Chapter 1

Application/Redetermination Process

Table of Contents

Change History Log

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
1.1				
1.2	6/1/19	772	1.2.3.A	Outlining worker responsibilities for certain felonies
	4/1/20	784	1.2.2.A	Changed inROADS to WV Path
			1.2.6, B & C	
			1.2.9	
			1.2.11	
			1.2.12.B.3	
			1.2.12.E	
	5/1/20	785	1.2.1.E.1	Defining major life activities in reference to ADA
1.3	4/1/20	784	1.3.1.B & 2	Changed inROADS to WV Path
			1.3.4.A.2	
			1.3.5	
1.4	5/1/19	771	1.4.17.C.2	Revised language for drug felons
	5/1/19	771	1.4.17.C.5	Revised language for drug felons
	6/1/19	772	1.4.17.C.2	Lottery and gaming winnings
	12/1/19	779	1.4.2	Clarifying what constitutes as a completed SNAP application
	4/1/20	784	1.4.1	Changed inROADS to WV Path
			1.4.3	
			1.4.4, A&B	
			1.4.9	
			1.4.13	
			1.4.18.A&D	
			1.4.19.C	
1.5	10/23/17	746	1.5.7D	Policy was added to include drug use requirements as part of the initial interview for applicants of WV WORKS.
			1.5.9	The drug use questionnaire must be completed within 10 working days of the initial contact when a client expresses an interest in applying for WV WORKS.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
			1.5.11	Added policy regarding the requirements of a payee for the WV WORKS benefit for not cooperating with drug testing.
	4/1/18	755	1.5.7.A.2	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/18	756	1.5.18	Clarified positive drug test must not be offered DCA
	5/1/19	771	1.5.18	Moved language from 18.19.3.G
	6/1/19	772	1.5.8	Application processing due to non-receipt of compliance
	6/1/19	772	1.5.9	Removed duplicate sentence
	9/1/19	776	1.5.9	Clarified WV WORKS
	3/1/20	782	1.5.7.E & 1.5.8.18	Changed language to transitional benefit
	4/1/20	784	1.5.17.B.2	Changed inROADS to WV Path
	4/1/20	784	1.5.18	
1.6	4/1/18	755	1.6.11.B	Reflect the December 2017 change in the way Medical ID cards are issued.
	6/1/18	760	1.6.11.A.1	Updated to include the steps required when the Marketplace determines potential eligibility for a MAGI coverage group
	6/1/18	760	1.6.11.B.1	Updated language to change HBPE to PE. Also changed the word hospital to Qualified Provider when the text refers to a facility making a presumptive eligibility decision.
	4/1/20	784	1.6.1 1.6.4 1.6.5 1.6.11.B	Changed inROADS to WV Path
1.7	4/1/18	755	1.7.3 1.7.8.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	4/1/20	784	1.7.7.B	Changed inROADS to WV Path
1.8	4/1/18	755	1.8.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
	5/1/19	771	1.8.6.A	Added timeframes that had been removed
	4/1/20	784	1.8.6.A	Changed inROADS to WV Path
1.9	4/1/18	755	1.9.6.A	Reflect the December 2017 change in the way Medical ID cards are issued.

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
1.10	4/1/18 4/1/20	755 784	1.10.6.A 1.10.5	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.11	4/1/18 4/1/20	755 784	1.11.2, 1.11.6.A 1.11.5.B	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.12	4/1/18	755	1.12.1.C.1	Reflect the December 2017 change in the way Medical ID cards are issued.
1.13	4/1/18	755	1.13.3.A	Reflect the December 2017 change in the way Medical ID cards are issued.
1.14	4/1/18	755	1.14.7, 1.14.7.A	Reflect the December 2017 change in the way Medical ID cards are issued.
1.15	4/1/18 4/1/20	755 784	1.15.3, 1.15.3.A 1.15.2	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.16	4/1/18 4/1/20	755 784	1.16.4, 1.16.11.A, 1.16.11.B 1.16	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.17	4/1/18 4/1/20	755 784	1.17.3, 1.17.7 1.17.1	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.18	4/1/18 4/1/20	755 784	1.18.9.A.1, 1.18.10.A 1.18.1	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.19	4/1/18 4/1/20	755 784	1.19.7.A 1.19.1	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.20	4/1/18 4/1/20	755 784	1.20.7.A.1, 1.20.7.B 1.20.1	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path

Section	Date of Change	Change Number	Sub-section(s) Changed	Description of Change
1.21	4/1/18 4/1/20	755 784	1.21.7.A 1.21.6.B	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.22				
1.23	4/1/18 4/1/20	755 784	1.23.10 1.23	Reflect the December 2017 change in the way Medical ID cards are issued. Changed inROADS to WV Path
1.24	4/1/18	755	1.24.1	Reflect the December 2017 change in the way Medical ID cards are issued.
Appendix A	4/1/20	784		Changed inROADS to WV Path
Appendix B				
Appendix C				
Appendix D	4/1/18 3/1/20	755 782		Reflect the December 2017 change in the way Medical ID cards are issued. Changed language to transitional benefit
Appendix E	4/1/20	784		Changed inROADS to WV Path
Appendix F				
Appendix G				

1.1 INTRODUCTION

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

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

1.2 COMMON INFORMATION

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

1.2.1 APPLICANT'S AND POTENTIAL APPLICANT'S RIGHTS

1.2.1.A Right to Apply

In addition to addressing all questions and concerns the client may have, the Worker must explain the benefits of each program and inform the client of his right to apply for any or all of them.

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

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

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

When it is not feasible for the applicant to be interviewed, if an interview is required or requested, on the date he expresses his interest, he must be allowed to complete the process at a later date. An appointment may be scheduled for his return, or the client may return at his convenience, depending upon the procedure established by the Community Services Manager (CSM). The same procedure must be used for all applicants within the county. If a follow-up appointment is scheduled and the applicant appears for the interview at the scheduled time, he

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

SNAP ONLY: SNAP applicants must be given a scheduled interview if it is not feasible to conduct an interview on the date the application is made. Any special needs such as, but not limited to, the applicant's work schedule, must be accommodated.

1.2.1.B Right to General Information

The Worker must provide the requested information to all those who have applied for benefits, or who inquire about the requirements for receiving benefits. This information includes a basic explanation of the eligibility requirements and answers to general questions.

- If the Worker does not know the answer to the general question, he must consult with his Supervisor.
- If the answer is unknown to the Supervisor, they may submit the question to the appropriate Policy Unit.
- Applicants, potential applicants, or their authorized representative must not be referred to the Policy Unit for a direct response.
- The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation.

1.2.1.C Right to Consideration for All Programs

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

When an applicant has been evaluated and eligibility is confirmed, a client notice is issued from the eligibility system to inform the applicant that he may be eligible for a benefit for which he did not apply and that he must contact his local office for information or to apply.

1.2.1.D Right to Voter Registration Services

The National Voter Registration Act of 1993 (NVRA), also known as the Motor Voter Act, is a federal civil rights law that requires public assistance agencies to provide voter registration services. A voter registration application and declination form must be provided at any point a client engages in contact with the DHHR in conjunction with benefits. If the contact is made via any method other than a face-to-face, the application and declination form must be mailed to the client.

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

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

NOTE: When an individual who applied for Medicaid through the Federally Facilitated Marketplace (FFM) expresses to the DHHR an interest in voter registration, the Worker must provide a voter registration application. The Worker must also send a declination form if the inquirer decides not to register.

Workers must provide the same level of assistance with voter registration applications as they would with any other agency form or service. This includes reviewing the voter registration application to ensure all required fields are completed and answering any questions the client may have. Workers must submit all completed declination forms, including those marked “yes,” “no,” or those left blank by the client, and voter registration applications to their county NVRA Coordinator.

See Appendices E, F, and G for Worker, County, and State Coordinator responsibilities related to assistance with voter registration.

The BCF State Coordinator may be contacted at (304) 356-4619.

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

West Virginia has established procedures for ensuring fair and equitable treatment of applicants and recipients of public assistance (clients). The DHHR prohibits discrimination against its applicants and clients on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or

parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information, in employment or in any program or activity conducted or funded by DHHR. (Not all prohibited bases will apply to all programs and/or employment activities.)

Applicable state and federal laws include the following:

- The West Virginia Human Rights Act, West Virginia Code §5-11-1
- The Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794
- The Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.
- Title VI of the Civil Rights Act of 1964, 42 U.S.C. §20000d et seq.
- Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 et seq.
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996
- The Civil Rights Restoration Act of 1987
- The Food and Nutrition Act of 2008
- United States Department of Agriculture (USDA) Departmental regulation 4330-2
- USDA Regulation, 7CFR Part 16

1.2.1.E.1 Individuals with Disabilities

Federal law protects individuals with a disability and defines that as a person who:

- Has a physical or mental impairment that substantially limits one or more of the major life activities of that individual;
- Has a record of such an impairment; or
- Is being regarded as having such an impairment.

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

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

1. Individualized Treatment: Individualized treatment requires that individuals with disabilities be treated on a case-by-case basis, based upon facts and objectivity. Such individuals may not be treated differently on the basis of generalizations or stereotypes.

2. Effective Opportunity and Access: Effective opportunity and access means that individuals must be given the same access and opportunities to programs of assistance as individuals who do not have disabilities.

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

Federal law also protects individuals with Limited English Proficiency (LEP) and defines that as individuals who:

- Do not speak English as their primary language; and
- Have a limited ability to read, speak, write, or understand English.

1.2.1.E.3 Worker Responsibilities

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

- Consider whether a person may have a special need, and how that may affect his ability to comply with rules, fill out forms, attend scheduled appointments, etc.
    - If the Worker determines that a person has a disability or LEP and that affects his ability to comply, the Worker has the authority to make reasonable modifications or accommodations to ensure that the person receives equal access to all programs and services. Any evidence must be documented in the case record and in case comments.
    - If an individual requires an interpreter, the Worker must contact local resources to locate one.
- Enter an indicator in the case record to alert that an accommodation may be needed and also to track cases for Federal reporting requirements.

1.2.1.E.4 Methods and Examples of Accommodations

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

➢ *Sign Language Interpretation*

The Worker must:

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

➢ *Visual Impairment Services*

All general public information should be made available in accessible formats such as large print, audio, and Braille.

Public entities such as the DHHR are responsible for providing these upon request, unless doing so causes an undue burden. Public entities are prohibited from charging a fee for auxiliary aids and services.

➢ *Foreign Language Interpreter Services*

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

- Phone Companies: Verizon offers interpreter services free of charge. An Interpretation Unit is accessible through Verizon's main phone number.
- Community Resources: Examples of community resources include, but are not limited to the Board of Education, local colleges, and the Division of Rehabilitation Services (DRS).
- Participants in the Refugee Assistance Program: Interpreter services are available for individuals who are participating in the Refugee Assistance Program (See Section 15.8). A request for services can be made by contacting the following agency:

  Office of Migration and Refugee Services
  1116 Kanawha Boulevard
  East Charleston, West Virginia 25301
  (304) 343-1036

> **Accommodations for an Individual with Disabilities Example 1:** An individual applies for WV WORKS. He has a learning disability and is unable to read,

comprehend, or complete the application. A reasonable accommodation is for the Worker to read the application to the individual and to explain the information fully.

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

Accommodations for an Individual with Disabilities Example 3: A client who has limited mobility comes into the office for a redetermination of benefits. An accommodation for this person is to ensure that an interview room equipped for disabled individuals is available for this client at the time of his appointment. If no such room is available, the Worker may assist the client to an appropriate workstation to conduct the interview.

1.2.1.E.5 Complaint Procedures – Client Responsibilities

Any person, who believes that he has been the subject of discrimination on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department has a right to file a complaint. (Not all prohibited bases will apply to all programs and/or employment activities.)

The individual or his authorized representative can file the complaint using the Civil Rights Discrimination Complaint form (IG-CR-3) by phone or in person to the Civil Rights Compliance Officer, within 180 days of the incident to the following address:

Employee Management
DHHR Equal Employment Opportunity (EEO) Officer
One Davis Square, Suite 400
Charleston, West Virginia 25301

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

Health and Human Services
Office for Civil Rights
U.S. Department of Health & Human Services
Room 515-F

200 Independence Avenue, SW
Washington, D.C. 20201
Or call (202) 619-0403 (voice) or
(800) 537-7697 (TTY)

A written complaint should include the following information:

- The name of the person(s) felt to have been treated unfairly;
- The date and description of the alleged discriminatory action;
- The name(s) of other persons, if any, who were present when this action occurred;
- The date the complaint is made; and,
- The signature of the person or representative making the complaint.

➢ *SNAP Only*

For SNAP benefits only, a copy of the IG-CR-3 must be sent to the following address, or the individual may file a direct complaint to:

United States Department of Agriculture (USDA)
Director, Office of Adjudication
1400 Independence Ave., SW
Washington, D.C. 20250-9410
(800) 632-9992

The individual may also file a Civil Rights program complaint of discrimination with USDA by completing the USDA Program Discrimination Complaint Form, found online, at any USDA office, or by calling (866) 632-9992 to request the form.

The individual may write a letter containing all of the information requested in the form. Send the completed complaint form or letter by mail to:

U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
Fax: (202) 690-7442
Email: program.intake@usda.gov

Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with SNAP issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish, or call the State

Information/Hotline Numbers (click the link for a listing of hotline numbers by State) found online.

1.2.1.E.6 Complaint Procedures – DHHR Responsibilities

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

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

➢ *SNAP Only*

For SNAP benefits only, the following USDA nondiscrimination statement must be included, in full, on all materials produced for public information, education, or distribution regarding the program:

> *The U.S. Department of Agriculture also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)*
>
> If an individual wishes to file a Civil Rights program complaint of discrimination with USDA, they can complete the USDA Program Discrimination Complaint Form, found online, at any USDA office, or by calling (866) 632-9992 to request the form. The individual may write a letter containing all of the information requested in the form. Send the completed complaint form or letter by mail to: U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
>
> Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).
>
> For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800)

221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online.

USDA is an equal opportunity provider and employer.

1.2.2 OVERVIEW OF THE ELIGIBILITY DETERMINATION PROCESS

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

1.2.2.A Application Process

This process determines initial eligibility for one or a combination of programs. Depending on the program or coverage group for which an individual applies, the application may be submitted by mail, phone, electronically, through the FFM, through People's Access to Help (WV PATH), in person, or it may be received by DHHR through the SSA's data exchange.

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

1.2.2.B Redetermination Process

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

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

1.2.2.C Case Reviews and Case Maintenance

While a redetermination is a required periodic review of total eligibility, a review may be conducted at any time on a single or combination of questionable eligibility factor(s).

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

Some special situations may require a more formal review process. This may be a special procedure to target an error problem.

1.2.2.D Resource Development

SNAP clients must be encouraged to take advantage of any potential resources that may be available, but failure to apply for or accept such benefits does not affect SNAP eligibility.

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

Medicaid clients are responsible for applying for and accepting alternative means of support. This is an eligibility requirement for this program. See Section 8.2.

1.2.3 WORKER RESPONSIBILITIES

1.2.3.A General

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

- Accept an application from any person or his representative who wishes to apply.

- Determine if the applicant requires special assistance.
- Ensure the client is given the opportunity to apply for all of the Department's programs on the date that he expresses an interest.
- Inform the client of his responsibilities, the process involved in establishing his eligibility, including the Department's processing time limits, and how the beginning date of eligibility is determined.
- Adhere to the Department's policies and procedures to establish eligibility, including those regarding timely action and/or decision.

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

- Prior to eligibility system entry for disposition of another application, the Worker must determine if there is an existing case number for the client.
    - When an existing case number is found in another county, the Worker must request immediate eligibility system transfer to the client's new county of residence. The case record must be mailed to the new county of residence within 10 working days. The request may be accomplished by memorandum, electronic mail, or by telephone.
    - The Worker must determine if there is an existing EBT account and reactivate expunged accounts. He must also inform the client of the availability date of any balance remaining in the account.
- Obtain all pertinent, necessary information through verification, when appropriate.
- During the SNAP interview, explain to the client they are required to self-attest whether they or any other member of their household have been convicted of certain crimes as an adult and if they are complying with the terms of their conviction. See 3.2.1.B.3. The worker should emphasize this attestation is legally binding. If the applicant's attestation is questionable, the Agency must verify each element of the questionable attestation.
- Assist the client in obtaining information required to establish his eligibility.
    - Determine whether or not the client is able to cooperate.
    - If he is able, but has not complied, instruct the client that his failure to fulfill his obligation may result in one or more of the following actions:
        - Denial of the application
        - Closure of the active AG
        - Removal of the individual from the AG

    - Repayment of benefits
    - Reduction in benefits
  - The action taken by the Worker depends on the specific requirement. These actions are found with the specific policy or in this chapter under the program-specific information.

- Maintain the confidentiality of all information received from or about the client.
- Per client request, make his case information available, including all electronic submissions and paper documentation, during normal business hours. See DHHR Common Chapters Section 230 for additional information.
- Ensure that copies of all pertinent information are placed in the client's case record or given to appropriate staff to file.
- Ensure that proper case recordings are made to document the Worker's actions and the reason for such actions.
- Ensure that information about available community resources addressing domestic violence is available to all persons who request it, or who, in the Worker's judgment, may benefit from it. In addition, the Worker must make an immediate referral to the appropriate domestic violence or community agency when the client requests such assistance. When possible, the referral must be made the same day. If the agency cannot make arrangements to see the client the same day, a referral to the Division of Children and Adult Services must be made the same day, if possible. See Section 1.2.12.D, Special Situations for additional information about handling domestic violence situations.
- Inform the client that he is authorized to receive information and referral services about Temporary Assistance to Needy Families (TANF; i.e. WV WORKS) and other programs offered by the DHHR.
- Provide a voter registration application and declination form at any point a client engages in contact with the Department in conjunction with benefits. If the contact is made via any method other than a face-to-face, the application and declination form must be mailed to the client. See Section 1.2.1.D to assure compliance with this procedure.
- **MEDICAID ONLY**: Provide each Medicaid applicant with a copy of the Department's Notice of Privacy Practices (NOPP). This includes clients who are completing a redetermination of Medicaid eligibility. In addition, the Worker must answer any questions the client may have about the document or about HIPAA or must refer the client to another source of information, such as the Regional or State-level DHHR HIPAA Privacy Officer. When an in-office intake interview is not conducted, the Worker must

mail the NOPP with a notice about how to obtain more information. This must be done at each mail-in or online Medicaid application and redetermination.

- Notify the client of the eligibility decision as soon as possible, but at least within the processing time frames for each program or Medicaid coverage group.

NOTE: When an application has been made for WV WORKS and/or Medicaid and the application is denied, withdrawn, approved for a DCA payment, or held pending additional information, the AG must not be required to make a separate application for SNAP benefits as long as the application taken is appropriate for the additional program and includes questions and answers to determine that program's eligibility. See Section 1.2.9.

1.2.3.B Home Visits

Home visits may be conducted for any program, during any phase of the eligibility determination process, when the Worker or Supervisor believes a home visit is advisable. The client may also request a home visit due to illness or inability to travel, when he has no person to act on his behalf.

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

NOTE: For SNAP, home visits must be scheduled. For all other Programs, the visit may be scheduled or unscheduled, at the Worker or Supervisor's discretion. If a home visit is made for another Program, and information is obtained which affects SNAP eligibility or benefit level, it is acted upon whether or not the home visit was scheduled. The client may refuse entry to the Department's representative.

1.2.3.C Collateral Contacts

When the Worker must make a collateral contact, such as with a client's employer, the Worker must not disclose the client's status as an applicant/client of a Department program.

1.2.3.C.1 SNAP Only Exception

DHHR staff must not initiate contact with law enforcement officials to disclose information regarding SNAP clients. However, information pertaining to a SNAP client or member of his household may be provided when written requests from federal, state, or local law enforcement officers are received on the official department letterhead of the issuing law enforcement agency and verifies the following:

- The individual is fleeing to avoid prosecution, custody, or confinement for a felony; or
- The individual is violating parole or probation; or
- The individual has information necessary for the officer to conduct an official duty related to either of the two statements immediately above.

The Worker provides only the individual's last known address, SSN, and, if available, a photograph of any member of the individual's household. It is the responsibility of the CSM to review and approve the release of all such information. If a written request for information is questionable, the Supervisor or CSM must contact the DFA Economic Services Policy Unit for assistance. Additional guidance on releasing confidential information is outlined in the DHHR Common Chapters Sections 200 – 250.

1.2.3.D Coding Cases as Confidential

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

1.2.3.E Cases Involving Domestic Violence

When the client discloses a domestic violence situation, extreme caution must be taken to safeguard any information about the individual's location or living situation.

- The Worker must not contact the individual named as the abuser, or his relatives or friends, for any information or verification required from the client.
- The case must be coded in the eligibility system with the domestic violence indicator to alert all who access the case about the client's situation.
- Copies of any information that involve a domestic violence situation must never be placed in the case record to ensure the safety of the client and to ensure that the alleged abuser does not gain access to information that may compromise the safety of the client.
- If it is necessary to make contacts with a domestic violence agency or the Division of Children and Adult Services, or to maintain records for the purpose of documentation of the situation for a WV WORKS temporary exemption from work requirements, the information must be maintained in a separate file that is secured and available only to Supervisors. Information maintained in a separate file regarding domestic violence may be presented as evidence at a Fair Hearing, as long as the client agrees to use of the information for such purpose.
- Information about a domestic violence situation or the whereabouts of an individual or family who has left a domestic violence situation for a safer residence must never be recorded in the case record, in order to ensure the safety of the individual or family.

1.2.3.F Determining Race and Ethnicity for Federal Reporting

It is the Worker's responsibility to determine the client's appropriate race and ethnic category and correctly enter the information in the eligibility system.

1.2.3.F.1 Race

When a client identifies himself as being of a single race or a combination of races, the appropriate race is entered in the eligibility system. The following are the races with which he may identify:

- Asian Indian
- Black or African American
- American Indian or Alaska Native
- White
- Native Hawaiian or other Pacific Islander
- Chinese

- Filipino
- Japanese
- Korean
- Vietnamese
- Guamanian or Chamorro
- Samoan
- Other Asian

1.2.3.F.2 Ethnicity

The client must be placed in an ethnic category, regardless of the race with which he identifies:

- Hispanic or Latino
- None of the above

If Hispanic or Latino:

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

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

When the client refuses to identify his race and/or ethnicity, the Worker must use his best judgment when entering the information in the eligibility system.

1.2.4 CLIENT RESPONSIBILITY

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

1.2.5 INTAKE INTERVIEW

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

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

The interview may be completed by the client or authorized representative visiting the office, or by the Worker making a home visit. Whether or not a face-to-face interview is required is found in program-specific sections of this chapter, along with any information that is specific to a particular program.

When it is not feasible for the applicant to be interviewed, if an interview is required or requested, on the date he expresses his interest, he must be allowed to complete the process at a later date. An appointment may be scheduled for his return, or the client may return at his convenience, depending upon the procedure established by the CSM.

- The same procedure must be used for all applicants within the county.
- If a household misses a scheduled interview appointment, it is the household's responsibility for rescheduling. To the extent practicable, the State agency must accommodate the applicant.

> *SNAP-ONLY EXCEPTION: SNAP applicants must be given a scheduled interview when it is not feasible to conduct an interview on the date the application is made. Any special needs such as, but not limited to, the applicant's work schedule, must be accommodated.*

Regardless of the program or Medicaid coverage group for which the client applies, the Worker is responsible for the following when an interview is conducted:

- Screening the client for all DFA benefits and explaining that he may be eligible for more than one benefit. The client must be given the opportunity to apply for any programs in which he expresses an interest, even if the Worker is able to pre-determine his ineligibility.
- Informing him that providing SSN's for non-applicants is not required but will be used to facilitate enrollment in insurance affordability programs for verification of financial information.

- Reviewing the DFA-2 or other application form to make certain that the client understood each question and answered to the best of his ability. If the client is unable to complete the form himself, and there is no one else to help him, the Worker must complete the form based on information provided by the client.
- Explaining the applicant's responsibility to provide complete and accurate information and the penalties for failure to do so.
- Discussing all statements on the DFA-RR-1 with the client to be sure he understands each one and marks each appropriately.
- Explaining fully the benefits of the program(s) for which the client applies. This includes: when benefits are received, how the benefits are received, description of the benefit, how to use the benefit, as well as any other pertinent information related to receipt and use of the benefit.
- Explaining how eligibility for the program(s) is determined and, if applicable, how the amount of the benefit is computed.
- Explaining the applicant's reporting requirements.
- Providing the applicant with a list of verifications needed to determine eligibility, using form DFA-6 or the verification checklist. He must also be told the penalty for failure to provide the verifications and what he must do if he finds he cannot obtain it by the deadline.
- Explaining other resources within the agency from which the client may benefit.
- Explain to the client that he is authorized to receive information and referral services about TANF, and other programs offered by the Department.
- Finding resources to meet the client's emergency needs by referral to a community resource or by an application for Emergency Assistance.
- Ensuring that information about available community resources that address domestic violence issues is made available to all persons who could benefit from it. All clients who request assistance in dealing with domestic violence should be referred to a local domestic violence agency, so that an interview may be conducted the same day. When this is not possible, referring the client to the Division of Children and Adult Services.

NOTE: When the applicant has completed the interactive interview, and there is a technical failure that prevents printing the DFA-2, form DFA-5 must be signed by the applicant and filed in the record with the DFA-2 after it is printed. He must not be required to return to the office to sign the DFA-2 when the DFA-5 has been signed.

1.2.6 APPLICATION SUBMISSION

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

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

1.2.6.A Paper Applications

The Department responds to requests for applications to be mailed to potential applicants and accepts applications submitted by mail. The following is a general description of the mail-in application process.

NOTE: The same basic process applies when the client or his representative picks up and/or drops off an application for the client, without a contact with the Worker, and when the client requests in writing that an application form be mailed to him. The following description does not indicate which form is mailed, because the form depends upon the program or Medicaid coverage group for which the client wishes to apply. The appropriate forms are shown with each program and coverage group found in the program-specific sections which follow.

1.2.6.A.1 Applications Requested by Telephone

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

- If the applicant wishes, a Worker will complete the application for him in a face-to-face interview, either in the office or in his home.
- The mail-in application procedure will result in a delay in processing his application due to a delay in receipt of the form through the mail, and depending on the program, a face-to-face or telephone interview, if required.
- If the applicant wishes, he may complete the WV PATH application process, if applicable.

1.2.6.A.2 Applications Submitted by Mail

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

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

Complete applications forms must be date-stamped when received.

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

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

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

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

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

1.2.6.C Community Partners

Some WV PATH applications are submitted with the assistance of a Community Partner. This is an agency or organization that assists individuals and families in applying for benefits that include, but are not limited to, SNAP, Medicaid, WVCHIP, SCA, and LIEAP. An example of a Community Partner is the Primary Care Association.

Community Partners who enter into an agreement with DHHR are permitted to verify the identity and citizenship of the applicant and submit the application with an electronic signature. The Community Partner may choose to submit any verification to the local office on behalf of the applicant.

1.2.6.D Federally Facilitated Marketplace

Individuals may apply online at the Federally Facilitated Marketplace (FFM, the Marketplace) for insurance affordability programs and MAGI Medicaid coverage groups, including Parents/Caretaker Relatives, Adult, Pregnant Women, Children Under Age 19, and WVCHIP. When the individual's income is at or below the income limits for Medicaid, the Marketplace will determine the applicant's eligibility for Medicaid or WVCHIP and forward the data file to the eligibility system. The eligibility system will determine the specific Medicaid or WVCHIP coverage group through which Medicaid will be issued without delay.

The Marketplace's responsibility of determining eligibility for Medicaid is limited to Medicaid coverage implemented through the Affordable Care Act (ACA) in West Virginia effective October 1, 2013 and includes MAGI groups only. The Marketplace is not responsible to assess or determine eligibility for other Medicaid or other Department programs, benefits, or services. When the Worker identifies the individual's potential eligibility, the Worker notifies the individual of the application process for any other programs or services.

1.2.7 CLIENT NOTIFICATION

The client must be notified in writing of the final decision on his application and the reason for it. Notification must be provided for each Program for which the client applied, but notification for more than one program may be included on one form letter. Under some circumstances, the eligibility system automatically generates notification to the client.

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

During the intake interview or during some other client contact prior to written client notification, the Worker may know whether or not the client is eligible and, if so, the amount of the benefit. The Worker may tell the client the status of his application and/or benefit level, if he so chooses. However, even if the client has been told his status and/or benefit level, he must still receive the information in writing.

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

1.2.8 COMPLETION OF THE APPLICATION PROCESS

The application process is completed when the following have occurred:

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

The client receives his initial benefit, if eligible.

1.2.9 ADDITION OF A BENEFIT TO AN ACTIVE CASE

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

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

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

1.2.10 REAPPLICATIONS

1.2.10.A SNAP

When an application has been made and requested information is not received, according to the time limits established in Section 1.4, the client must not be made to complete a new application if the information is returned within 60 days of the original application date. Once a decision is made to deny, the applicant must reapply.

1.2.10.B WV WORKS and Medicaid

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

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

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

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

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

1.2.11 REDETERMINATIONS

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

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

1.2.11.A Redeterminations Submitted by Mail

Clients of some Medicaid coverage groups, WVCHIP, and other programs receive an instruction letter and redetermination form that is submitted by mail, along with appropriate verifications. The client must complete, sign, and mail or bring the form and other required information to his local DHHR office or the Customer Service Reporting Center as directed by the letter. The client may always request a face-to-face interview.

1.2.11.B Redeterminations Submitted by WV PATH

Clients of some Medicaid coverage groups, WVCHIP, and other programs receive an instruction letter and redetermination form. The client may choose to return the completed form and information by mail or complete the redetermination online by using WV PATH. The client receives certain information in the letter that must be entered online to use the WV PATH redetermination process.

No signature page is required, and the redetermination is considered electronically signed when the client uses this process and enters information from the letter and other identifying information requested.

The online process is available for use through the end of the month the redetermination is due.

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

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

1.2.12 SPECIAL SITUATIONS

1.2.12.A Applicant Receives Benefits from Another State

When an applicant states that he is or has been receiving SNAP benefits, cash assistance, and/or Medicaid from another state and presents a letter that shows the last date for which he received benefits, contact with the other state is usually necessary only to inquire about repayment of benefits in that state, if the issue is not addressed in the letter.

NOTE: The effective date of benefit closure in West Virginia is the month for which the client last received benefits. This may not be true in other states.

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

- Date on which the client last received or will receive his last benefits;
- Effective date of the termination of benefits;
- The individuals included in the benefit;

- Whether or not any of the client's last benefits were returned to the agency; and,
- Whether or not the client owes a repayment to any program.

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

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

1.2.12.A.1 SNAP Cases Containing ABAWDs

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

1.2.12.A.2 WV WORKS

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

States had until July 1997 to convert from AFDC/U to a TANF-funded program. Therefore, for benefits received prior to July 1997, the Worker must also determine how many months of the cash assistance payments were funded under TANF. Appendix C contains information about when other states converted to TANF funding.

1.2.12.A.3 Medicaid

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

1.2.12.B Application Made or Received in the Incorrect County

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

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

When a mail-in application is received in the incorrect county office, it must be mailed to the correct county office the same day it is received. In addition, the correct county office must be notified the same day by electronic mail that the application is being mailed.

If the client visits the incorrect office to apply, the application must be accepted, and an intake interview completed. The Worker must:

- Complete a system transfer to the correct county office on the date the application is made. The correct county office must be notified by electronic mail that the case is being transferred.
- Inform the client of additional requirements he may have to complete in the correct county.
- If the client, after explanation of the available programs, wants to apply for SNAP benefits, the contact county screens for Expedited Service eligibility, explains this to the client, and notifies the correct county office that this was done. Expedited benefits are issued by the county of residence.

1.2.12.B.2 Applications Requested by Telephone

If the client telephones the incorrect office:

- The Worker must give him the address and telephone number of the appropriate office.
- If he requests an application be mailed to him and does not choose to contact the appropriate office to have this done, one is mailed to him from the contact office, along with instructions to return it to the address of the correct county office. The Worker must notify the other office by electronic mail within prescribed time limits, based on the date of application established by the contact office.

1.2.12.B.3 Applications Submitted by WV PATH

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

1.2.12.C Communication with the Social Security Administration (SSA)

Each CSM is responsible for appointing a contact person to communicate with a contact person in the local SSA office. This contact person does not interpret policy but works out communication problems and any problems dealing with the completion and forwarding of forms, including those involved in the joint application process for SNAP benefits. The Department's contact works directly with the contact from SSA.

Any matters that cannot be worked out between the local office and the SSA contact person are referred to a DFA Policy Unit and to the SSA District Office by the appropriate staff.

NOTE: The Worker must not contact the SSA regarding LIS files received through data exchange. The SSA uses different eligibility criteria than DHHR. The Worker may issue a verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

1.2.12.D Domestic Violence

Information about community resources that address the issue of domestic violence must be readily available in each waiting room of each county office. The information must be written and must be available for the client to take with him discreetly, without having to ask for it.

In addition, the Worker must provide such information when it is requested. When possible, this must be accomplished during the office interview. In order to ensure the safety of the individual to whom information about domestic violence is given, it is suggested that the domestic violence information be part of a packet that contains a variety of information.

If, during the interview, the Worker observes language or other behavior that is threatening and discussion of such matters could pose a possible threat to the client, the Worker must avoid direct discussion with the client. In those instances, a referral to the local domestic violence program, other available community resources, or to Social Services is in order so that a contact can be made without the threat of additional harm to the client.

Each CSM is responsible for coordinating efforts between DFA staff, Division of Children and Adult Services, and available community resources. The CSM is also responsible for making sure that up-to-date information about domestic violence services is available at all times.

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

1.2.12.E Applications Submitted from the WV Division of Corrections (DOC) or Regional Jail Authority (RJA)

The West Virginia Division of Corrections (DOC) or Regional Jail Authority (RJA) will provide the Bureau for Medical Services (BMS) a list of incarcerated individuals who have been admitted as inpatients in medical institutions for at least 24 hours. Hospitals will also provide a list to BMS of incarcerated individuals who have been admitted for services for reconciliation against the DOC and RJA list.

- If the individual is a current Medicaid recipient, BMS will code the Medicaid Management Information System (MMIS) with the appropriate incarceration status. This will place a restriction on payment of Medicaid services while the recipient is an inmate or incarcerated. BMS will also notify the Customer Service Reporting Center (CSRC) if the client is not coded as incarcerated, so the living arrangement code in the case can be updated.
- If the individual is not a current Medicaid client, BMS will notify DOC or RJA to assist the individual with submitting an application via WV PATH.
    - The WV PATH applications will be forwarded to the CSRC for processing. If Medicaid eligible, the incarcerated individual living arrangement code will inform BMS/MMIS of the recipients' incarcerated status. The CSRC notifies BMS by email that the application has been processed.

1.3 APPLICATION FORMS

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

The application:

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

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

1.3.1 COMMON APPLICATION FORMS

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

1.3.1.A Application for Benefits DFA-2

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

1.3.1.A.1 Purpose

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

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

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

1.3.1.A.2 Submission Format

The DFA-2 may be:

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

1.3.1.A.3 Related Forms

➢ *Rights and Responsibilities DFA-RR-1*

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

The Worker must provide any explanation and information the client needs to understand the statements. After completing all applicable sections, the client signs the form. Failure to sign the form results in ineligibility.

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

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

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

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

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

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

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

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

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

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

1.3.1.B WV PATH Application

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

1.3.1.B.1 Purpose

This application can be used for:

- SNAP
- Medicaid
- WVCHIP

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

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

1.3.1.B.2 Submission Format

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

1.3.2 SNAP ONLY APPLICATION FORM DFA-SNAP-1

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

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

1.3.3 WV WORKS ONLY DFA-RFA-1

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

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

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

1.3.4 MEDICAID APPLICATION FORMS

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

1.3.4.A.1 Purpose

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

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

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

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

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

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

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

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

1.3.4.A.2 Submission Format

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

1.3.4.A.3 Related Forms

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

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

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

1.3.4.B Medical Assistance Application DFA-MA-1

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

The DFA-RR-1 is not required.

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

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

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

No DFA-RR-1 is required.

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

1.3.5 OTHER PROGRAMS

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

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

Program	Application Form – Common		Application Form – Program-Specific
	15 for special instructions related to refugees.		
Special Pharmacy	Not applicable.	-	Special Pharmacy Application DFA-SP-1
West Virginia School Clothing Allowance (WV SCA)	DFA-2 WV PATH	OR	SCA Application DFA-WVSC-1

1.4 SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

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

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

1.4.1 APPLICATION PROCESS

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

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

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

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

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

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

1.4.1.A Failure to Provide Requested Verifications

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

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

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

Different procedures apply when the case is closed because of failure to provide needed verification at the time of redetermination. When the client provides the verification within 30 days of the end of the certification period, it is still considered a redetermination and a new application is not required. See Section 1.4.18, Application and Redetermination Variations, for instructions on proration due to delayed processing.

> **Application Example 4:** Ms. Sunflower reports the start of a new job on July 1. A DFA-6 is issued to her with a due date of July 10. Ms. Sunflower does not provide the requested information by that date and the benefit is closed effective

July 31. On July 30, she provides the requested information and benefits are reopened effective August 1. No new application form or interview is required. The AG remains in the original certification period.

Application Example 5: Same example as above, except that the information is not returned until August 5. Benefits may not be approved until Ms. Sunflower completes a new application and interview. The AG will be assigned a new certification period if the application is approved.

1.4.1.B Categorically Eligible AGs

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

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

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

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

1.4.1.C SNAP Work Requirement Penalty Expires

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

1.4.1.D Failure to Complete the Interim Contact Form

When a SNAP AG is closed for failure to complete the interim contact form, a new application is not required when the form is returned by the last day of the 13th month for households certified for 24 months. For households certified for 12 months, the form must be returned by the last day of the seventh month. Benefits are prorated from the date the interim contract form is returned. If the form is not returned, a new application must be completed.

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

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

- The ABAWD becomes exempt;
- The county in which he resides becomes exempt;
- The county of which he resides becomes a NILC;
- The State of West Virginia begins a new 36-month tracking period.

1.4.1.F Face-to-Face Interview Waiver

When a SNAP AG is included in the face-to-face interview waiver and is closed for failure to return a completed CSLE form, a new application is not required when the completed CSLE is returned by the last day of the month following the end of the certification period. See Section 1.4.18, Application/Redetermination Variations.

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

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

- The SNAP benefits must be in closed status,
- The SNAP AG has at least one full month remaining in the certification period after the last month benefits are received,

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

1.4.2 COMPLETE APPLICATION

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

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

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

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

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

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

1.4.3 DATE OF APPLICATION

The date of application is the date the applicant submits a DFA-2 or DFA-SNAP- 1 in person, by fax, other electronic transmission, or by mail, which contains, at a minimum, his name, address,

and signature. When the application is submitted by mail or fax, it is considered an original application and the date of application is the date that the form with the name, address, and signature is received in the local office.

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

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

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

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

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

1.4.4 INTERVIEW REQUIRED

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

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

The worker must explain the interview options that are available.

When an interview is completed by phone, an application form is still required. If the client submits an application form with only a name, address, and signature to protect their application date, the customer must provide another signature attesting the information provided during the phone interview is accurate.

If the client provided enough information to determine eligibility, but the Worker discovers discrepancies or additional information from the interview, it is not necessary to send the client another application for signature. Instead, the Worker documents in the case record the differences.

> **Interview Required Example 1:** An application is received that contains only the applicant's name, address, and signature. The Worker schedules and completes a phone interview. During the interview, the applicant reports information about household members, income, and expenses that was not included on the application. The Worker must print the Common Application Form (CAF) and mail to the client for a signature to attest to the information provided during the interview.
>
> **Interview Required Example 2:** An application is received providing income, household composition, and utility amounts. During the interview, the Worker discovers there is a rent obligation. It is not necessary to require another signature or updated application.

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

1.4.4.A Procedures for Missed Scheduled Interviews

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

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

information to establish eligibility. The beginning date of eligibility is the date the information is supplied. Provisions in Section 1.4 for the beginning date of eligibility apply when the client completes all application requirements, including the interview, within 60 days of the date of application.

- Deny the application on the 30th day after the date of application when the client misses the scheduled interview and does not contact the office to reschedule it.

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

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

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

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

1.4.5 WHO MUST BE INTERVIEWED

1.4.5.A AG Member

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

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

1.4.5.B Authorized Representative

An adult non-AG member may participate in the interview as an authorized representative (AR) of the AG, either with or without an AG member. This individual must be authorized and designated in writing by an adult member of the AG or by any AG member if there is no member at least age 18. The authorized representative must have sufficient knowledge of the AG's circumstances to provide the necessary information. The authorized representative may act on the AG's behalf in making an application, completing a redetermination or reporting information during the certification period. See Section 10.4 for reported changes.

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

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

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

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

➢ *Restrictions of Authorized Representatives*

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

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

The Worker must send written notification to the affected AG and the authorized representative or authorized cardholder 30 days prior to the date of the disqualification. The letter must include: the fact that disqualification of the individual is proposed, the reason for the action, the AG's

right to a Fair Hearing, the telephone number of the office and the name of the person to contact for additional information.

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

The following restrictions apply for SNAP Authorized Representatives:

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

1.4.6 WHO MUST SIGN

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

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

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

1.4.7 CONTENT OF THE INTERVIEW

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

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

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

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

- For homeless AGs with shelter costs, explain the option of using the Homeless Shelter Standard Deduction versus actual shelter and SNAP Standard Utility Allowance (SUA) costs.
- Explain that the receipt of SNAP has no effect on time limits for WV WORKS, and SNAP benefits may continue even when WV WORKS stops.
- Explain certification periods and specific reporting requirements.
- Explain the Department of Health and Human Resources' (DHHR) employment and training programs and the requirements for keeping job/training appointments, accepting employment or training, registering for SNAP Employment and Training (SNAP E&T) and the consequences for failing to comply with the requirements.
- When appropriate, explain the definition of an ABAWD, the time limits, the work requirements, and exemptions.
- Explain the authorization to receive information and referral services about Temporary Assistance for Needy Families (TANF) and other programs offered by the West Virginia DHHR.
- Explain the following about Electronic Benefits Transfer (EBT):
    - SNAP benefits will be deposited into an EBT account and accessed with an EBT card
    - When the card will be received and how to create a personal identification number (PIN).
    - The card must be activated prior to use.
    - When the benefits will be available in the account

- The importance of choosing an authorized cardholder who can also access the EBT account

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

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

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

1.4.8 DUE DATE OF ADDITIONAL INFORMATION

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

1.4.9 AGENCY TIME LIMITS

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

The Worker must take eligibility determination action on all applications.

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

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

Following are the time limits for denying an application.

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

1.4.10 AGENCY DELAYS

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

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

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

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

1.4.11 REPAYMENT

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

1.4.12 PENALTIES

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

1.4.12.A Work Requirement Penalty

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

1.4.12.B Disqualifications

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

1.4.13 BEGINNING DATE OF ELIGIBILITY

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

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

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

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

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

1.4.14 CERTIFICATION PERIOD

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

The client's certification period must be the longest possible period but must not exceed 24 months for AGs in which all adult members are elderly or disabled with no earned income or only excluded earned income. All other AGs are certified for 12 months except for applications that qualify for expedited services and verifications have been postponed.

1.4.14.A Establishing the Certification Period

1.4.14.A.1 Certification Periods

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

- ***One Month***

Expedited Service cases which apply prior to the 16th of the month and do not provide the necessary verifications prior to approval. If verifications are provided within the time limit given, the certification period is extended an additional 11 or 23 months based on the AG's reporting requirements.

- ***Two Months***

AGs eligible for Expedited Service who apply on or after the 16th of the month and have verification postponed. See Section 1.4.19.A.3, Combined Issuance. If verifications are provided within the time limit given, the certification period is extended an additional 10 or 22 months, based on the AG's composition and income.

- ***12 Months***

All AGs except those described below for 24 months.

- ***24 Months***

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

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

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

1.4.14.A.2 Interim Contact Report

A contact report must also be made midpoint of certification. However, no interview is required for this report. The Interim Contact Report is automatically mailed to the AG by the eligibility system. The client must complete the Interim Contact Report and return it to the local office.

1.4.14.B Adjusting the Certification Period

1.4.14.B.1 Extending a Certification Period

Once a 12-month certification period is established, the Worker may extend it to a total of 24 months only when all adult AG members are elderly or disabled and the AG has no earnings or only excluded earnings. No certification period may exceed a total of 24 months.

1.4.14.B.2 Shortening a Certification Period

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

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

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

AGs certified for 12 months may not have their certification period shortened for any reason except ineligibility.

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

➢ *Shortening a Certification Period Examples*

Example 1: An AG is composed of two elderly individuals who have only unearned income. The 24-month certification period is January 2015 through December 2016. On June 2, 2016, the AG adds their 25-year old son, who is not disabled. The Worker notifies the AG that the certification period is being shortened and they must report for a redetermination in July 2016. When the redetermination is completed, a new 12-month certification period is assigned based upon the AG's new circumstances.

Example 2: An elderly couple with only unearned income is certified for 24 months beginning January 2016. On May 20, 2016, their 30-year-old daughter and her 10-year-old child move into the home. The daughter applies for WV WORKS for her and her child and is approved for benefits beginning in June 2016. The Worker sends advance notice to the household that their certification is being shortened and they must complete a redetermination. When the redetermination is completed and changes are made for the current circumstances, the certification is reset to 12 months.

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

Example 4: A one-person AG with no income is certified for 12 months, as the AG member has a pending Retirement, Survivors, and Disability Insurance (RSDI) disability claim. In the second month of the certification period, the RSDI is awarded and it is determined the AG is still eligible for SNAP. The certification period is extended 22 months to equal a total of 24 months, now that all adult AG members are disabled without earnings.

Example 5: An AG composed of two elderly adults with earnings and one child is certified for 12 months. In the second month, the AG reports the loss of earned income. Because all of the adult AG members are elderly without earned income, the certification period must be extended to 24 months. The extended certification period starts the month the change is effective.

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

completion of the interview and changes made for the current circumstances, their certification period is reset at 12 months.

1.4.15 REDETERMINATION

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

1.4.16 EXPEDITED PROCESSING

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

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

1.4.16.A Eligibility Requirements

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

- Those whose monthly gross income is less than $150 and whose liquid assets do not exceed $100.
- Migrant and seasonal farm worker AGs which have been determined Destitute, as defined in Chapter 4, and whose liquid assets do not exceed $100.
- Eligible AGs whose combined monthly gross countable income and liquid assets are less than the AG's monthly paid and unpaid shelter and the appropriate utility standard, if eligible. The AG's income and liquid assets must be less than the AG's monthly paid and unpaid shelter costs and the SUA amount for which the AG is eligible.

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

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

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

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

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

1.4.16.B Screening for Expedited Service

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

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

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

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

1.4.16.C Variations in Application Processing Procedures

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

1.4.16.C.1 Verification/Work Requirements

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

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

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

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

Postponed verification must be received prior to the second issuance.

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

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

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

1.4.16.C.2 Time Limits

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

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

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

1.4.17 SPECIAL CONSIDERATIONS

Special considerations are outlined below.

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

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

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

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

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

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

1.4.17.A.1 The SSA Responsibilities

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

1.4.17.A.2 Worker Responsibilities

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

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

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

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

  If verification not provided by the SSA is needed, the Worker must notify the client of the required information within three working days of the date the application is received from the SSA.

- Process according to normal procedures if the AG does not qualify for Expedited Service.
- Process any SSA/DHS-1 forms completed as redeterminations the same way applications are handled.

1.4.17.A.3 Quality Control (QC) Errors

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

1.4.17.B Mail-In SNAP Applications

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

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

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

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

1.4.17.C Categorical Eligibility

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

1.4.17.C.1 Who Is Eligible?

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

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

Authorized to receive means the AG is coded in the eligibility system as active for a benefit whether they are receiving it or not. Those authorized to receive include individuals who have been determined eligible for benefits and notified of the determination, even if benefits have not been received or accessed or the benefits have been suspended, recouped or not paid because they are less than a minimum amount or they have not yet received the information or referral.

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

- WV WORKS: Any month for which the AG is authorized to receive benefits

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

Authorized for Information and Referral Services

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

➢ *AGs Containing Only Individuals Authorized to Receive SSI*

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

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

1.4.17.C.2 Who Is Not Categorically Eligible?

An AG cannot be categorically eligible in the following situations:

- A person who is normally required to be a member of the AG is disqualified due to an IPV.
- The AG refuses to cooperate in providing information necessary to make an eligibility determination.
- The AG is ineligible due to the striker provisions.
- An AG who is the recipient of a substantial lottery or single gaming win that is greater than or equal to the SNAP asset limit for AGs containing an elderly or disabled member.

- An AG who contains an individual(s) who have been convicted of certain felony offenses as an adult and is not complying with the terms of their sentence.
- A person who is normally required to be a member of the AG is disqualified due to being convicted of a specific felony offense. The felony must meet two criteria:

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

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

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

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

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

1.4.17.C.3 Presumed Eligibility Requirements

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

- Asset limit: The transfer of assets policy is applied as appropriate. See Chapter 5.
- Gross income limit, when applicable
- Net income limit

- Sponsored alien information
- Residency
- SSN information: Only if the AG member is receiving a benefit which requires the SSN to be verified.

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

NOTE: While categorically eligible AGs are presumed to meet both income limits, those with more than two members are not automatically eligible for SNAP. The monthly net income of an AG must be eligible for an issuance based on Chapter 4, Appendix C.2. Categorically eligible AGs containing one or two individuals automatically receive the minimum benefit, unless it is a prorated benefit.

1.4.17.C.4 Special Processing Requirements

The following special processing requirements apply.

➢ *TANF Benefit Applicants*

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

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

This applies to AGs that:

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

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

➢ *SSI Applicants*

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

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

1.4.17.C.5 Categorical Eligibility Examples

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

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

Categorical Eligibility Example 3: A family of five with a total gross income of 185% FPL applies for SNAP benefits. The household income exceeds the gross income limit for SNAP; however, the family is eligible to receive information and referral services because their income is below 200% FPL, which means the AG is presumed to have met the gross income limit (as well as the other requirements listed in 1.4.17.C.3). The family's net income must then be calculated to determine if they are eligible for an issuance.

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

requirements to be eligible, including being within the gross income, net income and asset limits.

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

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

1.4.18 APPLICATION/REDETERMINATION VARIATIONS

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

1.4.18.A Redetermination Forms

The following methods can be used for redetermination:

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

The eligibility system automatically mails the CSLE in the last month of the certification period. The form must be completed and returned prior to the scheduled interview date specified on the CSLE/CSLR. The form is considered complete when signed and dated by the client or his authorized representative or completed and submitted by WV PATH.

1.4.18.B Redetermination Cycle

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

1.4.18.C Redetermination Interview

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

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

1.4.18.D Scheduling Interviews

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

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

> **Scheduling an Interview Example 1:** A SNAP redetermination is scheduled for September 1. The client calls the office and requests a redetermination form be mailed to him and that an interview be scheduled to accommodate his work hours. The interview is scheduled for September 10 and the client returns the redetermination form by mail on September 7. The client misses the scheduled interview on September 10. Because he filed a redetermination by mail, but missed a scheduled interview, the Worker sends a notice to inform the client he is responsible for scheduling another interview. At adverse notice deadline, if the client has not completed the interview, a closure notice is sent.
>
> **Scheduling an Interview Example 2:** Same situation as above, but the client does not file a redetermination or appear for an interview. No notice is required

> for a missed interview because a redetermination was not submitted, but a closure notice is sent.

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

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

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

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

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

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

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

- If the CSLE/CSLR is not completed and returned by the end of the certification period, benefits are stopped. Notice of closure is required, but advance notice is not required.
- If the CSLE is returned in the month after the end of the certification period, no DFA-2 or DFA-SNAP-1 is required for reapplication. The CSLE/CSLR is used as the application form and benefits are prorated from the date the application is received in that month.
- If the CSLE/CSLR is used as an application form, an interview is required.

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

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

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

1.4.18.E Completion

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

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

1.4.18.E.1 Benefit Issuance at Redetermination

➢ *Uninterrupted Benefits at Redetermination*

Clients who submit their redetermination form in a timely manner, complete the interview and provide requested verification within the agency time limits, must receive uninterrupted benefits or have lost benefits restored if the Agency's delay causes benefits to be interrupted. The client does not lose the right to uninterrupted benefits if the time limits established for verification extends into the new certification period.

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

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

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

➢ *Benefits Not Prorated*

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

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

➢ *Benefits Prorated*

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

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

1.4.18.E.2 When a New Application Is Required

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

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

  If the CSLE/CSLR is not completed and returned by the end of the certification period, benefits are stopped. Notice of closure is required, but advance notice is not required. If the CSLE is returned in the month after the end of the certification period, no DFA-2 or DFA-SNAP-1 is required for reapplication. The CSLE/CSLR is used as the application form and benefits are prorated from the date the application is received in that month.

> **Redetermination Example 1:** A SNAP AG is redetermined on July 3 and submits required verification by July 20. The new certification period begins August 1. Benefits are not prorated.
>
> **Redetermination Example 2:** Same situation as above, but the verification is not provided until August 4. No reapplication is required, and August is the first month of the new certification period. Benefits are prorated from August 4.
>
> **Redetermination Example 3:** A SNAP AG is redetermined on July 29 and the verification is due by August 8. The verification is received in the local office on August 4. The first month of the new certification period is August. Benefits are not prorated.
>
> **Redetermination Example 4:** Same situation as above, but the verification is returned on August 20. The first month of the new certification period is August. Benefits are prorated from August 20.
>
> **Redetermination Example 5:** Same situation, but the verification is not returned until September 3. The AG must apply with a new application because the verification was not returned within the month following the last month of the certification period.

1.4.18.F Overdue Redetermination

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

1.4.19 THE BENEFIT

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

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

1.4.19.A Initial Benefits

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

1.4.19.A.1 Amount

A determination of the initial SNAP benefit month must be made to determine if initial benefits must be prorated. Any month determined to be an initial month must have benefits prorated. The amount of the initial allotment is prorated over the remainder of the month from the date of application. The full month's countable income is used to determine the full month's allotment. The amount of the initial benefit due the recipient is based on the number of days left in the approval month from the date of application as compared to the full month's benefit. Use Chapter 4, Appendix D.

1.4.19.A.2 Method of Issuance

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

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

1.4.19.A.3 Combined Issuance

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

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

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

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

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

1.4.19.B Ongoing Benefits

1.4.19.B.1 Amount

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

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

1.4.19.B.2 Method of Issuance

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

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

1.4.19.C Electronic Benefits Transfer

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

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

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

1.4.19.C.1 EBT Definitions and Terminology

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

ADMINISTRATIVE TERMINAL

EBT vendor system used to inquire into EBT account information, reactivate expunged accounts, deactivate EBT cards and, in some instances, make changes to the EBT account.

AUTHORIZED CARDHOLDER

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

CUSTOMER SERVICE REPRESENTATIVE (CSR)

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

DEMOGRAPHIC INFORMATION

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

DORMANT CARD

335 days of non-use.

ELECTRONIC BENEFITS TRANSFER (EBT)

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

EBT HELPLINE

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

EXPUNGMENT

365 days of non-use.

INTERACTIVE VOICE RESPONSE UNIT (IVRU)

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

MOUNTAIN STATE CARD

The West Virginia EBT card.

PAYEE

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

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

PERSONAL IDENTIFICATION NUMBER (PIN)

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

POINT OF SALE (POS) EQUIPMENT

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

PROTECTIVE PAYEE

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

STATUS THE EBT CARD

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

1.4.19.C.2 EBT Card Issuance

➢ *Initial Card Issuance*

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

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

➢ *Legal Guardian or Protective Payee*

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

➢ *Authorized Cardholder*

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

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

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

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

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

➢ *Cardholder Security*

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

➢ *Frequent Card Replacement*

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

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

1.5 WV WORKS

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

1.5.1 APPLICATION FORMS

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

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

1.5.2 COMPLETE APPLICATION

The application is complete, when the client signs a DFA-2 or DFA-5 which contains, at a minimum, his name and address.

If the client chooses not to sign the DFA-2, the application is considered incomplete and the Worker must take appropriate eligibility system action to deny the application, complete client notification, and record in case comments that the client did not want to sign the application and the reason for his decision. The Worker must encourage the

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

client to sign the application so there is no misunderstanding that he was denied the right to apply.

1.5.2.A Caretaker Relative Option

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

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

1.5.3 DATE OF APPLICATION

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

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

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

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

1.5.4 INTERVIEW REQUIRED

A face-to-face interview is required.

If a home visit is scheduled for the intake interview, eligibility is not affected by the client's failure to be home for a home visit, unless:

- At least two attempts have been made; and
- At least the second visit was scheduled; and
- The client has not contacted the county office to make other arrangements.

The Missed Home Visit DFA-HV-1 may be left at the client's home, after the first attempt, to advise the client of a return visit. If the DFA-HV-1 is used for this purpose, a copy must be retained by the Worker.

1.5.5 WHO MUST BE INTERVIEWED?

1.5.5.A Parent(s)

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

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

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

1.5.5.B Specified Relative

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

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

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

1.5.6 WHO MUST SIGN?

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

1.5.7 CONTENT OF THE INTERVIEW

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

1.5.7.A Local Services

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

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

1.5.7.A.2 Medicaid

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

1.5.7.A.3 Domestic Violence

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

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

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

1.5.7.B Work Requirements

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

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

1.5.7.C Outstanding Claims

Before the case is approved, the Worker must determine if there is a WV WORKS, Aid to Families with Dependent Children (AFDC), or AFDC-Related Medicaid claim outstanding

against any member of the AG or the non-recipient Work-Eligible Individual. If so, the Worker must initiate appropriate repayment procedures prior to approval.

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

1.5.7.D WV WORKS Eligibility

The worker must discuss the following:

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

1.5.7.E WV WORKS TRANSITIONAL BENEFIT

Discuss the two types of transitional benefit options

- Option 1 – Up to a six-month period during which the former WV WORKS participant may be eligible for continued support payments and services; or

- Option 2 – The West Virginia Employment Assistance Program (EAP) which allows the employed former WV WORKS recipient to continue to receive the WV WORKS payment he received prior to becoming employed for up to a six-month period.

1.5.7.F Client Reporting Responsibilities

1.5.7.F.1 Lump Sum

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

1.5.7.F.2 Pregnancy

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

1.5.7.G Benefit Issuance Options

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

1.5.7.G.1 Direct Deposit

The Worker must:

- Provide an enrollment brochure.
- Explain the advantages of receiving WV WORKS, child support pass- through, and Child Support Incentive (CSI) benefits by direct deposit and that enrollment is optional. The client uses a bank of his choice and once the benefit is deposited, the client is responsible for all dealings with his bank and for all fees and penalties associated with his own bank account. The WV WORKS benefit is deposited on the last State workday of the month prior to the month the benefit is due. The CSI benefit is available on approximately the 20th calendar day of the month.

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

1.5.7.G.2 EBT

The Worker must explain:

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

- When the benefits will be available in the account.

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

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

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

- EBT WV WORKS or Temporary Assistance for Needy Families (TANF) funds must not be used or accessed in adult entertainment establishments, casinos, gaming establishments, or liquor stores. This provision applies only to establishments which primarily or exclusively sell these products and does not include grocery stores or other establishments which also offer gaming activities or sell these products in addition to other goods.

1.5.8 DUE DATE OF ADDITIONAL INFORMATION

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

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

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

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

1.5.9 AGENCY TIME LIMITS

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

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

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

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

The Worker must approve, deny or withdraw the application within 30 days of the date of application. When the application must be denied because the client has not responded to a DFA-6 or verification checklist, the Worker must wait until after the tenth day but no later than the 31st day to deny the application.

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

> **Time Limits Example 1:** An applicant telephones the office on June 26, to find out how to apply for WV WORKS. At that time, an appointment is scheduled for him to meet with a Worker on July 5. The next group orientation after the application is completed is July 12, which is past the 10-day time limit. Therefore, the Worker must complete an individual orientation session for this applicant, preferably at the intake interview on July 5.
>
> **Time Limits Example 2:** An applicant contacts the office by telephone on September 10, to find out how to apply for WV WORKS. At that time, an appointment is scheduled for him to meet with a Worker on September 13 and to attend group orientation on September 19. The applicant is caring for his mother until she can be placed in a nursing home. Placement is expected on September 25, so he requests that his appointments be rescheduled for later that same week. He is then scheduled to meet with the Worker on September 26 and to attend group orientation later that same day. Although the application process is completed outside the time limit, it is due to the client's request which is recorded in case comments.

1.5.10 AGENCY DELAYS

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

1.5.11 PAYEE

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

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

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

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

1.5.12 REPAYMENT AND SANCTIONS

1.5.12.A Repayment

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

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

1.5.12.B Sanctions

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

1.5.13 BEGINNING DATE OF ELIGIBILITY

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

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

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

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

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

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

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

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

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

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

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

> **Eligibility Date Example 2:** A parent is placed in full-time employment on March 5. His anticipated earnings make him ineligible and the AG is closed on March 7, effective March. On March 22, the parent comes to the office to ask for WV WORKS benefits again and states that he quit his job on March 19. The Worker determines that he did not have good cause for quitting, but that he met all other eligibility requirements. His eligibility starts April 1 since he already received benefits for March. There is no sanction applied to the April benefits for this offense, but the Worker notifies him immediately about the imposition of a sanction beginning in May and schedules a good cause hearing.
>
> **Eligibility Date Example 3:** A parent is placed in full-time employment with a produce shipping company. Two months later, he is laid off. The 45-day waiting period does not apply.
>
> **Eligibility Date Example 4:** A caretaker relative included in the payment is hired by a temporary agency. Three months later the temporary job ends. The 45- day waiting period does not apply.
>
> **Eligibility Date Example 5:** A non-recipient Work-Eligible Individual has been working 25 hours per week at a fast-food restaurant. He quits and then applies for WV WORKS, it is established he did not have good cause. The 45-day waiting period applies.

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

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

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

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

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

1.5.14 EXPEDITED PROCESSING

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

1.5.15 CLIENT NOTIFICATION

See Chapter 9.

1.5.16 REDETERMINATION SCHEDULE

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

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

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

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

1.5.17 THE BENEFIT

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

1.5.17.A The WV WORKS Benefit

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

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

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

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

1.5.17.A.1 Direct Deposit

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

➢ *Enrollment in Direct Deposit and Effective Date*

The client must complete an enrollment form, attach any other appropriate information requested on the form and mail it directly to the State Auditor's Office. If he returns the form to the local office, the Worker forwards the form to the Auditor's Office. Questions about the direct deposit process or the individual's effective date, after submission of the enrollment form, must be directed to the Auditor's Office at the toll-free number, 1-800-500-4079 or at 304-558-2251.

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

➢ *Receipt of the Direct Deposit Benefit*

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

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

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

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

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

➢ *Disenrollment from Direct Deposit*

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

1.5.17.B EBT

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

1.5.17.B.1 EBT Definitions and Terminology

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

ADMINISTRATIVE TERMINAL

EBT vendor system used to inquire into EBT account information, reactivate expunged accounts, deactivate EBT cards, and, in some instances, make changes to the EBT account.

AUTHORIZED CARDHOLDER

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

AUTOMATED TELLER MACHINE (ATM)

May be used to access cash EBT benefits.

CUSTOMER SERVICE REPRESENTATIVE (CSR)

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

DEMOGRAPHIC INFORMATION

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

ELECTRONIC BENEFITS TRANSFER (EBT)

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

EBT HELPLINE

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

EXPUNGED ACCOUNT

When benefits are not used from the EBT account for 365 days, those benefits are removed from the account and are not available to the AG. Other grant months may remain on the account. The Worker must reset the account for these benefits to be accessed.

INTERACTIVE VOICE RESPONSE UNIT (IVRU)

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

MOUNTAIN STATE CARD

The West Virginia EBT card

PERSONAL IDENTIFICATION NUMBER (PIN)

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

POINT OF SALE (POS) EQUIPMENT

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

STATUS THE EBT CARD

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

1.5.17.B.2 EBT Card Issuance

➢ *Initial Card Issuance*

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

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

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

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

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

➢ *Authorized Cardholder*

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

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

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

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

➢ *Cardholder Security*

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

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

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

1.5.18 DIVERSIONARY CASH ASSISTANCE (DCA)

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

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

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

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

The DCA benefit is deposited into the EBT account.

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

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

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

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

After receipt of a relocation payment due to employment, the household is ineligible for Temporary Assistance for Needy Families (TANF) in West Virginia for three months following the month of receipt. This restriction does not apply to victims of domestic violence who have been relocated or relocation for proximity to public transportation

The Case Manager must make a case comment regarding relocation and the three-month ineligibility period.

The West Virginia Employment Assistance Program (EAP) is considered a transitional benefit payment. Participants choosing this option will be ineligible for TANF in West Virginia for three months following the final EAP payment when a relocation payment has been received.

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

1.5.18.A Determining If DCA Is Appropriate

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

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

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

- The household does not include any member who is serving a WV WORKS sanction. The entire AG remains ineligible until the sanction period ends. ~~When the reason for the most recent AG closure is imposition of a sanction, no member of the sanctioned AG may be approved or included in DCA.~~

  ~~Once WV WORKS has been approved again and eligibility is lost for a reason other than imposition of another sanction, the AG may be considered for DCA upon reapplication.~~

  Once the sanction period ends, he may be again considered for DCA.

  DCA Example: A WV WORKS AG is closed due to imposition of the fourth sanction. During the time the AG is closed, the client finds part-time employment and is later offered a better-paying full-time job out of state. He reapplies at the end of his ineligibility period and asks to be considered for a DCA payment to accept the job out of state. ~~Because the benefit stopped due to a sanction, DCA is not appropriate~~. The AG is approved for a DCA, ~~ongoing WV WORKS benefit. Once he becomes an active participant, he may be eligible for a support service payment to pay relocation expenses,~~ if he is otherwise eligible for such payment.
- If an adult or child would be required to be included in a WV WORKS AG, he is required to be included in a DCA AG and cannot be excluded simply to qualify for DCA. This applies even when no member of the applicant AG has previously received a DCA payment.

- The applicant must agree to have the WV WORKS application withdrawn.

1.5.18.B Determining Financial Eligibility for the DCA

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

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

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

1.5.18.C Determining the DCA Amount

The DCA amount is determined as follows.

- Determine the maximum WV WORKS amount that is payable to a family of the same size. This number does not include a non-recipient Work-Eligible Individual. No incentives or reductions are applied when determining the DCA amount.
- Multiply the amount by three. This result is the maximum DCA payment which may be issued.
- There are no circumstances under which the maximum DCA payment amount may be exceeded.
- Determine the amount needed to meet the temporary financial need. The amount may include expenses related to future employment needs and ongoing household expenses.

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

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

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

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

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

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

1.5.18.D Verification of Temporary Needs

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

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

> **Verifiable Costs Example:** An applicant has agreed to accept a DCA payment instead of an ongoing WV WORKS benefit. In order to accept an offer of employment, he must move his family to another state. The following needs are identified: car repairs, overnight lodging for the family for the trip, food for the family for the trip, rent in a new dwelling for a month, utility deposits and some specialized tools for the new employment. The Worker verifies that the applicant has a car and has the client obtain an estimate of the repair costs.
>
> He also verifies the cost of the specialized tools for the new employment based on the client's statement that they are necessary. The client does not want his future employer to know that he is receiving help from the DHHR to accept the job, so the Worker does not contact the employer to confirm the need for the tools. However, he does contact some local employers of the same type to ensure that such tools would be used. Note that, in this case, it is assumed that the client has written verification of his employment. Otherwise, contact with the future employer would be necessary to verify the employment.

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

1.5.19 ORIENTATION

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

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

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

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

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

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

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

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

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

1.5.19.B PRC

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

1.5.19.C WV WORKS List of Local Services

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

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

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

- A discussion of the DHHR’s efforts to protect the safety of clients in domestic violence situations by choosing the Family Violence Option included in welfare reform legislation;

- Explain literature is available in different locations throughout the office and from the Worker;
- The benefits of disclosure of domestic violence as it relates to work participation requirements and program time limits; and
- How to disclose, i.e., to the Worker, other individual, etc. It is important that the Worker inform the client that this information is given to everyone who applies and does not indicate the Worker has any knowledge or suspicion of domestic violence. This is especially important when two parents or two non-parent caretakers are being interviewed.

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

1.5.20 PERSONAL RESPONSIBILITY CONTRACT (PRC)

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

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

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

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

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

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

The PRC is the same for all WV WORKS participants. It states the purpose of the WV WORKS Program and lists the participant's rights and responsibilities.

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

1.5.21 SELF-SUFFICIENCY PLAN (SSP)

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

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

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

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

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

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

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

1.5.21.A Initial SSP

A full assessment of the family situation is required to complete a valid, long-term SSP. To prevent a delay in the receipt of benefits to the client, an initial SSP must be completed within 10 days of the initial contact when a client expresses an interest in applying for WV WORKS. It is understood that the initial SSP will not be as comprehensive as subsequent plans.

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

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

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

1.5.21.B First Full SSP

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

1.5.21.C Subsequent Changes to the SSP

Changes may be made to the SSP when the participant and the Worker agree that changes are appropriate. These changes may be a result of identifying a new impediment to a goal, acceleration of the progress toward self-sufficiency, or on any other change in the client's

circumstances. It may also be changed based on the addition of available services to the area or the loss of such services.

1.5.21.D Domestic Violence Considerations

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

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

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

1.5.22 RIGHTS OF APPLICANTS AND PARTICIPANTS WITH DISABILITIES

1.5.22.A Introduction

The West Virginia Human Rights Act, West Virginia Code § 5-11-1, the Americans with Disabilities Act of 1990 (ADA) and the Rehabilitation Act of 1993 apply to all programs established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996

(PRWORA) which established the TANF program. WV WORKS was established as a TANF program, and as such, the laws established under the Acts referenced above apply to WV WORKS.

These Acts provide:

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

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

1.5.22.B Accommodations for the Disabled in WV WORKS

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

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

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

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

same manner as all other participants and must be allowed to have meaningful access to the program.

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

Workers must make appropriate referrals to local service agencies that provide the services and assistance necessary to ensure the applicants' successful participation. Referrals are made using the DFA-ADA-1. Only one referral is made on each form. Distribution of the form is as follows:

- One copy remains in the client file.
- One copy to the client.
- One copy is for the client to deliver to the referral agency.

The DFA-ADA-1A is the follow-up form. The Worker completes this form to summarize the services that have been received and the outcomes of the services.

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

1.6 COMMON POLICIES IN THE MEDICAID APPLICATION PROCESS

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

1.6.1 APPLICATION FORMS

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

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

1.6.2 NO INTERVIEW REQUIRED

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

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

1.6.3 DATE OF APPLICATION

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

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

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

1.6.4 DUE DATE OF ADDITIONAL INFORMATION

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

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

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

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

1.6.5 COMPLETE APPLICATION

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

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

1.6.6 AGENCY DELAYS

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

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

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

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

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

1.6.6.A Documenting Reason for Delay

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

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

The instructions for these procedures are found below.

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

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

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

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

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

- Date of application.
- Date the verification checklist or DFA-6 and 6A were mailed or given to the client.
- Date medical bills submitted by the client were received in the local office.
- Date medical expenses were added to the eligibility system.
- The result of each 30-day review found on comments (instructions in item 2 below).
- All actions related to the MRT process, when applicable, which include, but are not limited to:
    - Date initial medical reports are requested
    - Date of follow-up activity required to obtain initial reports
    - Date medical reports are received in the county office
    - Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
    - Date of follow-up activity required to obtain the additional medical information
    - Date additional medical reports are received in the county office
    - Date material is referred to MRT
    - Date the Worker is notified of the final MRT decision.

This information appears in the eligibility system.

1.6.6.A.2 Procedure for Review of Pending Applications

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

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

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

1.6.7 EXPEDITED PROCESSING

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

1.6.8 ELIGIBILITY SYSTEM ACTION

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

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

1.6.9 CLIENT NOTIFICATION

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

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

1.6.10 REPAYMENT AND PENALTIES

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

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

1.6.11 SPECIAL SITUATIONS

1.6.11.A Coordination between DHHR and the Federally Facilitated Marketplace

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

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

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

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

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

1.6.11.A.1 Applications Taken by the Marketplace

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

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

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

- Accept the SLA;
- Check for existing Medicaid or WVCHIP coverage;
- Verify citizenship/immigration status, residency, incarceration status, current monthly income and annual income;
- Apply the reasonable compatibility standard and reconcile any differences;
- Apply West Virginia's state eligibility rules;
- Complete the eligibility determination;
- Provide appropriate notices, fair hearing rights, and communications to the client;
- Transfer the eligible client's electronic account to the Department, without delay;
- Transfer applications to the Department for applicants requesting a full determination of Medicaid on a basis other than MAGI; and,
- Transfer to the Department for a full eligibility determination, without delay, the electronic account of a client that indicates on their application potential eligibility for a non-MAGI coverage group.

- If the individual is over income for MAGI Medicaid or WVCHIP, evaluate him for the insurance affordability programs, Advance Premium Tax Credits and Cost Sharing Reductions (APTC/CSR).

➢ *Marketplace Determines Eligibility for a MAGI Coverage Group*

When the Marketplace determines the applicant is eligible for a MAGI coverage group, the DHHR must:

- Accept electronic accounts transferred from the Marketplace for clients determined Medicaid or WVCHIP eligible based on MAGI.
- Promptly complete enrollment into the correct Medicaid or WVCHIP coverage group.
- Not request any additional information or verifications from the client.
- Provide additional notification of enrollment to the client, including benefits available.

➢ *Marketplace Determines Potential Eligibility for a MAGI Coverage Group*

When the Marketplace determines the applicant is potentially eligible for a MAGI coverage group, the DHHR must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a MAGI group
- Notify the Marketplace of receipt of the electronic account
- Not request additional information of verifications from the client already verified electronically
- Conduct any additional verifications that may be required
- Promptly determine eligibility without requiring another application; ensure timeliness standards in this chapter are met
- Notify the client and the Marketplace of the final eligibility determination

➢ *Marketplace Determines Potential Eligibility for a Non-MAGI Coverage Group*

When the Marketplace determines the client is potentially eligible for a non-MAGI coverage group, the Department must:

- Accept the electronic account for the client who is assessed by the Marketplace as potentially eligible for a non-MAGI group, or when the client requests a full determination.
- Notify the Marketplace of receipt of the electronic account.
- Not request additional information or verifications from the client already verified electronically.
- Promptly determine eligibility without requiring another application; ensure timeliness standards in this chapter are met.
- Notify the Marketplace of the final eligibility determination.

1.6.11.A.2 Applications Taken by DHHR

The Worker determines eligibility for MAGI Medicaid and WVCHIP groups. Non-financial and financial information about the applicant is matched by the Federal Data Hub in real time.

➢ *DHHR Determines Eligibility for a MAGI Coverage Group*

When the Department determines the client is eligible for Medicaid or WVCHIP based on MAGI, the Department must:

- Promptly enroll the applicant into the MAGI coverage group. The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group.

➢ *DHHR Determines Applicant Not Eligible for a MAGI Coverage Group*

When the Department determines the applicant is not eligible for Medicaid or WVCHIP based on MAGI, the Department must:

- Promptly determine potential eligibility for APTC/CSR and transfer the applicant's electronic account to the Marketplace; and
- Certify for the Marketplace the criteria applied in determining eligibility; and
- Provide the applicant with a combined eligibility notice, including notice of the Medicaid denial or closure, transfer of their electronic account to the Marketplace, and fair hearing rights.

The DHHR does not determine eligibility for the Marketplace's benefits but may refer individuals to an in-person assistor or Navigator for assistance.

When an individual is ineligible for MAGI Medicaid or WVCHIP due to income, and he attests to disability, he may be eligible for an SSI-Related, Medicaid Work Incentive Network (M-WIN) or other Medicaid Group. During this time, he may receive Marketplace benefits. If approved for other non-MAGI Medicaid coverage, the Marketplace is electronically notified.

When the Department determines the applicant is not eligible for Medicaid or WVCHIP based on MAGI, but are completing a determination for a non-MAGI coverage group, the Department must:

- Promptly determine potential eligibility for APTC/CSR and transfer the client's electronic account to the Marketplace.
- Provide notice to the Marketplace that the client is not Medicaid or WVCHIP eligible based on MAGI, but that a final determination based on non-MAGI is pending.
- Provide notice to the client in simple language that the Department determined them ineligible for Medicaid or WVCHIP based upon MAGI standards but are continuing to evaluate them for coverage for non-MAGI coverage groups.
- Provide coordinated content in the notice including that the client's account was transferred to the Marketplace for an evaluation for APTC/CSR, and that enrollment in APTC/CSR will not affect their potential Medicaid eligibility.
- Provide the client notice of the final non-MAGI Medicaid eligibility determination and fair hearing rights. If the client is determined eligible for a non-MAGI coverage group, the notice should inform the client that the Marketplace will be notified of the client's eligibility, and that Medicaid eligibility will result in closure of APTC/CSR.
- Notify the Marketplace of the final eligibility determination based on non-MAGI.

1.6.11.A.3 Coordination between DHHR and the Marketplace Involving Appeals

The Department must establish a secure electronic interface so that:

- The Marketplace can notify the Department when an applicant has requested a fair hearing; and
- The applicant's electronic account, including information provided as part of the appeal, can be transferred between the Department and the Marketplace.

When conducting a fair hearing, the Department should not request information or documentation from the applicant that is already included in their electronic account.

The Department must transmit to the Marketplace the hearing decision made by the Department.

1.6.11.B Presumptive Eligibility

Individuals receiving services through a Qualified Provider who are interested in applying for Medicaid may apply with the assistance of an Authorized Employee. Qualified Providers may elect to provide Presumptive Eligibility (PE) determinations to individuals who are without any other form of health coverage. Additional information about Qualified Providers can be found in Chapter 400 of the West Virginia Medicaid Provider Manual. Presumptive Eligibility (PE) is not permitted for any other program. It is unrelated to Presumptive Medical decisions for the Medical Review Team (MRT). Eligibility is established on date of determination. Back-dating does not apply to this provision.

Coverage groups eligible for PE:

- Children under age 19
- Pregnant Women
- Parents/Caretaker Relatives
- Adult Group
- Former WV Foster Children
- Breast and Cervical Cancer (BCC) women receiving current treatment

Presumptive Eligibility is limited to once every twelve months, with the exception of pregnant women, who are eligible once per pregnancy.

➢ *Duties of the Authorized Employee*

The Authorized Employee, which could also include the DHHR hospital employee, makes a PE decision based on preliminary information provided by the individual seeking treatment, or his Authorized Representative (AR) (someone with the patient who would reasonably be expected to know about the individual seeking benefits, including attesting to the individual's U.S. citizenship or satisfactory immigration status). The Authorized Employee is prohibited from requiring any other verification prior to approval. Additional information gathered includes name, household size, income limit, sex, address, and prior approval for PE in the last 12 months.

Using the same WV PATH portal as Community Partners, the Authorized Employee sends the information electronically to the eligibility system and issues a Medical ID card with a PE Medicaid ID. The period of eligibility begins on the date of determination and ends on the last day of the next month, or when a full Medicaid application determination is made, whichever occurs earlier. The decision is not subject to fair hearing rights and advance notice is not required.

The Authorized Employee must assist the applicant or his AR in completing the single streamlined application (SLA) for Medicaid and forward the application to the Department.

If the applicant or his AR is unable or unwilling to complete the full Medicaid application at that time, the Authorized Employee will explain to the patient or AR the different options for completing the SLA. If the applicant indicates he would like to complete his application via telephone, the Authorized Employee must have him contact the call center at 1-877-716-1212. The Authorized Employee should explain that he must call this number because he will be required to give a recorded telephonic signature.

➢ *DHHR Worker Responsibilities*

Upon receipt of a completed PE application, which should include the PE Medicaid ID, the DHHR Worker begins processing the application. This process combines the two applications together and closes the PE period upon approval or denial of the Medicaid application. The Worker must establish whether the client was eligible at the time of the PE determination, as well as ongoing Medicaid eligibility. Income is verified by the same method as any other application. Medicaid eligibility begins on the first day of the month of the PE determination. Retroactive backdating is allowed with the Medicaid application, if the client is eligible.

The DHHR Worker or the Qualified Provider must take the BMS-approved PE training and receive certification prior to becoming an Authorized Employee that will be permitted to take application for Presumptive Eligibility. The facility at which the DHHR Worker is placed will have agreed to accept responsibility for all decisions and outcomes of the DHHR Authorized Employee. The DHHR Worker that is at the facility will follow the same procedures for taking Presumptive Eligibility applications as any other PE worker.

1.6.11.C Changing Coverage Groups and Redetermination Period

When one coverage group is closed and another opened, the AG may be assigned a new certification period.

1.6.11.D Spenddown

Spenddown applies to SSI-related and AFDC–related coverage groups only.

Cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.6.11.E Death of the Only Individual Prior to Application or Approval

Death of an individual does not interfere with approval of a Medicaid application. If an application is made prior to an individual's death, the application is processed as usual and approved, if eligible. This item outlines the special procedures that the Worker must follow in the application process and at approval when the only member of a Medicaid AG dies prior to making an application.

1.6.11.E.1 Who Must Sign the Application?

If another individual makes the application on behalf of the deceased person, it is preferable that the person be a relative, but any other individual who is interested may make the application.

The Worker must obtain as much information as possible about the deceased person’s income and assets, but routine verification is not required.

1.6.11.E.2 MRT Referral

It is not necessary to refer the case to MRT when the deceased person’s disability resulted in his death. However, a MRT referral may be necessary to establish blindness or disability when there is a request for Medicaid coverage for a month(s) prior to the person's death and such blindness or disability was not the cause of death, or the Worker is unable to determine if the blindness or disability existed during the month(s).

All other policies and procedures related to disability coverage groups apply.

1.7 MAGI CHILDREN UNDER AGE 19

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The new Children Under Age 19 coverage group combines prior coverage for children under the AFDC group, Qualified Child and Poverty-Level Children coverage groups into one group. Eligibility is determined using MAGI methodologies.

1.7.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

The following can be included on the same application:

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.7.2 WHO MUST SIGN?

The following person(s) must sign the application, depending on the living situation of the child:

- One parent with whom the child lives; or
- The adult with whom the child lives; or
- The representative of an adoption agency that has legal custody of the child; or
- The child who does not live with a parent(s) or other adult.

1.7.3 CONTENT OF THE INTERVIEW

Although not required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable. In addition, the following must be discussed with the client:

- An explanation of the 12-month period of continuous Medicaid eligibility (CME). See Section 10.7.
- That any child under age 18 may be evaluated for SSI-Related Medicaid as a blind or disabled child
- That the client must report when any child becomes pregnant

1.7.4 AGENCY TIME LIMITS

Action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a complete application is received in the county office. A complete application is defined in Complete Application, above. If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it, as required in Section 1.6.4 above, and to complete the application process within 13 days.

When application is made at the same time for another Medicaid coverage group(s) for another family member(s), or for other Programs, the application process for the Children Under Age 19 group must be completed within 13 days, even though the application process for other individuals or for other Programs may still be pending.

1.7.5 PAYEE

Depending on the child's living situation, the payee is a parent, other adult household member, or the child.

1.7.6 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

1.7.7 REDETERMINATION

1.7.7.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. The Reasonable Compatibility Provision applies each time this occurs. See Section 7.2. If determined eligible after completing the redetermination process, the DHHR will notify the client. The notice will identify the information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated auto-renewal verification checklist form provides the following information:

- A statement that the AG may receive a verification checklist for completion and return, if

reported changes require follow-up,

- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call is included if the individual has questions about submitting the pre-populated auto-renewal verification checklist online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to three months.

1.7.7.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DHHR must only request the information on the change reported.

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 12-month SNAP or TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid or WVCHIP AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month Medicaid certification period. The new Medicaid certification period is renewed from June 1, 2014, through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.7.8 THE BENEFIT

1.7.8.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.7.8.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.8 MAGI ADULT GROUP

The Affordable Care Act (ACA) established a categorically mandatory coverage group known as "the Adult Group." Eligibility for this group is determined using MAGI methodologies.

1.8.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.8.2 WHO MUST SIGN?

The application must be signed by an adult in the household or their authorized representative.

1.8.3 AGENCY TIME LIMITS

Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.

1.8.4 PAYEE

The payee is the primary person in the household.

1.8.5 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

1.8.6 REDETERMINATION

1.8.6.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated which matches current information with the hub. The Reasonable Compatibility Provision applies each time this occurs. See Section 7.2.

If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the client agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and requires the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the information must be submitted;
- Specific information necessary to complete the redetermination;
- The opportunity to report changes;
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up;
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed; and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call is included if the individual has questions about submitting the pre-populated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefits.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to 3 months.

1.8.6.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DHHR must only request the information on the change reported.

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 12-month SNAP or TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month

> Medicaid certification period. The new Medicaid certification period is from June 1, 2014, through May 31, 2015.

When the redetermination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.8.7 THE BENEFIT

1.8.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.8.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.8.7.C Medical Frailty

Clients in the Adult Group self-attested as medically frail are eligible for either of the following Benefit Packages:

- Traditional Medicaid Benefit Package
- Alternative Benefit Package

If an individual attests they are medically frail, such as having a physical, mental or emotional health condition or a chronic substance abuse, physical, behavior, intellectual or developmental condition in which assistance is needed, the client is placed in the Traditional Benefit Package. Should the client contact the Department and opt to enroll in the Alternative Benefit Package the Worker will code as such in the eligibility system to ensure the correct alternative is provided to Molina Member Services.

1.9 MAGI PREGNANT WOMEN

The Affordable Care Act (ACA) simplified eligibility categories by combining certain existing mandatory and optional eligibility groups. The Pregnant Women coverage group combines former Poverty-Level and Deemed Poverty-Level Pregnant Woman coverage groups.

1.9.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

> *EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.*

- Individuals who are under age 19 may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.9.2 AGENCY TIME LIMITS

Eligibility system action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a completed application is received in the local office. If additional information or verification is required after the complete application is received, the Worker must

request it immediately to allow the client 10 days to provide it, and to complete the application process within 13 days.

When a DFA-2 is used, the application for Medicaid coverage as a pregnant woman must be processed within 13 days of the date a complete application is received, even though the application for another program may not require faster processing.

1.9.3 BEGINNING DATE OF ELIGIBILITY

1.9.3.A Application while Pregnant

The beginning date of eligibility is the first day of the month of application, if eligible. Eligibility may be backdated up to three months prior to the month of application, provided all eligibility requirements were met.

1.9.3.B Application after Pregnancy Ends

When the client applies within three months of the termination of the pregnancy, eligibility may be backdated up to three months, prior to the month of application, in which she met all eligibility requirements.

1.9.4 REFERALS TO THE OFFICE OF MATERNAL CHILD AND FAMILY HEALTH (OMCFH)

When the pregnant woman's application is denied for any reason, or a WVCHIP or children’s Medicaid application is denied when a child is pregnant, a referral is made to the OMCFH. A list of these denied applications is generated by the eligibility system and made available to the OMCFH. This permits OMCFH to evaluate the client for other available government-sponsored health care.

1.9.5 REDETERMINATION

A redetermination is completed the second month of the postpartum period. Reviews are scheduled two months after the pregnancy end date, or, if information about the pregnancy is not updated, two months after the pregnancy due date.

In no instance is Medicaid coverage under one coverage group stopped without consideration of Medicaid eligibility under other coverage groups. This is determined before the client is notified that her Medicaid eligibility will end. If eligible for other Medicaid, or WVCHIP, that coverage must not begin until expiration of the postpartum period.

If no redetermination is completed, Medicaid coverage is automatically closed after the adverse notice period.

Rolling Redeterminations do not apply to the Pregnant Women coverage group. When the pregnancy is due or reported ending, the client will be evaluated for MAGI Medicaid using the automatic procedures described above for the Adult Group.

1.9.6 THE BENEFIT

1.9.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.9.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

The eligible pregnant woman must be notified that she remains eligible for two months after the month in which her pregnancy ends.

NOTE: A Child Under Age 19 who becomes pregnant must receive Medicaid in the Pregnant Women coverage group.

The Pregnant Woman's eligibility ends on the last day of the 60-day postpartum period or on the last day of the effective month of closure.

1.10 CONTINUOUSLY ELIGIBLE NEWBORN (CEN) CHILDREN

1.10.1 APPLICATION FORM

No application is required for CEN children who are born to Medicaid eligible women. See Chapter 23. An application is required for children who are born to non-Medicaid Eligible women as described in Section 1.7.

1.10.2 AGENCY TIME LIMITS

The Worker must open CEN coverage within five workdays of the date the birth is reported.

1.10.3 PAYEE

Depending on the child's living situation, the payee is a parent, other adult household member, or the child.

1.10.4 BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month the child was born.

1.10.5 REDETERMINATION

The redetermination for the CEN child is scheduled in the month before the month the child becomes one year old to ensure that the child is evaluated for all coverage groups.

The redetermination process is initiated by the eligibility system, which generates the redetermination form. The redetermination form may be submitted by mail or online by use of WV PATH.

The redetermination form provides the following information:

- A statement that the assistance group(s) (AG(s)) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;
- The date by which the redetermination must be submitted;
- Any verification which must be submitted with the form;
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed;
- Instructions for submitting the redetermination online by using WV PATH; and,
- A phone number to call if the individual has questions about submitting the redetermination online.

The redetermination may be submitted online by use of WV PATH until the end of the month in which the redetermination is due. Redeterminations submitted online are considered electronically signed.

When the redetermination is completed and the individual(s) remains eligible under another coverage group, the new eligibility period must begin the month immediately following the month of the redetermination.

1.10.6 THE BENEFIT

1.10.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.10.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.11 MAGI PARENTS/CARETAKER RELATIVES

1.11.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of the applicant.

NOTE: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes – himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.

- Individuals who are under age 19 may be included on an application submitted by an adult application filer, even if the child and the application filer are not in a familial or tax relationship.

  Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.11.2 PAYEE

The payee is the individual in whose name the Medical ID card is written.

1.11.3 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. However, eligibility may be backdated up to three months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

When the client is eligible for backdated coverage, the system must be coded with the month, year on which the backdated period begins.

This date is always the first day of the month of backdated coverage.

1.11.4 CLIENT NOTIFICATION

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

See Chapter 9.

1.11.5 REDETERMINATION

1.11.5.A Redetermination Schedule

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

Redeterminations occur annually. When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. The Reasonable Compatibility Provision applies each time this occurs. See Section 7.2. If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,
- The date by which the information must be submitted,
- Specific information necessary to complete the redetermination,
- The opportunity to report changes,
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated redetermination form online by using WV PATH. A phone number to call if the individual has questions about submitting the pre-populated redetermination form online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to three months.

1.11.5.B Rolling Redeterminations

A rolling redetermination will be completed for all MAGI Medicaid and WVCHIP AGs only during a 12-month SNAP or TANF review or another MAGI Medicaid or WVCHIP review. The agency must begin a new 12-month certification period for all MAGI Medicaid AGs in the case.

> **Rolling Redetermination Example:** A redetermination for SNAP benefits is completed on May 14, 2014. The original Medicaid certification period is April 1, 2014, through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to begin a new twelve-month Medicaid certification period. The new Medicaid certification period is from June 1, 2014, through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.11.6 THE BENEFIT

1.11.6.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.11.6.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.12 DEEMED PARENTS/CARETAKER RELATIVES

Eligibility is based on the income of the Parents/Caretaker Relatives coverage group. See Section 23.10.8 for the eligibility requirements that must be met. There are three groups in this section: Extended Medicaid, Children Covered as Recipients of Adoption Assistance, and Children Covered as Recipients of Foster Care Payments.

1.12.1 EXTENDED MEDICAID

1.12.1.A Application

There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to onset or increase of spousal support.

The client must be notified that his Medicaid continues and of the eligibility period. If the case is closed in error, the client cannot be required to reapply. The Worker must evaluate the client for all other coverage groups when Extended Medicaid ends.

1.12.1.B Redetermination

Extended Medicaid cases are not redetermined.

1.12.1.C The Benefit

1.12.1.C.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.12.1.C.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the four-month Extended Medicaid period.

At the end date of eligibility, all AG members must be evaluated for all other Medicaid coverage groups.

1.12.2 CHILDREN COVERED AS RECIPIENTS OF ADOPTION ASSISTANCE

The Office of Children and Adult Services is responsible for these cases.

1.12.3 CHILDREN COVERED AS RECIPIENTS OF FOSTER CARE PAYMENTS

The Office of Children and Adult Services is responsible for these cases.

1.13 TRANSITIONAL MEDICAID (TM)

Eligibility is based on the income of the Parents/Caretaker Relatives Medicaid Coverage Group. See Section 23.10.9 for the eligibility requirements that must be met. This coverage group is for AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to increase or onset of employment income.

1.13.1 APPLICATION PROCESS

There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to increase or onset of employment income.

1.13.2 REDETERMINATION

Although there is no formal redetermination process for TM cases, clients must comply with the requirements for Phase I recipients found in Chapter 23, to qualify for Phase II coverage.

1.13.3 THE BENEFIT

1.13.3.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.13.3.B Ending Date of Eligibility

Phase I coverage ends on the last day of the sixth month of the Phase I period, or on the last day of the effective month of closure, whichever occurs first.

Phase II coverage ends on the last day of the sixth month of the Phase II period, or on the last day of the effective month of closure, whichever occurs first.

1.14 SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

1.14.1 APPLICATION PROCSES

There is no application form for SSI Medicaid. The Worker receives an eligibility system alert when data exchange information indicates that a person is approved for SSI. See Section 6.3.4.A.

When the Worker fails to open an SSI Medicaid case for an individual listed on the data exchange, and the person is a recipient of SSI and Medicare, Part B, the Buy-In Unit requests that a case be opened. The Worker must open the SSI Medicaid AG at the request of the Buy-In Unit, unless he knows that the client is not living in the State.

The Worker may use information found in SOLQ to open SSI Medicaid. See below to determine the beginning date of eligibility.

When the client has been approved for SSI and needs medical coverage, but has not appeared on the data exchange, the Worker may use a written or verbal referral from Social Security Administration (SSA), which contains the necessary information to approve the AG. When the client requests this method, his request must be honored. When an SSI recipient moves to West Virginia from another state, the Worker must verify SSI eligibility with SSA and must notify the former state of residence that a case is open in West Virginia. See Chapter 2.

Some states make a supplemental payment to SSI recipients. Receipt of the state supplement qualifies them for Medicaid in these states. However, such payments from other states do not qualify a client for SSI Medicaid in West Virginia. Therefore, receipt of SSI Medicaid in another state does not always automatically result in eligibility in West Virginia.

1.14.2 DATE OF APPLICATION

The date of application is the first day of the month which shows on data exchange as the Medicaid effective date, or the date given on the SSA referral or by the Bureau for Medical Services (BMS) Buy-In Unit.

1.14.3 AGENCY TIME LIMITS

The Worker must enter the State Data Exchange (SDX) information for approval within 45 days of the date on which the client first appears on data exchange, or the referral from SSA or the BMS Buy-In Unit is received.

1.14.4 PAYEE

The SSI recipient is the payee, unless the use of a substitute payee is justified.

1.14.5 BEGINNING DATE OF ELIGIBILITY

When the data exchange is used to approve the Medicaid AG, the beginning date of Medicaid eligibility is established as follows:

- SSI Medicaid eligibility begins with the first month for which an SSI payment is made. This is either the month after the month of application for SSI or the month following the month in which SSI eligibility is established.

  The beginning date of eligibility is based on the age of the individual. The date is determined by the following:

  - Age 21 or over – The beginning date of eligibility is the Medicaid effective date on data exchange.
  - Under age 21 –The beginning date of eligibility is the month prior to the month of the Medicaid effective date on data exchange.
- If the individual has past medical bills, his eligibility begins up to three months prior to the month of the first SSI payment. Past medical bills are indicated on the SDX file and the Medicaid effective date on data exchange reflects this for backdated Medicaid coverage.

When documentation other than data exchange is used to approve the Medicaid AG, the beginning date of Medicaid eligibility is established as follows:

- If the document used for verification gives the beginning date of SSI payment, but does not indicate if any back medical bills exist, the client must be questioned about any unpaid medical bills incurred during the 3 months prior to that date. If he has unpaid bills, coverage is backdated to the earliest of the 3 months in which the bills were incurred. If

he has no unpaid bills, the first day of the month the SSI payment began is his Medicaid eligibility date.

- If the document used for verification does not give the beginning payment date for SSI, the Medicaid eligibility date is no more than 3 months prior to the month in which his receipt of an SSI payment is verified. If he has unpaid bills, coverage is backdated to the earliest of the 3 months. If the client has unpaid medical bills incurred more than 3 months prior to the date of verification, the approval must be delayed until his name appears on data exchange.

1.14.6 REDETERMINATION

There is no redetermination of SSI Medicaid eligibility. The SSI Medicaid eligibility continues as long as the client is considered eligible according to SSA. The eligibility system will provide an alert when the client is no longer eligible.

1.14.7 THE BENEFIT

The Medical ID card for the SSI recipient will be included in the Medicaid approval notice.

1.14.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.14.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.15 DEEMED SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

Deemed SSI Recipients includes the following:

- Disabled Adult Children (DAC)
- Blind, Disabled - Substantial Gainful Activity (SGA)
- Essential Spouses of SSI Recipients
- Pass-Through
- Pickle Amendment Coverage (PAC)
- Disabled Widows and Widowers
- Drug Addicts and Alcoholics

1.15.1 APPLICATION PROCESS

No application is required for Deemed SSI Recipients. When SSI benefits are terminated, eligibility as a Deemed SSI Recipient must be evaluated. SDX alerts indicate potential eligibility.

- SGAs, Essential Spouses and Pass-Throughs do not require a Worker determination.
- PAC AG cases require a financial determination by the Worker and a PAC evaluation is completed for any Medicaid applicant or client who may meet the eligibility requirements.

When the Worker determines that the client is a Deemed SSI Recipient, he must enter the appropriate code in the eligibility system.

1.15.2 REDETERMINATION

The only Deemed SSI coverage group which requires a redetermination is Pickle Amendment Coverage (PAC).

- The PAC redetermination is completed annually.
- The redetermination form is generated by the eligibility system and mailed to the recipient in the 11th month of eligibility and is due by the first day of the 12th month.
- The redetermination may also be completed using form DFA-PAC-4 or online by using WV PATH.

- Failure to complete and return the redetermination results in AG closure. The PAC AG may be reopened using the redetermination form when it is returned by the last day of the 13th month and the individual is otherwise eligible. After the end of the 13th month, a new application must be completed.

1.15.3 THE BENEFIT

The Medical ID card for the SSI recipient will be included in the Medicaid approval notice.

1.15.3.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.15.3.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.16 QUALIFIED MEDICARE BENEFICIARIES (QMB), SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLIMB), AND QUALIFIED INDIVIDUALS (QI-1)

QMB, SLIMB and QI-1 are Medicare Premium Assistance (MPA) programs.

1.16.1 APPLICATION FORMS

The DFA-QSQ-1 is used when application is made only for QMB, SLIMB or QI-1. The DFA-QSQ-1 may be mailed to the county office.

- The eligibility system automatically issues a DFA-QSQ-1 to potential MPA clients when the application was initiated by the LIS/MPA data exchange.

The Single-Streamlined Application (DFA-SLA-1) and supplement (DFA-SLA-S1), DFA-2 or WV PATH is used when application is also made for another Medicaid coverage group.

1.16.1.A Applications Requested by Client

When the QMB, SLIMB or QI-1 client requests an application, the Worker must explain:

- The date of application for QMB, SLIMB or QI-1 coverage is the day the signed application form, which contains a name and address, is received in the DHHR office or submitted through WV PATH.
- The processing time frame is 30 days, beginning with the date of application.
- In addition to QMB, SLIMB, or QI-1, the client may qualify for other coverage groups, but additional information or contact may be required.

1.16.1.B Applications Initiated from the Social Security Administration's (SSA) Low Income Subsidy (LIS)/MPA Data Exchange

If the individual expresses an interest in MPA when he applies for (LIS) prescription drug assistance at the SSA, an application is mailed to him when the eligibility system receives the LIS/MPA data exchange containing his file.

LIS files are sent daily, Monday through Friday, with the exception of federal holidays, to the eligibility system through data exchange. The Worker receives an eligibility system alert when a client's file is received and can access the LIS application information on the data exchange screens.

When the eligibility system receives a LIS file, it determines if the applicant is an MPA client, a client of other DFA program benefits, or is unknown to the system, and responds accordingly.

- When the LIS/MPA applicant is a current MPA client, no action is taken by the eligibility system nor required by the Worker.
- When the LIS/MPA applicant is a client of other programs, or known to the eligibility system, the system issues a DFA-QSQ-1. No action is required by the Worker.
- When the LIS/MPA applicant is unknown to the eligibility system, the system issues a DFA-QSQ-1. No action is required by the Worker.

The eligibility system issues the DFA-QSQ-1 the next business day after it receives the LIS data from SSA. The DFA-QSQ-1 is issued to the address in the eligibility system if there has been an active AG in the last 30 days. Otherwise, the DFA-QSQ-1 is issued to the LIS file address. If there are differences in the addresses, data exchange displays a discrepancy indicator.

NOTE: If the MPA applicant has had no case in the eligibility system in the last 30 days, the eligibility system designates a sending county based on the applicant's address in the LIS file. When the designated county is not the county of the client's residence, but the DFA-QSQ-1 is returned to the sending/incorrect county, that county is responsible for processing the DFA-QSQ-1 and responding to all applicant inquiries related to the application until an eligibility decision is determined. When application processing is complete, the case is transferred to the correct county, the DFA-QSQ-1 is forwarded, and the receiving county is notified electronically of the transfer.

NOTE: The Worker must not contact the SSA regarding LIS files received through data exchange. Different eligibility criteria are used by the SSA and the Department. The Worker may issue an eligibility system verification checklist or a DFA-6 if information in the LIS file and the Department's records differ and must be reconciled.

1.16.2 DATE OF APPLICATION

1.16.2.A Applications Requested by the Client

The date of application is the date the applicant submits a DFA-SLA with supplement, DFA-QSQ-1, or DFA-2 in person, by fax or other electronic transmission, WV PATH, the Marketplace, or by mail, which contains, at a minimum, his name and address and signature. When the application is submitted by mail or fax, the date of application is the date that the form with the name, address and signature is received in the local office.

1.16.2.B Applications Initiated from SSA's LIS/MPA Data Exchange

The date of application for a DFA-QSQ-1 initiated from the SSA's LIS/MPA data exchange submitted in person or by mail, is the LIS application date.

When an individual applies for LIS prescription drug assistance at the SSA and expresses an interest in MPA, he is considered to have made an application for QMB/SLIMB/QI-1 on that date.

EXCEPTION: When the LIS application date is prior to the beginning date of coverage in the active MPA AG, backdated eligibility must be considered and provided if applicable.

1.16.3 WHO MUST SIGN?

The applicant(s) for QMB, SLIMB or QI-1 or his authorized representative must sign the application.

1.16.4 CONTENT OF THE INTERVIEW

An interview is not routinely required, but when an interview is conducted, the interview requirements in Section 1.2 are applicable. The following must be discussed with the applicant(s) if an interview is conducted:

- The client may receive a refund of Medicare premiums from SSA after QMB, SLIMB, or QI-1 approval.
- Medicare Buy-In for QMB does not begin until the calendar month after approval of the application. The Department does not begin to pay his Medicare deductible, co-insurance and premiums until the following month.
- Medicare Buy-In for SLIMB and QI-1 may be backdated up to three months prior to the month of application, if eligibility is established.
- SLIMB and QI-1 recipients do not receive a Medical ID card.
- Individuals dually eligible for QMB and Medically Needy cases with a spenddown may receive more than one approval notice with their Medical ID card enclosed.
- QMB recipients are eligible for payment of co-insurance and deductibles for nursing facility costs without a contribution. See Chapter 24.

1.16.5 DUE DATE OF ADDITIONAL INFORMATION

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

When the client mails the application or completes the application in WV PATH or the Marketplace, the Worker then uses the verification checklist or form DFA-6 to inform the client of additional information needed. The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.

If the client does not return the DFA-QSQ-1 within 31 days from the date the eligibility system received the LIS file, the eligibility system sends a denial notice. No action is required by the Worker.

> **Additional Information Example 1:** Ms. Maple's LIS data file is received by the eligibility system on August 2, 2010. She has no history of benefits with the Department. The next business day, the eligibility system issues a DFA-QSQ-1.

Ms. Maple does not return the form. The eligibility system automatically denies the application and notifies Ms. Maple.

Additional Information Example 1.2: Same as above. Ms. Maple's DFA-QSQ-1 is received in the local office on August 16, 2010 and her application is approved for QMB.

1.16.6 AGENCY TIME LIMITS

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

For applications initiated from the LIS/MPA data exchange, action must be taken within 30 days of the date the file is received by the eligibility system.

When LIS files indicate an individual is not currently eligible for Medicare but will receive it in a future month beyond the allowable processing time for MPA applications, the Worker must deny the application. However, if this individual reapplies within three months of the date he began receiving Medicare and was previously denied MPA for the sole reason of being approved for, but not yet receiving Medicare, his reapplication must be considered as a request for backdated coverage. All other policy related to MPA and backdated coverage applies.

Time Limit Example 1.1: Mr. Birch's LIS/MPA file is received April 3 and indicates he will not receive Medicare until August. In order to comply with MPA processing time limits, the Worker must deny the MPA. Mr. Birch reapplies for MPA at the local office in September. The Worker must consider this application as including a request for backdated benefits to the month he began receiving Medicare and approves SLIMB effective August.

Time Limit Example 1.2: Same as above, except Mr. Birch reapplies for SLIMB in December. If he requests backdated MPA, his SLIMB application is treated like any other and can be approved effective September.

1.16.7 AGENCY DELAYS

When the Department fails to request necessary verification, the Worker must immediately send the eligibility system verification checklist or form DFA-6 to request it. He must inform the client that the application is being held pending. When the verification is received and the client is

eligible, medical coverage is retroactive to the date eligibility would have been established for QMB, SLIMB or QI-1.

When the QMB, SLIMB or QI-1 application is not processed within agency time limits, the application must be processed immediately upon discovery of the delay. QMB, SLIMB and QI-1 cases must have the eligibility period backdated.

> **Agency Delay Example:** Ms. Willow applies for LIS at the SSA on October 26, 2016 and expresses an interest in MPA. This is her LIS/MPA application date. She returns her DFA-QSQ-1 with all verifications on October 29, 2010, but they are misplaced. The Worker takes corrective action in December 2016 and notes the LIS application date in October. Since the client was otherwise eligible in October, the Worker backdates the QMB with a beginning eligibility date of November 2016.

The QMB client is eligible to receive direct reimbursement for out-of-pocket medical expenses if the Department has not acted on the application within a reasonable period of time. See Chapter 10.

1.16.8 PAYEE

The QMB, SLIMB or QI-1 recipient is the payee. When there are eligible spouses, the spouses choose the payee.

1.16.9 BEGINNING DATE OF ELIGIBILITY

1.16.9.A QMB

The beginning date of eligibility for QMB is the first day of the month following the month in which the application for QMB coverage is approved. Eligibility for QMB cannot be backdated unless there is a corrective action.

> **QMB Beginning Date of Eligibility Example:** Ms. Willow applies for LIS at the SSA on October 26, 2016 and expresses an interest in MPA. This is her LIS/MPA application date. She returns her DFA-QSQ-1 with all verifications on October 29, 2010, but they are misplaced. The Worker takes corrective action in

December 2016 and notes the LIS application date in October. Since the client was otherwise eligible in October, the Worker backdates the QMB with a beginning eligibility date of November 2, 2016 and approves her for QMB effective December 2016. Even though Ms. Willow's LIS application date is in October, QMB is effective the month following the month in which the application is approved. QMB cannot be backdated to November 2010.

NOTE: When the individual falls within the QMB income range and qualifies for that coverage, he is not approved for SLIMB to obtain backdated premium payment.

1.16.9.B SLIMB

The beginning date of eligibility for SLMB is the first day of the month in which the application for SLIMB coverage is approved. Eligibility for SLIMB coverage may be backdated up to three months prior to the month of application, if all eligibility requirements were met.

SLIMB Beginning Date of Eligibility Example: Mr. Cedar applies for LIS at the SSA on October 29, 2015 and expresses an interest in MPA. This is his LIS/MPA application date. He visits his local office on November 1, 2015, completes a DFA-QSQ-1 and is approved for SLMB with backdated coverage to August 2015. The LIS/MPA data exchange is transmitted November 2, 2015. The Worker checks her data exchange alerts and finds Mr. Cedar's LIS application date is October 2015. She takes corrective action and backdates his beginning date of coverage to July 2015, if otherwise eligible.

1.16.9.C QI-1

The beginning date of eligibility for QI-1 is the first day of the month in which the application for QI-1 coverage is approved. QI-1 cannot be backdated prior to January of the calendar year of application. Eligibility for QI-1 coverage may be backdated up to three months prior to the month of application, if all eligibility requirements were met.

QI-1 Beginning Date of Eligibility Example: Ms. Elm applies for LIS at the SSA on September 17, 2015 and expresses an interest in MPA. This is her LIS/MPA application date. She visits her local office on October 1, 2015, completes a DFA-

QSQ-1, and is approved for SLIMB with backdated coverage to July 2015. The LIS/MPA data exchange is transmitted October 2, 2015. The Worker checks her data exchange alerts and finds Ms. Elm's LIS application date is September 2015. She takes corrective action and backdates his beginning date of coverage to June 2015, if otherwise eligible.

1.16.10 REDETERMINATION

1.16.10.A Redetermination Process

The redetermination may be submitted by mail or online by use of WV PATH.

The redetermination may also be completed using the DFA-QSQ-1 or DFA-2.

1.16.10.B Redetermination Schedule

QMB, SLIMB and QI-1 cases are redetermined annually.

- QMB and SLIMB redeterminations are scheduled in the 12th month of eligibility.
- QI-1 redeterminations are due in December of each year, regardless of the beginning month of eligibility.

1.16.10.C Redetermination Date

The redetermination process for QMB, SLIMB and QI-1 is initiated by the eligibility system which generates a pre-populated form and letter of explanation to the client. The redetermination form is due by the first day of the 12th month of the certification period or December 1 for QI-1. If the redetermination form is not received by the adverse action date, the AG is issued a notice of closure.

The letter of explanation provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination;
- The address to which the form is returned, if submitted by mail;

- The date by which the redetermination must be submitted;
- Any verification which must be submitted with the form;
- A statement that the AG(s) will be closed after advance notice, if the redetermination is not completed;
- Instructions for submitting the redetermination by online by using WV PATH; and,
- A phone number to call if the individual has questions about submitting the redetermination online.

The redetermination may be submitted online by use of WV PATH until the end of the month in which the redetermination is due.

1.16.10.D Completion of the Redetermination

1.16.10.D.1 QMB and SLIMB

When the redetermination is completed and the individual(s) remains eligible, the new period of eligibility (POE) begins the month immediately following the month the redetermination was due.

NOTE: When a QMB redetermination is completed in the 13th month, the new POE begins the first day of the month the redetermination was due.

1.16.10.D.2 QI-1

The new POE begins in January with the new program year.

1.16.11 THE BENEFIT

1.16.11.A QMB

Medicaid coverage is limited to payment of the Medicare, Parts A and B, premium and payment of all Medicare coinsurance deductibles, including those related to nursing facility services. This is accomplished by the BMS Buy-In Unit.

The Medical ID card will be issued each time there is an approval or renewal for any household member. The Medical ID card does not include any date parameters since eligibility may terminate.

1.16.11.B SLIMB and QI-1

SLIMB and QI-1 clients do not receive a Medical ID card.

Medicaid coverage is limited to payment of the Medicare, Part B, premium. This is accomplished by the BMS Buy-In Unit.

1.16.11.B.1 Retroactive Benefits

When coverage is backdated, the SLIMB client receives a refund of paid Medicare premiums from SSA, after buy-in is accomplished.

1.16.11.B.2 Ongoing Benefits

The Department pays the client's Medicare, Part B, premium only.

1.16.11.C Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

When QMB, SLIMB and QI-1 eligibility ends, it ends effective the month following the month in which ineligibility occurs, or whenever the advance notice period ends.

1.17 QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)

1.17.1 APPLICATION FORMS

The Single-Streamlined Application (DFA-SLA-1) and supplement (DFA-SLA-S1), DFA-2 or WV PATH is used.

1.17.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse or the authorized representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.17.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements found in Section 1.2 are applicable. In addition, the following must be discussed if an interview is conducted:

- The QDWI recipient has only his Medicare, Part A, premium paid.
- The QDWI recipient receives no Medical ID card.

1.17.4 AGENCY TIME LIMITS

The Worker must send a copy of the DFA-2 or DFA-MA-1 to the Buy-In Unit at BMS within 30 days of the date of application, when the client is eligible for QDWI.

1.17.5 PAYEE

The QDWI client is the payee.

1.17.6 REDETERMINATION

The BMS Buy-In Unit notifies the county office when the QDWI case is due for redetermination.

The redetermination cycle is set by the eligibility system.

1.17.7 THE BENEFIT

Medicaid coverage is limited to payment of the Medicare Part A, premium. The Buy-In Unit at BMS is responsible for this process. No Medical ID card is sent to this coverage group.

Eligibility ends when the Buy-In Unit at BMS notifies SSA that buy-in has terminated.

1.18 SUPPLEMENTAL SECURITY INCOME (SSI)-RELATED MEDICAID (AGED, BLIND, DISABLED)

The definitions of disability for Medicaid purposes are the same as the definitions used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or Retirement, Survivors, and Disability Insurance (RSDI) based on disability, which are as follows.

AGED

Individuals age 65 and older.

BLINDNESS

To meet the definition of blindness, the individual must have:

- Central visual acuity that cannot be corrected to better than 20/200 in the better eye; or
- A limitation of the field of vision in the better eye so that the widest diameter of the visual field subtends an angle of 20 degrees or less.

DISABILITY, INDIVIDUALS AGE 18 OR OVER

An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment that has lasted, or is expected to last, for a continuous period of at least 12 months, or is expected to result in death.

DISABILITY, INDIVIDUALS UNDER AGE 18

The child who is under age 18 is considered to be disabled if he has a medically determinable physical or mental impairment (or combination of impairments), the impairment(s) results in marked and severe functional limitations, and the impairment(s) has lasted (or is expected to last) for at least one year or to result in death.

An individual under age 18 is not considered a child if he:

- Is legally married;
- Is divorced; or
- Is over age 16 and has been emancipated by a court of law.

1.18.1 DATE OF APPLICATION

The date of application is the date the Department of Health and Human Resources (DHHR) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name, address, and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.3 are met.

1.18.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse, or the authorized representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.18.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements in Section 1.2 are applicable. In addition, the following must be discussed with the applicant if an interview is conducted:

- That an aged individual may have his eligibility determined as a blind or disabled individual if he wishes.
- The spenddown processes.
- The specific months which will constitute the Period of Consideration (POC) based on the six-month POC that will most benefit the client. The beginning date of eligibility may be backdated up to three months prior to the month of application when all eligibility requirements are met, and the client has medical expenses for which he seeks payment.
- The MRT process, if applicable.
- That when a spouse apply, one spouse may be approved, when eligible, while the application for the other spouse remains pending.

- Relationship with QMB/SLIMB. See Section 1.16.

1.18.4 DUE DATE OF ADDITIONAL INFORMATION

Additional information related to medical bills is due 30 days from the date of application.

1.18.5 AGENCY TIME LIMITS

1.18.5.A Application Processing Limits

- SSI Age-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.
- SSI Blind-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.
- SSI Disability-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 90 days of the date of application.

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness or disability is established, the deprivation factor is changed.

Information related to medical bills in cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.18.5.B MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the time limits in the table below apply to the MRT process.

Required Action	Time Limit
Request medical records and reports	By the 7th day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request (and each 30 days thereafter)
Submission to the MRT	By the 7th day after medical records/reports received
Receipt of file and logged	By the 2nd day after receipt by the MRT
Initial review by the MRT staff	By the 7th day after receipt
Physician review (initial)	By the 14th day after receipt
Additional medical information requested (if required) by physician	By the 7th day after initial physician review
Physician's final review	By the 7th day after receipt of additional medical information
Final decision (completion of ES-RT-3 and/or DFA-RT-3M form[s])	By the 7th day after final physician's review
File returned to county office	By the 3rd day after final physician's review
Notice to the client	By the 7th day after receipt of final decision at county office

1.18.6 PAYEE

The client is the payee. Spouses may decide who the payee is.

1.18.7 BEGINNING DATE OF ELIGIBILITY

1.18.7.A Non-Spenddown

The beginning date of eligibility is the first day of the month of the period of consideration (POC).

1.18.7.B Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker in the eligibility system are not paid by Medicaid.

This date may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

1.18.8 REDETERMINATION

1.18.8.A Non-Spenddown

1.18.8.A.1 The Redetermination List

Non-Spenddown AGs are redetermined in the sixth month of the POC. The six-month period begins with the month of application. The date of the next redetermination is automatically coded in the eligibility system.

The eligibility system alerts the Worker when a redetermination is due and sends a redetermination form to the client.

1.18.8.A.2 Completion of Redetermination

When the redetermination is completed and the AG remains eligible, the new POC begins the month immediately following the month of the redetermination.

1.18.8.B Spenddown

Spenddown AGs are not redetermined and are closed at the end of the sixth month of the POC. The last month of the six-month POC is coded in the eligibility system.

The client must reapply for a new POC using one of the application methods described above.

Spenddown AGs are mailed a letter at adverse action notice deadline during the sixth month of the POC. This letter informs the client that his eligibility will end on the last day of the month and that he must reapply for Medicaid coverage.

1.18.9 THE BENEFIT

1.18.9.A.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.18.9.A.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.18.10 SPOUSES APPLY – ONE APPROVED, ONE PENDING

When an application for an SSI-Related coverage group is made for a couple and one spouse is eligible, but the application for the other remains pending because disability has not been established, the procedure is as follows:

- Approve the application for the eligible spouse. Deeming procedures in Chapter 4 apply.
- Send an approval notice to the eligible individual and include an explanation that eligibility for the spouse has not been established and the reason.

If the spouse is determined eligible at a later date, the procedures depend upon whether or not the previously ineligible spouse has income, whether or not such income was deemed to the client, and whether or not there is a spenddown.

1.18.10.A Income of Previously Ineligible Spouse Does Not Cause Spenddown

When the income of the previously ineligible spouse equals $0, or has been deemed to the client spouse, or does not cause the AG to have a spenddown, the following procedures apply.

- Take eligibility system action to add the spouse to the AG. The beginning period of consideration (POC) or period of eligibility (POE) for the spouse is the same as for the client;
- Send an approval notice to the recipient to inform him that eligibility for the spouse has been established and the date on which his medical coverage begins.
- If the individual is added after the deadline date in the sixth month of the POC, proper eligibility system procedures must be followed to insure issuance of a Medical ID card.

1.18.10.B Income of Previously Ineligible Spouse Causes Spenddown

When the previously ineligible spouse has income, but it was not deemed to the client spouse, and it causes the AG to have a spenddown, the following procedures apply.

If the eligible spouse did not previously have a spenddown, but the addition of the previously ineligible spouse and his income makes the AG subject to spenddown, the following actions are taken:

- The previously ineligible spouse is added to the AG; and
- The AG is closed after proper notice and is reopened with a new POC. The new POC must not cover any period of time in which the AG was in a POE; and
- The AG must be supplied with proper notice about the spenddown and the procedures which now apply.

If the eligible spouse had a spenddown which was met and is currently in an active AG, the following actions are taken:

- Add the previously ineligible spouse to the AG for the current POC. The AG is not closed prior to the end of the current POC due to increased countable income.
- When the AG reapplies for a new POC, all income is counted, and appropriate spenddown procedures apply.

If the spouse is determined ineligible, the Worker sends the recipient a denial notice.

The Worker must update the eligibility system and make a recording in case comments about the denial.

1.19 SSI-RELATED/NON-CASH ASSISTANCE

A coverage group for individuals who are eligible for but not receiving Supplemental Security Income (SSI) payments.

1.19.1 DATE OF APPLICATION

The date of application is the date the Department of Health and Human Resources (DHHR) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name and address and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.2.10 are met.

1.19.2 WHO MUST SIGN?

The application must be signed by the applicant, the spouse, or the representative.

When the applicant is a child under age 18, the parent(s) or legal guardian must sign.

1.19.3 CONTENT OF THE INTERVIEW

Although no interview is required, when an interview is conducted, the interview requirements in Section 1.2 are applicable. In addition, the following must be discussed with the applicant if an interview is conducted.

- That an aged individual may have his eligibility determined as a blind or disabled individual if he wishes.
- The beginning date of eligibility may be backdated up to three months prior to the month of application when all eligibility requirements are met, and the client has medical expenses for which he seeks payment.
- The MRT process, if applicable.

- That when a couple applies, one spouse may be approved, when eligible, while the application for the other spouse remains pending.
- Relationship with QMB/SLIMB. See Section 1.16.

1.19.4 AGENCY TIME LIMITS

1.19.4.A Agency Processing Limits

- SSI Age-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.
- SSI Blind-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.
- SSI Disability-Related Medicaid: Eligibility system action to approve, deny or withdraw the application must be taken with 90 days of the date of application.

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness or disability is established, the deprivation factor is changed.

1.19.4.B MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the time limits in the table below apply to the MRT process.

Required Action	Time Limit
Request medical records and reports	By the 7th day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request (and each 30 days thereafter)
Submission to the MRT	By the 7th day after medical records/reports received

Required Action	Time Limit
Receipt of file and logged	By the 2nd day after receipt by the MRT
Initial review by the MRT staff	By the 7th day after receipt
Physician review (initial)	By the 14th day after receipt
Additional medical information requested (if required) by physician	By the 7th day after initial physician review
Physician's final review	By the 7th day after receipt of additional medical information
Final decision (completion of ES-RT-3 and/or DFA-RT-3M form[s])	By the 7th day after final physician's review
File returned to county office	By the 3rd day after final physician's review
Notice to the client	By the 7th day after receipt of final decision at county office

1.19.5 PAYEE

The client is the payee. Couples may decide who the payee is.

1.19.6 REDETERMINATION

SSI-Related/Non-Cash Assistance Medicaid AGs are redetermined every six months in the last month of the current POC. The eligibility system alerts the Worker when a redetermination is due and sends a letter to the client.

The Worker, after receipt of the alert, is responsible for scheduling the redetermination so that it is completed prior to or during the month in which it is due.

An appointment letter is generated by the eligibility system to notify the client of the redetermination and the date the interview is scheduled.

When the redetermination is completed and the AG remains eligible, the new POC begins the month immediately following the month of the redetermination. The new beginning POC is automatically coded in the eligibility system.

1.19.7 THE BENEFIT

1.19.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month

1.19.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.20 AFDC-RELATED MEDICAID

Caretaker Relatives and pregnant women are eligible for Medicaid under this coverage group when certain conditions are met as described in Chapter 23. This coverage group is not subject to the spenddown provision. Medically Needy AGs are subject to the spenddown provision.

NOTE: Supplemental Security Income (SSI) recipients, whether they are adults or children, are not included in the AG, IG, or NG.

1.20.1 DATE OF APPLICATION

The date of application is the date the Department of Health and Human Resources (DHHR) receives the application in person, by fax or other electronic transmission, through WV PATH or the FFM, or by mail, which contains, at a minimum, the applicant's name and address and signature.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No DFA-2 is required when the requirements in Section 1.2.10 are met.

1.20.2 WHO MUST SIGN?

The specified relative with whom the child lives. If the child is living with both parents, both must sign unless:

- One parent is hospitalized; or
- One parent is incarcerated.

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

1.20.3 AGENCY TIME LIMITS

Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Information related to medical bills in cases that meet spenddown should be entered in the eligibility system in the 30-day application period.

1.20.4 PAYEE

The parent or other specified relative who is the caretaker relative is the payee. When both parents are in the home, either parent may be the payee.

1.20.5 BEGINNING DATE OF ELIGIBILITY

This date may be backdated up to 3 months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

1.20.5.A Non-Spenddown

The beginning date of eligibility is the first day of the month of the POC.

1.20.5.B Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker in the eligibility system, are not paid by Medicaid.

1.20.6 REDETERMINATION

1.20.6.A Non-Spenddown

Non-Spenddown AGs are redetermined every six months in the last month of the current POC. The eligibility system alerts the Worker when a redetermination is due and sends a letter to the client.

The Worker, after receipt of the alert, is responsible for scheduling the redetermination so that it is completed prior to or during the month in which it is due.

An appointment letter is generated by the eligibility system to notify the client of the redetermination and the date the interview is scheduled.

When the redetermination is completed and the AG remains eligible, the new POC must begin the month immediately following the month of the redetermination. The new beginning POC is automatically coded in the eligibility system.

1.20.6.B Spenddown

Spenddown AGs are not redetermined and are closed at the end of the sixth month of the POC. The client must reapply for a new POC.

Spenddown AGs may come into the office at any time to reapply for a new POC.

Spenddown AGs are mailed a computer-generated letter at the adverse action deadline of the 6th month of the POC. This letter informs the client that his eligibility will end on the last day of the month and that he must reapply for Medicaid coverage.

1.20.7 THE BENEFIT

1.20.7.A Non-Spenddown

1.20.7.A.1 Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.20.7.A.2 Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective month of closure.

1.20.7.B Spenddown

A Medical ID card is issued when the eligibility system entries bring the spenddown amount to $0. All eligible individuals who are included in the AG which meets spenddown appear on the Medical ID card.

1.20.7.B.1 Ending Date of Eligibility

The ending date of eligibility is the last day of the effective date of closure. The spenddown AG automatically closes at adverse action deadline of the 6th month of the POC, effective the last day of the POC.

- A member(s) of the Income Group experiences an increase in income;
- An individual(s) with income is added to the Income Group; or
- An individual(s) is removed from the Needs Group.

1.21 WV FORMER FOSTER CHILDREN

The Affordable Care Act (ACA) established a new categorically mandatory coverage group called the WV Former Foster Children group.

1.21.1 WHO CAN BE INCLUDED ON THE SAME APPLICATION?

- Individuals who have a familial relationship with the applicant (spouse, child - biological, adopted or stepchild; parent - biological, adopted or stepparent; sibling - biological, adopted, half or step sibling.)
- Individuals who are a tax dependent of, or on the same income tax return with, the applicant.

EXCEPTION: A non-custodial parent cannot apply for Medicaid or WVCHIP for their child even when claiming their child as a tax dependent. In this situation, based on MAGI rules, the child's MAGI household includes - himself, his parents (biological, adopted or step parents), and siblings (biological, adopted or step) under 19 with whom he resides. Information necessary to determine the child's eligibility cannot be determined based on the non-custodial parent's application; therefore, the case should fail for the child with the reason that the non-custodial parent cannot apply for the child.

- Individuals who are under age 19 and residing with the application filer may be included on an application submitted by an adult application filer, even if the child and application filer are not in a familial or tax relationship.

Adult individuals who do not fall into one of these categories will be notified that they must submit a separate application.

1.21.2 WHO MUST SIGN?

The application must be signed by an adult in the household or their authorized representative.

1.21.3 AGENCY TIME LMITS

Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.

1.21.4 PAYEE

The payee is the former foster child.

1.21.5 BEGINNING DATE OF ELIGIBILITY

Eligibility begins the first day of the month in which eligibility is established. Eligibility may be backdated up to 3 months prior to the month of the application, when the client met all eligibility requirements in the prior month(s).

1.21.6 REDETERMINATION

1.21.6.A Redetermination Process

Cases are normally redetermined annually. The redetermination schedule is set automatically by the eligibility system.

When possible, the redetermination process is completed automatically using electronic data matches without requiring information from the client. This redetermination process is initiated by the eligibility system, which matches current information with the hub. The Reasonable Compatibility Provision applies each time this occurs. See Section 7.2. If determined eligible after completing the redetermination process, the Department will notify the client. The notice will identify information used to determine eligibility. If the customer agrees with the information, no further action is required. If the client does not agree, he is to report the information that does not match the circumstances.

When the redetermination process cannot be completed automatically, the eligibility system sends a pre-populated form containing case information and require the client to provide additional information necessary to determine continuing eligibility. A signature is required.

The pre-populated redetermination form provides the following information:

- A statement that the AG(s) for the individual(s) listed is due for redetermination,
- The address to which the form is returned, if submitted by mail,
- The date by which the information must be submitted,
- Specific information necessary to complete the redetermination,
- The opportunity to report changes,
- A statement that the AG may receive a verification checklist for completion and return, if reported changes require follow-up,
- A statement that the AG(s) will be closed after proper notification, if the redetermination is not completed, and
- Instructions for submitting the pre-populated auto-renewal verification checklist form online by using WV PATH. A phone number to call if the individual has questions about submitting the pre-populated auto-renewal verification checklist online.

The client must be given 30 days from the date of the letter to return the information. The information may be submitted by mail, phone, electronically, Internet, or in person. Failure to respond and provide the necessary information will result in closure of the benefit.

If the client responds and provides the information within 90 days of the effective date of closure, the agency will determine eligibility in a timely manner without requiring a new application. If the client is found eligible, the coverage must be back dated up to 3 months.

1.21.6.B Rolling Redeterminations

When a change is reported during the certification period which affects eligibility, the DHHR must only request the information on the change reported. When the information is received, the client is evaluated for rolling redetermination. If the agency has enough information available to renew eligibility with respect to all the eligibility criteria, the agency must begin a new 12-month certification period.

> **Redetermination Example 1:** Rose is determined eligible from February 1, 2014 through January 31, 2015. On June 2, 2014, Rose calls and reports a change in income. The information is provided to the Department on June 6, 2014. The Worker evaluates and determines enough information is available to renew

eligibility. The benefit is given a new certification period effective July 1, 2014 through June 30, 2015.

Redetermination Example 2: A redetermination for SNAP benefits is completed on May 14, 2014. The certification period is April 1, 2014 through March 31, 2015. After the SNAP redetermination is completed, the Worker finds the information provided is enough to recertify. The WVCHIP certification period is renewed from June 1, 2014 through May 31, 2015.

When the determination is completed and the individual(s) remains eligible, the new eligibility period must begin the month immediately following the month of redetermination.

If the client's coverage is interrupted due to agency delay or error, procedures for reimbursement of the client's out-of-pocket expenses may apply.

1.21.7 THE BENEFIT

1.21.7.A Ongoing Benefits

Effective December 21, 2017 there was a change in the way Medical ID cards are issued. Instead of the separate blue paper card, the Medical ID card is now included in all Medicaid approval notices. The Medical ID card does not include any date parameters since eligibility may terminate.

Medicaid recipients will receive one Medical ID card per case each time there is an approval or renewal for Medicaid for any household member.

In situations where retroactive eligibility is established, the Medicaid coverage will be validated appropriately for each back-dated month.

1.21.7.B Ending Date of Eligibility

The ending date of eligibility is the last day of the month of the effective date of closure.

1.22 ILLEGAL NONCITIZENS

This coverage group provides emergency support to certain individuals with severe medical conditions.

1.22.1 WHO MUST SIGN?

The applicant or his authorized representative must sign the application.

1.22.2 PAYEE

The client who is the noncitizen or his authorized representative is the payee.

1.22.3 BEGINNING DATE OF ELIGIBILITY

Eligibility for emergency Medicaid coverage begins the date that the applicant's emergency medical situation starts.

1.22.4 REDETERMINATION

The case is opened when treatment for the medical emergency begins and closed at the end of the medical emergency.

When the client has an ongoing emergency, the Worker must check periodically to determine if the emergency has ended. If a Medical Review Team (MRT) decision was part of the client's eligibility determination, MRT redetermination requirements apply.

1.22.5 THE BENEFIT

1.22.5.A Ongoing Benefits

The client is issued a verification of medical coverage for the valid Period of Eligibility (POE).

1.22.5.B Ending Date of Eligibility

Eligibility for emergency Medicaid coverage ends on the date the medical emergency is resolved.

1.23 AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The AIDS Drug Assistance Program (ADAP), or also referred to as the AIDS Special Pharmacy Program or the ADAP West Virginia Special Pharmacy Program, is a Bureau of Public Health (BPH) program contracted with BMS to administer the medical services provided. The eligibility decision is made by Bureau for Medical Services (BMS), rather than the Worker.

1.23.1 APPLICATION FORMS

- DFA-2, Single-Streamlined Application (SLA), or WV PATH – The DFA-2 is completed to determine Medicaid eligibility.
- ADAP Application – Once determined ineligible for all full-coverage Medicaid groups except an SSI-Related Medicaid with an unmet spenddown, an ADAP application for West Virginia Special Pharmacy must be completed. This application is available on the Department of Health and Human Resources (DHHR) Intranet Forms page.

1.23.2 COMPLETE APPLICATION

The ADAP application is complete when page 1 is signed by the applicant and page 2, the Physician's Report, is signed by the physician.

NOTE: The resource development policies in Chapter 8 do not apply to ADAP. Potential eligibility for, or receipt of Medicare, Part D, does not affect the application or referral process for the ADAP eligibility determination.

1.23.3 DATE OF APPLICATION

The date of application is the date the Department of Health and Human Resources (DHHR) receives the application in person, by fax or other electronic transmission, through WV PATH or the Federally Facilitated Marketplace (FFM), or by mail, which contains, at a minimum, the applicant's name and address and signature.

When the client previously applied for Medicaid and is pending spenddown, the date the client inquiries about the AIDS Special Pharmacy program coverage is the date of application.

1.23.4 WHO MUST SIGN?

The client or his representative must sign the DFA-2, or DFA-5 or SLA.

1.23.5 AGENCY TIME LIMITS

From the date of application, defined above, the applicant must return the completed ADAP application to the Worker within 30 days of the Medicaid application.

Upon receipt, the Worker must forward the most recent DFA-2, SLA or ADAP applications to:

BMS, Eligibility Supervisor
Office of Administration and Claims Processing
350 Capitol Street, Room 251
Charleston, West Virginia 25301

1.23.6 AGENCY DELAYS

When the DHHR fails to request necessary verification or information, the Worker must immediately send form DFA-6 or the eligibility system verification checklist to request it. The Worker must inform the client that the application is being held pending.

Applications for the ADAP are processed by BMS. When a Worker determines he has not forwarded the eligibility information to BMS, he must forward it immediately.

1.23.7 PAYEE

The ADAP individual is the payee for services. BMS handles payment for all services.

1.23.8 THE BEGINNING DATE OF ELIGIBILITY

BMS determines the date eligibility begins.

1.23.9 REDETERMINATION

Redetermination does not apply to ADAP.

1.23.10 THE BENEFIT

No Medical ID card is issued.

If the client becomes eligible under any other Medicaid coverage group or meets his spenddown, the Worker must notify BMS immediately and specify the beginning date of Medicaid eligibility.

Otherwise, BMS determines when eligibility ends.

1.24 BREAST AND CERVICAL CANCER SCREENING PROGRAM (BCCSP) MEDICAID COVERAGE GROUP

A woman is eligible for Breast and Cervical Cancer Screening Program (BCCSP) Medicaid if she is diagnosed with a breast or cervical cancer or certain pre-cancerous conditions, regardless of income. She must also be receiving active treatment for her diagnosis and currently enrolled in the BCCSP through a screening provider to be eligible for this type of Medicaid coverage.

1.24.1 APPLICATION PROCESS

The application process must be completed in the following order:

- A woman is screened at a BCCSP site. If diagnosed with breast or cervical cancer, she is given a CDC Certificate of Diagnosis and completes form DFA-BCC-1.
- The DFA-BCC-1 form is forwarded by the CDC facility to the DHHR office in the county in which the applicant resides. The Worker enters the information in the eligibility system to issue a Medical ID card, provided all eligibility criteria described in Eligibility Requirements above are met.
- If information provided on the DFA-BCC-1 indicates that the woman is not income or asset eligible for any other mandatory Medicaid coverage group, no action is taken, but the decision must be recorded in the eligibility system.
- If the information indicates the woman may be eligible under one of the mandatory coverage groups listed in Eligibility Requirements above, the Worker contacts the woman, arranges for an application to be completed, and requests any additional information required to determine eligibility.
- If the woman is determined Medicaid eligible for a mandatory coverage group, the Worker closes the BCC AG and approves the new coverage group.
- If ineligible for a mandatory Medicaid coverage group, the woman remains in the BCC group and the Worker records the results of the determination process in the eligibility system.
- If the woman or a representative fails to apply within 30 days, or she fails to cooperate in determining eligibility for a mandatory Medicaid coverage group, the BCC case is closed.

1.24.2 REDETERMINATION PROCESS

An annual redetermination for BCC and Medicaid eligibility is required. OMCFH is responsible for providing a BCC Medicaid Continuation Form to verify continuing treatment and for assuring that a new completed DFA-BCC-1 is mailed to the local DHHR office.

If there are changes in the woman's circumstances that mean she may be eligible for one of the Medicaid groups listed in Eligibility Requirements above, the Worker must contact her to complete a Medicaid application. The BCC case remains open while the determination is being made. Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

If determined eligible for a mandatory Medicaid group, the Worker closes the BCC coverage and takes action to approve the woman for the appropriate Medicaid coverage group. See Eligibility Requirements above for mandatory coverage groups.

If it appears there have been no significant changes and the woman continues to meet all other BCC requirements, no action is taken in the eligibility system. The Worker files the forms in the case record and makes appropriate case comments.

1.24.3 COMMUNICATIONS WITH THE BCC

To insure that needed services are not delayed after approval for BCC and that BCC has current information about individuals who are closed or denied, the Worker must follow the procedures outlined below:

- Follow the eligibility system instructions for coding BCC using PRD-38.
- Print the current address screen, which must include the BCC applicant's name.
- Write the status of the case on the bottom of the printout. Examples include, but are not limited to, approved for BCC, needs CDC certificate or ineligible for BCC as eligible for another mandatory coverage group.
- Fax the printout, along with the CDC certificate of diagnosis and the BCC Medicaid application, to the attention of: BCCSP at (304) 558-7164 or mail to the Office of Maternal, Child and Family Health (OMCFH), ATTN: BCCSP, 350 Capitol Street, Room 427, Charleston, West Virginia 25301-3715.

APPENDIX A: APPLICATION FORMS AND INSTRUCTIONS BY PROGRAM

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
SNAP				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	10 days from the date of the DFA-6 or Verification Checklist.	• If eligible, the client must receive benefits by the 30th day. • If expedited, the client must receive benefits by the seventh day. • If denying for failure to return information, must wait until after the 10th day but no later than the 31st day.
DFA-SNAP-1	SNAP Application	Applicant is only applying for SNAP.		
WV WORKS				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional information must be returned (not to exceed 30 days).	• Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the initial contact. • When the application must be denied because the client has not responded to a DFA-6 or verification checklist, the Worker must wait until after the 10th day but no later than the 31st day to deny the application.
DFA-RFA-1	Request for Assistance	To protect the date of application for proration purposes when the client is in the local office and time does not permit conducting an interview on the date the client wishes to apply for benefits.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
MEDICAID AND OTHER HEALTH COVERAGE PROGRAMS				
Adult Group				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
AFDC-Related Medicaid				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information is due 30 days from the date of application	Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
AIDS Drug Assistance Program (ADAP)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The Worker and the client or his authorized representative decide on a reasonable time for the information to be returned.	• The ADAP eligibility determination must be based on current client circumstances. • From the date of application, defined in Section 1.23, the applicant must return the completed ADAP application to the Worker within 30 days.
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage – Long Form with Supplement	For a single individual applying for health care coverage only.		
DFA-SLA-2 with DFA-SLA-S1	Supplement for Healthcare Coverage - Short Form with Supplement	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
ADAP	ADAP Application	After determined ineligible for all full-coverage Medicaid groups except SSI-Related Medicaid with an unmet spenddown.		
Breast and Cervical Cancer (BCC)				
DFA-BCC-1	BCC Application			
Children Under Age 19				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When an interview is conducted, the Worker and the client decide on a reasonable time for the information to be returned. • When the application is returned by mail, left at the office or submitted by WV PATH and additional information is required, the client must be given at least 10 days after the mailing date of the request for additional information to respond.	• Action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a complete application is received in the county office. • If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it and to complete the application within 13 days.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
Continuously Eligible Newborn (CEN) Children				
N/A	N/A	No application required for CEN children who are born to Medicaid eligible women.		
Deemed Parents/Caretaker Relatives				
N/A	N/A	No application required.		
Deemed SSI Recipients				
N/A	N/A	No application required. State Data Exchange (SDX) codes indicate potential eligibility.		
Former West Virginia Foster Children				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Illegal Noncitizens				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained.	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application, 90 days if a disability must be established.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Parents/Caretaker Relatives				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained	Eligibility system action must be taken to approve, deny or withdraw the application within 30 days of the date of application

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Pregnant Women				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When an interview is conducted, the Worker and the client decide on a reasonable time for the information to be returned. • When the application is returned by mail, left at the office or submitted by WV PATH and additional information is required, the client must be given at least 10 days after the mailing date of the request for additional information to respond.	• Action must be taken to approve, deny or withdraw the application within 13 calendar days of the date a complete application is received in the county office. • If additional information or verification is required after the complete application is received, the Worker must request it immediately to allow the client 10 days to provide it and to complete the application within 13 days.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
Qualified Disabled Working Individuals (QDWI)				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.	The Worker must send a copy of the DFA-2 or DFA-MA-1 to the BMS Buy-In Unit within 30 days of the date of application, when the client is eligible for QDWI.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		
QMB, SLIMB, QI-1				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	• When the client visits the office and an interview is conducted, the Worker and client decide on a	Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-QSQ-1	Medicare Assistance Programs Application	When Low Income Subsidy (LIS) files are received from the Social Security Administration (SSA), applicants who are not current Medicare Premium Assistance (MPA) recipients are issued a DFA-QSQ-1 through the eligibility system.	reasonable time for the client to return the information. • When the client mails the application or completes the application in WV PATH or the Marketplace, the Worker then uses the verification checklist or form DFA-6 in inform the client of additional information needed. The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.	For LIS/MPA applicants: • Action must be taken within 30 days of the date the file is received by the eligibility system. • When the eligibility system determines a LIS/MPA applicant is a current MPA recipient, no notice is sent. • The next business day after the eligibility system receives SSA's LIS data, the system issues a DFA-QSQ-1. If the DFA-QSQ-1 is not returned within 31 days from the date the eligibility system received the LIS file, the eligibility system sends a denial notice. No action is required by the Worker
Special Pharmacy				
DFA-SP-1	Special Pharmacy Application	The DFA-SP-1 for Special Pharmacy coverage is completed by the Worker and forwarded to the DFA Medicaid Policy Unit for consideration. This is an interdepartmental form and is not given to or completed by the client.	All information must be submitted with the DFA-SP-1.	The Worker must submit the DFA-SP-1 to the DFA Medicaid Policy Unit within 10 days of completion. DFA must make a decision and notify the Worker of that decision within 30 days from the date the completed DFA-SP-1 is received.

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
SSI Recipients				
N/A	N/A	There is no application form. SSI recipients are categorically eligible.	Not applicable.	The Worker must enter the SDX information for approval within 45 days of the date on which the client first appears on the data exchange, or the referral from SSA or the BMS Buy-In Unit is received.
SSI-Related/Aged, Blind and Disabled				
DFA-2 or	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information related to medical bills is due 30 days from the date of application	SSI Age-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 30 days of the date of application SSI Blind-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 60 days of the date of application SSI Disability-Related: Eligibility system action to approve, deny or withdraw the application must be taken within 90 days of the date of application
DFA-SLA-1 with DFA-SLA-S1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2 with DFA-SLA-S1	Application for Healthcare Coverage – Short Form with Supplement	For a single individual applying for health care coverage only.		
SSI-Related/Non-Cash Assistance				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Additional information related to medical bills is due 30 days from the date of application.	See SSI-Related Aged, Blind, Disabled above.
DFA-SLA-1	Application for Healthcare Coverage with Supplement	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form with Supplement	For a single individual applying for health care coverage only.		
Transitional Medicaid				

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
N/A	N/A	There is no application procedure for this coverage group, instead the Worker is expected to evaluate all AGs which become ineligible for Parents/Caretaker Relatives Medicaid due to hours of employment, amount of employment income.	Not applicable.	Not applicable.
West Virginia Children's Health Insurance Program (WVCHIP)				
DFA-2 or WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Prior to approval for WVCHIP, the client must be determined ineligible for all MAGI Medicaid coverage groups; therefore, the Children Under Age 19 coverage group application procedures apply.	If the Worker decides that additional information is required, the Worker must immediately send a request for the information that includes notification that the application is being held pending receipt of that information and the start date of his WVCHIP coverage may be delayed if he does not respond by the due date.
DFA-SLA-1	Application for Healthcare Coverage	For a family or when there is more than one individual in the household applying for health care coverage only.		
DFA-SLA-2	Application for Healthcare Coverage – Short Form	For a single individual applying for health care coverage only.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
OTHER DHHR ASSISTANCE PROGRAMS				
Burial Assistance				
DFA-BU-1	Application for Indigent Burial Benefits	Used in taking applications for payment of burial expenses.	None.	The application must be completed within 30 days of interment or cremation. The completed burial packet must be sent to DFA Policy Unit within three business days of receipt.
DFA-BU-2	Affidavit of Responsible Relative	Required when the applicant is a relative who is liable for the burial costs of the deceased; preferred when the applicant is a relative who is not liable for the burial costs or the applicant is not a relative of the deceased. Used to determine financial ability of those responsible relatives who are liable for the burial costs of the deceased and to determine sufficient ability of other relatives who wish to contribute to the burial costs but are not liable.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
Emergency Assistance (EA)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	The Worker must clearly state on the DFA-6 what items must be returned by the applicant, as well as the date by which the information must be returned. The failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the application will be considered failure to provide verification and will result in a denial of the application.	A decision must be made on all applications as soon as possible, if the emergency currently exists, or prior to an imminent emergency but no later than three business days from the date of application.
DFA-EA-1	Emergency Assistance Application	Applicant wishes to be considered for EA only.		
Low Income Energy Assistance Program (LIEAP)				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	Applicants must be allowed 15 calendar days to return verification.	Applications ready for processing by the local DHHR office must be sent to that office on a daily basis with a signed and dated list with the name and address of each applicant. Applications held in excess of 30 days by any outside agency are not accepted.
DFA-LIEAP-1	LIEAP Application	Applicant wishes to be considered for LIEAP only.		
DFA-LIEAP-1b	Supplemental LIEAP Form	Applicant is being considered for LIEAP.		

Program and Form ID	Name of Form	When to Use	Due Date of Additional Information	Agency Time Limits
West Virginia School Clothing Allowance (WV SCA)				
DFA-2 WV PATH	Application for All Programs of Assistance	Applicant is being considered for all programs.	The client and the Worker agree on the date by which additional verification must be obtained. This date must be within 30 days of the date of application.	As long as the application is made by the last day of July and the applicant returns the requested information in the time frame specified by the Worker, the WV SCA is approved, if the family is otherwise eligible. All applications must be processed by August 31. Because WV SCA vouchers expire October 31 of the current year, every effort should be made to process all applications in a timely manner within 30 days of the date of application.
DFA-WVSC-1	SCA Application	Applicant wishes to be considered for WV SCA only.		
WV WORKS School Clothing Allowance (SCA)				
DFA-2	Application for All Programs of Assistance	Applicant is being considered for all programs.	See WV WORKS.	See WV WORKS.

APPENDIX B: GUIDE FOR SELF-SUFFICIENCY PLAN

Identify Goals

Identify Challenges

Identify Support Services or other resources/referrals needed

Assignments/Activities

Target Dates/Completion Dates/Follow-up Dates

MISCELLANEOUS

- Legal Aid
- Domestic Violence
- Schedule Date for Orientation
- Schedule Date for In-Depth Assessment (OFA-WVW-3A)
- TABE/Work Keys Testing
- Always Consider Sanctions/Compliance/Non-Compliance
- Always Consider Exemptions from Work Requirements
- Good Cause for Non-Participation
- Mentoring

WORK ACTIVITIES

- Subsidized Employment
- Unsubsidized Employment
- Work Experience (WE), Community Work Experience Program (CWEP), Joint Opportunities for independence (JOIN), and Community Service (CS)
- On the Job Training Employer Incentive Program (EIP)
- Providing childcare to a community service participant (CC)

JOB SEARCH IS:

- Register with the Job Service
- Parenting Classes
- Financial Literacy

- Relationship Education
- Substance Abuse/Mental Health Treatment
- Rehabilitation Activities
- Apply for Governor's Summer Youth Program (GSYP)
- Apply for Work Study Programs (College Students)
- Job Search - Looking for Work

EDUCATIONAL ACTIVITIES

- High School, High School Equivalency (GED), and Adult Basic Education (ABE) Literacy Classes
- English as a Second Language
- College
- Job Skills Training or Education Directly Related to Employment
- Vocational Training

SUPPORT SERVICES

- Child Care
- Transportation
- Tools
- Relocation
- Clothing/Uniforms
- Driver's License
- Professional Licenses
- Collateral Expenses
- Vehicle Repair and Insurance

PRC MANDATORY REQUIREMENTS (for everyone)

- Child Immunizations
- Schedule of Preventive Health Care for Children
- Children must be in School or in Appropriate Child Care

- Obtain Social Security Numbers for all Family Members
- Cooperation with Child Support:
    - Establish Paternity
    - Collection of Child Support

PRC MANDATORY REQUIREMENTS (for Teen Parents)

- Parenting Classes and/or Mentoring
- Living at Home/Adult Supervised Setting Educational Activity:
    - High School
    - Alternative School Setting
    - ABE Classes
    - Vocational Training

MEDICAL

- Medical Testing
- MRT Referral
- Vocational Assessment
- Social Security Administration Referrals
- Dental/Optometry
- Emotion Health Inventory
- Learning Needs Screening

APPENDIX C: EFFECTIVE DATES OF TANF STATE PLANS

State	Effective Date
Alabama	11/96
Alaska	11/96
Arizona	10/96
California	7/97
Colorado	11/96
Connecticut	7/97
Delaware	10/96
District of Columbia	3/97
Florida	3/97
Georgia	10/96
Guam	1/97
Hawaii	7/97
Idaho	7/97
Illinois	7/97
Indiana	7/97
Iowa	10/96
Kansas	1/97
Kentucky	10/96
Louisiana	1/97
Maine	11/96
Maryland	12/96
Massachusetts	9/96
Michigan	9/96
Minnesota	7/97
Mississippi	10/96

State	Effective Date
Missouri	12/96
Montana	12/96
Nebraska	12/96
Nevada	12/96
New Hampshire	10/96
New Jersey	2/97
New Mexico	7/97
New York	12/96
North Carolina	1/97
North Dakota	7/97
Ohio	10/97
Oklahoma	10/97
Oregon	10/96
Pennsylvania	3/97
Puerto Rico	7/97
Rhode Island	5/97
South Carolina	10/96
South Dakota	10/96
Tennessee	10/96
Texas	11/96
Utah	10/96
Vermont	No limit
Virginia	2/97
Virgin Islands	7/97
Washington	1/97
West Virginia	1/97
Wisconsin	9/96
Wyoming	1/97

APPENDIX D: WV WORKS LIST OF LOCAL SERVICES

INSTRUCTIONS

The template contains information in parentheses after each main heading. This information is what is required to be included on the form or discussed with the client. It should not appear on the final form used by Workers.

When the template states to “list” information, it is expected that the local office will type the information on the form. When the template states “discuss” or “tell” it is expected that the Worker will verbally provide information.

When a particular service is not available locally, the local office may list the nearest location where such services are available or may type on the form: “Not Available Locally.” In some locations in the State, there may be more service locations than it is practical to list on the form. When this is true, list all locations on a separate sheet(s) of paper and on the form, refer to the attachment.

Attachment A must be copied exactly as written and included with the WV WORKS List of Local Services provided to the client.

It is recommended that the Worker include the most recent Community Resource Guide or Quick Guide with the WV WORKS List of Local Services.

WV WORKS LIST OF LOCAL SERVICES

Name_____ Case No. or SSN_____

(Please put your initials beside each service as it is discussed with you)

_____ WORKFORCE West Virginia Career Centers/Other Employment Resources

(List addresses and telephone numbers for all available employment resources.)

_____ Activity Placements

(List available types of activities that may be possible to meet a work requirement, such as CWEP, providing day care. Explain each briefly here and provide more detail in discussion.)

_____ GED/Adult Basic Education Classes/Head Start

(List addresses and telephone numbers for contacting facilities about additional information. Explain what to expect from such classes.)

_____ College/Vocational Training

(List addresses and telephone numbers for colleges and vocational training within commuting distance. List the kinds of vocational training available. Discuss the availability of financial aid and how to apply. List information about how to contact the financial aid officer at each facility. Attach as many pages as necessary and refer to the attachments here).

_____ Statutory Benefits

(List address and telephone number of agencies where application can be made for disability payment, such as SSI, RSDI, VA. Explain MRT process.)

_____ Day Care

(List addresses and telephone numbers for child and adult day care available locally.)

_____ Vision/Dental Services

(Explain the benefits.)

_____ Support Service Payments

(Provide the client with an updated pamphlet describing support services. Tell the client whether or not he will qualify for continued support services if his case is closed due to earnings. Explain the limits and that verification is required.)

_____ Direct Deposit/EBT

(Explain these processes. List telephone numbers to call for problems.)

_____ Medical ID card

(List a contact telephone number for problems with Medical ID cards. Explain how to use one when the family is new to Medicaid and the reason Medicaid is received.)

_____ Fair Hearing Information

(Explain the purpose of a Pre-Hearing Conference and a Fair Hearing, when to request one and how one may be requested.)

_____ Legal Services

(List address and telephone number of available legal services groups. Explain the role such groups play in applying for SSI, in domestic violence situations, in Fair Hearing.)

_____ Home Visits

(Explain that home visits are required, and at which points in their receipt of assistance they will occur. When the client is employed, ask if he can be contacted at work.)

_____ Housing Assistance

(List the address and telephone number to apply for subsidized housing. Include verbal explanation of how to apply.)

_____ Health Department

(List the address and telephone number of local health services. Discuss vaccinations/immunizations and when to contact a medical professional.)

_____ Mental Health Services

(List the address and telephone number of agencies which provide counseling, substance abuse assistance, parenting skills, etc. Discuss appropriate times to contact these agencies.)

_____ WIC

(List the address and telephone number of the closest WIC location. Discuss the benefits of the Program.)

_____ Family Planning

(List the address and telephone number of agencies/organizations which provide information about family planning and/or supply birth control devices.)

_____ Domestic Violence

(List addresses and telephone numbers to obtain information about available services for victims of domestic violence. Discuss: this is offered to everyone even those who have no history of DV {especially important when both parents are present}, confidentiality of information, safety is the first concern, etc.)

_____ Earned Income Tax Credit (EITC)

(Explain that those who file an income tax return may qualify for EITC and how to apply for it. Provide a pamphlet with the information when they are available.)

_____ Transitional Benefit Options

Discuss the two transitional benefit options available to a former WV WORKS participant when the WV WORKS benefit is closed due to employment.

_____ Sexual Harassment

(Worker must provide the attached sexual harassment handout, Attachment A, and briefly discuss with applicant)

_____ Accommodations for Disabilities

If the client indicates or there is available documentation that he has a mental, physical or learning disability, the Worker must discuss with the client that special accommodations will be made in order for him to participate in the WV WORKS Program.

WHAT DOES “SEXUAL HARASSMENT” MEAN?

“Sexual harassment” means that someone is bothering you or doing unwanted or unwelcome things of a sexual or gender-related nature. For example, someone who makes unwelcome sexual or gender-related remarks and gestures by:

- Touching you inappropriately
- Making offensive jokes or remarks about women or men
- Making sexual requests or suggestions
- Staring at or making unwelcome comments about your body
- Displaying sexually offensive pictures
- Being verbally abusive to you because of your gender

WHAT CAN YOU DO IF YOU ARE “SEXUALLY HARASSED”?

- Contact your WV WORKS Worker or Supervisor if you are in a WV WORKS employment or training activity.
- Contact the nearest Equal Employment Opportunity Commission (EEOC) representative or call the EEOC office at (800) 669-4000.

WV WORKS List of Local Services – Attachment A

APPENDIX E: WORKER RESPONSIBILITIES

1. Complete NVRA training prior to their first assignment to work with clients. They shall complete NVRA refresher training every six months.

2. Provide a voter registration application (R-28-05) and a declination form at any point a client engages in an application, recertification, or reports a change of address.

3. Provide the red “What happens next card” when a client indicates that they would like to complete a voter registration application. This card informs the client how to fill out the application and how long it will take for their voter registration to be completed. The card also tells the client what to do if they do not receive notification of their registration. The Worker must advise the client that this is an application for voter registration, not a voter registration card.

4. Ensure that no action stated or implied can be interpreted to mean that the client’s decision to complete the voter registration application or declination form could affect the availability of benefits or services.

5. Provide the same quality of assistance to complete the voter registration application as with any other agency form or service while ensuring that no political party preference is conveyed to the customer.

6. Accept completed voter registration applications, declination forms and any uncompleted forms that the client does not use. The Worker shall review all completed forms to ensure all required fields are completed prior to submitting them to the County NVRA Coordinator. The Worker shall assist the customer to complete any incomplete forms when requested by the customer.

7. Complete appropriate eligibility system screen/s to indicate if a client accepted or declined voter registration services.

8. Provide a maximum of four mail-in voter registration application forms for use by other household adults, when requested by the customer. When the client requests more than four applications, the Worker shall make available the contact information to the Secretary of State’s Office. They may contact the elections division staff at (304) 558-6000 or 1-866-767-8683 or by e-mail at http://www.wvsos.com.ext

APPENDIX F: COUNTY COORDINATOR RESPONSIBILITIES

1. Coordinate voter registration services within the local office and the Agency State Coordinator.

2. Ensure that all Workers comply with the registration process.

3. Train designated alternates to assume coordinators duties in the absence of the coordinator.

4. Maintain an office log of registration procedures, supply locations, ordering procedures, contact people and phone numbers.

5. Maintain and secure an office voter registration “date” hand stamp.

6. Ensure that each application is “date” stamped the day it is received in their office.

7. Retain declination forms for 22 months.

8. Completed NVRA applications must be submitted to the Secretary of State’s Office every Friday. The applications must be submitted the next working day when the office is closed on Friday.

9. Maintain a log of all NVRA training completed by Workers. Coordinating with Supervisors and training staff as appropriate to ensure that Workers continue to receive NVRA refresher training every six months. Training may be completed by reviewing the Voter Registration Application Guide located on the Secretary of State’s website at: http://www.sos.wv.gov

10. Maintain confidentiality of applicants.

APPENDIX G: BCF STATE COORDINATOR RESPONSIBILITIES

1. Appoint a current employee as county coordinator of voter registration services for each office or program delivery center.

2. Administer voter registration services in all programs within his or her jurisdiction.

3. Coordinate voter registration services with the Secretary of State.

4. Monitor the county coordinators of his/her delivery programs and reporting assignments.

5. Ensure all coordinators and employees have reviewed all training material and receive periodic updates.

6. Review complaints concerning voter registration activities filed against employees.

7. Notify the Secretary of State within five days of any change of county coordinators.

8. Post all required notices as provided by the Secretary of State.