicant/recipient is responsible may be used; and
- costs of prescription and medically necessary over-the-counter (OTC) drugs paid in the retroactive budget period or costs of these drugs as they are incurred during the prospective budget period. Only costs which are not paid by a third party, such as a Medicare Drug Plan, may be used.

Example

Mr. Noravian has a heart condition. He takes Ecotrin every month and is expecting to continue taking it for the next six months. As he incurs the expense of buying Ecotrin, the cost may be used toward meeting his spend-down.

Allowable medical expenses may include the following:

- routine, preventive, and emergency medical treatment and services including;
 - physician services,
 - inpatient and outpatient medical services,
 - prescription and medically necessary OTC drugs,
 - medical equipment and devices prescribed by a physician,
 - ambulance services,
 - other medical expenses usually covered by Medicaid,
 - other medical expenses not usually covered by Medicaid but medically necessary, and
 - health insurance premiums.

In order to be applied to spend-down, each medical expense must meet all of the following criteria:

- The expense must have been incurred by either a member of the assistance unit or by an individual who has been provisionally included in the assistance unit.
- The expense must be for a medical service that is either customarily covered by MA or required by a physician for medical reasons. Additionally, customers may count any legitimate medical expense for a non-covered service including:
 - dental care for persons over 21
 - chiropractic services, or
 - transportation to obtain a countable medical service, such as for a medical appointment, or to purchase medications.
- The expense is not subject to payment by an MA program of any jurisdiction, a health insurance program, or any other liable third party (any portion of an expense that is subject to such payment is not countable).
- The expense must not have been counted toward a previous spend-down deductible that resulted in earlier certification of eligibility in any jurisdiction.
- The document verifying the expense must be legible and must include the date of service, the name of the person or organization that provided the service, the cost of service, the individual's liability (net of the amount owed by a third party such as an insurer), the type of service provided, and the current billing date for the balance due.

The expenses are allowable even if they are paid by a 'public program' (other than the Medicaid program) of the District of Columbia if the program is financed by the District of Columbia. A 'public program' must meet the following criteria:

- be under the administrative control of the District of Columbia, and
- receive its funding, except for beneficiary deductibles and coinsurance amounts, directly from the District of Columbia (or funding transferred from another District of Columbia public program.)

Third Party Liability 7.4.1

In addition, the expense must not have been fully covered or paid by a third-party (Medicaid, Medicare, or other public or private insurance). If a third-party is liable for a portion of the medical expense, only the remaining liability of the applicant/recipient can be counted as an allowable medical expense. If third party liability cannot be ascertained, or third party payment has not been received, the Department cannot delay eligibility determination beyond the prescribed time period for reaching a decision on Medicaid eligibility, and the applicant/recipient's liability for the partially covered bills must be estimated.

Example

Ms. Ogden has several medical bills from the past several months, some of which were covered by her former employer's health plan. If the health plan covered 80 percent of her \$1,000 in doctor bills, then the only allowable medical expense deducted from Ms. Ogden's spend-down deductible is the remaining \$200, her share of the expense.

Allowable medical expenses are deducted in the order most advantageous to the recipient. In general this will mean the expenses should be deducted in the following order:

- health insurance premiums (see Section 7.4.2: Health Insurance Premiums and 7.4.3: Medicare Part B premiums in this Chapter);
- medical expenses not usually covered by Medicaid;

- medical expenses usually covered by Medicaid but that exceed limitations on amount, duration, or scope of services customarily covered (more than \$500 of psychiatric services in a year or hospice care of more than 210 days); and
- medical expenses usually covered by Medicaid deducted in chronological order.

Health Insurance Premiums 7.4.2

Health insurance premiums can be counted toward a group's spend-down deductible as the premium costs are incurred. They can only be projected over the entire budget period if the applicant/recipient is institutionalized. Premiums paid prior to the prospective budget period may not be applied to the prospective spend-down deductible (unlike outstanding medical bills prior to the budget period which can be applied.)

Medicare Part B Premiums 7.4.3

Medicare Part B premiums paid in a retroactive budget period are considered similarly to other health insurance premiums and are deducted from the spend-down deductible amount. The recipient who has been certified for a retroactive eligibility period will not receive a lump sum reimbursement for Part B premiums paid during the retroactive months.

Medicare Part B premiums to be paid during the prospective budget period are an exception to the deduction of health insurance premiums from the spend-down deductible. Medicare Part B premiums are paid by the Department after Medicaid eligibility is determined and certified, and SSA provides lump sum reimbursement for Medicaid recipients who paid Part B premiums out-of-pocket while awaiting the Medicaid program to begin paying the premiums. Therefore, deduct from the spend-down deductible only Medicare Part B premiums paid in months of the prospective budget period when the applicant/recipient is not eligible for MA.

Example				
Ms. Muriel is 69-years-old and applies for MA benefits on December 12. Her monthly excess income is \$75 which results in a spend-down deductible of \$450 for the six-month prospective budget period. Ms. Muriel has \$250 in outstanding medical bills not covered by her Medicare. She also pays \$40 out-of-pocket each month for transportation to and from doctor appointments. Ms. Muriel also pays \$20 per month for her Medicare Part B premium.				
Prospective Budget Period				
		Amount	Total to Date	Not allowable
Before December	Doctor bill	\$250	\$250	Medicare premiums paid before December
December	Medicare B	\$20	\$270	
	transportation	\$40	\$310	
January	Medicare B	\$20	\$330	
	transportation	\$40	\$370	

February	Medicare B	\$20	\$390	
	transportation	\$40	\$430	
March	prescription	\$40	\$470	
<p>Ms. Muriel does not reach her spend-down deductible with only her outstanding medical bills of \$250. Her prospective budget shows her Medicare Part B premiums and her regular monthly transportation costs. If Ms. Muriel has no additional medical expenses during the next few months, she would become eligible for MA in March when she reaches her spend-down liability of \$450.</p> <p>Ms. Muriel's Medicare Part B premium for March is not used towards the spend-down deductible because she meets her spend-down for March and will be eligible for reimbursement for the Medicare premium for that month.</p>				

RETROACTIVE ELIGIBILITY DETERMINATION 7.5

Eligibility through spend-down is determined differently for retroactive and prospective periods.

Retroactive Budget Period 7.5.1

The retroactive budget period is the three-month period prior to the month of application. Months in which an individual lived outside the District of Columbia can be included in the retroactive budget period and medical expenses incurred during such months can count toward the spend-down limit. However, retroactive eligibility cannot be granted for months in which the individual resided outside the District of Columbia for the entire month. Similarly, months in which an individual would have been ineligible for MA for a reason other than being over-income can be included in the budget period and medical expenses incurred during this period can count toward the group's spend-down deductible. However, retroactive eligibility cannot be granted for a month in which an individual was ineligible for MA for a reason other than being over-income.

Example

Ms. Reynolds applies for Medicaid in June and is found to meet all Medicaid eligibility requirements except that she is over-income. She wishes to use her medical expenses over the past three months toward retroactive eligibility. In March, Ms. Reynolds exceeded the resource limit. Medical expenses incurred in March can count toward her spend-down deductible. She cannot be determined eligible for March, even if her medical expenses exceed her spend-down deductible because she was ineligible for Medicaid in March for a reason other than being over-income.

Retroactive Eligibility Period 7.5.2

The retroactive eligibility period is the portion of the retroactive budget period (the three months prior to the month of application) for which the applicant/recipient is eligible for MA though the spend-down provisions. A group may be eligible for only one month, for two months, or for all three months of the retroactive budget period. During the retroactive eligibility period, the MA program for which the group became eligible through spend-down will pay bills for medical expenses incurred in excess of the spend-down deductible. The retroactive eligibility period may not include months in which the applicant/recipient was not a resident of the District of Columbia or months in which the applicant/recipient was ineligible for MA benefits for some reason other than excess income.

Example

Mr. Marcus (aged 70), who moved to the District on February 6, applies on April 12 for retroactive MA eligibility. He presents to the SSR prescription medication receipts from December, laboratory test receipts from January, a doctor's bill from February, and hospital and doctor bills from March. The retroactive budget period is three months. The SSR determines that his excess income for the three-month retroactive budget period is \$1,700; therefore his spend-down deductible amount is \$1,700. His expenses are as follows:

		Amount	Total to Date
Before January	(prescriptions)	expenses incurred before the retroactive budget period do not count toward the spend-down deductible	
January	lab tests	\$150	\$150
February	doctor	\$125	\$275
March	hospital	\$2,400	\$2,675
April	doctor	\$75	\$2,750

Because Mr. Marcus was not a resident of D.C. in January, the first month he could be eligible for retroactive MA is February. However, his total to date of allowable medical expenses reached only \$275 through February, less than his spend-down deductible amount. His \$2,400 hospital bill in March put him over his spend-down deductible amount by \$975. Even if his hospitalization occurred at the end of March, Mr. Marcus is certified eligible for MA as of March 1. He is responsible for the first \$1,425 of the hospital bill (his spend-down deductible amount less his January-March medical expenses). MA will pay the remainder of his hospital bill and his March doctor bill of \$75.

PROSPECTIVE ELIGIBILITY DETERMINATION 7.6

This section details the policies for determining prospective eligibility through spend-down.

Prospective Budget Period 7.6.1

The prospective budget period is the six-month period beginning with the month of application or recertification.

Example

Ms. Jonelle comes into the service center to apply for MA on March 16. Her six-month prospective budget period would begin on March 1 and end August 31.

Prospective Eligibility Period 7.6.2

The prospective eligibility period is the portion of the prospective budget period for which the applicant/recipient is eligible for MA through the spend-down provisions. An individual or group may be eligible for no months, some months, or all months of the prospective budget period. If the spend-down deductible is met entirely by unpaid expenses incurred prior to the prospective budget period, prospective eligibility is certified for the full six-month period.

The prospective eligibility period may not include months in which the applicant/recipient is ineligible for MA for reasons other than being over-income. For example, an individual who is over the applicable resource limit cannot be eligible for MA during the prospective budget period, even if s/he has met his/her spend-down deductible.

Certification or Conditional Denial 7.6.3

The Department is required to process MA applications and determine eligibility for benefits within 45 days from the application date (see Section 2.3: Time Standards in [Part III](#) and Section 2.2.6: Salazar Court Order in [Part I](#)).

During the prospective MA eligibility determination, the applicant/recipient may present outstanding or new bills within the first 45 days of the prospective budget period. If all other eligibility criteria have been met, the Agency will notify the applicant/recipient in writing of the conditional denial, but will also note that the case, including medical expenses, is being transferred to the IMA Spend-Down Unit for further processing. If the expenses presented during the application process are equal to or greater than the spend-down deductible, the applicant/recipient must be certified as eligible within the prescribed time period for the month in which s/he incurred a medical expense which brings his/her total medical expenses above the spend-down deductible amount and for all subsequent months up to a maximum of six months of prospective eligibility.

If within the first 45 days of the prospective budget period, the applicant/recipient does not present accrued medical expenses which total or exceed his/her spend-down deductible amount, MA eligibility is 'conditionally denied' and the case is transferred to the IMA Spend-Down Unit. The Department will notify the applicant in writing of the conditional denial and the spend-down deductible for the prospective budget period. The IMA Spend-Down Unit will notify the applicant in writing of the remaining amount of medical expenses needed to meet the spend-down liability and will continue to monitor the application and recalculate spend-down deductible if additional allowable medical expenses are submitted by the applicant/recipient.

TWO METHODS FOR DETERMINING ELIGIBILITY THROUGH SPEND-DOWN PROCESS 7.7

There are two methods which can be used to determine whether a group is eligible for MA through the spend-down process. These methods apply both to determining retroactive and prospective eligibility.

Month-by-Month 7.7.1

Under this method, each month's medical expenses are compared to the monthly spend-down deductible. If the month's expenses exceed the monthly spend-down deductible, MA will pay for all covered medical expenses in excess of the group's spend-down deductible in that month.

Example 1

Retroactive Eligibility

Ms. Garay applies for Medicaid in August. She is found to be over-income for Medicaid. Her spend-down deductible is \$50 per month. Ms. Garay incurred monthly medical expenses of \$375 in May, \$300 in June, and \$400 in July and wants to apply for retroactive eligibility. Using the month-by-month method, Ms. Garay would qualify for Medicaid in May, June, and July because each month's medical expenses exceeded her monthly spend-down deductible. In each month, Medicaid pays the covered expenses in excess of her spend-down deductible.

Example 2

Prospective Eligibility

Ms. Taylor applies for Medicaid in August. She is found to be over-income for Medicaid. Her spend-down deductible is \$100 per month. Ms. Taylor wants to be considered for prospective eligibility only. Ms. Taylor expects to have medical expenses of \$250 per month. Using the month-by-month method, Ms. Taylor will qualify for Medicaid each month her medical expenses exceed \$100, and Medicaid will pay all covered expenses incurred in those months above the \$100 spend-down deductible.

Cumulative Spend-Down 7.7.2

Alternatively, the cumulative spend-down for the budget period can be calculated. When total medical expenses exceed the cumulative spend-down deductible, all future covered medical expenses are paid by MA.

Example 1

Retroactive Eligibility

Mr. Brown applies for Medicaid in September and is found to be over-income. He has a \$200 per month spend-down deductible. Over the three-month retroactive period (June - August), Mr. Brown has a cumulative spend-down deductible of \$600. In June, Mr. Brown was hospitalized and incurred \$30,000 in medical expenses. In July, his medical expenses totaled \$1,000, and in August, they totaled \$100. Mr. Brown has not paid the \$30,000 hospital bill, but he has paid his July and August expenses in full. Using the cumulative method, Mr. Brown meets his spend-down deductible in June. Thus, all but \$600 of his June hospital bill will be paid, and Mr. Brown will be reimbursed for all of his July and August expenditures. Mr. Brown will remain liable for \$600 of his June hospital bill.

If the month-by-month method had been used in this case, Mr. Brown would have been eligible in June and July, but not in August. All but \$200 of his \$30,000 hospital bill would be paid by Medicaid. Mr. Brown would be reimbursed \$800 (\$1,000 minus his \$200 spend-down deductible) for his July expenses and would not receive any reimbursement for his August expenditures since his August expenditures did not exceed his spend-down deductible.

In this case, Mr. Brown should be given the choice of methodologies since it is not clear which is better for him. Using the cumulative method, he is eligible for all three months and receives more in direct reimbursements but remains liable for \$600 in hospital bills. Using the month-by-month method, he receives less reimbursement but owes the hospital just \$200 rather than \$600. Assuming he intends to pay his outstanding hospital liability, his total out-of-pocket costs are less using the month-by-month method (\$200 in June, \$200 in July, and \$100 in August). If he does not intend to pay his outstanding hospital bill, he might prefer the larger direct reimbursement.

Example 3*Prospective Eligibility*

Ms. Jones applies for Medicaid in November and is found to be over-income. She wants to see her past unpaid medical expenses toward prospective eligibility. Over the seven-month period prior to applying for Medicaid, Ms. Jones accumulated \$2,200 in unpaid medical bills. Her spend-down deductible is \$400 per month, or \$2,400 over the six-month prospective eligibility period. She expects to spend \$500 on medication in November alone. By using the cumulative spend-down method, her past unpaid liabilities plus her expenses in November are likely to exceed her \$2,400 spend-down limit. Once this spend-down liability is met, all additional covered medical expenses will be paid for the Medicaid.

NOTIFICATION OF SPEND-DOWN STATUS 7.8

An applicant who is ineligible due to being over-income shall be sent a denial notice which informs him/her that s/he should contact the Spend-Down Unit. If the applicant is over-income and has submitted his/her medical bills to the SSR, the SSR should transfer the file and the medical bills directly to the Spend-Down Unit and send the applicant a denial notice which indicates that his/her file, including the medical bills, has been transferred to the Spend-Down Unit.

An applicant who meets the prospective spend-down deductible must be notified in writing of his/her eligibility for MA. This notification must include the dates for which the applicant is eligible for coverage and a statement that the Department will not pay for medical expenses used to meet the prospective spend-down deductible.

If eligibility under the spend-down provision has been considered for a retroactive budget period but has not been established because incurred medical bills do not exceed the spend-down deductible, the applicant must be notified in writing that retroactive spend-down eligibility is denied. This requirement for notification must be met even if the application has also been considered for prospective eligibility for MA, and a notice of approval or denial of prospective eligibility is sent.

INTERIM CHANGES 7.9

The SSR must assess the effect of any interim change that occurs during the prospective spend-down budget period. A change in income that occurs before a prospective spend-down deductible has been met requires the recalculation of the prospective spend-down deductible. The months in the budget period, however, are not affected.

A change in income that occurs after MA eligibility has been established with a spend-down deductible may require changes in the group's spend-down deductible and may affect the group's eligibility under the spend-down provision. If a previously eligible group must now meet a spend-down deductible, the SSR should conditionally deny the group.

If an additional prospective spend-down deductible is calculated, eligibility must be conditionally terminated. Eligibility may be re-approved if the applicant meets the amount of the additional spend-down deductible. In addition, if income increases for a group without a spend-down deductible, they may now be subject to meeting a spend-down liability.

RECERTIFICATION 7.10

If, at the time of recertification for MA, a recipient meets all eligibility requirements except that net income exceeds the MNIL, all spend-down provisions must be met.

The recipient must be notified of a conditional termination of assistance and of the amount of the prospective spend-down deductible.

This applies whether or not the assistance unit's eligibility during the previous period was established on the basis of spend-down.

LONG-TERM CARE AND SPEND-DOWN 7.11

Income eligibility for LTC assistance units is established in accordance with the policies governing the determination of the Patient Pay Amount (PPA) (see Section 2.14: Patient Pay Amount (PPA) in [Part VII](#)).

Chapter 8 - Determining Income Eligibility

INTRODUCTION 8.1

A group's countable income is used to determine whether the group is income-eligible for program benefits. The group's income is also used to determine the level of benefits for which the group is eligible in the TANF, GC, and FS programs. With the exception of groups eligible for MA through the spend-down provision (see Chapter 7: Spend-Down in this Part) and groups eligible under the QM category, once a group is determined eligible for Medicaid or D.C. Medical Charities, the group is eligible for a certain package of benefits and services. Groups with incomes further below the income-eligibility threshold are not eligible for different services than groups with incomes closer to the eligibility threshold.

If a group is categorically eligible for Medicaid or categorically eligible for FS because all household members receive TANF or SSI, the SSR does not have to determine income eligibility. The SSR must determine the level of FS benefits to which a categorically-eligible group is entitled.

Groups that have expanded categorical eligibility for FS because of the receipt of a prescribed TANF-funded service are subject to a gross income test, with the exception of groups with an elderly or disabled member. The SSR must determine the level of FS benefits to which an expanded-categorically eligible group is entitled.

Income is budgeted prospectively for all programs. Prospective budgeting means that you use the income receive in the month to determine eligibility. Since benefits are usually issued on the first of the month for the entire month, prospective budgeting requires that you:

- make a 'best estimate' of what the income will be in the month, and
- in some circumstances, compute an overpayment or underpayment if that estimate was not correct.

Exhibit VI-2: Summary of Earned/Unearned Income contains a summary table listing various types of income; these various types of income are discussed in greater detail in Chapter 4: Determining Countable Income in this Part.

All issues related to determining eligibility for MA through the spend-down provision are addressed in Chapter 7: Spend-Down in this Part. Similarly, determining eligibility for LTC (and the group's expected contribution toward LTC costs) is addressed in [Chapter 2: Long-Term Care/Impoverished Spouse in Part VII](#).

LEGAL AUTHORITY 8.2

AREA/TOPIC	DISTRICT	FEDERAL
Determining Income Eligibility	TANF: D.C. Code 3-205.10-11; 3-205.52	MA: 42 USC 1396a(a)(10); 1396a(l)-(m); 1396u-1; 1396u-3
	GC: See TANF and D.C. Code 3-205.5a	FS: 7 USC 2014(c); 7 CFR 273.9(a); 7 CFR 273.10(e)(2)

INCOME BUDGETING 8.3

MA	Total countable income for eligibility is determined on the basis of the income anticipated to be received during the certification period.
	A person may receive income less often than monthly or may receive a payment that is for a period of more than one month. The SSR enters into ACEDS information on the amount of income and how often

the income is received – weekly, bi-weekly, semi-monthly, or monthly. ACEDS then converts all income to a monthly amount if necessary by multiplying the average payment amount by the average number of payment periods in a calendar month:

- if payments are received weekly, multiply by 4.3, and round to the nearest cent;
- if payments are received bi-weekly, multiply by 2.15, and round to the nearest cent; and
- if payments are received semi-monthly, multiply by 2.

If the payments received in a month are not identical, then average the payments and then convert this average figure to a monthly amount.

The process of converting earnings or other income to monthly figures evens out a group's earnings so that the timing of paychecks and pay periods does not affect program eligibility. For example, if a person is paid bi-weekly, s/he will receive 26 paychecks in a year. Most months the person will receive 2 paychecks, but in two months s/he will receive 3 paychecks. Without converting bi-weekly pay to an average monthly earnings figure, the group might become ineligible for program benefits in the two months during the year in which the earner receives three paychecks.

Example

Ms. Elizondo and her two children apply for MA. Ms. Elizondo works and is paid bi-weekly. In the month of application, she has already received one paycheck for \$350 and is expecting to receive a second paycheck for \$400. She worked more hours in the second pay period than in the first. The SSR enters both paychecks into ACEDS and indicates that the applicant is paid bi-weekly. ACEDS uses that information to compute a monthly earnings figure. ACEDS performs the following steps:

1. Average the two paychecks to compute average bi-weekly earnings.
2. Convert the bi-weekly earnings to monthly earnings by multiplying the average bi-weekly earnings by 2.15.

In this case, Ms. Elizondo's average bi-weekly earnings are \$375. Her countable monthly earnings are computed to be \$806.25

When income is received in fewer months than are covered by a contract or agreement, divide the income for the contractual period by the number of months in the period.

Example

Mr. Thompson is under contract to renovate a home. The renovation is scheduled to take six months. The contract calls for paying Mr. Thompson \$6,000 for the work which will be provided when the work is completed. Divide the \$6,000 (contracted earnings) by the contractual period (six). Mr. Thompson is treated as if he earns \$1,000 per month during the months covered by the contract.

If self-employment or rental income is received less often than monthly, convert the self-employment or rental income to a monthly amount based on past or estimated future proceeds.

Divide educational benefits by the number of months in the period the benefits are intended to cover (that is, semester, term, and so on).

If income is received on a regular basis and is representative of the amount the applicant or recipient can reasonably be expected to receive throughout the eligibility period, total countable income is projected on the basis of the income actually received during the thirty days preceding the date of application or recertification.

If total countable income received during the thirty days preceding the date of application is not representative of the income that the applicant or recipient can reasonably be expected to receive, as in cases where the individual has been ill, is performing seasonal labor, or anticipates an increase in income, make the necessary adjustment for an accurate projection of income.

If income is received on an irregular basis, review the case circumstances with the applicant or recipient to determine the most appropriate means of projecting income. A lump sum payment of earned income must be prorated over the months it is expected to take to earn the payment. If the irregular income is from self-employment or seasonal employment, review the income earned during the three months prior to the month of application or recertification if that is the best estimate of what future earnings during the certification period are likely to be.

Example

Ms. Weiss earns \$6.15 an hour and usually works 40 hours a week. She is paid every other Friday. Her last three gross pay amounts (from the month prior to the month of application) were \$492, \$492, and \$522.75. The higher pay amount was the result of working overtime.

Ms. Weiss has submitted a signed statement from her employer to verify that her hours will be cut back to 35 hours per week effective the first day of the next month.

When determining Ms. Weiss's income for the month of application (when she was still working 40 hours per week), use her expected gross pay for the month of application. If she expects to work 40 hours during the month of application and does not expect to work overtime, assume that she will earn \$492 per paycheck. (ACEDS will convert her gross earnings from these two paychecks to a monthly earnings figure based on her being paid bi-weekly.) Determine the group's eligibility for the month of application based on her expected monthly income in that month.

When determining the group's eligibility in future months, Ms. Weiss's expected earnings, taking into account her reduced hours of work, should be used. Ms. Weiss's paychecks are expected to be reduced to \$430.50 based on working 35 hours per week at \$6.15 per hour. This bi-weekly earnings figure should be used when determining the group's prospective eligibility.

In determining eligibility on the basis of income, certain deductions are subtracted from countable income to determine net MA income (see Section 6.3: Income Disregards and Deductions in this Part. Net MA income is then compared to the applicable income levels to determine eligibility.

TANF	See MA.
GC	Income is budgeted prospectively. GC groups rarely have countable earnings since GC groups are comprised solely of children enrolled in school who are not working full-time. A child eligible for GC has his/her earnings disregarded entirely. If a GC child is married however, earnings could be deemed. In this rare case, earnings would be converted to expected monthly earnings as in TANF.

FS	See MA.
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DETERMINING INCOME-ELIGIBILITY 8.4

MA	<p>For groups categorically eligible for MA (i.e., groups receiving TANF, GC, and/or SSI; see Section 12.3: Who is Categorically Eligible in Part IV), no income-eligibility determination must be made.</p> <p>For a non-categorically eligible group, determine the group's countable income (including income deemed from individuals outside the group) applying applicable disregards (see Section 6.3: Income Disregards and Deductions in this Part). Compare countable income to the income standards listed in Exhibit VI-3: MA Income Standards.</p> <p>If the group's income is below the relevant income standard and the group meets all non-financial eligibility criteria and, if applicable, the asset limit, the group is eligible for MA. If the group is ineligible for MA based on its income exceeding the income-eligibility criteria, the group may be eligible for MA through the spend-down provisions which enable individuals with medical bills to 'spend down' their income to qualify for Medicaid coverage (see Chapter 7: Spend-Down in this Part).</p>
TANF	<p>The steps for determining whether a group is eligible for TANF differ depending on whether the group is applying for benefits (applicant) or is already receiving benefits (recipient). Exhibit VI-4: TANF Standard of Assistance and Payment Levels shows the income standards SSRs should use when determining eligibility for groups applying for benefits or for groups already receiving benefits.</p> <p>Effective April 1, 2011, there are two different Payment Levels for TANF. Use the Full Payment Level when determining eligibility for groups that have received TANF for 60 months or less. Use the Reduced Payment Level to determine eligibility for groups that have received TANF for 61 months or more (See Part IV, Chapter 13: Lifetime Limits.)</p> <p><i>Determining Applicant Eligibility</i></p> <p>The following should be used to determine whether a group applying for benefits is eligible for TANF:</p> <ul style="list-style-type: none"> • Determine gross countable earned and unearned income (see Chapter 4: Determining Countable Income in this Part). • Apply applicable applicant disregards to calculate net countable income (consisting of net countable earned income and countable unearned income). Applicant disregards consist only of the \$160 Work Expense Deduction (per employed group member) and the Child Care Disregard based on out-of-pocket child care expenses (see Section 6.3: Income Disregards and Deductions in this Part). • Compare net countable income to the appropriate Payment Level. If net countable income exceeds the payment level, the group is ineligible for TANF.

Example

Ms. Dawes and her two children apply for TANF. Ms. Dawes earns \$350 per month and receives \$200 per month in child support. No group member receives any other income. Ms. Dawes spends \$120 per month on child care for her two-year-old son.

Gross Earned Income	= \$350	
Gross Unearned Income	= \$200	
Unearned Income	= \$200	
	– \$150	Child Support Disregard
Countable Unearned Income	= \$50	
Earned Income	= \$350	Gross Earned Income
	– \$160	Work Expense Deduction
	– \$120	Child Care Disregard
Countable Earned Income	= \$70	
Net Countable Income	= \$70	Net Earned Income
	+ \$50	
	= \$120	

Ms. Dawes has received TANF in the past for a total of 40 months.

The payment level for a group of three is \$428 (as of January, 2009.) Since the group's net countable income is less than the payment level, the group is income-eligible for TANF.

Determining On-Going Recipient Eligibility

To determine whether a group that received TANF in the prior month remains income-eligible for TANF assistance, determine the following:

- Determine gross countable earned and unearned income. Generally, a TANF recipient must assign the child support rights of his/her children to the District of Columbia government. Child support collected by CSED does not count as unearned income (see Section 4.9: Child Support in this Part).
- Apply applicable recipient disregards to calculate net countable income (consisting of net countable earned income and countable unearned income). Recipient disregards consist of the \$160 Work Expense Deduction (per employed group member), the two-thirds (2/3) Earned Income Disregard (two-thirds of earnings not already disregarded), and the Child Care Disregard based on out-of-pocket child care expenses (see Section 6.3: Income Disregards and Deductions in this Part).
- Compare net countable income to the appropriate Payment Level (see Exhibit VI-4: TANF Standard of Assistance and Payment Levels) for the appropriate group size. If net countable income exceeds the payment level, the group is ineligible for TANF.

Example

Ms. Roberts and her daughter receive TANF. Ms. Roberts has found a job since receiving TANF and now earns \$500. She does not have out-of-pocket child care expenses.

Gross Earned Income	= \$500	
Gross Unearned Income	= \$0	
Net Earned Income	= \$500	Gross Earned Income
	- \$160	Work Expense Deduction
	- \$227	two thirds of \$340 (earnings not already disregarded)
	= \$113	
Net Countable Income	= \$113	Net Earned Income
	+ \$0	Unearned Income
	= \$113	

Ms. Roberts has received TANF in the past for a total of 63 months.

The Reduced Payment Level for a family of two is \$269 (as of April, 2011.) Since the group's income is below this level, the group is income-eligible for TANF.

GC Since a GC child's earnings are not counted when determining eligibility, net and gross income in the GC program are generally the same. If, however, a GC child is married, applicable earned income disregards and dependent care deductions must be applied to his/her earnings. To determine income-eligibility for GC, compare the sum of countable earned and unearned income to the payment level (see Exhibit VI-4: TANF Standard of Assistance and Payment Levels) for the appropriate group size. If the income is less than the payment level, the group is eligible for GC.

FS For categorically eligible groups in which all members receive TANF or SSI, no income-eligibility determination needs to be made. Groups with expanded categorical eligibility due to receiving a prescribed TANF-funded service are subject to a gross income test, unless they include a disabled or elderly person. Information on determining the level of benefits for these groups is provided in Section 8.5: Determining Benefits Level / Amount of Assistance in this Chapter.

For most other groups, there are one or two 'tests' a group (regardless of whether it is an applicant or recipient group) must pass in order to be found income-eligible for FS; the gross income test and the net income test. Groups that include an elderly (a person age 60 or over) and/or a disabled person do not have to meet the gross income test nor the net income test once, once they qualify for expanded categorical eligibility by receiving a prescribed TANF-funded benefit. There is one exception: a household with an elderly or disabled member where any member is disqualified for fraud or Intentional Program Violation (IPV) cannot qualify as an expanded-categorically eligible household and is subject to the net income test. Exhibit VI-5: FS Income Standards shows the standards for each test by household size.

Gross Income Test

To pass the gross income test, gross countable income (that is, the sum of gross earned and gross unearned income before any deductions are taken) must be less than the gross income limit for the relevant group type and size. The gross income limit is set at 200% of the FPL for expanded-categorically-eligible groups and at 130 percent of the FPL for other groups subject to the Gross Income Test.

	<p>The following groups are not subject to the Gross Income Test:</p> <ul style="list-style-type: none"> • Categorically eligible groups in which all group members receive TANF or SSI; and • Groups that include an elderly person (age 60 or over) or a disabled person. <p>Expanded-categorically eligible groups that do not contain an elderly or disabled person and all other groups must pass a Gross Income Test See Exhibit VI-5: FS Income Standards for the current gross income limits and other FS parameters (maximum benefit, etc.).</p> <p><i>Net Income Test</i></p> <p>Some groups that pass the gross income test, or are not subject to the Gross Income Test, must pass a Net Income Test. To determine if a group passes the net income test, compare the group's net countable income to the net income test level for the appropriate group size. The net income test levels for each group size are set by the federal government at 100 percent of the FPL.</p>
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Net Countable Income =	Gross Countable Earned Income
–	Earned Income Deduction (20 percent of gross countable earnings)
+	Gross Countable Unearned Income
–	Standard Deduction
–	Excess Medical Deduction (only applies to groups w/ an elderly or disabled group member)
–	Dependent Care Deduction
–	Child Support Deduction
–	Excess Shelter Deduction

The following groups are not subject to the net income test:

- Categorically-eligible groups where all members receive TANF or SSI;
- Expanded-categorically eligible groups that have received a prescribed TANF-funded service

Other groups must meet the net income test to be eligible for FS benefits.

Future Ineligibility Based on Receipt of a Lump Sum or Accrued Benefit 8.4.1

MA	N/A
TANF	<p>A lump sum/accrued benefit received in the month of application is considered in determining ineligibility in future months. Receipt of a lump sum or accrued benefit by anyone in the household will cause future ineligibility or a reduction in payment if it together with other income exceeds the standard of assistance (see Exhibit VI-4: TANF Standard of Assistance and Payment Levels).</p> <p>Consider a lump sum as income in the month received.</p> <p>Calculate the period of ineligibility by dividing the lump sum/accrued benefit plus the group's countable income after disregards in the month the lump sum was received (see Section 6.3: Income Disregards and Deductions in this Part) by the standard of need based on the group's size. The result of this calculation is the number of months the group is ineligible. Any remainder is considered available income in the month following the final month of ineligibility.</p>

Example

A group of three receives a lump sum of \$3,000 and also has earnings of \$200 (after disregards) in the month. Its need standard is \$712. Consequently, the group is ineligible for four months and \$352 is considered available income in the 5th month ($3,000/712 = 4$ with 352 remaining).

Recalculate the period whenever a group reapplies for assistance before the end of the period or whenever the group requests it.

The period of ineligibility will be shortened if:

- the need standard increases,
- the number of people in the group increases,
- the lump sum becomes unavailable to the group for a reason beyond its control, or
- the group incurs and pays for medical expenses.

'Unavailable' means that the funds are no longer in the possession of the group. 'A reason beyond the group's control' means that the funds were either stolen or spent for any of the following:

- back rent or mortgage after threatened with eviction;
- repair or replacement of essential appliances such as stoves or refrigerators;
- funeral or burial expenses for a spouse, child, or parent;
- travel costs related to the death of a spouse, parent or person in that role, or child;
- overdue utility bills after threatened with cut off;
- court judgments including legal fees;
- repair of motor vehicle essential for employment;
- replacement of essentials lost due to fire, flood, or other natural disaster or theft; and
- essential repairs to owner-occupied homes.

The following should be used to recalculate a period of ineligibility.

- Determine the number of months of ineligibility already used.
- Multiply the number of months of ineligibility already used by the need standard originally used to calculate the period to arrive at the amount of income already used.
- Subtract the amount of income already used, any unavailable portions of the original lump sum, and any medical expenses from the original income used to calculate the period to arrive at a revised income amount.
- Determine the need standard for the current group, adding new members if any and excluding original members now absent.
- Divide the revised income amount by the need standard.

The result is the number of remaining months of the ineligibility period. Any remainder is considered available income in the month following the final month of ineligibility. If the calculation results in no period of ineligibility, assistance begins with the date of re-application or request for re-calculation. No underpayments exist for prior months.

A person who joins the group, such as a newborn, may not establish a separate group. Instead, recalculate the period of ineligibility.

Example

A group of two receives a lump sum of \$10,000. Its need standard is \$560. The group is ineligible for 17 months with \$480 available in the 18th month. After five months of ineligibility, the family re-applies. Twins were born during this time, and the family paid \$1,000 in medical expenses.

\$560	original need standard for 2
x 5	number of months of ineligibility already used
= \$2,800	amount of income already used
 \$10,000	 original income
– \$2,800	amount of income already used
– \$1,000	medical expenses
= \$6,200	revised income amount
 \$870	 new need standard for 4
 \$6,200	 revised income amount
÷ \$870	new need standard for 4
= 7	additional months of ineligibility

The group is ineligible for 7 more months including the month of re-application with \$110 available for the 8th month.

Do not apply this lump-sum/accrued benefit policy to the deemed income of a person who is not required to be in the group (see Section 5.4: Deeming Income in this Part). It is available for only one month. Apply the policy to lump sum/accrued benefits received by mandatory group members who are disqualified. Compute the period of ineligibility by including their needs in the need standard amount.

GC	See TANF
FS	N/A

Determining Retroactive Eligibility 8.4.2

MA	<p>AR: When a person applies for Medicaid, s/he can also apply for three months of retroactive eligibility. In order to determine retroactive eligibility, determine the group's countable income (including income deemed from individuals outside the group) after applying applicable disregards (see Section 6.3: Income Disregards and Deductions in this Part) in each month of the three-month retroactive period. Compare countable income to the income standards listed in Exhibit VI-3: MA Income Standards.</p> <p>In each month in which the group's income is below the relevant income standard, the group meets all non-financial eligibility criteria, and, if applicable, the asset limit, the group is eligible for MA. If the group is ineligible for retroactive MA based on its income exceeding the income-eligibility</p>
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	<p>criteria, the group may be eligible for retroactive MA through the spend-down provisions which enable individuals with substantial medical bills to 'spend down' their income to qualify for Medicaid coverage (see Chapter 7: Spend-Down in this Part).</p> <p>AX: See AR.</p> <p>SR: See AR.</p> <p>QM: QMBs are not eligible for retroactive eligibility. For SLIMBs, QDWIs, QI-1s, and QI-2s, see AR.</p> <p>MC: N/A</p>
TANF	N/A
GC	N/A
FS	N/A

DETERMINING BENEFITS LEVEL/AMOUNT OF ASSISTANCE 8.5

MA	See Chapter 7: Spend-Down in this Part for a description of how to determine a group's spend-down liability. Groups eligible for Medicaid under the QM categories (and not otherwise eligible for Medicaid) are eligible only for full or partial reimbursement for Medicare premiums, deductibles and co-payments. Otherwise, groups determined eligible for MA are eligible for the full range of services without co-payments, premiums, or deductibles.
TANF	<p>If an applicant/recipient has been found to meet all non-financial eligibility criteria, the asset test, and the income-eligibility criteria (the calculation to determine whether a group is income-eligible for TANF differs depending on whether the group is an applicant or recipient group; see Section 8.4: Determining Income-Eligibility in this Chapter), the group is eligible for TANF. The level of monthly benefits for which the group is eligible must now be determined by taking the following steps (information on how to prorate the first month's benefits based on date of application is found in Section 8.5.1: Prorating Benefits for New Applicants in this Chapter).</p> <ul style="list-style-type: none"> • Determine gross countable earned and unearned income. Generally, a TANF recipient must assign the child support rights of his/her children to the District of Columbia government. Child support collected by CSED does not count as unearned income. Child support received by the family in the first two months of TANF receipt (prior to the assignment becoming effective) does count as unearned income (see Section 4.9: Child Support in this Part). After two months, the SSR should assume that CSED is collecting and retaining the group's child support. If the SSR learns that this is not the case, the SSR should inform CSED that child support is being paid to the family. The SSR should not, however, count the child support received unless the adult failed to cooperate with CSED requirements and the group is under a CSED sanction with respect to the child on whose behalf support is being received directly. • Apply applicable recipient disregards to calculate net countable income (consisting of net countable earned income and countable unearned income). Recipient disregards consist of the \$160 Work Expense Deduction (per employed group member), the two-thirds (2/3) Earned Income Disregard (two-thirds of earnings not already disregarded), and the Child Care Disregard based on out-of-pocket child care expenses (see Section 6.3: Income Disregards and Deductions in this Part). In cases in which a group fails, without good cause, to report its earnings in a timely manner, the two-thirds (2/3) earned income disregard is disallowed. • Subtract net countable income from the appropriate Payment Level for the appropriate group size. Round the result to the next lowest whole dollar. If the group is eligible for

	benefits of less than \$10 but more than \$0, the group will remain eligible (and its case will remain 'open') but TANF EBT benefits will not be issued. In such a circumstance, the group remains categorically eligible for Medicaid under the TANF Standard category in AR
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Example		
Ms. Berry and her three children receive TANF. Ms. Berry works and is paid bi-weekly. She expects to earn \$250.50 per pay period. One of her children receives \$150 per month in Social Security Survivor's benefits.		
Countable Gross Monthly Earned Income = \$250.50 *2.15 = \$537.50		
Countable Gross Monthly Unearned Income = \$150		
Total Gross Countable Monthly Income = \$687.50		
Net Earned Income	= \$537.50	Gross Earned Income
	- \$160	
		Work Expense Deduction
	= \$377.50	
	- \$251.67	two-thirds (2/3) of remaining earnings
	= \$125.83	
Net Countable Income	= \$125.83	Net Earned Income
	+ \$150	Unearned Income
	= \$275.83	
Ms. Berry has received TANF for a total of 43 months, so the Full Payment Level is used		
Monthly Benefit Level	= \$528	Full Payment Level for a Group of Four
	- \$275.83	
	= \$252.17	This must be rounded down to the nearest dollar.
Ms. Berry and her children are eligible for \$252 per month in TANF benefits.		

GC	Since a GC child's earnings are not counted when determining eligibility or benefit levels, net and gross income in the GC program generally are the same (the only exception is when a GC recipient is married). To determine GC benefits, subtract countable earned and unearned income from the payment level for the appropriate group size. Round the result to the lowest whole dollar. If the group is eligible for less than \$10, the group will not receive GC benefits, but remains eligible for Medicaid under the AR - TANF Standard. The same payment level is used in GC as in TANF. See Section 8.5.1: Prorating Benefits for New Application in this Chapter for information on how to prorate benefits.
FS	If a group is categorically eligible for FS, or found to meet all criteria of expanded-categorical-eligibility, or a group is found to meet all non-financial eligibility criteria, the asset test, the gross income test, and the net income test, the group is usually eligible for FS benefits. To determine the FS

benefit level for which a group is eligible, follow these steps (see Section 8.5.1: Prorating Benefits for New Applicants in this Chapter for information on how to prorate benefits):

- Calculate net countable income (see Section 6.3: Income Disregards and Deductions in this Part; this is the same calculation used to determine whether the group meets the net income test).

Net Countable Income	=	Gross Countable Earned Income
	–	Earned Income Deduction (20 percent of gross countable earnings)
	+	Gross Countable Unearned Income
	–	Standard Deduction
	–	Excess Medical Deduction (only applies to groups w/ an elderly or disabled group member)
	–	Dependent Care Deduction
	–	Child Support Deduction
	–	Excess Shelter Deduction

- Multiply net countable income by 30 percent. If 30 percent of the group's income ends in cents, round the figure up to the next dollar.
- FS Benefits = Maximum Allotment – 30 percent of net countable income (see Exhibit VI-5: FS Income Standards for a table that lists the Maximum Allotment by group size).

Example

Ms. Akers, her two children (18 months and four years), and Ms. Akers' mother (68) live together and meet all the non-financial and financial criteria for FS. Ms. Akers works and is paid weekly. Ms. Akers expects to earn \$156.20 per pay period and has no other earned income. Ms. Akers' mother receives \$200 per month in alimony from her ex-husband. Ms. Akers rent is \$420 per month, including utilities. Ms. Akers attends school two evenings a week under a Pell Grant which pays her tuition of \$200 per month. In order for Ms. Atkins to work, she pays \$100 per month for daycare for her four-year-old child. Her mother takes care of the 18-month-old baby.

Ms. Akers' household should receive the following disregards and deductions when calculating the FS benefit level:

- Earned Income Deduction
- Standard Deduction
- Dependent Care Deduction
- Excess Shelter Deduction

Because the group has an elderly member, it does not have to meet the gross income test.

Monthly Countable Gross Earned Income = $\$156.20 \times 4.3 = \671.66

Monthly Countable Gross Unearned Income = \$200

Excluded Income = \$200 (Pell Grant)

Monthly Countable Gross Earned Income	\$671.66
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Earned Income Deduction (20% of \$671.66)	– \$134.33
	\$537.33
Monthly Countable Gross Unearned Income	+ \$200.00
	= \$737.33
Standard Deduction	– \$139.00
	= \$598.33
Dependent Care Deduction	– \$100.00
	= \$498.33
Excess Shelter Deduction (Elderly/Disabled) (\$420 - ½ *\$498.33)	– \$170.83
Net Countable Income	= \$327.50
\$327.50 * 30% = \$98.25 (round up to \$99)	
FS Benefits = \$518 (Maximum Allotment for a Household of Four) – \$99 = \$419	

Effective November 1, 2013, all groups of two or fewer members that meet all financial and non-financial eligibility requirements will receive a minimum monthly allotment of \$15 (except in the first month when benefits are pro-rated).

Groups of three or more persons may meet non-financial and gross income and net income criteria, but be determined to be eligible for \$0 in FS benefits. Deny FS in this situation.

Example

Mr. Jones and his three children apply for FS. Mr. Jones works, and has monthly gross earnings of \$3,600. He is given the TANF Domestic Violence brochure and under Expanded Categorical Eligibility, his income is less than 200 % FPL, \$3,676. He only pays \$100 in rent, is eligible for the Heating/Cooling Utility Allowance because he received LIHEAP, and does not pay any dependent care or child support.

Mr. Jones' household should receive the following disregards and deductions when calculating the FS benefit level:

- Earned Income Deduction
- Standard Deduction

Because the group has Expanded Categorical Eligibility, it does not have to meet the net income test.

Monthly Countable Gross Earned Income \$3,600.00

Total Monthly Countable Gross Income	= \$3,600.00
Earned Income Deduction (20% of \$3,600)	– \$720.00
	= \$2,880.00
Standard Deduction	– \$153.00
	= \$2,727.00
Excess Shelter Deduction	– \$0.00

$(1/2 * \$2127) - (\$100 + 300)$	
Net Countable Income	= \$2,727.00
$\$2,727.00 * 30\% = \818.10 (round up to \$819)	
FS Benefits = \$668 (Maximum Allotment for a Household of Four) – \$819 = \$0	
This household meets the gross and net income tests but is not eligible for an allotment. Deny the application.	

Other groups eligible for less than \$10 receive the amount for which they are actually eligible, except that groups eligible to receive \$1, \$3, and \$5 allotments receive \$2, \$4, and \$6 allotments respectively.

A FS allotment cannot be increased when a household's income has been reduced as a result of a penalty imposed under another assistance program. If a group's income is lower due to a penalty, such as a TANF sanction, compute the group's FS benefits as if no sanction were imposed.

Applicant groups consisting of residents of public institutions who apply jointly for SSI and FS prior to release from the public institution will have their eligibility determined for the month in which the applicant group was released from the institution. For these groups, the benefit level for the initial month of certification shall be based on the date of the month the group member is released from the institution and benefits are received from the date of release from the institution to the end of the month. Recertification shall be processed in accordance with [Chapter 4: Recertification in Part VIII](#).

Groups applying for FS who are migrant and seasonal farm workers after a break in benefit receipt are not always treated the same as other FS applicants. In such cases, the IMA Administrator's office should be contacted

Prorating Benefits for New Applicants 8.5.1

MA	N/A
TANF	<p>When a new applicant group is determined eligible, its first month's benefits are prorated based on the date of application. To prorate benefits, ACEDS will do the following calculations:</p> <ol style="list-style-type: none"> 1. Calculate benefits as if the group would be eligible for a full month of benefits. 2. Determine the number of days between the date of application and the end of the month, including the date of application: Number of Days in the Month – Application Date + 1 3. Divide the result in (2) above by the number of days in the month and multiply the result by the full-month benefits for which the group would have been eligible (see (1) above). Benefits are rounded down to the nearest dollar. If benefits are less than \$10, no benefits are issued (even if the group would generally receive a \$10 minimum benefit).

Example

Ms. Smith applies for benefits on June 17 and is found eligible. Based on her income, she would have been eligible for a \$200 TANF grant in June, had she applied on June 1. Her June benefits must be prorated. There are 30 days in June. Since her eligibility is effective on the date of application, June 17,

she is eligible for 14 days of benefits in June.	
Full-month benefits = \$200	
Days left in the month	= 30 Days in June
	- 17 Date of Application
	+ 1
	= 14
Prorate Benefits	
0.4667	14 divided by 30
x \$200	full-month benefits
\$93.33	This must be rounded down to the nearest dollar.
The group will receive \$93 in TANF benefits for the month of June.	

GC	See TANF
FS	See TANF. In months in which benefits are pro-rated, the \$16 minimum monthly benefit guaranteed to certain FS groups does not apply.

VERIFICATION 8.6

Requirements 8.6.1

MA	<p>AR/AX D.C. Healthy Families Application Users: Only verification of gross income and out-of-pocket dependent care expenses is required.</p> <p>AR/AX Combined Application Users: Verify income prior to authorizing benefits at application, at redetermination, and whenever a change affecting income occurs.</p> <p>Verify all countable earned and unearned income.</p> <p>Verify disabled applicant's claim that s/he receives no disability benefits. The last known employer is a suggested contact.</p> <p>Any income change must be verified when reported.</p> <p>Document excluded income in the case record. Verification is not normally required because excluded income does not affect eligibility. The SSR may request it if there is not enough information to determine whether the income can be excluded. The SSR must verify income that is only partially excluded or when the amount affects allowable expenses.</p>
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	<p>There might be unreported income such as SSI, SSDI, UCB, educational income, or public assistance. Request verification if the case is questionable, and document your reasons in the case record. Some situations which might indicate unreported income are:</p> <ul style="list-style-type: none"> • Beneficiary Data Exchange (BENDEX) indicates receipt of SSI, Railroad Retirement Board Benefits, or Black Lung Benefits; • shelter payments are higher than reported income; • an employable applicant reports no income; or • the client is attending school and might receive educational income. <p>The usual source of verification of income is the pay envelopes or paycheck stubs that the employed individual receives with each paycheck. Request recent consecutive pay stubs representing at least four weeks of earnings at the outset, and then ask for additional stubs if the four are not representative of average earnings. A statement from the employer may also be accepted.</p> <p>SR: See AR/AX Combined Application Users.</p> <p>QM: See AR/AX Combined Application Users.</p> <p>MC: See AR/AX Combined Application Users.</p>
TANF	See AR/AX Combined Application Users.
GC	See AR/AX Combined Application Users.
FS	<p>Gross non-exempt income must be verified. However, do not deny an application or close a case solely because the source of the income is uncooperative. After trying all other means to verify the income, consult the client and use the best available information. The SSR must document in the case record the attempts to verify and why they were unsuccessful.</p> <p>Budgetable educational income from the school must be verified. A Student Financial Aid statement may be used for this purpose. Other forms of verification provided by the school may be used if complete.</p> <p>Since categorically eligible households include only members who receive TANF and/or SSI and income is verified in these programs, verification of income for categorically eligible FS groups is not required unless needed to determine benefit level.</p> <p>The following expenses must be verified, at least at initial certification, if they result in a FS deduction: medical expenses, shelter costs, and child support payments. Dependent care expenses only need to be verified if questionable.</p> <ul style="list-style-type: none"> • Medical Expenses: All medical expenses that result in a deduction must be verified during the initial application process. At recertification or when a change is reported, the SSR will verify the expense if it results in a deduction and only if: <ul style="list-style-type: none"> ○ the source of the expense has changed, ○ the amount of the expense has changed by more than \$25 monthly, or ○ the information provided is incomplete or inconsistent. <p>If the eligibility of the person claiming medical expenses is questionable, the SSR may request verification of age or disability. Other factors, such as allowability of services, do not have to be verified unless questionable.</p>

	<p>If there is any question whether a medical service was performed, prescribed, or approved by a licensed practitioner, qualified health professional, or recognized facility, the SSR may request verification.</p> <ul style="list-style-type: none"> Shelter Expenses: Shelter expenses (other than heat, utilities, and telephone) must be verified at initial application and at redetermination. In addition, reported changes in shelter expenses must be verified if the source or amount changes and the change would result in an increase in benefits. <p>When the SUA is used, the heat and/or utility obligation does not have to be verified unless questionable. When the group chooses to use actual expenses, the expenses must be verified prior to inclusion in the budget. Changes in actual utility expenses must be verified if the source or amount changes and the change would result in an increase in benefits. Actual heat and/or utility expenses for an unoccupied home must always be verified as the utility standard cannot be used. If verification of utility costs is not received within the applicable timeframes, the SSR should use the SUA provided the unit pays for heating and/or cooling.</p> <p>The SSR is not required to assist FS groups to obtain verification of shelter costs for an unoccupied home in another state.</p> <ul style="list-style-type: none"> Child Support Payments: The SSR must obtain verification of each group member's legal obligation to pay child support, the amount of the obligation, and the monthly amount of child support the group actually pays
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Verification Sources for Unearned Income 8.6.2

ALL	<p>The client is the primary source to verify income. Verification may be from the following sources:</p> <ul style="list-style-type: none"> documents (such as pay stubs or award notice), or written statements from persons with knowledge of the group's income (such as an employer or agency issuing benefits). <p>You may verify most types of unearned income by a written statement from the agency, organization, or person administering the payment. The verification must confirm:</p> <ul style="list-style-type: none"> the monthly benefits amount, amount of deductions, and whether deductions are mandatory <p>A recipient award notice is acceptable if it is dated within the past 60 days and there is no reason to suspect the amount has changed.</p> <p>The following provides a list of common forms of unearned income and verification sources:</p> <ul style="list-style-type: none"> Educational Income can be verified through the educational institution. If verification of a Bureau of Indian Affairs Higher Education Grant is not available from the institution, the Indian tribe's Education Director can furnish it. A student financial aid award notice can also verify educational benefits. Court-Ordered Child Support and Spouse Support can be verified by information from the court (verification of public records, other written statement, or contract). CSED may also be
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	<p>able to provide verification of support received.</p> <ul style="list-style-type: none"> • SSDI and SSI can be verified by: <ul style="list-style-type: none"> ○ BENDEX report, or ○ SSDI/SSI award notice • Unemployment Compensation (UCB) can be verified by a UCB check stub or award letter. • Voluntary Support can be verified by: <ul style="list-style-type: none"> ○ written statement from the absent parent, ○ payment records, or ○ client's statement if the absent parent refuses to cooperate and the payments are in cash. <p>For all unearned income, a copy of the benefits check(s) or check stub(s) is adequate if:</p> <ul style="list-style-type: none"> • it clearly shows the benefit amount and deductions, • it is dated within the past 60 days, and • you have no reason to believe the amount has changed.
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Verification of Earned Income 8.6.3

r	<p>The client is the primary source to verify income. Verification may be from the following sources:</p> <ul style="list-style-type: none"> • Documents (such as pay stubs or award notice) • Written statements from persons with knowledge of the group's income (such as employer or agency issuing benefits). <p>Verify the following types of income with one of the stated sources or its equivalent:</p> <ul style="list-style-type: none"> • Child Care, Child Services, and Adult Foster Care Income <ul style="list-style-type: none"> ○ statement from the person receiving the service, ○ written statement from the worker who authorizes payment for the service, or ○ bills or statements from the provider stating the cost of care, the period for which the care was provided, and the nature of the care • Earnings from Employment <ul style="list-style-type: none"> ○ income tax returns, ○ pay stubs, or ○ other written statement, signed by the employer, giving the necessary information • Property-Related Income (this could be earned or unearned income depending on the extent to which the individual serves in a property management capacity; see Section 4.37: Rental Income in this Part). <ul style="list-style-type: none"> ○ mortgage or land contract, or ○ bills or receipts • Rental and Room and Board Income (this could be earned or unearned income depending on the extent to which the individual serves in a property management capacity; see Section 4.37.1: Room and Board in this Part). <ul style="list-style-type: none"> ○ written statement from the boarder/renter, ○ accounting or other business records, ○ lease or contract, ○ rent receipt book, or ○ request for rental information statement if the boarder/renter receives public assistance • Self-employment
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- business receipts
- accounting or other business records, or
- clients
- Tips
 - pay stubs if the employer confirms that they reflect actual tips (tips shown on pay stubs are usually a percentage for tax purposes); or, if not available,
 - client's statement.

Verification of Expenses 8.6.4

ALL The applicant/recipient is the primary source for verification. Verification may be from the following sources:

- documents (such as receipts), or
- written statements from persons with knowledge of the group's income (such as employer or agency issuing benefits).

Verify the following types of expenses (when needed to determine eligibility or benefit levels) with one of the stated sources or its equivalent:

- Medical bills and receipts for prescriptions and medically necessary OTC medication can serve as verification for medical expenses. For the excess medical deduction in the FS program, you may have to verify age. Examples of acceptable verification of age include:

- records of birth or baptism,
- adoption records,
- hospital or physician's records,
- Social Security records,
- school records,
- marriage certificates,
- insurance policies, and
- enrollment records of voting districts.

The SSR also may have to verify if the service was provided by an appropriate source. Acceptable verification includes, but is not limited to:

- copies of prescriptions, or
- statements or bills from physicians, pharmacists, or other certified providers.
- Dependent Care Expenses can be verified by a bill from the provider, canceled checks showing payment, or a written statement by the provider.
- Shelter Expenses can be verified with:
 - lease,
 - canceled rent/mortgage checks,
 - statement from lender or landlord, or
 - bill or receipt
- Utility Costs can be verified with bills from utility providers. If the utility bills show unpaid past liabilities, the SSR must determine usual utility costs incurred each month.

FS	Effective January 1, 2010, every Food Stamp recipient is expected to receive a LIHEAP payment. For active FS cases, no verification of utility costs is needed. Applicants may need to document utility costs if the applicant would not be eligible for FS without a utility allowance.
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EXHIBIT VI-3 MA INCOME STANDARDS

Policy Category	Eligibility Criteria	Subtype	Group Size	Income Standard (effective February 2013)
AR	TANF Standard	Individuals receiving TANF	All	None—Categorically Eligible
		Individuals who meet the TANF payment standard but are not receiving TANF (categorically needy standard)		See Exhibit VI-4: TANF Standard of Assistance and Payment Levels
	Foster Care/Department Wards/Adoption Assistance Recipients		All	None—Categorically Eligible
	Medically Needy Families and Children (MNIL)		1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	\$613.94 \$646.25 \$813.75 \$981.25 \$1,148.75 \$1,316.25 \$1,483.75 \$1,651.25 \$1,818.75 \$1,986.25 \$2,153.75 \$2,321.75 \$2,488.75 \$2,656.25 \$2,823.75 \$2,991.25 \$3,158.75 \$3,326.25 \$3,493.75
	Poverty Level Families and Children	Pregnant women and children under age one (185 percent of	1	\$1,771.38

		FPL)	2	\$2,391.13
			3	\$3,010.88
			4	\$3,630.63
			5	\$4,250.38
			6	\$4,870.13
			7	\$5,489.88
			8	\$6,109.63
			9	\$6,729.38
			10	\$7,349.13
			11	\$7,968.88
			12	\$8,588.63
			13	\$9,208.38
			14	\$9,828.13
			15	\$10,447.88
			16	\$11,067.63
			17	\$11,687.38
			18	\$12,307.13
			19	\$12,926.88
		Children under age six (133 percent of FPL)	1	\$1,273.48
			2	\$1,719.03
			3	\$2,164.58
			4	\$2,610.13
			5	\$3,055.68
			6	\$3,501.23
			7	\$3,946.78
			8	\$4,392.33
			9	\$4,837.88
			10	\$5,283.43
			11	\$5,728.98
			12	\$6,174.53
			13	\$6,620.08
			14	\$7,065.63
			15	\$7,511.18
			16	\$7,956.73
			17	\$8,402.28

			18	\$8,847.83
			19	\$9,293.38

Policy Category	Eligibility Criteria	Subtype	Group Size	Income Standard (effective February, 2013)
AR (cont.)	Poverty Level Families and Children (cont.)	Children ages six and over who were born after September 30, 1983 (100% of FPL)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19	\$957.30 \$1,292.50 \$1,627.50 \$1,962.50 \$2,297.50 \$2,632.50 \$2,967.50 \$3,302.50 \$3,637.50 \$3,972.50 \$4,307.50 \$4,642.50 \$4,977.50 \$5,312.50 \$5,647.50 \$5,982.50 \$6,317.50 \$6,652.50 \$6,987.50
		Children 19 and 20 (200% of FPL, effective May 1, 2008)	1 2 3 4 5 6 7 8 9 10 11	\$1,915.00 \$2,585.00 \$3,255.00 \$3,925.00 \$4,595.00 \$5,265.00 \$5,935.00 \$6,605.00 \$7,275.00 \$7,945.00 \$8,615.00

			12	\$9,285.00
			13	\$9,955.00
			14	\$10,625.00
			15	\$11,295.00
			16	\$11,965.00
			17	\$12,635.00
			18	\$13,305.00
			19	\$13,975.00
AX	Parents, except for Pregnant Women (200% of the FPL)		1	\$1,915.00
			2	\$2,585.00
			3	\$3,255.00
			4	\$3,925.00
			5	\$4,595.00
			6	\$5,265.00
			7	\$5,935.00
			8	\$6,605.00
			9	\$7,275.00
			10	\$7,945.00
			11	\$8,615.00
			12	\$9,285.00
			13	\$9,955.00
			14	\$10,625.00
			15	\$11,295.00
			16	\$11,965.00
			17	\$12,635.00
			18	\$13,305.00
			19	\$13,975.00
	Children Under 19 and Pregnant Mothers (300% of the FPL, effective June 1, 2007)		1	\$2,872.50
			2	\$3,877.50
			3	\$4,882.50
			4	\$5,887.50
			5	\$6,892.50
			6	\$7,897.50

			7	\$8,902.50
			8	\$9,907.50
			9	\$10,912.50
			10	\$11,917.50
			11	\$12,922.50
			12	\$13,927.50
			13	\$14,932.50
			14	\$15,937.50
			15	\$16,942.50
			16	\$17,947.50
			17	\$18,952.50
			18	\$19,957.50
			19	\$20,962.50
Policy Category	Eligibility Criteria	Subtype	Group Size	Income Standard (Effective February 1, 2013)
SR	SSI Recipients		All	None—Categorically Eligible
	Aged/Disabled (100% of FPL)			See AR: Poverty Level Families and Children—Children age six or over who were born after September 30, 1983.
	Individuals in a LTC facility		See Section 2.4 in Part VII	
	Medically Needy (MNIL)		1	\$613.94
			2	\$646.25
QMB	QMB (300% of FPL, effective February 1, 2007)		1	\$2,872.50
			2	\$3,877.50
	SLIMB (at least 100% of the FPL and less than 300% of the FPL, effective February 1, 2007) (Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application.)		1	\$2,872.50
			2	\$3,877.50
	QWDI (300% of the FPL, effective February 1, 2007)		1	\$2,872.50
			2	\$3,877.50

MC	DC Healthcare Alliance (200% of the FPL)			See AX: Parents, except for Pregnant Women.
	Childless Adult Medicaid (200% of the FPL)			See AX: Parents, except for Pregnant Women

EXHIBIT VI-4 TANF STANDARD OF ASSISTANCE AND PAYMENT LEVELS

Group Size	Standard of Assistance	Full Payment Levels (effective January 1, 2009)	Reduced Payment Levels For Families Receiving TANF over 60 Months (effective October 1, 2013)
1	\$450	\$270	\$162
2	\$560	\$336	\$202
3	\$712	\$428	\$257
4	\$870	\$528	\$314
5	\$1,002	\$602	\$362
6	\$1,178	\$708	\$425
7	\$1,352	\$812	\$488
8	\$1,494	\$897	\$539
9	\$1,642	\$987	\$593
10	\$1,786	\$1,072	\$644
11	\$1,884	\$1,131	\$679
12	\$2,024	\$1,216	\$730
13	\$2,116	\$1,271	\$763
14	\$2,232	\$1,340	\$804
15	\$2,316	\$1,391	\$835
16	\$2,432	\$1,461	\$877
17	\$2,668	\$1,602	\$962
18	\$2,730	\$1,639	\$983
19	\$2,786	\$1,673	\$1,004

EXHIBIT VI-5 FS INCOME STANDARDS

Household Size	Maximum Gross Monthly Income Eligibility Standard for Expanded Categorically Eligible Households (effective October 1, 2013) 200% FPL	Maximum Gross Monthly Income Eligibility Standard (effective October 1, 2013) 130% FPL	Maximum Net Monthly Income Eligibility Standard (effective October 1, 2013) 100% FPL	Maximum Allotment (effective November 1, 2013)
1	\$1,915	\$1,245	\$958	\$189
2	\$2,585	\$1,681	\$1,293	\$347
3	\$3,255	\$2,116	\$1,591	\$497
4	\$3,925	\$2,552	\$1,963	\$632
5	\$4,595	\$2,987	\$2,298	\$750
6	\$5,265	\$3,423	\$2,633	\$900
7	\$5,935	\$3,858	\$2,968	\$995
8	\$6,605	\$4,294	\$3,303	\$1,137
Each Additional Member	+\$670	+\$436	+\$335	+\$142

PART VII - SPECIAL MA PROCESSING

CHAPTER 1: SPECIAL MA GROUPS AND PROGRAMS

INTRODUCTION 1.1

This chapter presents the policies concerning the following groups or programs and applies to MA only:

- Transitional Medicaid Assistance,
- Refugee-Related Assistance,
- Pickle Amendment (Section 503 Individuals),
- Disabled Widow(er)s,
- Early Widow(er)s (Kennelly Widow(er)s),
- Adult Disabled Children,
- Medicare Buy-In (QMBs, SLIMBs, QI-1, and QDWIs),
- Disabled Individuals Returning to Work, and
- 50-64 Demonstration.

See Exhibit VII-1: Income and Asset Standards below for income and asset standards for these special MA groups.

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Special MA Groups	MA: D.C. Code 4-110(3)	MA: 42 USC 1383c et seq; 42 USC 1396a (a); 42 USC 1396a(a)(10)(E); 42 USC 1396d(p)(1)-(2); 42 USC 1396d(s); 42 USC 1396r-6 et seq.; 42 USC 1396u-3; 42 CFR 435.133-.134; 42 CFR 435.137-.138
Refugee Medical Assistance		MA: 45 CFR 400.93-.107

TRANSITIONAL MEDICAID ASSISTANCE (TMA) 1.3

AR: N/A

AX: TMA is not related to a recipient's losing eligibility for TANF. It is related to a recipient's losing eligibility for regular MA.

TMA is available to groups consisting of parents, caretaker relatives, and/or children under 19 when an increase in earnings or child support causes the group's income to exceed the AX income standard (200 percent of the FPL for parents, 300 percent for children.)

TMA is only available if increased earnings or child support cause the group to exceed the income standard for AX. Also, the group must have received MA for at least three of the six months prior to their income exceeding the income standard for AX.

For a group ineligible due to an increase in earnings, the group is eligible for six months of TMA, beginning the first month the agency can act on information that the customer is no longer eligible under AX standards.

For a group ineligible due to an increase in child support, the group is eligible for four months of TMA, beginning the first month the agency can act on information that the customer is no longer eligible under AX standards.

When TMA eligibility ends, the SSR should reevaluate the group's income to determine if it has fallen below AX standards. If the group's income still exceeds AX standards after the TMA eligibility period, the group is no longer eligible for MA. If the group's income has fallen below AX standards, the SSR should recertify the group for MA based on either the AR or AX standards.

Example 1

Ms. Goldman and her two daughters receive MA. Mr. Goldman begins paying child support, which causes Ms. Goldman and her daughters to be over-income for MA. The group's income now exceeds the AX income eligibility limit for both parents and children. Ms. Goldman and her two daughters are eligible to receive TMA for four months. Because the group's income still the AX standard after the four-month period, they are no longer eligible for MA.

Example 2

A group, consisting of a mother (Ms. Baird) and her two children (John and Steve), leaves TANF. The SSR must first determine whether the group is eligible for MA under the AR or AX program types. Ms. Baird and her two children qualify for MA - she is eligible under AX, and John and Steve are eligible under AR. Eight months later, Ms. Baird's earnings increase, making all family members over-income for MA, even under the AX standards. The group is now eligible for six months of TMA.

Example 3

Ms. Arlo and her two children receive MA. Ms. Arlo's earnings increase to an amount greater than 200% of the FPL, but less than 300%. The two children are eligible for MA through the AX program for one year. Ms. Arlo is eligible for TMA under AR for a six-month period. After the TMA period, if her income remains above 200% but below 300% of the FPL, Ms. Arlo will be over-income for Medicaid although her children remain eligible for the remainder of their twelve-month certification.

SR: N/A

QM: N/A

REFUGEE MEDICAL ASSISTANCE (RMA) 1.4

The Refugee Medical Assistance (RMA) program provides health insurance comparable to Medicaid to eligible immigrants who do not qualify for Medicaid due to non-financial eligibility requirements. Thus, single, non-disabled individuals and couples without children who would otherwise be ineligible for Medicaid can qualify for RMA.

The following immigrants are eligible for RMA during their first eight months in the United States:

1. those who were paroled as a refugee or asylee under section 212(d)(5) of the Immigration and Nationality Act (INA);
2. those admitted as a conditional entrant under section 203(a)(7) of the INA;
3. those admitted as a refugee under section 207 of the INA;
4. those granted asylum under section 208 of the INA; and
5. those admitted for permanent residence, provided the individual previously held one of the statuses identified above.

The RMA program uses the MNIL and budgeting methodologies.

Immigrants eligible for RCA are categorically eligible for RMA.

Once an immigrant has been found eligible for RMA, s/he is not required to recertify his/her eligibility nor is s/he required to report any changes in income or resources. That is, once eligible for RMA, the immigrant remains eligible through his/her 8th month in the United States.

For more information about RMA and RCA, see Section 7.5: Refugee-Related Cash and Medical Assistance in Part IV.

SR: N/A

QM: N/A

COBRA ASSISTANCE PROGRAM 1.5

The District will pay health insurance premiums for certain HIV-infected residents who are eligible for COBRA coverage from a former employer. This program is administered by the HIV/AIDS Administration. Customers may call (202) 727-2500 to apply for this and other benefits for HIV-infected persons. See Section 3.5: HIV Programs in Chapter 3 of this Part.

PICKLE AMENDMENT 1.6

AR: N/A

AX: N/A

SR: MA is available to former SSI recipients who receive Title II benefits (Social Security) and would be currently eligible for SSI if the Title II COLAs received since SSI eligibility ended were excluded.

To be eligible under the Pickle Amendment, the individual must:

- currently receive Title II benefits,
- have stopped receiving SSI benefits after April 1977, or
- have received both SSI and Title II benefits in the same month in any month after April 1977.

QM: N/A

DISABLED WIDOW(ER)S 1.7

AR: N/A

AX: N/A

SR: Prior to 1984, persons age 50 through 59 receiving disabled widow(er)s Title II benefits (Social Security) received less cash assistance than widow(er)s who began receiving benefits at age 60 or older. In 1983, the difference in benefit amount was eliminated. The elimination caused some persons to lose SSI or SSP eligibility and consequently MA categorical eligibility. These individuals are eligible for MA on a categorically needy basis (see Chapter 12: Categorical Eligibility in Part IV) if they meet certain criteria. A person is eligible if s/he:

- applied to MA before July 1, 1988;
- was entitled to Title II benefits (Social Security) for December 1983;
- was entitled to and received Title II benefits (Social Security) for disabled widow(er)s for January 1984;
- became ineligible for SSI/SSP the first month the increase in disabled widow(er)s Title II benefits (Social Security) was paid;
- has been continuously entitled to disabled widow(er)s benefits since the increase was received; and
- would be eligible for SSI/SSP benefits if the amount of the increase and any subsequent Title II benefit (Social Security) COLAs were disregarded.

QM: N/A

EARLY WIDOW(ER)S 1.8

AR: N/A

AX: N/A

SR: MA is available to widow(er)s age 60 through 64 who are not entitled to Medicare Part A (hospital insurance) and who became ineligible for SSI because of a Title II entitlement or increase.

MA is available to an individual who:

- receives Title II benefits for early widow(er)s;
- was terminated from SSI because of Title II payments;
- was at least 60 years old but not yet 65 years old on August 2, 1988;
- is not entitled to Medicare Part A; and
- would be eligible for SSI if all Title II payments were excluded.

QM: N/A

GRANDFATHERED 1972 AND 1973 RECIPIENTS 1.9

AR: N/A

AX: N/A

SR: Individuals who would be eligible for SSI except for the 20 percent increase in Social Security benefits that occurred in August 1972 are eligible for Medicaid provided the individual would have been entitled to and receiving both Social Security benefits and cash assistance benefits.

In addition, individuals eligible for MA in December 1973 based on disability, blindness, status as an essential person, or institutionalization continue to be eligible for MA provided they have continued to meet the December 1973 criteria.

QM: N/A

DISABLED ADULT CHILDREN 1.10

AR: N/A

AX: N/A

SR: Persons who meet the following criteria are eligible for MA coverage:

- at least 18 years old and have received SSI benefits on the basis of blindness or disability,
- become entitled to Social Security child's benefits or an increase in such benefits on the basis of a disability that began prior to age 22, and
- cease to be eligible for their SSI benefits because of the Social Security benefits.

QM: N/A

QUALIFIED MEDICARE BENEFICIARIES (QMB) 1.11

AR: N/A

AX: N/A

SR: N/A

QM: Certain Medicare beneficiaries, including persons receiving Title II benefits (Social Security), are eligible for Medicaid as QMBs. Coverage as a QMB means Medicaid will pay the following:

- Medicare Part A deductible,
- Medicare Part B annual deductible,
- Medicare Part B premium, and
- Medicare Part B annual copayments.

A QMB is an individual:

- who is entitled to Medicare Part A (hospital insurance), including voluntary enrollment;
- whose income does not exceed 300 percent of the FPL; and
- who meets the non-financial eligibility requirements of the MA program (see [Part IV: Non-Financial Eligibility](#)).

Income eligibility is determined using SR methodologies.

Note that effective November 1, 2008, there is no asset limit for QMB.

Persons applying for eligibility as QMBs cannot spend-down income to meet QMB eligibility requirements.

Persons eligible as QMBs can also be eligible for Medicaid. Because the income standard for QMB is the same as the income standard for Aged/Disabled in SR, many of these individuals are also eligible for Medicaid. Such persons are described as dually-eligible.

QMB coverage begins the month after the month in which a person is determined to be eligible (i.e., if a determination is made on August 15, benefits are effective beginning September 1). Three-month retroactive eligibility is not available under the QMB provision.

If an individual eligible as a QMB receives Title II income, the amount of the Title II COLA is disregarded for the first three months of the calendar year, from January 1 through March 31. The Title II COLAs are disregarded to alleviate problems caused by the disparity between the effective dates of the COLAs and the annual adjustments made to the FPLs.

SPECIAL LOW-INCOME MEDICARE BENEFICIARIES (SLIMB) 1.12

AR: N/A

AX: N/A

SR: N/A

QM: A SLIMB is an individual who:

- is enrolled in Medicare Part A, and
- has income between 100 percent and 300 percent of the FPL.

Note that effective November 1, 2008, there is no asset test for SLIMB.

Individuals and couples whose incomes are below 300 percent of the FPL are QMB eligible (see Section 1.10: Qualified Medicare Beneficiaries (QMB) in this Chapter).

Benefits for SLIMBs are limited to payment of the Medicare Part B premium only.

SLIMB coverage begins the month of application. Additionally, SLIMBs are eligible for the three-month retroactive eligibility determination.

There are no spend-down provisions for SLIMBs.

If an individual eligible as a SLIMB receives Title II income, the amount of the Title II COLA is disregarded for the first three months of the calendar year, from January 1 through March 31. The Title II COLAs are disregarded to alleviate problems caused by the disparity between the effective dates of the COLAs and the FPLs.

(Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application, since the QMB income limit has been increased to include these customers for the period beginning with the month following the month of application.)

QUALIFIED INDIVIDUALS I (QI-1) 1.13

AR: N/A

AX: N/A

SR: N/A

QM: A QI-1 is a Medicare beneficiary whose income is at least 120 percent of the FPL and less than 135 percent of the FPL and whose resources are no more than twice the SSI standard. The Medicaid program pays the Medicare Part B premium for a QI-1. (Note that effective July 1, 2005, there are no QI-1 eligible customers, since the QM and SLMB income limits have been increased to include these customers.)

QI-1 coverage begins the month of application. Additionally, QI-1s are eligible for the three-month retroactive eligibility determination.

There are no spend-down provisions for QI-1s.

QUALIFIED DISABLED AND WORKING INDIVIDUALS (QDWI) 1.14

AR: N/A

AX: N/A

SR: N/A

QM: A QDWI is an individual who:

- lost his/her free Medicare Part A benefits due to his/her return to work,
- is eligible to receive or receives Medicare Part A,
- has income that does not exceed 200 percent of the FPL,
- has assets that do not exceed twice the SSI limit, and
- is not eligible for MA under any other category.

Benefits for QDWIs are limited to payment of Medicare Part A premiums only.

Use the SR methodologies to determine income and resource eligibility.

Eligibility as a QDWI is effective on the date all eligibility factors are met. Three-month retroactive eligibility is available to QDWIs. There are no spend-down provisions for QDWI eligibility.

If a customer appears to be eligible as a QDWI, please contact the Policy Unit for assistance in processing the case.

Example

Ms. Lindsay applies for benefits on October 1 and is enrolled in Medicare Part A. Her eligibility is effective October 1 (or up to 3 months retroactively if all eligibility criteria are met).

DISABLED INDIVIDUALS RETURNING TO WORK 1.15

AR: N/A

AX: N/A

SR: Certain SSI recipients and former recipients are eligible for continued SR coverage even if their earnings appear to make them over-income. These customers may be covered under 1619(a), 1619(b), Plans to Achieve Self-Sufficiency (PASS), and other relevant provisions of the Social Security Act. If a customer formerly received SSI, even in the distant past, and now appear over-income for SR due to earnings, please contact the Policy Unit for guidance.

QM: See SR above. Former SSI beneficiaries may actually be eligible for continued SR coverage if they lost SSI because of increased earnings. These new or recertifying customers often appear to be (a) ineligible for SR but (b) eligible for QM due to the increase in earnings. In addition, this group includes customers who may have stopped receiving SSI in the past and may until now have appeared to be SR eligible. Please contact the Policy Unit for guidance.

Example

Mr. Gomez applies for SR Medicaid but appears to be over-income due to earnings. The SSR notes that Mr. Gomez received SSI between 1992 and 1999 and promptly contacts the Policy Unit for guidance. With assistance from the Policy Unit, the SSR directs Mr. Gomez to complete several forms; after doing so, Mr. Gomez becomes automatically entitled to Medicaid coverage.

Example

Ms. Jackson recertifies for SR Medicaid but appears to be over-income because of earnings. The SSR notes that Ms. Jackson received SSI until recently; her SSI termination actually generated the recertification notice. The SSR contacts the Policy Unit for guidance; with assistance from the Policy Unit staff, the SSR directs Mr. Gomez to complete several forms; after doing so, Mr. Gomez becomes automatically entitled to Medicaid coverage.

50-64 DEMONSTRATION 1.16

AR: N/A

AX: N/A

SR: N/A

QM: N/A

MC: **Note:** This program ended effective July 1, 2010. These persons are now eligible under the Childless Adult group for Medicaid (See “Childless Adults” under Section 2.2.1: MA Program Eligibility Criteria in [Part I.](#)) . This section is left here for historical purposes.

This special Demonstration program provides Medicaid benefits to customers age 50-64. These customers must have income and resources below the Medically Needy income limits, and they must meet all other criteria for Medicaid (e.g., citizenship/alienage, SSN, District residency, etc.) except disability.

However, application for the 50-64 Demonstration was suspended on November 5, 2003. These customers are enrolled in the MC program type in ACEDS and use the 370 program code.

EXHIBIT VII-1 INCOME AND ASSET STANDARDS

Special MA Group Program	Size of Assistance Unit	Monthly Income Limit (generally effective February 2007, but see individual Special MA Group Program notes)	Asset Limit (effective March 1, 2004)
Transitional Medicaid Assistance	All	None	None
Refugee Assistance: Adult only cases	All	Medically Needy income limit (unless person is receiving Refugee Cash Assistance)	Medically Needy asset limit (unless person is receiving Refugee Cash Assistance)
Refugee Assistance: Child only cases and Adult/Child cases	All	See AR in Exhibit 5: MA Income Standards in Part VI	See AR in Exhibit 2: Asset Limits in Part VI (unless person is receiving Refugee Cash Assistance)
Pickle Amendment, Disabled Widow(er)s, Early Widow(er)s, and Disabled Adult Children	1 2	Contact IMA Policy Unit for assistance	Contact IMA Policy Unit for assistance
QMB (effective February 1, 2008)	1 2	\$2,600.00 \$3,500.00	None, effective November 1, 2008
SLMB (effective February 1, 2008)(Note that effective July 1, 2005, SLMB eligibility applies only to the month of application and the three month retroactive period.)	1 2	\$2,600.00 \$3,500.00	None, effective November 1, 2008
QI-1 (effective January 1, 2006)(Note that effective July 1, 2005, there are no QI-1 eligible customers, since the QM and SLMB income limits have been increased to include these customers.)	1 2	\$2,552.50 \$3,422.50	\$4,000 \$6,000
QDWI (effective February 1, 2008)	1 2	\$1,733.34 \$2,333.34	\$4,000 \$6,000

CHAPTER 2 - LONG-TERM CARE/IMPOVERISHED SPOUSE

INTRODUCTION 2.1

In addition to meeting the needs of families and individuals who reside in the community, the MA program provides coverage of some or all of the costs of care for persons who reside in certain LTC facilities.

In order to receive coverage, LTC residents must establish both MA eligibility and LTC eligibility (also referred to as payability). Individuals eligible for MA but over-income are eligible for LTC coverage. The LTC Eligibility Unit handles all LTC cases. The LTC unit determines MA eligibility for LTC residents (if they have not already established MA eligibility) and payability. Exhibit VII-2: Diagram of LTC Processing depicts how LTC processing differs depending on how the LTC resident enters LTC status.

LTC residents are eligible for additional income allowances when determining LTC eligibility or payability; these additional income allowances are used in the calculation of the Patient Pay Amount (PPA). The PPA is another way in which LTC differs from standard MA. Unlike standard MA coverage, eligible LTC residents often contribute to their cost of care by paying the PPA.

LTC residents also spend-down their income in a different manner than in standard MA. Unlike standard MA where total countable income must meet a certain standard, LTC spend-down is governed by the comparison of the PPA to the cost of care rate.

LTC facilities are licensed by the District and have provider agreements with the Department. Types of LTC facilities authorized to accept District residents who are eligible for LTC coverage include:

- nursing facilities,
- intermediate care facilities for the mentally retarded (ICF/MR),
- institutions for mental diseases (person under age 21 or age 65 or older only), and
- certain youth residential treatment facilities.

For the purposes of this chapter, the following terms are used:

- LTC recipient: an individual who and residing in a LTC facility;
- institutionalized spouse: an individual who is married and is:
 - residing in a LTC facility,
 - likely to be hospitalized for at least 30 days, or
 - likely to reside either in a hospital or a LTC facility for at least 30 consecutive days;
- community spouse: an individual who is married to an institutionalized spouse and who is living in the community, and
- family member: any minor or dependent child, dependent sibling, or dependent parent of the institutionalized spouse or community spouse who is claimed as a dependent for tax purposes.

Example

Mr. Newman is married and enters the hospital on June 25th. His doctors expect that he will be discharged on July 10th to a LTC facility and that he will stay at the LTC facility for three weeks. Even though he is expected to stay in the hospital for only 15 days, he is considered an institutionalized spouse because he is likely to spend a total of 36 days in either a hospital or a LTC facility.

The policies in this chapter apply to LTC recipients and institutionalized spouses. However, the income and assets of institutionalized spouses who have a community spouse are treated differently if the institutionalized spouse was institutionalized after September 30, 1989. The income and asset allowances and deductions are designed to prevent the impoverishment of the community spouse. The policies regarding institutionalized spouses who have a community spouse and who entered a LTC facility after September 30, 1989 are referred to as the "Impoverished Spouse" provisions. For the purposes of this chapter, Impoverished Spouse provisions, which apply only to institutionalized spouses who entered a LTC facility after September 30, 1989 and who have a community spouse, will be set off by the italicized heading *Impoverished Spouse*. Unless otherwise noted, the policies in this chapter also apply to those individuals eligible for the Impoverished Spouse provisions.

Because there are very few individuals currently in LTC who were institutionalized before October 1, 1989 and have a community spouse, Exhibit VII-3: Provisions for Pre-October 1989 Institutionalization lists how policies are to be adjusted for these individuals by section. However, unless otherwise noted, the policies in this chapter also apply to these individuals.

The policies in this chapter supersede any MA policy which is inconsistent with these policies. The policies apply the first month the individual resides in a LTC facility and is MA-eligible and cease the first full calendar month following changes in circumstances (i.e., if changes occur in November, these policies would not apply in December).

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Long-Term Care		MA: 42 USC 1396a(a)(10); 42 USC 1396a(q)-(r); 42 USC 1396r; 42 USC 1396r-5; 45 CFR 435.700; 45 CFR 435.725; 45 CFR 435.726

MEDICAL CERTIFICATION FOR LTC 2.3

The Medical Assistance Administration (MAA), a part of DOH, certifies the individual's medical need for LTC prior to approval of coverage of the costs of care.

The MAA is responsible for:

- reviewing the medical documentation from the individual's physician, the acute hospital arranging the placement, or other competent medical authority to determine the level of care appropriate to the individual's needs; and
- notifying the appropriate LTC facilities of the individual's level of care.

The facility which accepts the individual submits a Patient Start of Care Notice and a Level of Care Notice to the LTC Eligibility Unit in IMA indicating the assigned level of care and the date of admission or date of transfer to MA status.

The PSRO (at DOH) reviews the level of care determinations periodically. If the patient's medical needs change significantly and a different level of care is determined, the individual may be transferred to a different facility or discharged to a community placement. The PSRO submits a new level of care and the effective date of the change to the facility which in turn submits the information to the LTC Eligibility Unit.

LTC APPLICATION PROCESS 2.4

Transfer of Case Record 2.4.1

Determining eligibility for LTC coverage (payability) is the responsibility of the LTC Eligibility Unit. An individual who is already a recipient of MA as a community-assistance unit (AR, AX, SR, or QM (must be Medicaid eligible)) must have his/her eligibility for LTC coverage re-determined by the LTC Eligibility Unit at the time of admission to a LTC facility (see Section 2.4.3: Assistance Unit Requirements in this Chapter). The SSR should transfer the recipient's MA case record to the appropriate LTC SSR (see [Chapter 2: Case Transfers Between Service Centers in Part VIII](#)).

Time Standards 2.4.2

See Section 2.3: Time Standards in Part III. In addition, if the Patient Start of Care Notice has not been received from the facility by the 45th day of pending disposition, the application for MA must be processed as if it was for a community-assistance unit (i.e., no eligibility for LTC coverage).

If the start of care date falls within the 45 days of pending disposition but not within the month of application, eligibility for the first month, or first and second months, must be established as a community-assistance unit. If the start of care date falls within the three months prior to the month of application, then the LTC SSR should determine if the LTC resident is eligible for retroactive LTC coverage.

Assistance Unit Requirements 2.4.3

The individual or couple entering a LTC facility must establish eligibility as either an AR, AX, SR, or QM (must also be Medicaid-eligible) unit (see Section 2.5: MA Income Eligibility Determination and Section 2.9: MA Asset Eligibility Determination in this Chapter and Part IV: Non-Financial Eligibility). Once the individual or couple has been certified by the MAA (see Section 2.3: Medical Certification for LTC), then s/he is considered an SR unit, regardless if s/he was initially considered as an AR, AX, or QM unit.

If the individual or couple is residing in a LTC facility and has not yet established MA eligibility, then s/he must establish eligibility as an SR unit. Because s/he is establishing eligibility while residing in a LTC facility, his/her income and assets are treated differently (see Section 2.5: MA Income Eligibility Determination in this Chapter and Section 2.9: MA Asset Eligibility Determination in this Chapter).

If an individual who is residing in or entering a LTC facility has an eligible spouse who is residing in or entering the same LTC facility, include both spouses in the same assistance unit whether or not they share a room.

If the individual in LTC has an eligible spouse who is residing in a different LTC facility, each spouse is considered to be financially responsible for the other for the month of their physical separation. During this one-month period, both spouses are included in the same assistance unit.

See Exhibit VII-3: Provisions for Pre-October 1989 Institutionalization for additional policy for LTC residents institutionalized before October 1, 1989 who have a community spouse.

Impoverished Spouse: See above. However, if the individual in LTC is eligible for the Impoverished Spouse provisions (i.e., has a community spouse and was institutionalized after September 30, 1989), then no income from the community spouse should be deemed to the institutionalized spouse for any month in which

s/he is institutionalized (see Section 2.5: MA Income Eligibility Determination and Section 2.15: Determining Total Countable Income for P/A Calculation in this Chapter).

SSI Recipients 2.4.4

If an individual is a recipient of MA as a community-assistance unit and is also a recipient of SSI, s/he or his/her authorized representative is responsible for notifying the SSA of his/her plans to enter a LTC facility.

The SSI payment will be reduced to \$70 (or less in some instances) if the individual has no other income. SSI will be terminated if the individual has other income that totals \$45 or more. If SSI is terminated, then categorical eligibility (see Chapter 12: Categorical Eligibility in Part IV) is also terminated. If the individual's categorical eligibility is terminated, the SSR must advise him/her or the authorized representative to submit a new application for MA to the LTC Eligibility Unit.

MA INCOME ELIGIBILITY DETERMINATION 2.5

If an individual or couple is about to enter or has entered a LTC facility and is seeking assistance for the costs of LTC, s/he must first establish eligibility for MA (in many cases, individuals will already be MA-eligible; if this is the case, this section does not apply). An individual or couple over-income for MA but otherwise eligible for MA, may be eligible for LTC placement. LTC eligibility or payability is determined after MA eligibility is established (see Section 2.14: Patient Pay Amount (PPA) in this Chapter).

If the individual applies while residing in the community, the SSR should follow the policies detailed in Chapters 4-8 in Part VI for the appropriate MA category. If, however, an individual applies while residing in the LTC facility, then the LTC Eligibility Unit processes the application and not a service center. After a child has remained in the institution for 30 days, the parent's income is disregarded when determining MA eligibility and LTC payability.

Example 1

Mr. Goldman is divorced and lives in the community. He currently does not receive MA. Mr. Goldman learns that he may have to enter a LTC facility in the next few weeks following his scheduled surgery. He applies for MA. Since he is living in the community at the time of his MA application, the policies in Chapter 4 - 8 in Part VI apply, and an SSR in the appropriate service center determines his eligibility.

Example 2

Ms. Raikes is widowed and unexpectedly enters a LTC facility. She applies for MA after her admittance to the LTC facility. Because she is residing in the LTC facility at the time of her MA application, the LTC Eligibility Unit processes her application.

Impoverished Spouse: If an individual with a community spouse is about to enter or has entered a LTC facility and is seeking assistance for the costs of LTC, s/he must first establish income eligibility for MA (in many cases, individuals will already be MA-eligible; if this is the case, this section does not apply). LTC eligibility (payability) is determined after MA eligibility (see Section 2.14: Patient Pay Amount (PPA) in this Chapter). If, however, the individual is over income for MA but has income of less than the cost of care in the LTC facility, the individual is eligible for LTC coverage.

If s/he applies while residing in the LTC facility, then his/her income is treated differently than it would be if s/he applied while residing in the community. In addition, if an individual applies while residing in the LTC facility, then the LTC Eligibility Unit processes the application and not a service center.

Determine the individual's income using the following rules irrespective of District laws governing division of marital property.

If the individual applies while residing in the community, then the SSR should follow the policies detailed in Chapters 4-8 in [Part VI](#) for the appropriate MA category.

If the individual applies while residing in the LTC facility, the SSR should separate the income of the couple and follow the SR policies detailed in Chapters 4-8. The SSR should not deem any income of the community spouse as available to the institutionalized spouse for any month in which the institutionalized spouse is in an institution. In addition, the SSR should subtract the following two allowances (known as the Impoverished Spouse Allowances; see Section 2.6: LTC Income Allowances in this Chapter) in addition to those discussed in [Chapter 6: Income Disregards and Deductions in Part VI](#):

- Community Spouse Monthly Income Allowance (see Section 2.6.6: Community Spouse Monthly Income Allowance in this Chapter) but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse; and
- family allowance (see Section 2.6.7: Family Members' Monthly Income Allowance in this Chapter) for each family member, including minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

When a Community Spouse Monthly Income Allowance is not made available to (or for the benefit of) the community spouse, do not deduct the allowance. When determining MA eligibility for the community spouse, include the Community Spouse Monthly Income Allowance in the income of the community spouse. Deduct allowances for other family members, whether or not the institutionalized spouse makes the income available to such persons

Example 1

Mr. Harris is married and lives in the community. He currently does not receive MA. Mr. Harris learns that he may have to enter a LTC facility in the next few weeks because his wife is no longer able to care for him at home. He applies for MA. Since he is living in the community at the time of his MA application, the policies in Chapters 4 - 8 in Part VI apply, and he is not eligible for the Impoverished Spouse Income Allowances.

Example 2

Mrs. Bigley is married and lives with her husband. She has a stroke, and her doctors expect her to be in the hospital or a LTC facility for at least 30 days. She applies for MA after her admittance to the LTC facility. Because she is residing in the LTC facility and her husband is living in the community, the Impoverished Spouse Income Allowances are applied when determining her eligibility for MA

LTC INCOME ALLOWANCES 2.6

The LTC Income Allowances are the amounts of monthly income that are set aside for the maintenance needs of the LTC resident and his/her family. They are used when calculating the PPA (see Section 2.1.4: Patient-Pay Amount (PPA) in this Chapter).

The LTC Income Allowances include the following:

- PNA (see Section 2.6.1: Personal Needs Allowance (PNA) in this Chapter),

- allowance for health insurance premiums, including Medicare (see Section 2.6.2: Allowance for Health Insurance Premiums in this Chapter),
- allowance for maintenance of the unoccupied home (see Section 2.6.3: Allowance for Maintenance of the Unoccupied Home in this Chapter),
- allowance for representative payee or conservator (see Section 2.6.4: Allowance for Representative Payee/Conservator in this Chapter), and
- allowance for incurred expenses for medical or remedial care for the institutionalized spouse (see Section 2.6.5: Allowance for Medical Expenses in this Chapter).

See Exhibit VII-3: Provisions for Pre-October 1989 Institutionalization for the LTC Income Allowances an individual institutionalized before October 1, 1989 who has a community spouse is eligible and how the allowances are applied.

Impoverished Spouse: If a married person is institutionalized after September 30, 1989 and has a community spouse, then s/he is eligible for certain allowances in addition to and in lieu of those listed above.

The following are all the income allowances a married person institutionalized after September 30, 1989 who has a community spouse may be eligible for:

- PNA (see Section 2.6.1: Personal Needs Allowance (PNA) in this Chapter);
- allowance for health insurance premiums, including Medicare (see Section 2.6.2: Allowance for Health Insurance Premiums in this Chapter);
- allowance for representative payee or conservator (see Section 2.6.4: Allowance for Representative Payee / Conservator in this Chapter);
- allowance for incurred expenses for medical or remedial care for the institutionalized spouse (see Section 2.6.5: Allowance for Medical Expenses in this Chapter);
- Community Spouse Monthly Income Allowance (see Section 2.6.6: Community Spouse Monthly Income Allowance in this Chapter) but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse (this allowance is unique to the Impoverished Spouse provisions); and
- family allowance (see Section 2.6.7: Family Members' Monthly Income Allowance in this Chapter) for each family member, including minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse (this allowance is unique to the Impoverished Spouse provisions).

When a Community Spouse Monthly Income Allowance is not made available to (or for the benefit of) the community spouse by the institutionalized spouse, do not deduct the allowance. Deduct allowances for other family members, whether or not the institutionalized spouse makes the income available to such persons.

Personal Needs Allowance (PNA) 2.6.1

The PNA is a portion of monthly income that an individual in LTC retains for his/her personal needs. Only goods and services not covered by the cost of care rate at the facility may be purchased with this PNA.

The PNA for an individual is \$70 per month.

The PNA for a Veteran's Aid and Allowance recipient is \$90.

If the PNA is not spent but allowed to accumulate in an account maintained by the facility or a bank, the balance in the account is considered a countable resource (see Section 1.4.1: Liquid Assets in [Part VI](#)).

The SSR must advise the individual or his/her authorized representative (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of an Individual or Group in [Part III](#)) before the account exceeds the asset limit that the accumulating PNA may result in termination of eligibility on the basis of excess resources.

Allowance for Health Insurance Premiums 2.6.2

When an individual or a couple residing in or entering LTC is purchasing health insurance coverage, the health insurance premiums, including those for Medicare, are deducted from the total value of countable income in order to encourage the LTC resident to maintain the third party coverage.

The Medicare premium should only be deducted if the LTC individual or couple is paying the premium. Once the Department assumes responsibility for payment of the Medicare premium, the LTC SSR should no longer deduct the Medicare premium as part of the allowance for health insurance premiums.

The allowance for health insurance premiums is the amount of the monthly premium or the amount of the premium if paid on a monthly basis.

Allowance for Maintenance of the Unoccupied Home 2.6.3

A home, whether it is owned or rented, is exempt from countable assets if the LTC resident provides a statement by his/her physician which states that the LTC resident is expected to return to the community residence within the first six months of the eligibility period. If the physician does not expect the LTC resident to return within the first six months, then the home is a countable asset as of the date of admission. If the physician did provide a statement noting an expected return date within six months but the LTC resident does not return within six months, the community residence becomes a countable asset the first day of the seventh month following the month of admission to the LTC facility. If, however, the individual is trying to sell the property, the asset is excluded, see Section 1.23: Pending Sale of Property in Part VI.

If the individual or couple residing in or entering a LTC facility has a home that is not occupied by a spouse or a dependent child and the home is exempt from countable assets, deduct an amount from the total countable income of the assistance unit receiving LTC coverage for maintenance of the unoccupied home. Apply the allowance only during the month or months the unoccupied home is exempt from countable assets for a maximum of six consecutive months per admission to a LTC facility.

The deduction is equal to the lesser of the following:

- \$377, or
- the actual cost of maintaining the home.

Allowance for Representative Payee/Conservator 2.6.4

If the LTC resident is paying a representative payee or conservator to handle his/her affairs, then deduct the monthly costs of this service.

Allowance for Medical Expenses 2.6.5

Deduct required and optional medical or remedial expenses from the individual's income (for types of allowed medical expense, see Section 7.4: Allowable Medical Expenses in Part VI). Determine the amount of the medical or remedial expenses to be deducted from the total income by considering the expenses as actually incurred each month.

Community Spouse Monthly Income Allowance 2.6.6

Impoverished Spouse: Unless a spousal support order requires support (court-ordered support) in a greater amount or a hearing officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct the minimum monthly maintenance needs allowance from the community spouse's gross monthly income.

The minimum monthly maintenance needs allowance is \$2,898.00 for 2013.

When a deficit remains after a community spouse's gross income is compared to the minimum monthly maintenance needs allowance, the remaining deficit is the amount of the Community Spouse Monthly Income Allowance. If no deficit remains, there is no Community Spouse Monthly Income Allowance

Example 1

The community spouse's monthly income equals \$800.

\$2,898.00 (minimum monthly maintenance needs allowance)
- \$800.00 (community spouse income)
\$2,098.00 (community spouse monthly income allowance)

The community spouse contributes \$800 to monthly costs which is \$2,098.00 less than the minimum allowance of \$2,898.00. Therefore, there is a deficit of \$2,098.00 remaining which is the allowable Community Spouse Monthly Income Allowance.

Example 2

The community spouse's monthly income equals \$3,000.

\$3,000.00 (community spouse monthly income)
- \$2,898.00 (minimum maintenance allowance)
\$ 102.00(excess monthly community spouse income)

Since the spousal income is over the minimum allowance amount, there is no deficit remaining in this example. Therefore, no Community Spouse Monthly Income Allowance is deducted.

Do not recalculate the Community Spouse Monthly Income Allowance when the institutionalized spouse does not actually transfer the amount to the community spouse.

Family Members' Monthly Income Allowance 2.6.7

Impoverished Spouse: Deduct for maintenance of each family member one-third of any deficit remaining after the family member's gross income is compared to a family monthly income allowance equal to the minimum monthly maintenance needs allowance of \$2,898.00 (see Section 2.6.6: Community Spouse

Monthly Income Allowance in this Chapter). The term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

Example

Mrs. Boria is institutionalized. Her husband, 15-year-old daughter (Ellen), and 12-year-old son (Ethan) live in the community. Ethan has a gross monthly income equal to \$1,400, and Ellen has a gross monthly income equal to \$1,600. The monthly income allowance for both Ethan and Ellen is calculated in the following manner:

\$2,898.00	\$2,898.00 Minimum Monthly Maintenance Needs Allowance
<u>- \$1,400.00</u>	<u>- \$1,600.00 Monthly Gross Income</u>
\$1,498.00	\$1,298.00

$$\$1,498.00 / 3 = \$499.33 \quad \$1,298.00 / 3 = \$432.66$$

Consequently, subtract \$499.33 for Ethan and \$432.66 for Ellen from Mrs. Boria's income.

PROJECTED INCOME 2.7

Any one or more of the following may be projected for a prospective period not to exceed six months:

- income the LTC recipient or institutionalized spouse expects to receive, and
- medical and remedial care expenses expected to be incurred based on expenses incurred in the immediately preceding six months (see Section 2.6.5: Allowance for Medical Expenses in this Chapter).

Projections are based on no more than six-month periods, and periodic adjustments of amounts must be made. However, adjustments must be made sooner when there are significant changes in specific projected amounts.

See Exhibit VII-3: Provisions for Pre-October 1989 Institutionalization for additional items that may be projected for individuals institutionalized before October 1, 1989 who have a community spouse.

Impoverished Spouse: See above. In addition, the following can also be projected for a prospective period not to exceed six months:

- monthly income allowance for the community spouse (see Section 2.6.6: Community Spouse Monthly Income Allowance in this Chapter), and
- monthly income allowance for family members based on income family members expect to receive (see Section 2.6.7: Family Members' Monthly Income Allowance in this Chapter).

ASSESSMENT OF ASSETS 2.8

Impoverished Spouse: The assessment of assets can occur prior to or during institutionalization and prior to the MA-eligibility determination.

Promptly assess the couple's combined countable assets when requested by either spouse or a representative acting on behalf of either spouse at the beginning of each continuous period of institutionalization.

Documentation (or verification if deemed appropriate in lieu of documentation) showing ownership interest and current value of resources must be provided. When necessary documentation and/or verification is not provided in a timely manner, advise requesting parties that assessments cannot be completed.

Assessments must be made within 45 days from the date of request unless relevant documentation or verification is not provided in a timely manner. If persons requesting assessments do not provide necessary information in a timely manner, assessments must be made within 45 days of receipt of documentation or verification.

Provide each spouse with a copy of the assessment and an explanation of how the assessment was calculated. Retain copies for the case file. Also, provide each spouse with a notice advising them that only community spouses of MA-eligible institutionalized spouses have a right to appeal the determination of countable assets at the time of the assessment. If the assessment was conducted prior to submitting an MA application, community spouses have an opportunity to appeal assessment findings if and when their institutionalized spouses actually apply for Medicaid.

Nursing homes are required to advise new admissions and their families that asset assessments are available upon request. A nursing home patient has the right to be advised of such assessment.

MA ASSET ELIGIBILITY DETERMINATION 2.9

If an individual or couple is about to enter or has entered a LTC facility and is seeking assistance for the costs of LTC, s/he must first establish asset eligibility for MA (in many cases, individuals will already be MA-eligible; if this is the case, this section does not apply). LTC eligibility or payability will be determined after MA eligibility is established (see Section 2.14: Patient Pay Amount(PPA) in this Chapter).

If the individual applies while residing in the community or while residing in the LTC facility, then the SSR should follow the policies detailed in Chapters 1-3 in Part VI for the appropriate MA category. If an individual applies while residing in the LTC facility, then the LTC Eligibility Unit processes the application and not a service center. The LTC SSR should follow the SR policies detailed in Chapters 1-3 in Part VI (if the individual is under 21 and is MA-eligible under AR, then follow the AR policies).

Impoverished Spouse: If an individual, or couple, is about to enter or has entered a LTC facility and is seeking assistance for the costs of LTC, s/he must first establish asset eligibility for MA (in many cases, individuals will already be MA-eligible; if this is the case, this section does not apply). LTC eligibility or payability will be determined after MA eligibility is established (see Section 2.14: Patient Pay Amount (PPA) in this Chapter).

If s/he applies while residing in the LTC facility, then his/her assets are treated differently than they would be if s/he applied while residing in the community. In addition, if an individual applies while residing in the LTC facility, then the LTC Eligibility Unit processes the application and not a service center.

If the individual applies while residing in the community, the SSR should follow the policies detailed in Chapters 1-3 in [Part VI](#) for the appropriate MA category (however, after the individual enters the LTC facility, then s/he is eligible for the designation of a Protected Spousal Amount; see Section 2.9.1: Protected Spousal Amount in this Chapter and Section 2.12: Treatment of Assets After MA Eligibility Determination in this Chapter).

If the individual applies while residing in the LTC facility, the SSR should consider all the resources held by either the institutionalized spouse and/or the community spouse as available to the institutionalized spouse, regardless of any District laws relating to community property or the division of marital property, and should do the following to determine the MA eligibility of the institutionalized spouse.

- Determine the couple's combined countable assets for the month of application (see SR policies unless institutionalized spouse under 21 and eligible for MA under AR in [Chapter 1: Determining Countable Assets in Part VI](#)).
- Deduct from the couple's combined countable assets owned at the time of application a Protected Spousal Amount (see Section 2.9.1: Protected Spousal Amount in this Chapter).
- Deduct the Protected Spousal Amount from assets held in the name of the institutionalized spouse from the time of the initial eligibility determination until the first regularly scheduled recertification.
- Compare the remaining asset amount to the SR resource standard for one person (unless institutionalized spouse under 21 and eligible for MA under AR) (see Section 3.3: Asset Limits in [Part VI](#)).

If the remaining assets are equal to or below the appropriate standard, the institutionalized spouse is eligible for MA. If the remaining asset amount is above the standard, the institutionalized spouse is not eligible for MA.

Do not deny MA eligibility to an institutionalized spouse who has resources in excess of the SR resource standard when one or more of the following circumstances exists:

- the institutionalized spouse has assigned to the District any rights to support from the community spouse,
- support rights cannot be assigned to the District because the institutionalized spouse has physical or mental impairments of a degree which under D.C. law prohibits him/her from legally assigning rights but the District has rights under D.C. law to bring support proceedings against the community spouse without such an assignment, or
- an impartial review has determined that a denial of eligibility creates undue hardship.

When changes in the amount of resources of the institutionalized spouse occur after initial eligibility for MA is established, recalculate the asset eligibility of the institutionalized spouse unless:

- the new assets combined with the other assets the institutionalized spouse intends to retain do not exceed the asset limit for one person, or
- the institutionalized spouse intends to transfer the new assets to the community spouse who has assets below the Spousal Share allowance (see Section 2.9.2: Spousal Share and Section 2.13: Transfer of Assets Before or After MA Eligibility Determination in this Chapter).

Assets owned by the community spouse are not deemed available to the institutionalized spouse after the initial eligibility determination (see Section 2.12: Treatment of Assets After MA Eligibility Determination in this Chapter).

Protected Spousal Amount 2.9.1

Impoverished Spouse: The Protected Spousal Amount is the greatest of the following amounts:

- the Spousal Share, provided it does not exceed \$115,920.00 for 2013 (see Section 2.9.2: Spousal Share in this Chapter);
- the Community Spouse Assets Allowance (\$23,184 for 2013);
- an amount transferred under a court support order (court-ordered support); or
- an amount designated by the OAH

Example

Mr. and Mrs. Lopez's combined countable assets at the time of Mr. Lopez's Medicaid application are \$12,000. The Community Spouse Assets Allowance is \$23,184. All of the couple's assets (\$12,000) are protected for the community spouse because they are below the Community Spouse Assets Allowance of \$23,184. Therefore, the Protected Spousal Amount is \$12,000.

Protected Spousal Amounts are revised:

- when either spouse alleges that the initial determination was incorrect and the OAH confirms such allegations (see Section 7.4.8: Hearing Decisions in [Part VIII](#)), or
- when a SSR determines that inaccurate information was provided at the time the Spousal Share was calculated for the current eligibility period.

If either spouse establishes during redetermination of eligibility that income generated from the Protected Spousal Amount is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (see Section 2.6.6: Community Spouse Monthly Income Allowance in this Chapter), recalculate the Protected Spousal Amount.

Spousal Share 2.9.2

Impoverished Spouse: The Spousal Share is equal to one-half of the couple's combined countable assets as of the beginning of the most recent continuous period of institutionalization. Spousal Shares are calculated between the time a spouse is admitted to an institution and the time the spouse applies for Medicaid and eligibility is determined. Calculation may be made even when there are no immediate plans for an institutionalized spouse to apply for Medicaid.

The amount of the Spousal Share remains the same for purposes of determining the amount of assets used to determine the institutionalized spouse's initial Medicaid eligibility in the current period. It does not change even when calculated prior to application.

Example

Mr. and Mrs. Smith's combined countable assets are assessed at \$20,000 at the beginning of the most recent continuous period of Mr. Smith's institutionalization. The Spousal Share is \$10,000 (one-half of the initial asset assessment amount).

RETROACTIVE ASSET ELIGIBILITY DETERMINATION 2.10

Determine the institutionalized spouse's assets for a retroactive eligibility determination for LTC coverage by using the policies in Section 2.9: MA Asset Eligibility Determination in this Chapter.

MULTIPLE APPLICATIONS IN THE SAME CONTINUOUS PERIOD OF INSTITUTIONALIZATION 2.11

Impoverished Spouse: If a person applies for MA coverage in the current continuous period of institutionalization and is determined ineligible due to excess resources, deduct the Protected Spousal Amount (see Section 2.9.1: Protected Spousal Amount in this Chapter) from the couple's combined resources when determining eligibility for each subsequent re-application filed in the same period of institutionalization. Following a determination of eligibility, deduct the Protected Spousal Amount until the next regularly scheduled redetermination. Do not deduct the Protected Spousal Amount when determining eligibility for a person applying for MA following a determination of eligibility and subsequent ineligibility in the same period of institutionalization.

Example 1

Mr. Black is residing in a LTC facility and Mrs. Black lives in the community. Mr. Black applies for MA, but he is found to have excess resources. Two weeks later, Mr. Black sells his car (he is still residing in the LTC facility). He re-applies for MA. The SSR should deduct a Protected Spousal Amount when determining eligibility.

Example 2

Mrs. Steel is residing in a LTC facility and is currently receiving MA and LTC coverage. Her husband is residing in the community. Mrs. Steel's brother dies, and she inherits \$3,000. Mrs. Steel is now ineligible for MA and LTC coverage because of excess resources. One month later, Mrs. Steel is still residing in the LTC facility. Mrs. Steel reapplies for MA and LTC coverage. The SSR should not deduct a Protected Spousal Amount when determining eligibility.

TREATMENT OF ASSETS AFTER MA ELIGIBILITY DETERMINATION 2.12

Impoverished Spouse: Assets owned by the community spouse are not deemed available to the institutionalized spouse after the initial eligibility determination for MA coverage. Consequently, if a community spouse acquires additional assets after the initial eligibility determination, the eligibility of the institutionalized spouse is not affected.

If an individual applied for MA while living in the community and is now living in a LTC facility, s/he is now eligible for a Protected Spousal Amount (see Section 2.9.1: Protected Spousal Amount in this Chapter).

LIMITATION ON HOME EQUITY FOR LONG TERM CARE ASSISTANCE 2.12.a

Individuals who have an equity interest in their home that exceeds \$750,000 are not eligible for LT unless one of the following conditions apply:

- the individual has a spouse who lives in the home;
- the individual has a child under 21 who lives in the home;
- the individual has an adult child who is disabled living in the home; or
- the limitation has been waived by the Medical Assistance Administration in the Department of Health, due to undue hardship.

TRANSFER OF ASSETS BEFORE OR AFTER ELIGIBILITY DETERMINATION 2.13

When an otherwise eligible institutionalized individual disposes of any countable assets for less than fair market value during or after a “look-back period”, impose a period of restricted Community Medicaid coverage. The look-back period is a period of time immediately before:

- the date the individual becomes an institutionalized individual if s/he is eligible for Community Medicaid on that date, or
- the date the individual applies for assistance while an institutionalized individual if s/he is not eligible for Community Medicaid on the date of institutionalization and the uncompensated value of the transferred asset exceeds the monthly cost of care. The uncompensated value is the difference between the fair market value and the amount that was actually paid for the item.

The look-back period depends upon the date of asset transfer:

- For transfers made before February 8, 2006, the look-back period is 36 months.
- For transfers made on or after February 8, 2006, the look-back period is 60 months.
- Effective February 8, 2011, the look-back period will always be 60 months.

Determine the period of restricted coverage in months by dividing the total uncompensated value by the average monthly cost of nursing home care in DC. If the calculation results in a partial month at the end of the period, the individual is only eligible for LTC for the portion of the month after the partial period ends. The total uncompensated value is the result of subtracting the payment actually received, if any, from the fair market value of the asset.

Effective September 1, 2010, the average monthly cost of nursing home care in DC is \$10,333.00. For periods prior to September 1, 2010, the average cost of care was \$7,149.00.

The start date of the period of restrictive coverage depends upon the date of the asset transfer:

- For transfers made before February 8, 2006, the period of restrictive coverage begins on the first day of the month in which the transfer was made, regardless of the date of the month the transfer actually occurs;
- For transfers that occurred on or after February 8, 2006, the period of restricted coverage begins on the later of the following:
 - The month of transfer, regardless of the date in a month the transfer is made, or

- The first month for which the institutionalized person has applied for LTC and has been found to meet all eligibility requirements except for the transfer of assets for less than full market value.

If the calculation of a restricted period of coverage results in a partial month at the end of the restricted period, the payability for the partial month will be prorated, using the following formula:

(Payability for full month) x (1 – (minus) the part of month not covered).

During the period of restricted Community Medicaid coverage, if the individual is otherwise eligible for Community Medicaid, the individual is eligible for all covered medical services except nursing facility services, equivalent care in a medical institution, and home and community-based services.

Example 1

Mr. Barth makes a transfer on January 2, 2006. The period of restricted coverage begins September 1.

Example 2

Ms. Adams makes a transfer on March 31, 2010. She enters a nursing home in June, 2010 and applies for LTC on July 16, 2010. She is found otherwise eligible for LTC effective July 1, 2010. The period of restricted coverage begins July 1, 2010.

Once a period of restricted Community Medicaid coverage is established, the period may only be recalculated if the LTC applicant provides documentation within forty-five days after the LTC application that all or part of the total uncompensated value was returned to the applicant. In such a case, divide the remaining uncompensated value by the average cost of care to establish the adjusted period of restricted coverage.

Undue Hardship

Once a period of restricted eligibility is assigned, an applicant can claim undue hardship when a penalty will result in inability to get necessary medical services so that health or life would be endangered. Undue hardship also exists when imposing the penalty would result in deprivation of food, clothing, shelter or other necessities of life. Undue hardship does NOT exist when the penalty causes inconvenience, restricts a person's lifestyle, or does not put a person at risk of serious deprivation.

Applicants can request an undue hardship waiver by calling Yvette Thomas on (202) 698-4247 within 15 days of the notice of restricted coverage.

Applicants need to provide the following information regarding eligibility for a Hardship waiver:

- the reason for the transfer;
- attempts that have been made to recover the transferred asset;
- notice of pending discharge from the nursing facility due to the denial of payment of LTC services;
- notice of pending termination of community-based services due to denial of payment;
- statement from doctor(s) saying that the inability to get LTC or community-based services would result in NOT getting medical services needed to prevent the endangerment of health or life;
- proof that the restriction would result in an inability to get food, clothing or shelter;

- lists of all assets and their value at the time of the transfer, if the applicant claims the assets were not transferred to become Medicaid eligible; and
- documents such as deeds or wills, if real property was transferred

ESA will notify the applicant of a decision regarding a hardship waiver. A denial of a hardship waiver may be appealed at the Office of Administrative Hearings.

See also *AZ: Elderly and Physically Disabled Home-And-Community-Based Services Waiver* in Section 1.28: Transfer of Assets in [Part VI](#).

Impoverished Spouse: Once initial Community Medicaid eligibility has been established, assets that were not used to determine the eligibility of the institutionalized spouse (i.e., the Protected Spousal Amount) must be legally transferred to the community spouse. In order for an institutionalized spouse to maintain eligibility, assets cannot be attributed to the community spouse but must actually be made available (i.e., transferred to the community spouse's name) to meet his/her needs in the community. This transfer must be completed by the first annual recertification following the initial LTC determination that considered the assets. Any assets that are not transferred by the first annual recertification must be counted to determine the eligibility of the institutionalized spouse until they are actually transferred to the community spouse.

When the institutionalized spouse acquires additional assets after the Protected Spousal Amount (see Section 2.3.3a: Protected Spousal Amount in this Chapter) has been calculated and initial Community Medicaid eligibility has been established, the additional assets are excluded and do not affect continuing eligibility when either of the following conditions exists:

- The new assets combined with the other assets the institutionalized spouse intends to retain do not exceed the asset limit for one person, or
- The institutionalized spouse intends to transfer the new assets to the community spouse who has assets below the Spousal Share allowance (see Section 2.3.3b: Spousal Share in this Chapter).

To exclude the additional assets, the institutionalized spouse or his/her authorized representative (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of an Individual or Group in [Part III](#)) must promptly report the receipt of the new assets and must provide the SSR with a written statement that s/he intends to transfer the new assets to the community spouse immediately

Example

Two months after Mr. Ross is determined to be eligible for Community Medicaid, he inherits \$4,000 from a deceased sibling. He promptly reports his inheritance and provides the worker with a written statement that he intends to transfer \$2,000 of the \$4,000 to Mrs. Ross.

When the \$2,000 of the inheritance is added to the Protected Spousal Allowance amount of \$9,000, the community spouse's assets now total \$11,000, which is less than the Community Spouse Assets Allowance. Mr. Ross continues to be eligible for Community Medicaid because his assets (\$2,000) are below the asset limit for one person.

Annuities

For the purpose of this chapter, the purchase of an annuity by an institutionalized or community spouse will be treated as a transfer of assets for less than fair market value unless:

- the District of Columbia is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
- the District of Columbia is named as a remainder beneficiary in the second position after the community spouse or a disabled child and is named in the first position if the community spouse or the disabled child or the disabled child's representative disposes of any remainder for less than fair market value.

The purchase of an annuity by or on behalf of an applicant for LTC will be considered a transfer of assets for less than fair market value unless:

- the annuity meets the Internal Revenue requirements of a 408(b) or (q) Individual Retirement Plan (IRA) under a qualified employer plan; or
- the annuity is purchased with the proceeds from;
 - a 408(a) or (c) or (p) retirement account,
 - a 408(k) simplified employee pension, or
 - a 408A Roth IRA, or
- The annuity is:
 - irrevocable,
 - non-assignable,
 - is actuarially sound, and
 - provides for payments in equal amounts during the term of the annuity with no deferral or balloon payments made.

PATIENT PAY AMOUNT (PPA) 2.14

After the assistance unit has been determined eligible for MA or eligible but over-income for MA, the LTC SSR must determine LTC payability by calculating the monthly amount the assistance unit must pay to the LTC facility toward the cost of care. This monthly amount is called the PPA. The PPA is determined by deducting the applicable LTC Income Allowances (see Section 2.6: LTC Income Allowances in this Chapter) from the total countable income of the assistance unit (see Section 2.15: Determining Total Countable Income for PPA Calculation in this Chapter).

The PPA is prorated for any month the individual enters the facility later than the first day of the month or leaves earlier than the last day of the month. When prorating the PPA, include the day admission occurred, but do not include the day discharge occurred.

If the assistance unit consists of a married couple residing in or entering the same facility, calculate two separate PPAs, one for the wife and one for the husband.

The individual or his/her authorized representative (see Section 1.6.2: Filing an Application/Accessing Benefits on Behalf of an Individual or Group in [Part III](#)) is responsible for submitting the PPA directly to the facility on a monthly basis. The Department pays the balance of the cost of care up to the established rate.

PPA and Spend-Downs 2.14.1

If the PPA is greater than the cost of care rate, eligibility for LTC coverage is conditionally denied as over-income until a six-month prospective spend-down liability is met. The conditionally-denied individual becomes a private-pay patient until s/he meets the six-month prospective spend-down liability. The liability is the sum of the PPAs for each of the six months in the prospective budget period.

To meet the prospective spend-down liability, the assistance unit must submit incurred allowable medical expenses (see Section 7.4: Allowable Medical Expenses in Part VI). Payments the individual makes to the LTC facility at the 'private pay' rate are countable medical expenses for purposes of meeting the spend-down liability.

When total submitted medical expenses equal or exceed the spend-down liability, eligibility is established. The assistance unit is certified for the balance of the prospective budget period with a PPA of zero. The Department pays the remainder of the cost of care through the sixth month of the budget period. At recertification, eligibility is conditionally terminated until the subsequent six-month prospective spend-down liability is met.

DETERMINATION TOTAL COUNTABLE INCOME FOR PPA CALCULATION 2.15

The LTC SSR should consult the policies for SR (unless the LTC resident is under 21 and is MA-eligible under AR or AX; in this case, consult the policies for AR or AX) in Chapters 4-6 and 8 in Part VI to determine total countable income. In addition, if the individual in LTC has an MA-eligible spouse who is also residing in a LTC facility, each spouse is considered to be financially responsible for the other for the month of their physical separation.

Impoverished Spouse: No income from the community spouse should be deemed to the institutionalized spouse for any month in which s/he is institutionalized (see Section 2.5: MA Income Eligibility Determination and Section 2.12: Treatment of Assets After MA Eligibility Determination in this Chapter).

Apply the following rules to determine income for the purposes of the PPA calculation for institutionalized spouses who have a community spouse and who were institutionalized after September 30, 1989:

- Determine the individual's total countable income following SR policies (unless the individual is under 21 and is MA-eligible under AR or AX; then follow AR or AX policies), and
- Deduct the applicable LTC Income Allowances (see Section 2.6: LTC Income Allowances in this Chapter) from the individual's total income.

Treatment of Income from Non-Trust Property 2.15.1

Impoverished Spouse: When determining the income of an institutionalized or community spouse for purposes of the PPA calculation and post-eligibility income determination, use the following policies, regardless of any District laws relating to community property or the division of marital property, to determine ownership in non-trust property unless otherwise specified as a part of the non-trust property and unless the institutionalized spouse establishes through the fair hearings process (see Chapter 7: Grievances and Fair Hearings in Part VIII) that ownership interest is other than that prescribed below:

- If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse.
- If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them.
- If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

If there is no instrument establishing ownership, one-half of the income shall be considered available to the institutionalized spouse and one-half shall be considered available to the community spouse.

Treatment of Income from Trust Property 2.15.2

Impoverished Spouse: When determining the income of an institutionalized or community spouse for purposes of the PPA calculation and post-eligibility income determination, use the following policies, regardless of any District laws relating to community property or the division of marital property, to determine ownership in trust property unless otherwise provided in the trust and unless the institutionalized spouse establishes through the fair hearings process that ownership interest is other than that prescribed below (see [Chapter 7: Grievances and Fair Hearings in Part VIII](#)):

- If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse.
- If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them.
- If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

ADJUSTMENT OF SPEND-DOWN LIABILITY 2.16

If the individual who is entering a LTC facility is already eligible for MA as a community-assistance unit and has a spend-down liability, the spend-down liability must be adjusted. The spend-down liability must be prorated to reflect only the months in the budget period prior to the date of admission to the LTC facility.

Example

Mr. Franco is eligible for MA and has a \$600 spend-down liability. His monthly spend-down liability is \$100. Unexpectedly, he enters a LTC facility in the third month of his budget period. Since he is residing in the LTC facility for the last three months of his budget period, his spend-down liability should be prorated to \$300 ($\100×3).

If the individual has already met the original spend-down liability, adjust the eligibility dates and the payments made by the LTC resident and the Department to the community medical providers.

THERAPEUTIC LEAVE 2.17

Pursuant to the Medicaid State Plan, the Medical Assistance Administration will continue payment to the facility for up to 18 therapeutic days per 12-month period. Absences of less than 24 hours are not counted toward the total number of therapeutic days. The 12-month period is defined as the District's fiscal year, October 1 through September 30.

Therapeutic leaves include visits with relatives and friends as well as leaves to participate in District-approved therapeutic and rehabilitative programs.

NOTIFICATION REQUIREMENTS 2.18

All policies governing notifications apply to assistance units receiving LTC coverage. In addition, notify the assistance unit, any responsible party, and the LTC facility in writing of the effective date of the LTC coverage by sending the Notice of the Patient Pay Amount which must state:

- the monthly amounts of each source of countable income,
- the applicable LTC Income Allowances (see Section 2.6: LTC Income Allowances in this Chapter),
- the prorated PPA for the month of admission which should include the day of admission (see Section 2.14: Patient Pay Amount (PPA) in this Chapter), and
- the ongoing PPA, including the PNA.

Complete a revised Notice of the Patient Pay Amount when changes occur in the individual's income, LTC Income Allowances, or other eligibility factors. If the individual is discharged from the facility, complete a revised Notice of the Patient Pay Amount showing the prorated PPA for the month of discharge. When prorating the PPA for the month of discharge, do not include the day of discharge or death.

COMMUNITY BASED LTC WAIVER 2.19

The District was awarded a waiver that allows the Medicaid program to pay for community-based care services in lieu of placing an individual in a LTC facility. This program is alternatively known as the "Elderly and Physically Disabled Home- and Community-Based Waiver." Please see Section 3.4: Elderly and Physically Disabled Home- and Community-Based Waiver in Chapter 3 in this Part for more information.

Generally, to be eligible for these services, the individual:

- must have income below 300 percent of the SSI payment level,
- have assets below the Medicaid categorically needy resource level,,
- would be eligible for Medicaid if placed in an institution,,
- must require a level of care provided in LTC facilities,, and
- could be served in a more cost-effective manner with community-based services.

The waiver limits the number of individuals who can receive Medicaid-funded community-based services under this waiver. Customers may apply by calling (202) 535 2178 or (202) 442 5912.

EXHIBIT VII-2 DIAGRAM OF LTC PROCESSING

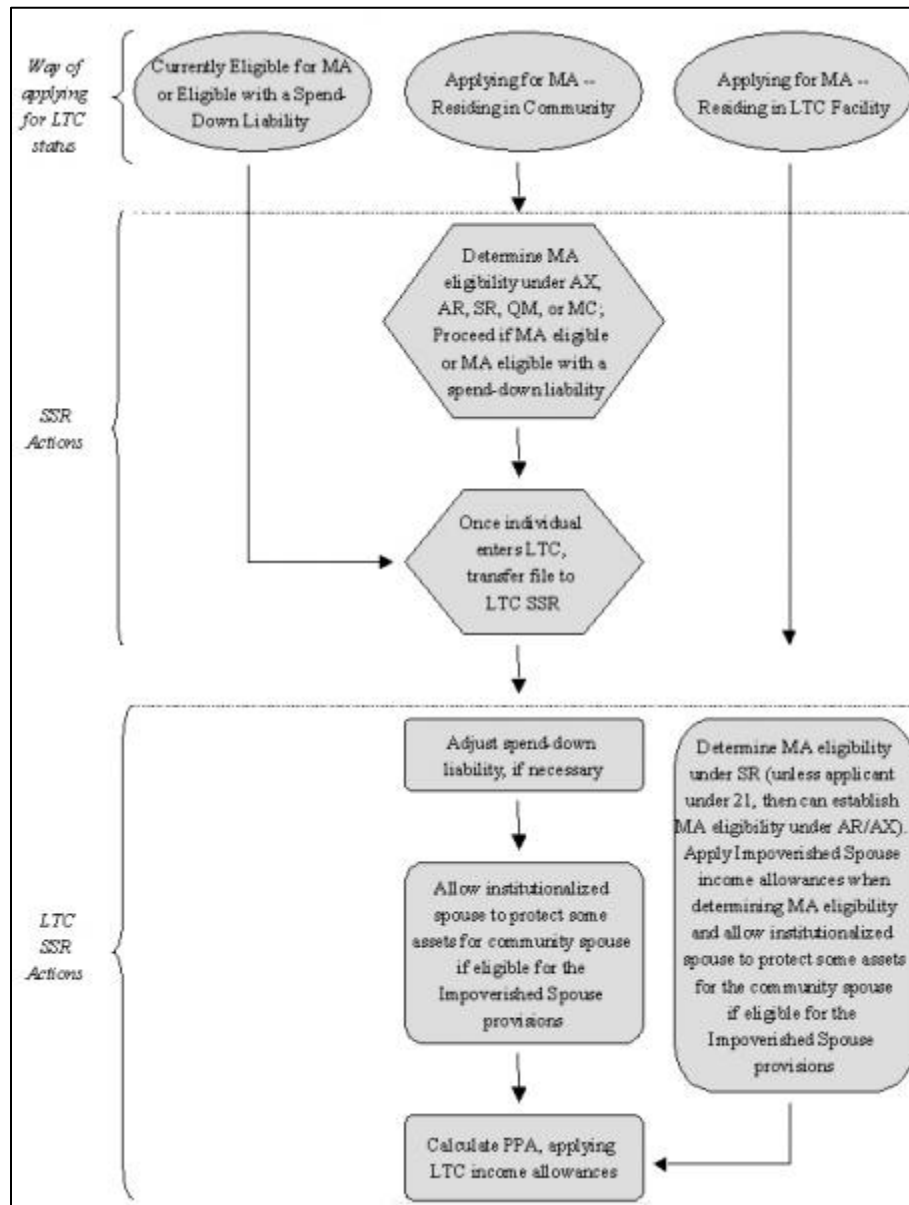


EXHIBIT VII-3 PROVISIONS FOR PRE-OCTOBER 1989 INSTITUTIONALIZATION

This table notes how various policies in Chapter 2: Long-Term Care/Impoverished Spouse need to be modified for individuals who entered LTC before October 1, 1989 and have a spouse living in the community.

Section	Adjusted Policy
2.4.3: Assistance Unit Requirements	If the community spouse is eligible for MA as SR, each spouse is considered to be financially responsible for the other for the month of their physical separation. During this one-month period, both spouses are included in the same assistance unit.
2.5: MA Income Eligibility Determination	In addition to the allowances listed, individuals institutionalized prior to October 1, 1989 who have a community spouse also receive an allowance for maintenance of the spouse and children (see Section 2.6: LTC Income Allowances below).
2.6: LTC Income Allowances	<p>If the community spouse is eligible for MA as an SR, apply the income deductions (see Chapter 6: Income Disregards and Deductions in Part VI) to the income of the community spouse before adding his/her net income to the income of the institutionalized spouse. The LTC SSR should then apply the LTC Income Allowances to their combined income.</p> <p>In addition to those listed, the LTC Income Allowances also include an allowance for maintenance of the spouse and children.</p> <p>When an individual entering or residing in a LTC facility has a community spouse and/or dependent children who are not included in his/her assistance unit, an amount may be deducted from the total countable income of the institutionalized spouse for maintenance of the community spouse and any dependent children. This allowance is only allowed for institutionalized spouses who were residing with the community spouse at the time of admission to the LTC facility.</p> <p>Before the allowance can be deducted, the financial eligibility for MA of the community spouse and any dependent children must first be established and verified (see Part VI: Financial Eligibility Requirements). If the community-assistance unit's total countable assets are within the appropriate medically needy asset limitation and net MA income is less than the appropriate MNIL, deduct an allowance from the institutionalized spouse's income for maintenance of the community-assistance unit. The allowance is the difference between the net MA income of the community-assistance unit and the MNIL that corresponds to the size of the community-assistance unit.</p> <div> <p>Example</p> <p>Mrs. Carey is 45 years old and is institutionalized. Her husband lives in the community with their two children, Sam (14) and Alissa (16). The total countable assets of Mr. Carey, Sam, and Alissa is less than the medically needy asset limitation. Their net MA income equals \$450. The MNIL for a group of three equals \$652.92. Consequently, Mrs. Carey is eligible for an allowance of \$202.92 (\$652.92 - \$450.00) to be deducted from her income.</p> </div> <p>If the institutionalized spouse is eligible for this allowance, then the community-assistance unit has effectively established financial eligibility for MA by meeting</p>

	<p>the financial eligibility requirements. However, the community-assistance unit cannot be certified for MA unless an application is submitted and the community-assistance unit meets all of the non-financial eligibility requirements (see Part IV: Non-Financial Eligibility).</p> <p>For the LTC assistance unit in which both the community spouse and the LTC spouse are SR, this allowance is not applicable until the month following the month of physical separation (i.e., when the community spouse and the institutionalized spouse are no longer considered to be members of the same assistance unit).</p>
2.7: Projected Income	<p>Projected Income The allowance for maintenance of the spouse and children also may be projected for a prospective period not to exceed six months.</p>
2.1 5: Determining Total Countable Income for PPA Calculation	<p>If the community spouse is eligible for MA as an SR, each spouse is considered to be financially responsible for the other for the month of their physical separation. In addition, apply the income deductions (see Chapter 6: Income Disregards and Deductions in Part VI) to the income of the community spouse before adding his/her net income to the income of the institutionalized spouse. The LTC SSR should then apply the LTC income allowances to their combined income.</p>

CHAPTER 3 - OTHER HEALTH PROGRAMS AND REFERRALS

INTRODUCTION 3.1

Many IMA customers may be ineligible for AR/AX or SR Medicaid but remain in need of health services. This chapter presents the policies and referrals information for special Medicaid expansions and other District programs, including:

- DC HealthCare Alliance
- Elderly and Physically Disabled Home- and Community-Based Services Waiver
- HIV Programs
- Breast and Cervical Cancer Program
- Mental Health Special Rehabilitation Option
- Drug Abuse Program (Addiction Prevention and Recovery)
- Mental Retardation and Developmental Disabilities Waiver

Because each of these programs is administered outside of ESA, it may be necessary to refer customers to the appropriate program agency.

LEGAL AUTHORITY 3.2

These programs are outside the purview of ESA. In specific instances, the ESA Medicaid Branch “enrolls” customers in these programs by creating an ACEDS record. However, the primary responsibility for enrollment, case maintenance, recertification, and de-enrollment remains with the respective program agency that administers the program.

DC HEALTHCARE ALLIANCE 3.3

Effective June 1, 2006, ESA administers eligibility for the DC HealthCare Alliance. This section has been expanded and moved to Chapter 4: DC HealthCare Alliance in this Part.

Note: Customers in the MC program type in ACEDS with a program code of 370 are actually enrolled in the 50-64 Demonstration; please see Section 1.16: 50-64 Demonstration in Chapter 1 of this Part for additional information.

ELDERLY AND PHYSICALLY DISABLED HOME-AND-COMMUNITY-BASED SERVICES WAIVER 3.4

Frail elderly or disabled customers may be able to receive both Medicaid and home-base care services through this Waiver program, even if their incomes are above the SR Medicaid limit. Waiver services include home nursing and personal care aide services, homemaker and chore services, home modifications, non-medical transportation, etc.

Generally, to be eligible for these services, the individual:

- must have income below 300 percent of the SSI payment level;
- must have assets below the Medicaid categorically needy resource level;
- would be eligible for Medicaid if placed in an institution;
- must require a level of care provided in LTC facilities; and
- could be served in a more cost effective manner with community based services.

The waiver limits the number of individuals who can receive Medicaid funded community based services under this waiver. Customers may apply by calling (202) 535 2178 or (202) 442 5912.

This program is funded and administered by the Medical Assistance Administration within the Department of Health, though the ESA Medicaid Branch establishes ACEDS records under the AZ program type for customers enrolled in the Waiver.

HIV PROGRAMS 3.5

In addition to HIV testing and counseling, the HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) offers a variety of programs for HIV-infected District residents. These programs include assistance with COBRA insurance premiums and pharmacy assistance through the AIDS Drugs Assistance Program (ADAP). Persons with gross incomes less than 400 percent of the Federal Poverty Level may be eligible for one or more of these programs.

To apply, customers should call HAHSTA on (202) 671-4900. Customers may also complete a "Application for Health Services" while at ESA; staff should facilitate the process by faxing documents as required.

These programs are funded and administered by the Department of Health, though the ESA Medicaid Branch establishes ACEDS records for customers who were enrolled in the Medicaid Demonstrations.

The Medicaid Demonstration program that provided services to this group ends on December 31, 2010. These persons may apply at ESA for other Medicaid categories or the DC HealthCare Alliance.

BREAST AND CERVICAL CANCER PROGRAMS 3.6

The Breast and Cervical Cancer Program, also known as "Project Wish", provides screening and treatment services to District residents with gross incomes below 250 percent of the Federal Poverty Level. Customers must be screened and diagnosed by a Project Wish provider before they can enroll in the program. The program is funded and administered by the Department of Health.

For more information, customers may call Project Wish toll free on 1-888-833-WISH (1-888-833-9474; TTY 1-877-672-7368)

The program is funded and administered by the Department of Health, though the ESA Medicaid Branch establishes ACEDS records under the AZ program type for customers enrolled in the program.

MENTAL HEALTH AND SPECIAL REHABILITATION OPTION 3.7

The Department of Mental Health provides a variety of services to customers to treat and recover from mental illness. These services include diagnostic/assessment services, medication, counseling, intensive day treatment, crisis/emergency services, residential treatment, and specialized services for adults and children. Fees for services are determined on a sliding scale basis. No one will be turned away because of inability to pay for service.

For more information or assistance, customers may call 1-888-7WE-HELP (1-888-793-4357).

DRUG ABUSE PROGRAM (ADDICTION PREVENTION AND RECOVERY) 3.8

The Addiction, Prevention and Recovery Administration (APRA) within the Department of Health provides a variety of services for the prevention of and recovery from addictions. These services include crisis

intervention, education, counseling; 24 Hour detoxification services; residential treatment; outpatient and methadone programs; and case management. APRA also offers special services for youth, pregnant and postpartum women.

For more information or assistance, customers may call 1-888-7WE-HELP (1-888-793-4357).

MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES HOME-AND-COMMUNITY-BASED SERVICES WAIVER 3.9

The Mental Retardation and Development Disabilities Administration (MRDDA) provides home- and community-based services for adult District residents. These services include home nursing and personal care aide services, adaptive equipment, residential care placements, rehabilitation services, vocation training and placement services.

To apply for MRDDA services on behalf of an individual, customers may contact an intake representative at (202) 673 4554 Monday through Friday from 8:15 am until 4:45 pm. TTY/TDD services 24 hours a day at (202) 673 3580.

These programs are administered and funded by MRDDA, though the ESA Medicaid Branch establishes ACEDS records under the AZ program type for customers enrolled in the Waiver.

CHAPTER 4 - DC HEALTHCARE ALLIANCE PROGRAM

INTRODUCTION 4.1

The DC HealthCare Alliance (Alliance) program is designed to provide medical assistance to needy District residents who are not eligible for federally-financed Medicaid benefits. This includes qualified aliens who do not meet the immigration requirements needed to be eligible for Medicaid and non-qualified aliens. Effective September 1, 2009, applicants who are enrolled in any part of Medicare or who have third party insurance are not eligible for the DC HealthCare Alliance. In addition, effective September 27, 2011, applicants must complete a face-to-face interview and may only be certified for six months. Enrollees recertifying for the Alliance must also complete a face-to-face interview. The Alliance program provides comprehensive health services, including preventative, primary, acute, and chronic care services such as clinic services, emergency care, immunizations, in-patient and out-patient hospital care, physician services and prescription drugs.

LEGAL AUTHORITY 4.2

AREA/TOPIC	DISTRICT	FEDERAL
DC Healthcare Alliance	22 DCMR Chapter 33	

DETERMINING NON-FINANCIAL ELIGIBILITY 4.3

Unless otherwise indicated, non-financial eligibility requirements for the Alliance program correspond to those of AR Medicaid (see Part IV, Non-financial Eligibility). Non-financial eligibility requirements must be verified.

Group Composition 4.3.1

The assistance unit must consist of the person requesting assistance and certain relatives and caretakers of children who live with the person, if these individuals wish to receive assistance. Relatives/caretakers who do not want to apply for benefits for themselves are never required to be included in the assistance unit, though their income and resources may be considered when determining the applicant's eligibility. Groups that include children must follow the rules for the AR program. Groups in which no child is included (or included provisionally) must follow the rules of the SR program.

An Alliance unit may consist of any of the following:

- a single individual;
- an individual and his/her spouse, including a common-law spouse;
- a parent and his/her child(ren) (The children would be included provisionally for income determination purposes. If ineligible for federally-funded Medicaid, the caseworker will determine the children's eligibility for the Immigrant Children's Program);
- a related or unrelated caretaker and the child and child's siblings under his/her care (The children would be included provisionally for income determination purposes. If ineligible for federally-funded Medicaid, the caseworker will determine the children's eligibility for the Immigrant Children's Program); or
- a pregnant woman and her unborn child(ren) (only if the pregnant woman is not a qualified alien).

In addition, at the group's option, the following persons may be included in groups that include a child:

- a stepparent,
- step-siblings,
- an essential person, and
- parents of a parenting minor.

While parents residing in the home with a dependent child do not have to be included in the assistance unit, parents living in the home with a dependent child are provisionally included for the purpose of determining financial eligibility. If an individual resides in the same home as his/her spouse, the spouse must be provisionally included in any case that includes that individual.

The following individuals must be excluded from any Alliance unit:

- persons eligible for Medicaid,
- persons enrolled in any part of Medicare,
- persons enrolled in any third party health insurance,
- children under the age of 21 (children may be included provisionally to determine financial eligibility for the Alliance application, but may not be eligible as an Alliance enrollee)
- fugitive felons,
- probation or parole violators,
- persons penalized for misrepresenting their residence to receive assistance in two or more states,
- persons who refuse to provide information needed to determine their eligibility, and
- persons included in another medical assistance unit,
- persons who say they are US citizens but have failed to document US citizenship after being given reasonable opportunity and have been terminated from Medicaid, and
- persons who say they are Qualified aliens who meet the Medicaid immigration requirements but have failed to document their status after being given reasonable opportunity and have been terminated from Medicaid.

In addition, the following individuals may be excluded;

- a child that the applicant/recipient has asked to excluded (the child would be included provisionally for income determination purposes; if the child has income, the Alliance applicant may ask that the child's needs and income not be considered in the Alliance determination),
- a parent whose needs are met by his/her spouse who is not a natural or adoptive parent of the dependent child and who chooses to be excluded, and
- a parent under age 21 who chooses to be excluded because his/her needs are met by his/her parents with whom s/he resides

Residency 4.3.2

To be eligible for program benefits, a person must be a presently living in the District of Columbia voluntarily and not for a temporary purpose and have no current intention of moving out of the District. See Part IV: Chapter 2, Non-Financial Eligibility Requirements: Residency, for additional information on establishing and verifying residency eligibility.

Social Security Number 4.3.3

The applicant/recipient who states that he/she is a US citizen must provide a valid and verifiable Social Security number.

For non-citizens, the applicant/recipient must provide a Social Security Number (SSN) for each member of the group who has one. Application for SSNs is not required for non-citizens.

Alien Number 4.3.3a

The applicant/recipient who states that he/she is a qualified alien (See Part IV, Chapter 4, Section 7.3: Qualified Aliens), must provide his/her nine-digit Alien Number.

Age/School Attendance 4.3.4

Children under the age of 21 who are neither U.S. citizens nor Qualified Aliens are excluded from the Alliance and should be placed in the Immigrant Children Program.

Adults 65 or older who are U.S. citizens or qualified aliens should be evaluated for federal Medicaid or QMB eligibility. Persons who are 65 or older may only be enrolled in the Alliance if they are non-Qualified Aliens or Qualified Aliens who do not meet Medicaid immigration requirements.

School attendance is not required.

Living with a Relative 4.3.5

There is no requirement that a child live with a relative to be considered part of the Alliance group for purposes of determining financial eligibility for the rest of the group.

Citizenship/Alienage 4.3.6

Unlike other Medical Assistance programs, the applicant/recipient does not need to be a U.S. citizen or a qualified alien as defined under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. However, customers who claim to be qualified aliens shall provide their Alien Identification number so that an evaluation of federal Medicaid eligibility may be done. See Part IV: Chapter 7, Non-Financial Eligibility Requirements: Citizenship/Alienage, for additional information on determining when non-citizens can receive Medicaid benefits.

Although there is no citizenship/alienage requirement for Alliance eligibility, an applicant must be a DC resident. Temporary non-immigrants, such as embassy personnel do not meet the residency requirement. See Part IV, Chapter 2, Section 2.3: Determining Residency.

Disability 4.3.7 (Repealed)

Other Medical Coverage 4.3.8

Effective September 1, 2009, persons may not enroll in the DC HealthCare Alliance program who are:

- eligible for federally-funded Medicaid;
- enrolled in any part of Medicare; or
- enrolled in any third-party health insurance program.

If an applicant is enrolled in any part of Medicare, the caseworker must determine eligibility for the QM program. See Part VII, Chapter 1.11: Qualified Medicare Beneficiaries (QMB) and Part VII, Chapter 1.12: Special Low-Income Medicare Beneficiaries (SLIMB).

DETERMINING FINANCIAL ELIGIBILITY 4.4

Applicants and recipients of the Alliance program must meet income and asset limits. Income and assets that are countable for Medicaid are countable for the Alliance program. Financial eligibility must be verified.

Income Limits 4.4.1

The group's net income must be below 200 percent of the Federal Poverty Limit (FPL) for the group size. See the table for the AX program in Exhibit VI-3, MA Income Standards in Part VI, Chapter 8.

Determining Income Eligibility 4.4.2

To determine if the group meets income requirements, complete the following:

- Determine the group's gross income in accordance with policies detailed in Part VI: Financial Eligibility Requirements,
- Deduct up to the first \$100 in earned income, and
- Compare the result to the current income standard.

The group is eligible if the income after deductions is below the current income standard based on the group size.

Individuals or groups ineligible for Alliance benefits because their incomes exceed income limits cannot become eligible by spending down their income on medical expenses.

Asset Limits 4.4.3

The group must meet the asset limits listed in the chart below:

Group Size	Limit
1	\$4,000
2 or more	\$6,000

Third Party Liability 4.4.4

Each applicant who is legally able must assign to the Department rights to third party resources, unless s/he has good cause for not cooperating. A third party resource is a person, entitlement, or program that is liable for payment of all or a part of an individual's medical expenses. In most instances, the third party is an insurance company.

An applicant must surrender to the District Government any reimbursements or other payments received from an insurance company, court settlement, or other source for health care or medical services that were covered, and paid for, by the District's Medicaid or medical assistance programs. See Part V, Chapter 3: Program Requirements and Sanctions, Third Party Requirements, for additional information.

PROCESSING APPLICATIONS 4.5

Applications for the Alliance program may be submitted by mail, facsimile, or in person at any IMA service center. Applicants should use the Combined Application that is used to apply for multiple programs. Applicants may also submit their applications to an out-stationed IMA employee working in a community setting. Every applicant has the right to file an application on the same day that s/he contacts IMA. An application is considered to be filed when the signed and dated application form is received by the IMA representative.

Except as otherwise stated below, applications for the Alliance program are processed in accordance with policies established for AR Medicaid in *Part III: Chapter 1, Application Processing: Filing an Application*.

Who May File the Application 4.5.1

Any individual or either spouse of a married couple may file the application for Alliance benefits. The applicant may designate an authorized representative to act on his/her behalf. See Part III: Chapter 1, Application Processing: Filing an Application, for additional information on designating an authorized representative. An applicant has the right to refuse to name an authorized representative.

Application Review 4.5.2

Effective September 27, 2011, a face-to-face interview with the applicant is required to complete applications for Alliance benefits. During the face-to-face interview, the SSR shall:

- inform the applicant of his/her rights and responsibilities;
- explain the program and related services;
- outline the conditions of eligibility and indicate what verification and information are necessary to determine eligibility;
- notify the applicant that information s/he provides will be matched by computer with information from other local, state and federal agencies; and
- explore and resolve any unclear or incomplete information.

Request for Waiver of Face-to-Face Interview 4.5.2a

Applicants may request a waiver of the face-to-face interview requirement on the basis of being unavailable during the application period due to hospitalization, disability, or being aged 65 or older. Applicants (or their authorized representatives) must submit the following supporting documentation to be considered for a waiver:

- For persons who are hospitalized, written documentation from a hospital or other medical professionals on the hospital or provider letterhead, attesting that the applicant is not available for an interview due to disability or illness, including a diagnosis and prognosis, and that the applicant will not be available for the 45-day period beginning with the date of application. These waiver requests will be reviewed by the Medical Review Team.
- For persons who are age 65 or older, a written statement from the applicant explaining why they cannot participate in the face-to-face interview during the 45-day period beginning with the date of application. Waiver requests from persons who are elderly will be reviewed by the Agency on a case-by-case basis.

Application Timeframes 4.5.3

Applications for the Alliance program must be processed within 45 days, counting from the day after the application was filed. A verification checklist, listing all information or actions still needed to determine eligibility must be issued through ACEDS and given to the applicant at the time the application is filed. The checklist and the date the application was filed are essential for the timely issuance of all application notices and timely disposition of the application.

If an applicant fails to provide all necessary verification by the tenth day following the application date, ACEDS will issue a Ten-Day Notice that lists the information or actions needed to complete the eligibility determination. If the applicant still has not provided all necessary verifications by the 30th day following the application date, ACEDS will issue a 30-Day notice that also reports what is needed to complete the eligibility determination.

If by the 15th day following the 30-day notice (or the next available workday), the applicant has not provided all verifications, ACEDS will issue a denial notice and deny the application.

It is ESA's goal to complete the eligibility determination within 10 days from the date that all information necessary to determine eligibility has been submitted.

Expedited Determinations 4.5.4

ESA shall conduct expedited determinations (on the same or next business day) for any applicant who has an urgent medical need that is certified by a clinician. Applicants may request an expedited determination from the IMA Office of the Administrator by telephone, fax, or in person. A need for an expedited determination does not relieve an applicant from the requirement to participate in a face-to-face interview, unless waived (see Section 4.5.2a: Request for Waiver of Face-to-Face Interview in this Part.)

Application Approvals 4.5.5

If all financial and nonfinancial conditions of eligibility are met, the SSR will approve benefits.

Period of Eligibility 4.5.6

Eligibility shall begin on the first day of the month of application. Effective September 27, 2011, applicants shall be certified for six (6) months.

Applicants are not eligible for coverage for any month prior to the month of application.

Application Denials 4.5.7

The application for Alliance benefits will be denied if:

- the applicant does not cooperate with IMA in providing the information needed to determine eligibility;
- conditions of nonfinancial eligibility have not been met;
- income and/or assets exceed established limits;
- the application has been voluntarily withdrawn or abandoned;
- the applicant establishes eligibility for federally-funded Medicaid; or
- the applicant fails to complete a face-to-face interview, unless a waiver has been granted in accordance with Section 4.5.2: Application Review in this Chapter.

The applicant must be notified of the denial, the reason for the denial, and his/her right to a fair hearing.

Terminations due to Non-Compliance with New Requirements 4.5.7a

Effective September 27, 2011, persons who were determined eligible for the Alliance under prior rules may be required to comply with rules effective September 27, 2011. The Agency shall give at least thirty days' notice of the new requirements. Persons who do not comply with the new requirements may be terminated after timely and adequate notice.

Notices 4.5.8

A notice indicating a decision to deny an application for the Alliance benefits must be issued by the 45th day after the date of application, or in the case of an automated denial for abandonment or failure to return verifications, by the 15th day after a 30-Day notice was sent (or the next available work day). If the applicant is denied benefits, the notice must include the reason for the denial and provide information on the applicant's right to a fair hearing. If the application is approved, the notice must be issued by the 45th day from the date of application, or within 10 days of establishing eligibility, if eligibility is established after the 35th day from the date of application. An approval notice should indicate the effective date of the approval, and notify the applicant of his/her right to request a fair hearing.

CASE MAINTENANCE 4.6

Recertification 4.6.1

Alliance program recipients must recertify for benefits every six (6) months. Recertifications will be completed in compliance with the policies and procedures detailed in Part VIII: Chapter 4: Recertification, with the following additional requirements:

- Persons who are recertifying for Alliance benefits must complete a face-to-face interview as part of the recertification process. The recertification form will not be considered complete until this requirement is satisfied. Persons may request a waiver of this requirement due to being hospitalized, disabled or elderly (for documentation needed to support a waiver request, see Section 4.5.2a: Application Review in this Chapter). For a recertification interview waiver request, the documentation must state that the person recertifying is not available and will not be available for the period beginning from the date the recertification form is mailed through the last day of the certification period.

- Persons who are recertifying for Alliance benefits must verify all of the following:
 - DC residence;
 - all income of the Alliance enrollee and spouse, if any;
 - all resources of the Alliance enrollee and spouse, if any;
 - US citizens must provide a valid and verifiable Social Security number, if not already provided and verified; and
 - qualified aliens must provide a valid nine-digit alien number, if not already provided.

If the recipient provides all information needed to re-determine eligibility, confirming that s/he continues to meet all financial and nonfinancial eligibility requirements, the SSR will recertify Alliance benefits for an additional six months.

Reporting Changes 4.6.2

Alliance program recipients must report changes that affect their eligibility for benefits by the 10th day of the month following the month of the change. If the group reports an additional group member, the SSR will make the change for the month of the change, if otherwise eligible. If the group reports that a group member has left or that a change has occurred that makes the group ineligible, the SSR will make the change for the month following expiration of adequate and timely notice.

A person who fails to report a change timely may lose his/her benefits and face civil and criminal penalties.

When an Alliance enrollee requests that a spouse be added to the case, and the spouse would be eligible for the Alliance, the spouse must complete a face-to-face interview, or request a waiver from the requirement.

Case Termination 4.6.3

If the recipient fails to complete all steps in the Alliance recertification process (see Section 4.6.1: Recertification in this Part), the SSR must send timely and adequate notice of the agency's intent to terminate Alliance benefits. If the recipient does not respond within 15 days, the SSR should terminate the Alliance benefits for the next available month.

If the recipient reports (and verifies when necessary) a change at Alliance recertification that results in termination of Alliance benefits and affects the person's eligibility for other program benefits also, the SSR should re-evaluate his/her eligibility for those programs.

Notices of Alliance program termination must meet all requirements listed in Part VIII: Chapter 10, Case Maintenance, Notice of Adverse Action.

Shortened Certification Period 4.6.3a

Effective September 27, 2011, persons who were approved for a twelve-month certification period at application or recertification may be required to comply with the following requirements:

- participate in a face-to-face interview, unless the requirement is waived;
- verify residence, income, and resources;

- for U.S. citizens, provide a valid and verifiable Social Security number, if not already provided; and
- for Qualified Aliens, provide a valid and verifiable Social Security number and a nine-digit Alien Number, if not already provided.

The Agency will send at least thirty days' advance notice of the requirement to comply with the new requirements for persons certified under the prior rules.

Persons who comply with the new requirements and are determined to be eligible will have their certification period shortened to end on the sooner of the following dates:

- six months from the month the recipient complies with the new requirements, or
- twelve months from the original determination, if there are less than six months remaining in the certification period.

Persons who do not comply, or who do comply and are determined to be ineligible for the Alliance, will be terminated after timely and adequate notice.

Fair Hearings 4.6.4

An applicant/recipient dissatisfied with an action taken by the Department which affects Alliance benefits, participation or requirements can request a fair hearing. The hearing process outlined in Part VIII: Chapter 7, Case Maintenance: Grievances and Fair Hearings should be used.

Fraud in Obtaining Benefits 4.6.5

An applicant, or his/her authorized representative, must give true, accurate and complete documents and information. A person who gives false, deceptive or misleading documents or information may lose his/her benefits and face civil and criminal penalties.

Non-cooperation in Eligibility Review 4.6.6

An applicant and his/her authorized representative must cooperate with District investigators and their duly authorized agents who review the applicant's eligibility record. The requirement for cooperation includes being interviewed by investigators, but the applicant may still refuse entry in his/her home. An applicant who fails to cooperate may lose his/her benefits. An applicant and his/her authorized representative may face civil and criminal penalties.

VERIFICATION 4.7

Except where noted earlier, the SSR should use standard verification procedures to verify financial and nonfinancial eligibility requirements.

PART VIII - CASE MAINTENANCE

Chapter 1 - Case Record Documentation Standards

INTRODUCTION 1.1

The department is accountable for validating the information used to determine program eligibility. Case records provide written documentation of the actions taken by the Department and the reasons for those actions. The Department is accountable for maintaining accurate records.

Case records must contain the most recent application and recertification forms for each program and documents in support of the eligibility determination.

All program records should be labeled and retained in an organized fashion for audit and review purposes including:

- application, re-certification forms, and related documents;
- verification documentation submitted by the applicant/recipient;
- customer responses to agency actions;
- copies of correspondence with the applicant/recipient that are not ACEDS-generated;
- copies of all correspondence from the customer to the agency; and
- copies of fair hearing requests and fair hearing outcome documentation.

All agency case records should be uniformly organized (see Appendix C-2: Case Record Organization).

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Standard for Case Record Documentation	TANF: 29 DCMR 5803, 5820-5821 See TANF and D.C. Code 4-205-5a	MA: 42 CFR 431.17, 431.40, 435.913 7 USC 2020 (a); 7 CFR272.1 (f)

STANDARDS FOR CASE RECORD DOCUMENTATION 1.3

ALL	All eligibility criteria and clarifying information are documented on the Record of Case Action, Form 1052. The case record should speak for itself. An outside reviewer shall be able to follow the chronology of events in the case by reading the narrative. All application documents including verification and correspondence must be date-stamped. For working recipients, the record should include the dates pay is received and how often the recipient is paid. When the recipient's statement is the best available source, the record should include both the applicant/recipient's and the agency's efforts to verify the information. All address changes should be documented.
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RETENTION OF DOCUMENTS 1.4

ALL	All case documents needed to document eligibility must be retained as long as the case remains open. Verification documents related to an overpayment must be retained until the overpayment is paid off or it is determined that no further action to obtain payment is appropriate.
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RECEIPT OF VERIFICATION DOCUMENTS THAT CANNOT BE RETAINED OR COPIED 1.5

ALL	<p>When an applicant/recipient provides verification documentation that cannot be retained or copied, the SSR must record in the case file the type of documentation that has been seen by the SSR to verify an eligibility criteria. The following information about such documentation should be recorded in the case file:</p> <ul style="list-style-type: none">• date documentation seen,• any title of the document,• source of document,• date on the document, and• content of the document that relates to the applicable eligibility criteria.
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Example 1

Ms. Littlejohn has an appointment to meet with her assigned SSR to complete the application process. She only needs to provide the Department with verification of her daughter Liza's relationship. Ms. Littlejohn has an original copy of the birth certificate. The SSR discovers that the photocopier in the service center is broken. The SSR should record in the case file that s/he has seen a copy of the birth certificate, the date seen, and other pertinent information such as the serial number on the certificate, Liza's date of birth, and Liza's parents' names. Ms. Littlejohn is considered to have met the verification requirement once this information is properly documented in the case file.

Chapter 2 - Case Transfers Between Service Centers

INTRODUCTION 2.1

All documents which establish group eligibility must be maintained under Department control, including when documents are transferred within the IMA.

Cases are transferred in two ways, electronically and physically. Unit supervisors are responsible for electronically transferring cases, and the unit clerk handles transfer of the physical case. Cases should be transferred electronically and physically on the same day.

A case cannot be transferred from one service center to another if the applicant/recipient is homeless.

CASE TRANSFER 2.2

ALL	<p>A case may be transferred between service centers when:</p> <ul style="list-style-type: none">• an applicant/recipient notifies the Department of a change of address and that address is served by a different service center, or• there is a realignment of the caseload. <p>A case may not be transferred if the next recertification or review is within 60 days. If a case is transferred, it must be screened for accuracy within ten days. If there are any errors in the case, it must be returned to the originating center within ten days of receipt.</p>
MA	A case cannot be transferred if a notice has been sent to the applicant/recipient informing them that his/her case is due to be re-certified.
TANF	A case cannot be transferred unless it has been reviewed by the SSR within the last 12 months.
GC	See TANF
FS	<p>See MA.</p> <div><p>Example</p><p>Mrs. Metzger and her son receive FS and Medicaid. Ms. Metzger and her son move and should now be served by a different service center. Ms. Metzger contacts the agency to inform them of the change in her address after her FS recertification notice was forwarded to her new address. Since a date and time for the FS recertification has already been set, Ms. Metzger's case should not be transferred until the recertification process has been completed.</p></div>

CHAPTER 3 - TANF REFERRAL PROCESSES

INTRODUCTION 3.1

This chapter applies only to TANF applicants/recipients and describes the support service referral process. Based on information from the Preliminary Assessment, the Combined Application (CA), and information gathered by the SSR during the initial intake interview, recertification, or other customer contact, the SSR will determine whether the applicant/recipient needs referrals to other service providers, is a candidate for the Diversion Payment Program, or whether the customer should be referred to POWER.

LEGAL AUTHORITY 3.2

AREA/TOPIC	DISTRICT	FEDERAL
Addiction, Prevention, and Recovery Administration (APRA)	TANF: DC Code 4-205.76; 29 DCMR 5829	
Child Care - Office of Early Child Development (OECD)	TANF: DC Code 4-205.19c(d); 4-205.19(e)(c); 205.19g(3); 4-205.61(3); 4-205.65(f)(1); 4-205.77(c); 4-304.1	TANF: 45 CFR 261.15-.16; 261.56; 261.57
Child Support – Child Support Enforcement Division (CSED)	TANF: DC Code 4-205.19; 4-217.8; 29 DCMR 1707-1715	TANF: 45 CFR 264.30-.31
Diversion Payment Program (DPP)	TANF: D. Code 4-205.81; 29 DCMR 5832-5835	
Domestic Violence	TANF: 29 DCMR 1708-1715; 29 DCMR 5819-5828	TANF: 45 CFR 260 Subpart B
Job Clubs	TANF: DC Code 4-205.19b-c; 29 DCMR 5806	TANF: 45 CFR 261.30
Negotiated Suitability Training (NST)	TANF: 20 DCMR 5808.1	TANF: 45 CFR 261.30
Program on Work Employment and Responsibility (POWER)	TANF: DC Code 4-205.72-.80; 29 DCMR 5829- 5831	
Teen Parent Program - New Heights	TANF: DC Code 4-205.63-.65; 29 DCMR 5800-5801	TANF: 45 CFR 261.33(b)

ADDICTION. PREVENTION, AND RECOVERY ADMINISTRATION 3.3

APRA is the District's one-stop agency for alcohol, tobacco, and other drug abuse (ATOD) prevention and recovery services. It is the initial intake and screening point for all District residents seeking detoxification, residential, and outpatient services. APRA offers comprehensive prevention, treatment, and rehabilitation services to District residents. These services include:

- youth treatment;
- central intake, assessment and referral;
- 24-Hour detoxification services;
- residential treatment;
- outpatient and Methadone programs;
- pregnant and postpartum women's treatment programs;
- crisis intervention, education, counseling and employment opportunity programs;
- case management;
- legal and social services referrals;
- HIV/AIDS counseling and testing;
- mental health screening and referrals; and
- patient advocacy.

Central Intake for APRA is located on the grounds of DC General, Building 12. The phone number is (202) 698-6080. Medicaid recipients should be encouraged to identify themselves as Medicaid clients when contacting APRA in order to facilitate services.

CHILD CARE 3.4

The Office of Early Childhood Development (OECD) cooperates with other public and private child and family advocacy and service organizations to provide a comprehensive, subsidized child care program for eligible children five-years-old and younger. OECD also:

- provides access to before and after school services for eligible children up to age 13, and
- oversees the DC Early Intervention Program (DCEIP) which promotes the identification and screening of infants and toddlers up to three-years-old for developmental delays.

If an applicant/recipient needs child-care assistance, s/he should call (202) 727-1839 between the hours of 9:00 a.m. and 4:00 p.m. to schedule an appointment with OECD.

SSRs should give TANF recipients TANF work activity referrals and immunization forms to facilitate services.

CHILD SUPPORT 3.5

As a condition of eligibility for TANF, each applicant/recipient with a child who has a living parent who does not reside with the family, must cooperate with the Child Support Enforcement Division (CSED) of the Office of the Attorney General by providing relevant information regarding the non-custodial parent or other obligor which may include the following:

- identifying and locating the absent parent(s) of children for whom assistance is requested or received;
- establishing paternity;
- establishing and modifying a support order;
- enforcing a support order; and
- obtaining any other payment or property due the applicant, recipient, or child(ren).

Cooperation includes:

- appearing at CSED when requested;
- providing information or attesting to the lack of information under penalty of perjury;
- taking any actions needed to establish paternity or obtain child support, such as testifying at hearings or obtaining blood tests; and
- paying to CSED any support payments received.

For more information on applicant/recipient requirements to assign child and medical support rights, see [Chapter 2: Child Support Requirements in Part V](#).

Customer Service for CSED can be reached at (202) 442-9900.

CUSTOMER SERVICE 3.6

The Customer Service Unit (CSU) provides quick and professional centralized, telephone-based access to the ESA and its various services for potential and current applicants/recipients. CSU representatives have knowledge of ESA programs and are able to research, mediate, and solve problems and concerns communicated by applicants/recipients.

The objectives of the CSU are as follows:

- increase general applicant/recipient satisfaction,
- improve service delivery,
- reduce applicant/recipient frustration and confusion related to the application and receipt of benefits and services, and
- provide management with information about applicant/recipient concerns and trends related to service delivery.

The CSU provides timely, immediate, and accurate information and referrals about benefits and services available through ESA and other District agencies. Applicants/recipients receive answers about ESA program requirements and information about the status of benefits and eligibility based upon analysis of data in ACEDS.

The Customer Service Unit can be reached at (202) 724-5506.

DIVERSION PAYMENT PROGRAM (DPP) 3.7

A head of household who is applying for TANF may be provided with cash assistance under DPP instead of receiving a TANF grant. DPP is used to resolve an immediate short-term financial need which, if resolved, will allow the applicant to continue in current employment or accept new employment. During TANF applicant intake, the SSR should assess whether an applicant is an appropriate candidate for DPP.

If the applicant indicates during the initial interview or subsequent discussions but prior to TANF approval that employment could be retained or obtained if a work-related crisis can be quickly resolved, then the SSR should inform the applicant of the program and encourage the use of DPP rather than TANF. Receipt of DPP does not count toward the TANF 60-month time limit.

It is important to note that an individual may not apply for DPP. It is the responsibility of the SSR to consider if DPP is appropriate, discuss it with the applicant, and, if appropriate, recommend DPP over TANF.

DPP is available to cover expenses that, if paid, will assure retention of employment or the ability to accept bona fide employment in lieu of monthly TANF assistance. These expenses include but are not limited to:

- auto insurance,
- motor vehicle repair,
- rent and utilities (but not utilities alone),
- work clothes, and
- professional licenses and fees.

In order to be considered for DPP, the applicant must meet the following criteria:

- have a job or bona fide offer of employment which s/he is willing to accept;
- meet both TANF income and assets tests (see Section 3.4: Determining Asset Eligibility/Asset Budgeting and Section 8.4: Determining Income-Eligibility in Part VI), except that the income of an applicant who would risk losing his or her job if the Diversion Payment was not provided is excluded;
- live with a minor child of a specified acceptable degree of relationship (See Section 5.4: Who is a Relative in [Part IV](#));
- have no receipt of TANF or POWER benefits (See Section 3.10: Program On Work, Employment and Responsibility (POWER) in this Chapter) in the last six months and no receipt of a DPP payment in the prior twelve months;
- have an immediate financial barrier which if eliminated will enable the individual to obtain or retain employment;
- agree to accept the one-time DPP payment rather than TANF assistance; and
- complete and sign the Combined Application, a Customer Statement of Need, and Customer/Agency Agreement for a DPP payment. If the applicant/recipient is married, both partners must sign the form.

If the applicant is employed or able to accept a bona fide offer of employment, the applicant must complete a Customer Statement of Need explaining in his/her own words why a DPP payment will prevent the need for an on-going TANF payment. The applicant should state and provide proof of why the current problem will disrupt current employment or create a barrier to future employment. For example, a rent arrearage by itself may not disrupt or prevent employment, but a rent arrearage which has resulted in an eviction notice may serve to disrupt actual or intended employment.

The SSR must inform the applicant of the amount, requirements, and condition of the DPP payment.

Disbursement of DPP Funds to Vendors 3.7.1

As a general rule, DPP payments will be made directly to vendors. However, in certain circumstances such as purchase of work clothes or other situations where it is not feasible to pay a vendor directly, it may be necessary to make payments directly to applicants. After the section chief approves the DPP request, it is forwarded to the Central Control Unit. Within one business day of receipt, a transmittal list will be prepared for payment authorization to the Office of the Chief Financial Officer (OCFO). Upon receipt of payment authorization, the OCFO will generate checks to the appropriate vendors or applicant/recipients within 20 days.

Any vendor to whom a payment may be made must include their tax I.D. number and verification of estimates. Vendors who do not have a tax I.D. number must provide their SSN. Failure to provide this information will result in an inability to process the payment.

The SSR must also verify that the lowest bidder (on services provided) will accept payment from the District for those services. If not, the next lowest bidder should be selected.

DPP Payment Formula 3.7.2

A DPP payment may not exceed the amount needed to remove the barrier to employment and can never exceed three times the full grant for the applicant household size. The applicant may, of course, contribute his/her own resources to the amount necessary to resolve the problem if it exceeds the maximum amount allowed by the District.

Example

Ms. Hernandez and her son apply for TANF and are found to be eligible. The SSR thinks Ms. Hernandez is a good candidate for DPP. The maximum benefit for a family of two is \$298. If DPP is appropriate, the payment cannot exceed $3 \times \$298$ or \$894.

Following receipt of a DPP payment, the assistance unit cannot receive TANF, GC, or POWER (see Section 3.10: Program on Work, Employment, and Responsibility (POWER) in this Chapter) benefits for a period of time determined by dividing the Diversion payment by the full TANF grant amount for the household size and rounding down to the nearest month.

Example

Ms. Travers has two children and receives a DPP payment of \$867 for car repairs to enable her to drive to a new job. She could not reapply for TANF assistance for two months ($\$867 / \379 (maximum TANF grant for a family of three) = 2.23 months of ineligibility).

Approval of DPP Benefits 3.7.3

Before proceeding with DPP processing, the applicant's employment or offer of employment must be verified either in writing or via telephone (written documentation is preferred). If the applicant is determined by the SSR to be a good candidate for DPP, the SSR must receive preliminary approval from the unit supervisor before proceeding. If the supervisor grants preliminary approval, the applicant must provide the following support documentation to the SSR:

- verification of the amount owed for auto insurance (if the policy has lapsed), rent, utilities, or professional licenses and fees; or
- at least three cost estimates of the item/service which may facilitate getting or keeping employment (e.g., auto repair, work clothes). (Note: if there are fewer than three providers of a particular good or service, such as a single uniform provider, three cost estimates are not required.)

If, at any time prior to the approval, the applicant decides that s/he does not wish to receive DPP assistance, s/he must submit a written statement rescinding the Customer Statement of Need.

If the applicant agrees to receive DPP in lieu of TANF, the SSR must obtain final approval from the unit supervisor and the section chief. The section chief should then process the DPP request within one business day of receipt and, if approved, forward it to the Central Control Unit.

If the DPP payment is authorized by the section chief, the TANF application must be denied and an entry must be made indicating that a DPP payment has been approved.

An applicant may not receive another DPP payment until 12 months have elapsed from the time of authorization of the prior payment. Additionally, the applicant cannot be granted TANF assistance for a period of time following the DPP which equals the DPP divided by the maximum grant amount for the household size.

Denial of DPP Benefits 3.7.4

If DPP is denied at any level, the applicant must be informed verbally and the TANF application must be reinstated and processed. The case narrative must reflect that a discussion of this decision outcome was held with the applicant.

DOMESTIC VIOLENCE 3.8

The SSR will screen all TANF applicants/recipients at initial application and each recertification. The SSR should also verbally review the assessment with the applicant/recipient and be particularly attentive to a customer's disclosure of any of the following acts (disclosure could occur at any time):

- physical acts that resulted in, or threatened to result in, physical injury to the individual;
- sexual abuse;
- sexual activity involving a dependent child;
- forced engagement in nonconsensual sexual acts or activities;
- threats of, or attempts at, physical or sexual abuse;
- emotional abuse; or
- neglect or deprivation of medical care.

When a client applies for TANF or comes in for TANF recertification, s/he must be informed and provided a notice about the right to request a domestic violence good cause waiver for TANF work requirements and/or child support cooperation requirements. The notice also informs the applicant/recipient that at any point in time s/he may receive referrals for appropriate services relevant to the issue of domestic violence. Further, his/her voluntary disclosure will not adversely affect or delay the receipt of aid, and any information disclosed will be confidential.

Each applicant/recipient presenting a history of domestic violence will be provided with instructions and a referral to professional counseling and/or supportive services. The referral form between the Department and the domestic violence services provider includes information about a domestic violence good cause waiver from the work requirement, and child support requirements.

TANF applicants/recipients referred to a work activity vendor will undergo an additional preliminary assessment conducted by the vendor which includes a discussion of domestic violence as a barrier to work. If an applicant/recipient discloses any of the above acts to the work activity vendor, the vendor will inform the Department of the disclosure and will inform the applicant/ recipient about the right to request a domestic violence good cause waiver from the work requirement. The Department will then refer the applicant/recipient to a domestic violence services provider as discussed above.

Decisions on granting or denying domestic violence waivers will be made within 15 business days. During that time, if the applicant/recipient is otherwise eligible for TANF, financial assistance shall not be delayed or denied. Since it may be necessary to waive work requirements to ensure the safety of the applicant/recipient, s/he will not be required to participate in work programs pending a decision on whether to grant a waiver.

For a discussion of domestic violence and child support requirements, see [Chapter 2: Child Support Requirements in Part V](#).

Confidentiality 3.8.1

Disclosure of any information pertaining to any applicant/recipient who claims to have a history of domestic violence, whether provided by the victim or a third party, shall be made solely for the purpose of making referral or determinations of eligibility for waivers except where the law dictates further disclosure (such as, in cases in which the Department believes a child or other dependent in the household is at risk of abuse or neglect). Information that must be kept confidential includes, but is not limited to, information concerning the applicant/recipient's:

- current address,
- workplace location,
- location of his/her children's school or child care,
- telephone number or contact numbers,
- identification as a victim of domestic violence, or
- identification of his/her service center.

Domestic Violence Verification 3.8.2

In determining whether domestic violence took place, the following evidence shall be used:

- police, government agency, or court records;
- documentation from a shelter, legal, clerical, medical, or other professional worker from whom the applicant/recipient has sought assistance;
- statements from other individuals with knowledge of the circumstances;
- physical evidence of domestic violence or any other evidence supporting the allegations; and
- in the absence of evidence listed above, allegations that the victim makes under oath, including (but not limited to) the applicant's petition for a Civil Protection Order, shall be sufficient to substantiate a claim.

Waiver of Work Requirement 3.8.3

During the 15-day screening/assessment period, the applicant/recipient shall not be required to participate in work programs until a determination is made.

Should the screening/assessment confirm the initial finding, a plan of service shall be developed in conjunction with the applicant/recipient when possible. The plan of service shall discuss a possible waiver of work requirements and/or child support cooperation and the duration of the suggested waiver.

If an applicant/recipient decides not to seek or declines services or waivers due to domestic violence, s/he will not be barred from seeking such services and waivers at a later date. An applicant/recipient may terminate an existing waiver at any time without penalty. No waiver will ever be implemented against the will of the applicant/recipient.

Once granted a waiver, any applicant/recipient who voluntarily chooses to participate in approved TANF program requirements shall be allowed to do so.

Good cause waivers for domestic violence are granted when work participation requirements would make it more difficult for the applicant/recipient to escape family violence.

An applicant/recipient who is denied a domestic violence good cause waiver may choose to withdraw his/her TANF application for benefits (see Section 3.4.2: Voluntary Withdrawal in [Part III](#)).

A waiver of the work participation requirement shall be granted for up to six months and may be renewed until the recipient is able to safely comply with program requirements. The applicant/recipient must be informed that renewal of waivers must be requested at least 30 days prior to expiration of the current waiver. A waiver shall be renewed if the recipient meets the plan of service requirements described within this subsection.

Denials of waivers shall be in writing, state the reason for denial, and explain the process for appealing the decision. Denials may be appealed through the fair hearing process (see [Chapter 7: Grievances and Fair Hearings in this Part](#)). Applicants/recipients have 90 days to file an appeal.

If the applicant/recipient appeals a decision within 15 days, the waiver request shall be considered pending for the duration of the appeal.

JOBS CLUBS 3.9

The Office of Work Opportunity (OWO) operates Job Clubs which assist TANF applicants and recipients in job search activities.

The Job Club is a six-week job readiness program which offers intensive and interactive instructional experiences and activities related to employment. Once an applicant, who is not exempt from work requirements, has been determined eligible to receive TANF benefits, his/her failure to cooperate in Job Club activities will result in the imposition of a sanction that will remove the individual's needs from the group (see [Chapter 1: Work Requirements in Part V](#)).

At the intake interview, the SSR should explain to TANF applicants Job Club goals and inform them of the services provided:

- assessment to identify educational and employability skill levels;
- assistance in developing or modifying career goals;
- planning job search activities and schedules;
- classroom activities, such as discussion of case studies on work habits and drafting household budgets;
- assistance in the preparation of employment applications and resumes and interview practice; and
- access to the Internet and other resources to facilitate the search for available employment opportunities.

Additionally, the SSR should inform the applicant of the requirement to contact the appropriate Job Club between the hours of 9:00 am and 4:00 pm Monday through Friday within three business days of receipt of the referral. However, applicants who are exempt from work requirements or who have reported medical problems that may indicate eligibility for POWER should not be referred to a Job Club.

The chart below identifies which IMA Job Club sites are assigned to serve applicants by service center.

Locations	Phone Number	Serves Applicants From:
51 N Street, NE	(202) 724-5220	Eckington Center Northeast Center
1207 Taylor Street, NW	(202) 576-9422	Taylor Street Center
645 H Street, NE	(202) 698-3966	H Street Center
2100 MLK Jr Avenue, SE	(202) 645-5102	Anacostia Center Fort Davis Center
4001 South Capitol Street, SE	(202) 645-3963	Congress Heights Center

NEGOTIATED SUITABILITY TRAINING (NST) 3.10

OWO operates the NST program, formerly known as Self-Initiated Training. NST provides assistance to TANF recipients who have independently enrolled or who wish to enroll independently in a training program. Customers who participate in NST must meet TANF work activity requirements (see Chapter 1: Work Requirements in Part V.) NST staff persons are responsible for monitoring the required activity hours. They also hold periodic advisory conferences with participants to check on their progress. They authorize stipends, and make referrals for other support services such as child care.

Prior to selecting a training program, the customer should work with NST staff to identify the training program most appropriate to his/her interests, potential and abilities. This would also help to ensure that the selected program is accredited, cost effective, and appropriate for the customer's particular work goals as set out in their Individual Responsibility Plan (IRP) or an addendum to the IRP.

NST staff can be reached at (202) 698-1860.

PROGRAM ON WORK, EMPLOYMENT, AND RESPONSIBILITY (POWER) 3.11

POWER is funded entirely by District funds. It will provide locally-funded cash assistance to families whose head of household (or caretaker whose needs are included in the grant) is unlikely to meet TANF work requirements due to short-term incapacity related to physical or mental health problems or substance abuse. POWER will also be available for TANF applicants/recipients needing additional support to achieve work requirements.

Screening and Referrals to the Medical Review Team (MRT) 3.11.1

At application for TANF benefits, the Preliminary Assessment form should be used to identify heads of households who face physical/mental incapacities that interfere with their ability to participate in countable work activities. Similarly, at recertification, the SSR should screen heads of households for incapacities.

Neither TANF applicants nor recipients can apply directly for the POWER program. Eligibility is determined by the SSR's identification of a possible incapacity and subsequent referral of an individual for a medical evaluation. The medical evaluation will be used as the basis for a determination of incapacitation.

In order for a case to qualify for POWER, the head of a single-parent assistance unit must be designated as incapacitated. In the case of a two-parent assistance unit, both parents must be incapacitated in order for the unit to qualify for POWER. If only one parent of a two-parent assistance unit is incapacitated, the assistance unit will be treated as a TANF single-parent assistance unit and the non-incapacitated parent will be subject to TANF work requirements.

Recipients of POWER are not subject to the TANF 60-month lifetime limit. Individuals are expected to return to the TANF program following successful completion of POWER activities.

Initial Evaluation of Incapacity 3.11.2

Individuals referred to POWER must have a medical evaluation form completed by a physician, physician assistant, nurse practitioner, or licensed registered nurse (RN). The medical evaluation form is then submitted to the MRT which determines whether the individual meets the 'incapacitated' standard. If the MRT determines the individual incapacitated due to a substance abuse problem, the individual is referred to APRA. If the individual is determined incapacitated due to physical or mental health problems, the individual is referred to the Rehabilitation Services Administration (RSA). Either APRA or RSA designs a service and treatment plan with which the POWER recipient must comply.

Decisions of incapacity cannot exceed 12 months at any one time. There is no limit, however, on the total number of months a case can be covered under the POWER program.

If the MRT does not determine the individual incapacitated, notice of the decision must be sent to the customer using a general communication notice. The notice must explain the decision and explain that ongoing TANF benefits will continue. The notice must also inform the customer of the right to appeal the MRT decision through the administrative review/fair hearing process (see [Chapter 7: Grievances and Fair Hearings](#) in this Part).

Re-evaluation of Incapacity 3.11.3

The medical incapacity is subject to reevaluation at intervals which are specific to each recipient's circumstances. The reevaluation of incapacity/disability for purposes of POWER eligibility will be handled by the MRT. No less than 60 days prior to the end of the incapacity period, the POWER recipient must be sent a medical review packet for a redetermination of eligibility. When the applicant returns the completed medical report and social data directly to the MRT, the packet will be considered for reevaluation. S/he will remain a recipient of POWER pending the MRT reevaluation. If the recipient fails to provide the requested information, the MRT will inform the SSR who will initiate action to convert the case to TANF (see Section 3.10.4: Conversion from POWER to TANF in this Chapter).

Conversion from POWER to TANF 3.11.4

There are a number of circumstances which will prompt a conversion from a POWER grant to a TANF grant. They include:

- a determination by the MRT that the individual is no longer incapacitated;
- a failure to return the medical examination and/or social information forms for reevaluation;
- a failure to comply with POWER treatment and training plans without good cause (see Section 3.11.5: Failure to Comply and Section 3.11.6: Sanctions and Good Cause in this Chapter); and
- recipient becoming employed.

The SSR and the MRT must share information regarding changes in circumstances that may impact the individual's POWER status. If any of these circumstances exist, the SSR must convert the POWER benefits to TANF without loss or delay of benefits. Adequate and timely notice of the decision to convert a POWER case to TANF must be given. The agency decision to convert a case from POWER to TANF can be appealed through the administrative review/fair hearing process (see [Chapter 7: Grievances and Fair Hearings](#) in this Part).

If a recipient requests a fair hearing (see Chapter 7: Grievances and Fair Hearings in this Part) prior to the effective date of conversion from POWER to TANF, the individual must be reinstated in the POWER program beginning with the first unissued benefit month. If the recipient requests a fair hearing decision on or after the effective date of conversion, TANF eligibility continues pending a hearing decision. Following receipt of the fair hearing decision, TANF or POWER eligibility is reinstated based on the hearing determination.

Failure to Comply 3.11.5

Failure to comply with POWER requirements, including design and adherence to treatment and training plans, disqualifies the recipient from the program. The sanction is not applied, however, under POWER. The benefit must be converted to TANF and the needs of the head of the household will be removed until compliance with POWER requirements or until active in a TANF work activity. Adequate and timely notice of the decision to end POWER eligibility and impose the sanction must be given to the recipient. The decision may be appealed by following the fair hearing process (see Chapter 7: Grievances and Fair Hearings in this Part). If the decision is appealed prior to the effective date of the conversion to TANF, eligibility under POWER must be continued until the appeal is resolved.

Sanctions and Good Cause 3.11.6

Good cause for failure to comply with POWER program requirements includes one or more of the following:

- a properly verified illness or medical condition of the applicant/recipient or a member of his/her household that prevents the applicant/recipient from meeting requirements;
- participation in self-sufficiency activities for a minimum average of 20 hours per week and the recipient has a child under six for whom s/he personally provides child care;
- an extraordinary and unforeseen circumstance beyond the control of the recipient verified to the satisfaction of the Department;
- applicant/recipient caring for a child who has special health needs (verified by competent medical evidence) that prevents the parent's participation in activities; or
- appropriate and affordable child care for a child under age six is not available within a reasonable distance from the applicant/recipient's home or work site.

REHABILITATION SERVICES ADMINISTRATION (RSA) 3.12

The mission of the Rehabilitation Services Administration (RSA) is to assist persons with mental and/or physical disabilities in becoming employed and/or to live independently in the home or community. RSA provides an array of services toward vocational preparation for entrance into the labor market. The services provided include but are not limited to counseling and guidance, assessment services, physical restoration, vocational training, job search and placement, and job retention services.

RSA also provides services to POWER recipients (see Section 3.11: Program on Work, Employment, and Responsibility (POWER) in this Chapter).

Intake for RSA can be reached at (202) 442-8400.

TUITION ASSISTANCE PROGRAM INITIATIVE FOR TANF (TAPIT) 3.13

OWO operates the TAPIT program, which is a scholarship program that helps eligible TANF recipients obtain a two or four-year college degree at a local university or college. The primary outcome of the program is for graduates to enter or re-enter the workforce with higher skill levels in jobs with the potential for salary and career progression, thus reducing the chance of a need for future assistance. TAPIT scholarships are based on the cost of attending the institution after other grants or loans received by the customer are deducted. TAPIT will pay up to \$4,000 per academic year to cover tuition, fees, and books at eligible institutions.

Candidates for TAPIT must meet the following requirements:

- be a DC resident,
- hold a high school diploma or GED certificate,
- not hold a postsecondary degree,
- be accepted for enrollment in a two or four-year degree program, and
- be approved by OWO-TAPIT.

TAPIT participants must also participate in a federally-mandated work activity, unless exempt.

OWO can be reached at (202) 698-1860.

TEEN PARENT PROGRAM 3.14

The FSA has established a Teen Parent Program (TPAP) to address the particular needs of pregnant/parenting teens. A pregnant or unmarried parenting teen who is under the age of 18 and not living at home with parents, a caretaker relative, or adult relative will be referred to FSA for assessment and development of a personal responsibility plan for independence if s/he is applying for or is in receipt of TANF benefits. TPAP participates in case conferences, provides assessments to its participants, and certifies suitability of living arrangements for custodial parents under 18-years-old.

Teen parents under the age of 20 are also referred to the District of Columbia Public School's program, "New Heights". This program assists and monitors teen school attendance and/or participation in other work-related activities, including training or post-secondary education.

Teen parents may call (202) 645-3030 between the hours of 9:00 am and 4:00 pm Monday through Friday to schedule an appointment for orientation.

OECD can provide child care assistance to teen parents.

Chapter 4 - Recertification

INTRODUCTION 4.1

The time between initial eligibility and the date the SSR must review the case, or the time between required reviews is the certification period. The recertification process involves recipients providing updated information to have their program eligibility recertified or re-determined by ESA for additional periods of time which vary by program. The recertification process must be completed within set time frames. No FS group may participate in the FS program beyond the end of their certification period unless they submit a signed recertification and complete the recertification process. If they do not complete this process within thirty days of the end of their certification period, they must re-apply, unless the delay is due to agency failure to provide the group with an opportunity to recertify. For MA groups, the group may not participate beyond the end of their certification period without a recertification of eligibility unless the agency either fails to provide the group with an opportunity to recertify or is seeking additional information to complete a recertification.

MA recertifications are done by mail. However, if a customer meets with his/her SSR for another purpose, the SSR should encourage the customer to recertify MA eligibility at that time if the MA certification period ends within ninety days. Groups categorically eligible for Medicaid do not need to recertify MA eligibility (see Section 12.6: Termination of Categorical Eligibility in [Part IV](#) for policy on handling groups who have lost their categorical eligibility).

GC cases must be reviewed once every twelve months. However, benefits in this program do not expire if a redetermination is not scheduled prior to the end of the twelve-month period.

DHS has developed a phased implementation plan for the mandatory assessment and orientation of work-eligible TANF customers. During the first phase, customers were permitted to voluntarily submit to the orientation and assessment. During the second phase, TANF customers who have not received a TANF orientation and assessment will be required to have a TANF review in order to maintain eligibility. Effective February 1, 2013, TANF reviews will consist of the completion of an Online Work Readiness Assessment, orientation, and Individual Responsibility Plan. Therefore, until further notice, TANF reviews will only be scheduled for TANF recipients who have not completed their in-depth assessment, orientation, and plan. DHS will provide instructions on the subsequent phases at the appropriate time.

LEGAL AUTHORITY 4.2

Area/Topic	District	Federal
Recertification	TANF: D.C. Code 4-205.19a-19b; 4-205.53	MA: 42 CFR 435.916
	GC: See TANF and D.C.	FS: 7 USC 2012(c); 7 USC 2020(e) (4); 7 CFR 273.2 (f) (8); 273.14
	Code 4-205.5a	

NOTIFICATION OF RECERTIFICATION/REVIEW DATE 4.3

MA	ACEDS will automatically generate a notice 90 days prior to the end of the current certification period. The notice includes the actual recertification form and informs the recipient that it is time to have his case recertified in order to determine continuing MA eligibility. MA recertifications are done by mail. However, if a customer meets with his/her SSR for another purpose during this 90-day period, the customer can (and should be encouraged to) recertify MA eligibility during the office visit. MA cases that are not recertified prior to the end of the current certification period will automatically be terminated by ACEDS.
TANF	<p>Effective February 1, 2013, ESA shall generate and mail a review scheduling notice, at least 10 days prior to the scheduled date of assessment and orientation. The notice shall tell the recipient:</p> <ul style="list-style-type: none">• it is time to have his/her case reviewed and that this will consist of an assessment and orientation and development and signature of an Individual Responsibility Plan;• the scheduled date of the assessment/orientation;• the location of the assessment/orientation;• deadline for completing the assessment and orientation if the TANF recipient is unable to make the original appointment;• information regarding how to reschedule an assessment appointment; and• information regarding the requirement to complete the assessment/orientation in order to maintain TANF eligibility. <p>Failure to complete the assessment, group orientation, and Individual Responsibility Plan by the deadline specified in the review scheduling notice shall result in termination of TANF benefits.</p>

GC	<p>The SSR should generate Form A600, the Review Due Notice, at least 10 days prior to the appointment date to inform the recipient that it is time to have his/her case reviewed. Form A600 should indicate the following:</p> <ul style="list-style-type: none">• time and date his/her review has been scheduled,• list of needed verifications, and• any adverse action that may be taken if the appointment is not kept. <p>Failure to attend the scheduled meeting and failure to provide requested information will result in GC benefits being terminated.</p> <p>For GC recipients who do receive FS, the Food Stamp Recertification Notice sent by ACEDS informs recipients that their GC benefits will be reviewed at the same time. When the recipient comes in for the FS recertification, the SSR will also initiate a GC review. The SSR must give the recipient written notification of any additional information needed. In this situation, the SSR must give the recipient 10 days to return additional information before initiating any adverse action. If the recipient does not come for the FS recertification appointment and does not reschedule, the SSR will initiate action to terminate the GC benefits after timely and adequate notice.</p>
FS	ACEDS will automatically generate a notice 60 days prior to the end of the certification period that will inform the recipient of the need to have her case recertified in order to determine ongoing eligibility. The notice gives the recipient a recertification appointment date and indicates that he/she can call to reschedule. The original appointment must be scheduled for a date at least 10 days prior to the end of the certification period. If a customer misses their appointment and calls to reschedule, they must be given a second appointment. This must be documented in the case record. FS cases that are not recertified prior to the end of the current certification period will automatically be terminated by ACEDS. An FS recipient may come in any time within 30 days after the termination of his/her

	<p>certification period and still be treated as a recertification. However, if she does come in after the effective date of the termination, the benefits for the first month will be prorated from the date she recertifies, unless the failure to recertify is due to agency error. In that case, benefits will be given for the entire month once eligibility is recertified.</p> <p><i>Mid-Certification Reports</i></p> <p>In addition to the requirement for recertification, FS households certified for twelve months will be mailed a "Mid-Certification Report" form at the end of the fourth month of their twelve month certification period. Recipients must complete and return the form, along with verifications of changes in household circumstances. If the household fails to comply with this requirement by the end of the fifth month, FS benefits will be terminated effective the end of the sixth month of eligibility. Households who comply will continue to receive benefits, although the Agency will process changes reported by the household and will redetermine the level of benefits.</p> <p><i>Interim Contact</i></p> <p>In addition to the requirement for recertification, FS households certified for twenty-four months will be mailed an "interim Contact" notice at the end of the tenth month of their twenty-four month certification period. They must call or contact the Agency and must report any changes in their circumstances. If the household fails to comply with this requirement, FS benefits will be terminated. Households who comply will continue to receive benefits, although the Agency will process changes reported by the household and will redetermine the level of benefits.</p>
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RECERTIFICATION INTERVIEW 4.4

ALL	<p>With the exception of Medicaid recertifications which are done by mail, and TANF reviews effective February 1, 2013, the purposes of the recertification interview include the following:</p> <ul style="list-style-type: none"> • to clarify information received by Department interfaces, such as wages, Unemployment Compensation, and Social Security benefits; • to inform recipients that information they provide regarding eligibility and benefits will be matched regularly against information from the Department of Employment Services, U.S. Internal Revenue Service, Social Security Administration, and other states; • to advise adult recipients of the opportunity to register to vote if they desire; • to explore and resolve unclear and incomplete information; and • to explain change reporting requirements to recipients. <p>Recipients (or their authorized representatives) must submit the appropriate form for recertification. For Medicaid, it is preferred that they use Form DHS-1209 "Recertification for Medical Assistance." For FS, recipients may use the "Food Stamp-Only Application." All recipients may use the combined "Recertification Form" or the combined "Application for Benefits."</p>
MA	<p>Medicaid recertifications are normally done by mail. However, if a customer meets with his/her SSR for another purpose, the SSR shall encourage the customer to recertify MA eligibility at that time if the MA certification period ends within ninety days.</p> <p>The "Recertification for Medical Assistance" form, DHS-1209, that is mailed out to clients includes information regarding EPSDT services and their availability.</p>
TANF	Effective February 1, 2013, the TANF review interview shall consist of a detailed assessment of the

	<p>TANF recipient's education, work experience, skills, employability and a screening for potential barriers to employment. The TANF recipient shall also complete an orientation covering TANF program rules and regulations. In addition, the TANF recipient shall participate in the development of an initial Individual Responsibility Plan and shall sign the plan. As part of the assessment, the staff person administering the work assessment shall provide the following to the TANF recipient:</p> <ul style="list-style-type: none"> • information regarding child support requirements and benefits, • a description of the POWER program, and • information regarding Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided now by the D.C. Department of Health "Health Check" program, formerly known as the D.C. Healthy Teens and Tots Program (see requirements in Section 2.2.8 of Part I: "EPSDT/D.C. Healthy Tots and Teens).
GC	<p>A face-to-face interview is generally required. For situations in which this requirement can be waived, see Section 1.8.2: Waiver of Face-to-Face Interview in Part III. The SSR shall explore the following with the caretaker during a GC review:</p> <ul style="list-style-type: none"> • any custody proceedings, FSA involvement, or parental contact since the application or last review that could affect the child's continued presence in the home; • any putative, but unestablished relationship between the child and the caretaker, and whether or not any progress has been made since the application or last review in determining relationship that could make the child ineligible for GC; • if the caretaker has taken any action to adopt the child; and • any changes in the household that bring a parent or relative of the child into the home. <p>The SSR shall inform the client orally and in writing of Early Periodic Screening Diagnosis and Treatment (EPSDT) services provided now by the D.C. Department of Health "Health Check" program, formerly known as the Healthy Teens and Tots Program (see requirements in Section 2.2.8 of Part I: "EPSDT/D.C. Healthy Tots and Teens).</p>
FS	<p>A face-to-face interview is generally required. For situations in which this requirement can be waived, see Section 1.8.2: Waiver of Face-to-Face Interview in Part III.</p> <p>The SSR shall screen for expedited service, using the Expedited Screening Form. Households who are timely recertifying are generally not eligible for expedited service.</p> <p>The SSR shall review the FSET status of the household. New referrals must be done every twelve months on FS participants who are not exempt from FSET.</p> <p>The SSR shall inform the household of their change reporting responsibilities.</p> <p>During the interview, the SSR shall give the customer a Change Report Form.</p>

PROCESSING OF RECERTIFICATION FORMS 4.5

ALL	<p>Disposition of a recertification must not be delayed when verification requirements can be met by material already available to the SSR.</p> <p>Information already included in the case record (e.g., copy of birth certificate or social security card, etc.) or verifiable through ACEDS should be used. The recipient is not required to produce</p>
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	<p>documentation again for eligibility factors that do not change and have already been verified.</p> <p>During any recertification, the SSR shall screen the group for possible participation by members previously excluded due to citizenship requirements that have changed.</p>
MA	<p>When processing any MA Recertification form, follow closely the procedures outlined on the Form 1210: "Processing Medicaid Recertifications."</p> <p>All terminations of MA due to a redetermination of eligibility must be authorized by a supervisor. In general, for recertification forms to be processed, they must be signed and they must be received no later than 30 days after the end of the certification period (except for extended recertifications as described below.)</p> <p>For the purposes of this section:</p> <ul style="list-style-type: none"> • A "timely recertification" is any recertification that is <ul style="list-style-type: none"> ○ signed and ○ received during the recertification period. • A "delayed recertification" is a recertification form that is <ul style="list-style-type: none"> ○ signed and ○ received during the 30 days following the end of the certification period. • An "extended recertification" is a recertification form that is sent to the recipient as the result of an extension of eligibility. The extension must have been granted in order to obtain information needed to complete a timely recertification. Information provided with an extended recertification is used to complete the previous timely recertification. <p><i>Registering MA Recertification forms</i></p> <p>The following recertification forms must be registered immediately:</p> <ul style="list-style-type: none"> • any timely recertification; and • a delayed recertification, as long as it has all needed information, or all needed information can be obtained by collateral contact immediately upon receipt

Example

Mrs. Jones receives a MA recertification form on January 5. She has just started a new job. The certification period ends March 31. She signs the form and mails it back in but does not include any paystubs. It is received on January 10. Even though she has not included enough information to redetermine eligibility, the form is timely and must be registered immediately.

Example

Mr. Thomas receives a MA recertification form on April 3. His only income is Social Security retirement, and he reports no resources and no changes. The certification period ends June 30. He returns the form on July 5, after the case closes. He signs it and reports no changes and no resources. Since it is received within 30 days after the end of the certification period and the income can be verified through the ACEDS BENDEX interface, it is a delayed recertification and must be registered immediately.

Any recertification form that is received but does not meet either of these criteria will be filed in the case record without further action, except that any information contained with an extended recertification should be examined to see if there is now enough information to process the outstanding timely recertification.

Example

Ms. Winter is sent a recertification form on August 31. The certification period ends September 30. Ms. Winter returns the form November 10. Since it was received more than 30 days after the end of the certification period, it will not be registered or processed, regardless of whether or not it has a signature or all needed information.

Eligibility for MA will be continued in ACEDS once the recertification form is registered until a redetermination of eligibility is completed. Notice X727, "Receipt of Medical Recertification Form," will be automatically generated by ACEDS when the recertification is registered. This notice informs the recipient of his continuing eligibility pending a final determination. No further Notices of Eligibility should be sent until a full redetermination is made.

Examining Recertification Forms for Eligibility

When processing a recertification, the SSR shall look at all information available on the form, in the case record and in ACEDS.

The SSR should follow these steps for processing all timely, delayed and extended recertifications:

1. Look for indicators of ineligibility (other than excess income) by looking at the recertification form and at information in ACEDS (such as reporting on the recertification form that the group has moved outside the District). If obvious ineligibility exists for everyone in the group, complete Form 1210: "Processing Medicaid Recertifications" and terminate benefits for the first available month after timely and adequate notice is sent. Supervisory authorization of the termination is required.

Example

Mr. Giles applied for Medicaid for his twenty year old grandson Eric and benefits were approved. The certification period ends April 30. Mr. Giles completes and signs the recertification form,

indicating that there are no changes. The form is received by the Agency April 2. The SSR checks and finds that Eric turns 21 this month. Unless Eric is the caretaker relative for a child or is disabled, the SSR should terminate benefits after supervisory authorization.

2. If ineligibility is not immediately apparent, check to see if the customer did any of the following to provide sufficient information to redetermine eligibility:

- the customer recertified for food stamps within the last three months and reported no change on the MA recertification form (in this case the SSR should use the information from the food stamp recertification);
- the customer submitted two or more paystubs for the last 60 days;
- the customer submitted a benefits statement for his only income that is dated within the last 12 months, and the statement reflects the most recent COLA;
- the customer stated that she only receives income from Social Security and/or Unemployment Benefits and current information is available through the ACEDS interface;
- for an AR/AX customer, the customer reported income in excess of the AR/AX standard **and** the customer has been enrolled in the AR/AX program (but not Transitional Medical Assistance [TMA]) for at least three of the last six months (in this last case the SSR should approve TMA);
- for an SR customer with reported resources, the customer has provided a checking or banking statement dated within the last three months, or any other proof of resources, consistent with the information reported on the recertification form; or
- the customer indicates that she is now receiving SSI, and verification is either attached or available through the ACEDS interface; and the case is not subject to recertification. The eligibility should be extended with an indefinite certification period in ACEDS, and proper notice should be sent to the customer.

3. If the customer did provide sufficient information, or if the SSR can verify missing information through collateral contact, the SSR should redetermine eligibility. The effective date will be the earliest month after the end of the certification period that can be effected after timely and adequate notice is sent.

Example

The SSR receives a timely MA recertification form from Ms. Standard. Ms. Standard works and does report it on the form, but does not attach any paystubs. The SSR sees in the case record that Ms. Standard recertified for food stamps last month and provided paystubs. The SSR should use this information to process the current MA recertification.

Recertifications Without Needed Information

If sufficient information is not available, the SSR will take the following actions, depending on the type of recertification form:

- For a timely recertification the SSR shall:
 - complete Form 1210: "Processing Medicaid Recertifications;"
 - consult with the unit supervisor and obtain his/her approval to request further information from the customer;
 - make telephone contact with the customer to request the missing information unless

	<p>there is no telephone contact number known to the Department;</p> <ul style="list-style-type: none"> ○ issue a General Communication notice requesting the missing information, regardless of whether or not the SSR succeeds in making telephone contact; ○ document the case record, clearly stating what information is missing, and file the Form 1210 with the supervisor's authorization; ○ approve eligibility with a four-month certification period (this will automatically generate an extended recertification form at the beginning of the extension period); ○ if the missing information is received within the extension period, either by itself or with the extended recertification form, redetermine eligibility (if eligibility is being terminated, timely and adequate notice must be sent. The new certification period will end 12 months after the end date of the last regular certification period.); and ○ if the information is not received, allow the case to be automatically closed by ACEDS at the end of the extension period. <ul style="list-style-type: none"> • For a delayed recertification, if there is missing information and the missing information cannot be immediately furnished by collateral contact, no action will be taken by the SSR except to file the form in the case record and document exactly what was missing. The case will remain closed. • For an extended recertification, if the information originally requested in the General Communication notice above is not with the returned extended recertification, take no action except to file the form in the case record. Any information that is included with an extended recertification can be used to process the outstanding timely recertification. If sufficient information is not received, benefits will automatically be terminated by ACEDS at the end of the extension period.
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Example

Mrs. Bailey's certification period ends November 30. She sends in her recertification form on October 10. She reports that she has begun to receive Veteran's Benefits but does not attach verification. The form is signed and is timely, so the SSR does register it. After consulting with his/her supervisor, the SSR calls Ms. Bailey and sends her a General Communication Notice requesting verification of the income and extends eligibility through March 31. On November 30, an extended recertification form is automatically mailed to Ms. Bailey. She sends it back on December 10, and attaches verification of the income. The SSR will not register the extended recertification form. However, on December 12, the SSR uses the verification of the income to process the timely recertification and redetermines eligibility effective January. A certification period through November 30 will be assigned.

TANF	Effective February 1, 2013, completion of the work assessment, orientation, and Individual Responsibility Plan shall fulfill the requirements of the TANF review.
FS	<p>Households that have met all application requirements shall be notified of their eligibility or ineligibility by the end of their current certification period. Eligible households who have met all application requirements shall be given an opportunity to participate by the household's normal issuance date in the month following the end of their current certification period.</p> <p>Effective February 1, 2013, for FS households who also receive TANF, changes reported at the time of FS recertification that effect TANF eligibility will be considered as a reported change, and handled in accordance with Part VIII, Chapter 5: Reporting and Processing Changes.</p>

CERTIFICATION PERIOD 4.6

MA	<p>Any signed recertification form which is completed prior to the last day of the certification period is considered timely, and every reasonable effort must be made by eligibility staff to complete the redetermination prior to the end of eligibility. If it is not possible for the agency to complete the recertification process prior to the end of the certification period, eligibility should be extended to give time to pursue all reasonable means to determine eligibility.</p> <p>The next certification period is set 12 months from the last effective date of eligibility. Groups determined ineligible due to excess income from earnings or child support may be eligible for up to a six-month certification period for TMA (if the group is an AR or AX case) or may be eligible for MA based on the spend-down process (see Section 1.3: Transitional Medicaid Assistance (TMA) in Part VII and Chapter 7: Spend-Down in Part VI).</p> <p>If the recipient has already received a Notice of Termination, Form A714, for failure to return a complete recertification form and it is subsequently determined that ineligibility exists for one or all members of the assistance unit, an appropriate Notice of Ineligibility must be issued. If the assistance unit is determined to be eligible based on the recertification form, an appropriate Notice of Eligibility must be issued indicating that it supersedes the previously issued termination notice. If any eligible person is terminated from an assistance unit, the eligibility for the remaining persons in the unit must be redetermined.</p> <p>When a TANF case is closed, the family's ongoing eligibility for Medicaid must be evaluated.</p> <p>IF TANF is closed for reasons that affect Medicaid eligibility, such as an increase in income, the family's eligibility for Medicaid must be evaluated under standard AR and AX program types. If the group is found eligible for Medicaid under standard AR or AX programs, the group should be given a 12-month certification period. If the group's income from earnings or child support exceeds the standards for AR/AX coverage, Transitional Medicaid is triggered. A six-month certification period would be given in the case of earnings, and a four-month certification period would be given in the case of child support. The certification period would begin on the effective date of the TANF case closure.</p> <div data-bbox="272 1209 1437 1514"> <p>Example</p> <p>Ms. Smith and her two children receive TANF. On May 17, Ms. Smith notifies her SSR that she has found a job. Ms. Smith provides documentation of her earnings and the SSR determines that she is over-income for TANF. The SSR issues an adverse action notice on May 28—thus, the effective date of the TANF case closure is July 1. The SSR determines that Ms. Smith remains eligible for Medicaid under the AX program type while her two children are eligible under the AR poverty level categories. Ms. Smith should be given a 12-month MA certification period beginning on July 1st.</p> </div> <p>If the TANF closing is due to administrative reasons such as failure to complete a TANF assessment, the group's Medicaid case is NOT closed. Instead, the SSR must enter a Medicaid recertification period end date in ACEDS so that ACEDS will generate a Medicaid recertification notice for the group. The group's Medicaid case will only close if the group fails to return the completed Medicaid recertification form or if the returned form indicates ineligibility. The SSR should set the certification end date for the earliest month that will enable ACEDS to send out a recertification notice 90 days prior to the end of the certification period.</p>
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	<p>Example</p> <p>Ms. Jones fails to complete a TANF assessment scheduled for May 15. The SSR issues an adverse action notice on May 19th indicating that her TANF case will close effective July 1st. The SSR establishes a Medicaid certification period end date of September.</p> <p>There are circumstances under which a Medicaid case should be closed at the same time as a TANF case closure, such as when the family reports a change in circumstances that affects both TANF and Medicaid eligibility. For example, if a family reports that the children in the family no longer reside in the home and the remaining group members are ineligible for TANF and Medicaid (under all program types), then both programs could close at the same time.</p>
TANF	If a client reports changes during the assessment that affects TANF eligibility or level of TANF benefits, the staff person administering the assessment will direct the recipient to staff in the Division of Program Operations, who will take appropriate action after timely and adequate notice (See Part VIII, Chapter 5: Reporting and Processing Changes.)
GC	SSRs are required to conduct a face-to-face eligibility review every twelve months. The SSR must issue an appointment notice at least 10 days prior to the GC review appointment. The notice must indicate a date and time for the review and the information the customer must bring to the appointment.
FS	The certification period shall not exceed six months unless all adult members in the household are elderly or disabled. Households in which all adults are either elderly or disabled should be certified for 24 months. Such households will be notified every 12 months that they must report changes in their circumstances. The case record must be annotated to reflect the contact.

SYNCHRONIZING PAYMENT PROGRAM REVIEWS WITH RECERTIFICATION 4.7

ALL	Case reviews, when possible, should be synchronized if a household is receiving multiple benefits. However, existing FS certification periods may not be shortened in order to synchronize with another program. If a group comes in for another program and the group has been sent a MA recertification form that has not been returned, the worker should encourage the group to recertify its MA eligibility during the office visit. This would eliminate the need for the group to return the mailed MA recertification form.
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BENEFIT PRORATION RELATED TO RECERTIFICATION 4.8

MA	If the Department caused a delay in recertification which leads to a delay in issuing benefits, benefits will be restored from the beginning of the new certification period. The reason for the delay must be noted on the case record.
TANF	Benefit proration is not required because benefits do not automatically terminate at the end of the review period.
GC	See TANF.
FS	See MA. When there is a break in certification that is not due to agency delay (i.e., client's benefits expired August 31, 2003 and client reapplies September 18, 2003), the benefits will be prorated from the date of reapplication. (i.e., September 18, 2003). Proration due to a break in certification does not apply to migrant and seasonal households in certain circumstances. If such a case presents itself to a service center, the Administrator's office should be contacted.

ELIGIBILITY DETERMINATIONS AT RECERTIFICATION 4.9

ALL	Clients must be notified in writing of determinations regarding continuing eligibility.
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MA	Once redetermination of eligibility or ineligibility is made, notice must be sent to the group. Each member of the existing group must be included in a notice of eligibility or ineligibility. Timely notice must be sent for any member who is being determined ineligible for Medical Assistance.
TANF	Effective February 1, 2013, once the recipient completes the required work assessment, orientation, and initial Individual Responsibility Plan, ESA shall generate and mail notice to the recipient that s/he has fulfilled the assessment requirement. If there are changes to the grant, timely and adequate notice for any adverse action shall be given using the appropriate notice.
FS	<p>Households that have met all application requirements shall be notified in writing of their eligibility or ineligibility by the end of their current certification period.</p> <p>FS recertifications do not determine continuing eligibility, but rather determine eligibility for a new certification period. Therefore, the client will be notified of recertification decisions by the SSR using notices of approval or denial, rather than notices of increase, reduction, or termination of benefits. Timely advance notice is not required.</p> <p>If the household is determined to be eligible for a new certification period, the agency shall mail a notice of reporting requirements to the household. If the household is subject to Simplified Reporting, Notice F722: "Notice of Simplified Reporting" shall be mailed to the customer. If the household is subject to Standard Reporting, Notice F723: "Standard Reporting Notice" shall be mailed to the customer.</p> <p>If a household files an application prior to the end of the certification period but the recertification cannot be completed within 30 days due to agency error, the agency must continue to process the application and provide benefits from the first day of the month.</p> <p>If a household files an application before the end of the certification period but fails to complete a required action, the agency will deny benefits. However, if the household then completes the required action within thirty days of the end of the certification period, the application will still be treated as a recertification. In this situation, benefits will be prorated from the date the client completes the required actions.</p> <p><i>Automatic Denial of Recertification</i></p> <p>The ACEDS system schedules all FS recertifications on or prior to the 15th day of the last month of the certification period. ACEDS automatically denies recertifications if customers do not complete the process. The date of termination depends on the situation:</p> <ul style="list-style-type: none"> • If a customer does not come in for their recertification at all during the certification period, ACEDS will send the customer a denial notice at the end of the last working day of the certification period. The customer can come in within the next thirty days and be treated as a recertification with regard to the items they must verify, but benefits will be prorated from the date they come into reapply. See Example 1 below. • If a customer comes in for their recertification before the last 10 days of the last month of the certification period, their recertification will be automatically denied if it remains incomplete at the end of the first working day of the month after benefits expired. ACEDS will automatically send the customer a denial notice at that time unless the worker has entered a PCN on the FSAD screen. See Example 2 below. • If a customer comes in during the last ten days of the month, the recertification will automatically deny if it is still incomplete ten days later. ACEDS will automatically send the customer a denial notice at that time unless the worker has entered a PCN on the FSAD screen. If the customer provides all needed information within ten days, the recertification is

	<p>timely and the effective date for the new certification period will be the 1st of the month. Benefits must be made available within 5 working days of the date the household provided all verification. See Example 3 below.</p> <p>Example 1</p> <p>April Ashton's Food Stamp eligibility expires on June 30. She is sent a Recertification Notice on April 28 (the last working day of April) giving her a recertification appointment for June 8. She does not keep the appointment and does not contact her worker to reschedule. Unless she comes in before the end of June, her benefits will automatically expire on June 30. ACEDS will send a termination notice to her the night of June 30.</p> <p>Example 2</p> <p>John Jacobs' Food Stamp eligibility expires on December 31. He comes to this ACEDS-scheduled recertification appointment on December 10, but does not provide all needed verification. His caseworker registers his recertification and issues a checklist to him for the missing verifications. Mr. Jacobs' Food Stamp recertification will automatically deny if his recertification is not completed by the first working day in January. A recertification denial notice will be issued that night.</p> <p>Example 3</p> <p>Jane Reynolds' Food Stamp eligibility expires on January 31. She completed her recertification interview on January 28, but does not have all her required verifications. Her caseworker registers her recertification and issues a checklist and also sends her a Request for Additional Information. If her recertification is not completed by February 7, Ms. Reynolds will be sent a recertification denial notice.</p> <p>To ensure the correct processing of recertifications, the SSR must take the following actions:</p> <ul style="list-style-type: none"> • register recertifications in ACEDS when they are received, • issue written requests for additional information to customers, and • complete eligibility determinations in ACEDS within agency timeframes. Receipting all information on a checklist in ACEDS has no effect on how ACEDS treats a recertification. Food Stamp recertifications will automatically deny even if the checklist is closed, unless the PCN is entered on the FSAD screen.
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VERIFICATIONS DURING RECERTIFICATION 4.10

ALL	If a client comes in for a recertification (or mails in their Medicaid recertification form), and it is determined that further information is needed to redetermine eligibility, written notice must be given to the client. This notice should include the information needed, and the amount of time the client has to provide the information. At least 10 days must be given to the client to return needed information.
MA	Requests for further information from a client during a MA review should be kept to a minimum. In general, when no changes are reported, or reported changes are minimal, or reported changes would not result in a change in eligibility for anyone in the group, no further verification should be requested. Information available in ACEDS should be utilized whenever possible to verify regular

	<p>income, such as Social Security benefits.</p> <p>AR and AX: Recipients reporting earnings for the first time should present at least one pay stub (if the information on the pay stub is not representative of expected future earnings, collateral contact with the employer or a second paystub may be needed.) Also, if paystubs are not submitted, an attempt must be made by the SSR to obtain verification by collateral contact with the employer by telephone. Collateral contacts must be documented in the case record. Customers with previously verified income who report minimal or no changes in their income should not be required to present new documentation.</p> <p>SR: See AR and AX. Also, resources of SR groups need to be verified. Verification should be dated within the past three months. However, if the group reports resources above allowed levels, their eligibility can be terminated based on their report if they are not eligible under any other Medicaid program.</p> <p>If the Department needs a new determination of disability for an SSR client, and that is the only information needed to complete a recertification, eligibility should be extended until the Medical Review Team makes a determination that the client is not disabled (see Section 9.4 in Part IV: Disability/Blindness Determinations for information regarding which clients need to be evaluated by the Medical Review Team). It is the responsibility of the Department to ask the client for current medical data. The client will be given 90 days to provide current medical information.</p>
TANF	<p>Effective February 1, 2013, and until the completion of the project of assessing TANF recipients who have not participated in an assessment other than the Preliminary Self-Assessment, the verification requirement at TANF review consists of the completion of an assessment and orientation, and the signing of an initial Individual Responsibility Plan. If a client reports changes during the assessment that affects TANF eligibility or level of TANF benefits, the staff person administering the assessment shall report the change to the staff of the Division of Program Operations, who will take appropriate action after timely and adequate notice (See Part VIII, Chapter 5: Reporting and Processing Changes.) Further instructions will be given following the completion of the project of assessing TANF recipients who have not participated in an assessment other than the Preliminary Self-Assessment.</p>

GC	<p>Residency must be verified at every review. Reported income and assets must be verified at every review. The Department should utilize information available in ACEDS whenever possible to verify unearned income. Families must verify that children who are sixteen or older in the grant meet school requirements (see Section 4.4 in Part IV: School Attendance and Student Status).</p> <p>However, income and assets should only be verified for the child/ren in the GC grant.</p>
FS	<p>The following items are subject to verification at recertification:</p> <ul style="list-style-type: none"> • residency, except for categorically eligible households; • previously unreported income, except for categorically eligible households; • resources except for categorically eligible households, only if the information provided would affect group eligibility and is questionable (i.e., unclear, inconsistent, or incomplete); • income that has changed by more than \$50, except for categorically eligible households • previously unreported medical expenses; • actual utility expenses that have changed by more than \$25 unless the household is using the SUA; • rent, mortgage, or other housing costs that have changed by more than \$25, unless the change will not affect the excess shelter deduction (i.e., if the change does not increase shelter costs enough to trigger the excess shelter deduction); • previously reported medical expenses that have changed by more than \$25; • for households eligible for the child support deduction, any changes in the legal obligation to pay child support, the obligated amount, and the amount of legally obligated child support a household pays to a non-household member; and • unless good cause is determined, proof of an application for a social security number for any household member who has not previously presented a social security number or proof of application and who does not have a social security number at the time of recertification, except that this requirement does not apply to newborns until six months after birth nor to categorically eligible households. <p>If the household does not provide needed verification of shelter, medical, child support, or child care expenses, but has otherwise provided all needed verification, their eligibility shall be determined without deducting the unverified expenses.</p> <p>Clients must be given at least 10 days to provide needed information.</p>

CHAPTER 5 - REPORTING AND PROCESSING CHANGES

INTRODUCTION 5.1

During periods of eligibility, groups experience changes that can affect their eligibility for benefits or the level of benefits they receive. Each program has different rules as to what changes groups must report and when they must report them. Within each program, different subgroups may have different rules. In general, every change that DHS discovers must be acted on, whether the change is reported by a customer or discovered through other means. If a customer reports a change for one program, the agency must re-determine eligibility for all programs in which the customer and his/her household participates.

It is important to record the date a change reports is made, since this can determine if the report is timely. The date a change is reported also can have an effect on what supplemental benefits the household may receive. The initial date of reporting a change is the date the group first made the request, whether by telephone, facsimile, mail or during an office visit.

LEGAL AUTHORITY 5.2

AREA/TOPIC	DISTRICT	FEDERAL
Reporting	TANF: DC Code 4-205.54; 4-205.56; 29DCMR 5814	MA: 42CFR435.916(b) and 435.916(c) FS: 7 CFR 273.12 District of Columbia Food Stamp Waiver-- Waiver Serial Number: 980126, granted for the period starting August 1998 District of Columbia Food Stamp Waiver-- Waiver Serial Number: 2060006, granted for the period starting October 1, 2005
Computer Matching		ALL: 5USC 552a(p) FS: 7CFR 273.2(f)(9)

RECIPIENT REPORTING REQUIREMENTS 5.3

ALL	<p>Generally, changes that customers are required to report between recertifications must be reported by the 10th day of the month following the month of the change. For income changes, the month of the change is the month during which the customer first receives the new or changed income. (However, for FS customers subject to Simplified Reporting, see Section 5.3.2 “Simplified Reporting” in this chapter.)</p> <p>Groups are not responsible for reporting changes in the amount of benefits they receive from other programs administered by the Income Maintenance Administration.</p>																				
MA	<p>After an application is approved, recipients are responsible for reporting all nonfinancial and financial changes by the 10th day of the month following the month of the change.</p>																				
TANF	<p>After an application has been approved, a TANF recipient is generally responsible for reporting all nonfinancial changes by the 10th day of the month following the month of the change. However, when a child in the grant leaves the home for more than 90 days, the change must be reported within five days of the caretaker's discovery that the absence will last for more than 90 days (See Part IV, Section 1.1.5: Temporary Absence.)</p> <p><i>Income Changes for TANF Groups</i> The responsibilities of TANF groups to report income changes depends on their status immediately prior to the change:</p> <ul style="list-style-type: none"> • If a TANF group has not reported income, or their only income is unearned income, they are responsible for reporting any new source of income and the amount by the 10th day of the month following the month of the change. • If a TANF group has reported earnings that are currently being counted, they are responsible for reporting changes in income that increase the total household income to a level above 130 percent of the Federal Poverty Guideline that was in effect on the first day of October on or before the budget month, as described in the table below: <p>130% of the FY 2007 Federal Poverty Guideline:</p> <table> <tr> <td>Household Size</td><td>Total Monthly</td></tr> <tr> <td>Income</td><td></td></tr> <tr> <td>1.</td><td>\$1,062</td></tr> <tr> <td>2.</td><td>\$1,430</td></tr> <tr> <td>3.</td><td>\$1,799</td></tr> <tr> <td>4.</td><td>\$2,167</td></tr> <tr> <td>5.</td><td>\$2,535</td></tr> <tr> <td>6.</td><td>\$2,904</td></tr> <tr> <td>7.</td><td>\$3,272</td></tr> <tr> <td>8.</td><td>\$3,640</td></tr> </table> <p>For each additional person, add: \$369</p> <ul style="list-style-type: none"> • However, if they have been placed in Simplified Reporting (See Section 5.3.2: Simplified Reporting below) they are subject to the change reporting levels listed in the Simplified Reporting Notice sent out through ACEDS, even if the Federal poverty level changes during 	Household Size	Total Monthly	Income		1.	\$1,062	2.	\$1,430	3.	\$1,799	4.	\$2,167	5.	\$2,535	6.	\$2,904	7.	\$3,272	8.	\$3,640
Household Size	Total Monthly																				
Income																					
1.	\$1,062																				
2.	\$1,430																				
3.	\$1,799																				
4.	\$2,167																				
5.	\$2,535																				
6.	\$2,904																				
7.	\$3,272																				
8.	\$3,640																				

	<p>their certification period.</p> <p>Households who are required to report total income above these limits shall report the change by the 10th day of the month following the month during which their household income exceeded the above levels.</p>
FS	<p>Eligible FS households must be issued a change reporting form at the time eligibility is established. Thereafter, new change-report forms must be issued every time a completed form is sent to the agency.</p> <p>For eligible FS households, there are two different types of reporting, “standard” and “simplified.”</p> <p>Standard Reporting 5.3.1</p> <p>“Standard” reporting requirements apply to an FS household assigned a certification period longer than six months, as well as to migrant or seasonal farm workers. These include households who are eligible for IDA (and who have also been given a certification period of 12 months) and other households in which all adult members are either disabled or elderly (and who have been given a certification period of 24 months. Note that elderly/disabled households with earnings are given six-month certification periods and would be subject to Simplified Reporting, discussed below.)</p> <p>Households subject to standard reporting are required to report changes in the following areas between recertifications:</p> <ul style="list-style-type: none"> • changes in earned income of more than \$100 monthly; • changes in unearned income of more than \$50 monthly (except for income from programs administered by IMA); • changes in household composition; • changes in legal child support obligations; • changes in liquid resources that increase the total to over \$2,000, except that households in which any member is elderly or disabled are not required to report unless the total exceeds \$3,000; and • changes in residence and resulting changes in shelter costs. <p>If a FS household is subject to standard reporting and experiences a change between the application interview and the date of the notice of eligibility, household members must report the change by the 10th day of the month following the month of change.</p> <p>Simplified Reporting 5.3.2</p> <p>“Simplified” reporting requirements apply to all FS households assigned a six month certification period. This includes most TANF households, households without disabled/elderly adults and disabled/elderly adults with earnings. However, no household is subject to simplified reporting requirements until they have been notified of the requirements through an ACEDS notice.</p> <p>Recipients subject to “simplified” reporting are not required to report any nonfinancial changes between recertifications, such as household composition. They are only required to report financial changes if the change results in their total gross monthly household income exceeding 130 percent of the Federal poverty level (see table under TANF above). If the income does increase above the 130 percent level, it must be reported by the 10th of the month following the month during which the income increased. These recipients are subject to the change reporting levels listed in the Simplified Reporting Notice they are sent through ACEDS, even if the Federal poverty level changes during</p>

	<p>their certification period.</p> <p>If an FS household is subject to simplified reporting and experiences a change between the application interview and the date of the notice of eligibility, members must report the change only if it is a reportable change under Simplified Reporting. If it is a reportable change, they must report it within ten days of the notice of approval.</p>
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CHANGES DISCOVERED BY OTHER MEANS 5.4

ALL	<p>Even in situations where customers are not required to report changes, the Department must take action on changes that it discovers. This includes the following:</p> <ul style="list-style-type: none"> • information received through ACEDS interfaces with— <ul style="list-style-type: none"> ○ DOES ○ Social Security (BENDEX and SDX) ○ DC Public Schools ○ DMV ○ IEVS • information received through reports from IMA sources, including— <ul style="list-style-type: none"> ○ OQAA investigations ○ TANF Home Visit Grantees ○ DHS-886 • information received from other Agencies such as— <ul style="list-style-type: none"> ○ OIC Investigations ○ QC Reviews ○ TEP Vendors • voluntary reports from customers, even when not required to make a report • reports from recipients regarding other IMA programs that affect FS eligibility, and • third-party reports, such as a report of suspected fraud submitted by a neighbor.
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RE-DERMINATION DUE TO CHANGES 5.5

ALL	<p>ESA (formerly)IMA must take appropriate action on all changes, whether reported by the recipient or discovered through other means.</p> <p>If further information is needed to verify changes that cannot be obtained by collateral telephone contact, the SSR shall notify the customer in writing of the following:</p> <ul style="list-style-type: none"> • what information is needed, • what the information is due (at least ten days from the date of the notice), and • the consequences if the customer does not contact ESA. <p>If a customer does not provide the needed information, ESA must give timely and adequate notice of any adverse action.</p> <p>Once sufficient information is received, the SSR shall take appropriate action on all changes within 10 days.</p>
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	<p>For situations where the change was discovered due to a computer matching program, see Section 5.5.1: Information Discovered Through Computer Matching in this Part.</p> <p>For TANF and FS, if a redetermination results in a reduction or termination of benefits, the SSR shall review the case to see if an overpayment of TANF or an over-issuance of FS occurred. The SSR shall take into consideration the reporting requirements the customer was subject to during the months under review. If a recipient reports a change in a timely manner and the agency takes appropriate action within the next 10 days, there is no overpayment or over-issuance.</p>
MA	<p>When a change is reported or is discovered by the agency that renders any member of the group ineligible, the SSR shall re-evaluate his/her eligibility under all other possible categories of Medical Assistance before terminating his/her eligibility.</p> <p>Note that a newborn who has been deemed to be eligible for Medicaid remains eligible for one year following the month of birth as long as the mother remains eligible (or would have been eligible if she were still pregnant) and the newborn remains in the same household as the mother. Eligibility for the other group members must be re-determined for the remainder of the existing certification period.</p> <p>Medicaid eligibility for a new member of a household other than a newborn shall start on the latest date of the following:</p> <ul style="list-style-type: none"> • the first day of the month when the report of the new member was made; • the first day of the month for which the new member meets eligibility requirements, if this is later than the month of the report; or • if the new member is eligible for Medicaid in another jurisdiction, the first day of the first month following termination of Medicaid in the other jurisdiction. <p>If information is received through a data exchange program (such as BENDEX, SDX, interstate computer matches) that could make a customer ineligible for Medicaid, the customer must be given 30 days to respond, clarify or present further information before action is taken by the agency.</p> <p>If additional information is needed to document a proposed change, the customer must be given 30 days to provide the needed information.</p>
TAN F	<p>When information regarding a change is received from any source other than the recipient, the SSR shall send written notice to the recipient that contains the following:</p> <ul style="list-style-type: none"> • the information that the agency has received; • an opportunity for the recipient to comment, take exception to or provide further information regarding the change; and • at least 15 days for the recipient to provide clarifying information. <p>The 15-day comment period is separate from the 15-day adverse action period.</p>
	<p>Example</p> <p>Ms. Jackson receives TANF for herself and two children. The father of the two children, Mr. Williams, calls the SSR on June 2 and claims that the children actually live with Mr. Williams' mother. The SSR sends a notice on June 3 to Ms. Jackson, telling her about the allegation and giving her until June 18 to provide any clarifying information. She does not contact the worker. On June 19, the SSR takes action to close the TANF case and sends an adverse action notice to Ms. Jackson. The effective date of the closure will be August 1, the first day of the effective month after 15</p>

	<p>days' notice.</p> <p>When a customer reports a new member of his/her household (other than a newborn) and requests that the person be added to their TANF case, eligibility shall generally begin effective the date the person came into the TANF home, once eligibility for the person is established. However, if the new household member was eligible for TANF in another jurisdiction outside of the District, eligibility shall start on the first day of the first month following termination of TANF in the other jurisdiction.</p> <p>The limitation on the time period for which supplemental payments may be given still applies (See Part VIII, Section 6.5: Underpayments.)</p>
FS	<p>The SSR shall take prompt action on all reported changes. The timeframes for making changes depend on whether the change results in an increase to the allotment or a reduction to or termination of the allotment. These time frames are as follows:</p> <ul style="list-style-type: none"> • If the group is eligible for an increase in benefits because of a decrease in monthly income of more than \$50 or the addition of group members, the change must be made for the monthly allotment following the report month. • For other changes that will result in increases, the effective date of the change depends on the date that needed information is provided. <ul style="list-style-type: none"> ○ If no additional information is needed, or if the customer provides any needed information within 10 days of the SSR issuing a request, the SSR shall make the change effective no later than the first monthly allotment issued 10 days after the change is reported. ○ If the customer provides the needed information later than the 10-day request, the 10-day timeframe for action starts from the date the verification is provided rather than the date the report was received. <p>Example</p> <p>On June 25, Mr. Wallace reports to the agency that his hours have decreased at work and his monthly earnings have decreased by \$100. The agency contacts the employer and receives verification of the reduced wages on July 10. The decrease in income will be processed for the monthly allotment for August and an under-issuance will be given to Mr. Wallace for July.</p> <p>Example</p> <p>On March 19, Ms. Patterson reports that she has moved and is now paying higher rent, which the SSR determines will increase her food stamp allotment. Although the change in address does not have to be verified until the next recertification, the SSR notifies Ms. Patterson in writing that she provide proof of the change in rent within 10 days. She provides verification on March 23. Since this is within 10 days of the date she reported the change; the SSR processes the increase effective April 1.</p> <p>Example</p> <p>On September 10, Ms. Mathers reports that she now pays for cooling costs since a window a/c unit has been placed in her unit. The SSR is unable to contact the building manager and notifies Ms. Mathers in writing that she needs to provide verification of the change within 10 days. Ms. Mathers provides a statement from the management company on September 30. Since this is longer than 10 days after the change was reported, the SSR will process the change for November, the first monthly allotment that will be issued 10 days after the verification was provided.</p>

	<p>If a change results in a decrease in an allotment or termination of the allotment, the action shall be effective the first month that can be affected following timely and adequate notice.</p> <p>If a change is submitted by a household on a Change Reporting Form, the agency will mail a replacement Change Report Form to the household.</p>
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Information Discovered Through Computer Matching 5.5.1

Federal privacy laws set requirements on how agencies will act on information discovered through a computer matching program. Certain information regarding federal benefits is considered to be verified upon receipt through the computer match, such as Social Security Disability and Retirement and Supplemental Security Income, as well as Unemployment Benefits. Other information is required to be independently verified. This includes reports of unearned income received from the IRS and wages reported by state employment agencies.

ALL	<p>The agency must independently verify needed information by contacting the household and/or the source of the income, resource, or benefit. If the agency chooses to contact the household for verification, it must be done in writing, informing the household of the information that has been received, and requesting that the household respond within 10 days. This notice is not the same as a notice of adverse action. The following information must be verified:</p> <ul style="list-style-type: none"> • the total income and/or total value of owned assets, • that the applicant/recipient has or did have access to the assets or income, and • confirmation of the period of time when the applicant/recipient owned the asset or earned or received the income.
MA	When taking adverse action on the basis of information received through a computer matching program, notice must be sent to the recipient of the Agency's findings and proposed actions at least 30 days in advance of the effective date.
TANF	See FS
GC	See FS
FS	When taking adverse action on the basis of information received through a computer matching program, notice must be sent to the recipient of the Agency's findings and proposed actions at least 15 days in advance of the effective date.

ADDING A NEWBORN 5.6

MA	<p>AR : The effective date for adding a newborn to an MA case is the date of birth if:</p> <ul style="list-style-type: none"> the mother is eligible for and receiving MA on the date the child is born, or the mother is determined retroactively to be eligible for the date the baby was born. <p>This also applies to a child born to a non-qualified alien mother whose labor and delivery are covered by emergency Medicaid services. The newborn is deemed eligible for one year provided:</p> <ul style="list-style-type: none"> the mother remains eligible or would have remained eligible if she were still pregnant, and the child remains in the same household as the mother. <p>The one-year period begins the month following the month of birth. If the child loses his/her deemed eligibility, his eligibility must be redetermined. A newborn who is deemed eligible is not subject to the citizenship verification requirement until the first recertification after the newborn turns one-year-old (See Part IV, Section 7.1 2.5: US Citizen or National.)</p> <p>AX: See AR</p> <p>SR : N/A</p> <p>QM : N/A</p>
TANF	<p>The effective date for adding a newborn to an existing TANF case is the date of birth.</p> <p>The date of birth establishes the effective date of eligibility, but the child may not be added to the grant until all factors of eligibility have been verified. Technical factors of eligibility (such as applying for a SSN) are considered to be met retroactively to the date of birth if the person cooperates with the Department when the verification is requested. However, no underpayment can be issued for more than 12 months of lost benefits (see Section 6.5: Underpayments in Part VIII).</p>
GC	N/A
FS	<p>The effective date for adding a newborn to an existing FS unit is the month following the month in which the birth was reported. If the change is reported too late for DHS to affect the normal issuance cycle for the following month, the SSR shall issue supplementary benefits to the household's EBT card and provide an opportunity for the household to obtain the increase in benefits by the 10th day of the month following the month in which the birth was reported. Households that report the birth by completing the "Request to Add newborns to D.C. Medicaid, Public Assistance, and Food Stamps Rolls" form at a hospital will be considered to have reported the birth to IMA on the date the form is signed.</p> <p>If the newborn does not have a social security number (SSN) and if the family has not already applied for an SSN, the SSR should instruct them on how to do so, but should not delay in adding the newborn to the open food stamp case. A household has six months from the date of birth or six months from the last recertification— whichever is later—to apply for an SSN for a newborn. If the newborn has no SSN and the SSR does not know whether an application for an SSN has been filed (and, thus, has no SS-5 date), the SSR should enter a verification code of good cause (GC) on the SSDO screen.</p> <p>Restoration of lost benefits shall be provided to the household if DHS fails to take timely action on a correctly reported change that increases the household's benefits. Since the effective date for adding a newborn is the month following the month in which the birth is reported, no proration of FS</p>

	benefits for the month in which the child is born or the month in which the birth was reported is permitted.
	<p>Example</p> <p>A mother completes and signs the hospital-generated request to add her newborn child to her case on March 13. The agency receives the form from the hospital on April 5th. The SSR will adjust EBT benefits to ensure benefits for the full month of April for the added member.</p>
	<p>Example</p> <p>A mother completes and signs the hospital-generated request to add her newborn child to her case on June 15. The agency does not receive the form until August 10. The department will initiate restoration of lost benefits to ensure the child received food stamp benefits for the full months of July and August since the household reported the birth in June.</p>

LOSS OF BENEFITS 5.7

FS	<p>Each recipient who has received an EBT card has the right to receive a replacement card within two days of notifying the Department of the loss of his/her card. The recipient also has the right to replacement benefits remaining in the EBT account at the time the card was reported lost or stolen. The Department, and not the beneficiary, is liable for benefits drawn on an EBT account following the notification of a lost or stolen EBT card. The Department may collect a fee for issuing a replacement card.</p> <p>Each recipient, who has purchased food with their Food Stamp allotment and then suffers the loss or destruction of the purchased food due to a household misfortune, has the right to receive a replacement allotment of the lesser of the following two amounts:</p> <ul style="list-style-type: none"> • the value of the destroyed food; or • the amount of the Food Stamp benefit that was given to the household for the month in which the loss occurred. <p>In order to qualify for replacement benefits, the recipient must meet the following conditions:</p> <ul style="list-style-type: none"> • the household received Food Stamps for the month in which the loss occurred; • the household purchased food that was subsequently destroyed in a household misfortune, including, but not limited to; <ul style="list-style-type: none"> ○ fire, ○ flood, or ○ power loss; • the household reports the loss orally or in writing and completes a written affidavit attesting to the loss within ten days of the loss; and • the Department can verify that the loss occurred with a community agency, Fire Department, Red Cross, utility company, rental office, or home visit.
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Chapter 6 - Overpayment and Underpayment

INTRODUCTION 6.1

This chapter provides information on TANF and FS overpayment policy and underpayment policy in TANF, FS, GC, and IDA programs. An overpayment occurs when a recipient receives benefits for which s/he is ineligible to receive. Similarly, an underpayment occurs when a recipient receives fewer benefits than s/he is eligible to receive.

In this chapter only the term "All" refers to the Food Stamp Program and all Cash Assistance programs. The term "Both" refers to TANF and Food Stamps only.

The overpayment section outlines when to charge a TANF or FS overpayment and pursue overpayment recovery. In cases in which an overpayment has been charged and the group continues to receive TANF or FS, a portion of the group's benefits are withheld to repay the overpayment. In cases in which the group no longer receives benefits, the Office of Chief Financial Officer, Payment and Collections Division, is responsible for pursuing overpayment recovery. Overpayments are not charged in the GC or the IDA programs.

The underpayment section outlines when to provide supplemental benefits to adjust for an underpayment in TANF, FS, GC, or IDA.

This chapter does not apply to MA. However, the Department of Health (DOH) may seek to collect funds expended on behalf of individuals ineligible for health benefits or medical expenses paid to providers not eligible for Medicaid reimbursement.

LEGAL AUTHORITY 6.2

AREA/TOPIC	DISTRICT	FEDERAL
Overpayments	TANF: D.C. Code 4-210.19; 3-218.1; 29 DCMR 5816	FS: 7 USC(2022); 7 CFR 273.18
Underpayment	TANF: D.C. Code 4-208.3; 29 DCMR 5817 GC: See TANF and D.C. Code 4-205.5a	FS: 7 USC 2020(b); 7 USC 2020(e)(10)-(11); 7 CFR 273.18

OVERPAYMENTS 6.3

Types of Overpayments 6.3.1

TANF	Persons are overpaid when they receive benefits for which they are not eligible. There are three types of overpayments: <ul style="list-style-type: none">Error overpayments resulting from DHS failure to take action on known or reported information: This includes miscalculation of a budget or failure to make a timely reduction in benefits based on information fully and timely reported by the recipient.
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	<p>Two examples of agency error are:</p> <ul style="list-style-type: none"> ○ failure to take prompt action on a change the unit reported, and ○ miscalculation of the unit's income or deductions which results in an overpayment of benefits. <ul style="list-style-type: none"> • Applicant/recipient error overpayments: These overpayments may be due to inadvertent household error or suspected fraud. Inadvertent household errors are caused by misunderstanding or unintentional errors by the household. <p>Some examples of inadvertent household error overpayments are:</p> <ul style="list-style-type: none"> ○ failure to report a change between recertifications, unless there is documentation of contact with the customer during which he failed to report the change; for example, calling the Change Center to report an address change and not reporting new employment that is later discovered; ○ failure to report a change promptly; and ○ failure to report the absence of a child who has unexpectedly not returned home within 90 days. <p>Errors due to suspected fraud are caused by documented incidents of false or misleading statements, misrepresentation, concealment or withholding of facts. Errors for which DHS suspects fraud, but for which there is no documentation of intentional misrepresentation, shall be treated as an inadvertent error when calculating the overpayment. Cases suspected of fraud or intentional program violation (IPV) are considered to be applicant/recipient error overpayments until a determination of fraud or IPV is made (see Section 1.5.2: Intentional Program Violation in Part IV.)</p> <p>Some examples of suspected intentional program violation overpayments are:</p> <ul style="list-style-type: none"> ○ failure to give correct or complete information at application, ○ failure to report an income change at recertification, ○ failure to report a change in household size at recertification, and ○ providing false verification at application or recertification. <ul style="list-style-type: none"> • Fraud overpayments: Cases suspected of fraud are considered to be applicant/recipient error overpayments until the court makes a determination of fraud, a determination of IPV has been made, or the customer has signed a waiver to an administrative disqualification hearing. An SSR can only make an allegation of fraud; the actual determination of fraud is made by the court or through an IPV disqualification proceeding.
FS	<p>See TANF. In addition, an applicant/recipient error overpayment is further defined as:</p> <ul style="list-style-type: none"> • an error that is the result of a group erroneously being categorized as categorically eligible, provided the erroneous categorization is due to a household error, or • a FS error that is the result of a group erroneously being categorized as categorically eligible due to an error on the part of SSA. <p>Department error is further defined as errors that result when:</p> <ul style="list-style-type: none"> • DHS fails to reduce the unit's benefits when its cash assistance benefits change, • the department issues the group's FS benefits after their certification period expired,

	<ul style="list-style-type: none"> the department fails to verify that nonexempt group members completed a current work registration form, or the department erroneously classifies a group as categorically eligible and this mistaken classification is the fault of the department (not the fault of SSA or the recipient).
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Circumstances Under Which Overpayments are Not Charged or Recovered 6.3.2

BOTH	<p>Overpayment claims are not established when:</p> <ul style="list-style-type: none"> DHS fails to verify that a group signed the application; the department has documentation that shows the group cannot be located (such as returned mail with no forwarding address); the claim amount is \$125 or less and the household is not currently participating, unless the overpayment was discovered through a quality-control review; or an overpayment occurs based on changed circumstances, but the circumstances were reported promptly by the recipient and DHS acted on the reported change in a timely manner. The department must take action on a reported change within 10 days of the report of the change to be considered timely action. (The action taken generally means recalculating benefits and issuing adequate and timely notice of the reduced benefit to the recipient.) <p>If a recipient promptly reports a change but the Department does not act on a reported change within the 10-day standard, an agency error overpayment can be charged for excess benefits that were provided because the Department did not act within the 10-day standard.</p> <p>If a TANF group was subject to quarterly reporting, the group was not required to report income or asset changes between quarterly reporting submissions. Thus, overpayments should not be charged based on income fluctuations for groups subject to quarterly reporting, provided that the quarterly reports were submitted in a timely manner (note that reporting requirements were changed 5/01/01.) For groups now subject to semi-annual or simplified reporting, if a group reports an income change between semi-annual certifications, no overpayment is charged when the income is below the reporting threshold, though benefits are changed prospectively based on the updated income information. Prior to reducing benefits based on new information, adequate and timely notice must be provided (see Chapter 10: Notice of Adverse Action in this Part.)</p> <p>If an overpayment claim is found to be unjustified in an administrative review, fair hearing, or court determination, the claim will be terminated and any money already recovered through recoupment or any other mechanism will be returned to the recipient.</p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p>Example 1</p> <p>Ms. Wright receives TANF. In June, she finds a job and gets her first paycheck. She calls her caseworker June 17, two days after receiving her paycheck. She is paid twice a month and earns \$150 per paycheck. The caseworker issues a notice on June 19 informing Ms. Wright that her TANF benefits will decrease by \$47 per month and her FS benefits will be reduced by \$58 based on her new earnings. These changes cannot be effective until August 1 because there are not 15 days between the date the notice is issued (June 19) and July 1, when July benefits are issued.</p> <p>The recipient promptly reported the income change (she reported the earnings by the 10th day of the month following the month she received her first paycheck) and the Department swiftly acted on the information (the notice of reduced benefits was issued within 10 days of receiving the new</p> </div>
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	<p>information). Therefore, no TANF or FS overpayment is charged for June or July, even though benefits in both months were issued based on incorrect earnings information.</p> <p>Example 2</p> <p>Ms. Lewis is employed and receives TANF and Food Stamps. She was sent a simplified reporting notice at her last review. Ms. Lewis receives a pay raise in June and her total income for July exceeds her reporting threshold. Ms. Lewis calls her caseworker August 3 to report her increased income. The caseworker fails to issue a termination notice for TANF and FS until August 25. Due to the 15-day notice requirement, benefits cannot be reduced until October. No overpayment is charged for either program for June, July and August since these benefits would not have been reduced even if DHS had acted in a timely manner. TANF and FS overpayments are charged for the excess benefits received in September due to the Department's failure to act promptly on the reported change.</p>
TANF	<p>The SSR should not compute an overpayment for the dual receipt of TANF and SSI unless:</p> <ul style="list-style-type: none"> • ESA informed SSI that a person would be removed from the grant on a specific date, and • the person was not removed from the grant on that date. <p>If the SSI check was not reduced due to TANF benefit, the SSR should notify SSA of the dual receipt. SSA will process an SSI overpayment.</p>

Determining the Time Period of Overpayments 6.3.3

Time Limitations on Calculating and Collecting Overpayments

BOTH	<p>Overpayments shall be calculated for periods not to exceed 12 months prior to the month in which the overpayment is discovered, except when IPV or fraud is found or suspected. If IPV or fraud is found or suspected, overpayments shall be calculated for the entire period over which excess benefits were received, provided that period does not exceed six years from the date the overpayment was discovered. Although IMA may calculate overpayments exceeding 12 months when fraud is suspected, it may not collect for a period exceeding 12 months unless fraud or IPV has been determined (see Section 6.3.1: Types of Overpayments in this Chapter.)</p> <p>Example 1</p> <p>Ms. Freeman and her two children receive FS. In March, 2005, it is discovered that the group received excess FS benefits because her oldest child had countable earnings. Ms. Freeman says she did not know that her son's wages were countable. Although the income dates back several years, the group's overpayment should be calculated for the 12-month period from April 2004 to March, 2005, since fraud is not suspected.</p> <p>Example 2</p> <p>Ms. White and her three children receive TANF. In March, 2005, it is discovered that James, O'Brien, the father of her youngest child, has lived with them for the past two years. A review of Ms. White's records show that she failed to list James O'Brien as a household member on the recertification forms she completed during the two-year period. Since case documentation show that Ms. White misrepresented her household's composition, an overpayment should be calculated for the entire two-year period.</p>
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Determining an Overpayment's Start Date

BOTH	<p>When determining the amount of the overpayment, the SSR must determine the first month benefits would have been adjusted had the change been reported timely and the agency acted on that information timely. Effective October 1, 2005, a recipient has until the 10th day of the month following the month of the change to report a change affecting benefits. Prior to October 1, 2005, recipients on standard reporting were required to report a change within 10 days of the change. The SSR has 10 days to take action on the reported change. A notice of adverse action must be sent at least 15 days prior to the effective date of a case action that reduces or terminates benefits.</p> <p>Example 2</p> <p>Ms. Wonder and her child receive TANF. Ms. Wonder finds a job and receives her first paycheck on June 8. Ms. Wonder does not tell her caseworker until August 5 about the new earnings. Ms. Wonder needed to report her wages by July 10. If she had done so, her case worker had until July 20 to process her change in benefits. Since a 15-day notice of adverse action is required, the first month benefits could have been changed was September. Despite Ms. Wonder's late report, the SSR can still issue timely notice for a September change, the first month that benefits could be changed. Therefore, there is no overpayment.</p> <p>Example 2</p> <p>Mr. Porter receives Food Stamps. Mr. Porter starts work in March and receives his first paycheck on March 27. Mr. Porter waits until his recertification appointment on July 19 to report his employment, and his wages are used to determine his benefits for the new certification period that begins August 1. Mr. Porter was expected to report his earnings by April 10. Had he done so, his case worker had until April 20 to process his income change. Since a 15-day notice of adverse action is required, the first month benefits could be changed is June. There is no over-issuance for March, April, and May. A Food Stamp claim should be established for June and July.</p> <p>Example 3</p> <p>Ms. Schwarte receives TANF and Food Stamps. Ms. Schwarte is approved for Maryland unemployment benefits and receives her first check on May 15. She reports her new income at her TANF review on July 19. Since her case worker cannot give a 15-day timely notice for August, she adjusts her TANF and Food Stamp benefits for September. Ms. Schwarte had until June 10 to report her unemployment benefits. Her case worker had 10 days—until June 20—to process the change and send a 15-day notice of change for August. There are no overpayments or over-issuances for May through July. A TANF and Food Stamp overpayment should be established for August.</p>
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RECOVERY 6.4

TANF	<p>Methods of recovery vary depending on whether the overpaid person is currently receiving benefits.</p> <p>Recovery methods for overpayments from persons currently receiving benefits include:</p> <ul style="list-style-type: none">• recoupment,• voluntary repayment,• expunged benefits,• civil recovery,• criminal restitution, and• offset of an overpayment with an underpayment.
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	<p>The primary method of recovering overpayments from persons who are currently receiving benefits is recoupment of a portion of the group's current benefits to repay the amount owed.</p> <p>Recovery methods for overpayments from persons who are no longer receiving benefits include:</p> <ul style="list-style-type: none"> • voluntary repayment, • expunged benefits, • civil recovery, • criminal restitution, and • offset of an overpayment with an underpayment.
FS	See TANF, except recovery of overpayments may also be made by former and current recipients through the Treasury Offset Program (TOP).
BOTH	In cases in which the group charged with an overpayment no longer receives benefits in the program for which the overpayment was charged, the Payment and Collections Division in the Office of the Chief Financial Officer is responsible for negotiating repayment terms.

Initiating Recovery 6.4.1

BOTH	<p>Within the calendar quarter following discovery of the overpayment, one of the following shall be initiated:</p> <ul style="list-style-type: none"> • recovery of the overpayment, • recoupment from a recipient's benefit, or • sending a letter requesting repayment and trying to arrange a repayment agreement from a former recipient. <p>Failure to take any of the above actions within the timeframe does not affect the group's responsibility to repay. It also does not affect the department's responsibility to recover the overpayment.</p>
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Recoupment 6.4.2

BOTH	<p>When a group that has been charged an overpayment continues to receive assistance, a portion of the group's benefit is withheld or recouped to repay the overpayment. DHS shall not recoup more than the actual overpayment of assistance.</p> <p>The SSR must identify the overpayment and gather all the verification associated with the cause of the overpayment (i.e. pay stubs, proof of income, household composition, residence, verification of expenses, change in resources, etc.) The case record must also be documented in reference to the overpayment. The SSR should compile and forward a claims package (see Section 6.4.4: Reporting of Overpayment in this chapter) to the Overpayment Unit, which will calculate the overpayment after reviewing the verification and documentation. After the claim has been established, the Overpayment Unit will mail the appropriate Demand Letter and, for Food Stamp claims, the Repayment Agreement Letter (F719).</p>
TANF	<p>The steps for calculating the TANF recoupment amount differ for customers with no gross earned and unearned income and for those with such income.</p> <p>For those customers with no gross earned and no gross unearned income, the recoupment amount is equal to 10 percent of the maximum benefit amount.</p> <p>For those customers with gross earned or unearned income, the recoupment is the largest amount</p>

that can be taken from the TANF grant that will still leave the household with gross income that is at least 90 percent of the maximum benefit level. Follow these steps to determine the recoupment amount:

- Step 1: Calculate the grant amount the group would be eligible for if no recoupment were required, applying all applicable disregards and deductions.
- Step 2: Add together the grant calculated in Step 1 and the group's gross earned and unearned income.
- Step 3: Subtract 90 percent of the maximum benefit level for a family of the appropriate group size from the result of Step 2. This difference is the recoupment amount, unless this difference is greater than the grant calculated in Step 1. In this case, the group's entire benefit is recouped.

Example 1

Mr. Temple receives \$379 in TANF for his two children and himself. Beginning in June, his TANF benefits will be reduced to recover an overpayment. Since he has no other income, 10 percent of his TANF benefit (\$38) will be recouped to recover the overpayment. He will receive \$341 ($\$379 - \$38 = \341) in TANF.

Example 2

Ms. Kremer receives \$63 in TANF for her three children and herself. She also receives \$400 in Social Security. Beginning in July, her TANF benefit will be reduced to recover an overpayment. Her recoupment is calculated as shown:

TANF Entitlement \$ 63.00

+ Gross Unearned Income \$400.00

= \$463.00

- 90% of Payment Level for 4 \$416.00

= Recoupment \$47.00

Ms. Kremer will receive \$16 in TANF after the \$47 recoupment is deducted.

Example 3

Ms. Benton is working and receives a reduced TANF benefit. She earns \$1,000 monthly and gets \$70 in TANF for her three children and herself. Beginning in May, her TANF benefit will be reduced to recover an overpayment. Her recoupment is calculated as shown:

TANF Entitlement \$70.00

+ Gross Earned Income \$1000.00

= \$1070.00

- 90% of Payment Level for 4 \$416.00

	<p>= Recoupment \$654.00</p> <p>Since the amount that may be recouped—\$654—is more than Ms. Benton's TANF entitlement—\$70—her entire TANF benefit will be recouped.</p> <hr/> <p>Example 4</p> <p>Mr. Calhoun works part time while receiving TANF. He earns \$200 a month and gets \$284 for his daughter and himself. Beginning in October, his TANF benefits will be reduced to recover an overpayment. His recoupment is calculated as shown:</p> <p>TANF Entitlement \$284.00</p> <p>+ Gross Earned Income \$200.00</p> <p>= \$484.00</p> <p>- 90% of Payment Level for 2 \$268.00</p> <p>Recoupment \$216.00</p> <p>Mr. Calhoun will receive \$68 in TANF after the \$216 recoupment is deducted from his benefit.</p>
FS	<p>The amount recouped each month from a participating FS group with an outstanding FS overpayment depends on the type of overpayment:</p> <ul style="list-style-type: none"> • For non-fraud error overpayments, recoup 10 percent of the group's monthly allotment or \$10 a month, whichever is greater. • For fraud overpayments, recoup 20 percent of the group's monthly allotment or \$20 a month, whichever is greater. <p>For households with one or two members for which the minimum benefit rule generally applies, the application of the minimum benefit rule occurs prior to the reduction in benefits due to recoupment. That is, a group with one or two members can receive a benefit of less than \$10 if the reason the benefit is below this amount is because of the recoupment of an overpayment.</p> <hr/> <p>Example 1</p> <p>Mr. Ford is charged a non-fraud overpayment. His monthly FS entitlement is \$60. Although 10 percent of his allotment is \$6, a \$10 recoupment will be deducted from his benefits. If Mr. Ford was receiving \$120 in FSs, \$12 (10 percent) would be recouped.</p> <hr/> <p>Example 2</p> <p>Ms. Franklin is charged a fraud overpayment. Her monthly FS entitlement is \$250. Ms. Franklin's allotment will be reduced by \$50 (20 percent of her entitlement).</p> <hr/> <p>Example 3</p> <p>A one-person FS group receives a \$10 minimum benefit. The group has an outstanding non-fraudulent overpayment. The group's \$10 minimum benefit can be reduced by 10 percent in this case.</p>

Circumstances Under Which Overpayments are Not Collected for Nonparticipating Households 6.4.3

TANF	<p>When a group continues to receive TANF, all overpayments are collected by withholding a portion of the group's TANF benefits to repay the overpayment. When a group with an outstanding overpayment no longer receives TANF, the Division of Payment and Collections is responsible for collecting outstanding overpayment claims. In some cases, the Division of Payment and Collections may write-off a claim for a non-participating household if the claim meets any of the following criteria:</p> <ul style="list-style-type: none"> • all adult household members are deceased and the District is not planning to pursue collection from the estate; • the claim has been determined not cost-effective to collect, because the claim balance is \$100 or less and the claim has been delinquent for 90 days or more; • the claim has been delinquent for three years; or • the household cannot be located. <p>Claims meeting the termination and write-off criteria should be reported as terminated claims.</p> <p>Claims records should be maintained separately from other case information. When the remaining case record is destroyed, if the claim has not been fully recovered, the claim record will be maintained in the Overpayment Unit for three years after closure of the claim. A claim is closed only when it has been adjusted or reduced to \$0.</p>
FS	<p>See TANF, except the Division of Payment and Collections may write-off a claim for a nonparticipating household if the claim meets any of the following criteria:</p> <ul style="list-style-type: none"> • all adult household members are deceased and the District is not planning to pursue collection from the estate; • the claim has been delinquent for ten years; • the household cannot be located; or • the claim has been determined not cost-effective to collect, because the claim balance is \$25 or less and the claim has been delinquent for 90 days or more. However, if the household has multiple overpayment claims against it that total \$25 or more, then recovery actions can be taken.

Reporting Overpayment 6.4.4

BOTH	<p>The SSR must submit the following information on Form 726, Report of Overpayment:</p> <ul style="list-style-type: none"> • identifying information on the recipient (minimally name, SSN, and case number); • the day, month, and year the overpayment was discovered; • the type of overpayment alleged; • the time period covered by the claim; • the reason for the overpayment; and • the signature of the supervisor who reviews the submittal. <p>The SSR must also submit documentation that supports the overpayment claim along with a copy of the case narrative that explains the reason for the overpayment and records when the overpayment was discovered.</p>
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	<p>The documentation must include:</p> <ul style="list-style-type: none"> • copies of any recertification or application forms completed during the period of the overpayment; • any case record documentation that verifies that the customer had contact with DHS during the period of the overpayment, but failed to report the change; and • verification of monthly income, including the start and end dates of employment, if the income was earnings. <p>Overpayments are calculated for period not to exceed 12 months prior to the month in which the overpayment is discovered, except in situations where the SSR suspects that a client has a possible IPV or fraud overpayment. In these instances, the SSR must submit wage verification along with the recertification forms for the entire period of the suspected IPV, provided that the entire period does not exceed six years from the date the overpayment was discovered.</p> <p>Example</p> <p>Ms. Jenkins receives TANF. In July, 1999, she found a job, but never reported this change to her caseworker. Ms. Jenkins has recertified every six months from 1999 through 2004. In January 2005, her caseworker discovers that Ms. Jenkins is employed and has received unreported earnings since July 1999. The caseworker suspects an IPV. When the caseworker submits the TANF overpayment, she will submit a copy of the wage verification showing all earnings received since Ms. Jenkins started work and each recertification/application form that Ms. Jenkins completed for the period 1999 through 2004.</p> <p>The SSR must complete the Possible Claims (POCL) screen in ACEDS. The SSR must also compile and submit to the Overpayment Unit a claims package that includes:</p> <ul style="list-style-type: none"> • the Form 726, Report of Overpayment, signed by a Supervisor; • a printout of the POCL screen; and • all required documentation that supports the claim. <p>Additional information shall be kept by the Overpayment Unit in the claim record such as:</p> <ul style="list-style-type: none"> • the method of recovery, • overpayment notices and billing records, and • the amount of the overpayment recovered to date.
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Compromising Food Stamp Claims 6.4.5

A Food Stamp claim may be reduced in full or in part if the claimant is unable to repay the full claim within a three-year period.

Requesting a Compromise

A Food Stamp claimant may request a compromise at any time after a claim is established, but only one compromise will be granted per claim. Once the Agency grants a compromise, future requests for compromise will be denied. The request must be directed to the IMA office or personnel listed in the customer's Demand Letter.

What Claims May Be Compromised

A Food Stamp claim may be reduced through compromise when:

- the claim is not the result of court-determined fraud nor a finding by the Office of Administrative Hearings that the customer committed an intentional program violation (IPV);
- the claim cannot be repaid within three (3) years; and
- the claimant's gross income at the time of the request to compromise the claim does not exceed 200% of the Federal Poverty Level in effect during the month of the request for the household size as it is during the month of request. When calculating the income:
 - all types of income that would be counted for Food Stamps will be counted, and
 - all countable income from any adult in the household during the month of request who was also an adult in the Food Stamp household at the time of the overpayment will be counted.

Determining if the Claim Can Be Repaid Within Three (3) Years

When Food Stamps are over-issued to a customer, FNS allows a state Food Stamp agency to collect 10 percent of the customer's monthly Food Stamp benefits through recoupment. This amount will never exceed 10 percent of the maximum allotment. When determining the amount of a claim that can be repaid within 3 years, IMA must ensure that the Food Stamp recipient is not expected to repay more than the maximum amount that could be collected through recoupment of active benefits.

The amount of the over-issuance that may be expected to be repaid within three (3) years is based on:

- a) the total amount of Food Stamp benefits that was over-issued;
- b) the size of the claimant's Food Stamp group in the month the compromise is requested, or if the Food Stamp case is closed, the group size if the household applied for Food Stamps during the month of request; and
- c) the maximum Food Stamp Allotment for the Food Stamp group size in effect in the month the compromise is requested. To determine the amount that the Food Stamp claimant may be expected to repay within three years, take ten (10) percent of the maximum allotment for the group size and multiply by 36 (months). If the amount of the claim that can be repaid within three years is more than the total over-issuance, the claim may not be compromised.

Example 1

Ms. Barnes is charged a \$1,000 over-issuance. She requests a compromise on April 19, 2010. Ms. Barnes' household in the month of April consists of two persons. The maximum allotment for two persons in April 2010 is \$367. Ten (10) percent of \$367 is \$36.70. Ms. Barnes is expected to repay \$1,321 ($\$36.70 \times 36 = \$1,321$) within three (3) years. Since the over-issuance is only \$1,000, the claim cannot be compromised.

Amount of the Claim Reduced by Compromise

If the claimant meets the requirements of "What Claims May Be Compromised" above, the claim may be reduced to the amount that the claimant may be expected to repay within three (3) years. A hardship reduction may also be given when the claimant's shelter cost, as determined by FS rules, exceeds one-half

of the claimant's gross income at the time of the request for compromise. If the claimant's shelter cost is more than one-half of the claimant's monthly gross income, reduce the claim by the difference of the claimant's shelter cost and one-half of the claimant's gross income.

If a reduction due to compromise results in a balance of less than \$0.00, no previous payments by the claimant will be restored to the claimant.

Example 1

Ms. Parker has been charged a \$3000 Food Stamp over-issuance. After applying the rules in "Determining if the Claim Can Be Repaid Within Three (3) Years" above, she is expected to repay \$1500 within three years. Ms. Parker's monthly income is \$900 in Social Security. Her shelter cost consisting of her rent of \$650 and a Heating and Cooling Standard Utility Allowance of \$300 totals \$950. As seen in the calculation that follows, Ms. Parker's Food Stamp claim may be reduced by an additional \$500 because of her high shelter costs.

Total Shelter Costs \$950

- 1/2 of Gross Income ($\$900/2 = \450) \$450

Additional Reduction \$500

After the added hardship reduction, Ms. Parker's Food Stamp claim may be reduced to \$1,000 ($\$1,500 - \$500 = \$1,000$) through compromise

Example 2

Mr. Jones was over-issued \$1,500 in Food Stamps. He repaid \$1,100 through recoupment, leaving a balance of \$400 and then requested a compromise. After applying the rules in "Determining if the Claim Can Be Repaid Within Three (3) Years" above, he is expected to repay \$1,000 within three (3) years which is \$500 less than the original claim amount. Mr. Jones' shelter cost is less than one-half of his gross income so he is not eligible for a hardship reduction. Mr. Jones's' claim can be reduced by only \$500 ($\$1,500 - \$1,000 = \500) through compromise. Since he only owes \$400, the remaining balance is compromised, but he will not receive any restoration of payments that he already made.

Restoring Compromised Benefits to a Food Stamp Claim

The Food Stamp claimant must comply with his/her repayment agreement. If the claimant fails to make a required repayment for three consecutive months, the compromise will be voided, and the claimant must repay the full amount of the over-issuance. In addition, any portion of a claim that was compromised must be restored to the full amount of the over-issuance when there is a subsequent finding by the Office of Administrative Hearings or DC Superior Court that the claim is the result of fraud or an intentional program violation.

Restrictions on the Number of Compromises

Only one compromise may be made on any individual Food Stamp claim. The amount of benefits that were compromised may not be recalculated even if the claimant's income, expenses, or group size changes.

Notification That a Compromise May Be Requested

Food Stamp claimants will be sent notification when a food stamp claim is established telling them that they may ask to have the over-issuance reduced through compromise.

Restrictions on Consolidating Multiple Claims When Determining If a Compromise May Be Made

Separate Food Stamp claims cannot be consolidated to determine if all or a portion of the claimant's combined debt may be compromised. A separate claim is defined as an over-issuance for one month or two or more consecutive months that is the result of the same action or inaction of the claimant or the agency.

Example 1

Mr. Pondexter failed to report his wages from UPS timely. He was charged a Food Stamp over-issuance for May 2008 through October 2008. Mr. Pondexter's job terminated and he failed to report when he began getting unemployment benefits. He was charged an over-issuance for December 2008 through April 2009. Mr. Pondexter's over-issuance cannot be combined because the months of the over-issuance are not consecutive and the over-issuances are based on two separate incidences of Mr. Pondexter's failing to report changes of his income.

UNDERPAYMENTS 6.5

ALL	Persons are underpaid if they do not receive the benefits for which they are eligible (i.e., a recipient of public assistance receives a payment or series of payments in an amount less than that for which the recipient is eligible).
TANF	<p>TANF Underpayments cannot be corrected for more than 12 months prior to the date whichever of the following has occurred:</p> <ul style="list-style-type: none">• the recipient requested correction of benefits, or• the date the agency is notified or otherwise discovers that a loss to a group has occurred. <p>If both occurred, the underpayment shall be corrected for the 12 months prior to whichever occurred earlier.</p> <p>Underpayments are not corrected when a recipient fails to timely report a change in circumstances except in cases of the addition of a mandatory group member such as a newborn. If a recipient reports the addition of a mandatory group member (such as a newborn), the underpayment is corrected regardless of the timeliness of the report (see Section 1.7: Adding a Newborn in Part IV).</p> <p>Example 1</p> <p>Mr. Johnson and his two children receive TANF. Mr. Johnson works and earns \$350 per month. Mr. Johnson loses his job in October but does not report the loss of income until December. No underpayment correction is issued for the underpayment that occurred in October, November or December. January benefits must reflect the lost income. If there is insufficient time from the date of the reported change to affect January's benefit amount, a supplemental payment must be issued.</p> <p>Example 2</p> <p>Ms. Pike and her three-year-old receive TANF. In March, Ms. Pike has a baby, but she does not</p>

	report the newborn until September. Ms. Pike must receive supplemental benefits to correct the underpayment for the period of March–September.
GC	See TANF
IDA	See TANF
FS	<p>The date that an underpayment is discovered affects how it is corrected. The discovery date is whichever of the following occurs first:</p> <ul style="list-style-type: none"> the date someone notifies the department (verbally or in writing) of the underpayment, or the date the department discovers the underpayment. <p>Underpayments caused by a DHS error must be corrected, even if the household has not requested the correction. In addition, underpayments that are the result of a reversal of department actions at administrative review or fair hearing or the reversal of a fraud/IPV disqualification must be corrected.</p> <p>Underpayments that are caused by a recipient error, such as a delay in reporting a change that results in increased benefits, are not corrected. However, the change must be made prospectively, if applicable.</p> <p>Underpayments cannot be corrected for more than 12 months prior to the date of discovery.</p> <p>When a household adds a newborn or other mandatory group member, the group's benefits are increased in the first available month after the birth or addition of the group member is reported (see Section 5.6: Adding a Newborn in this Part).</p> <p>Example</p> <p>Ms. Allison contacts DHS on April 25, 2005, and requests correction of FS benefits for a three-month time interval from February to April of 2005, since the increased shelter costs she reported in January were not entered in ACEDS. Since she made the discovery within 12 months of underpayment, she can receive a supplementary payment for the entire period.</p>

DETERMINING OVER/UNDERPAYMENT AMOUNTS 6.6

BOTH	<p>The overpayment or underpayment is the difference between the benefit amount the client actually received before recoupment and the benefit amount the client should have received before recoupment.</p> <p>The FS 20 percent earned income disregard and the two-thirds (2/3) TANF earned income disregard are not allowed if earned income is not reported timely (See Section 6.3: Income Disregards and Deductions in Part VI.) If group was on periodic reporting and did not submit its report by the 10th of the month in which it was due, the earned income disregard was not allowed.</p> <p>When policy for determining overpayments has changed, the policy in effect for the payment month is used. For a group on standard reporting prior to October 1, 2005, a report is considered timely when income is reported within ten days from the date the income was received. For a group on standard reporting on or after October 1, 2005, or for a group on semi-annual or simplified reporting, a report is timely when the income is reported by the 10th day of the month following the month in which their total income exceeds their reporting threshold. The \$160 work expense deduction in TANF is allowed even if income is not reported timely. The earned income disregards</p>
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	<p>are allowed prospectively once the income is reported.</p> <p>If a recipient does not cooperate by providing actual information to determine the amount of the incorrect payment, the best estimate or the best information available may be used. One source of information is IEVS. If the SSR has information from some months in an earlier quarter, the information is used for subsequent months. If the SSR has quarterly wage information (from DOES or the recipient's previous employer) and the recipient is unwilling or unable to provide monthly earnings amounts, average the quarterly wages over the quarter and use the resulting monthly average to determine the correct payment amounts. The SSR must attempt to get monthly wage information directly from the recipient's employer, before using an estimate or best available information to report or establish the claim.</p> <p>When there is one month or more of total ineligibility and then one month or more of eligibility, the unit is presumed to have reapplied on the first day they were eligible. The amount that the unit should have received based on the first day they were eligible (prorate if necessary) is calculated.</p>
TANF	<p>Recipients must report changes in their household composition. When a mandatory unit member enters a household and the unit fails to report the change in a timely manner, the underpayment is calculated starting with the month the mandatory unit member arrives.</p>
	<p>Example</p>
	<p>Ms. Leidy gave birth to her son Abraham on May 18. She does not report the change in household composition until June 4. She has already been issued June benefits. When calculating her underpayment, it will start with May benefits.</p>
FS	<p>See TANF except no overpayments or underpayments are established because of changes (e.g., person becomes elderly or disabled and becomes eligible for a higher shelter deduction) that were not required to be reported by the unit during the certification period. Also, when a group member is added to the group, the change is made prospectively after the change is reported.</p>
	<p>When calculating overpayments or underpayments for FS households who also receive TANF, the amount of TANF cash assistance actually received in the payment month is used, even if the cash assistance was later determined to be an overpayment.</p>
	<p>DHS keep a record of underpayments, corrective payments, overpayments and recovery. The information must be sufficient to keep track of people who:</p> <ul style="list-style-type: none">• currently receive assistance (including people who move from one unit to another), or• no longer receive assistance.

CHAPTER 7 - GRIEVANCES AND FAIR HEARINGS

INTRODUCTION 7.1

ALL	<p>An applicant/recipient dissatisfied with an action taken by DHS that affects benefits, program participation or program requirements may request a fair hearing. The applicant/recipient may file a hearing request with any member of the department. He may also file a request with the Office of Administrative Hearings (OAH), the District agency that is responsible for adjudicating disputes regarding eligibility for department programs. Upon receiving a request from an applicant/recipient or his/her representative, a fair hearing shall be held within a reasonable time not to exceed 45 days.</p> <p>When an applicant/recipient requests a fair hearing from a DHS representative, the request shall be forwarded to the Office of Administrative Review and Appeals (OARA). Upon receiving the request for a hearing, OARA schedules an administrative conference and notifies OAH. OAH shall assign the case to an administrative law judge (ALJ) and set a date and time for the fair hearing. The purpose of the administrative review conference is to try to resolve the disagreement informally. If the administrative review conference resolves the issue, the applicant/recipient may sign a written request to withdraw the fair-hearing request. Participation in the administrative review conference is always optional. Unless an applicant/recipient opts to participate in the administrative review conference and agrees to withdraw the request, the fair hearing will proceed as scheduled.</p> <p>OAH holds hearings and renders decisions on disputes between applicants/recipients and the agency. OAH also provides a written final decision explaining its findings and ruling to the applicant/recipient, his representative and DHS/ESA. An applicant/recipient who is dissatisfied with the outcome of a fair hearing can appeal the final hearing decision to the DC Court of Appeals.</p> <p>Written information regarding the right to request a hearing and the method of making such request shall be furnished to each public assistance applicant/recipient at the time of application and whenever DHS notifies the household that it intends to take action which may adversely affect benefits, including changes in or terminations of assistance payments. Such written notice shall include:</p> <ul style="list-style-type: none">• that the applicant/recipient has the right to be represented by legal counsel or by a lay person who is not an employee of the District,• that she may bring witnesses on her behalf,• that reasonable expenses related to the hearing, such as transportation costs for the applicant/recipient and his witnesses will be paid by the department, and• a list of public and private sources providing legal services at low or no cost. <p>ESA will monitor the implementation of all final decisions for ESA programs to ensure that it has complied with all final determinations.</p> <p>Applicants/recipients may also report complaints about the quality of service provided by the agency. An applicant/recipient that has a complaint about DHS procedures or staff related to any ESA-administered programs may contact the Customer Service Unit, a supervisor, center manager or the Administrator or Deputy Administrator of the ESA. The FS program has a formalized mechanism for handling complaints related to the FS program (see Section 7.6: Federal Reporting Requirements for Compliance in this Chapter). OARA handles FS complaints and is required to submit annual reports on the number and type of complaints received.</p>
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LEGAL AUTHORITY 7.2

AREA/TOPIC	DISTRICT	FEDERAL
Fair Hearings	DCMR, Title 1, Chapter 28, 2800-2899 TANF: D.C. Official Code 4-210; 4-205.19h; 4-205.55; 4-205.56, 4-205.57 GC: See TANF and D.C. Official Code 4-205.5a	MA: 42 CFR 431.200 - .246 FS: 7 USC 2020(e)(10); 7 CFR 273.15

ADMINISTRATIVE REVIEWS 7.3

ALL	<p>When an applicant or recipient requests a fair hearing, OARA schedules an administrative review conference which the applicant/recipient has the option of attending. The administrative review conference provides an informal forum for the Department and recipient to review the Department's decision regarding benefits and, where appropriate, Department errors can be corrected. Applicants/recipients who choose not to attend an administrative conference or are dissatisfied with OARA's decision in a dispute remain entitled to a fair hearing.</p> <p>The OARA will:</p> <ul style="list-style-type: none">• review contested agency determinations;• maintain records of all requests for fair hearings transmitted to OARA;• discuss pertinent laws and regulations with applicants/recipients (and their legal representative, if applicable) to clarify policy and legal issues once a fair hearing has been requested; and• conduct administrative review conferences for all programs administered by ESA. <p>Any case alleging discrimination based on age, religion, sex, race, color, disability, national origin, political belief, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, source of income, or place of residence or business will be forwarded to the OIC.</p> <p>Any complaint concerning collection of a Food Stamp debt through the Treasury Offset Program (TOP) will be referred to the Payments and Collections Division. Only delinquent Food Stamp claims are subject to collection through TOP. These customers were previously given the opportunity to exercise their fair hearing rights when their Food Stamp claims were established.</p>
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Guidelines for Reviews 7.3.1

MA	<p>OARA will set a date for the administrative review conference. Administrative review conferences will be held not later than 20 days from the date the fair hearing request is received by DHS. (The fair hearing will be held not later than 45 days from the date of the request.) Notification of the administrative review conference will be made through ACEDS to the applicant/recipient and notice will also be sent to his/her representative, OAH and the appropriate center manager.</p> <p>The written notice shall inform the applicant/recipient of the following:</p> <ul style="list-style-type: none">• the time and place for the administrative review,• that the review will not be held if s/he does not attend,• that failure to attend will not affect the scheduled fair hearing which s/he has requested,• his/her right to review the case record, and• the right to be represented by a person of his/her choosing, including legal counsel, as well
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	<p>as the availability of low or no cost legal services from public and private sources.</p> <p>When appropriate, prior to the administrative conference, OARA shall:</p> <ul style="list-style-type: none"> • hold a discussion about the issues surrounding the case with the center manager or others who are knowledgeable about the case to determine if the administration's action or inaction was proper (If the action or inaction was not proper, the center manager shall be instructed to implement corrective action within three business days. If the corrective action is not completed in a timely manner, the ESA Administrator shall be notified of the inaction by OARA.); • review the case record to ensure that it is properly documented and accurately reflects the determinations made by the SSR; and • request that the supervisor prepare a justification for action taken in relation to the contested facts or issues. <p>At the scheduled time, the administrative conference will be conducted and the applicant/recipient must be:</p> <ul style="list-style-type: none"> • informed of his right to review the case record, • advised that if the result of the review is not satisfactory to him the requested fair hearing will be held as scheduled, and • informed that if she is satisfied with the result of the review, the request for a hearing may be withdrawn by signing a written statement of withdrawal. <p>After the administrative conference, written findings, conclusions and recommendations (Conference Summary and Determination) are prepared and sent simultaneously to the applicant/recipient, his representative, if any, the center manager and OAH.</p> <p>If the applicant/recipient prevails, OARA shall instruct the center manager to implement corrective action within three business days. If the corrective action is not completed timely, the Administrator of ESA will be notified of the inaction by OARA.</p>
	<p>Example</p> <p>Ms. Hernandez applied for TANF for herself and her two children on June 4th. The SSR found them ineligible based on immigration status and sent a denial notice. Upon receiving the denial notice, Ms. Hernandez requested a fair hearing. She attended an administrative review conference and OARA found that she and her children were eligible based on their immigration status. On August 3, OARA sent the center manager the OARA determination. By August 6, Ms. Hernandez's application must be re-opened, and her eligibility for TANF re-determined in accordance with OARA's instructions.</p>
	<p>If the applicant/recipient does not sign a statement of withdrawal, the fair hearing will proceed as scheduled.</p> <p>If the applicant/recipient fails to appear at the scheduled conference or to contact the OARA, the appeals officer will send a Conference Summary and Determination letter to advise the applicant/recipient that the matter has been forwarded to OAH for resolution. Failure to attend the administrative conference will not impact the course or conduct of the scheduled fair hearing.</p>
TANF	See MA.
GC	See MA.

FS	See MA. In addition, the OARA will give priority to a request for review or a fair hearing in an expedited FS case. If an applicant/recipient requests expedited FS services and it is denied, the OARA shall schedule an agency conference within 2 days, unless the household requests that it be scheduled later or states that it does not wish to have a conference.
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STATUTORY REQUIREMENTS FOR CONDUCTING FAIR HEARINGS 7.4

Fair Hearing Entitlement 7.4.1

ALL	At the time of application for benefits and on any notice of adverse action, each applicant/recipient will be informed, verbally and in writing, of the conditions under which he is entitled to request a fair hearing, the process for requesting such a hearing, the right to present witnesses, the right to be represented by legal counsel or other spokespersons of his choosing, the right to have reasonable expenses related to the hearing paid by DHS, and that legal services are available to the applicant/recipient.
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Request a Hearing 7.4.2

ALL	<p>Any applicant/recipient for public assistance aggrieved by department action or inaction which affects her participation in a particular program or level of benefits received may request a fair hearing. A hearing request is a clear expression, oral or written, by the applicant/recipient or her representative that:</p> <ul style="list-style-type: none"> • she wishes to appeal a decision of DHS, or • she wants an opportunity to present its case to a higher authority. <p>DHS/ESA shall treat a request made by a representative of the applicant/recipient as if made by the applicant/recipient, as long as written authorization of representation is provided within 10 days of the request.</p> <p>The request for a hearing may be filed with any employee of DHS/ESA or may be filed directly at the OAH.</p> <p>The right to request a hearing may not be limited or restricted in any way. The request may be made verbally or in writing. DHS must assist the applicant/recipient in completing his/her hearing request, when asked. Upon receiving a request for a fair hearing, the ESA representative shall complete Form 1348. A request for a fair hearing must always be accepted and should be electronically transmitted by facsimile to OARA on the date it was received. The original copy of the fair hearing request and the customer's case record should be forwarded to OARA within 48 hours.</p> <p>All applicants/recipients shall be afforded the right to request a hearing on any action taken by the agency, including loss of benefits, which occurred in the prior 90 days. All applicants/recipients shall also be afforded the right to request a hearing to appeal a denial of a request for restoration of benefits lost more than 90 days ago but less than one year prior to the request. All applicants will be afforded the right to request a hearing if they are not notified of a decision on their application within the time allowed. In addition, at any time during the certification period, a recipient may request a fair hearing to dispute his current level of benefits.</p>
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Scheduling a Hearing 7.4.3

ALL	A fair hearing shall be held not later than 45 days from the date of the request. At least 10 days prior to the hearing, OAH will send written notice of the date and time of the hearing to the applicant/recipient, his/her representative (if any), and DHS/ESA. This allows all parties involved to
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	have adequate time to prepare for the hearing. However, the applicant/recipient may request or agree to less advance notice to expedite the scheduling of the hearing.
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Request Postponement of Hearing 7.4.4

ALL	The household may request and is entitled to receive a postponement of a scheduled hearing. In the case of Food Stamps, postponement shall not exceed 30 days.
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Continuation of Benefits Pending Fair Hearing Determinations 7.4.5

ALL	Under certain circumstances, if a recipient requests a fair hearing within specified time frames; adverse actions cannot become effective pending the outcome of the appeal. The SSR shall not permit the adverse action to become effective if the following criteria are met:
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- the recipient requests the fair hearing before the effective date of the adverse action or within 15 days of the postmark date on the notice of adverse action, whichever is later; and
- in the case of FS (but not Medicaid), the certification period has not expired.

Benefits shall be continued at the previous level unless the recipient specifically waives continuation of benefits. The SSR shall implement the adverse action, only if a recipient requests in writing that the adverse action be allowed to take effect pending the outcome of the appeal. If the department's action is upheld by the hearing decision, any benefits paid to the recipient to which he was not entitled must be recovered (see Chapter 6: Overpayment and Underpayment in this Part.)

Example 1

Ms. James and her two children receive Medicaid. On November 22, she is sent a notice of adverse action indicating that her Medicaid benefits will be terminated effective January 1 because she has moved from DC. On December 23, Ms. James contacts the SSR and requests a fair hearing. Ms. James's MA certification period expires March 1. Ms. James's Medicaid cannot be terminated pending the outcome of the fair hearing.

Example 2

Mr. Hamilton receives FS. On October 3, he is sent a notice indicating that his FS benefits will be terminated effective November 1 for failing to comply with FSET requirements. Mr. Hamilton contacts the SSR on November 10 and requests a fair hearing. Mr. Hamilton is entitled to a fair hearing, but he will not continue to receive FS benefits pending the outcome of the appeal because the effective date of the action has passed.

ESA may reduce or terminate benefits while a fair hearing is pending if:

- a mass change occurs that affects the group's eligibility or level of benefits, or
- a change is reported by the group or discovered by ESA that affects the group's eligibility or level of benefits and is unrelated to the original hearing request and the group fails to request a hearing after a timely and adequate adverse action notice is sent because of the change.

Example

Mr. Logan requests a hearing after being notified that his TANF check will be reduced because he failed to cooperate with CSED. His TANF benefits are continued at the original level, because he does not agree to a reduction pending the hearing. While his hearing is pending, the SSR receives a request to sanction Mr. Logan for nonparticipation in work activities. The SSR sends an adverse action

	notice to Mr. Logan, telling him that his TANF grant will be reduced if he does not comply with work activity requirements. If Mr. Logan does not comply and does not request a fair hearing to protest the work activity sanction, the SSR should impose the work activity sanction and reduce Mr. Logan's TANF benefits.
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Conducting a Hearing 7.4.6

ALL	Hearings shall be conducted by an ALJ who is assigned to the Office of Administrative Hearings. All hearings shall be conducted in accordance with federal and District rules and regulations of the applicable program and the regulations and procedures of OAH. In addition, DHS shall not be represented by an attorney at any hearing in which the applicant/recipient is not represented by an attorney.
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Rights of the Applicant/Recipient During the Hearing 7.4.7

ALL	<p>The applicant/recipient or her representative must be given adequate opportunity to:</p> <ul style="list-style-type: none"> • examine all documents and records to be used at the hearing at a reasonable time before the date of the hearing as well as during the hearing (This includes the application/recertification form and documents of verification used to determine ineligibility or benefit level, provided that confidential information is not released. Confidential materials withheld from the applicant/recipient may not be used for the hearing.); • present the case or have it presented by a legal counsel or other representative; • bring witnesses; • advance arguments without undue interference; • question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses; and • submit evidence to establish all pertinent facts and circumstances in the case.
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Hearing Decisions 7.4.8

ALL	<p>A record of the hearing and recommendation(s) for final decision will be provided to the Director of the Department by the hearing officer. Recommendations of the hearing officer will comply with federal law and regulations and will be based on the record. The hearing officer's written findings, conclusions, and recommendations will be transmitted to the applicant/recipient or the representative with an explanation that the decision or determination has been submitted simultaneously to the Director of the Department. The package sent to the applicant/recipient will explain that the decision of the fair hearing officer is a recommendation and does not constitute the final decision of DHS.</p> <p>If the hearing officer recommends that the action of the department be sustained, the applicant/recipient will be notified that he has 10 days to present newly discovered evidence for review by the hearing officer.</p> <p>The OFH will monitor implementation of all final decisions. The Administrator for the ESA will implement all final hearing decisions.</p>
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PROCESSING CUSTOMER COMPLAINTS 7.5

MA	Individuals having complaints about DHS procedures or staff can contact the Customer Service line, a supervisor, center manager, or the Administrator or Deputy Administrator of ESA. Any of these entities or individuals should gather all of the information about the complaint from the
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	applicant/recipient and contact the appropriate ESA staff to resolve the issue. Resolving the issue could include ensuring that all appropriate actions were taken with respect to the applicant/recipient's benefits and discussing the complaint with the applicant/recipient and/or the ESA personnel involved. If an ESA staff member acted improperly, the Department may take disciplinary action against the employee.
TANF	See MA.
GC	See MA.
FS	<p>OARA is responsible for handling FS program complaints filed by applicants, recipients or other concerned individuals or groups. Complaints involving such areas as processing standards and service to applicants/recipients will be reviewed and resolved within the complaint process. Complaints involving legal or policy issues will be referred to the OFH. The FS complaint system augments but does not supplant the fair hearings system. Any complaint alleging discrimination on the basis of race, age, sex, religion, disability, color, national origin or political beliefs will be forwarded to the OIC.</p> <p>The purpose of the complaint system is to improve service by reviewing all complaints, recommending corrective action where warranted, recording and analyzing the nature and types of complaints, and achieving an informal solution to case processing and service complaints.</p>

FEDERAL REPORTING REQUIREMENTS FOR COMPLAINTS 7.6

MA	N/A
TANF	N/A
GC	N/A
FS	<p>Federal FS regulations mandate that the department maintain records of complaints received and their disposition and review records at least annually to determine whether any pattern of problems exists in local offices. The results of this review will be provided to the General Counsel and the Administrator of the ESA for appropriate action and for inclusion in the State Corrective Action Plan.</p> <p>The information provided to the General Counsel and Administrator will include the identification of any potential or actual patterns of deficiencies and the causes of these problems.</p> <p>In light of the federal reporting requirements, OARA:</p> <ul style="list-style-type: none"> • maintains a computerized ledger of all complaints with the date, the service center where the complaint arose, and the SSR or staff member interacting with the applicant/recipient at the time in question; • codes all complaints so that a determination may be made as to the most frequently occurring issues; • prepares a monthly report of the findings pertaining to program complaints including, at a minimum, the nature or categories of complaints, origination of complaints, and the SSRs and center managers involved; • analyzes the monthly report to determine if patterns exist and transmits the analysis to the General Counsel and the Administrator; and • develops an annual statistical report which includes an analysis of the monthly reports and any overall impressions derived from discussions with staff, program participants, and other interested parties or advocates. This report will be transmitted to the General Counsel and the Administrator.

CHAPTER 8 - CASE CLOSURE

INTRODUCTION 8.1

When a finding of ineligibility has been made, assistance shall be terminated and the case closed and sent to one of the two Closed Files Unit, MA Closed File Unit or the TANF/GC/FS Closed File Unit.

EFFECTIVE DATE CASE CLOSURE 8.2

ALL	In nearly all cases, a case cannot be closed until the customer has received adequate and timely notice. To be 'timely,' the notice must be sent at least 15 days prior to the effective date of the case closure. For more information on notice requirements and exceptions to notice requirements, see Chapter 10: Notice of Adverse Actions in this Part.
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RETAINED CASE RECORDS 8.3

ALL	The Department will retain all records and documents related to the case for three years from the date of closure.
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CASE CLOSURE CANCELLATION 8.4

ALL	<p>The closing of a case may be canceled when:</p> <ul style="list-style-type: none">• a case was closed (within the month) in error because the basis for the closing was not in accordance with Department policy and the applicant/recipient is in fact eligible for assistance, or• an unanticipated change in the applicant/recipient's situation occurs within the month of closing which reestablished eligibility and assistance must be continued.
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CHAPTER 9 - FOOD STAMP CASE CHANGES

INTRODUCTION 9.1

The District or Federal government may initiate certain changes which may affect the entire or a significant portion of the caseload of households receiving FS benefits. This chapter addresses special rules that are applied when a change is made that:

- simultaneously affects the entire caseload;
- affects a significant portion of the caseload; or
- Involves conducting individual desk reviews in place of a mass change.

Mass change to the caseload is defined as changes that affect the eligibility requirements, amount of benefits, deductions, standards, etc., which may result in an increase or decrease of FS benefits to the entire caseload or a significant portion of the caseload.

Depending on the type of mass change, the District will provide different types of notification to the entire caseload or the affected households. In certain situations, the District will publicize the mass change through the news media, posters in ESA service centers, issuance locations or other sites frequented by certified households. In other situations, the District will mail a general notice to the households. In some situations, the District must mail an individual Notice of Adverse Action to each household affected by the change.

LEGAL AUTHORITY 9.2

AREA/TOPIC	DISTRICT	FEDERAL
Case Changes	D.C. Official Code §§4-205.05a; 4-210.01, <i>et seq.</i> ; 4-204.07, <i>et seq.</i>	FS: 7 C.F.R. §§ 273.12, 273.13, 272.12, 273.2

MASS CHANGES 9.3

The District or Federal government may initiate changes to the entire or a significant portion of the caseload of households receiving benefits. These mass changes include, but are not limited to:

- income eligibility standards;
- shelter and dependent care deductions;
- maximum FS allotments (the Thrifty Food Plan);
- standard deductions;
- utility Standards (annual and seasonal adjustments);
- periodic Cost-of-Living Adjustments (COLAs) to Old Age, Survivors and Disability (OASDI), Supplemental Security Income (SSI), Veteran's Benefits and other Federal benefits;
- periodic adjustments in payment levels in Temporary Assistance for Needy Families (TANF) and General Assistance Programs such as Interim Disability Assistance (IDA) and General Assistance for Children (GAC); and
- legislative or regulatory changes to the FS eligibility and/or benefit criteria

FEDERAL FOOD STAMP CHANGES 9.4

The Federal government may periodically make adjustments to eligibility standards, allotments, and certain deductions. Annual adjustments to the following: income eligibility standards, maximum allotments,

standard deduction, shelter deduction and dependent care deduction, shall apply to all households and take effect prospectively at a specific time designated by the Food and Nutrition Service (FNS). These adjustments are usually made effective October 1.

NOTICE REQUIREMENTS FOR FEDERAL GOVERNMENT INITIATED FOOD STAMP MASS CHANGES 9.5

When the Federal government initiates mass changes to the income eligibility standards, standard deductions, shelter deduction, dependent care deduction or maximum Food Stamp allotments, ESA may issue a general notice to all certified households or publicize the mass change through methods of mass publication, such as news media, posters in ESA service centers, issuance locations or other sites frequented by certified households. ESA will provide notification of these federal adjustments through mass publication after FNS releases its annual update. Although ESA is not required to issue a general notice to participating households, it may choose to send a general notice when mass changes are made outside of the normal time periods.

When the Federal government initiates mass changes such as periodic COLAs in OASDI, SSI, Veteran Benefits and other Federal benefits, ESA shall issue an individual Notice of Adverse Action to the specific households that will be affected by the mass change (see Part VIII, Chapter 10, Notice of Adverse Action).

DISTRICT GOVERNMENT INITIATED FOOD STAMP MASS CHANGES 9.6

The District government makes annual adjustments which incorporate seasonal changes to the utility standards. This annual adjustment shall take effect in the month of October or as specified by ESA. This annual or time specified adjustment shall be made for all certified households.

NOTICE REQUIREMENT FOR DISTRICT GOVERNMENT INITIATED FOOD STAMP MASS CHANGES 9.7

Changes in Utility Standards

When the District government initiates annual adjustments to the utility standards, ESA shall issue a general public notification, which may be publicized by news media, posters in ESA service centers, issuance locations or other sites frequented by certified households.

Changes in Public Assistance Benefits

When the District government initiates a mass change to TANF, IDA and GAC benefits, ESA shall issue a general notice to all households on the Food Stamp caseload receiving the TANF, IDA, or GAC benefits who will be affected by the mass change(s).

Example

The District enacts legislation to increase TANF full payment levels. Because the income of all TANF recipients will increase and Food Stamps counts TANF benefits when calculating the Food Stamp allotment, most TANF recipients that also get food stamps will receive reduced Food Stamp benefits. ESA sends TANF customers a general notice telling them about the increase in TANF benefits. In the notice it also tells them that because their income is increasing they should expect that their Food Stamp benefits will decrease.

Other District-Initiated Changes

In instances where ESA adopts a new FS policy that adversely affects some FS households, the affected household shall be notified by a general notice.

Example

The District adopts a policy to require that all Food Stamp households use a mandatory utility allowance. Under this policy, Food Stamps recipients will no longer be able to claim actual utility costs. The District plans to make a mass change that will convert the current utility expenses to the new utility standards. Because of this change, some Food Stamp households will receive more in food stamps and others will receive less. ESA must send a general notice to all Food Stamp household notifying them of the expected change in their benefits.

NOTICE REQUIREMENT OF DESK REVIEWS COMPLETED IN PLACE OF A MASS CHANGE 9.8

If ESA chooses to complete an individual desk review of cases that are subject to a mass change, it must, at a minimum, send a general notice describing the change to each of the affected households. If a general notice is not sent, the household must be sent an individual notice of adverse action instead.

REQUIREMENTS OF A GENERAL NOTICE 9.9

A general notice shall at a minimum include the following information:

- the general nature of the change;
- examples of the change's effect on the households' FS allotments;
- the month in which the change will take effect;
- the households' rights to a fair hearing;
- the households' right to continue FS benefits, if any, and under what circumstances FS benefits will be continued pending a fair hearing;
- general information on whom to contact for additional information; and
- the liability the household will incur for any over-issued FS benefits if the fair hearing decision is adverse.

At a minimum, ESA must notify the household by the date the household is scheduled to receive the allotment that has been changed. ESA shall notify the household as much before the household's scheduled issuance date as reasonably possible, although the notice need not be given any earlier than the time required for advance notice of adverse action.

RIGHT TO A FAIR HEARING AND CONTINUED BENEFITS 9.10

The household shall be entitled to request a fair hearing when it is aggrieved due to the mass change. The household shall also be entitled to continued FS benefits if the household meets the three (3) criteria below:

1. The household requests a fair hearing;
2. The household does not specifically waive its right to a continuation of benefits; and
3. The households' fair hearing is based upon improper computation of food stamp eligibility or benefits, or upon misapplication or misinterpretation of Federal law or regulation.

Example

Mary Minor requests a Fair Hearing and continuation benefits when her FS benefits are reduced because of a federally mandated reduction in the maximum FS allotments. Ms. Minor is not allowed to continue getting FS benefits at her previous level, because the reduction is not due to improper computation of her benefit amount nor misapplication of Federal rules.

CHAPTER 10 - NOTICE OF ADVERSE ACTION

INTRODUCTION 10.1

ALL	<p>Before taking any adverse action that reduces or terminates assistance to a recipient, the SSR will send the recipient a written notice that describes the action to be taken (including the amount of any benefit reduction), the reason for the reduction or termination, the effective date of the action, and the right to a hearing to contest the action (see Chapter 7: Grievances and Fair Hearings in this Part).</p> <p>All notices to applicants/recipients must be in writing and contain the following information:</p> <ul style="list-style-type: none">• action to be taken,• reason for the action,• effective date of the action, and• right to appeal or request a fair hearing. <p>In most cases, ACEDS will produce a standard notice. Some circumstances require the SSR to customize the standard notice.</p> <p>There is one exception to the requirement that the Department issue a notice of adverse action, even though the change(s) results in a reduction in benefits. When the federal government mandates a mass change be made in certain FS program parameters, no notice of adverse action is required except in cases in which all benefits will be terminated. The Department can choose to issue such a notice (see Section 9.5: Notice Requirements for Federal Government Initiated Food Stamp Mass Changes in this Part)</p>
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LEGAL AUTHORITY 10.2

AREA/TOPIC	DISTRICT	FEDERAL
Notice of Adverse Action	ALL: D.C. Code 205.55	MA: 42 CFR 431.206-.214, 435.919FS: 7 CFR 273.13

TIME STANDARD FOR ISSUANCE OF NOTICE OF ADVERSE ACTION 10.3

ALL	Except as noted below in Section 10.5: Exceptions to Timeliness Requirements in this Chapter, Department adverse action notifications must be adequate and timely. A notice meets the timeliness standard if it is issued 15 days before the effective date of action.
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NOTICE OF CHANGE IN BENEFITS 10.4

ALL	<p>If the household's benefit level decreases or the household becomes ineligible as a result of the change, the SSR will issue the appropriate notice of adverse action within ten days of the date the change was reported.</p> <p>If there are 15 days between the date the notice is mailed and the end of the month, the change must be made effective in the month following the month in which the notice was issued. If there are not 15 days between the date the notice was mailed and the end of the month, the change must be made effective in the second month following the month the notice was sent.</p> <p>For a discussion of the exceptions to the 15-day timeliness requirement for adverse actions, see Section 10.5: Exceptions to Timeliness Requirement in this Chapter.</p>
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	Example 1
	Ms. Manning is receiving TANF benefits for herself and daughter Phoebe who has gone to live with her father in Georgia. On July 7, Ms Manning contacts her assigned SSR to inform her that Phoebe has not resided with her since the first of the month. The SSR should send a notice of adverse action on July 8th, informing Ms. Manning that the TANF grant will be terminated effective August 1st.
	Example 2
	On August 25, the SSR is informed that Mr. Larde, who receives FS in a one-person group, failed to comply with FSET requirements. On August 26, the SSR issues a FS termination notice. Because there are not 15 days between the date the notice was issued and September 1st, the termination is effective October 1st.

EXCEPTIONS TO TIMELINESS REQUIREMENT 10.5

ALL	The following are the only circumstances under which timely notice does not have to be provided (note that under these circumstances, adequate notice must be provided): <ul style="list-style-type: none"> the agency has factual information confirming the death of the recipient. In the case of TANF, this exception to notice only occurs when no other relative can serve as the payee; the recipient requests - in writing - that his/her case be closed; or the recipient has been accepted for assistance in another jurisdiction and that fact has been established by the Department.
MA	N/A
TANF	In addition, when a reduction or termination of benefits is required based on information submitted on a TANF quarterly report, the timeliness standard does not apply. An adequate notice must be sent in this circumstance. While the notice does not have to be sent 15 days prior to the effective date of the action, it must be sent such that it is received by the customer prior to or on the effective date of the action.
GC	N/A
FS	See TANF. Also, when an individual is disqualified based on a finding of IPV, an adequate notice must be sent prior to the effective date of the termination, but the 15-day standard does not apply.

NOTICES OF RETURNED BY MAIL 10.6

ALL	If the Department mail any form of communication to a recipient and the correspondence is returned indicating that the applicant/recipient's whereabouts are unknown ('Return to Sender'), the SSR will send a notice indicating that all benefits will be terminated. The notice must be issued even if it is likely it too will be 'Returned to Sender.' The 15-day timeliness standard must be adhered to in these cases as well.
	Example The Department sends Ms. Combs a notice to come to DHS for an appointment on August 2nd. On August 10th the letter is returned to the Department and stamped "Return to Sender." The SSR should issue a benefit termination notice. The case cannot be terminated prior to 15 days after the termination notice was sent.

CHAPTER 11 - RESTRICTING TANF PAYMENTS

INTRODUCTION 11.1

This chapter only pertains to TANF. TANF benefits are usually issued as unrestricted cash grants posted to the recipients' EBT accounts. The recipient is expected to manage his/her own affairs, exercising the same right of choice in the manner of spending as other members of the community. In situations in which the recipient has demonstrated an inability to manage funds in the best interest of the children in the group, the benefits may be restricted. The restriction may be voluntary or involuntary and benefits may be issued as rental vendor payments or protective payments.

LEGAL AUTHORITY 11.2

AREA/TOPIC	DISTRICT	FEDERAL
Restricted TANF Payment	D.C. Code 4-212.2	

PROTECTIVE PAYMENTS 11.3

A protective payment is a restricted TANF payment paid to a person other than the parent or caretaker relative who has shown interest in the welfare of the TANF children. When the need for a protective payment has been established, a protective payee must be selected. The protective payee acts for the recipient in receiving and managing the TANF benefit. In order to assign a protective payee to a case, the head of the TANF group must agree to the arrangement. IMA cannot assign a protective payee to a case without the head of the group's consent.

The protective payee may be a friend or relative of the TANF family, or a staff member of a private agency or other appropriate organization which will act on behalf of the best interest of the children. Staff of the Department or other persons whose selection might create a conflict of interest, such as landlords or other persons providing goods or services to the recipient, may not be named as protective payees.

Third parties, including individuals who have not been paid for services rendered, charitable organizations, clergy, or family members, can request that the Department assign a protective payee. A payee cannot, however, be assigned without the consent of the head of the group.

A protective payee should be responsible and dependable and exhibit an interest in and concern for the welfare of the family.

Assignment of a protective payee is voluntary; therefore selection of the payee must be made in consultation with the recipient. FSA staff may also be consulted if they are providing services to the family. The recipient must provide written consent to the assignment of the protective payee. The protective payee should sign an acknowledgment that indicates that s/he will use the family's funds in the family's best interests.

Review of Protective Payee Status 11.3.1

Continuation of the protective payee assignment must be discussed at each TANF eligibility review. Written consent of the recipient must be obtained at each review to continue the assignment.

RENTAL AND VENDOR PAYMENTS 11.4

A Rental Vendor Payment (RVP) is a restricted TANF payment made to an individual or organization providing living accommodations to a TANF recipient. The purpose of the RVP is to reduce the frequency in which TANF families face eviction or the threat of eviction by assisting recipients in meeting their monthly rent obligations.

RVPs can be made by the Department on a voluntary or involuntary basis. In both cases, the TANF benefit is split. A direct deposit is electronically issued directly to the bank account of the landlord or entity providing housing to the TANF group for the amount of the rental charge. The balance of the TANF benefit (the grant level minus the RVP) is posted to the recipient's EBT account.

Voluntary Participation 11.4.1

A discussion of a voluntary RVP agreement is generally initiated by the TANF recipient (often at the urging of the individual's landlord), but may be initiated by an SSR or FSA staff member.

When discussing the agreement with the recipient, the SSR must explain the following to the recipient:

- the purpose of the agreement is to assist the recipient in paying the rent regularly;
- the agreement will initially be in place for six months;
- the payment will be made directly to the landlord in the amount of the full rental obligation;
- the agreement is voluntary and can be terminated prior to six months;
- if the recipient chooses to terminate the agreement, s/he must provide 30 days advance notice and sign a request to withdraw from the rental vendor program;
- the recipient's benefit after payment of the rent charge must be \$10 or more;
- the execution of the agreement requires notifying the landlord of the tenant involved; and
- the agreement should not be established, if the recipient does not want the landlord to know who is paying the rent or that the family is receiving TANF.

No pressure or coercion should be applied to force an agreement. The SSR, however, should explain to the recipient that involuntary agreements may also be initiated by the Department.

If the recipient chooses to participate in the Rental Vendor Program, the SSR must complete a voluntary agreement for Direct Rental Payment. This agreement must be signed by the recipient and witnessed by a third party. The agreement is sent to the RVP unit for processing.

Involuntary Participation 11.4.2

To initiate an involuntary or mandatory RVP, a complaint must be filed by one of the following: staff of the District of Columbia Housing Authority, staff of the Office of Emergency Shelter and Support Services, FSA, private landlords, or an adult relative of the recipient. The complaint must be submitted in writing on the prescribed form and must be signed and dated by the complainant. It should include as much identifying information as possible on the TANF recipient and the family's current housing arrangement. In addition, the complaint should include:

- a description of the events which took place, including the months and years in which non-payment of rent, or late payments, occurred;
- an explanation of how rent was paid, if it was paid late. For example, if the rent was paid late and the complainant knows the rent was paid by contributions made by relatives or charitable organizations, that information should be on the complaint filed.; and

- any unusual circumstances the complainant knows about that affected the recipient's ability to pay rent.

The RVP unit is responsible for screening complaints to determine if the recipient to whom the complaint refers is a candidate for mandatory RVP. In addition, the RVP unit will complete the following tasks:

- Review the identifying information to verify that the individual referred to in the complaint receives TANF and that the TANF payment minus the full rental charge is at least \$10;
- Notify the complainant if the complaint is incomplete or does not meet the criteria for consideration under the RVP;
- Send a notice of the complaint to the recipient, and his/her SSR. The notice must inform the recipient that the complaint has been filed and that s/he has 15 days to provide a written response to the complaint, and that a mandatory RVP will be established if the recipient is found to be mismanaging the TANF grant to the detriment of the children in the family; and
- Submit to the Administrative Support Office a copy of the complaint, the notice sent to the recipient, and any correspondence from the recipient (if any) and any observations the RVP staff deem important to share about the case (these observations are recorded on Form 886).

The Administrative Officer will review the information submitted by the RVP staff and, when necessary, will attempt to gather additional information. The Administrative Officer will determine if the recipient has mismanaged the TANF grant such that the health and safety of the children in the family have been threatened.

When determining whether the funds were mismanaged all relevant considerations must be taken into account, including:

- Did the family have an emergency or extraordinary event for which it was appropriate to spend the available funds?
- Did expenses for necessary items exceed the recipient's income? If so, did the recipient make reasonable choices about the purchase of goods and services?
- Did the family withhold payment as a reasonable exercise of consumer rights when there is a legitimate dispute as to whether terms of an agreement have been met?

The following are examples of circumstances that provide evidence of the mismanagement of funds:

- repeated evictions,
- repeated failure to pay rent or utilities resulting in threat of eviction and utility cutoffs,
- improper clothing and feeding of the children which may result in frequent absences from school, and
- an inability to plan expenditures so that the funds last through the month which leads to frequent referrals to private charities.

If the need for a RVP is not affirmed, notices are sent to the recipient and complainant indicating that no RVP has been established. If the Administrative Officer determines that an RVP should be established, the RVP unit must send a notice to the recipient. The notice must record the reason the RVP is being established and advise the recipient of the right to request a fair hearing. If, after 15 days, the recipient has not requested a hearing, the RVP will be processed for the next month's TANF benefits and notice will be sent to the complainant and, if different, the landlord informing them of the decision. Individuals who are required to participate in the RVP program must do so for at least one year.

Changes in Vendor Payments 11.4.3

If a recipient participating voluntarily in the RVP program reports a change in rent amount or address, the SSR should submit the new information to the RVP unit on Form 886 with supporting documentation attached. If the recipient reports a change in landlord and still wishes to participate in the program, a new RVP agreement should be completed.

If a mandatory RVP participant reports a change in address, rent amount, or landlord, the SSR should report the change to the RVP unit on Form 886. The recipient will be required to remain in the RVP program, despite the change in address, landlord, or rent amount, except in circumstances in which the TANF grant no longer exceeds the rent charged by at least \$10. If, after one year, the mandatory participant wishes to be removed from the program, s/he must submit a withdrawal request to the RVP unit.

PART IX - SPECIAL LOCAL PROGRAMS

CHAPTER 1 – BURIAL ASSISTANCE PROGRAM

INTRODUCTION 1.1

The Burial Assistance program is designed to provide assistance in paying for burial costs for individuals who die with very few resources and who do not have families who can afford burial costs. The Burial Assistance program has been allocated limited funding and, therefore, will operate on a first-come, first-served basis until available funding has been exhausted.

All applications for Burial Assistance are processed by the Burial Unit at the 645 H Street Service Center.

LEGAL AUTHORITY 1.2

AREA/TOPIC	DISTRICT	FEDERAL
Burial Assistance	D.C. Act 13-180; D.C. Act 13-263, 29 DCMR 2600-2699	

ASSISTANCE PROVIDED 1.3

Family members who apply for burial assistance on behalf of a deceased person will receive \$800 toward the cost of burial or \$450 toward the cost of cremation services. This assistance can be used to help pay for a cemetery plot and/or other burial-related costs. This program will only provide assistance in paying for burial-related costs if the burial is handled through one of the funeral homes under contract with the District to participate in this program and the funeral takes place within the Washington Metropolitan area. All payments are made directly to the funeral home. In addition, the total cost of the funeral, including the family contributions, cannot exceed \$2,000 (not including the cost of opening and closing the grave), except in the case of a deceased person who requires an oversized casket. The total cost of the burial for a deceased person who requires an oversized casket shall not exceed \$3,000.

PROGRAM ELIGIBILITY 1.4

The deceased person must have been a District resident immediately prior to his or her death. In addition, his/her countable resources, when combined with those of any financially responsible relative, must be less than \$800.

District residents, who *had* a prepaid funeral plan, or for whom a pre-paid funeral plan is held, are not eligible for assistance.

District Residency 1.4.1

For the purposes of this program, a resident of the District of Columbia is a person who was living voluntarily and not for a temporary purpose within the District. It includes the following:

- someone who maintained a home in the District as his/her principal residence;
- a District of Columbia resident residing in an institution outside the District, including, but not limited to, a hospital or nursing facility, and he or she retains a home or his or her spouse or parent maintains residence in the District;
- a person, including prisoners, that a District agency placed in an institution located in another state;
- a migrant worker who lived in the District; or
- someone who was homeless, physically present in the District, and not a resident of another state.

Citizenship/Immigration Criteria 1.4.2

There are no immigrant-related restrictions for this program; thus, SSRs should not inquire about the deceased's immigration status, the immigration status of the relative submitting the application, or the immigration status of the legally responsible relatives.

Determining Financial Eligibility 1.4.3

The assets of the deceased and his/her financially responsible relatives should be considered when determining financial eligibility. The financially responsible relatives are:

- the spouse of the deceased, if they were residing together at the time of death; and
- the parents of the deceased, if the deceased was a minor child.

Countable assets shall include:

- financial accounts (savings and checking) of the deceased and his/her financially responsible relatives;
- life insurance benefits already received by any financially responsible relatives;
- cash available from the deceased and his/her legally responsible relative; and
- the net monthly earned and unearned income of the deceased person and his/her financially responsible relatives that was received during the thirty (30) day days preceding the application for burial assistance, less the Medicaid Medically Needy Income Level, based on the household's size.

When the financially responsible relative is the parent(s) of the deceased, the household size includes the deceased, his/her parent(s), the minor children of the parent(s), and any other dependents of the parent(s). When the financially responsible relative is the spouse of the deceased, the household size includes the deceased, his/her spouse, the minor children of the spouse, and any other dependents of the spouse.

Example 1

John and Jane Smith are husband and wife who live together. They have no children. John dies on 3/24/04. John was not working at the time of his death. Jane is employed and her net monthly income is \$2000.00.

\$2000.00 - Monthly net income received in 30 days preceding death.

- 520.42 - Medically needy income level for h/h of 2

= \$1479.58 - Countable Assets

Because the countable assets of Mr. & Mrs. Smith are more than \$800, Burial Assistance will be denied.

Example 2

Thomas Jenkins, 17, was living with his mother Mary. Mary Jenkins has 3 surviving minor children and 2 adult children who reside with her. Mary receives \$1000.00 monthly from unemployment benefits and one of her adult children receives net income of \$3000.00 per month. Since Thomas's adult siblings are not financially responsible relatives, their income and needs are not considered when determining

Thomas' eligibility. The household will consist of Mary, Thomas and Mary's three remaining minor children.

\$1000.00 - Mary's net income received in 30 days preceding death.

_ - 917.92 - Medically needy income level for h/h of 5

\$82.08 - Countable Assets

Because the countable assets of Ms. Jenkins are less than \$800, she is eligible for Burial Assistance for Thomas.

The following types of income and assets are not considered:

- individual retirement accounts;
- life insurance policies other than benefits already received by a financially responsible relative due to the death of the applicant;
- trust funds, when not available to the deceased person or his/her financially responsible relative prior to the funeral;
- vehicles;
- real property; or
- any other asset not immediately accessible prior to the funeral.

PROCESSING APPLICATIONS 1.5

Who May Apply 1.5.1

An applicant for burial assistance must be a relative of the deceased, or a person authorized to act on behalf of the relative of the deceased. IMA would prefer the relative applying be the next-of-kin such as a spouse or a parent if the deceased was a minor child. If the deceased was neither married nor a minor child, the next-of-kin would include parents or siblings. A relative other than the next-of-kin is permitted to apply; however, that relative must have information about the circumstances of the deceased's spouse (if married) or parent (if a minor child) and must have authority to make funeral arrangements on behalf of the deceased.

An authorized representative must be at least eighteen (18) years of age and have sufficient knowledge of the circumstances of the death to provide the required information, or be a person with legal authorization to act on behalf of the applicant. In addition an authorized representative must provide a written statement from the applicant naming him/her as the authorized representative and stating why the applicant cannot attend an interview in person.

The application must be submitted prior to the release of the body to a funeral home, unless the funeral home is under contract to provide Burial Assistance services. If the body of the deceased person is released to a contractual funeral home, the application must be filed prior to receipt of burial or cremation services.

Application Form 1.5.2

To apply, the relative, or his/her authorized representative, must fill out the Burial Assistance Application form. This form requires information about the financial circumstances of the deceased and financially responsible relatives of the deceased — namely, spouses and, in the case of minor children, parents.

Application Interview 1.5.3

In order to process applications as quickly as possible, each applicant shall be interviewed on the date burial assistance is requested or, if that is not possible, on the following business day. The SSR shall provide the applicant with a written request specifying the information needed to complete the application and discuss how to obtain the needed information. The SSR shall not request documentation that they can obtain more easily than the person applying for burial assistance. This would include information available through agency records, ACEDS interfaces, or collateral contacts with organizations that typically share information with IMA.

The application may not be denied if the applicant is attempting to obtain and furnish the required information, and has informed IMA accordingly. The application is considered complete when all requested information has been furnished.

Time Standard 1.5.4

An eligibility determination must be made within 3 days of receipt of all information. The day on which all information is received counts as the 1st day. (That is, if the SSR has all the needed information on a Monday, the eligibility determination must be made and a notice of denial or approval issued by Wednesday.) If possible, the SSR should attempt to make an eligibility determination when the relative submitting the application provides the final information so that the relative does not have to return to the Service Center to get the forms s/he will need to access the assistance with an undertaker under contract with DHS.

Relatives submitting an application should be encouraged to leave a phone number with the SSR and the SSR should attempt to call the relative when an eligibility determination has been made so the relative does not have to wait until the notice arrives in the mail.

SSRs should make every effort to accommodate families, including expediting cases in which the family is attempting to hold the funeral in less than two days from the date of application.

If all required information has not been submitted within 14 days of the date of application, the application should be considered abandoned and the SSR should send a denial notice to the relative submitting the application.

Notices 1.5.5

A notice of approval or denial must be issued for each application for Burial Assistance. The Authorization for Burial Assistance (see Section 1.5.5: Approved Applications in this Chapter) serves as the application approval notice.

Approved Applications 1.5.6

When an application is approved, the *Authorization for Burial Assistance* form must be completed. This form documents the funeral home selected by the customer and serves as a "receipt" for the customer to take to the funeral home. The original form must be given to the recipient, a copy kept in the case file, a copy faxed to the selected funeral home, and a copy forwarded from the Burial Unit to the agency's Chief Financial Officer who will provide payment to the funeral home.

Denied Applications 1.5.7

IMA must give each applicant whose application has been denied a clear, concise written statement of the reasons for the denial within three (3) business days of the denial. Each written notice should also inform the applicant of the right to an administrative review and fair hearing to contest the denial, and the steps the applicant may take to seek review.

APPEALS 1.6

Each applicant has the right to appeal a denial of burial or cremation assistance. The applicant may request a fair hearing either orally or in written form. This request must be accepted by any staff person within ESA.

Except as indicated below, the hearing process outlined in Part VIII: Chapter 7, Case Maintenance: Grievances and Fair Hearings should be used.

The applicant shall have ten (10) calendar days from the date of the denial notice to file an appeal. An administrative review shall be held, unless waived by the applicant, as soon as possible but no later than ten (10) business days following the request for a hearing.

ESA shall not be represented by an attorney at the hearing or administrative review, unless the applicant is represented by an attorney.

ESA shall take all reasonable steps to hold a hearing, make a final decision, and where the decision is to grant benefits, provide burial assistance in a timely manner. In cases where a decision favoring the applicant is made, payment must be issued within thirty business days of completion of the administrative review or hearing.

VERIFICATION 1.7

The SSR should verify the following information:

- the identity of the deceased;
- the address of the deceased;
- resources of the deceased;
- net earned and unearned income of the deceased;
- net income and resources of the relative(s) that are financially responsible;
- household composition, when questionable; and
- the cost of the funeral.

No information already entered in ACEDS needs to be verified further. Thus, if the deceased was a current recipient of TANF, SSI, FS, GS, or MA and information about his/her income and assets are in ACEDS and matches the information provided by the relative filing the application, further verification of the deceased's financial circumstances should not be requested. Similarly, if the financially responsible relative (spouse or parent) is a current recipient of TANF, SSI, GS, FS, or MA, information already in ACEDS should not be verified.

In some circumstances, relatives may have difficulty providing needed verification. In these cases, verification requirements can be waived if the information provided by the relative filing the application does not appear questionable.

CHAPTER 2 - INTERIM DISABILITY ASSISTANCE PROGRAM

INTRODUCTION 2.1

The Interim Disability Assistance (IDA) program is designed to provide temporary financial assistance to disabled adults who are ineligible for TANF and who have applied for and are awaiting approval of Supplemental Security Income (SSI). Approval of IDA is contingent on the availability of funds. If funds are exhausted at the time the customer is determined to meet all eligibility requirements, the customer will be placed on a waiting list, and approved when funds become available. Applications for Interim Disability Assistance are processed by IDA staff at designated ESA centers.

LEGAL AUTHORITY 2.2

AREA/TOPIC	DISTRICT	FEDERAL
Interim Disability Assistance	DC Act 13-539; Fiscal Year 2002 Budget Support Act of 2001	

CASE MANAGEMENT 2.3

IDA households may be assigned a disability advocate to assist them in the process of qualifying for SSI. The advocate assists the household in acquiring and providing information to process the SSI claim, setting up necessary appointments, tracking the progress of the claim, and representing the household throughout the appeals process. Customers will have access to case management services provided under contract to ESA.

DETERMINING NON-FINANCIAL ELIGIBILITY 2.4

Unless otherwise indicated, non-financial eligibility requirements for IDA correspond to those of SR Medicaid (see Part IV, Non-financial Eligibility). Non-financial eligibility requirements must be verified.

Assistance Unit 2.4.1

A person eligible for Interim Disability Assistance must be:

- between ages 18 and 65;
- ineligible for TANF because no eligible child lives in the home;
- permanently and totally disabled;
- awaiting a decision on eligibility for Supplemental Security Income; and
- ineligible for a category of cash assistance in which there is federal financial participation, except that an individual who has applied for SSI or Social Security Disability Insurance (SSDI) may be eligible during the period that the SSI or SSDI application is being processed.

The only mandatory group member is a spouse, who also lives in the home and meets all eligibility criteria. An IDA household cannot include an essential person or optional group member.

Residency 2.4.2

To be eligible for program benefits, a person must be a resident of the District of Columbia. See Part IV: Chapter 2, Non-Financial Eligibility Requirements: Residency, for additional information on establishing and verifying residency eligibility. Residency standards are intended to be consistent with those of the SSI program. As such, residents of public institutions are not eligible for IDA benefits. Residents of private institutions that provide mental health or substance abuse services in many cases may not be eligible for IDA benefits. A person who lives in a Community Residential Facility (CRF) located within the District of Columbia meets residency requirements.

An applicant who abandons residency in the District during the processing of his/her application must report this immediately and becomes ineligible for IDA. IDA recipients must report abandonment of residency within 10 days. Recipients must be sent adequate and timely notice prior to termination of their benefits because of loss of District residency, unless they request in writing immediate case closure.

Social Security Number 2.4.3

The applicant/recipient must furnish a Social Security Number (SSN) for each member of the group or apply for a number and furnish the number when it is received from the Social Security Administration. See Part IV: Chapter 3, Non-Financial Eligibility Requirements: Social Security Number, for additional information on provision and verification of SSNs.

Citizenship/Alienage 2.4.4

To be approved for program benefits, a person must be a U. S. citizen, or an alien who meets the alien eligibility requirements for SSI under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. See Part IV: Chapter 7, Non-Financial Eligibility Requirements: Citizenship/Alienage, for additional information on determining when non-citizens can receive benefits.

Disability 2.4.5

To qualify for program benefits, the Medical Review Team (MRT) must find that the person is permanently and totally disabled, based on the criteria used by the Social Security Administration in determining eligibility for SSI. A person is considered disabled under the guidelines of the SSI program when:

- She/he has a medically determined physical or mental impairment;
- His/her impairment prevents him/her from engaging in any substantial gainful employment; and
- His/her impairment
 - can be expected to result in imminent death,
 - has lasted at least 12 consecutive months, or
 - is expected to last at least 12 consecutive months.

IDA applicants and recipients must provide a current medical report from a certified medical professional, or authorize release of current medical information, in order to make the disability determination. Whenever possible a Social Information form should also be completed. IMA may request additional medical information, when necessary to determine eligibility or to establish the eligibility period. See Part IV: Chapter 9, Non-Financial Eligibility Requirements, Disability/Blindness for additional information on determining disability.

If an applicant for IDA has previously been determined by SSA as not meeting the disability requirements of SSI, the applicant may resubmit medical information. The applicant will be ineligible however, unless s/he:

- claims to have a disabling condition different from, or in addition to, that considered by SSA in making its determination;
- alleges more than 12 months after that most recent SSA determination denying disability, that his/her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Social Security Act (comprising or expecting to comprise twelve months or more), and has not applied to SSA for a determination with respect to these conditions; or
- alleges less than 12 months after the most recent SSA determination denying disability, that his/her condition has changed or deteriorated since that SSA determination, alleges a new

period of disability that meets the durational requirements of the Social Security Act, and has applied to SSA for reconsideration or reopening of its decision.

Application for Supplemental Security Income 2.4.6

Applicants for IDA must also apply for Supplemental Security Income (SSI) and provide proof of the date of the SSI application. IDA must be terminated when SSA makes a final decision on the IDA recipient's SSI eligibility. If SSA denies the initial SSI claim and the IDA recipient files a timely appeal, benefits will be continued until the appeals process is exhausted.

Reimbursement for IDA Payments 2.4.7

Applicants for IDA must sign a DHS 340, Authorization for Reimbursement of Interim Assistance, agreeing to reimburse IMA for the cost of their IDA payments. The reimbursements will be deducted from their retroactive SSI benefit payment. No reimbursement is required for any month for which SSI is not approved. The IDA recipient will repay the entire amount of the IDA assistance payments received if the SSI benefits received for the same period equals or exceeds the IDA payments. If the SSI benefits are less than the IDA payments for the same period the SSI benefits were received, the recipient will repay that portion of the IDA payments that equals the amount of SSI benefits.

Cooperation in Case Management 2.4.8

Recipients of IDA must cooperate in case management services.

This includes:

- providing materials needed to pursue the SSI application, including medical reports,
- keeping appointments with medical providers,
- keeping appointments with his/her disability advocate,
- keeping appointments with SSA and its representatives, and
- participating in treatment programs, as required.

Failure to cooperate with the disability advocate/case manager may result in termination of IDA benefits, unless a good cause reason can be established for non-cooperation. Good cause for non-cooperation with case management includes circumstances that are beyond the recipient's control, such as, but not limited to the following:

- personal illness,
- illness of another household member requiring the presence or care of the recipient, and
- a household emergency such as a death in the family.

DETERMINING FINANCIAL ELIGIBILITY 2.5

Applicants and recipients of IDA must meet income and asset limits. Financial eligibility must be verified.

Benefit Amount 2.5.1

IDA payment levels match those for a TANF household of the same size.

Group Size	Payment Level (effective October 1, 2007)
1	\$270
2	\$336

Income Limits 2.5.2

There is no gross income limit for the household. The household's net income must be at least \$10 less than the TANF payment level for a family of the same size.

Example

Mrs. Jackson's net income is \$262. Since the TANF benefit amount for one person is \$270, Mrs. Jackson's net income is only \$8 less than the corresponding TANF grant ($\$270 - \$262 = \$8$). Mrs. Jackson is over income for IDA benefits.

Single Applicant/Recipient or Disabled Married Couple

No earned income or unearned income deductions are allowed, when calculating a household's countable income. Income is deducted dollar-for-dollar from the payment level to determine the household's financial eligibility and benefit amount.

Applicant/Recipient with Non-Disabled Spouse

The income of the applicant/recipient is counted dollar-for-dollar like that of a single person or disabled couple.

The income of a spouse who lives with the applicant/recipient and is not included in the IDA household must be deemed using the following formula:

Total income of non-IDA spouse minus TANF payment level for one person equals net income deemed to IDA household.

Example 1

Ms. Campbell is single. She earns \$150 a month babysitting for her daughter, and gets \$60 in countable contributions. Her net countable income is \$210. Ms. Campbell is eligible for a \$60 IDA payment.

Gross Earned Income	= \$150	IDA Payment Level	= \$270
Gross Unearned Income	= \$60	- Net Income	-\$210
		IDA Benefit	= \$60
Net Countable Income	= \$150		
	+ \$60		
	= \$210		

Example 2

Mrs. Hawkins is married and lives with her husband, who is not disabled, and is not included in the IDA household. Mrs. Hawkins has no income. Mr. Hawkins does odd jobs and earns an average of \$400 a month. Mrs. Hawkins' net countable income is \$130. Mrs. Hawkins is eligible for an IDA benefit of \$140

Gross Earned Income	= \$0	IDA Payment Level	= \$270
Gross Unearned	= \$0	- Net Income	-\$130
		IDA Benefit	= \$140
Deemed Income	= \$400		
	- \$270		
	= \$130		

Income Types 2.5.4

Unless otherwise indicated all income types countable toward SR Medicaid that are listed in Part VI: Chapter 4, Financial Eligibility Requirements, Determining Countable Income, should be used to determine IDA benefits also. In addition, SSI presumptive payments must be counted. In-kind benefits are excluded when determining IDA eligibility.

Form of Payment 2.5.5

IDA benefits will be issued through electronic benefit transfer (EBT) accounts. Rental vendor payments cannot be deducted from IDA benefits.

Asset Limits 2.5.6

The household must meet the asset limits of an SR Medicaid unit of the same size.

Group Size	Limit
1	\$2,000
2	\$3,000

PROCESSING APPLICATIONS 2.6

Applications for Interim Disability Assistance must be submitted in person at designated service centers, using the Combined Application that is used to apply for multiple programs. Every applicant has the right to file an application on the same day that s/he contacts ESA. An application is considered to be filed when it is received at the designated IMA service center and a face-to-face interview is completed. If a customer reports that s/he is unable to complete an in-person interview because of his/her disability and there is no one who can act as his/her authorized representative, ESA must complete a home visit to allow the customer an opportunity to participate. Unless otherwise stated, applications for IDA are processed in accordance with policies established for SR Medicaid in *Part III: Chapter 1, Application Processing: Filing an Application*.

Who May File the Application 2.6.1

Any individual or either spouse of a married couple may file the application for IDA. The applicant may designate an authorized representative to act on his/her behalf. See Part III: Chapter 1, Application Processing: Filing an Application, for additional information on designating an authorized representative.

Applications Filed in Person 2.6.2

Applications filed in person will be processed by designated staff at selected ESA locations. If an individual who wishes to apply for IDA benefits is currently receiving or applying for other benefits at an ESA location that does not provide IDA services, the individual will be directed to apply for IDA at the appropriate IDA location.

Except as indicated below, if the individual is currently receiving or applying for other program benefits, his/her case record should be forwarded to the appropriate IDA unit within one day of notification that the customer has applied for IDA. If the originating center has all information to approve benefits for a non-IDA program, such as Food Stamps or Medicaid, non-IDA benefits must be approved prior to

forwarding the case record. The originating center must forward the case record, including the newly-approved non-IDA application, within 2 days.

Application Requests Received by Mail 2.6.3

Application requests received by mail will be forwarded, if necessary, to the appropriate ESA location, however the application will not be considered as filed until the customer or his/her authorized representative is interviewed in person. ESA will attempt to contact customers who send applications to advise them that they need to complete an in-person interview to officially file the application.

Application Review 2.6.4

A face-to-face interview with the applicant or his/her authorized representative is required for all applications for Interim Disability Assistance. During the application interview, the SSR will:

- inform the applicant of his/her rights and responsibilities;
- explain the program and related services;
- outline the conditions of eligibility and indicate what verification and information are necessary to determine eligibility;
- advise the applicant of the opportunity to register to vote;
- notify the applicant that information s/he provides will be matched by computer with information from other local, state and federal agencies;
- complete the Authorization for Reimbursement of Interim Assistance, Form 340;
- complete SSA Form 1696-U4, Appointment of Representative, authorizing an ESA designated organization, to act as the applicant's representative to SSA;
- issue medical report forms, as needed;
- complete social information form; and
- explore and resolve any unclear or incomplete information.

Application Timeframes 2.6.5

Applications for Interim Disability Assistance must be processed within 60 days, counting from the day after the application was filed. A verification checklist, listing all information or actions still needed to determine eligibility must be issued through ACEDS and given to the applicant at the time the application is filed. The checklist and the date the application was filed are essential for the timely issuance of all application notices and timely disposition of the application.

If an applicant fails to provide all necessary verification by the tenth day following the application date, ACEDS will issue a Ten-Day Notice that lists the information or actions needed to complete the eligibility determination. If the applicant still has not provided all necessary verifications by the 30th day following the application date, ACEDS will issue a 30-Day notice that also reports what is needed to complete the eligibility determination.

If by the 60th day following date of application, the applicant has not provided all verifications, ACEDS will issue a denial notice and deny the application.

It is ESA's goal to complete the eligibility determination within ten days from the date that all information necessary to determine eligibility has been submitted.

Application Approvals 2.6.6

If all financial and non-financial conditions of eligibility are met, and funds are currently available, the SSR will approve benefits.

Period of Eligibility 2.6.7

An applicant's period of eligibility for IDA benefits begins on the first of the month following the month in which the application for IDA benefits was filed, or the month following the month that his/her application for SSI was filed with SSA, whichever is later.

Example 1

Ms. Hamilton applies for IDA benefits on February 2, and brings proof that she filed for SSI on February 12. She establishes eligibility for IDA. Ms. Hamilton is approved for IDA benefits effective March 1.

Example 2

Mr. O'Brien applies for IDA benefits on March 23, and brings proof that he filed for SSI on April 3. He establishes eligibility for IDA. Mr. O'Brien is approved for IDA benefits effective May 1.

The period of eligibility will end either at the end of the month in which SSA makes a final decision on the application for SSI benefits, if the decision is to deny the application, or at the end of the month in which SSA begins payment of benefits, if the decision is to approve benefits.

Example 1

Mr. Boyd's initial SSI payment is sent on March 3. His IDA benefits end effective March 31.

Example 2

MSSA makes its final decision on August 7 to deny SSI benefits for Mrs. Campbell. Mrs. Campbell's IDA benefits end effective August 31.

The final decision of SSA is the decision by the Appeals Council of the Office of Hearings and Appeals, or the denial by the Disability Determination Division or Administrative Law Judge, if the IDA recipient fails, without good cause, to file a timely appeal from that decision.

Application Denials 2.6.8

The application for IDA will be denied if:

- the applicant does not cooperate with IMA in providing the information needed to determine eligibility;
- conditions of non-financial eligibility have not been met;
- income and/or assets exceed established limits;

- the application has been voluntarily withdrawn or abandoned; or
- funding for the program is exhausted.

The applicant must be notified of the denial, the reason for the denial, and his/her right to a fair hearing.

Application Extension 2.6.9

An applicant should be given an extension of up to 15 days to establish IDA eligibility under the following circumstances:

- a determination of disability is pending with the Medical Review Team; or
- the Medical Review Team has found that additional information is needed to determine disability and the information cannot be provided by the 60th day.

Conditional Denial 2.6.10

Because funding for the IDA program is capped, no new applications can be approved once funding of benefits to current recipients through the end of the fiscal year reaches the funding level. Applicants denied benefits because funding is exhausted will be placed on a waiting list and approved for benefits when funds are available. A notice of conditional denial must be sent. Applicants, who have been denied benefits and placed on the waiting list, will be re-considered for benefits in the order in which they applied, based on the date of application.

Notices 2.6.11

A notice indicating a decision to deny an application for IDA benefits must be issued by the 60th day after the date of application. If the applicant is denied benefits, the notice must include the reason for the denial and provide information on the applicant's right to a fair hearing. If the application is approved, the notice must be issued by the 60th day from the date of application, or within 10 days of establishing eligibility, if eligibility is established after the 50th day from the date of application. An approval notice should indicate the effective date of the approval, and notify the applicant of his/her right to request a fair hearing.

CASE MAINTENANCE 2.7

Recertification 2.7.1

IDA recipients must recertify for benefits within 12 months of their month of approval and every 12 months thereafter. The following eligibility requirements must be re-determined and re-verified at the IDA review:

- residency,
- income,
- resources, and
- status of the SSI claim.

IDA recipients are not required to submit new medical information to continue IDA eligibility.

If the recipient provides all information needed to re-determine eligibility, confirming that s/he continues to meet all financial and non-financial eligibility requirements, the SSR will recertify IDA benefits for an additional 12 months.

Food stamp cases that are certified in conjunction with the IDA review should be certified for twelve months to coincide with the next IDA review. SSI-related (SR) Medicaid does not need recertification, if the customer retains his/her IDA eligibility.

Reporting Changes 2.7.2

IDA recipients must report, within 10 days, changes that affect their eligibility for benefits. If the change will result in an increase in the customer's benefits, the SSR will make the change for the following month. If the change will result in a decrease in the customer's benefits, the SSR will make the change for the month following expiration of the timely notice period.

Case Termination 2.7.3

If the recipient fails to attend an IDA review or fails to provide verifications needed to confirm continuing eligibility, the SSR must send timely and adequate notice of the agency's intent to terminate IDA. If the recipient does not respond within 15 days, the SSR should terminate IDA benefits for the next available month. The recipient's Medicaid eligibility period should be reset to recertify Medicaid in three months. If the recipient is getting food stamps also, and reported a change that required verification to continue Food Stamp eligibility, but failed to provide the information, the SSR must send a written request for the information and timely and adequate notice prior to terminating Food Stamps. The SSR should not terminate Food Stamps because the customer failed to attend the IDA review.

If the recipient reports (and verifies when necessary) a change at the IDA review that results in termination of IDA and affects the person's eligibility for other program benefits also, the SSR should re-evaluate his/her eligibility for those programs.

Except as noted previously in "Period of Eligibility," IDA benefits may not continue once SSA has made its final decision on the customer's SSI claim.

Notices of IDA termination must meet all requirements listed in Part VIII: Chapter 10, Case Maintenance, Notice of Adverse Action.

Reinstatement and Re-application 2.7.4

An IDA recipient may be reinstated for benefits, if s/he provides by the effective date of closing all information needed to re-establish eligibility. A person who does not provide all needed information by the effective date of closing must re-apply for IDA.

At re-application the customer must verify all eligibility requirements. S/he must provide current medical information, if the Medical Review period has expired. Representation and reimbursement agreements must also be re-signed. If at re-application, the customer re-establishes eligibility, but IDA funds are exhausted, the customer will be added to the waiting list, effective the date of re-application.

Fair Hearings 2.7.5

An applicant/recipient dissatisfied with an action taken by the Department which affects IDA benefits, participation, or requirements can request a fair hearing. The hearing process outlined in Part VIII: Chapter 7, Case Maintenance: Grievances and Fair Hearings should be used with the following exception:

- If a customer requests continuation of benefits, while the Fair Hearing is pending, benefits may not be continued after a final determination of SSI eligibility has been made.

Refund of Reimbursement 2.7.6

Upon receipt of an IDA recipient's retroactive SSI benefit payment, the DHS Office of the Controller (DHS-OC) has 10 days to determine what portion may be retained by DHS and what portion, if any, should be refunded to the IDA recipient. DHS-OC in conjunction with IMA will provide a written explanation of the calculation and pay any amount due within those 10 days.

Overpayments 2.7.7

IDA recipients are not required to repay wrongly issued benefits. No claims will be established for IDA overpayments.

VERIFICATION 2.8

The SSR should use standard verification procedures to verify financial and non-financial eligibility requirements.

APPENDIX A - ACRONYMS

ACE:	Active Corps of Executives
ACEDS:	Automated Client Eligibility Determination System
AFDC:	Aid to Families with Dependent Children
AIDS:	Acquired Immunodeficiency Syndrome
ALJ:	Administrative Law Judge
APRA:	Addiction, Prevention, and Recovery Administration
AR:	AFDC-Related
ATM:	Automated Teller Machine
ATOD:	Alcohol, Tobacco and Other Drug Abuse
AX:	AFDC-Exception
BENDEX:	Beneficiary Data Exchange
BEQG:	Basic Education Opportunity Grants
BTE:	Bureau of Training and Employment
CA:	Combined Application
CAD:	Citizenship/Alienage Declaration
CAMP:	College Assistance Migrant Program
CAPTA:	Child Abuse Prevention and Treatment Act of 1996
CD:	Certificate of Deposit
CFR:	Code of Federal Regulations
CFSA:	Children and Family Services Agency
CHAMPUS:	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA:	Civilian Health and Medical Program of the Veterans Administration
CHIP:	Child Health Insurance Program
COBRA:	Consolidated Omnibus Budget Reconciliation Act of 1985
COLA:	Cost of Living Adjustment
CPI:	Consumer Price Index
CSED:	Child Support Enforcement Division of the Office of the Corporation Counsel
CSU:	Customer Service Unit
CSV:	Cash Surrender Value
D.C.:	District of Columbia
DCEIP:	DC Early Intervention Program
DCPS:	DC Public Schools
DHS:	Department of Human Services
DHHS:	United States Department of Health and Human Services

DMV:	Department of Motor Vehicles
DOE:	Department of Education
DOES:	Department of Employment Services
DOH:	Department of Health
DOL:	Department of Labor
DPP:	Diversion Payment Program
DRS:	Disqualified Recipient Subsystem
EBT:	Electronic Benefits Transfer
EITC:	Earned Income Tax Credit
EPSDT:	Early Periodic Screening Diagnosis and Treatment
FNS:	Food & Nutrition Services
FPL:	Federal Poverty Level
FS:	Food Stamp(s)/Food Stamp Program
FSA:	Family Services Administration
FSET:	Food Stamp Employment and Training Program
FY:	Fiscal Year
GC:	General Assistance for Children
GED:	General Educational Development
GSL:	Guaranteed Student Loans
HEP:	High School Equivalency Program
HIV:	Human Immunodeficiency Virus
HUD:	United States Department of Housing and Urban Development
ICF:	Intermediate Care Facilities
ICF-MR:	Intermediate Care Facilities for the Mentally Retarded
ID:	Identification or Identity
IDA:	Interim Disability Assistance (Program)
IEVS:	Income and Eligibility Verification System
IMA:	Income Maintenance Administration
INA:	Immigration and Nationality Act
INS:	Immigration and Naturalization Service
IPV:	Intentional Program Violation
IQ:	Intelligence Quotient
IRA:	Individual Retirement Account
IRAP:	Indochinese Refugee Assistance Program
IRP:	Individual Responsibility Plan

IRS:	Internal Revenue Service
JTPA:	Job Training Partnership Act
LIHEAP:	Low Income Home Energy Assistance Program
LPR:	Legal Permanent Resident
LTC:	Long Term Care
MA:	Medical Assistance
MAA:	Medical Assistance Administration
MNIL:	Medically Needy Income Level
MRT:	Medical Review Team
N/A:	Not Applicable
NMI:	Northern Mariana Island
NPA:	Non-Public Assistance
OAA:	Old Age Assistance
OARA:	Office of Administrative Review and Appeals
OASDI:	Old Age and Survivors Disability Insurance
OCFO:	Office of the Chief Financial Officer
OCFPD:	Office of the Chief Financial Operation Payment and Collection Division
OCFS:	Office of Child and Family Services
OECD:	Office of Early Childhood Development
OFCS:	Office of Family Children Services
OFH:	Office of Fair Hearings
OHCF:	Office of Health Care Financing
OIC:	Office of Investigations and Compliance
OTC:	Over-the-Counter
PASS:	Plan to Achieve Self Support
PATHS:	Paving Access Trails to Higher Security
PI:	Primary Informant
P.L.:	Public Law
PNA:	Personal Needs Allowance
POS:	Point of Sale
POWER:	Program on Work, Employment and Responsibility
PPA:	Patient Pay Amount
PRUCOL:	Permanently Residing Under Color of Law
PRWORA:	Personal Responsibility and Work Reconciliation Act of 1996
PSRO:	Professional Standards Review Organization

PWE:	Principal Wage Earner
QCHS:	Quarters of Coverage History System
QCR:	Quality Control Review
QDWI:	Qualified Disabled Working Individual
QI:	Qualified Individual (QI-1)
QM:	Qualified Medical Benefits
QMB:	Qualified Medicare Beneficiary
QMP:	Qualified Medical Providers
QQ:	Qualifying Quarters
RAW:	Replenishment Agricultural Worker
RCA:	Refugee Cash Assistance
RERE:	Register Recertification/Review
RMA:	Refugee Medical Assistance
RN:	Registered Nurse
RSA:	Rehabilitation Services Administration
RSVP:	Retired Senior Volunteer Program
SAVE:	Systematic Alien Verification for Entitlements
SAW:	Special Agricultural Worker
SCORE:	Service Corps of Retired Executives
SDX:	State Data Exchange
SEOG:	Supplemental Education Opportunity Grants
SGA:	Substantial Gainful Activity
SLIMB:	Special Low Income Medicare Beneficiary
SNF:	Skilled Nursing Facility
SR:	SSI-Related (Medicaid program type code)
SSA:	Social Security Administration
SSDI:	Social Security Disability Insurance
SSI:	Supplemental Security Income
SSIG:	State Student Incentives Grant
SSN:	Social Security Number
SSP:	State Supplemental Payment
SSR(s):	Social Service Representative(s)
SUA:	Standard Utility Allowance
TAA:	Trade Adjustment Assistance
TANF:	Temporary Assistance to Needy Families

TAPIT:	Tuition Assistance Program in TANF
TDD	Teletype Device for the Deaf
TMA:	Transitional Medicaid Assistance
TPAP:	Teen Parent Program
TPL:	Third Party Liability
TPS:	Temporary Protected Status
TRA:	Trade Readjustment Assistance
TTPI:	Trust Territory of the Pacific Islands
TTY:	Teletypewriter
UCB:	Unemployment Compensation Benefit
UDC:	University of the District of Columbia
UIB:	Unemployment Insurance Benefits
U.S.:	United States
USDA:	United States Department of Agriculture
VA:	Veterans Administration
VISTA:	Volunteers in Service to America
WIA:	Workforce Investment Act
WIC:	Women, Infants and Children

APPENDIX B – GLOSSARY OF TERMS

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A

Acknowledgment of TANF Program Requirements	The applicant/recipient signature on the combined application that they have read and understand the TANF program requirements.
Adequate Notice	A written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting such actions, explanation of the individual's right to request a fair hearing, and the circumstances under which assistance will be continued if a hearing is requested.
Adverse Action	A written notice which informs a customer that benefits are to be reduced or to be terminated. The notice must describe the action to be taken (including the amount of any benefit reduction); the reason for the reduction or termination, the effective date of the action, the right to a hearing to contest the action and the circumstances under which assistance will be continued if a hearing is requested.
Affidavit	A written declaration made under oath before a notary public or other authorized officer.
Agency/Department Error	Occurs when a person receives an overpayment or underpayment as a result of any action or failure to act by a District of Columbia government employee.
Agent Orange	A herbicide used in the Vietnam War to eliminate foliage.
Aid to Families with Dependent Children (AFDC)	The former federal entitlement program authorized under Title IV-A of the Social Security Act to provide financial assistance and support services to needy families with dependent children. The program was repealed under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 and was replaced with Temporary Assistance to Needy Families (TANF).
Amerasian	Amerasian is a child fathered by a U.S. citizen in certain Southeast Asian countries during the years of conflict in that region. These immigrants have been granted Legal Permanent Resident (LPR) status.
Applicant	An individual who has made application for assistance either directly or through his/her authorized representative.
Application	The written request for assistance on the form prescribed by the Department for this purpose.
Appraisal	Estimation of worth of a good or item.

Asset Limit	The maximum amount of countable assets an applicant/recipient may own or have available and remain eligible for assistance.
Assets	Cash or other liquid assets, non-liquid financial assets, and any real or personal property that a member of an assistance unit owns.
Assignment	To transfer a legal claim, such as assignment of child support or medical support.
Assistance Unit	Those persons whose needs, income and resources are considered when making a determination of eligibility for, and the amount of, public assistance.
Authorization Date	The date the Social Service Representative (SSR) or supervisor completes the authorization action.
Authorized Representative	Generally, an adult non-member of a Food Stamp household who may act on behalf of the household in applying for, obtaining, or using program benefits. A private, nonprofit organization or institution managing a drug addiction or alcoholic treatment and rehabilitation center may also serve in this capacity. An authorized representative can also be a person who applies for MA on behalf of others.
Automated Teller Machine (ATM)	An electronic banking device used by TANF recipients to access their cash assistance benefits.

B

Beneficiary	The person named to receive benefits or payments.
Beneficiary Data Exchange (BENDEX)	A computerized system which makes available to the Department information from the Social Security Administration regarding the Old Age and Survivors Disability Insurance (OASDI) benefits and Medicare coverage.
Buy-in	The purchase of Medicare premiums, co-payments or deductibles by the Department of Human Services for certain low-income individuals who are eligible for Medicare. After the Department of Human Services has 'picked up' the buy-in costs, Medicare premiums are no longer withheld from the recipient's monthly OASDI check, also referred to as a Social Security check.

C

Capitol Access Card	The District of Columbia's electronic benefits transfer card. It allows eligible program beneficiaries to access cash and food stamp benefits electronically at point of sale terminals and cash assistance benefits at ATMs.
Caretaker	A person who is responsible for the day-to-day care of the child. This includes physical care, supervision, and making decisions about the child.
Caretaker Relative	A non-parent individual responsible for the care and support of a dependent child and who is related to the child within a specified degree of relationship.
Case Error	An overpayment, underpayment, or payment to ineligible individuals.

Cash Value	The amount an insurance company will pay upon the cancellation of a life insurance policy.
Categorically Eligible	A group that qualifies for medical assistance or food stamps on the basis of certain characteristics such as receipt of SSI or TANF benefits. This means that the group does not have to be tested against asset and some or all income limits to determine eligibility.
Child Support	Voluntary or court-ordered benefits from the absent parent for support of his/her child(ren).
Citizenship	The status of being a native born or naturalized citizen of the United States.
COBRA Coverage Program	The Consolidated Budget Reconciliation Act of 1985 (COBRA) authorized the payment of health care premiums for low and moderate-income individuals who are HIV positive or diagnosed with AIDS and who are eligible to receive health insurance coverage from a former employer.
Collateral Contact	A contact made by the worker to a third party for the purpose of verifying information about an applicant/recipient.
Combined Application	The application used to apply for Medical Assistance (MA), Temporary Assistance for Needy Families (TANF), General Assistance for Children (GC), and Food Stamps (FS) benefits. Individuals applying only for Medicaid can often use a different application.
Common Law Marriage	A marriage that is legally recognized even though there has been no ceremony and there is no certification of marriage. A common-law marriage exists if the two persons are legally free to marry, if it is the intent of the two persons to establish a marriage, and if known in the community as husband and wife.
Community Assistance Unit	An assistance unit in which all members reside in the community. For MA this includes any member who is temporarily in an acute care hospital.
Continued Absence from the Home	<p>The absence of a parent or caretaker from a home for:</p> <ul style="list-style-type: none"> •Desertion or abandonment •Divorce or legal separation •Imprisonment •Voluntary separation involving a detachment of marital and family relationship <p>Continued absence does not include absence of a parent for:</p> <ul style="list-style-type: none"> •Employment elsewhere when s/he is also meeting the financial needs of the family •On active military duty elsewhere
	<ul style="list-style-type: none"> • Separate living arrangements for the purpose of establishing eligibility for assistance
Cost of Living Adjustment (COLA)	An adjustment to benefit levels to compensate for inflation.

Countable Assets	Those assets belonging to members of the assistance unit (and certain disqualified household or family members) that are included when determining asset eligibility.
Countable Income	Earned and unearned income that is received by members of the assistance unit (and certain disqualified household or family members) and is counted when determining income-eligibility and benefits levels.
Customer/Agency Agreement	Form signed at application and recertification in which the customer agrees to comply with work requirements.

D

Date of Entry	The date an individual entered the United States with the intent to remain permanently in the country.
DC Resident	A person living in Washington, DC voluntarily and not for a temporary purpose, who at present has no intention of moving out of Washington, D.C.
Deduction	A portion of income that is not counted when determining income eligibility and/or benefit levels under various programs.
Deem	To consider the assets and income of certain financially responsible persons not in the assistance unit as available to members of an assistance unit, whether or not the assets and income are actually contributed to the members of the assistance unit.
Deemed Income	Income of people in the unit that is treated as if it were income the unit received
Department	The District of Columbia's Department of Human Services.
Department Ward	Any child who has been committed to, or placed with, the Children and Family Service Administration (CFSA) by a court order due to abuse or neglect; or who has been placed in either a foster care home or a licensed child-care institution by the Department of Human Services.
Dependent Child	A child under the age of 21 who is living in the home of a parent or other caretaker relative (Obsolete as of February, 2010)
Deprivation	The lack of care or support from at least one parent of a dependent child due to the continued absence, death, incapability, or unemployment/underemployment of the parent.
Disability, Permanent & Total	A medically determined physical or mental impairment that causes an individual to be unable to engage in any substantial gainful activity and that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.
Disqualified Person	A household member ineligible for assistance because s/he failed to meet an eligibility requirement (such as immigration status requirements), or program requirement (such as TANF work requirement).

Diversion Payment Program (DPP)	A program that provides a lump sum payment to a TANF applicant to divert him/her from receiving an on-going TANF grant. It is used to resolve an immediate short-term financial need that will allow the applicant to secure or continue in current employment.
DNA Testing	A genetic test used to verify the biological father or mother of a child.
Documentation	A written statement or record that substantiates or validates an assertion made by a person, agency or entity.
Domestic Violence	The condition of being subject to physical acts that result in or threaten to result in physical harm, forced engagement in non-consensual sexual activity, threats of physical or sexual abuse, emotional abuse, or neglect or deprivation of medical care.
Domestic Violence Waiver	A waiver of one or more TANF program requirements granted to a victim of domestic violence when compliance would make it more difficult for such individuals to escape domestic violence, or compliance would place him/her at-risk of further domestic violence.

E

Early Withdrawal Penalty	A monetary penalty for deductions, before a specified date, from a Keogh plan, IRA, Certificate of Deposit, etc.
Earned Income	Cash or in-kind income earned by a needy individual through the receipt of wages, salary, commission or profit from activities in which s/he is engaged as a self-employed individual or as an employee.
Earned Income Tax Credit (EITC)	A refundable federal tax credit that is available to working low-income individuals and families.
Educational Skill Training	A program designed to provide the participant with the basic educational skills considered necessary for employment.
Effective Date	The date for impending denial, termination, or other changes in eligibility or benefit amount after giving proper notice.
Electronic Benefit Transfer (EBT)	Uses automated data processing technology to allow beneficiaries to use a magnetic-stripped plastic card to withdraw their benefits electronically at an automated teller machine (for cash benefits) or at a point of sale terminal (for cash and Food Stamp benefits).
Encumbrance	Any claim against an asset, such as a loan or mortgage, held by a financial institution or other third party.
Essential Person	An individual who resides with a dependent child and is recognized by the applicant or recipient as essential to the well-being of the dependent child. An essential person can be included in on MA case in either the AR or AX program types.
Excess Income	The amount of income in excess of the Medically Needy Income Level that an applicant must 'spend-down' in order to establish MA eligibility.

Excluded Income	Income not counted as available to the group when determining eligibility.
Exempt	An applicant/recipient who is not required to meet a program requirement.
Expanded Categorical Eligibility	A group that qualifies for food stamps on the basis of receiving a prescribed TANF-funded service. This means that the group must meet a gross income limit at or below 200% of the Federal Poverty Level but does not have to be tested against asset and net income limits to determine eligibility.
Expedited Food Stamp Processing	Federal mandate that certain Food Stamp applicants with limited income and resources have their applications processed within certain timeframes. If the applicant is eligible, benefits must be received within seven days from the date of application.

F

Face Value, Life Insurance Policy	The basic death benefit of a life insurance policy, excluding the dividend additions or additional amounts payable because of an accidental death or other special condition.
Fair Hearing	A review by the Office of Fair Hearings of case circumstances that is conducted at the request of the applicant/recipient.
Fair Market Value	The monetary value for which an item can be expected to sell on the open market.
Financially Responsible Relative	A relative living in the home of the applicant/recipient who is legally responsible for the financial support of one or more members of assistance unit.
Food Stamp Employment and Training (FSET)	An employment and training program for non-exempt food stamps participants.
Food Stamp (FS) Program	The program that provides monthly benefits to low-income households usable only to purchase food needed to maintain adequate nutrition.
Fraud	The deliberate act of misrepresenting circumstances for the purpose of obtaining Medical Assistance benefits, Temporary Assistance to Needy Families, GC and Food Stamp benefits. A finding of fraud can only be made by a court and is punishable by fine and/or imprisonment.
Full-Time Student	A minor is considered a full time student when enrolled in:
	<ul style="list-style-type: none"> • A public school or a licensed private school and the program call for at least 20 hours of classroom vocational training per week.
	<ul style="list-style-type: none"> • A junior college, or university and is carrying at least eight semester or quarter hours.
	A training program designed to prepare the student for gainful employment, issues a certificate or diploma upon successful completion of the program, and calls for attendance of at least 20 hours per week.

G

General Assistance for Children Program (GC)	Provides direct financial support to children living in households that do not include a parent or caretaker relative.
Good Cause	Valid reasons for non-compliance with program requirements. Individuals who have good cause for failing to meet a program requirement are not subject to penalties or sanctions for failing to meet those requirements.
Grievance	Applicant or Recipients dissatisfaction with an action taken by the Department.
Gross Income	Total countable earned and unearned income before any deductions are taken to reduce the amount of income considered in certain eligibility determinations.
Gross Income Test (GIT)	An eligibility test based on gross income.

H

Head of TANF Assistance Unit	A person who is the head of a TANF assistance unit is:
	<ul style="list-style-type: none">• The adult parent of a minor child, if both are part of the same single-parent assistance unit.
	<ul style="list-style-type: none">• The parent who is the principal wage-earner or the non-incapacitated parent in a two-parent assistance unit, if that parent is an adult parent of a minor child and the parent and child are part of the same assistance unit. If both parents are incapacitated the group chooses a head.
	<ul style="list-style-type: none">• A caretaker relative residing with and caring for a minor child.
	<ul style="list-style-type: none">• A minor parent of a minor child if both are part of the same assistance unit and there are no adults in the unit.
Head of Food Stamp Household	A person who all adult household members agree should be the head of household.
Hearing Request	Clear expression by the claimant or his/her legal counsel (or in the case of Food Stamps, his/her authorized representative) that indicates that s/he disagrees with a case action taken by the Department and wishes to have a hearing to determine whether the agency was in error.

I

Incapacity, Physical or Mental	A physical or mental disability, illness, or impairment of such a debilitating nature as to reduce substantially or eliminate a parent's ability to support a dependent child. The incapacity does not have to be permanent.
Income	The money received by an individual for labor or services currently rendered or from property, trusts, operations, or benefits.

Income Disregard	An amount of income that is excluded when determining net income.
In-Kind Income	Food, clothing, shelter, or any item other than cash provided to one or more members of the assistance unit by someone who is not a member of the assistance unit. In-kind income can be earned or unearned.
Income Maintenance Administration	The local agency which oversees eligibility determinations and processing for Medical Assistance, Temporary Assistance to Needy Families, General Assistance for Children, and/or Food Stamps.
Individual Responsibility Plan	A contract which a TANF recipient must sign which outlines the recipient's plan for preparing for, finding and retaining employment.
Institutional Status	In the Food Stamp program, a person is considered a resident of an institution when it provides him/her with the majority of his/her meals (over 50% of three daily meals) as part of the institution's normal services.
IV-D Agency	The entity responsible for establishing paternity, establishing child support orders, and enforcing those orders. In the District of Columbia, the Child Support Enforcement Division (CSED) is the IV-D Agency. 'IV-D' refers to a particular section of the Social Security Act.

J

Job Club / Search	An activity to which non-exempt TANF applicants are referred for the purpose of searching for work. ESA's Office of Work Opportunity operates the Job Club/Search for applicants. TANF applicants/recipients may also participate in Job Club/Search as a countable activity to meet the requirements of the TANF work program.
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K

L

Lawfully Present	Immigrants who have authorization to be in the United States from the Immigration and Naturalization Service.
Lawfully Residing	Immigrants who have authorization to be in the country from the Immigration and Naturalization Service, and who are not in the country on a temporary basis (such as a student or tourist).
Legally Responsible Relatives	In Medicaid, spouses living together are legally responsible for each other and parents are legally responsible for children in their care (and who live with them) who are under age 21. The income of legally responsible adults is always considered in some way when determining Medicaid eligibility.
Liquid Assets	Resources in the form of cash or other financial instruments that are convertible to cash.
Long Term Care Assistance Unit	An assistance unit consisting of an individual residing in or entering a long-term care facility or a couple when both spouses are residing in or entering the same long-term care facility.

Long Term Care Facilities	Licensed skilled nursing facilities (SNF), skilled nursing units (SNU), intermediate care facilities (ICF), intermediate care facilities for the mentally retarded (ICF-MR) and psychiatric institutions.
Lump Sum Payment or Settlement	A monetary payment received at one time which will not be repeated on a regular basis.

M

Mandatory Work Registrant	A Food Stamp applicant/recipient who is required to register for employment as a condition of program eligibility.
Marriage	A legally recognized union of a man and a woman by ceremony or common law.
Mass Change	A change brought about by a shift in federal or state policy that affects many or all assistance units.
Medicaid Program	The federally-funded program authorized under Title XIX of the Social Security Act to provide medical assistance to low-income individuals under the age 21, families with dependent children, individuals and couples who are age 65 or older, and blind or disabled individuals.
Medical Assistance Program	The program authorized by the District of Columbia to provide medical coverage to residents of the District. The Medical Assistance program incorporates the federal Medicaid program, the COBRA Coverage program, and the local DC Medical Charities program.
Medical Review Team (MRT)	Staff of the Income Maintenance Administration that are designated or contracted to determine incapacity or disability for applicants/recipients of MA, TANF or FS.
Medical Support Order	An absent parent's voluntary or court-ordered agreement to be responsible for all or a portion of his/her child's medical expenses.
Medicare	The federally-funded and federally-administered health insurance program authorized by Title XVIII of the Social Security Act. This program provides health insurance to individuals ages 65 and older and individuals who are disabled and receiving Title II Social Security Benefits.
Medicare Buy-In	Some low-income Medicare beneficiaries, including persons receiving or eligible to receive Medicare based on their receipt of Title II benefits (Social Security), can receive assistance paying for some or all of their Medicare premiums, co-payments, and deductibles. Medicare beneficiaries eligible for this type of assistance are often referred to as participating in the 'Buy In' Program.

Minor	A person who has not attained 18 years of age, or has not attained 19 years of age and is a full-time student in a secondary school (or in the equivalent level of vocational or technical training) and is expected to graduate from such school or program by the person's 19th birthday.
Minor Parent	An individual under the age of 18 who is the parent of a child.
Motor Vehicle	An automobile, passenger car, or other motor vehicle used to provide transportation of persons or goods.

N

Net Income Limit	The maximum level of total countable income less all applicable income deductions and disregards an assistance group may have and still qualify to participate in a benefit program.
Non-Compliance	The situation in which an applicant/recipient fails to cooperate or comply with program requirements (i.e., work or child support requirements).
Non-Dependent Child	An individual under the age of 21 who does not meet the definition of a dependent child either because s/he is not living with a parent or other caretaker relative

O

On-the-Job Training	A work activity in which a benefit recipient is hired by a private or public employer and is providing training by the employer.
Overpayment	A benefit received by an assistance unit in excess of the amount for which the unit was eligible.

P

Parent	The child's natural or adoptive parent.
Patient Pay Amount	The amount of monthly income that an eligible Medical Assistance patient in a long-term care facility must pay toward his/her cost of care.
Payee	The person to whom a benefit is paid.
Payment Month	The fiscal or calendar month for which assistance is paid.
Personal Needs Allowance	The portion of monthly income that an individual in a long-term care facility is allowed to retain for his/her personal needs.
Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)	The law signed on August 22, 1996 that eliminated the federal entitlement program Aid to Families with Dependent Children (AFDC) and created a new program called Temporary Aid to Needy Families (TANF). The law also changed immigrant-eligibility rules for most means-tested benefits, altered many Food Stamp rules, and

	restructured the eligibility of children for the SSI program.
Program on Work, Employment, and Responsibility (POWER)	The District of Columbia program that allows TANF applicants/recipients whose physical and/or mental incapacities interfere with their ability to participate in countable work activities to be placed in a special District-funded program to assist them in becoming work ready.
Pregnant or Parenting Teen	A person who has a child or children, or is in the third trimester of pregnancy and is under 20 years of age.
Preliminary Assessment Form	The Income Maintenance Administration (IMA) form completed with new TANF applicants and TANF groups and those completing eligibility reviews to identify candidates for Diversion, POWER, to screen for Domestic Violence, and to determine whether the adult qualifies for an exemption to work requirements.
Primary Informant	The group member who files the application for benefits and is the person to whom the Department of Human Services generally directs correspondence and notices. In Food Stamp cases, the group can opt to have the authorized representative be the individual principally responsible for providing information to the Department.
Principal Wage Earner	The parent in a two-parent family who earned the larger amount in a 24-month period immediately preceding the month of application. This designation is only required for TANF.
Processing Time Standard	The period of time the agency is allowed to process an application for assistance.
Prorated Patient Pay Amount	The patient pay amount for the month of admission to or discharge from a long-term care facility, adjusted to represent payment for only the portion of the month that the patient was in residence.
Prospective Budget Period	The six-month period beginning with the month of application for which an individual requests coverage under the spend-down provisions of Medicaid.
Protective Payee	An individual who is interested in or concerned with the recipient's welfare and who acts for the TANF recipient in receiving and managing assistance.
Provisional Inclusion	The temporary inclusion of individuals in an assistance unit for purposes of determining financial responsibility.

Q

QI-1	A Medicare beneficiary whose income is at least 120 percent of the Federal Poverty Level (FPL) but less than the 135 percent of the FPL and whose resources are no more than twice the SSI resource standard. Such an individual is eligible for Medicare Part B premium only. QI-1s are not eligible for retroactive coverage, and there are no spend-down provisions for them. (Note that effective July 1, 2005, there are no QI-1 eligible customers, since the QM and SLMB income limits have been increased to include these customers.)
Qualified Disabled Working Individual (QDWI)	A disabled, employed individual who lost access to free Medicaid Part A benefits due to their return to work whose income does not exceed 200 percent of the Federal Poverty Level (FPL) and whose resources are no more than twice the SSI resource standard. Medicaid pays the Medicare Part A premiums only for these individuals.
Qualified Medicare Beneficiary (QMB)	A Medicare beneficiary whose income does not exceed 150 percent of the Federal Poverty Level (FPL) and whose resources do not exceed twice the Supplemental Security Income (SSI) resource standard. QMBs are not eligible for retroactive coverage nor for the month of application. There are no spend-down provisions for them.

R

Recertification	The scheduled redetermination of MA or FS eligibility. If eligibility for MA or FS is not recertified prior to the end of the certification period, benefits are terminated. Benefits may not be terminated if the group was not given an opportunity to recertify eligibility.
Recipient	An individual who receives benefits.
Refugee	A person determined by the Immigration and Naturalization Service (INS) to be unable to return to their country of origin because of fear of persecution.
Refugee Cash Assistance	A program that provides case assistance to certain immigrants ineligible for TANF and SSI.
Refugee Medical Assistance	Program that provides Medical Assistance to certain immigrants in their first eight months in the country.
Rental Vender Payment	A restricted TANF benefit paid directly to a landlord. A TANF recipient can request such an arrangement or can be required to enter into such an arrangement.
Removal of Needs	When an adult fails to comply with TANF requirements, s/he is disqualified from the unit and his/her "needs" are removed when determining continued eligibility and benefit level. That is, the individual's income and resources are counted, but the individual is not counted when determining the household size and maximum benefit level.

Representative Payee	A person or organization selected by the Social Security Administration to receive benefits on behalf of Old Age Survivors Disability Insurance (OASDI) or Supplemental Security Income (SSI) recipient and obligated to use those benefits for their personal care and well-being.
Resources	A general term used to refer to an individual's assets.
Retroactive Budget Period	The three consecutive months immediately preceding the month of application for Medicaid. Applicants can apply for "retroactive" Medicaid coverage of incurred medical expenses for the three-month period prior to application either under the standard Medicaid or under spend-down provisions.
Review	Term used to describe the redetermination of a group's eligibility for TANF benefits.
Roomer	A person to whom the group furnishes lodging, but not meals, for compensation.

S

Salazar Court Order	A court order that governs the District of Columbia processing of Medicaid applications filed on behalf of groups who are neither categorically eligible nor applying based on disability.
Sanctions	Actions taken against applicants/recipients who fail to comply with program requirements and do not have a good cause reason for failing to comply.
Social Service Representative (SSR)	A caseworker responsible for determinations of eligibility for Medical Assistance, Temporary Assistance to Needy Families, General Assistance to Children, and Food Stamps.
Special Low-Income Medicare Beneficiary (SLIMB)	A beneficiary whose income is at least 100 percent of the Federal Poverty Level (FPL) but less than 150 percent of the FPL and whose resources do not exceed twice the Supplemental Security Income (SSI) resource standard. Benefits for SLIMBs are limited to payment of the Medicare Part B premium only. SLIMBs are eligible for the three-month retroactive eligibility determination. However, eligibility cannot be effective prior to January 1, 1993. There are no spend-down provisions for SLIMBs. (Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application, since the QMB income limit has been increased to include these customers for the period beginning with the month following the month of application.)
Spend-down Budget Period	The period of consecutive months over which total countable income and allowable medical expenses are reviewed to determine whether a group that is over-income for MA has incurred sufficient medical expenses to qualify for MA for part or all of either a three-month retroactive period or a six-month prospective period. Those timeframes are measured from the month of application.
Spend-down Liability	The amount of income in excess of MNIL. This represents the level of medical expenses the group must incur in order to establish eligibility for Medical Assistance.

Sponsor	A person or organization who has signed an affidavit of support or other statement of agreement to support an alien as a condition of the alien's entry into the United States.
Spouse	A legally recognized husband or wife through civil or common-law marriage.
Standard Utility Allowance	A type of FS income deduction available to units that incur expenses for heating and/or cooling. The allowance covers heating, cooling, electricity, water, sewage, garbage, and phone expenses.
Stepparent	An individual who is not the child's natural or adoptive parent, but who is the spouse of the child's natural or adoptive parent by ceremony or common-law marriage.
Standards of Promptness	The time standards within which the Department must take a required case action.
Salazar Court Order	A court order that governs the District of Columbia processing of Medicaid applications filed on behalf of groups who are neither categorically eligible nor applying based on disability.
Sanctions	Actions taken against applicants/recipients who fail to comply with program requirements and do not have a good cause reason for failing to comply.
Social Service Representative (SSR)	A caseworker responsible for determinations of eligibility for Medical Assistance, Temporary Assistance to Needy Families, General Assistance to Children, and Food Stamps.
Special Low-Income Medicare Beneficiary (SLIMB)	A beneficiary whose income is at least 100 percent of the Federal Poverty Level (FPL) but less than 150 percent of the FPL and whose resources do not exceed twice the Supplemental Security Income (SSI) resource standard. Benefits for SLIMBs are limited to payment of the Medicare Part B premium only. SLIMBs are eligible for the three-month retroactive eligibility determination. However, eligibility cannot be effective prior to January 1, 1993. There are no spend-down provisions for SLIMBs. (Note that effective July 1, 2005, SLIMB eligibility applies only to the month of application and the three months prior to the month of application, since the QMB income limit has been increased to include these customers for the period beginning with the month following the month of application.)
Spend-down Budget Period	The period of consecutive months over which total countable income and allowable medical expenses are reviewed to determine whether a group that is over-income for MA has incurred sufficient medical expenses to qualify for MA for part or all of either a three-month retroactive period or a six-month prospective period. Those timeframes are measured from the month of application.
Spend-down Liability	The amount of income in excess of MNIL. This represents the level of medical expenses the group must incur in order to establish eligibility for Medical Assistance.
Sponsor	A person or organization who has signed an affidavit of support or other statement of agreement to support an alien as a condition of the alien's entry into the United States.

Spouse	A legally recognized husband or wife through civil or common-law marriage.
Standard Utility Allowance	A type of FS income deduction available to units that incur expenses for heating and/or cooling. The allowance covers heating, cooling, electricity, water, sewage, garbage, and phone expenses.
Stepparent	An individual who is not the child's natural or adoptive parent, but who is the spouse of the child's natural or adoptive parent by ceremony or common-law marriage.
Standards of Promptness	The time standards within which the Department must take a required case action.
State Data Exchange (SDX)	A computerized system that makes information from the Social Security Administration regarding the eligibility, living arrangements, and sources of income of a recipient of Supplemental Security Income (SSI) available to the Department.
State Supplements	Cash payments made by a state and the District to certain recipients of Supplemental Security Income (SSI).
Supplemental Security Income (SSI) Program	The federal program authorized under Title XVI of the Social Security Act and administered by the Social Security Administration (SSA) to provide financial assistance to low-income, aged, blind, and disabled individuals.
Striker	A person who has agreed, in cooperation with others, to stop work. Special eligibility conditions are imposed on strikers in the Food Stamp program.
Student	An individual who is attending a school, college, or university or a course of vocational or technical training designed to fit him/her for gainful employment and includes a participant in the Job Corps Program under the Workforce Investment Act (WIA) of 1998, the replacement legislation for the Job Training Partnership Act (JTPA).
Systematic Alien Verification for Entitlement (SAVE)	A computerized system which makes information from the Immigration and Naturalization Service regarding an alien's eligibility for public benefits available to the Department.

T

Temporary Assistance for Needy Families (TANF)	TANF is the program that replaced AFDC as described in PL 104-193 (the Personal Responsibility & Work Reconciliation Act of 1996). The TANF block grant received from the federal government funds a variety of District of Columbia programs, including the main cash assistance program for families with children. The District cash assistance program is referred to as the 'TANF' program
Termination	A discontinuation of program participation and benefits.

Timely Notice	A notice that is mailed at least 15 days before the effective date of the case action.
Trade Adjustment Assistance (TAA)	Federally provided benefits for people whose employment was adversely affected by the importation of goods.

U

Underpayment	Amount by which benefits received are less than amount for which the assistance unit was eligible.
Unearned Income	Monetary or in-kind compensation that is not received as the direct result of an individual's own labor or services.

V

Verification	Proof that statements made by the applicant/recipient are true.
Voluntary Quit	An individual who deliberately reduces income without good cause; this is a sanctionable action under both TANF and FS.

W

Work Participation Allowance or Stipend	An amount of money under both TANF and FS designed to reimburse participants for employment or work-related training activities.
Work Participation Rates	The federally mandated percentage of TANF recipients who must be engaged in specified work activities for a minimum number of hours each month.

X

Y

Z

APPENDIX C1 - COMMONLY USED FORMS

The following is a list and description of the forms most commonly used by ESA. The first set of forms are those which do not have form numbers; these forms are referred to by name or title. The second set of forms are those which have form numbers.

ACEDS Verification Checklist - document that informs an applicant what information is needed to determine program eligibility. All applicants from whom information is needed must be given a checklist. If the system is inoperable, issue a 1356 Manual Application Checklist. Original to applicant/recipient, copy in record.

Acknowledgment of Paternity - form completed by a father whose name does not appear on the birth certificate (or whose name is on a D.C. birth certificate issued prior to 10/81, but the father was not married to the mother and there has been no adjudication) to establish that the individual is, in fact, the father of the child. Original to CSED, copy in record, copy to father, copy to mother.

Combined Application (aka Generic Application) - application used for TANF, GC, IDA, and FS, available in multiple languages.

DC Healthy Families Application [PDF] [English] [En Español] - Medicaid application used by families with children.

EBT Referral - form completed by SSR to reinstate benefits for a recipient whose EBT account has been closed due to inactivity. Original faxed and filed in case record.

Food Stamp Expense Addendum to Generic Application - form completed at application and recertification explaining that dependent and shelter care expenses will not be considered if verification is not provided.

Food Stamp Only Application - application usable for Food Stamps only

Generic Application (aka Combined Application) - application used for TANF, GC, IDA and FS.

Generic Recertification Form - form used to recertify TANF, GC and FS.

Immigration and Citizenship Initial Declaration Form - an initial form used to determine household members who are US citizens, nationals or "qualified" immigrants.

IV-D Partnership Agreement - form used to notify TANF and Medicaid customers of child support requirements and the good cause reasons for non-cooperation.

Notice of Privacy Practices [PDF] [English] [En Español] - form used to notify Medicaid/Medical Assistance customers of their rights pertaining to the release of protected health information and other personal data.

Periodic Report - form completed quarterly by employed TANF recipients to report earnings and certain household changes.

Preliminary Assessment- form completed by SSR and TANF applicant to assess his/her employability. Original forwarded, copy in record, copy to applicant/recipient.

Rental Vendor Referral Form - form used to refer a TANF applicant/recipient for rental vendor payment. Original forwarded, copy in record.

Report of Non-Compliance with TANF Requirements - form issued by TANF operations unit to report non-compliance with TANF work requirements.

TANF Work Activity Referral - form used to refer mandatory and voluntary applicants/recipients to Job Club, Teen Parent program, and Negotiated Suitability Training (for those interested in self-initiated training). The referral form can also be used to refer applicants/recipients who need child care assistance to the Office of Early Childhood Development. Original forwarded, copy in record, copy to customer.

Token Receipt Form - form completed by SSR authorizing bus tokens. Original to customer, copy in record, copy to TANF operations unit.

Voter Registration Agency Certification - form completed by recipient when a household's address changes or a voting-age adult is added to the unit indicating whether the recipient would like to obtain a voter registration form. Original in record.

Numbered Forms

FSET-1	Food Stamp Registration for Employment and Training Services - form completed at application and annually thereafter by FS recipients mandated to work register. The form serves as the work registration and the referral form to the FSET program. Original to FSET, copy in record.
FSET-3	Report of Non-Compliance - form sent to SSR by FSET to report recipient's non-compliance with FSET requirements.
1-2140	Spend-down Tracking Form - form sent to the Medical Assistance Administration so that medical bills are paid for spend-down customers. Original forwarded to MAA, copy in record.
26	Expedite Form - form required at application and recertification to determine if applicant/recipient is eligible for expedited food stamp service. While required at recertification, individuals recertifying FS eligibility that have experienced no break or lapse in benefits are ineligible for expedited processing. Original in record, copy to applicant/recipient.
30A	Medical Assistance Data Entry Form - form that indicates Medicaid eligibility period for spend-down, YSA, CFSA, and other customers. Original in record.
30-AW	Medical Assistance Data Entry Form - form that indicates Medicaid eligibility period for Medicaid Waiver and Demonstration customers. Original in record.
107	Request for BMS Investigation - form used to request an investigation from the Office of Quality Assurance & Analysis (formerly known as the Bureau of Management Systems). Original to OQAA, copy in record.
107	Verification of Residence - form that can be used to verify residence.
107	Verification of Employment - form that can be used to verify employment and earnings.
107	Verification of Child Care - form that can be used to verify child care expenses.

107	Verification of Household Composition - form that can be used to verify household membership.
107	Financial Verification Statement - form that can be used to verify income.
107	Referral to APRA/POWER - form used to refer POWER recipients to the Addiction Prevention and Rehabilitation Administration for substance abuse treatment or counseling. Original to recipient, copy in record.
107	Referral to RSA/POWER - form used to refer POWER recipients to the Rehabilitation Services Administration. Original to recipient, copy in record.
107	Referral for Domestic Violence Services - form used to refer TANF applicant/recipient to the Domestic Violence Unit.
FNS 387	Food Stamp Change Report Form - form given to applicant/recipient to report interim changes to the Agency. Forms submitted by the recipient to report a change are kept in the case record.
495	Authorization for Investigation - form signed by applicants to authorize the agency to seek information from collateral contracts. Required for all MA, TANF, GC and FS cases (except by those applicants/recipients who use the DC Healthy Families application). Original and copy in record.
495-ARI	Release of Information [PDF] - form used by the customer to authorize the release of information, included protected health information to a third party.
496-COA	Change of Address - form used by Medicaid/Medical Assistance customers to report change of address.
726	Report of Overpayment - form used to report TANF overpayments to OIC and identify amount to be recouped. Original to recipient, copy in record, copy to Special Services.
854	Social Information-Medical Review - form completed by MA and TANF applicant/recipient and their SSR to determine incapacitation/disability in cases in which the applicant/recipient claims to be disabled or incapacitated. Original to MRT, copy in record.
856	Medical Examination Report [PDF] - form completed by applicant's/recipient's physician which is used to determine incapacitation/disability. Original to MRT, copy in record.
886	Information Exchange - form used when there is formal exchange of information within ESA or between ESA and other DC government entities. Original forwarded, copy in record.
886-Waiver	Notification of New Medicaid Waiver Case - form used by the Medicaid Branch to communicate to SSRs in a Service Center that one of their current customers has enrolled in a Medicaid Waiver program.
886-Ward*	Notification of District Ward Status [PDF] - form used by the Medicaid Branch to communicate to SSRs in a Service Center that one of their current customers has been declared to be a ward of the District.

1016	Verification of Marriage - form used to verify marriage.
1020	Referral to Medical Review Team - cover sheet for submitting the medical packet to MRT. Original forwarded, copy in record.
1049	Verification of Vital Event - form used for confirmation of birth or death in the District of Columbia.
1052	Record of Case Action - dictation sheet for case actions that is kept in the case record.
1209	Medicaid Recertification Form [PDF] [English] [En Español] - form used to re-determine Medicaid eligibility for non-TANF MA cases.
1209 W	Medicaid Recertification Form - form used by District agencies to report Medicaid eligibility recertification information for customers enrolled in Medicaid Waivers and Demonstrations.
1210	Medicaid Recertification Worksheet [PDF] - form used to determine the appropriate procedure for processing a Medicaid recertification form that is returned by the customer.
1288/A	Notice To Child Support Agency - form used to report information about absent parent(s) to the Child Support Enforcement Division (CSED). Original plus one copy to IV-D and copy in record.
1348	Request for a Fair Hearing - form completed by applicant/recipient or Agency representative to report request for a fair hearing. Original forwarded, copy in record.
1356	Manual Application Checklist - form used to request information needed to determine program eligibility from applicants when ACEDS is inoperable. Original to applicants, copy in record.
1400	Notice to Applicants [PDF] - form that notifies applicants of their rights. Original to applicant, copy in record.
1503	Redetermination of Eligibility - form generally used to schedule a TANF review. Form can also be used to gather additional needed information from applicants/recipients in any ESA program. Original to applicant/recipient, copy in record.
1549	Verification of School Attendance - form required for all TANF children 16 years of age and older to verify that a minor child is enrolled and/or attending school. This form can also be used to verify "Living With" and residency. Returned form is kept in case record.
1673A	Insurance Reporting Form (Third Party Liability) - form used to notify the Medical Assistance Administration of private health insurance coverage. Information must be entered on ACEDS "HEIC" screen. Original forwarded, copy in record.
1673B	Notice of Potential Medicaid Payment Recovery - form used to report potential resources such as lawsuit or workman's compensation to MAA. Original forwarded, copy in record.
1692	Countable Medical Expenses - form lists medical expenses incurred during the six month prospective period for spend-down cases. Original in record.

1693	Spend-down Worksheet - form used to compute periods of Medicaid eligibility under spend-down provisions. Original in record.
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1747	Food Stamp Claims Report - forms used to report FS overpayment. Original plus one copy along with verification is sent to FS Special Services Unit. Copy kept in case record
1779	Referral for Photo ID - form used to refer those FS applicants/recipients who have no official form of identification.
1926	Citizenship/Alienage Declaration - addendum used at application to ascertain citizenship and/or immigration status. When adding a person to the assistance unit, use a new addendum.
1934	Notice of Presumptive Eligibility Determination - form completed by agency to notify applicant/recipients of eligibility for presumptive eligibility for ambulatory prenatal care. Original to customer, copy in record.
1935	Presumptive Eligibility Determination Form - form completed by customer to determine eligibility for presumptive eligibility prenatal services. Original in record.

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES**

Income Maintenance Administration



Authorization for Release of Information

I hereby authorize the Department of Human Services, Income Maintenance Administration, to release the information contained in my case file to _____.

I understand that this request will expire thirty (30) days from the signature date below.

Customer Signature

Date



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

SOCIAL INFORMATION: MEDICAL REVIEW

NAME: PHONE: BIRTHDATE:

PART A: (To be completed by customer or a representative) Today's Date:

1. Your usual job:

2. Highest grade you completed in school: If you have any special training or skills please give a description:

..... Are you currently in a training program?

Are you interested in training? Why?

3. Why do you feel you are unable to work? (Customer's statement of illness; how it affects ability to work.)

4. **HOW HAVE YOU MANAGED UP TO NOW** (Include past periods getting TANF and also how you got by when unemployed.)

Type of work (starting with your last job)	Describe the duties and activities of the job	DATES		Why did you leave this job?
		From	To	

5. YOUR CURRENT MEDICAL TREATMENT

<i>What health problem?</i>	<i>What doctor, clinic or hospital</i>	<i>Last Appointment/ Next Appt.</i>
.....
.....
.....

6. IF YOU STAYED IN THE HOSPITAL

<i>What was it for? (starting with your last stay)</i>	<i>When was it?</i>
.....
.....

Customer's Name:

PART A was completed by: ☐ Customer ☐ SSR ☐ Telephone Contact ☐ Other

PART B (to be completed by SSR)

1. Is current medical report from customer's treating facility/doctor? If no, explain why not:

.....

.....

.....

2. From your contact with and observation of the customer, describe any physical, mental, and/or social factors you feel might impair the customer's ability to support self.

.....

.....

.....

.....

3. CUSTOMER'S STATUS WITH REHABILITATION/TREATING FACILITIES

(List if active at time of application and/or actions taken on team recommendations at time of review.)

Name of Agency/Facility	Date Referred	ACTIVE	NOT ACCEPTED OR CASE CLOSED
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

Has customer refused or failed to follow through with training or treatment? If yes, explain:

.....

.....

4. REMARKS:

SSR: **Date:**



Government of the District of Columbia
Department of Human Services
Income Maintenance Administration

For DHS Use Only

Worker: _____

Case #: _____

MRT Doctor

Reviewer: _____

MEDICAL EXAMINATION REPORT

Customer/Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Physician's Name: _____ Address: _____

Agency: _____ Phone: _____

The information provided in this form will be used to determine eligibility for benefits requiring a finding of disability under the Social Security disability criteria. Please focus your responses on the patient's ability to perform work functions.

Physical Examination Report *(To be completed by a medical professional):*

Date of exam: _____ Height: _____ Weight: _____

Medical Conditions, Clinical Manifestations, and Diagnosis:

(Please include ICD-9 Codes or DSM-IV Codes and avoid abbreviations as much as possible):

Describe Objective Findings, Clinical Findings and your treatment recommendations:

(Especially since we do not see the individual and need your observations. Please include all of the patient's positive test results and signs found during examination.):

Functional Limitations	Degree of Limitation				
Restrictions of Activities of Daily Living	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked <input type="checkbox"/>	Extreme <input type="checkbox"/>
Difficulties in maintaining Social Functioning	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked <input type="checkbox"/>	Extreme <input type="checkbox"/>
Difficulties in maintaining Concentration, Persistence, and/or Pace	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked <input type="checkbox"/>	Extreme <input type="checkbox"/>
Repeated episodes of decompensation in work or work like settings, each of an extended duration	None <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Marked <input type="checkbox"/>	Extreme <input type="checkbox"/>

Physical Capacities	Less than 2 hours	At least 2 hours	About 6 hours
Sit			
Stand			
Walk			

Check the heaviest weight the patient can lift/carry:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 25 lbs ☐ 50 lbs ☐ 100 lbs ☐ more than 100 lbs

Check the weight the patient can lift/carry frequently:

☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ more than 50 lbs

Evaluation: Based upon your evaluation, has your patient's medical condition lasted, or can it be expected to last, at least 12 months? **Yes** ☐ **No** ☐

Is the patient's medical condition expected to result in death? **Yes** ☐ **No** ☐

Does the patient's medical condition prevent him/her from working? **Yes** ☐ **No** ☐

If yes, please give the duration: Day___ Month___ Year___ to Day___ Month___ Year___

Remarks: (Please provide any additional information clarifying how the patient's condition limits his or her ability to work. If possible, include a description of any restrictions in Activities of Daily Living, and/or Social Functioning, and/or Concentration, Persistence, and/or Pace due to the patient's condition):

Please attach records or other additional medical or mental health evidence.

Signature of Medical Provider

Printed Name of Medical Provider

Date



DHS Form 886-W: Notification of District Ward Status

This is to advise you that the following child(ren) are now considered to be District wards. Accordingly, they have been coded out of a former AR/AX Medicaid cases. They have **NOT** been coded out of their former TANF and Food Stamps households. Please take appropriate case actions and send a timely notice to the TANF/Food Stamp head-of-household. Also, please work to resolve matters related to any TANF overpayments or Food Stamp over-issuances.

Child's Last Name	Child's First Name	SSN	Date of Birth	TANF/FS Case Number(s)

Comments/Notes:

SSR – Medicaid Branch

Tel: (202) _____
 Fax: (202) 724-8963

Carbon Copy to:
Maude Holt
Chief, Managed Care
Medical Assistance
Administration

(202) 442-9074 tel
(202) 442-4790 fax

PROCESSING MEDICAID RECERTIFICATIONS

Note: this worksheet is to be completed and stored in the case record for every case for which an SSR sends: (1) a request for additional info. and/or (2) a denial of continued Medicaid coverage.

STEP 1: Registering All Signed Recerts

Has this customer signed the recert form?

- ☐ Yes ☐ No

If "YES," register the recert in ACEDS and proceed to Step 2. If "NO," do not register the recert. Instead, file the unsigned recert in the case record; then, document this and sign the case dictation. Stop here.

STEP 2: Denials

Check if the following applies:

- ☐ Customer has moved outside of the District.

If you checked the box above, **STOP** here and send a denial notice.

Also, check if the following applies:

- ☐ Customer's only minor child turned 21.

If you checked the box above, deny AR/AX, add the SR or MC program for the Parent/Caretaker, if any. Register and process a separate MC application for the 21 year old. Go to Step 3 to determine Parent/Caretaker's eligibility.

Also, check if any of these apply:

- ☐ Customer's only remaining minor child turned 19 and their income is over the MNIL.
☐ Customer's only child moved out.

If you checked either box above, deny AR/AX, add the SR or MC program and go to step 3.

If you did **not** check any box above, go to Step 3.

STEP 3: Sufficient Info. to Process

Check if any of these apply:

- ☐ Customer recertified for Food Stamps within the last 3 mos. (and reports no change).
☐ Customer submitted 2 or more pay stubs for the last 60 days.
☐ Customer submitted a benefits statement that is dated within the last 12 mos. (if statement reflects most recent COLA).
☐ Customer stated that s/he receives only SS DI, SS RE, or SS SU income (see BENDEX).

AR/AX: If you checked any box above, you may have enough information to process the case. If you did not check a box, go to Step 4.

MC and SR: continue to Step 5.

STEP 4: AR/AX Customers Only

AR/AX only: check if any of these apply:

- ☐ AR/AX customer reported income in excess of the AR/AX standard; and
☐ Customer has been enrolled in the AR/AX program (but not Transitional Medical Assistance) for at least 3 of the last 6 mos.

If you checked **both** of the above, you have enough info. to process the Transitional MA (TMA); **STOP** here and process the case. Send an approval for the appropriate TMA period (six mos. for earnings, four mos. for child support). Otherwise, please proceed to Step 7.

STEP 5: MC and SR Customers Only

MC and SR only: check if any of these apply:

- ☐ Customer is 65 or older.
☐ Customer claims to be blind or disabled.
☐ Customer reports SSI or SSDI income.

If you checked any box above, then go to Step 6.

Otherwise, you may have enough information to process the case. If not, go to Step 7.

STEP 6: MC and SR Customers Only

MC and SR only: check if any of these apply:

- ☐ Customer is 65 or older.
☐ Customer's has current DIS period on MERT.
☐ Customer reports SSDI income.
☐ Customer has Medicare (check BENDEX).
☐ SR customer is now getting SSI (check SDX) and should have "9999" in cert thru field.

If you checked any of the above, then you may have enough info to process the case.

Otherwise, you should give the customer a Medical Exam Report (DHS Form 856). Go to Step 7. Customers will remain eligible for 120 days in order to have the 856 form completed.



NOTICE TO APPLICANTS

TANF and/or Medicaid/DC Healthy Families Applicants

You have a right to have your application resolved by DHS within **Forty-Five (45)** days. This means:

- We will send to you your notice of eligibility or your notice of ineligibility no later than **Forty-Five (45)** days from the day after your application was received. In Medicaid cases where a disability is claimed and a medical review is required, you will receive your notice within **Ninety (90)** days.
- If you are found eligible for TANF and/or Medicaid and wish to question the amount of your payment or your Medicaid coverage, you may contact your worker or request a Fair Hearing.
- If you have not received your eligibility notice or your notice of ineligibility within **Forty-Five (45)** days (or **Ninety (90)** days in Medicaid cases requiring a medical review) from the day after your application was received, you have a right to request a Fair Hearing. Please see "All Applicants" section on the reverse side of this form for more information.

Food Stamps Applicants

You have a right to have your application resolved by DHS within **Thirty (30)** days. This means:

- If you are eligible for Expedited Food Stamps, you will receive them within **Seven (7)** days after we receive your application. Expedited Food Stamps are available to you if (a) you have \$100 or less in available resources and less than \$150 in gross monthly income; (b) your monthly income and resources are less than your shelter costs; *or* (c) you are a migrant or seasonal farm worker.
- We will send to you your notice of eligibility or your notice of ineligibility no later than **Thirty (30)** days from the day after your application was received.
- If you are found eligible for Food Stamps and wish to question the amount of your benefit, you may contact your worker or request a Fair Hearing.
- If you have not received either your eligibility notice or your notice of ineligibility within **Thirty (30)** days from the day after your application was received, you have a right to request a Fair Hearing. Please see "All Applicants" section on the reverse side of this form for more information.

Interim Disability Assistance Applicants

You have a right to have your application resolved by DHS within **Sixty (60)** days. This means:

- We will send to you your notice of eligibility or your notice of ineligibility no later than **Sixty (60)** days from the day after your application was received.
- If you are found eligible for Interim Disability Assistance and wish to question the amount of your benefit, you may contact your worker or request a Fair Hearing.
- If you have not received your eligibility notice or your notice of ineligibility within **Sixty (60)** days from the day after your application was received, you have a right to request a Fair Hearing. Please see "All Applicants" section on the reverse side of this form for more information.

HealthCheck (EPSDT)

The HealthCheck program provides free check-ups and treatment to Medicaid- and D.C. Healthy Families-eligible children under age 21. The HealthCheck program is very important and can be obtained from any doctor or clinic participating in the Medicaid program. The HealthCheck program also helps in scheduling appointments and providing transportation to the doctor's office. For help in scheduling appointments and obtaining transportation call 1-800-MOM-BABY. For more information about the program, call (202) 727-0725.

I hereby declare that this form was discussed with me.

Signature of applicant: _____ Date: _____

Worker: _____ Telephone No: _____

All Applicants

You may call your worker, the **Office of Administrative Review and Appeals (698-4650)**, or the **Office of Fair Hearings (724-5431)** to request a Hearing. In addition, you may request a Hearing through one of the legal service agencies listed below. Should you request a Hearing, the law provides that:

1. You have a right to be represented by legal counsel or by a layperson who is not an employee of the Government of the District of Columbia.
2. You may bring witnesses on your behalf.
3. Reasonable expenses relating to the Hearing, such as transportation costs for you and witnesses, will be paid by the DHS.
4. You may expect a decision within **Sixty (60)** days of the date of your request.
5. **Free** legal services are available to you. A list of locations where free legal services may be obtained is listed below.

Free Legal Services

Neighborhood Legal Services
1213 Good Hope Rd., SE
(202) 678-2000

Neighborhood Legal Services
3rd Floor
701 Fourth St., NW
(202) 682-2735

Legal Aid Society
Suite 800
666 11th St., NW
(202) 628-1161

Neighborhood Legal Services
1st Floor
701 Fourth St., NW
(202) 682-2700

Bread for the City Free Legal
Clinic
1525 Seventh St., NW
(202) 265-2400

Legal Counsel for the Elderly
(for people age 60 and older)
601 E St., NW
Building A, 4th Floor
(202) 434-2120

***For legal help with
Medicaid issues, contact:***

Terris and Pravlik
1121 12th St., NW
Washington, DC 20005
(202) 682-0578

STEP 7: Request for Additional Info.

Note: if this customer just got a 120-day certification in order to provide missing verifications, then proceed to Step 8. Otherwise:

Check areas for which the customer may not have provided sufficient info:

- ☐ Earnings
- ☐ Unearned income
- ☐ Resources (MC and SR customers only)
- ☐ New Medical Form (**not** for customers 65+)
- ☐ Verifications for other reported changes
- ☐ Other (specify): _____

If you checked any of the above, speak with your supervisor before requesting additional info. With your supervisor's approval (noted with their signature below), you should:

- (1) *contact the customer by telephone to request the missing info.; **and***
- (2) *issue a General Communication (C617) requesting verifications marked above; **and***
- (3) *approve eligibility with a **4** month cert period.*

Supervisor's Authorization:

- ☐ Yes, issue the notice and approve eligibility with 4-month cert period. Make sure that the recert is registered.

Signature

Date: _____

For SSR:

Customer's telephone: _____

Date of telephone contact: _____

Date General Communication (C617) sent:

STEP 8: Terminations

You may initiate a termination if:

- ☐ The customer did not respond to the prior General Communication requesting additional info;
- ☐ AR/AX-customer has exhausted Transitional MA period (6 mos. for earnings, 4 mos. for child support) and continues to report earnings above the scale;
- ☐ MC customer did not return Medical Form after four months as requested in a General Communication or MC Approval-Short Cert A822);
- ☐ MC customer did not provide Alien ID # after 4 months, as requested in an A822;
- ☐ 21 year old MC customer did not apply for continued benefits after 4 months as requested in an A822;
- ☐ MC or SR-customer is over-income; or
- ☐ MC or SR-customer is over-resourced.

If you checked any of the above, speak with your supervisor about initiating a termination. If your supervisor agrees that the customer's Medicaid should be terminated (denoted by their signature below), then please ensure that:

- (1) *you send a notice before terminating benefits in ACEDS; and*
- (2) *you terminate benefits at the end of the certification period (or thereafter in order to comply with adequate and timely notice requirements). **

Supervisor's Authorization:

- ☐ Yes, issue a denial notice to the customer and then terminate eligibility in ACEDS.

Signature

Date: _____

* Note: you may terminate benefits prior to the end of the certification period in the event that the customer dies, moves outside of the District, or loses contact with IMA (i.e., mail is returned.)

APPENDIX C2 - CASE RECORD ORGANIZATION

This section illustrates the appropriate location of materials kept in the case record including the application, various forms, and verification materials. All documents dated within last three years must be maintained. Do not purge case records without supervisory authorization.

TANF/Power Cases

(Notices and Forms Should Be Filed Accordingly)

Section One

- Preliminary Assessment
- Photo ID Referral
- Token Receipt Form
- Voter Registration
- EBT Referral Form

Section Two

- MEAE Printout
- TANF Work Activity Referral
- Medical/MRT Packet (856,854,1020)
- Referral to RSA
- Referral to APRA
- FSET-1
- 495 Authorization for Investigation
- Referral for Domestic Violence
- 1673A Third Party Liability
- 1673B Notice of Potential Medicaid Payment Recovery
- Presumptive Eligibility Forms
- Report of Non-compliance with TANF Requirements
- FSET-3

Section Three

- Generic Application/CAD Addendum
- Food Stamp Expense Addendum
- 1052 Record of Case Action
- 1400 Notice to Applicant
- Generic Recertification Form

- Food Stamp Penalty Warning
- 26 Expedite Form

Section Four

- Rental Vendor Payment
- Food Stamp Change Report Form
- Periodic Reports
- Cap 1/Cap 2 Printouts
- 1747 FS Claim Report
- 726 Report of Overpayment
- Approval/Denial Notices
- Adverse Action Notices
- Benefit Change Notices

Section Five

- 1288 Notice to IV-D
- 1348 Request for Hearing
- 886 Information Exchange
- UCB Printout(s)
- Request for OQAA Investigation
- SSI, DMV, BENDEX Printouts
- Report of Investigation
- IV-D Partnership Agreement
- Printout of Child Support Noncompliance Alert

Section Six

- Verifications for:
 - Age/Relationship
 - Enumeration
 - Living With
 - Child Care
 - Residency/Shelter Cost
 - Earnings/Unearned Income
 - Resources
- 1503 Redetermination of Eligibility
- 1549 School Form

- 1049 Verification of Vital Event
- Receipt of Application for SSN
- Application Checklist

Medicaid-only Cases

(Notices and Forms Should Be Filed Accordingly)

Section One

- Generic or D.C. Healthy Families Application
- 1052 Record of Case Action
- CAD Addendum
- Generic Recertification
- Checklist
- 1209 Recertification Form
- 1288/a Notice to IV-D
- Presumptive Eligibility Form(s)
- 1673A Third Party Liability Form
- 495 Authorization for Investigation
- 1400 Notice to Applicant
- 1673B Notice of Potential Medicaid Payment Recovery

|Section Two

- Recertification Packet
 - Disposition Notice
 - Interface Printout(s)
 - Income Verification
 - Asset Verification

- Application Packet
 - Disposition Notice
 - Interface Printout
 - Income Verification
 - Medical Bills
 - Non-Financial Verifications
- Medical/MRT Packet (856,854, 1020)
- 1503 Redetermination of Eligibility
- Request for OQAA Investigation
- 1348 Request for Fair Hearing

Food Stamp Only Cases

(Notices and Forms Should Be Filed Accordingly)

Section One

- 1052 Record of Case Action
- Generic Application/CAD Addendum
- Food Stamp Expense Addendum
- 26 Expedite
- Checklist
- Generic Recertification Form
- Penalty Warnings Form
- 495 Authorization for Investigation Form

Section Two

- 1747 Food Stamp Claim Report Form
- 387 Change Form
- Income Verification
- Asset Verification
- Disposition Notices
- Non-financial Verifications
- EBT Referral
- FSET-1 Referral Form

- FSET-3 Noncompliance Form
- Photo ID Referral Form
- Request for OQAA Investigation
- 1348 Request for Fair Hearings
- 1503 Redetermination of Eligibility

APPENDIX C3 - CHECKLIST FOR CASE ACTIONS

The following sections provide checklists of common forms and actions that need to be completed for specific case circumstances such as taking a TANF application, completing a FS recertification or adding a newborn to a group.

I. TAKING AND PROCESSING A TANF APPLICATION

I-1: Forms that must be completed or given to applicant:

- ☐ Generic Application
- ☐ Checklist for Customer
- ☐ Preliminary Assessment
- ☐ Dictation Sheet
- ☐ Voter Registration (If Applicable)
- ☐ TANF Work Activity Referral (If Applicable)
- ☐ 1400 Notice to Applicants
- ☐ 1288 Notice to Child Support
- ☐ IV-D Partnership Agreement
- ☐ 1549 School Form (If Applicable)

I-2: Information to collect from applicant

- ☐ Living with Verification (Two (2) Verifications Needed)
- ☐ Residency Verification (Unless Homeless)
- ☐ Asset Verification
- ☐ Income Verification
- ☐ Relationship Verification
- ☐ Enumeration Verification

I-3: Actions to Be Taken:

- ☐ Explain EPSDT
- ☐ Check Interface Screen Before Terminating Interview
- ☐ Discuss Work Requirements and Sanctions
- ☐ Discuss Child Support Requirements, Good Cause for Non-cooperation, and Sanctions
- ☐ Discuss Requirement That Changes Be Reported

II. TANF REDETERMINATION

II-1: Forms that must be completed or given to recipient:

- ☐ Recertification Form
- ☐ Checklist (If Applicable)
- ☐ 1052 Record of Case Action
- ☐ TANF Work Activity Referral (If Applicable)
- ☐ If Recertifying for Food Stamps, Use Expedite Form
- ☐ Child Care Expense Form (If Applicable)

II-2: Information to Collect from Recipient:

- ☐ School Verification (If Applicable)
- ☐ Residency Verification
- ☐ Income Verification
- ☐ Asset Verification

II-3: Actions to Be Taken:

- ☐ Check Interface Screen Before Terminating Interview
- ☐ Discuss Work Requirements and Sanctions
- ☐ Discuss Child Support Requirements, Good Cause for Non-cooperation, and Sanctions
- ☐ Discuss Requirement That Changes Be Reported

III. TAKING AND PROCESSING A FOOD STAMP APPLICATION

III-1: Forms that must be completed or given to applicant:

- ☐ Generic or Food Stamp Only Application
- ☐ Checklist to Be Given to Customer
- ☐ 26 Expedite Form
- ☐ 1400 Notice to Applicants
- ☐ FSET-1 Employment - Training Referral (Done Every 12 Months)
- ☐ 1052 Record of Case Action
- ☐ FNS 387 Food Stamp Change Report Form
- ☐ Photo ID Referral (If Applicable)
- ☐ Voter Registration (If Applicable)
- ☐ Domestic Violence [Brochure](#)

III-2: Information to Collect from Applicant:

- ☐ Living with Verification (If Questionable)
- ☐ FS Shelter Cost Verification
- ☐ Child Care Expense Verification
- ☐ Residency Verification (Unless Categorically Eligible)
- ☐ Asset Verification (Unless Categorically Eligible)
- ☐ Earning Verification (Unless Categorically Eligible)
- ☐ Unearned Income Verification (Unless Categorically [Eligible](#))

III-3: Actions to Be Taken:

- ☐ Check Interface Screen Before Terminating Interview
- ☐ Discuss FSET Requirements and Sanctions
- ☐ Discuss Requirements That Changes Be Reported, Including Simplified Reporting If [Applicable](#)

IV. FOOD STAMP RECERTIFICATION

IV-1: Forms that must be completed or given to recipient:

- ☐ Expedite Forms
- ☐ Generic Recertification Form
- ☐ FNS 387 Food Stamp Change Report Form
- ☐ 1052 Record of Case Action
- ☐ FSET-1 Employment Training Referral (Every 12 Months)
- ☐ Voter Registration (If Applicable)
- ☐ Domestic Violence Brochure

IV-2: Information to Collect from Recipient:

- ☐ Living with Verification (Only If Questionable)
- ☐ Expense Verification
- ☐ Residency Verification (Unless Categorically Eligible)
- ☐ Child Care Expense Verification
- ☐ Income Verification (Unless Categorically Eligible)
- ☐ Asset Verification (Unless Categorically Eligible)

IV-3: Actions to Be Taken:

- ☐ Check Interface Screen Before Terminating Interview
- ☐ Discuss FSET Requirements and Sanctions
- ☐ Discuss Requirements That Changes Be Reported, Including Simplified Reporting **If Applicable**

V. Taking and Processing a Medicaid Application Using Generic Application

V-1: Forms that must be completed or given to applicant:

- ☐ Generic Application/DC Healthy Families Application
- ☐ 1288A Notice to Child Support Office (If Applicable)
- ☐ 856/854 Medical Report/Social Information (If Applicable)

- ☐ Notice of Privacy Practices (If Applicable)
- ☐ 1400 Notice to Applicants
- ☐ Third Party Liability Form (If Applicable)
- ☐ 1052 Record of Case Action
- ☐ Checklist to Be Given to Applicant/recipient
- ☐ Voter Registration (If Applicable)
- ☐ Presumptive Eligibility Form(s) (If Applicable)

V-2: Information to Collect from Applicant:

- ☐ Residency Verification
- ☐ Income Verification
- ☐ Asset Verification
- ☐ Relationship Verification (If Applicable)
- ☐ Age Verification (If Needed)
- ☐ Confirmation of Pregnancy (If Applicable)
- ☐ Confirmation of Disability from SSA (If Applicable)

V-3: Actions to Be Taken:

- ☐ Explain EPSDT (If Applicable)
- ☐ Check Interface Screen Before Terminating Interview
- ☐ Discuss Child Support Requirement and Sanction (If Applicable)

Appendix C4 – FACT SHEETS

The following factsheets are available in PDF form.

- Medicaid Overview [\[English\]](#) [\[En Español\]](#)
- Spend-Down Overview [\[English\]](#) [\[En Español\]](#)
- Long-Term Care Overview [\[English\]](#) [\[En Español\]](#)
- Medicare and Prescription Drugs [\[English\]](#) [\[En Español\]](#)
- Summary of the DC Healthcare Alliance Transition [\[English\]](#) [\[En Español\]](#)
- Shifting from DC Healthcare Alliance to Medicaid Eligibility Rules [\[English\]](#)

APPENDIX D1 - MEDICAID PROGRAM CODES

The following table explains the various Medicaid Program Codes used in ACEDS.

The 'First Digit' identifies the program and/or income level.

Digit	Program/Scale	Definition
000	QM	Eligible for Medicare Buy-in Only (applies to QMB's, SLMB's, QI's, and QDWI's).
100	SSI OR TANF	Eligible for Title XIX reimbursement. Individual receives SSI or TANF and, therefore, is categorically eligible for Medicaid.
300	Medically Needy	Eligible for Title XIX reimbursement. Group passed at the Medically Needy Income Level and medically needy resource test.
400	Special Programs	Not eligible for Title XIX reimbursement. Individual eligible for Immigrant Children's Program or other locally-funded program.
500	Spend-down	Eligible due to meeting Spend-Down (used by Spend-Down Unit ONLY).
600	Not Eligible	Not eligible or conditionally eligible (eligible if the group meets the spend-down liability.)
700	Poverty	Eligible for Title XIX. Child/pregnant woman who passed under various poverty scales or an elderly/disabled person who has income below 100 percent of poverty line.
800	D.C. Healthy Families	Eligible for Title XIX reimbursement. Child or caretaker with income below 200 percent of the poverty level. Individual ineligible under other AR categories.
900	Categorically Needy	Eligible for Title XIX reimbursement. AR group eligible because income was below TANF payment level and resources were below \$1,000 but group does not receive TANF. Passed at 'categorically needy' level

The 'Second Digit' identifies characteristics about the person.

Digit	Definition
010	Person is 65 years old or older
020	Child under 21
030	AR or AX adult
040	Blind person
050	Person is disabled and under 65
060	Child under 21 in foster care or ward of the city
070	Adult who is not 65, disabled, blind, or deceased and is not a caretaker of a child
090	Deceased Person

The 'Third Digit' identifies additional information about the person. When none of these apply, the individual is coded with a '0' in the 3rd digit

Digit	Definition
001	Child is a ward
002	Child in non-medical D.C. Gov't institution (i.e. Oak Hill)
003	Person is in LTC
006	Not eligible due to excess resources
007	Not eligible due to failure to provide information
008	Not eligible due to excess income
009	Not eligible due to non-residence

The following suffixes trail the standard Medicaid codes and provide additional information.

Letter	Definition	Example
----A	Qualified Individual-1 (QI-1)	010 A
----B	Qualified Individual-2 (QI-2) [Retired]	050 B
----C	DC Healthy Families/CHIP child	820 C
----G	Extended/Transitional Medicaid	938 G
----H	Hurricane/Disaster Evacuee	930H
----P	Eligible because of the Pickle decree, not a QMB	910 P
----Q	Qualified Medicare Beneficiary (QMB)	710 Q
----R	Eligible because of the Pickle decree and Qualified Medicare Beneficiary	910 R
----S	Special Low Income Medicare Beneficiary (SLIMB)	050 S
----W	Presumptive Eligibility	730 W

APPENDIX D2 - ACTIVE MEDICAID PROGRAM CODES

Program Code	ACEDS Recertification Period	Processing Notes	Full Definition
010A	12 mos.		Aged person non-eligible for Medicaid but meeting requirements of Qualified Individual (QI-1) program. Medicaid pays the full Medicare Part B Premiums.
010Q	12 mos.		Aged person non-eligible for Medicaid but meeting eligibility requirements of Qualified Medicare Beneficiary (QMB) program and/or Special Low-Income Medicare Beneficiary (SLMB) program. Medicaid pays the full Medicare Part B Premiums. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
010S	12 mos.		Aged person non-eligible for Medicaid but meeting eligibility requirements of Special Low-Income Medicare Beneficiary (SLMB) program. Medicaid pays the full Medicare Part B Premiums.
050A	12 mos.		Disabled person non-eligible for Medicaid but meeting requirements of Qualified Individual (QI-1) program. Medicaid pays the full Medicare Part B Premiums.
050Q	12 mos.		Disabled person non-eligible for Medicaid but meeting eligibility requirements of Qualified Medicare Beneficiary (QMB) program and/or Special Low-Income Medicare Beneficiary (SLMB) program. Medicaid pays the full Medicare Part B Premiums. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
050S	12 mos.		Disabled person non-eligible for Medicaid but meeting eligibility requirements of Special Low-Income Medicare Beneficiary (SLMB) program. Medicaid pays the full Medicare Part B Premiums.

110	N/A (categorically eligible)		Aged person and receiving SSI and/or State Supplement. Eligible for Title XIX (Medicaid) reimbursement.
110Q	N/A (categorically eligible)		Aged person and receiving SSI and/or State Supplement and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare)

			and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
113	N/A (categorically eligible)	Processed by LTC unit only	Aged person and receiving SSI personal need allowance and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
113Q	N/A (categorically eligible)	Processed by LTC unit only	Aged person receiving SSI personal needs allowance and subject to long term care financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
120	N/A (categorically eligible)		Child under 19 receiving AFDC/TANF. Eligible for Title XIX (Medicaid) reimbursement.
130	N/A (categorically eligible)		Adult receiving AFDC/TANF. Eligible for Title XIX (Medicaid) reimbursement.
140	N/A (categorically eligible)		Blind person and receiving SSI and/or State Supplement. Eligible for Title XIX (Medicaid) reimbursement.
140Q	N/A (categorically eligible)		Blind person and receiving SSI and/or State Supplement and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
143	N/A (categorically eligible)	Processed by LTC unit only	Blind person receiving SSI personal needs allowance and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
143Q	N/A (categorically eligible)	Processed by LTC unit only	Blind person receiving SSI personal needs allowance and subject to long term care financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
150	N/A (categorically eligible)		Disabled person and receiving SSI and/or State Supplement. Eligible for Title XIX (Medicaid) reimbursement.
150G	N/A (categorically eligible)	Processed by Medicaid Branch	Former SSI recipient who is deemed to be receiving SSI for purposes of Medicaid eligibility

		only	but not in receipt of any SSI cash payment. Eligible for Title XIX (Medicaid) reimbursement; may also be dually-eligible for Title XVIII (Medicare.)
150Q	N/A (categorically eligible)		Disabled person and receiving SSI and/or State Supplement and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
153	N/A (categorically eligible)	Processed by LTC unit only	Disabled person receiving SSI personal needs allowance and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
153Q	N/A (categorically eligible)	Processed by LTC unit only	Disabled person receiving SSI personal needs allowance and subject to long term care financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
160	N/A (categorically eligible)	Processed by Medicaid Branch only	Child residing in the District of Columbia who is a ward of another state and who is not being involuntarily detained. Eligible for Title XIX (Medicaid) reimbursement.
161	N/A (categorically eligible)	Processed by Medicaid Branch only	Child who is a ward of the District of Columbia Government (e.g., CFSA or DYRS customer) and who is not being detained in a penal institution. Eligible for Title XIX (Medicaid) reimbursement.
161M	N/A (categorically eligible)	Processed by Medicaid Branch only	Child who is a ward of the District of Columbia Government (e.g., DYRS customer) and who is not being detained in a penal institution but rather is being served in a community setting. Eligible for Title XIX (Medicaid) reimbursement.
313	12 mos.	Processed by LTC unit only	Aged person meeting medically needy eligibility requirements and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
313Q	12 mos.	Processed by LTC unit only	Aged person meeting medically needy eligibility requirements and subject to long term care financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.

320	12 mos.		Child under 21 meeting AFDC/TANF definition and medically needy eligibility requirements, but not eligible for financial assistance. Eligible for Title XIX (Medicaid) reimbursement.
330	12 mos.		Adult meeting AFDC/TANF definition and medically needy eligibility requirements, but not eligible for financial assistance. Eligible for Title XIX (Medicaid) reimbursement.
343	12 mos.	Processed by LTC unit only	Blind person meeting medically needy eligibility requirements and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
343Q	12 mos.	Processed by LTC unit only	Blind person meeting medically needy eligibility requirements and subject to long term care financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
353	12 mos.	Processed by LTC unit only	Disabled person meeting medically needy eligibility requirements and subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
353Q	12 mos.	Processed by LTC unit only	Disabled person meeting medically needy eligibility requirements and subject to long term care financial provisions and also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
360	12 mos.		Emancipated minor (under 21) meeting medically needy eligibility requirements. Eligible for Title XIX (Medicaid) reimbursement.
361	N/A (categorically eligible)	Processed by Medicaid Unit only	Child under 21 who is a ward of the District of Columbia Government who is neither being maintained in a penal institution nor foster home setting. Rather, these customers are under the Shelter Care and Temporary Placement Program through CFSA. Eligible for Title XIX (Medicaid) reimbursement.
362	N/A (categorically eligible)	Processed by Medicaid Unit only	Child under 21 is a ward of the District of Columbia Government who is in the Guardianship program (e.g., CFSA client). Eligible for Title XIX (Medicaid) reimbursement.
370	12 mos.		Special Needs: 50-64. Eligible for Medicaid.
420	12 mos.	Processed by	Non-qualified alien child under 21 eligible for

		Multi-National Unit only	Immigrant Children's Program.
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460	12 mos.		Child under the age of 21 who is eligible for the DC Healthcare Alliance.
470	12 mos.		Adult who is eligible for the DC Healthcare Alliance.
518	6 mos.	Processed by Spend-Down unit only	Aged person who acquires eligibility by the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.
518A	6 mos.	Processed by Spend-Down unit only	Aged person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid); Part B premium paid because customer is a QI-1.
518Q	6 mos. for SR/ 12 mos. for QM	Processed by Spend-Down unit only	Aged person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) and meets requirements of a QMB and/or SLMB. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
518S	6 mos.	Processed by Spend-Down unit only	Aged person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX as a SLMB.
528	6 mos.	Processed by Spend-Down unit only	Child under 21 meeting AFDC/TANF definition who acquires eligibility by the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.
538	6 mos.	Processed by Spend-Down unit only	Adult meeting AFDC/TANF definition who acquires eligibility by the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.
548	6 mos.	Processed by Spend-Down unit only	Blind person who acquires eligibility by the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.
548Q	6 mos. for SR/ 12 mos. for QM	Processed by Spend-Down unit only	Blind person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) and meets requirements of a QMB and/or SLMB. Medicaid pays the full Medicare Part B premiums. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
558	6 mos.	Processed by Spend-Down unit only	Disabled person who acquires eligibility by the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.

558A	6 mos.	Processed by Spend-Down unit only	Disabled person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid); Part B premium paid because customer is a QI-1.
558Q	6 mos. for SR/ 12 mos. for QM	Processed by Spend-Down unit only	Disabled person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) and meets requirements of a QMB and/or SLMB. Medicaid pays the full Medicare Part B premiums. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
558S	6 mos.	Processed by Spend-Down unit only	Disabled person who acquires eligibility by the Spend-Down process. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) and meets requirements of a SLMB.
606			Person whose resources exceed Medicaid resource limit (generally for SR, LT, and AZ Medicaid only.)
607			Insufficient information to determine eligibility or continued eligibility.
609			Not domiciled in the District of Columbia.
618			Aged person. Must spend-down.
628			AFDC/TANF related child whose countable income is above the Medicaid eligibility requirements. Must spend-down.
638			AFDC/TANF related adult whose countable income is above the Medicaid eligibility requirements. Must spend-down.
648			Blind person whose countable income is above the Medicaid eligibility requirements. Must spend-down.
658			Disabled person whose countable income is above the Medicaid eligibility requirements. Must spend-down.
668			Non-AFDC/TANF related child whose countable income is above the Medicaid eligibility requirements. Must spend-down.

690			Deceased person who was eligible as categorically related or non-categorically related prior to the date of death.
710	12 mos.		Aged person and eligible because countable income is below the Federal Poverty Level. Eligible for Title XIX (Medicaid) reimbursement.

710Q	12 mos.		Aged person and eligible because countable income is below the Federal Poverty Level and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
720	12 mos.		AFDC/TANF related child under 21 eligible because countable income is below: 1) 185% of the Federal Poverty Level for children under 1; 2) 133% of the FPL for children aged 1-5; 3) 100% of the FPL for children aged 6-18; or 4) 200% of the FPL for children aged 19 or 20. Eligible for Title XIX (Medicaid) reimbursement.
726	12 mos.		Child under political asylum or refugee status. Eligible for Title XIX (Medicaid) reimbursement.
730	12 mos.		AFDC/TANF related pregnant woman or mother eligible because countable income is below 185% of the Federal Poverty Level. Eligible for Title XIX (Medicaid) reimbursement.
730W	approx. 2 mos. (See Policy Manual)		AFDC/TANF related pregnant woman presumed eligible for a limited period because countable income is below 185% of the Federal Poverty Level. Eligible for Title XIX (Medicaid) reimbursement.
740	12 mos.		Blind person eligible because countable income is below the Federal Poverty Level. Eligible for Title XIX (Medicaid) reimbursement.

740Q	12 mos.		Blind person eligible because countable income is below the Federal Poverty Level and also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
750	12 mos.		Disabled person eligible because countable income is below the Federal Poverty Level. Eligible for Title XIX (Medicaid) reimbursement.
750Q	12 mos.		Disabled person eligible because countable income is below the Federal Poverty Level and also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day

			retroactive period.
757	N/A	Processed by Medicaid Unit only	Special Needs: BCCEDTP. Eligible for Medicaid.
757A	N/A	Processed by Medicaid Unit only	Special Needs: BCCEDTP customer who is dually eligible for Title XVIII (Medicare) and Medicaid and meets requirements of a QI-1.
757Q	N/A	Processed by Medicaid Unit only	Special Needs: BCCEDTP customer who is dually eligible for Title XVIII (Medicare) and Medicaid and meets requirements of a QMB and/or SLMB. Medicaid pays for the Medicare Part B premiums. Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
757S	N/A	Processed by Medicaid Unit only	Special Needs: BCCEDTP customer who is dually eligible for Title XVIII (Medicare) and Medicaid and meets requirements of a SLMB.
760	12 mos.		Non-AFDC/TANF related child eligible because countable income is below 185% of the Federal Poverty Level Eligible for Title XIX (Medicaid) reimbursement.
762	12 mos.	Processed by Medicaid Unit only	Subsidized adopted child. Eligible for Title XIX (Medicaid) reimbursement.
763	12 mos.		Repatriate child. Eligible for Title XIX (Medicaid) reimbursement.

766	12 mos.		Unaccompanied minor under refugee status. Eligible for Title XIX (Medicaid) reimbursement.
774	12 mos.		Childless Adult with countable income under 133% of Federal Poverty Scale. Eligible for Title XIX reimbursement.
775	12 mos.		Childless Adult with countable income between 133% and 200% of Federal Poverty Level. Eligible for Title XIX reimbursement.
776			Adult under political asylum or refugee status. Eligible for Title XIX (Medicaid) reimbursement.
780	Varies	Processed by Multi-National Unit only	Non-qualified alien eligible for coverage for emergency medical services. Persons must otherwise be eligible for Medicaid. Persons may qualify for emergency coverage via the Spend-Down process. Eligible for Title XIX (Medicaid) reimbursement.
820	12 mos.		Medical Expansion for children under 19 who

			have health insurance. Eligible for Title XIX (Medicaid) reimbursement.
820C	12 mos.		Medical Expansion for uninsured children under 19 (SCHIP). Eligible for Title XXI (Medicaid/SCHIP) reimbursement.
830	12 mos.		Medical expansion for parents of eligible children. Eligible for Title XIX (Medicaid) reimbursement.

830A	12 mos.		Medical expansion for parents of eligible children. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid); Part B premium paid because customer is a QI-1.
830Q	12 mos.		Medical expansion for parents of eligible children. Part B premium paid because customer is a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid.) Note: Effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.

830S	12 mos.		Medical expansion for parents of eligible children. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid); Part B premium paid because customer is a SLMB.
850	N/A	Processed by Medicaid Unit only	Special Needs: H2O. Eligible for Medicaid.
850A	N/A	Processed by Medicaid Unit only	Special Needs: H2O. Dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QI-1.
850Q	N/A	Processed by Medicaid Unit only	Special Needs: H2O. Dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QMB and/or SLMB. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
850S	N/A	Processed by Medicaid Unit only	Special Needs: H2O. Dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a SLMB.
853	N/A	Processed by Medicaid Unit only	Special Needs: EPD. Eligible for Medicaid.
853A	N/A	Processed by Medicaid Unit only	Special Needs: EPD customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QI-1.
853Q	N/A	Processed by	Special Needs: EPD customer who is dually

		Medicaid Unit only	eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QMB and/or SLMB. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
853S	N/A	Processed by Medicaid Unit only Special Needs:	EPD customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a SLMB.
870	N/A	Processed by Medicaid Unit only	Special Needs: TWWIIA. Eligible for Medicaid.

870A	N/A	Processed by Medicaid Unit only	Special Needs: TWWIIA customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QI-1.
870Q	N/A	Processed by Medicaid Unit only	Special Needs: TWWIIA customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QMB and/or SLMB. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
870S	N/A	Processed by Medicaid Unit only	Special Needs: TWWIIA customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a SLMB.
873	N/A	Processed by Medicaid Unit only	Special Needs: MRDD. Eligible for Medicaid.
873A	N/A	Processed by Medicaid Unit only	Special Needs: MRDD customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QI-1.
873Q	N/A	Processed by Medicaid Unit only Special Needs:	MRDD customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a QMB and/or SLMB. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
873S	N/A	Processed by Medicaid Unit only	Special Needs: MRDD customer who is dually eligible for Title XVIII (Medicare) and Medicaid; Part B premium paid because customer is a SLMB.
880	N/A	Processed by Medicaid Unit only	Special Needs: 1115. Eligible for Medicaid.

910	12 mos.		Aged person meeting medically needy eligibility requirements with income less than the SSI payment standard but not receiving SSI. Eligible for Title XIX (Medicaid) reimbursement.
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910H	initially, 4 mos.		Aged person eligible for Medicaid who is a hurricane/natural disaster evacuee now living in DC. Eligible for Title XIX (Medicaid) reimbursement.
910Q	12 mos.		Aged person meeting medically needy eligibility requirements with income less than the SSI payment standard but not receiving SSI; also meets requirements of a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
913	12 mos.	Processed by LTC unit only	Aged person receiving income less than SSI payment standard but not receiving SSI, and who is subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
913Q	12 mos.	Processed by LTC unit only	Aged person receiving income less than SSI payment standard but not receiving SSI, and who is subject to long term care financial provisions; also meets requirements of a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
920	12 mos.		AFDC/TANF related child meeting medically needy eligibility requirements with income less than the AFDC/TANF financial assistance payment standard. Eligible for Title XIX (Medicaid) reimbursement.
920H	initially, 4 mos.		Child eligible for Medicaid who is a hurricane/natural disaster evacuee now living in DC. Eligible for Title XIX (Medicaid) reimbursement.
928	4 mos.		AFDC/TANF child eligible for extended coverage for four months because of increased child support. Eligible for Title XIX (Medicaid) reimbursement.

928G	6 mos.		AFDC/TANF related child eligible for six additional months due to termination of Medicaid
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			benefits because of increased earnings. Eligible for Title XIX (Medicaid) reimbursement.
930	12 mos.		AFDC/TANF related adult meeting medically needy eligibility requirements with income less than the AFDC/TANF financial assistance standard. Eligible for Title XIX (Medicaid) reimbursement.
930H	initially, 4 mos.		Parent, adult caretaker or pregnant individual who is eligible for Medicaid and who is a hurricane/natural disaster evacuee now living in DC.
930Q	12 mos.		AFDC/TANF related adult meeting medically needy eligibility requirements with income less than the AFDC/TANF financial assistance standard. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement as a QMB and/or SLMB. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
938	4 mos.		AFDC/TANF child eligible for extended coverage for four months because of increased child support. Eligible for Title XIX (Medicaid) reimbursement.
938G	3 mos.		AFDC/TANF related adult eligible for six additional months due to termination of coverage because of increased earnings or hours of employment of a member of the AFDC/TANF family unit. Eligible for Title XIX (Medicaid) reimbursement.
940	12 mos.		Blind person meeting medically needy eligibility requirements with income less than the SSI payment standard but not receiving SSI. Eligible for Title XIX (Medicaid) reimbursement.

940Q	12 mos.		Blind person receiving income less than SSI payment standard but not receiving SSI, and who is subject to long term care financial provisions; also meets requirements of a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
943	12 mos.	Processed by LTC unit only	Blind person with income less than the SSI payment standard but not receiving SSI, and who is subject to long term care eligibility financial provisions. Eligible for Title XIX (Medicaid) reimbursement.

943Q	12 mos.	Processed by LTC unit only	Blind person with income less than the SSI payment standard but not receiving SSI, and who is subject to long term care eligibility financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
950	12 mos.		Disabled person meeting medically needy eligibility requirements with income less than the SSI payment standard but not receiving SSI. Eligible for Title XIX (Medicaid) reimbursement.
950H	initially, 4 mos.		Disabled person eligible for Medicaid who is a hurricane/natural disaster evacuee now living in DC. Eligible for Title XIX (Medicaid) reimbursement.
950Q	12 mos.		Disabled person receiving income less than SSI payment standard but not receiving SSI, and who is subject to long term care financial provisions; also meets requirements of a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.

953	12 mos.	Processed by LTC unit only	Disabled person receiving income less than SSI payment standard but not receiving SSI, and who is subject to long term care financial provisions. Eligible for Title XIX (Medicaid) reimbursement.
953Q	12 mos.	Processed by LTC unit only	Disabled person with income less than the SSI payment standard and subject to long term care eligibility financial provisions and is also eligible as a QMB and/or SLMB. Dually eligible for Title XVIII (Medicare) and XIX (Medicaid) reimbursement. Note: effective July 1, 2005, SLMB eligibility is only for the month of application and any eligibility during the 90-day retroactive period.
960	12 mos.		Person under the age of 21 and receiving General Assistance for Children. Eligible for Title XIX (Medicaid) reimbursement.

APPENDIX E - IMPORTANT LINKS

Policy and Program Information

Medicaid Information

CMS' Medicaid Overview

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/index.html?redirect=/ESMD>

State Medicaid Directors Letters

<http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>

The Medicaid Resource Book (Kaiser Family Foundation)

<http://www.kff.org/content/2003/2236/>

Medicaid Eligibility Overview (Chapter 3 of Understanding Medicaid Home and Community Services: A Primer, US Department of Health and Human Services)

<http://aspe.hhs.gov/daltcp/reports/primer.htm>

CMS' Medicare Overview

<https://www.cms.gov/Medicare/Medicare.html>

TANF Program

DHHS Administration for Children and Families

http://www.acf.hhs.gov/acf_services.html#walia

Food Stamp Program

Food and Nutrition Service

<http://www.fns.usda.gov/fsp/>

Social Security

Social Security Homepage

<http://www.socialsecurity.gov/>

SSI Eligibility and Overview

<http://www.socialsecurity.gov/pgm/ssi.htm>

Social Security Act Online

http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm

Legal/Regulatory Sites

DC Medicaid State Plan

<http://dhcf.dc.gov/page/medicaid-state-plan>

CMS' State Medicaid Manual

http://cms.hhs.gov/manuals/45_smm/pub45toc.asp

Social Security Act Online

http://www.ssa.gov/OP_Home/ssact/comp-toc.htm

CFR Online

<http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>

United States Code

<http://www4.law.cornell.edu/uscode/>

Legislative Information (text of bills, etc.)

<http://thomas.loc.gov/>

DC Code

<http://dccode.westgroup.com/home/dccodes/default.wl>

DCMR

<http://os.dc.gov/>

Social Service Resources

Local Medicaid Links

Non-Medicaid Health Care Programs

DC HealthCare Alliance

(202) 842-2810

[DC Healthcare Alliance](#)

HIV/AIDS Services

(202) 727-2500

<http://www.hivservices.com/>

Medicare Homepage

1-800-MEDICARE (1-800-633-4227)

<http://www.medicare.gov>

Housing and Homelessness

DC Housing Authority (including Section 8 information)
(202) 535-1000

<http://www.dchousing.org/>

Washington Legal Clinic for the Homeless
(202) 328-5500

<http://www.legalclinic.org/>

DC Housing Network

<http://www.headinghome.org/>

Mental Health/Drug and Alcohol Abuse Services

Addiction, Prevention and Recovery Administration
1-888-7WE-HELP (1-888-793-4357)

http://dchealth.dc.gov/services/administration_offices/apr/services.shtm

Department of Mental Health
1-888-7WE-HELP (1-888-793-4357)

<http://dmh.dc.gov>

Beehive Mental Health Locator

<http://www.thebeehive.org>

Alcoholics Anonymous (AA)

(202) 966-9115

(202) 797-9738

<http://www.aa-dc.org>

Al-Anon

1-888-4AL-ANON (1-888-425-2666)

<http://www.al-anon.alateen.org>

Food and Nutrition Programs

WIC

1-800-345-1WIC (Appointments)

<http://dchealth.dc.gov/services/wic/index.shtm>

Capital Area Food Bank

(202) 526-5344

<http://www.capitalareafoodbank.org/site/PageServer>

Bread for the City
(202) 265-2400 (NW)
(202) 561-8587 (SE)
<http://breadforthecity.org/>

So Other Might Eat
(202) 797-8806
<http://some.org/>

Legal Assistance

Legal Aid Society
(202) 628-1161
<http://www.legalaiddc.org/>

Neighborhood Legal Services
(202) 682-2720
<http://www.nlsp.org/welcome.htm>

Legal Counsel for the Elderly
(202) 434-2170
<http://www.aarp.org/lce/>

Washington Legal Clinic for the Homeless
(202) 328-5500
<http://www.legalclinic.org/>

Other Public Programs

DC Energy Office
(202) 673-6700
<http://www.dcenenergy.org/>

Office on Aging
(202) 724-5622
<http://dcoa.dc.gov/dcoa/site/default.asp>

Child and Family Services Administration
(202) 442-6000
<http://cfssa.dc.gov/cfssa/site/default.asp>

APPENDIX F - POLICY MANUAL CHANGES

Welcome to the Change Page for the ESA (formerly known as the ESA) Policy Manual. Listed below are the changes to the Manual since December, 2004.

[Sign up to receive future updates to the ESA Policy Manual](#), and we will send a notification to you whenever the Manual is revised or updated.

If you have any questions about these changes, please contact the [ESA Policy Unit by email](#) or call (202) 698-4276.

Policy Manual Changes

Date of Change	Part/Section	Description of Changes
May, 2000	VIII/4.3-4.7	Setting Certification Periods.
July, 2000	IV/7.5-7.7	Change in Asylee Eligibility for Refugee Assistance.
September, 2000	IV/4.32	Requirement Change for Pursuing Potential Income.
April, 2001	VI/6.3 VI/7.3 VI/8.5	Expansion of Earned Income Disregard and End of Periodic Reporting.
June, 2001	VI/1.31	Limiting Vehicles as Countable Assets.
July, 2001	VIII/Chapter 6	Changes in Food Stamp Over issuance/Under issuance Policy.
September, 2001	VI/Exhibit VI-3 VI/Exhibit VI-5	Update to Medicaid and Food Stamp Income Standards.
March, 2002	X VI/Exhibit VI-3	Interim Disability Assistance Program Update to Medicaid Income Standards.
November, 2002	VI/7.1	Correction Regarding Calculation of Medically Needy Income Level.
June, 2003	VIII/Chapter 6	Start Date of Overpayments and Changes in TANF Overpayment Procedure.
February, 2004	IV/2.3	Clarification to Residency Requirement.
February, 2004	VI/4.42 VI/4.45	Use of OASDI, SSI Recoupments in Determining TANF Benefits.

March, 2004	VIII/Chapter 4	Recertification Policy.
March, 2004	V/Chapter 1 V/Chapter 2	Updates to TANF Work and FS FSET Sanction and Exemption Policy Updates to Policy Regarding Referral of Customers to CSED.
April, 2004	II	Confidentiality Policy, Discrimination Policy, FS Reporting Requirements

December, 2004	Table of Contents	Update. Part 9, Burial Assistance and Part 10, Interim Disability Assistance, are combined as Part 9, Special Local Programs. Burial Assistance is covered in Part 9, Chapter 1. IDA is covered in Part 9, Chapter 2.
December, 2004	I/Chapter 1	Exhibits 1 and 2 are updated with legislation related to ESA programs.
December, 2004	I/2.2.1	Expands the description of Program Eligibility criteria for Refugee-Related Medicaid.
December, 2004	I/2.2.2	Updates the ACEDS MA Program Types table to show that Transitional Medicaid should be processed under the AR program and the QI-2 program is deleted.
December, 2004	I/2.2.3	Clarifies the Medicaid program assignment of disabled children.
December, 2004	I/2.2.4	Outlines some exceptions to placement of AR/AX Medicaid recipients in managed care.
December, 2004	I/2.2.6	Updates instructions on registration of Medicaid recertifications, requiring that all <i>signed</i> Medicaid recertifications be registered in ACEDS as soon as they are received.
December, 2004	I/2.2.8	Updates the name of the DC EPSDT program from DC Healthy Tots and Teens to Health Check.
December, 2004	III/Chapter 1	Establishes a new policy that an application for all programs except IDA is considered filed on the date it is received at any ESA center.
December, 2004	III/1.4.1	Eliminates the requirement that a major parent sign the MA application of a pregnant, parenting, or emancipated minor.
December, 2004	III/1.8	Updates interviewing requirements of customers that complete specialized MA applications. Persons applying for QM using the Buy-In mail-in application do not need to complete an interview. Persons applying for AR/AX using the DCHF application do not need to complete an interview.

December, 2004	III/4.3	Clarifies that residents of shelters for battered women and children who meet the criteria for expedited Food Stamps can receive expedited benefits even if they already received food stamps that month in a Food Stamp case that included the alleged abuser.
December, 2004	III/4.5	Clarifies that if the issuance of expedited Food Stamp benefits is delayed because of an agency error in screening or processing the application for expedited service, ESA is accountable for failing to provide expedited benefits timely.
December, 2004	IV/1.3	Updates definition of a "ward," removing bullet saying a ward does not live with his/her parent.
December, 2004	IV/1.3	Clarifies that a child with an adoption assistance agreement is eligible for Medicaid until age 21.

December, 2004	IV/1.3	Removes reference to evaluating customer claiming disability under AX before evaluating under SR.
December, 2004	IV/1.3	Clarifies examples of establishing the TANF household when an adult couple is applying.
December, 2004	IV/1.3	Clarifies that a parenting child under age 22 cannot be separated from his/her parents even if s/he has married.
December, 2004	IV/1.4	Incorporates previously issued policy saying parents of parenting minors should only be included in the parenting minor's MA case as optional members.
December, 2004	IV/1.5	Includes a requirement that a fleeing felon know that an arrest warrant has been issued in order to be considered "fleeing."
December, 2004	IV/1.6	Deletes step-parents as possible essential persons for MA since step-parents can be included as optional group members.
December, 2004	IV/1.7	Incorporates previously issued policy extending to six months the period of time a newborn can receive Food Stamps without provision of an SSN.
December, 2004	IV/2.5	Prohibits requiring homeless persons to provide a mailing address.
December, 2004	IV/2.7	Prohibits requiring verification of mailing addresses.
December, 2004	IV/4.5.1	Corrects the listing of supplemental verifications of age for TANF.
December, 2004	IV/5.4	Adds second cousins as an acceptable degree of relationship for TANF.
December, 2004	IV/5.8.1	Specifies that TANF relationship is only verified at application or when adding a child to the case.
December, 2004	IV/5.8.2	Specifies that TANF "living with" is only verified at application and when adding a child to the case.
December, 2004	IV/6.7	Specifies that pregnancy does not need to be verified by applicants using the DCHF application.

December, 2004	IV/6.7	Specifies that pregnancy should be verified by applicants using the Combined application.
December, 2004	IV/7.3;7.4.2	Updates Immigration tables to include trafficking victims as qualifying immigrants.
December 2004	IV/7.4.1	Defines Refugee, Asylee, and Parolee.
December, 2004	IV/7.4.2	Expands the definition of Disability-related Benefits to include IDA and SSI-related Medicaid.
December, 2004	IV/7.4.2	Includes previously issued information on the DCHF expansion coverage of non-qualified immigrant children.
December, 2004	IV/7.4.2	Updates Food Stamp table to show the eligibility of all qualified immigrant children under age 18, and the elimination of 40 quarters requirement for immigrants with 5 years of qualified residency.

December, 2004	IV/7.6	Requires completion of a CAD form only when the household reports on their initial declaration that there is a qualified immigrant in the home.
December, 2004	IV/7.7	Includes information previously issued on the eligibility of sponsored immigrants.
December, 2004	IV/7.9.6	Updates the Credit of Qualifying Quarters chart through 2005.
December 2004	IV/7.10	Creates a new section for victims of trafficking and domestic violence, incorporating previously issued materials and reorganizing the previous manual content.
December, 2004	IV/7.12.6	Creates new subsection for verifications relating to domestic violence.
December, 2004	IV/7.12.7	Creates new subsection for verifications relating to trafficking.
December, 2004	IV/Exhibit IV-10	Creates new exhibit for Declaration of Sponsorship.
December, 2004	IV/8.3	Clarifies that when deprivation can be established for a two parent household by incapacity or unemployment, incapacity takes precedence
December, 2004	IV/8.3.2	Refers reader to the Credit of Qualifying Quarters chart in the immigration chapter when determining work history for U.P. deprivation.
December, 2004	IV/9.3	Corrects definition of blindness to corrected vision of 20/200 or less.
December, 2004	IV/9.6	Corrects the time frame for providing medical information for an SR determination to 45 days, giving a total of 90 days for MRT to issue a determination.
December, 2004	VII/2.5	Includes material previously issued on determining the assets of sponsored aliens.
December, 2004	VII/5.4.1	Includes material previously issued on determining the income of sponsored aliens.

December, 2004	VII/Exhibit VII-3	Updates the MA income standards.
December, 2004	VII/Exhibit VII-5	Updates the Food Stamp income standards.
December, 2004	VII/1.5	Removes description of eligibility requirements for the COBRA Assistance program.
December, 2004	VII/1.12	Clarifies that SLIMB coverage begins the month of application.
December, 2004	VII/1.13	Deletes references to the QI-2 program which was defunded.
December, 2004	VII/1.13	Corrects information on QI-1 to indicate that coverage begins the month of application and 3 months of retroactive eligibility can be given.
December, 2004	VII/1.14	Directs staff to call the Policy unit if they think a customer is a QDWI.
December, 2004	VII/1.15	Adds a new section on disabled individuals returning to work. These are present or past recipients of SSI, whose earned income appears to make them over-income. They retain categorical

		eligibility for SR Medicaid.
December, 2004	VII/1.16	Adds a new section on the 50-64 demonstration under which non-disabled adults ages 50 to 64 can receive Medicaid benefits if they meet Medically Needy income and asset limits.
December, 2004	VII/Exhibit VII-1	Updates income and asset limits for specialized Medicaid programs, correcting the information on Refugee Medicaid to show that MNIL income and asset limits must be met.
December, 2004	VIII/3.9	Updates the table of Job Club locations.
December, 2004	IX/Chapter 1	Includes material issued previously regarding changes in the process of determining eligibility for the Burial Assistance program.

June, 2005	VI/Exhibit VI-3 VII/Exhibit VII-1	Updates income limits for Medicaid programs effective March 1, 2005.
July, 2005	Appendix C1	Displays updated Combined Application form in English and Spanish.
July, 2005	I/2.2.1 and 2.2.2 VI/Exhibit VI-1 VI/ Exhibit VI-3 VII/1.11-1.13 VII/Exhibit VII-1 Appendix B	Increases SR Asset Limit Increases QM and SLMB Income Limits Adds language that SLMB and QI-1 eligible customers are now eligible for QM/SLMB and that SLMB should only be used for the month of application and retroactive period.
September, 2005	VI/6.3 pp3-4 VI/Exhibit VI-5 VI/8.5	Updates FS deductions effective October 1, 2005 Updates FS income limits and benefit levels effective October 1, 2005 Updates example of determining FS benefit level
September, 2005	Appendix D1 Appendix D2	Updates Medicaid Program Codes, including new codes for hurricane/disaster evacuees.
November, 2005	Appendix G	Adds new appendix with procedures to handle Medicare Part D concerns
November, 2005	Appendix C4	Adds new fact sheet regarding "Medicare and Prescription Drugs."
November, 2005	Appendix C1	Updates Form 1209 "Medicaid Recertification Form"
November, 2005	VIII/ Chapter 1	Clarifies sections on retaining documents in case records and on doing case dictation regarding documents that cannot be photocopied
November, 2005	VIII/Chapter 3	Updates lists and descriptions of Agencies to which ESA may refer TANF applicants/recipients
November, 2005	VIII/4.3	Updates section on Diversion payments
January, 2006	VIII/6.1 through 6.6	Updates policy regarding overpayments
January, 2006	VIII/5.1 through 5.6	Adds new chapter on reporting and acting on changes

January, 2006	VIII/7.1 through 7.6	Updates policy regarding fair hearings
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March, 2006	VIII/4.3	Clarifies policy on processing TANF reviews with Food Stamp recertifications
March, 2006	Exhibits VI-3 and VII-1	Updates Medicaid income scales for 2006
March, 2006	VI/6.3	Adds new earned income disregard for AX Medicaid cases effective January 1, 2006
May, 2006	VII/4	Adds chapter on determining eligibility for the DC Healthcare Alliance
May, 2006	Appendix C-4	Adds two fact sheets summarizing DC Healthcare Alliance eligibility determinations
June, 2006	VI/6.3	Updates policy regarding utility costs and the excess shelter deduction for Food Stamps
July, 2006	IX/2.5.1 Exhibit VI-4	Updates cash assistance payment levels effective July 1, 2006
August, 2006	IV/7.9.6	Updates Credit for Qualifying Quarters Chart for 2006
October, 2006	I/2.1, 2.2.1	Adds language clarifying that the Department of Health administers the Medical Assistance programs and correcting income limits in descriptions of Qualified Medicare Beneficiaries
October, 2006	IV/7.12.5	Adds citizenship requirements for Medicaid
October, 2006	VI/Chapter 7	Removes language referring to projecting medical expenses for Spend-Down, and substitutes phrase "Spend Down deductible" for "Spend Down liability"
October, 2006	VI/ Exhibit VI-5 VI/6.3, pages 2 and 3	Updates Food Stamp income limits, deduction amounts, and maximum benefits for FY 2007
October, 2006	VIII/5.3	Updates 130% of FY 2007 Federal Poverty Guidelines Table
October, 2006	IV/7.9.6	Updates Credit of Qualifying Quarters Table for 2006 and 2007
October, 2006	VIII/11.4-11.4.3	Updates procedures regarding vendor rental payments for TANF recipients
November, 2006	IV/4.3 VI/8.5	Clarifies that for FS, an elderly person is a person who is 60 or older Corrects example referring to an elderly member of a FS household
November, 2006	Appendix C4	Updates "Medicare and Prescription Drugs" Fact Sheets to include 2007 Medicare Drug Plans
December, 2006	Appendix C1	Updates DHS Form 1210 "Processing Medicaid Recertifications"
December, 2006	VI/4.42	Clarifies that Medicare premiums deducted from Social Security benefits must be counted as income

January, 2007	Appendix C1	Updates DHS Form 1209 "Medicaid Recertification Form"
January, 2007	VI, Exhibit VI-3, page 2	Updates income scales for QMB, SLMB, and QWDI for 2007
February, 2007	VI/ Exhibit VI-3	Updates Medicaid income scales due to new Federal Poverty Levels
February, 2007	1/2.2.1 VI, Exhibit VI-3 VII/1.11-1.12 VII/Exhibit VII-1	Increases QMB/SLMB income level to 300% of Federal Poverty Level
February, 2007	IV/7.12.5	Adds SSDI recipients, Foster Care Children and Adoption Subsidy Children to list of persons exempt from Medicaid citizenship verification requirement
February, 2007	VIII/4.9	Updates policy on timeframes for completing Food Stamp Recertifications and automatic Food Stamp denials
March, 2007	III/1.8 VIII/4.4 VIII/5.5	Adds requirement that a Change Report Form be given to customers at Food Stamp application interviews, Food Stamp recertification interviews, and when a household reports a change on a Change Report Form
March, 2007	III/3.3	Clarifies that households approved for Food Stamps must be sent written notice of their responsibilities to report changes
March, 2007	VII/2.6.6-2.6.7 VII/2.9.1	Updates minimum monthly maintenance needs allowance, Spousal Share asset limit, and Community Spouse Assets Allowance for 2007.
March, 2007	VII/2.6.5	Clarifies that reference to Section 7.3 is only for types of allowed medical expenses
April, 2007	VI/Chapter 1	Updates policy regarding asset types and how they are counted
April, 2007	VI/Chapter 4	Updates policy regarding income types and how they are counted
May, 2007	VI/5.4.2 VI6.3.1	Clarifies that utility allowances are not prorated for Food Stamp households with disqualified members
May, 2007	VI/Chapter 3	Updates policy regarding providing and verifying Social Security Numbers
June, 2007	Appendix C-1	Updates Medical Examination Report
June, 2007	V/1.8	Clarifies that TANF income must continue to be counted for Food Stamps if TANF is terminated due to work sanction

June, 2007	VI/Exhibit VI-3	Medicaid Income Scale for children under 19 and for pregnant women has been increased to 300% of the Federal Poverty Level
June, 2007	VI/8.3	Updates policy to say that income from the thirty days preceding the application or recertification date is used to project future income, if it is representative of expected income

June, 2007	VII/1.16, 3.3	Removes obsolete language regarding Medical Charities and DC HealthCare Alliance
June, 2007	III/4.6	Updates Food Stamp policy to say that an applicant must participate in a face-to-face or telephone interview before expedited services can be provided.
June, 2007	VI/1.24.1 VII/Table of Contents VII/2.12a	Adds new section placing a limitation on home equity for Long Term Care Assistance except for certain conditions.
July, 2007	VI/4.45	Updates Food Stamp policy to say that SSI recoupments are never considered as income
July, 2007	IV/1.5.2 V/1.8	Updates Food Stamp periods of disqualification for Intentional Program Violations (IPV)
July, 2007	IV/2.4 IV/10.1	Updates Food Stamp policy regarding exemptions from institutional status
September, 2007	VI/Exhibit VI-5 VI/6.3, pages 2 and 3	Updates Food Stamp income limits, deduction amounts, and maximum benefits effective October 1, 2007
September, 2007	VI/Exhibit VI-4 IX/2.5.1	Updates cash assistance payment levels effective October 1, 2007
September, 2007	VII/1.3	Updates Transitional Medical Assistance policy to take into account the difference between Medicaid income limits for children and the limits for parents
February, 2008	VI/Exhibit VI-3	Updates Medicaid income scales due to new Federal Poverty Levels
February, 2008	VII/2.6.6, 2.6.7,2.9.1	Updates Impoverished Spouse Standards for 2008
May, 2008	IV/2.3, VII/4.3.6	Adds language regarding residency of temporary non-immigrants such as embassy personnel
May, 2008	I/2.2.1 IV/4.3 VI/Exhibit VI-3, page 2 Appendix D2/pages 1,2	Increases Medicaid income standard for 19 and 20 year olds to 200% of FPL
May, 2008	VI/4.55	Adds language regarding special payments from Veterans Administration

June, 2008	VIII/4.1	Changes review period for TANF and GC from six months to twelve months
June, 2008	VIII/4.3	Adds requirements for Mid-Certification Report for Food Stamp households certified for twelve months and for Interim Contact for Food Stamp households certified for twenty-four months.
July, 2008	IV/9.3	Makes corrections to definition of disability for persons who were disabled under 1972 criteria

September, 2008	IV/12.1,12.5 VI/6.3,8.5.1 Exhibit VI-5	Updates Food Stamp income limits, deduction amounts, and maximum benefits, increases automatic Food Stamp benefit for certain categorically eligible households, and uncaps Food Stamp dependent care deductions effective October 1, 2008
September, 2008	VI/8.4 Exhibit VI-4	Updates TANF Payment Levels effective November 1, 2008
November, 2008	I/2.2.1 Exhibit VI-1 VII/1.11-1.12 Exhibit VII-1	Removes Asset Test for QMB/SLIMB effective November 1, 2008
November, 2008	IV/7.9.6	Updates Credits of Qualifying Quarters chart for 2008 and 2009
December, 2008	VI/1.28 VII/2.13	Adds Language Regarding Penalties Under Long-Term Care and Home-And-Community-Based Services Waiver for Transferring Assets for Less than Market Value
December, 2008	V/1.6	Clarifies that a woman in the second or third trimester of pregnancy is exempt from TANF work participation requirements
December, 2008	IV/4.4	Clarifies for Food Stamps that students must be enrolled in an institution of higher education at least half-time before they can be required to meet extra criteria to participate.
December, 2008	VI, Exhibit VI-4	Updates TANF Payment Levels effective January 1, 2009
December, 2008	VI/4.16b	Corrects Food Stamp policy regarding Guardianship Subsidy payments to say that children for whom Guardianship Subsidy payments are received can be included in or excluded from the Food Stamp household like a Foster Child

December, 2008	VI/4.16a	Adds language expanding the definition of who can receive the Grandparents Caregivers Subsidy to include persons who were grandparents, great-grandparents, great-aunts, and great-uncles of a child before adopting the child.
January, 2009	VII/2.6.6, 2.6.7, 2.9.1	Updates Impoverished Spouse Standards for 2009
February, 2009	VI/Exhibit VI-3	Updates Medicaid income scales due to new Federal Poverty Levels
February, 2009	IV/12.1, 12.5 VI/8.5.1 VI/Exhibit VI-5	Updates Maximum and Minimum Food Stamp Allotments Effective April 1, 2009
August, 2009	II/1.4 VIII/TOC VIII/5.7	Moves EBT card replacement information from Part II to part VIII and adds information on replacing Food Stamp benefits lost due to household misfortune
August, 2009	VII/TOC VII/4.1, 4.3.1, 4.3.8	Updates requirements for DC HealthCare Alliance to exclude persons enrolled in any part of Medicare or who are enrolled in any third party health insurance program
September, 2009	VI/Exhibit VI-5 VI/6.3, pages 3-4	Updates Food Stamp income limits and deduction amounts effective October 1, 2009

September, 2009	IV/2.7	Updates policy regarding verifying residence, including new requirements for the DC HealthCare Alliance
February, 2010	III/1.6.1 IV/1.1, 1.3, 1.4,1.5, 1.10,9.1 IV/Chapter 8 V/1.6 VI/5.4.4, 5.4.5 VIII/4.4, 5.5 Appendix B pages 2 and 4 Appendix C-3 page 2	Eliminates deprivation as factor of eligibility for TANF and gives parent a choice in TANF household composition where there is a step-parent and no child-in-common

February, 2010	IV/ 1.5 VIII/6.3.2	Moves information regarding overpayments due to duplicate TANF and SSI receipt from Part IV Chapter 1 to Part VIII Chapter 6
March, 2010	IV/12.1,12.3,12.4, 12.6,12.7 VI/1.1, 8.1,8.4,8.5, Exhibit VI-5 Appendix B Appendix C-3	Updates Food Stamp policy to give expanded categorical eligibility to groups that have received a prescribed TANF-funded service
March, 2010	IV/4.4	Clarifies for Food Stamps that any TANF or SSI recipient meets the student criteria for Food Stamp eligibility
May, 2010	VIII/6.4.5	Adds language regarding compromising Food Stamp claims
June, 2010	VII/2.6.3	Clarifies language regarding allowance for maintaining unoccupied home
December, 2010	VII/3.5	Updates description of HIV programs and notes end of Medicaid Demonstration program
March, 2011	I/2.3 IV/Chapter 13 VI/8.4, 8.5 Exhibit IV-4	Updates TANF policy to implement reduced TANF payments to families who have received TANF over 60 months
May, 2011	III/3.4.5 VI/8.5	Updates FS policy to deny applications for FS households of three or more persons who meet gross and net income tests but are eligible for \$0 in benefits
October, 2011	VII/Chapter 4	Updates DC HealthCare Alliance policy to; require face-to-face interviews at application and recertification, change Alliance recertification verification requirements, mandate provision of SSNs by US citizens and nine-digit Alien numbers by Qualified Aliens, and change Alliance certification period to six months.
November, 2011	IV/7.12.4, 7.12.5	Updates citizenship/alien documentation requirement for Medicaid to provide for reasonable opportunity periods for both US citizens and Qualified Aliens to provide documentation of status.

November, 2011	VI/6.3, Exhibit VI-5	Updates Food Stamp Income Limits and Deductions effective October 1, 2011
November, 2011	VI/6.3, 8.6.4	Updates Food Stamp policy effective January 1, 2010 to give Heating/Cooling Standard Utility Allowance to all active Food Stamp households due to expectation of receipt of Low Income Energy Assistance Program benefit
December, 2011	I/2.2.1,2.2.2 VI/Exhibit VI-1,6.3, Exhibit VI-3 VII/1.16 Appendix D-2, page 2	Updates Medicaid policy to include Childless Adults with limited income (implemented effective May 1, 2010) and corrects resource limit for DC HealthCare Alliance
January, 2012	VI/6.3	Corrects Food Stamp Heating/Cooling Standard Utility Allowance effective October 1, 2011
March, 2012	VI/Exhibit IV-3	Updates Medical Assistance Income Limits for 2012, effective February, 2012
September, 2012	VI/6.3 Exhibit VI-5	Updates Food Stamp Deduction Levels and Income Standards effective October 1, 2012
November, 2012	VI/1.4, 4.3, 4.4, 4.5.2	Update TANF requirements to remove requirement that 18 year old children be expected to graduate before s/he turns 19 and to clarify school enrollment verification policy
March, 2013	V/1.1, 1.2, 1.3, 1.5 VIII, 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.9, 4.10	Updates TANF policy to; require a Work Readiness Assessment, Orientation, and Individual Responsibility Plan at application and at recertification; to temporarily redefine a TANF recertification as completion of the assessment, orientation, and Individual Responsibility Plan; and to update descriptions of allowable work activities
March, 2013	VI/ Exhibit VI-1	Updates the Food Stamp (now known as SNAP) resource limit for households containing a disabled or elderly member, effective October 1, 2011
April, 2013	VI/ Exhibit VI-3	Updates Medicaid income scales for 2013 and corrects income scale for QMB and SLMB
June, 2013	II/3.9, 3.10	Adds language regarding safeguarding and disclosing information and training requirements regarding safeguarding information
June, 2013	VII/2.6.6, 2.6.6, 2.9.1	Updates Allowances in Long Term Care Program under Medicaid for 2013
December, 2013	VIII/Chapter 9	Updates policy regarding notifying customers when mass changes impact SNAP benefits

APPENDIX G - PROCEDURES FOR RESOLVING MEDICARE PART D CONCERNS

Many DC Medicaid and QMB recipients have questions about the new Medicare Part D program. The questions and answers below should help you provide assistance to these customers. To search for a particular word or phrase (for example, "Veteran" or "Kaiser") just hit CTRL-F and search for that term.

ESA's most important role: reassure customers with Medicare that they will still be able to get their prescriptions under the new program. These customers just need to pick a Part D drug plan. To get help choosing a plan, customers can call **(202) 739-0668** or **1(800) MEDICARE (1-800-633-4227)**.

For customers in distress: please write down the customer's information and email it to medicaid@dc.gov. We will reach out to the customer and try to help.

Frequently Asked Questions

Should you enroll in Part D if you have DC Medicaid? (*"Should I enroll in Part D if I have a blue or white DC Medicaid card?"*)

YES! Starting January 1, 2006, you must get your drugs through a Part D drug plan if you have Medicare. Even if you have both DC Medicaid and Medicare, you will have to use your red, white, and blue Medicare card to get most of your drugs.

You can pick a plan by calling (202) 739-0668 or 1(800) MEDICARE (1(800) 633-4227). If you pick a plan before New Year's, then you will get your drugs from this new plan. You will still have drug coverage after January 1, 2006.

What if Medicare has "auto-enrolled" you into a Part D drug plan?

Medicare recently sent letters to customers who also have DC Medicaid. These letters explain the "automatic enrollment" process. If you do not pick a Part D drug plan before January 1, 2006, then Medicare will randomly assign you to a drug plan. However, you can change your plan. To find out if you should keep this plan or switch to another plan, call (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

What drug plan is best for you?

Each drug plan covers different drugs. You need to pick a plan that covers the drugs that you take. To find out which drug plan is right for you, call (202) 739-0668 or 1(800) MEDICARE (1(800) 633-4227).

There are 15 special drug plans for people who have DC Medicaid or who get extra help for Part D. (See Question #5 below.) If you pick one of these 15 special plans, then you will not have to pay a monthly premium for Part D. Also, these special plans will have no deductibles. The ESA Fact Sheet on Part D lists these 15 plans and their contact information.

Note: ESA staff should (a) offer to transfer the call and (b) counsel customer to call back to ESA if he or she does not get any assistance.

When can you sign up?

You should pick a Part D plan between November 15 and December 31, 2005. If you pick a plan before New Year's, then you will be able to get your drugs starting on January 1, 2006.

Will you have to pay more for Part D?

If you have DC Medicaid, then you can choose a plan with no monthly premium. If you choose one of these special plans, then your prescriptions will cost \$1 (or \$3 for some drugs). Also, these special plans have no deductibles.

If you do not have DC Medicaid, then you can get for "extra help" to pay for Part D. You can get this help if your income is less than \$1,200 (\$1,600 if you are married). The income limit is higher if you are working.

If you get the extra help, then you can choose a plan with no monthly premium. If you choose one of these special plans, then your prescriptions will cost \$2 (or \$5 for some drugs). Also, these special plans have no deductibles.

You need to apply for this extra help if Social Security takes money out of your check now for insurance. To apply, please fill out our Combined Application form. We can mail you a form if you need one. If you are already eligible as a QMB, then you do not need to apply.

Please Ask:

"Does Social Security take out money from your check for insurance?"

If YES, ESA staff should fix any existing problems with the Medicare Buy-In (see Buy-In Procedures below). If the customer is new (or inactive), explain that he or she can apply for "extra help" to pay their Medicare costs. Please offer to mail the customer a Combined Application form. Customers can apply by mail, or if they prefer, they can come to ESA to apply. Also, remind them about the need to pick a Part D plan.

If the customer already participates in the Buy-In, then just remind them that they need to pick a Part D plan between November 15 and December 31, 2005. They can pick a plan by calling (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

Note: Social Security deducts overpayments from some checks; many customers think that these overpayments are actually for Medicare. If they say that they pay \$50 each month for Medicare, then this is likely an overpayment. You may need to check BENDEX and clarify this for them.

Should you enroll in Part D if you have insurance (other than DC Medicaid)? ***"Should I enroll in Part D if I have Aetna, Kaiser, or Blue Cross/Blue Shield?"***

Some customers get their drugs through the Veterans Administration, Federal Employees' Health Benefits Plan (FEHBP), TriCare, or through retiree benefit programs. If this is true for you, then you may want to keep this insurance. In that case, you may not need to sign up for Part D. To talk to a counselor about this decision, call (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

Note: Customers may confuse private retiree plans with the Medicare "Advantage" plans discussed in Question #11 below. For example, Kaiser offers both retiree plans and Medicare "Advantage" plans. However, this distinction between retiree plans and Advantage plans is very important. Please refer customers with these concerns to (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

What if you have already signed up for ElderHealth, Kaiser, or another plan?

You can change your mind and change plans. To talk to a counselor about this decision, call (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

What if you applied for "extra help" from Social Security?

The District offers more generous help than Social Security does. If DC is not paying your Medicare premium already, you should apply through ESA.

What if you already have a drug discount card?

Many of these drug discount cards will end in early 2006. These drug discount cards are not the same as Part D. You still need to sign up for Part D. To pick a Part D drug plan, call (202) 739-0668 or 1(800) MEDICARE (1-800-633-4227).

What if you live in a nursing home?

If you live in a nursing facility and have DC Medicaid, you will not have to pay for your drugs. If you have other questions, please talk to the social worker at your nursing home. You can also call (202) 739-0668 or 1(800) MEDICARE 1(800) 633-4227.

Will you have to change doctors?

No. The other parts of Medicare (Parts A and B) are not changing. You can keep your same doctor unless you sign up for a Medicare "Advantage" plan (such as Aetna, Elder Health, Kaiser, SecureHorizons, or United). If you are in "regular" Medicare (instead of an "Advantage" plan), you can keep your same doctor no matter which Part D drug plan you choose. To find out more, call (202) 739-0668 or 1(800) MEDICARE.

What is a Medicare "Advantage" plan?"

Medicare has several "Advantage" health plans that are different than regular Medicare. These "Advantage" plans include Aetna, Elder Health, Kaiser, SecureHorizons, and United. These health plans manage your doctor's visits and other care. You may also get some extra benefits. However, you may have to pay a monthly premium for an "Advantage" plan. You can choose an "Advantage" plan, or you can stay with regular Medicare Part A and B. In either case, you may still need to sign up for a Part D drug plan. To find out more, call (202) 739-0668 or 1(800) MEDICARE.

Note: Customers may confuse private retiree plans discussed in Question #6 above with the Medicare "Advantage" plans. For example, Kaiser offers both retiree plans and Medicare "Advantage" plans. However, this distinction between retiree plans and Advantage plans is very important. Please refer customers with these concerns to (202) 739-0668 or 1(800) MEDICARE (1(800) 633-4227).

Can you sign up for Part D if you are in a Medicare "Advantage" plan?

Yes. If you are already in an "Advantage" plan (such as Aetna, Elder Health, Kaiser, SecureHorizons, or United), you can still sign up for Part D drug coverage. However, you must choose the Part D drug plan offered by your "Advantage" plan. You cannot choose a different Part D drug plan. To find out more, call (202) 739-0668 or 1(800) MEDICARE.

Note: Customers may confuse private retiree plans discussed in Question #6 above with the Medicare "Advantage" plans. For example, Kaiser offers both retiree plans and Medicare "Advantage" plans. However, this distinction between retiree plans and Advantage plans is very important. Please refer customers with these concerns to (202) 739-0668 or 1(800) MEDICARE (1(800) 633-4227).

Will you still need to recertify for Medicaid or QMB?

Yes. You will get the "extra help" for Part D as long as you recertify for Medicaid or QMB. If you do not recertify, you may lose the extra help for Part D. Remember: you can now call (202) 727-5355 to recertify by phone. You must recertify for Medicaid or QMB each year.

Procedures for Buy-In Queries

Step 1: Verify that the QM, SR, or AZ program type is open.

If there is not current case open, then the customer may need to re-apply. Note: a very, very small number of customers have AR/AX programs.

Step 2: Verify that an active Medicaid program code appears on MEAE for the customer for the period in question.

Step 3: Verify that the customer has Medicare Part B by checking the Option Code (under "Supplemental Medical Insurance" on the right of the BENDEX screen) is Y.

- (a) If the Premium Payer is 090, then the District is paying the premium or will shortly begin paying the premium.
- (b) If the Premium Payer is a number other than 090, then SSA is reporting that another state is paying the Part B premium; refer these cases to me.
- (c) If the Premium Payer is SELF, then continue with procedures below.

Step 4: Verify that the following in BENDEX matches exactly the customer information on CAP2:

- (a) Date of birth
- (b) Sex
- (c) Spelling of last name (use spaces instead of hyphens)
- (d) Spelling of first name

If necessary, please correct any customer information on CLIM.

Step 5: Verify that the correct claim number (as it appears on BENDEX) has been entered on MEAE (or VIRE).

Notes: Some customers have more than one claim number (e.g., widows/widowers, adult disabled children, Railroad beneficiaries, etc.), Forward these queries to Chris Proctor.

Make sure that you are looking at the most current data, which you can verify by making sure that there is an entry on the CURRENT line. If not, just hit ENTER until you are back at the main menu, at which point you will enter "8" as the function.

Codes: If a **1728** code appears on the BUY-IN screen, then another state may be paying the Part B premium.

If a **16** code appears on the Buy-In screen, then SSA believes the customer to be deceased. Please refer both types of cases to Chris Proctor.

Other codes that may be helpful:

1751: ACEDS-initiated termination

2961: Accretion by ACEDS attempted after date of death

2161: Accretion attempted by ACEDS but rejected because of data mismatch.

OVERVIEW OF PART D

Starting in January 2006, Medicare will cover prescription drugs. This new program is called Part D. Part D will help many people get their prescriptions. If you have Medicare Part A or B, then you can get Part D.

Customers must choose a Part D drug plan. The Part D drug plans will cover many if not most drugs. However, each Part D drug plan covers different medications. Customers need to pick the right plan for their needs. Customers may pick a drug plan starting November 15, 2005.

Part D is not free, but customers can get “extra help.” This extra help pays for the Part D deductible and monthly premiums. It also reduces the co-payments for each prescription.

ESA determines eligibility for this extra help. The Medicare Modernization Act of 2003 requires that District and other states determine the eligibility for Part D’s low income subsidy. Customers may apply through ESA to get this extra help with Part D.

The District has minimized these costs by automating this process. Specifically, the District aligned the income limit of the “Qualified Medicare Beneficiary” (QMB) program with that of the new Part D subsidy. Thus, persons eligible for the Part D low-income subsidy would also be eligible as QMBs. As required by law, the federal government then “deems” all QMB enrollees as automatically eligible for the full Part D subsidy. By merging these eligibility processes, the District eliminated the need for duplicative, stand-alone eligibility determinations for the Part D subsidies.

This automated process vastly streamlines the eligibility process. District residents need to complete only one form (ESA’s new Combined Application) to apply for the Part D subsidy, the QMB program, Medicaid, Food Stamps, and cash assistance. Thus, the District’s process is both fiscally attractive and customer-friendly.

Moreover, this process maximizes the number of District residents who will get the full Part D subsidy. By enrolling all eligible persons under 150 percent Federal Poverty Level (FPL) as QMBs, the District ensures that these customers will not have to pay a Part D monthly premium and will not have to pay a deductible. Further, all customers will pay the lowest possible cost-sharing amounts (\$1 and \$3 per prescription) under Part D. If this were not done, those customers with incomes between 135 percent and 150 percent FPL would be responsible for monthly premium payments of approximately \$37 and an annual deductible of \$50. Additionally, all persons above 100 percent FPL would face higher cost-sharing under Part D.

The costs of this streamlined approach are nominal. To align the eligibility criteria of the QMB and new Part D subsidy programs, the District simply increased the income eligibility limit for the QMB population from 100 percent to 150 percent of the FPL.

To explain these changes, the District developed a simple, one-page fact sheet. This flyer, which is available in both Spanish and English, is easy to read and understand. Customers can request this flyer from their ESA worker or by calling (202) 724-5506.

Privacy Note: As with all Medical Assistance programs, ESA staff member are bound by the confidentiality provisions of 42 CFR 431 Subpart F and other District and federal statutes and regulations. These provisions are detailed in Part II, Chapter 3 of the ESA Policy Manual. To safeguard the confidentiality of customer data, it is essential to fully comply with these confidentiality procedures.