WEST VIRGINIA Department of Health & Human Resources

West Virginia Department of Health and Human Resources
Rights and Responsibilities

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

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

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

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, *USDA Program Discrimination Complaint Form* which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

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

This institution is an equal opportunity provider.

Read each statement carefully and answer Yes or no to each statement.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Yes	No		
☐	☐	1	**I understand** that SNAP benefits are to be used by or on behalf of my assistance group and me to purchase food or seeds. I cannot sell my SNAP benefits or use someone else's benefits for myself. The SNAP benefits will not be used for any other purpose. **I understand** that I may not use my EBT SNAP benefits to purchase food on credit. This means I cannot pay for food already purchased or food to be received in the future. **I understand** that I cannot do, or attempt to do the following either in public, in private, or online: buy, sell, trade, steal or otherwise use SNAP benefits for monetary gain or other considerations; purchase food in containers with deposits and discard the product to receive cash refund deposits; and purchase or sell food originally purchased with SNAP benefits for monetary gain or other considerations. *These actions are considered SNAP trafficking.*
Yes ☐	No ☐	2	**I understand** if any member of my assistance group is found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation including trafficking, the individual will not receive SNAP benefits as follows: **First Offense** - one year; **Second Offense** - two years; **Third Offense** - permanently. In addition, I understand my assistance group will have to repay any benefits received for which it was not eligible.

Yes ☐	No ☐	3	**I understand** if I or any individual: A. is found guilty in a federal, state or local court of trading SNAP benefits for firearms, ammunition, explosives or controlled substances; is a convicted felon for possession, use, or distribution of a controlled substance(s); or is found guilty of trafficking $500 or more in SNAP benefits, the guilty party will be **permanently disqualified from participating in the SNAP Program**. B. makes a false statement or misrepresentation of identity and/or residence to receive duplicate benefits at the same time, the responsible party will be **disqualified from the SNAP Program for 10 years.** C. is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, the guilty party will not be eligible for benefits for two (2) years for the first offense and permanently for the second
Yes ☐	No ☐	4	**I understand** that my SNAP benefits will be deposited in an Electronic Benefits Transfer (EBT) account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced. **I understand** that if I do not use the entire SNAP benefits deposited in an EBT account for any given month, for a period of 274 days from the date of issuance, then that benefit only will be removed from my account. I may voluntarily request that benefits in my account be used to repay claims established against my SNAP account at any time. **I understand** SNAP benefits in an EBT account will be removed immediately when it has been determined and verified that all certified members of the household are deceased.
Yes ☐	No ☐	5	**I understand** that if I fail to report or verify any household expense(s) that may entitle my household to an income deduction, I will not receive that deduction. This means I may not receive the full amount of SNAP benefits for which my household may be eligible. **I understand** that once I report and verify the expense(s) as required I have the right to receive any calculated deduction beginning the following month.
Yes ☐	No ☐	6	**I understand** that as an Able-Bodied Adult Without Dependents (ABAWD) from the age of 18 until the month I turn 50 who does not live with a child under 18, I may receive SNAP benefits for not more than 3 months out of each 36-month period, if otherwise eligible, if I do not work at least 20 hours a week (averaged monthly), or do not participate in a work program for at least 20 hours per week. If I lose eligibility because of this issuance limit, I can become eligible again after I work or participate in a work program for at least 80 hours in a 30-day period. **I understand** this issuance-limited policy does apply in all counties in West Virginia.
Yes ☐	No ☐	7	**I understand** that **if** I receive SNAP benefits I have to report when my total household income exceeds the SNAP gross income limit. **I also understand** that I will be notified what this amount is and that I must report this to DHHR by the 10th of the month after the increase happens. **I also understand** that if my household lives in an issuance-limited county and contains an ABAWD, I must report when that person's work hours are reduced to less than 20 hours a week, averaged monthly. I further understand that I must report when any individual within my household wins an amount of money greater than or equal to the SNAP maximum allowable asset limit for assistance groups containing an older or disabled member through a single bet, game of chance, or lottery.

Yes ☐	No ☐	8	**I understand** that unless I am exempt, I must comply with work requirements: registering with WorkForce West Virginia, providing information about employment status, job availability, and training programs.
Yes ☐	No ☐	9	**I understand** that if I refuse or quit employment or reduce my work hours to below 30 hours per week without good cause I may be penalized.
Yes ☐	No ☐	10	**I understand** that I am authorized to receive information and referral services about TANF-funded programs as well as other programs offered by the WV Department of Health and Human Resources (DHHR) and other organizations in West Virginia. **I understand** that this information will be included in every SNAP notification letter sent to me.

HEALTH COVERAGE PROGRAMS

HEALTH COVERAGE PROGRAMS

Federal law prohibits discrimination on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. A complaint of discrimination may be filed by visiting www.hhs.gov/ocr/office/file or by writing HHS Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, DC 20201, or call 202-619-0403 (voice) or 202-619-3257 (TDD). HHS is an equal opportunity provider and employer.

Yes ☐	No ☐	11	**I understand** that as a recipient of Medicaid, I may volunteer for DHHR's Bureau for Child Support Enforcement (BCSE) services, including obtaining medical support. These services are provided by BCSE at no charge to me.
Yes ☐	No ☐	12	**I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).
Yes ☐	No ☐	13	**I understand** that if my income is above the Medicaid limits, I may be eligible to receive a medical card if I have excess medical bills. **I further understand** that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife, or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.
Yes ☐	No ☐	14	**I understand** that a period of ineligibility for Medicaid long-term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse. This includes transfers into certain trusts.
Yes ☐	No ☐	15	**I understand** that I am required to disclose to the State any interest my spouse or I have in an annuity. **I understand** the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long-term care services.
Yes ☐	No ☐	16	**I understand** that federal and West Virginia law mandates the recovery of Medicaid payments made after June 9, 1995, for nursing care or home and community-based waiver services and related hospital and prescription drug services on behalf of individuals age 55 or older at the time the payment is made. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for an intellectual or developmental disability or other medical institutions when an individual is determined permanently institutionalized. The State will not impose a lien or will defer recovery from the estate when:

			• The individual qualifies for Medicaid under the adult expansion provisions of the Affordable Care Act; or • The individual has a surviving spouse living in the home; or • The individual has a surviving child who is under age 21 living in the home; or • The individual has a child living in the home who meets the Social Security Act's definition of blindness or permanent and total disability; or, • The individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution. The amount of the recovery is the amount Medicaid pays for these medical services for the individual. After a proof of claim is filed against the estate, heirs affected by Estate Recovery may file a hardship waiver. Estate Recovery is not an eligibility requirement to receive Medicaid or payment for the services.
Yes ☐	No ☐	17	**I understand** if I am in a nursing home, I must notify the local DHHR office within **10 days** if: A. I am discharged from a nursing or intermediate care facility to go to another facility or return home. B. There are changes in my gross unearned or earned income or the income of my spouse and any dependent children who live with my spouse. C. There are changes in my assets or those of my spouse, including receiving, selling, purchasing or giving away assets. **I understand** that failure to provide this information may result in a penalty or case closure.
Yes ☐	No ☐	18	**I understand** that certain adult Medicaid recipients (identified on this application as having a chronic substance use disorder; serious and complex medical condition; or a physical, behavioral, intellectual, or developmental disorder for which assistance is needed) will have the option to choose the benefit that best fits their health needs. West Virginia Medicaid will provide additional information about selecting a benefit package with their eligibility notice by calling 1-877-716-1212.
Yes ☐	No ☐	19	**I understand** it is an eligibility requirement that I must cooperate with DHHR and with any provider of medical services in pursuing any resource available to meet the medical expenses of any Medicaid recipient. **I agree** to assign to the DHHR benefits available to any Medicaid recipient from any third-party source as a result of injury, accident, or illness. **I understand** that the amount payable to DHHR will never exceed the amount of the Medicaid liability. **I authorize payment** of any such third-party resources directly to DHHR. If the liable third-party makes payment directly to me, I agree to refund to DHHR an amount up to, but not exceeding, the amount of Medicaid liability. **I understand** that this repayment must be made even if my eligibility for Medicaid has stopped prior to my receiving such monies. **I further authorize** the release of any medical information or any information regarding medical insurance to DHHR and also authorize the release of any medical insurance information to medical provider(s) for billing purposes and the release of medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

Yes ☐	No ☐	20	I understand I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
Yes ☐	No ☐	21	I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed) or I confirm that _____ (name of person) Is incarcerated.
Yes ☐	No ☐	22	**I understand** to make it easier to determine my eligibility for help paying for health coverage in future years, **I agree** to allow the local DHHR office to use income data, including information from tax returns. The local office will send me a notice, let me make any changes, and I can opt out at any time. **Yes, renew my eligibility automatically for the next:** ☐ 5 years (the maximum number of years allowed), or for a shorter number of years: ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.
Yes ☐	No ☐	23	I **understand** by accepting Medicaid under any category, I agree to give back to the State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the DHHR office if I or anyone listed on this application is involved in any accident. I understand that this assignment of funds continues as long as I or anyone listed on this application received Medicaid.

WV WORKS

Yes ☐	No ☐	24	**I understand** that if I am included in the WV WORKS payment, I have a lifetime limit of 60 months to get cash assistance, whether I live in West Virginia or any other states/territories in the United States. **I further understand** that any TANF benefits that I have received from other states/territories will be counted toward the 60-month lifetime limit. **I understand** that I may obtain the number of months remaining in my lifetime limit from my Worker.
Yes ☐	No ☐	25	**I understand** that if I am a recipient or non-recipient Work-Eligible parent or stepparent, I must sign a Personal Responsibility Contract (PRC), Self-Sufficiency Plan (SSP) and will be required to participate in a work activity beginning with the first month of WV WORKS benefits as a condition of eligibility. Failure to sign the PRC or SSP will result in ineligibility for WV WORKS for my family.
Yes ☐	No ☐	26	**I understand** that if I have a learning disability, or a physical or mental condition, I may have legal rights under the Americans with Disabilities Act (ADA). If the ADA applies to me and I am unable to perform the action requested by DHHR, A. DHHR can help me do it, or DHHR can change what I have to do; B. DHHR can call or visit if I am not able to come to the DHHR office; or C. DHHR can tell me what DHHR forms and letters mean.
Yes ☐	No ☐	27	**I understand** that if a child is moving out of my home for at least 30 days, I must report this change within 5 days of my knowing that the child will no longer be living with me or I am permanently removed from the WV WORKS benefit.

Yes ☐	No ☐	28	**I understand** that parents who receive WV WORKS and who work or attend school are usually eligible for child care with no fee. A parent who loses WV WORKS due to earnings may also be eligible for 12 months of additional child care by paying a fee for the services. For more information on how to complete the required application, I may be referred to a child care agency.
Yes ☐	No ☐	29	**I understand** that unless I choose direct deposit into a bank account, my WV WORKS benefit will be deposited into an EBT account and cannot be replaced under any circumstances. If I choose an authorized cardholder who has access to my EBT account, benefits used by the authorized cardholder also cannot be replaced. **I understand** that if I do not use the entire cash benefits deposited in an EBT account for any given month, for a period of 365 days from the date of issuance, then that benefit only will be removed from my account. I may voluntarily request that benefits in my account be used to repay claims established against my cash assistance at any time. **I understand** that I must not use or access my EBT, WV WORKS or TANF funds in adult entertainment establishments, casinos, gaming establishments, or liquor stores.
Yes ☐	No ☐	30	**I understand** that as a WV WORKS participant, I may be eligible for support service payments to assist me in completing my work activities. **I also understand** that if these payments are not used for their intended purpose, I will be responsible for reimbursing DHHR.

EMERGENCY ASSISTANCE (EA)

Yes ☐	No ☐	31	**I understand** that if approved for Emergency Assistance benefits, I will not be eligible to receive Emergency Assistance within 12 months after the beginning date of my 30-day period of eligibility unless I qualify for Emergency Assistance created by natural or man-made disasters.
Yes ☐	No ☐	32	**I agree** to cooperate fully with instructions received from my Worker regarding my request for or receipt of Emergency Assistance benefits and I am fully aware that my failure to cooperate with or failure to otherwise carry out the instructions may cause the denial of or loss of Emergency Assistance benefits. **I further agree** to cooperate by accepting a referral to community resources in order to eliminate or prevent an emergency.

LOW-INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

Yes ☐	No ☐	33	**I understand** that if I knowingly provide false or fraudulent information that is used in connection with the eligibility determination for LIEAP benefits I may be subject, upon conviction, to fines or imprisonment or both.
Yes ☐	No ☐	34	**I understand** that I will be notified, in writing, within 30 days from the date of application regarding the decision made on my application and that I may request a hearing if I have not been notified within 30 days. If I receive a direct payment, **I understand** the payment must be used to pay for the cost of primary home heating and that a receipt which verifies my payment for the cost of primary home heating must be submitted with my application for Emergency LIEAP. **I understand** that if I am found eligible, I am entitled to only one regular LIEAP payment and one Emergency LIEAP payment during the LIEAP Program year. I **understand** intake for Regular or Emergency LIEAP will close without notice.

FOR ALL PROGRAMS

Yes ☐	No ☐	35	**I understand** that any information given is subject to verification by an authorized representative of DHHR.
Yes ☐	No ☐	36	**I understand** that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or SNAP Programs, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who apply for and/or receive benefits and not for any other person.
Yes ☐	No ☐	37	**I understand** for all programs that all persons included in the benefit must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits received. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts. **SNAP only:** This information may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.
Yes ☐	No ☐	38	**I hereby consent** to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.
Yes ☐	No ☐	39	**I understand** that DHHR may obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Homeland Security, a consumer reporting agency, the Division of Motor Vehicles, Veteran's Administration, Workers' Compensation carriers, Bureau of Employment Programs, DHHR's Bureau for Child Support Enforcement, DHHR's Bureau for Public Health – Division of Vital Statistics and Office of Maternal, Child and Family Health, DHHR's Office of Inspector General, DHHR's Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service about each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.
Yes ☐	No ☐	40	**I understand** it is an eligibility requirement to cooperate with the Quality Control Reviewer in any review of my benefits. This may require a home visit by the Reviewer and include additional verification of my situation, but I also understand that I am not required to permit the Quality Control Reviewer to enter my home. **For WV WORKS Benefit Only:** this requirement does not apply. Other benefits received in addition to WV WORKS may be reviewed and I must cooperate with the Quality Control Reviewer on these.
Yes ☐	No ☐	41	**I understand** that I may receive information and a referral to receive Family Planning Services upon request.
Yes ☐	No ☐	42	**I understand** that I may receive information and a referral for Domestic Violence services upon request.
Yes ☐	No ☐	43	**I agree** to notify DHHR of the following changes within **10 days** if: A. We move and/or change our address, name, or telephone number; B. There are changes in my shelter costs because I have moved; C. Anyone obtains/loses employment; D. There are changes in my household's amount or source of unearned income; E. There are changes in my household's amount or source of earned income or number of hours worked;

			F. Anyone moves into/out of my household; G. Any individual in my home starts, finishes or drops out of school or job training; H. There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment; or I. Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits, and I may be expected to live on this income for a specific period of time. **For SNAP Benefits Only: these requirements do not apply. My reporting requirements were explained in the SNAP program section.** **I understand** that failure to provide this information may result in a penalty or sanction.
Yes ☐	No ☐	44	**I understand** if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation, I can ask for a Fair Hearing orally or in writing. **I understand** that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-3, at my local DHHR office.
Yes ☐	No ☐	45	**I understand** that appointments/meetings with my Worker may include scheduled/ unscheduled home visits, but **I also understand** that I am not required to permit the DHHR Worker to enter my home.
Yes ☐	No ☐	46	**I understand** that I may be qualified to apply for low-priced telephone services called America and Tel-Assistance/Lifeline that the telephone company in my area offers. **I give permission** to DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, **I understand** DHHR will notify the telephone company.
Yes ☐	No ☐	47	**I give my permission** to DHHR to refer my family to any agency for needed services.
Yes ☐	No ☐	48	**I give my permission** specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.
Yes ☐	No ☐	49	**I give my permission** to DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration, DHHR's Bureau for Child Support Enforcement, DHHR's Bureau for Medical Services, DHHR's Bureau for Public Health, Division of Rehabilitation Services, or any other state or federal department/agency/organization primarily for the purpose of providing me with access to the services and benefits offered by these departments/agencies/organizations in an efficient manner that allows for coordination rather that duplication of service(s).

Yes ☐	No ☐	50	**I understand** DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services or activities. This notice is available in large print, on audio tape, or in Braille from any DHHR office. This notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State DFA ADA Coordinator: Bureau for Family Assistance State BFA ADA Coordinator 350 Capitol Street, Room 730 Charleston, WV 25301 (304) 558-0628 Monday through Friday, 9:00 a.m. to 5:00 p.m
Yes ☐	No ☐	51	**I give my permission** for any of the following entities to release any information to DHHR when this information is related to my receipt of assistance, including LIEAP. **I understand** that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any financial institution; government agency or department; landlords, both private and public housing authorities; physicians, including psychiatrists, psychologist or other counselor; drug testing facilities; hospitals, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services or other person(s) with related information. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.
Yes ☐	No ☐	52	**I understand** that my assistance group may be required to repay any benefits paid to or on behalf of it for which I was not eligible because of unintentional errors made by me or by DHHR. **I also understand** that if I give incorrect or false information or if I fail to report changes that I am required to report, my assistance group may be required to repay any benefits I receive and I may also be prosecuted for fraud. Additionally, **I understand** that all adult members of my assistance group are equally and separately responsible for an overpayment of assistance. **I also understand** that any person who obtains or attempts to obtain benefits from DHHR by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device can be charged with fraud. Punishment upon a conviction may be a fine up to $10,000 and/or a jail sentence of 10 years in state correctional facility. **For the SNAP Program Only** - federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years. **For the LIEAP Program Only** - failure to repay such benefits may result in loss of future LIEAP benefits.
Yes ☐	No ☐	53	**I certify** that all statements on this form have been read by me or read to me and that I understand them. **I certify** that all the information I have given is true and correct and I accept these responsibilities.

X _____ _____

Signature of Applicant or Authorized Representative — Date

X _____ _____

Signature of Co-Applicant — Date

_____ _____

Signature of Interviewing Worker Who Witnessed Signature — Date

To Apply for SNAP Benefits:

X _____

Signature of Applicant or Authorized Representative

_____

Telephone Number

_____

Street Address

_____

City, State, Zip Code