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FAMILIES FIRST

POLICY

HANDBOOK

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INTRODUCTION

Families First is goal-oriented, time-limited assistance program for families with dependent children. The values of work and child support, as primary means of achieving and maintaining self-sufficiency, are the basis of the program. In addition to providing cash benefits, work and child support, the Families First program promotes the values of education and healthy children through the requirements of school attendance, immunizations and health checks. Each applicant and recipient of Families First is expected to make a commitment through a Personal Responsibility Plan that will become the blueprint for accomplishing the goals of self-sufficiency and family stability. The plan for the family is individualized, recognizing that all individuals do not start at the same place and do not achieve their goals on the same schedule.

The Department of Human Services is committed to providing the assistance families may need to meet their goals. The Department will determine eligibility for Families First and will provide case management services throughout the development and the accomplishment of each individual's goals. Assistance will be provided to all family members who sign a Personal Responsibility Plan in preparation for or continuation of work. Placement in activities such as Fresh Start, ABE, Job Search, Job Development, Work Experience, Training and Education will enhance their chances for success and self-sufficiency. The Department will provide other support as needed, such as child care, transportation, dental and optical services. Individuals who need help with drug, alcohol, mental health problems, or vocational rehabilitation services will be referred to agencies that can provide that assistance. Minor parents will be required to stay in school or return to school or alternate training activities and will be given other opportunities to improve their future through Fresh Start, work experience, etc. Each family, regardless of their composition or their personal circumstances, will receive the support they need to develop and follow a plan to meet their goals for an improved family life.

AUTHORITY FOR FAMILIES FIRST:

The Tennessee Department of Human Services is granted authority to implement Families First as a demonstration project under section 1115 of the Social Security Act. Tennessee enabling legislation to support Families First is known as "Families First Act of 1996", passed by the Tennessee General Assembly April 25, 1996 and approved by Governor Don Sundquist on May 13, 1996. Except as set forth in the waiver terms and conditions, the Families First program will operate under the AFDC provisions in Part IV A of the Social Security Act.

Families First is a statewide demonstration program that will be conducted in all 95 counties. There will be a random assignment of control cases in Davidson and Madison counties that will continue to operate under the State's approved AFDC plan for the duration of the demonstration.

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POLICY CHAPTER DIGEST
(Comparison between Families First and AFDC)

DEFINITIONS:

- Families First contains all definitions in a single chapter.
- AFDC contains the definitions in the section most commonly associated with the definitions.

ASSISTANCE GROUP:

- The Families First Handbook contains the same information and additional chapters have been added following the assistance group chapter that addresses the added eligibility provisions of Family Cap and Marriage During the Receipt of Assistance.
- The Family Assistance Manual has a section that specifies the policies for inclusion, exclusion, or options for AFDC grouping.

ENUMERATION:

- The Families First Handbook has one change. If a Families First individual fails OR refuses to comply with the enumeration requirement, the individual's needs are left out of the assistance group.
- In AFDC, the AG that has refuses to cooperate with the enumeration requirement is ineligible.

RESIDENCE:

- Families First and AFDC have the same provisions.

CITIZENSHIP AND ALIEN STATUS:

- Families First and AFDC have the same provisions.

AGE REQUIREMENT:

- Families First and AFDC have the same provisions.
- Age is addressed in the Age and School Attendance section of the Family Assistance Manual, but is a separate chapter in the Families First Handbook.

RELATIONSHIP:

- Families First and AFDC have the same provisions.

LIVING IN THE HOME WITH A RELATIVE:

- Families First and AFDC have the same provisions.

DEPRIVATION:

- Families First and AFDC have the same provisions.

STRIKERS:

- Families First and AFDC have the same provisions.

PERSONAL RESPONSIBILITY PLAN:

- This is a new requirement with Families First which identifies that all AG's must have a PRP.
- AFDC does not have a PRP requirement.

IMMUNIZATIONS AND HEALTH CHECKS:

- This is a new requirement with Families First which requires all children to have immunizations and health checks unless good cause for not doing so is established by the AG.
- AFDC does not have this requirement.

SCHOOL ATTENDANCE:

- Families First has incorporated the school attendance requirements for all children and minor parents in the AG. Families First has added new penalties for failure to attend school without good cause. School attendance is a work requirement for minor parents.
- AFDC does not have school attendance requirements. The section of the Family Assistance Manual that addressed school attendance also addresses age.

CHILD SUPPORT COOPERATION:

- Families First has a separate chapter for Child Support Cooperation. The policy for failure to cooperate with child support is different in that the entire AG is ineligible until compliance with child support requirements are met.
- Child Support is addressed in the Deprivation Section of the Family Assistance Manual.

WORK REQUIREMENT

- Families First addresses work in chapters entitled Work Requirement, Work Components, Renegotiating Work Components, Work Experience, Participation Expectations, Support Services, and Plan Follow-up Responsibilities. The policy chapters give guidance to the development, monitoring, and support of the work component of the PRP. The policy chapters are meant to be used in tandem with the Case Management, Community Resources, and Supervising Case Management materials.
- AFDC's work program, JOBSWORK, is addressed in the work (WIN) section of the Family Assistance Manual and the JOBSWORK Handbook.

RESOURCES:

- Families First resource policy has been changed to address the maximum amount of resources allowable for an AG and the change in calculating the value of vehicles. Two additional chapters have been added to address two exceptions to resource policy; the Low Income Entrepreneurial Escrow Accounts which is statewide policy, and the Individual Development Account Demonstration Project which will be applicable in 12 counties. Both permit accounts with values up to $5000 that is not considered against the $2000 resource limit. The equity value test for a vehicle is $4600.
- The AFDC resource section does not have the increased resource limit, vehicle value, or the Entrepreneurial or IDA accounts. The equity value test of a vehicle is $1500.

INCOME:

- Families First and AFDC have the same provisions when determining countable and non-countable income.

TREATMENT OF INCOME:

- Families First policy removes the $30 plus 1/3 earned income disregard and substitutes a $150 disregard. Otherwise treatment of income is the same as AFDC.
- AFDC policy continues to have a $30 plus 1/3 earned income disregard.

PERIODS OF ELIGIBILITY:

- The Families First Handbook has two chapters that address periods of eligibility - Time Limits and Re-Entry After a Period of Eligibility. Both address the change in Families First that ends eligibility because benefits have been received for a specified period of time and the rules for continuing or re-entering after those time limits are met.
- AFDC does not have a time limit or re-entry provision.

CHILD CARE:

- Families First has a separate chapter that addresses child care for the eligible AG and the AG that is closed and is eligible for transitional benefits. Transitional benefits are available for 18 months to all AG's that close for any reason other than failure to cooperate with Child Support. Payment is made only when the caretaker is employed and has income that is below 60% of the state median income.
- AFDC continues to have a Transitional Child Care provision that is limited to 12 months and is provided only when the caretaker is employed and has received assistance for 3 out of the last 6 months. Payment is made only when the caretaker is employed and has income that is below 60% of the state median income.

MEDICAID COVERAGE:

- The Families First Handbook describes the Medicaid coverage that must be made available to assistance groups that apply for Families First and are denied or that receive Families First and are closed. Eligibility for Medicaid is provided to all families that are closed because of a sanction or time limits or that are denied because of child support under the same rules that apply to AFDC. If not eligible under AFDC rules, recipient families will receive 18 months of Transitional Medicaid. Applicant families will have eligibility determined in other Medicaid categories.
- AFDC applications and closures are automatically tested for any other potential Medicaid category. AFDC closures that are closed due to employment or child support are tested for Transitional or Extended Medicaid. Transitional Medicaid is for 12 months; Extended Medicaid is for 4 months.

SANCTIONS:

- Families First addresses sanctions for work, child support, or other PRP requirements in a single chapter. Voluntary quit of a job, without good cause, is also a reason for sanction in Families First. The sanctions for work and child support are total family ineligibility. Unmarried minor parents who fail to attend school or an alternate activity are sanctioned by having their needs removed from the AG. A grant reduction is mandated for failure to comply with school attendance or immunizations/health checks.
- AFDC does not have these sanctions. Mandatory JOBSWORK individuals who fail to comply are sanctioned by having their needs removed from the grant.

DEPARTMENT OF HEALTH VISITS:

- Families First requires a visit by a DOH professional when an application is denied for voluntary quit provisions or when the AG is closed due to sanctions or time limits.
- This is not a requirement in AFDC.

GENERAL ADMINISTRATIVE PROCEDURES:

- Families First Handbook has been updated to include ACCENT procedures for case file maintenance.

RIGHT TO APPLY FOR FAMILIES FIRST:

- Families First and AFDC applicants have the same rights.

RIGHTS AND RESPONSIBILITIES:

- Families First and AFDC applicants and recipients have the same rights and responsibilities.

APPEALS AND FAIR HEARINGS:

- Families First and AFDC applicants and recipients have the same rights to appeal and will have the same procedures for a fair hearing.

APPLICATION PROCESS:

- Families First and AFDC applicants will have the same process for filing an application. The Families First Handbook has been updated to reflect the changes brought about by ACCENT.

TIMELINESS STANDARDS:

- Families First and AFDC applicants both have a 45 day timeliness standard.

INTERVIEWING FOR ELIGIBILITY:

- Families First interviewing process has an added component, the development of the PRP. Otherwise Families First and AFDC have the same process.

VERIFICATION PROCEDURES:

- Families First requires added verifications for immunizations/health checks, school attendance, and good cause that is addressed throughout the Families First provisions. Families First also places the responsibility of verification with the applicant/recipient unless it is available to the Department through automated data interfaces or unless it is more reasonable for the Department to secure the information.

AUTHORIZATION OF GRANTS:

- The Families First Handbook has been updated to include the ACCENT procedures, but the process is the same for Families First and AFDC.

CONTINUING RESPONSIBILITIES:

- Families First and AFDC have the same provisions. The Families First chapter has been updated to reflect the requirement for a six month face-to-face review and has removed references to a declaration review.

OVERPAYMENTS AND UNDERPAYMENTS:

- Families First policy removes the improper payment error provision for changes reported on or after 9-1-96. Families First overpayments as of 9-1-96 will be calculated using the same provisions as Food Stamps, i.e. the 10-10-10 policy. A change that is reported will not be effective until the first month possible after the change and the NOAA (if one required).
- AFDC continues to have the improper payment error provision and the same calculation provisions.

PROTECTION OF CHILDREN:

- Families First and AFDC have the same provisions.

FAMILIES FIRST-DEFINITIONS

The following definitions are applicable to the Families First program:

Absence	Refers to an individual who is physically not in the home.
Acceptable Placement	Placement in employment after completion of a course.
Administrative (Agency) Error	An overpayment or underpayment caused by an error made by any representative of the Department of Human Services. Examples of administrative errors include, but are not limited to, the following: • failure to take timely action on a change reported by the AU or known to this department; • incorrect computation of the AU's income or deductions, or authorization of an incorrect grant amount; or • incorrect application of policy.
Adoptive Parent	The mother and/or father of a child whose relationship to the child has been formally established in a court of competent jurisdiction.
Adult Basic Education	Adult Basic Education is a work component which provides literacy, basic skills and GED education and training.
AFDC-UP	AFDC payments made for families in which the basis for deprivation is the unemployment of the Principal Wage Earner parent.
Alleged Father	The natural father of a child born out of wedlock for whom paternity has not been established.
Approved Day Homes	Day Homes which are operated under the aegis of a licensed Day Care center.
Assessment	It is the process of determining how prepared or ready the participant is to enter the workforce and to achieve self-

	sufficiency based on educational levels/training and work history.
Assistance	The cash benefits paid to an eligible Families First group.
Assistance Group	A group of individuals for whom Families First is requested or authorized. An assistance group may be referenced as AG.
Bona Fide Job Offer	A job, paying at least the minimum wage and for at least 35 hours per week, which is offered by a private employer, DES, JTPA, or other work/training programs under contract to or in agreement with DHS.
Care	Refers to the provisions of protection, attention, personal services, and maintenance.
Caretaker	A relative within a specific degree of relationship to the child who: – provides a home for the child; **and** – exercises primary responsibility for care/control, **and** – is included in the assistance group (AG).
Case Management	The activities associated with empowering and managing the eligibility of families through the Families First Personal Responsibility Planning and plan implementation process.
Child Care Services	Child care Services are provided when necessary for the participant to take part in work or training activities while the family is still receiving case assistance.
Child or Children	A person or persons under 18 years of age or a person(s) who has not reached 19 years of age and who is a full-time student and is expected to graduate by the 19th birthday.
Component	A component is an activity designed to help a participant meet his/her Personal Responsibility Plan employment goals.
Community Service Programs	Work component activities such as Americorps and VISTA which meet Families First rules.

Custody	Immediate charge and control exercised by a person (or an authority) over another. Legal custody is granted by a court of competent jurisdiction.
Debilitate	To impair the strength of, enfeeble; weaken.
Demand Occupation	An occupation for which there are employers in the local community or area with vacant positions for this job; or employers are willing to establish positions for this occupation if trained individuals are available for work.
Department	The Department of Human Services
Dependent Child	A child age 17 or younger who is deprived of parental support or care because of the unemployment of the primary wage earner if both parents are in the home or because one or both parents are absent from the home , deceased, **or** physically/mentally incapacitated; **or** A person age 18 who is deprived of parental support or care **and** **- is** a full-time student in a secondary school or an equivalent level of vocational or technical school, **and** - is reasonably expected to complete the course of education/training before age 19 or in the month of the 19th birthday.
Diagnosis	The art or act of identifying a disease from its signs and symptoms.
Disability	A physical or mental condition that is permanent and renders the individual unable to perform work. A caretaker deemed disabled will exempt the assistance group from time limits.
EITC	The federal Earned Income Tax credit available to low-income families, a portion of which is available as a monthly advance from the employer when the worker completes IRS Form 5. It is also available as a lump sum at the end of the tax year.
Earnings of Not Less Than $50 per Quarter	Wages, salaries or commissions paid to an individual or self-employment income.

Family	A family is an eligible group of children and parent(s) or caretaker relatives residing in a common residence.
Family Cap	A ceiling on assistance group grant payments for a period of eligibility that occurs when a child is born to assistance group 10 months or greater from the initial payment.
Fresh Start	A work component which provides life skills and intensive job readiness training. It is usually the first work activity entered.
Grantee Relative	A person who receives Families First for children in his/her care. This may be a relative other than a parent. A relative other than a parent may be included/excluded from the assistance group depending on case circumstances.
Guardian	An individual named by a court of competent jurisdiction (usually the County Court) to manage the affairs of an adult who has been adjudicated mentally or physically incapacitated; or one who has been named to manage the affairs and/or person of a minor.
Half-Siblings	Half-brother/sisters who share one natural or adoptive parent.
Handicap	A disadvantage that makes achievement unusually difficult; especially an incapacity.
Home	A home is considered to be a family setting maintained (or in the process of being established) by the relative who requests Families First for a child living with her/him. Under this definition, the family setting may vary from a homeless shelter to another temporary arrangement. A home exists as long as the relative exercises care and control of the child, even though either the child or the relative is temporarily absent from the customary family setting.
Illness	An unhealthy condition of the body or mind; sickness.
Impairment	To make worse by diminishing in some material aspect. Synonyms include: injury, weakening, incapacitation, deterioration, crippling, maiming.

Improper Payment Error (IPE)	Examples of improper payment errors include but are not limited to the following: ● the assistance unit was overpaid because the recipient or legally responsible relative was on strike as of the last day of the month; ● the assistance unit received sufficient income (earned and/or unearned) in the payment month to result in ● ineligibility; or the assistance unit received a lump sum payment which resulted in a period of ineligibility being established.
Inadvertent Client Error (ICE)	A misunderstanding or unintentional failure on behalf of the A/R to provide correct information or to report changes timely and accurately.
Incapacity	Is deemed to exist when one parent has a physical or mental defect, illness, or impairment. The incapacity shall be supported by competent medical testimony and must be of such a debilitating nature as to reduce substantially, or eliminate the parent's ability to support or care for the otherwise eligible child and be expected to last for a period of at least 30 days. Incapacity may be a reason for deprivation or may be a reason for a temporary exemption from a work requirement and time limits.
Inmate	An inmate is a person living in an institution who is not free to leave on his own volition or who has been committed to the institution; especially a person is confined (as to a prison or a hospital).
Intentional Program Violation (IPV)	A determination or adjudication by a court that an individual or group of individuals knowingly obtained benefits to which they were not entitled.
Job Club	A work component activity in which the individual participates with other individuals in job readiness and work search activities.
Job Development	The act of contacting employers and obtaining job orders for specific vacancies and matching those to a participants skills and abilities.

Job Search	A work component activity in which the individual actively looks for a job by contacting employers, completing applications, and interviews.
Job Training	Training which is employer specific. This means an employer has expressed a need for individuals with a defined skill and a training program is available or can be designed to meet that need.
Joint Custody	Legal custody of a person held by two or more other persons. Usually joint custody is granted to parents of children when the parents are divorced.
Labor Market Connection	Six or more quarters of work within any 13 calendar quarter period ending within one year prior to the application month. Full-time elementary or secondary school attendance and/or training or JTPA participation may be substituted for a maximum of four of the six quarters of work in establishing a labor market connection; **or**-receipt of unemployment benefits within one year prior to application; **or**-if the person did not receive unemployment benefits, but would have received if he/she had made application for them.
Legal Father	The biological father of a child married to the child's mother; the mother's husband when a child is born during the marriage; the child's legally adoptive father; the natural father whose paternity of a child has been legally established.
Limitations	Obstacles which may interfere with the participant's participation or success in work, education, or training activities such as drug/alcohol, mental health domestic violence or other serious problems or conditions.
"Living With"	Occupying a place of residence maintained by (A Relative) a specified relative as his/her own home and the home of the child (for whom AFDC is requested).
Marriage During the Receipt of Assistance	A legal union between a caretaker and another Receipt of Assistance individual during a period of eligibility.
Minor	A person under 18 years of age. A minor is considered a

	dependent child if he/she is living with a specified relative and is otherwise eligible. A minor parent may apply for assistance for her/himself and her/his child as an independent assistance group if living outside of a parent's home or if living in the parent's home when the parent chooses not to apply for assistance or is ineligible for assistance.
Natural Parent	The birth mother; the biological father of child born in or out of wedlock.
Non-Collegiate Institution	A post-secondary institution which does not award degrees. State Technology Centers and private not-for profit trade schools meet this criteria.
Orientation	A clear explanation of Families First, the Personal Responsibility Plan requirements, work and training opportunities, child care, supportive services, penalties, and processes.
On-the-Job Training	On-the-job training (OJT) usually refers to training in which up to 50% of the wages are being subsidized by funds such as JTPA or other federal or state training programs. For Families First, this term may also be used to describe any training the participant receives through an unpaid Work Experience placement.
Parent	The biological or adoptive mother and/or father of a child when relationship has been properly established. This does not apply to alleged parents for whom relationship has not been established.
Payee	The person to whom an AFDC grant check is payable.
Post-Secondary Institution	An institution of higher education which awards degrees or certificates. State Technical Schools, Community Colleges, Technology Centers, four year institutions all meet this definition.
Principal Wage Earner (PWE)	Whichever parent had the greater amount of earnings in the 24 month period, including the month immediately preceding, the month of application. If both parents have the same amount of income, the case manager and the family will designate principal wage earner.

Prognosis	The prospect of recovery as anticipated from the usual course of disease or peculiarities of the case.
Protective Payee	The person other than the caretaker or grantee relative to whom an AFDC grant check is payable. A protective payee has responsibility for administering the benefits of the assistance group grant payment for the benefit of the assistance group.
Quarter of Work	Three consecutive calendar months ending 03/31, 06/30, 09/30 or 12/31 during which an individual: - earned not less than $50; **or** - participated in a JOBS program; **or** - attended an elementary or secondary school, or voc or technical course designed to prepare the person for gain- full employment on a full-time basis.
Registered Family Day Care Provider	A family home provider serving fewer than 5 children unrelated to the provider who chooses to meet child care standards and is regulated provider monitored by a local sponsoring organization under contract with the Department of Human Services. (Not available in every county).
Regulated Child Care	Child care provider in a facility which is subject to licensure by the Department of Human Services (or in some instances the Department of Education or a sponsoring organization for registered homes under contract with the Department of Human Services).
Relative Within a Specified Degree Relationship	Any blood relative, i.e., father, mother, brother, sister, uncle, aunt, first cousin, nephew, niece, of or first cousin or first cousin once removed. This includes relationships to preceding generations as follows: grandparents, great-grandparents, great-great grandparents, great uncles or aunts, and great-great-great grandparents. - Any of the above relatives who are of half-blood relationship. - Stepfather, stepmother, stepbrother, and stepsister. - Legally adoptive parents of the child or of the child's parents, the natural and other legally adopted children of such persons, and the blood relatives of such persons, including first cousin's, first cousins once removed, nephews and nieces; and - legal spouses of any of the persons named in the above

groups. This applies even though the marriage may have been terminated by death or divorce.

Set of Children	A set of children is one child, or two or more children who are whole brothers and/or sisters, half-brothers and/or sisters, or adoptive brothers and /or sisters.
SSI Beneficiary	A person who receives Supplemental Security Income benefits through the Social Security Administration.
Standards	At a training facility or post-secondary institution is at least 80% in the field for which the participant is trained.
State Accreditation	The Higher Education Commission is responsible for accrediting any post-secondary education or training institution which accepts state or federal financial aid.
Step-parent	A person who is not the natural or adoptive parent of the child, but who is married to the child's natural or adoptive parent.
Step-sibling	Stepbrothers/sisters share no natural or adoptive parent but their respective parents are married to each other.
Strike	Any strike or other concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees. The term "participating in a strike" means an actual refusal in concert with others to provide services to one's employers.
Support	Refers to the furnishing of a means of livelihood or sustenance.
Support Services	Transportation, optical, and dental services which are provided when necessary for participation in work or training activities.
TABE Test	The literacy test given to all participants without a high school diploma or GED. TABE stands for Test of Adult Basic Education.

Technically Eligible	Meets all non-financial Families First eligibility requirements.
Temporary Absence	Being away from the home for a short period of time (usually not to exceed three months) with specific intention of returning to the home on or about a specific date.
Transitional Child Care Services	Child care which begins at case closure and is available for up to 18 months for working families. The parent or caretaker relative must help contribute to the cost of care and meet certain income guidelines.
Unemployment Benefits Compensation Insurance	Collective terms denoting payment made when one is made unemployed through no fault of his own. State administered through Employment Security. Sometimes, UC or UIB.
Unemployed Parent	A principle wage earner (PWE) parent who: - is employed less than 100 hours per month; **or** - is employed 100 hours per month or more; **IF** the excess is of a temporary nature, the 100 hour rule was met in the two months prior to the current month, and is expected to be met the month following current month, **AND is** employed for reasons other than participation in a labor dispute.
Vocational Education Training	Training which is industry specific. This means employers in the community, county, or area has a need for individuals with a particular skill which can be met through this training.
Whole Siblings or Siblings	Brothers/sisters who share the same mother and father.
Work Experience	A work component which places the participant in a public or not-for-profit agency for the purpose of gaining work experience, developing good work habits, and eventually qualifying for a vacant position in that or a similar agency. This is un-paid work.

I. ASSISTANCE GROUP

POLICY STATEMENT:

An assistance group is a group of people applying for or receiving Families First benefits. An assistance group may be referred to as an AG.

General principles for assistance groups include the following:

- all AG members must be technically eligible;
- income and resources of AG members must be counted, unless exempt;
- if optional members are included, all of their income/resources are included; and
- children must be within the specified degree of relationship to the person requesting assistance.

Mandatory AG Members Include:

- the dependent child; and
- the technically eligible whole, half, or adopted siblings of the dependent child; and
- the technically eligible parent(s), including an incapacitated parent or an unemployed parent, living in the home with the dependent child;
- the technically eligible **alleged parent** in the home who meets incapacity or unemployed parent criteria. The blood relationship to the child must be established. An alleged parent cannot be included in the AG if the child has a legal father. When an alleged parent of one or more children lives in the home with the child's other parent and their child's technically eligible half sibling(s), all siblings and both parents must be included in a single AG.
- any eligible married or single minor who lives with or moves into the home with a Families First recipient caretaker parent who is receiving Families First for the minor's siblings cannot be a separate AG, but must be included in his/her parent's AG with her/his sibling(s).
  - A minor parent's child may be included or excluded from the major parent's AG depending on who is applying.
    - If the minor parent is applying for his/her child, the child must be included in the major parent's AG.

- If the major parent is applying for the minor parent, the minor parent's child is an optional AG member.

- If the minor parent moves into the home of the major parent and must be included in the AG with his/her siblings, the minor's child is optional.

NOTE: If the minor opts to exclude the child, the child cannot be eligible for a separate grant.

- the income of a parent who is not a Families First recipient but with whom the married/single minor parent resides is deemed to be available to the minor parent who requests Families First.

- the income of the minor's spouse in the home must be considered available in its entirety to the minor (the AG which includes the minor).

- the child of a married/single minor must meet all Families First eligibility requirements if included in the AG. If both parents live in the home, one parent must be incapacitated or be an unemployed parent.

- a minor parent who marries during the receipt of assistance may choose to include or exclude the spouse during the period of eligibility from the marriage until the AG closes.

Construction of the AG:

- Begin the construction of the assistance group with the child(ren) for whom Families First is requested.

- Add the child's technically eligible whole, half, and /or adoptive sibling(s).

- Add the child's technically eligible parent(s), including an incapacitated parent or an unemployed parent, living in the home.

Optional AG Members Include:

- Grantee relative other than a parent, e.g. grandparent, aunt, uncle, or other relative within the specified degree of relationship who:

  - provides a home for the child;

  - exercises primary responsibility for the care and control of the child;

  - asks to be included; and

  - is otherwise eligible.

Consider the relative's income and all of the income of the relative's spouse, if the spouse lives in the home, as available to the AG. If the AG is eligible (when the relative's spouse's income is included,) the relative can be included in the AG. If the relative is included, her/his resources must be considered as available to the AG. If the income causes ineligibility, the relative should be advised that her/his income will make the AG ineligible. Eligibility for the AG can be determined without the relative and her/his spouse.

- Stepparent living in the home with the child when a natural/adopted parent in the home is incapacitated, or when the stepparent is the only relative in the home who meets requirements as a caretaker.

- Parent or other caretaker relative of a child who receives SSI and the SSI child is the only child in the home,

  - the SSI child meets Families First technical eligibility requirements,
  - the parent/specified relative of the SSI child meets Families First income/resource eligibility criteria,
  - both parents in the home with an SSI child may be included in a Families First AG if at least one parent is incapacitated or is an unemployed parent,
  - a stepparent may be included with the SSI child's parent if the parent is incapacitated
  - a specified relative (e.g. a grandparent) who meets requirements as a caretaker may receive Families First as caretaker of an SSI child. The spouse of the caretaker relative is not eligible to be included in the AG.

- Parent of a minor parent. When the minor's parent is in the home but is not requesting assistance for the minor or any half or whole sibling(s) of the minor parents, the minor parent may apply for assistance. Income of parents in the home will be deemed to the minor's AG.

- Spouse Married During the Receipt of Assistance. When a caretaker marries during the receipt of assistance, the caretaker may choose to include the spouse in the assistance group for the remainder of that period of eligibility if the income of the spouse is less than 185% of the AG's need standard. (see Marriage During Receipt of Assistance.)

The following individuals must be excluded from the AG:

- individuals who receive SSI benefits;

- unenumerated individuals or any individual who does not meet a technical eligibility requirement;

- individuals sanctioned for failure, without good cause, to cooperate with the minor parent school attendance requirement;

- individuals disqualified for Intentional Program Violations;
- aliens who do not meet requirements;
- aliens who would be included but are ineligible due to the deemed income or resources of their sponsors, or due to sponsorship by an agency or organization;
- AGs who have been sanctioned for failure to cooperate with Child Support (IV-D) or work requirement;
- individuals who are convicted or who enter a guilty plea or plea of nolo contendere in a federal or state court for having made a fraudulent statement or representation with respect to the place of residence in order to receive assistance simultaneously from two or more states;
- fleeing felons – individuals who have knowledge that they are or could be wanted for a felony level criminal act and have taken or are in the process of taking action to avoid prosecution (see Procedures section for further discussion) and;
- individuals who are convicted (under Federal or State law) of any felony offense which occurred after August 22, 1996 which has as an element of possession, use, or distribution of a controlled substance
  - unless they meet the criteria listed in the Exceptions section in this chapter.
  - Individuals who are convicted of Class A felonies are **not** eligible to be included in the grant under any circumstances.

EXCEPTIONS:

- **Emancipation** of a minor by court order or any other action has no effect on a person's status as a minor for Families First purposes.
- **Different sets of children living in the same home** (e.g., a mother and her children plus her two nephews who are siblings must be in separate assistance groups).
- **Legal Guardians** may receive Families First for a child only if the guardian is within a specified degree of relationship to the child
  - If a child lives with a specified relative who has a legally appointed guardian, the guardian must file the application and be named payee for the grant.

- A guardian may file an application on behalf of a dependent child and be appointed payee for the grant. The child must, however, live in the home of a specified relative to be eligible.

- Convicted Drug Felons may be eligible to receive Families First if the felony has **NOT** been classified as a Class A felony **and** the convicted individual:
  - is complying with, or has already complied with, all obligations imposed by the criminal court, including any substance abuse treatment obligations; **and**
  - is currently participating in a substance abuse treatment program approved by the Department of Human Services; **or**
  - is currently enrolled in, and/or on a waiting list for, an approved substance abuse treatment program approved by the Department of Human Services, as long as he/she enters the treatment program at the first available opportunity; **or**
  - has satisfactorily completed a substance abuse treatment program approved by the Department of Human Services; **or**
  - has been determined by a treatment provider licensed by the Department of Health, Division of Alcohol and Drug Abuse Services, not to need treatment according to TennCare guidelines.

Note: An approved substance abuse treatment program is one that has been licensed by the Tennessee Department of Health. A listing of such programs may be found on the Department of Health's website at www.state.tn.us/health. If the individual received treatment in a state other than Tennessee, this definition would extend to a substance abuse treatment program licensed or approved by the appropriate state agency in the state where the individual received treatment. **Other treatment programs not covered in this definition may be considered on a case-by-case basis by contacting the Families First Policy Section in the state office.**

GOOD CAUSE:

Not applicable.

VERIFICATION:

All required verification must be in writing. Relationship must be established. Verifications are required which establish the relationship of the child to the caretaker/caretaker relative. Eligibility cannot be established until it is proven that the child for whom assistance is requested is within the specific degree of relationship. Verification may include:

- marriage license/divorce decrees;

- birth certificates;

- doctor's/mid-wife's statement;
- paternity orders; or
- statement from individuals in a position to know.

The Classification of the Drug Felony status must be established before eligibility can be established. The specific violation may be verified by:

- a Judgement Sheet from the court or
- Probation/Parole documents

DOCUMENTATION:

Record the relationship of every individual to every other individual in the AG on AEIHH. The verification field must contain the source of documentation. The caretaker relative field must be answered to specify inclusion or exclusion of the non-parent caretaker in the AG.

Document CLRC to include:

- the classification status of the Drug Felony; and
- the conviction date of the felony; and
- the details to fully explain whether or not the individual is included/excluded in the AG and how this was verified.

CLRC should be documented to complete or clarify any verifications that are needed to establish eligibility.

PROCEDURES:

- Enter all individuals in the ACCENT record.
- Enter the relationship of each individual to every other individual.
- Specify caretaker name.
- Explain options to the caretaker about inclusion/exclusion of individuals.
- Secure verifications and document record

SPECIAL PROCEDURES FOR FLEEING FELONS

An individual must be given the chance to clear up a fleeing felon charge and demonstrate, if possible, that the charges are no longer, or were never valid. This opportunity must be given regardless of whether he/she is learning about the felony for the first time from the Department or whether it was reported/verified from another source that he/she has previous knowledge of the charge.

When you are notified that someone is or may be a fleeing felon, contact the individual **prior to** taking action on the case. If the individual denies that he/she is a fleeing felon give him/her the opportunity to:

- view the evidence that has been received about his/her felony status; **and**
- provide evidence that the warrant, indictment or other instrument charging the individual with a felony has been satisfied, retired, never existed, or that an error has been made that would make a denial of eligibility for fleeing status inapplicable.

In order to provide coverage for other AG members, it may be necessary to take action on the case prior to the resolution of the individual's fleeing felon status. In these situations, approve the case without including the individual charged with being a fleeing felon. If the issue is resolved in the individual's favor at a later date, restore benefits back to the date he/she would have been eligible had the fleeing felon issue not been a factor.

I. UNSTABLE ASSISTANCE GROUPS:

POLICY STATEMENT:

Frequently, a relative other than the parent of a child requests and receives Families First for that child. The relative may be included in the AG if (s)he meets requirements as caretaker. From time to time the child's parent comes into the home but does not stay for long periods of time. When this occurs, the case manager must consider whether changes in the AG are needed.

GOOD CAUSE:

There is good cause to have both a non-parental caretaker and a parent (2 adults) in the AG when it is determined that the parent is in and out of the home and the non-parental caretaker relative continues to maintain a home and assumes primary responsibility for the care and control of the child.

VERIFICATION:

When a non-parental caretaker relative is receiving assistance for a child and the Child's parent returns to the home, verify that both the non-parental caretaker and the parent are in the home. To the extent possible, verify the plans of the parent to return or remain in the home.

DOCUMENTATION:

Document in running record comments (CLRC) the composition of the assistance group and the parent's plans about remaining in the home. A full explanation of the decision to include the parent in the non-parental caretaker's case or to close that case and open another case with the parent as caretaker is needed.

PROCEDURES;

- Determine who is providing a home and who has primary responsibility for the care and control of the child.
- Determine the pattern of the parent's absence(s) from and return (s) to the home.
- Determine whether this particular return is likely to be relatively permanent (3 to 6 months).

If it is determined that the parent has returned to assume parental rights/ responsibilities and is requesting continued Families First for herself and her child(ren):

- close the caretaker relative's case,
- open the case in the parent's name and determine eligibility and develop a Personal Responsibility Plan, and
- continue Medicaid eligibility for the former grantee relative if she/he qualifies in any Medicaid category.

- If it is determined that the parent is likely to leave again:
  - continue the case in the grantee relative's name
  - add the parent to the existing AG as a 2nd adult if otherwise eligible to be added;
  - include any income/resources the parent has in the AG's eligibility determination;
  - complete a Personal Responsibility Plan for the parent, including a work component, unless exempt; and
  - set an expected change prior to the next review to determine whether changes have occurred which affect on-going eligibility.
- A child support referral must be made during any absence of the parent.

II. PREGNANT WOMAN ONLY CASES:

POLICY STATEMENT:

A Families First assistance group may consist of a pregnant woman only when:

- there are no living eligible children in the home, and
- it is medically verified that the woman is at least in her sixth month of pregnancy, and

- the woman and child (if born) would meet all other eligibility criteria (i.e., the unborn is deprived of parental support, etc.), and

- the pregnant woman is not a minor whose parent is in the home and is receiving Families First for the pregnant minor's sibling(s).

  The pregnant woman must have a Personal Responsibility Plan, including a work component unless exempt. Pregnancy does not exempt the woman from work; however, conditions associated with her pregnancy may cause a temporary incapacity which would exempt her from work.

VERIFICATION:

The pregnancy must be verified by:

- a statement of a licensed physician or osteopath; or

- a statement by medical personnel in a public health clinic or an in-patient hospital clinic.

The verification must include:

- verification of pregnancy;

- estimated date of conception;

- the current estimated month of pregnancy, and

- the signature of the person who provided the verification including the name, and/or location of the clinic, doctor's office, etc.

DOCUMENTATION:

The ACCENT record should contain documentation and verification of the pregnancy and the anticipated day of birth.

PROCEDURES:

- Authorize a medical examination for any woman who cannot secure verification of her pregnancy.

- If the woman is receiving Medicaid as a pregnant woman, she must complete

an application for Families First as she approaches the 6th month of pregnancy.

- Complete the Personal Responsibility Plan, including the work component, at the time of the application for cash benefits.
- If eligible, authorize the benefits for a one-person-only cash payment.
- Terminate Families First if the pregnant woman aborts, miscarries, surrenders the child for adoption, or if the child is placed in foster care when born.

IV. MINOR PARENTS

POLICY STATEMENT:

A minor parent may apply for Families First for his/her child. However, if the minor parent lives in or moves into the home with a parent or a caretaker relative who is applying for or receiving assistance for at least one child that is a half or whole sibling of the minor parent, **the minor parent and the child(ren)** of the minor parent **for whom he/she is applying**, must be included in the AG with the minor parent's parent. **NOTE:** See the "Mandatory AG Members Include:" section in this chapter for further discussion on when the minor parent's child is included/optional.

A minor may apply for and receive Families First for siblings or other relatives to whom he/she is within the proper degree of relationship, if the minor is providing a home for the child. The minor relative may be included in the AG if he/she meets requirements as caretaker. The minor parent who receives assistance for his/her child and receives assistance for siblings will have two AG's. The minor will be included in the AG with his/her own child.

Living Arrangement Requirement:

A Families First applicant under the age of 18, who has **never been married** and is pregnant or has a dependent child in his/her care, **must live in the home with** his/her parent, legal guardian, other adult relative, or a foster home, maternity home, or other supportive living arrangement supervised by an adult, as a condition of eligibility for the minor and his/her child.

School Attendance:

- A minor parent (less than age 18) who is not married, has not completed high school or does not have a GED, and whose child is 1 year of age or older, must attend high school, GED classes, or an alternative educational or training (cont.)

program that is approved by the department.

- The unmarried minor parent who does not attend school, without good cause, is ineligible for Families First benefits. The minor's child continues to be eligible for a cash payment if otherwise eligible. In this instance the minor parent's needs will be removed from the group for calculation of the grant. The minor parent will continue to be eligible for Medicaid.

  A married minor parent who is an eligible child in her/his parent's AG or a caretaker of her/his own AG must attend school. Failure to do so will result in a 20% reduction in the assistance payment.

Time Limits:

- A minor parent who is the head of her/his own assistance group will be exempt from the 18/60 month time limits until:

  - the minor attains the age of 18 **and**

  - has graduated from high school or has dropped out of school, **or**

  - until the class of which the minor parent **is** a member, when the minor parent reaches age 18, graduates from high school.

Work/work Preparation Requirements:

- There is no work requirement during the school year other than attending school. During the summer the minor parent may be required to participate in Fresh Start, parenting classes, etc.

<u>EXCEPTION:</u>

The minor parent is **not required to live in the home** of a parent, legal guardian, adult relative, foster home, maternity home, or other supportive living arrangement when:

- the department determines after investigation that there is a good cause for the separate living arrangement and the health or safety of the applicant or the dependent child(ren) would be jeopardized if they were required to live in one of the arrangements specified; or

- the person applying for assistance has no parent, other adult relative, or legal

guardian whose whereabouts are known; or

- no parent, other adult relative, or legal guardian of the applicant allows the applicant to live in her/his home.

GOOD CAUSE:

Good cause for a separate living arrangement must be explored with the minor parent applicant. Good cause reasons may include, but are not limited to such situations as illegal substance abuse, abuse of alcohol, physical or mental abuse of the applicant or child, serious overcrowding in the home, or dangerous or potentially dangerous physical environment. Case managers must use "common sense" judgement when making this determination.

When good cause is not established, the minor parent and child(ren) are ineligible.

VERIFICATION:

- The living arrangement of the minor parent
- Verification to support a good cause claim
- School attendance or good cause for not attending school
- Relationship of all individuals to all other individuals in the home

DOCUMENTATION:

- The ACCENT record must identify all individuals in the home and the verification of their relationship to each other.
- The minor parent screen must be complete. If the minor parent is not living with a parent, relative, or guardian, the record must contain documentation supporting good cause or failure to meet good cause.
- The record must have verification of school attendance or documentation to support good cause.
- The record must contain the minor parent's personal activities and supportive service needs in her/his Personal Responsibility Plan.

ASSISTANCE GROUP

PROCEDURES:

- Identify and record all members of the AG's household.
- Establish the minor parent's living arrangement criteria.
- Determine if good cause is met when the minor parent does not meet the living arrangement criteria.
- Verify school attendance or good cause for not attending.

When a minor parent meets the requirement or has good cause for failing to meet the requirement:

- include the minor and her/his child(ren) in the AG when the minor's parent in the home does not receive Families First or when the minor has been determined to meet the criteria for maintaining a separate resident. If the minor' s parent receives Families First for the minor's sibling(s), the minor will be included in the parent's AG.
- deem the income of the non-recipient parent living with a minor parent applicant/recipient as available to the AG.
- name a payee to receive the minor parent's grant when:
  - the minor parent is age 14 or under, or
  - the minor parent lives with a parent, other adult relative, or a legal guardian or
  - the services of a payee are needed to assist the minor in managing the cash payment.
- establish protective payee when appropriate.
- develop the personal responsibility activities.

FAMILY CAP

POLICY STATEMENT:

A Family Cap prohibits an increase in the cash payments when a newborn is added to the assistance group. It is applied when:

- the AG has applied for Families First and the birth occurs more than ten (10) calendar months **after** the application month; **or**
- the AG has applied, has stopped receiving assistance, has subsequently reapplied, been determined eligible and the birth occurs more than ten (10) calendar months **after** the reapplication month.

- **EXCEPTION:** The Family Cap may also be applied to a child born after or during a period of ineligibility but within 10 months of the reapplication. The criteria for application of this policy are discussed later in this chapter.

When the Family Cap is applied to a newborn, the AG's cash payment will not exceed the maximum assistance payment for the AG without the new child. For example, if the AG consists of a mother, her son and a Family Cap child, the cash payment will not exceed the maximum payment amount for a two-person AG. The Family Cap will not affect other increases in benefits, as long as the increase does not exceed the maximum assistance payment for the AG without the newborn.

- Though the Families First payment will not be increased, a Family Cap child is a member of the assistance group in all other aspects. Therefore, the Family Cap child:
  - will be included in determining the GIS and the CNS amounts for the AG;
  - is added to the AG's Medicaid;
  - is subject to child support, enumeration, immunizations, school attendance, and all other eligibility requirements.
- Child care is provided for the Family Cap child if necessary for the participant to meet her work requirement.
- The Family Cap policy applies to children born to a woman who:
  - is a member of the assistance group; or
  - would have been a mandatory AG member except for technical ineligibility, such as a SSI recipient or illegal alien; and
  - conceived **during** receipt of assistance
- Family Cap policy applies to both single parent and two-adult assistance groups.

- Family Cap still applies when the non-Family Cap children leave the home or age-out leaving only the Family Cap child and the EA caretaker. The maximum grant would be the amount for the caretaker only.

- Family Cap still applies when the parent is a NA caretaker, such as a SSI recipient, and the non-Family cap children leave the home or age out leaving only the Family Cap child and the caretaker. The Families First grant would be $0, but the case would remain open.

When to apply the Family Cap

- An AG child is subject to a Family Cap when the AG has applied and has received continuous Families First cash payments for more than ten (10) calendar months when the birth occurs. **The 10-month count begins the month after the application month.**

  EXAMPLE: The caretaker applies on 9/10/97 and receives Families First benefits for herself and one child continuously since that date. On 9/21/98, she reports that she has given birth to another child on 9/3/98.

First month in the count is	October 1997
Tenth month in the count is	July 1998
The first month the family cap will apply	August 1998

  Action on case: This child will be added to the AG but since 10 months have passed since the application month, the **grant will not be increased** to an amount greater than the maximum grant for a two-person AG.

  EXAMPLE: The caretaker applies 10/10/97 and receives Families First benefits for herself and one child continuously since that date. She reports that she has given birth to another child on 7/7/98.

First month in the count is	November 1997
Tenth month in the count is	August 1998
The first month the Family Cap will apply	September 1998

  Action on case: This child will be added to the assistance group and **the grant will be increased** to include the caretaker and two children since the birth occurred within 10 months of the application month.

- When a minor mother who has her own Families First case turns 18 or leaves the major mother's household, the original family cap date follows her to her new case if there has been no lapse in benefits.

EXAMPLE: An active Families First AG has an application date of 9/17/97. The AG consists of a major mother, major mother's child, a minor mother and the minor mother's child. The minor mother moves out of the household on 12/13/97 and is removed from the AG effective 12/31/97. The minor mother reapplies in her own case on 12/30/97 and is approved 1/15/98. There is no lapse in benefits.

First month in the count is	October 1997
Tenth month in the count is	July 1998
The first month the Family Cap will apply	August 1998

EXAMPLE: An active Families First AG applies 9/17/97. The AG consists of a major mother, a minor mother and the minor mother's child. The minor mother turns 18 and applies for Families First in her own name. Her Family Cap date will remain the same even though ACCENT has resequenced the Families First into a new AG.

First month of the count is	October 1997
Tenth month of the count is	July 1998
The first month the Family Cap will apply	August 1998

- For an AG that has reapplied for Families First cash payments, **the ten-month count will begin with the month after the reapplication month** unless there has been no gap in eligibility for the AG.

EXAMPLE: The caretaker applies on 9/17/97 and receives Families First benefits for herself and one child. The AG is subsequently closed on 11/1/97 effective 11/30/97. The caretaker reapplies and is approved on 11/24/97. The caretaker later reports that she has had another child born on 8/17/98. Since there was no period of ineligibility in this case, the continuous receipt of benefits still applies.

First month in the count is	October 1997
Tenth month in the count is	July 1998
The first month the Family Cap will apply	August 1998

Action on case: This child will be added to the AG **but the grant will not be increased** to include the second child since the birth occurred more than ten months after the initial application month.

EXAMPLE: The caretaker applies on 9/17/97 and is approved for Families First benefits. The AG is subsequently closed effective 11/30/97 because of excess income. The caretaker reapplies on 1/4/98. The caretaker reports that her child was born 12/17/98. There was a gap in the receipt of benefits. Therefore, the month following the reapplication month is the first month of the 10-month count.

First month of the count is	February 1998
Tenth month in the count is	November 1998
The first month the Family Cap will apply	December 1998

Action on case: This child will be added to the AG and **the grant will not be increased** since the birth occurred more than 10 months after the reapplication month.

EXAMPLE: The caretaker applies on 12/17/97 and is approved for Families First benefits. The AG is subsequently closed effective 2/28/98 because of excess resources. The caretaker reapplies on 4/4/98. The caretaker reports that her child was born on 12/17/98.

First month in the count is	May 1998
Tenth month in the count is	February 1999
The first month the Family Cap will apply	March 1999

Action on case: The child will be added to the AG and **the grant will be increased** since the birth occurred within 10 months of the application month.

- Family Cap will be applied to a child born <u>after or during</u> a period of ineligibility, but <u>within</u> 10 months of the **reapplication** month when:

  - a woman becomes pregnant while receiving Families First; **AND**

  - the AG was closed prior to the child's birth; **AND**

  - the child was born more than 10 months after the previous application month; **AND**

  - the reason for closure was non-cooperation with Departmental policies and rules which include:

    - failure to cooperate with Child Support without good cause; or
    - failure to fulfill Personal Responsibility Plan provisions and requirements.

    EXAMPLE: The AG applies for Families First on 7/1/99. The AG is approved and the woman becomes pregnant in 9/99. The Families First AG is closed effective 5/1/00 due to failure to comply with ECS without good cause. The child is born on 6/3/00. The A/R reapplies on 7/3/00 and is approved. The Family Cap is applied to the newborn because:

    - the woman became pregnant while receiving Families First;
    - the case was closed prior to the birth;
    - the child was born more than 10 months after the previous application month; and

- the AG was closed because of failure to comply with ECS without good cause.

When the Family Cap Has Been Applied

Once the Family Cap has been applied to a child, it will continue for a period of 18 countable months, plus any extension months, and will end when the case is closed for time limits.

- When an AG that has had the Family Cap applied to an AG child closes, Family Cap **will be continued** upon **reapplication** when:

  - the case was not closed for time limits (an 18-countable month period of eligibility has not been completed); **OR**

    EXAMPLE: The Families First AG is closed effective 9/30/99 due to earned income. The AG had 10 countable months in their current 18-month period of eligibility. The AG reapplies 12/01/99.

    Action on case: The Family Cap will continue as the cap has not been applied for an 18-month period of eligibility (the previous closure was not due to time limits).

  - the AG was closed for both time limits **AND** a sanction due to non-cooperation with the following Departmental policies and rules:

    - failure to cooperate with Child Support; or
    - failure to fulfill Personal Responsibility Plan provisions and requirements.

    NOTE: These PRP provisions and requirements apply to work requirements and to the immunization, health check, and school attendance agreements. Though non-compliance with the latter agreements don't cause case closures if, at the time of a closure for time limits, a non- compliance is discovered in these areas or a 20% grant sanction is already in place, the Family Cap will continue at reapplication.

    EXAMPLE: The Families First AG is closed effective 9/30/98 due to time limits and failure to comply with ECS. The caretaker reapplies for benefits on 12/15/99 and is approved.

    Action on case: The Family Cap continues to apply to this case because the closure was due to time limits and failure to comply.

- The Family Cap **will not continue** at reapplication once a case has been closed for time limits with no additional sanction reason.

EXCEPTIONS

- Do not apply Family Cap to a child who was born more than 10 months after the application month, but was **conceived prior to the application for assistance**. Obtain a physician's statement to prove conception occurred prior to the application date.

- Do not apply Family Cap to a child born to an AG between periods of eligibility unless:

  - the child was **conceived during receipt of assistance; and**
  - the case closed prior to birth; **and**
  - the child was born more than 10 months after the previous application month; **and**
  - the reason for closure is deemed to be non-cooperation with departmental policies and rules.

- Do not apply Family Cap to the first child born to a minor in an assistance group even if the pregnancy occurs after receipt of assistance.

- Do not apply Family Cap to children, other than newborns, who join the assistance group. For example, when a child who has been residing with another relative rejoins the assistance group. The Families First grant payment will be increased as a result of adding the child.

- Do not apply Family Cap to a child who is born to an assistance group member as a result of incest or a verified rape.

VERIFICATION:

- Verify the newborn's date of birth.

- Verify the child's conception date if the child is born more than 10 months after the application or reapplication month. A physician's statement of the conception date is acceptable proof.

- Verify rape or incest if the individual is claiming good cause for exemption to the Family Cap provision. Doctor's statements, court records, supporting statements from protective services, are examples of verification for granting good cause.

DOCUMENTATION:

- Document circumstances regarding the newborn – when reported, how verified, etc.

- Document whether or not Family Cap applies to the newborn;
- Document good cause or exemptions to the Family Cap provision, if applicable;
- Document the reasons why the Family Cap provision will or will not be applied to an AG in a new period of eligibility when Family Cap was applicable in a previous period of eligibility.

PROCEDURES:

When a newborn to the assistance group is reported, determine if Family Cap applies to the newborn. If the Family Cap provision **does not apply**:

- add the newborn to the AG, if otherwise eligible; and
- provide benefits to the AG including the newborn.

- If the Family Cap provision **does apply**:
  - add the child to the assistance group per all other eligibility requirements;
  - determine eligibility for the AG using the gross income standard (GIS) and the consolidated need standard (CNS) for the assistance group size including the newborn. Cap the maximum payment at the standard for the assistance group size not including the newborn.

    EXAMPLE: The AG consists of the caretaker and one child. The caretaker reports the birth of a child for which Family Cap applies. The AG has SS income and, if the newborn were added to the payment amount, the AG would be eligible for $160. $160 exceeds the maximum grant amount for the AG size minus the Family Cap child. Therefore, the AG would only be eligible for $142, the maximum two-person grant amount.

    EXAMPLE: The AG consists of the caretaker plus two children plus one Family Cap child. In looking at the GIS and the CNS for an AG of four, this particular AG, based on their income, would have been eligible for a grant of $175. $175 is less than the maximum grant amount ($185) for the AG size minus the Family Cap child. Therefore, they would receive the $175 grant amount.

- When an assistance group that has a Family Cap closes and later reapplies, evaluate the AG to determine if the Family Cap should apply to the new period of eligibility.

MARRIAGE DURING THE RECEIPT OF ASSISTANCE

POLICY STATEMENT:

Families First encourages marriage.

Recipient caretakers who marry during the receipt of assistance may continue to qualify for Families First benefits without meeting the incapacity, unemployed parent requirements or stepparent deeming rules. When a caretaker marries during the receipt of assistance, he/she may be given the option of including/excluding the new spouse in the assistance group. This option is dependent upon:

- whether the spouse's income, minus child support payments to children outside the home, is less than the gross income standard; and

- whether the marriage was reported timely.

Before Offering the Inclusion/Exclusion Option

- Determine if the marriage was reported timely (within 10 days of the marriage).

- Test the spouse's income for the month of the marriage against the gross income limit (185% of the CNS) for the assistance group. When testing the income, use the gross income minus any court ordered child support payments made to children outside of the home. Use the GIS for the current assistance group plus the spouse and any additional mandatory AG children.

- If the spouse's income is greater than the GIS, determine AG eligibility based on all Families First policies, such as deprivation, income, deeming, etc.

- If the income of the spouse is less than the gross income standard, explain to the caretaker that he/she has the option to include/exclude the spouse in the AG. Explain the impact of each option to the caretaker.

When the Caretaker Elects to Include the Spouse as an AG Member

- When the gross income standard test is passed, and the option is made to add the spouse, calculate the Families First budget using the countable income of all assistance group members except the spouse. Income of the spouse is disregarded.

- Add any of the spouse's children who:

  - reside with the spouse; and
  - are mandatory AG members (siblings, half-siblings, stepsiblings, etc.).

  Include any countable income and resources of the children. The children must meet all eligibility requirements.

- Use the gross income standard, the consolidated need standard, and the maximum payment standard for the new assistance group size, including the spouse, to determine the assistance payment.

- The spouse will be eligible for Medicaid as a Families First assistance group member.

- The spouse, unless exempt, will be subject to work requirements and sanction provisions.

- Resources of the spouse will be considered available and, therefore, countable to the assistance group. The spouse must meet enumeration, citizenship, and all other eligibility provisions.

- **The marriage during receipt of assistance policy (exception to income, stepparent deeming and deprivation rules) will only apply to the assistance group until the AG closes for any reason.**

- When the assistance group closes, the AG (including the spouse and mandatory children) will be eligible for TM and TCC, in accordance with those policies.

- When the assistance group is approaching the 18/60-month time limit, the AG will have a *time limit good cause review* to determine if the benefits should continue. Count the income of all assistance group members including the spouse's income, except for court ordered child support payments paid to children outside of the home, when evaluating the good cause "income" provision.

When the Caretaker Elects to <u>Exclude</u> the Spouse as an AG Member

- If the option is chosen to exclude the new spouse from the assistance group, determine group eligibility as if the spouse <u>was not</u> in the home. This is true even if the spouse is the father of an AG child.

- Do not include the income and resources of the spouse in the eligibility determination for Families First.

- Any children who moved into the home with the spouse at the time the marriage occurred must be considered for addition to the assistance group using assistance group policy.

- When the assistance group closes, the excluded spouse will not be eligible for TCC and TM.

- Do not count the excluded spouse's income when evaluating good cause for a time limit extension.

The Chosen Option Is in Effect Until the AG Closes

Once either of these options is chosen, the marriage during the receipt of assistance policy will be in effect **until the assistance group closes** for any reason. When the assistance group reapplies, use the application policy to establish eligibility. If the spouse is the parent of at least one assistance group child, the assistance group must meet deprivation requirements through incapacity or unemployed parent policy. If the spouse is a stepparent, deeming rules will apply.

NOTE: If a case has been closed and the 10-day notice has expired, the marriage during the receipt of assistance policy no longer applies even if the closure effective date has not been reached.

EXAMPLE: A closure notice was mailed 8/20 to be effective 10/1. The AG reapplied 9/10 after the 10-day notice expired. Marriage during the receipt of assistance no longer applies to this case.

Liability of Spouse's Federal or State Share of Court Ordered Child Support Arrearages

The spouse who marries a Families First caretaker will not be liable for the federal or state share of court ordered child support arrearages that are owed to an AG child. This continues as long as the new spouse resides in the home.

This applies to:

- a spouse who the caretaker opts to include in the AG;
- a spouse who the caretaker opts to exclude from the AG; and
- a spouse who continues to live in the home of an AG that is closed and later regains eligibility during a subsequent application.

If the spouse leaves the home where the children reside, prior to the termination of child support obligations under state law, the spouse becomes liable for the full child support arrearage.

Two Families First Caretakers Marry

Both the caretaker and the spouse will continue to be eligible as separate assistance groups when:

- the caretaker marries an individual who is also receiving Families First cash payment; and
- there is no common child.

If there is a common child, then both assistance groups will be combined into one AG. The designation of the caretaker is the decision of the adults in the AG.

NOTE: Since time limits are attached to the caretaker, the time limit count will depend on which adult is designated as the caretaker.

In some instances, one spouse is not receiving Families First, but is grouped as a separate AG because there is no common child. In these instances:

- the new spouse can elect to join the caretaker's AG; or
- both AGs can receive assistance separately, as double stepparent AGs.

EXCEPTIONS:

Marriage during the receipt of assistance does not apply to:

- initial applications;
- cases that have closed and are re-applying;
- couples who are married at the time of application; and
- spouses who have been out of the home and are returning.

NOTE: If a couple who has been legally divorced remarry during the receipt of assistance, the marriage during the receipt of assistance policy would apply.

GOOD CAUSE:

There are no good cause provisions to the **marriage during the receipt of assistance policy.**

VERIFICATIONS:

The following verifications are required when the spouse is included in the assistance group:

- proof of marriage;
- proof of divorce (if remarrying an ex-spouse);
- proof of relationship of the spouse's children to the spouse or to existing assistance group members;
- proof of income to be used for the Gross Income Standard test and the time limit good cause extension; and

- all other pertinent eligibility factors including, but not limited to, proof of social security numbers, citizenship, and resources of the spouse and any mandatory children.

DOCUMENTATION:

When the marriage occurs during the receipt of assistance, clearly document the following information:

- the date the marriage occurred;
- the date the marriage was reported to the agency;
- the new spouse's income;
- the results of the income test;
- the decision of the caretaker to include or exclude a spouse in the AG and the date;
- the supporting verification related to the addition of the spouse; and
- all other eligibility factors including, but not limited to, proof of social security numbers, citizenship, and resources of the new spouse and any mandatory children.

It is important to document the above information clearly so that the marriage during receipt of assistance policy can be maintained for the duration of the period of assistance.

PROCEDURES:

- Obtain income information for the spouse and complete the 185% income test.

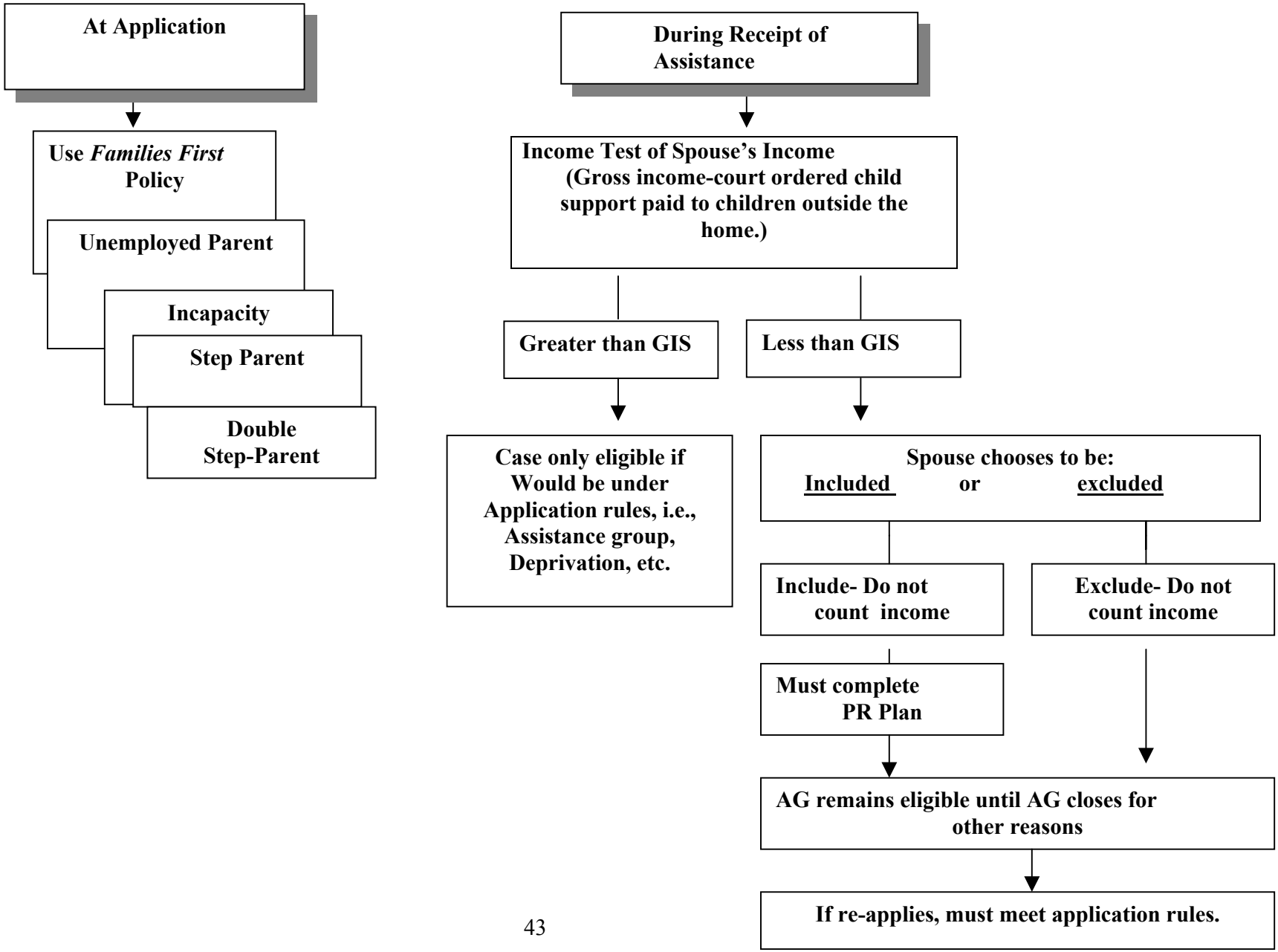
- If income is over 185% of the CNS, determine on-going eligibility using all Families First AG composition, relationship, deprivation, income, etc. rules.

- If income is under 185% of the CNS:
  - explain the options available to the caretaker at the time the marriage is reported;
  - explain that **marriage during the receipt of assistance policy** applies until the AG closes; and
  - explain the child support arrearage policy to the caretaker.

- Notify the Child Support office that the arrearage is on hold for the time the spouse is living in the home. In order to notify IV-D of the situation; close the AP as usual. Print the AP screens and note at the top of the printed document: "Marriage – Hold Harmless Arrearages." Send the printouts to The Director of Child Support, IV-D, DHS State Office.

- If the spouse should leave the home, notify the Child Support office that the spouse is no longer in the home and that arrearage enforcement is appropriate. To do this, reopen the AP. Print the AP screens and note at the top of the printed document: "Spouse Left Home - Resume Arrearages." Send the printouts to The Director of Child Support, IV-D, DHS State Office.

FAMILIES FIRST- Married?



CARETAKER- SSI CHILD

POLICY STATEMENT:

When application is made for Families First for an assistance group which includes a child(ren) who is an SSI beneficiary, the presence of the SSI child(ren) may be taken into account for purposes of qualifying for the caretaker and second Parent for Families First. In such cases, this child(ren) would be the only eligible child(ren) in the home, if he were not receiving SSI.

In this situation, the SSI child beneficiaries are determined to be "needy" for purposes of making the caretaker and second parent eligible for Families First since SSI is a means tested program. The child(ren) must meet all other eligibility factors such as age, residence, deprivation, etc. and the caretaker (and second parent, if any) must meet all eligibility requirements. The income and resources of all responsible relatives must be taken into consideration. However, the needs, income, and resources of the SSI recipient would not be considered. If eligibility is determined, a grant will be authorized only for the caretaker or caretaker and second parent.

SSI child- caretaker cases are not subject to IV-D requirements; i.e. absent parents of the SSI child are not referred to IV-D and child support paid on behalf of an SSI child is not assigned.

ENUMERATION

POLICY STATEMENT:

Enumeration is the procedure by which the Social Security Administration (SSA) in cooperation with the Department assigns and/or verifies Social Security numbers (SSN) for Families First applicants/recipients.

- Each applicant/recipient included in the AG must furnish his/her Social Security account number (SSN) or numbers if more than one number has been issued.

- If an individual does not have a Social Security number or does not know the number, he/she must apply for a number prior to being approved for benefits or prior to being added to an existing AG.

- If the caretaker fails or refuses to enumerate a mandatory assistance group member, then that individual is technically ineligible and must not be included in the assistance group.

EXCEPTIONS:

There are no exceptions to enumeration for individuals requesting eligibility for Families First. All AG members must have a Social Security number or apply for one.

GOOD CAUSE:

There are no good cause provisions for failure to provide or apply for a Social Security number.

VERIFICATIONS:

- The applicant/recipient must present the Social Security card for all members who must be included in the AG or who desire to be included in the AG or

- The applicant/recipient must present other forms of acceptable evidence of the Social Security number for all members who must be included in the AG or who desire to be included in the AG or

- The case manager may verify the Social Security number through the SDX, Bendex, or wire- to- wire matches or

ENUMERATION

- If the applicant/recipient does not have a Social Security number for an individual who must be included in the AG or who desires to be included in the AG, the applicant/recipient must complete an SS5 for the individual requiring a Social Security number. The SS5 is completed by the case manager and forwarded to the Social Security office along with the original documents verifying age, identity, and citizenship of the individual. If the individual chooses to provide the verifications to the Social Security Office, (s)he may do so, but the application for a Social Security number is not complete until the verifications are provided.

- if the individual states that an application for a number has been made with the Social Security Office, or if the applicant/recipient insists on applying for the number directly with the Social Security Office, the application/recipient must provide proof of application to the case manager prior to approval. Form SSA 5028, Receipt for Application for a Social Security Number, is acceptable for a number.

DOCUMENTATION:

The ACCENT case file must contain:

- the Social Security number and the source of verification; or

- the date the Social Security number was applied for and the verification that application was made; and,

- any supporting statements needed to clarify the actions taken or the running record comments (CLRC).

  A newborn must have a Social Security number or an application for a number prior to being added to the AG. Babies who are enumerated during the hospital enumeration at birth process are considered enumerated and the case file should be documented to reflect such.

PROCEDURES:

The applicant/recipient should be given the following information:

- Furnishing a Social Security number or applying for a number is a condition of eligibility.

ENUMERATION

- Failure to furnish the number or apply for the number will result in ineligibility of the individual.

- The Social Security number will be used in the administration of the Families First (as well as Food Stamps and Medicaid) program.

- The Social Security number will be used to check other government records that may impact Families First eligibility such as IRS, Wage records, Unemployment Compensation, Social Security and SSI benefits.

RESIDENCE

POLICY STATEMENT:

- As a condition of eligibility, a Families First assistance group must reside in Tennessee. Families First does not have a county residence requirement; however, the application is to be filed in the county of residence for processing purposes.

- A resident is one who is:

  - living in the state (or county) voluntarily with the intention of making her/his home here and not for a temporary purpose. (Persons in the state or county for visits or vacations are not residents.)

  OR

  - living, at the time of application in the state (or county), not receiving benefits from another locality, and entered the state (or county) with a job commitment

  - or seeking employment (whether or not currently employed). This definition enables migrant and itinerant workers and their families to establish residence in the location where they came for employment purposes.

- no individual may receive benefits as a member of more than one assistance group, in more than one county or state, within the same month.

- There is no durational residency requirement for Families First.

EXCEPTIONS:

- Temporary absences from the state with subsequent returns, or intent to return once the purpose of the absence has been accomplished, do not terminate residence.

  - When a recipient of Families First notifies the Department that he is leaving the state temporarily, the case manager will need to determine if the assistance should be continued. The case manager will determine if the AG continues to maintain an identifiable residence in the State and if there are plans to return to the residence and if the AG has applied for or is receiving assistance in the state where the AG presently is visiting.

- If the absence appears to be temporary, usually not to exceed the three months, and the plan is to return to the residence, assistance will be continued.

- There are instances when the child may be absent for a longer period of time or have long-term specific absences from the home. For example, a child may be in a school that requires the child to reside out of the home, but the caretaker provides for the child and maintains care and control of the child.

- If the absence appears to be permanent, or there is not a plan to return to the state or the AC has applied for/is receiving assistance in the other state, assistance will be discontinued.

- When it is determined that the assistance group is temporarily in another county but the AG retains their residence, assistance may continue in the county of residence.

- When it is determined that the assistance group has moved their residence to another county within the state, the assistance group case must be transferred to the new county of residence.

VERIFICATIONS:

- Evidence of the applicant's/recipient's residence at the time of application and at redetermination, if questionable, is required.

- Verification of residence may be achieved through driver's license, rent receipt, utility bills, other bills, voter registration card, collateral contacts, etc.

- If different addresses are reported for an AG, verification of residence must be obtained.

DOCUMENTATION:

- The ACCENT record should contain the physical address of the applicant/ recipient and the mailing address, if different.

- ACCENT should also contain the living arrangement code that is appropriate for the assistance group.

- Any discrepancies reported and the subsequent findings about the place of residence should be recorded in the running record comments (CLRC).

RESIDENCE

PROCEDURES:

- Determine the place of residence during the application/redetermination or reported change.

- Establish verifications as needed.

- When absences are reported, determine the duration and intent of the absence and determine whether to close or continue assistance.

- Close AG's that move out of state for reasons other than temporary absences, or when it is determined that the AG is receiving assistance in another state.

- Transfer cases that relocate to another county within the state. The transferred case must be reviewed in the new county of residence. At the time of the review, the Personal Responsibility Plan will be re-evaluated and re-negotiated.

CITIZENSHIP AND ALIEN STATUS

POLICY STATEMENT:

To receive Families First, an individual must be a citizen or an alien lawfully admitted to the United States.

The citizenship or alien status of each assistance group member must be acknowledged on the citizenship section of the application form (HS-0169).

The entire AG is ineligible for assistance if any adult applicant refuses or fails to sign HS-0169 or if the adult relative refuses or fails to sign for a minor in the AG.

An ineligible alien will be excluded from the Families First AG, but may receive a grant for children in her/his care, if they are eligible.

How is citizenship defined:

- As a condition of eligibility to receive Families First benefits, an individual must be either a citizen of the United States (The United States is defined as the 50 states and the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. In addition, nationals from American Samoa or Swain's Island are considered U.S. citizens for eligibility purposes); or an alien lawfully admitted under the conditions listed below:

  - an alien lawfully admitted for permanent residence as an immigrant as defined in Sections 101 (a)(15) and 101 (a)(20) of the Immigration and Nationality Act. However, an alien lawfully admitted for permanent residence pursuant to Section 245A of the Immigration and Nationality Act must be eligible as specified in paragraphs 7 of this section.

  - an alien who entered the United States prior to January 1, 1972 or some later date as required by law, and has continuously maintained residency in the United States since then, and is not ineligible for citizenship, but is considered to be lawfully admitted for permanent residence as a result of an exercise of discretion by the Attorney General pursuant to Section 249 of the Immigration and Nationality Act.

  - an alien who is qualified for entry pursuant to section 207 or 208 of the Immigration and Nationality Act;.

    Note: Amerasians in Vietnam, with certain family members, are to be admitted under this section. They should possess INS documents with an identifier in the range of AM1 through AM3 or AM6 through AM8. In Families First these are treated as refugees.

CITIZENSHIP AND ALIEN STATUS

An Amerasian is an individual who was:

- born in Vietnam between January 1, 1962 and January 1, 1976;
- fathered by a U.S. citizen, and
- residing in Vietnam as of March 20, 1988 (the date of enactment of the Amerasian legislation)

Amerasian family members who can be admitted under Section 207 or 208 of the Act include: the spouse or child of an Amerasian if the spouse or child is accompanying or planning to join the Amerasian; and the Amerasian's natural mother and the spouse or child of the Amerasian's natural mother or the person who has acted as the Amerasian's mother, father, or next of kin and such person's spouse or child if the family member is accompanying or planning to join the Amerasian.

- an alien granted asylum through an exercise of discretion by the Attorney General pursuant to Section 208 of the Immigration and Nationality Act;
- an alien lawfully present in the United States as a result of an exercise of discretion by the Attorney General for emergent reasons or reasons deemed strictly in the public interest pursuant to Section 212 (d)(5) of the Immigration and Nationality Act, or as a result of a grant of parole by the Attorney General.
- an alien living within the United States for whom the Attorney General has withheld deportation pursuant to Section 243 of the Immigration and Nationality Act;
- an alien who is defined as aged, blind or disabled in accordance with Section 1614 (a)(1) of the Social Security Act and is considered to be lawfully admitted for permanent residence pursuant to Section 245A (b) (1) of the Immigration and Nationality Act. Such aliens may obtain lawful permanent resident status under Section 245 (b) (1) of the Act no earlier than November 7, 1988.
- an alien who is, as of June 1, 1987, or thereafter, a special agricultural worker and lawfully admitted for temporary residence in accordance with Section 210 (a) of the Immigration and Nationality Act.
- an alien who is lawfully admitted for temporary residence as an additional special agricultural worker as of October 1, 1989 through September 30, 1993, in accordance with Section 210 (a) of the Immigration and Nationality Act.

CITIZENSHIP AND ALIEN STATUS

Establishing the Eligibility of Aliens:

- The initial criteria for determining an alien's eligibility is to establish the date of entry into this country and whether the alien is residing in Tennessee with the sponsorship of a public/private agency or an individual citizen. This policy applies to aliens, not refugees.

- The date of entry into this country by an alien can be established by viewing INS documents in the possession of the alien.

- An alien is ineligible for Families First for a five-year period beginning with the date on which the alien was granted lawful temporary resident status if the alien continuously resided in the United States illegally since before January 1, 1982, and was subsequently granted lawful temporary or permanent resident status by the Immigration and Naturalization Service (INS). The five-year disqualification provision does not apply to Cuban or Haitian applicants who have their immigration status adjusted to that of lawful temporary residents by the INS.

- Routine eligibility procedures will be applied to Families First assistance groups that have been in the country for more than three years.

- Aliens applying for Families First that have been in the country for less than three years, will have their eligibility determined according to their type of sponsorship.

Method of Verification of Alien Status:

Documentary evidence and the Systematic Alien Verification for Entitlements (SAVE) must be used to verify an alien's status.

Documentary Evidence:

- Immigration and Naturalization (INS) Form I-151 or I-551 (Alien Registration Receipt Card) or the Re-entry permit (a passport booklet for lawful permanent resident aliens)

- INS Form I-94, "Arrival Departure Record", which will be acceptable only if annotated with:

  - Section 207, 208, 212 (d)(5), or Section 243 (h) of the Immigration and Nationality Act;

  - an (S) indicating Haitian Nationals;

  - one or a combination of the following terms:

- Refugee;

  NOTE: Soviet Jewish refugees will possess Arrival-Departure Records (I-94) which contain the following statement:

  "This refugee is sponsored by the Hebrew Immigrant Aid Society and (name of local Jewish organization. Private resources are available. If public assistance is sought, please call (name of local agency) at (phone number)."

- Parolee or paroled;

- Conditional Entry or Entrant, or

- Asylum

  NOTE: If an INS Form I-94 is annotated with the letters (A) through (L), this verification that the alien does not meet citizenship requirements for FS/FF purposes and is ineligible for benefits. If, however, the alien can present other documentation from INS that he does meet requirements, this will be acceptable.

- Passports stamped with the annotation "Processed for I-551" will be acceptable verification of eligible alien status.

- Iranian Nationals were granted "Voluntary Departure" status until September 1, 1979. After that date, INS will decide on individual claims of persecution based on race, religion, or political opinion. Unless an Iranian has documentation supporting the eligible alien status, (s)he is not eligible for Families First.

- Temporary Resident Card, Form I-668, means that an amnesty alien has been approved for temporary residence. If the form is coded to show that the alien was admitted under Section 245A, the alien is <u>not</u> eligible. If the form is coded to show the alien was admitted under Section 210, the alien is eligible until the expiration date stated on the face of the document.

  Forms such as I-688A, Employment Authorization Card, or Employment Authorization Document (EAD) and I-689 shows that an alien has <u>applied</u> for admission. They are <u>not</u> acceptable documents to show that a person has been admitted under an eligible section. In addition, Form I-181-B cannot be used as acceptable verification.

- If the INS Form I-94 does not bear any of the above annotations, the alien may state the reason and submit other conclusive verification, such as a notice, letter, or

identification card that establishes that the alien has been admitted for permanent residence as a legal alien.

- Other evidence of eligible status includes:

  - verification of the alien's classification under Section 101 (a)(15), 101 (a)(20), 207, 208, 212 (d)(5), 243, 249, of the Immigration and Nationality Act; or

  - Form G-641 (Application for Verification of Information from Immigration and Naturalization Service Records) when it is properly annotated at the bottom by INS representative that the alien was admitted lawfully for permanent resident status or paroled for humanitarian reasons.

- A court order stating that deportation has been withheld pursuant to Section 243 (h) of the Immigration and Nationality Act.

  The alien may contact INS or otherwise obtain the necessary verification. If the household does not wish to contact INS, give the household the option of withdrawing the application or participating without the ineligible alien.

- If an alien is unable to provide an INS document that will verify alien status (not even an INS Form 1-94), the worker has no responsibility to contact INS on the alien's behalf. When a person indicates inability or unwillingness to provide documentation of alien status, that person should be classified as an ineligible alien status.

Systematic Alien Verification for Entitlements (SAVE) System

- The SAVE system is the process of verifying an alien's immigration status by validating the alien's INS documents through the Immigration and Naturalization Service (INS).

- Do not deny or reduce benefits pending verification of an alien's documentary evidence through SAVE.

- Use one of the following SAVE verification procedures to establish an alien's status:

  - Use telephone interaction between DHS and INS using the INS' Alien Systematic Verification Index (ASVI) data base as the primary verification method.

  - Counties with touch-tone telephones have direct access to the ASVI data base. These counties will have a unique four-digit identification number.

- Only those persons designated by District Family Assistance Directors are permitted to access the ASVI data base.

CITIZENSHIP AND ALIEN STATUS

- Use the following steps to access the ASVI data base:

  - Dial the toll free system access number: 1-800-365-7620

  - Listen for the following message:

    "Welcome to the INS ASVI System....(various messages). Please enter your authorization code followed by the pound sign"

  - Enter the Authorization Code: *42*91*81*62----#

  - Listen for the following message:

    Enter the A-Number. Substitute a leading zero (0) or zero, if appropriate, for the leading "A". A total of nine (9) digits must be entered to satisfy the Alien Registration Number response.

    EXAMPLE: An A-Number having 9 numeric digits will be entered as follows:

    A123 456 789 = 123 456 789

    An A-Number having 8 numeric digits will be entered as follows:

    A12345 678 = 012 345 678

    An A-Number having 7 numeric digits will be entered as follows:

    A1 234 567 = 001 234 567

  - Listen for further prompting from the "voice" to complete the verification process.

- Secondary Verification

  - INS Form G-845 is secondary method for verifying an alien's immigration status.

  - Use INS Form G-845 in the following situations:

    - the State Agency is unable to access the ASVI data base;

    - the alien is in a category which is not recorded in the INS computerized file;

- a determination is made that the documentation presented by the alien is questionable;

- a material discrepancy in the records requires resolution, when no record on the ASVI data base is found for the alien applicant;

- non-INS documents are accepted as reasonable evidence of the alien's immigration status; or

- the alien's documented status cannot be validated after accessing the ASVI.

- Secondary Verification Procedures

  - Complete INS Form G-845 for each applicant who is not a U.S. citizen

  - Copy the verification used to establish satisfactory immigration status

  - Attach a copy of the verifications to the Form G-845. (INS requests that we staple the verifications to Form G-845 in the upper left-hand corner using only one staple)

  - Submit the verification and Form G-845 to INS at the address below:

Immigration and Naturalization Service
1341 Sycamore View Road, Suite 100
Memphis, Tennessee 38134
Phone Number: (901) 544-0256

  - Review returned Forms G-845 to ensure that legal alien status is validated and document CLRC.

Income and Resources of Ineligible Alien

- Consider the countable income of an ineligible alien as available to the remaining AG members only if the ineligible alien is a parent, spouse of an AG member, or stepparent living in the home.

- If the ineligible alien is a parent, deem her/his income as available to her/his eligible dependent child by using the stepparent deeming formula.

- Consider the resources of an ineligible alien as available to the remaining AG members only if the excluded ineligible alien is a parent of dependent children included in the AG.

CITIZENSHIP AND ALIEN STATUS

When the alien presents acceptable verification of alien status which results in her/his meeting eligibility requirements, he or she will be added to the AG effective the first month following the month the verification requirements is met, assuming all other eligibility requirements are met.

Public or Private Agency Sponsors:

Effective October 1, 1984, any alien under the sponsorship of a public or private agency/ organization is not eligible to receive Families First within three years of entry into the country unless it is proven (and documented) that the agency is no longer in existence or has become unable to meet their sponsorship obligations to the alien.

If the status of any sponsoring agency/organization cannot be verified at the local level, contact the State Office Policy Section.

If it is determined that the agency is unable to meet their sponsorship obligations, determine the alien's eligibility by following routine eligibility procedures.

Exception: Soviet Jewish Refugees

Soviet Jewish refugees who are sponsored by the Hebrew Immigrant Aid Society and local Jewish organizations are:

- ineligible for Families First for <u>two</u> years from the refugee's date of entry or until the refugee is lawfully admitted by permanent residence status, whichever comes first, if the refugee's financial needs are being met by the sponsor.

- Do not deny any application filed by a sponsored Soviet Jewish refugee solely because of knowledge of a sponsorship agreement.

- Follow up with the sponsoring agency to determine whether the refugee has any income and resources and what assistance the agency is providing to the refugee.

Individual Citizen Sponsors:

- Effective October 1, 1981, aliens who apply for Families First for the first time must have the income and resources of their individual citizen sponsors considered in determining their eligibility for assistance.

- The income and resources of the sponsor shall be considered for a period of three years after the alien's entry into the United States.

CITIZENSHIP AND ALIEN STATUS

- An individual citizen is a person who signed an affidavit or other statement accepted by INS as an agreement to support an alien as a condition of the alien's admission for permanent residence in the United States.

Alien's Responsibility:

- The alien is responsible for obtaining the cooperation of her/his sponsor and for providing the information necessary to determine the alien's eligibility. This will include material provided in support of the alien's immigration application.

- Failure to obtain the sponsor's cooperation or to supply the information will result in denial/closure of the application/case.

Alien's Exempt From This Provision:
Aliens who are exempt from the provision are those who were:

- paroled into the United States as refugees;

- granted political asylum by the Attorney General;

- admitted as Cuban or Haitian entrants;

- admitted under Section 203 (a)(7) of the Immigration and Naturalization Act prior to April 1, 1980;

- admitted under Section 207 (c) of the Act after March 31, 1980;

- alien children of sponsors or of sponsor's spouse; or

- recipients of AFDC prior to October 1, 1981, or a former AFDC recipient who reapplies for Families First in the future.

Establishing Income and Resource Amount From Sponsors:

The following steps are necessary in establishing the amount of income and resources which shall be deemed from the individual citizen sponsor to the alien whether or not these are actually available to the alien.

INCOME of Sponsor:

- Determine the gross earned and unearned income of the sponsor and the sponsor's spouse (the latter's income will be considered even if the marriage occurred after the affidavit of support was executed).

NOTE: If the sponsor and/or spouse receives Families First or SSI, no income is to be Considered available to the alien.

- Deduct from the gross earned income (wages, salaries, or net earnings from self-employment) 20% of the total of such amounts or $175.00, whichever is less.

- Deduct the Consolidated Standard of Need for the number of individuals living with the sponsor who are claimed by the sponsor and/or the sponsor's spouse as dependents for federal personal income tax liability.

- Deduct the amount the sponsor and/or spouse pays to individuals outside the home who are claimed as dependents for federal income tax purposes.

- Deduct any amount paid by the sponsor and/or spouse for child support or alimony to individuals living outside the home.

- The remaining income is considered as unearned income to the alien and will be added to the alien's own income in determining eligibility for assistance.

- Follow Families First budgeting procedures beginning with the Gross Income Standard test.

RESOURCES of Sponsor:

- Determine the amount of countable resources of the sponsor and the sponsor's spouse as though the sponsor were applying for Families First.

- Deduct $1500 from the total countable resources.

  The balance of the resources are considered available to the alien and added to the alien's own countable resources in determining eligibility.

It is important to note that the provision for considering the income and resources of the individual citizen sponsor as available to the alien is not waived, even though the sponsor may have revoked his sponsorship agreement.

Income and resource which are deemed to a sponsored alien are not considered available to unsponsored members of the alien's family except to the extent the income and resources are actually available. Unsponsored members are not ineligible simply because a sponsored member fails to provide information regarding her/his sponsor.

Multiple Sponsorship:

When it is determined that an individual citizen sponsor has agreed to sponsor multiple families, the amount to be deemed to the eligible families is divided equally among the families who are applying for assistance. If only one family applies for Families First, then the total amount of the sponsor's liability (income and resources) is applied to the family so applying.

Liability For Overpayments:

Any sponsor of an alien and/or the alien is jointly and severably liable for any overpayment made to such alien during the three-year period following the alien's entry into the United States, if such overpayment was due to the sponsor's failure to provide correct information, except where it can be established that the sponsor was without fault or where good cause for failure to provide such information can be established. The same procedure for handling overpayment is applicable to aliens as for any other Families First recipient.

Good Cause For Sponsor To Fail To Provide Information:

Good cause for failure of the sponsor to provide correct information to the Department includes the following:

- the Department fails to request information regarding the sponsor's income and resources;
- the sponsor has had no direct contact with the Department concerning her/his income and resources, and (s)he is unaware of the information provided by the sponsored alien;
- social and/or language barriers preclude the sponsor's understanding and ability to provide the correct information; and
- other unusual circumstances which indicate that the failure to provide correct information is beyond the sponsor's control.

AGE REQUIREMENT

POLICY STATEMENT:

To be eligible for Families First benefits, a child must be

- under age 18; or
- under age 19 and will complete high school or an equivalent vocational/ technical training before his/her 19th birthday.

If an 18 year old child is in school, but will not complete high school or an equivalent vocational/technical training before turning 19, he/she will be ineligible for Families First benefits effective the month following the month of his/her 18th birthday. The 18-year old child who will complete the secondary education before becoming 19 will become ineligible the month after the month that he/she graduates.

EXCEPTIONS:

There are no exceptions to the age requirement for Families First.

VERIFICATION:

Age must be verified at each application. Once the children's age has been established it is not necessary to verify it again. Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information. For example, if the caretaker needs to obtain birth verification for a child and this information is listed on Clearinghouse, it is more reasonable for the case manager to obtain this information for the AG.

The age of an AG child will be verified using birth certificates, birth certificate information or delayed birth certificates. Pending receipt of the birth certificate , the following information which is listed in order of priority may be used to establish the child's age:

- hospital records or the records;
- records of physician or mid-wife who attended the birth of the child;
- Baptismal certificate;

- school records that show the child's age or date of birth;
- insurance policies that show the child's age or date of birth;
- Census Bureau records; or
- unaltered family Bible records.

When any verification other than the birth certificate or Division of Vital Statistics records is used, the verification must be evaluated and more than one document should be used.

In the instance where none of this documentary evidence is available and the appearance of the child obviously corroborates the caretaker's statement that the child is under 18 or 19, as appropriate, assistance may be approved pending receipt of the necessary documentary evidence. However, efforts to obtain the verification must begin during the application process and must continue until the date of birth and exact age of the child is established.

DOCUMENTATION:

The AG child's age and the information used to verify it must be recorded on the appropriate ACCENT screens. If verification is not immediately attainable and observation of the child is used for temporary verification, ACCENT running record comments, CLRC, must be documented to explain the situation.

RELATIONSHIP

POLICY STATEMENT:

To be eligible for Families First, a child must be living in the home of a parent or certain relative who is within the 5th degree of relationship to the child. A relative within the "specified degree of relationship," which is the fifth degree, are listed below. (See the chart at the end of this section for further clarification.)

- Any blood relative, i.e. father, mother, brother, sister, uncle, aunt, first cousin, nephew, niece, or first cousin once removed. This includes relationships to preceding generations, grandparents, great-grandparents, great-great grandparents, great uncles/aunts, and great-great-great grandparents.

- any of the above relatives who are of half-blood relationship.

- Stepfather, stepmother, stepbrother and stepsister.

- Legally adoptive parents of the child or of the child's parents, the natural and other legally adopted children of such persons, and the blood relatives of such persons, including first cousins, first cousins once removed, nephews and nieces.

- Legal spouses of any of the persons named in the above groups. This applies even though the marriage may have been terminated by death or divorce.

The caretaker relative does not have to be the legal guardian or custodian of the child in order to receive Families First benefits for the child. Blood relationships within a specified degree of the child and relative is the eligibility requirement for Families First purposes.

Relationship Terms:

Adoption of children - Legal adoption of a child or a child's parent establishes a legal relationship to a new set of relatives, both immediate and extended. The adoptive relatives within the specified degree of relationship qualify to receive families First for an adopted child as do the blood relatives of the adopted child.

Child Born of Annulled/Bigamous Marriage – Children born of an annulled or bigamous marriage are considered the legal children of that marriage.

Child Born During Marriage – By law in Tennessee, any child born during a marriage or within ten months of the termination of that marriage by death or divorce is presumed

to be the child of the mother's husband. This presumption can be overcome only by strong and convincing evidence that it would have been impossible for cohabitation between the mother and her husband to have occurred at the time of the child's conception. Therefore, when a child is born in these circumstances, the mother's husband will be considered to be the child's father. This is true, even if it is alleged that someone other than the husband is the child's father, until paternity is established in a court of competent jurisdiction.

Legitimated Children – Children who have been legitimated are entitled to all rights and privileges of a child born in wedlock. Therefore, relatives of the legitimating parent are considered as relatives eligible to receive Families First for the child.

Termination of Parental Rights – Termination of parental rights by a court of competent jurisdiction terminates all of the rights and responsibilities of a child's parents. However, such termination does not affect a child's relationship to his/her natural extended family. When blood relationship to these relatives can be factually established, they may receive Families First for the child.

EXCEPTIONS:

The relationship requirement cannot be waived. Therefore, even though a person may have been awarded legal guardianship or custody of a child or otherwise stands ***in loco parentis*** to the child, he/she is not eligible to receive Families First benefits for the child unless he/she is also a specified relative. However, when a child is born during a marriage or within ten months of the termination of that marriage by death or divorce, the child is presumed to be the child of the mother's husband. In this instance, legal relationship takes precedence over blood relationship. A court order changing the paternity of the child will be necessary to change the relationship for Families First purposes.

VERIFICATIONS:

Relationship must be verified before Families First benefits can be approved. Once the relationship is verified, it is not necessary to verify relationship again unless the information becomes questionable. Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information.

RELATIONSHIP

The following documents can be used to verify relationship whether legal or alleged. When any document other than a birth certificate or birth data obtained through Tennessee Clearinghouse is used to establish relationship, more than one document is required:

- birth certificates, copies of birth certificates or Tennessee Clearinghouse which establish relationship of the child to his/her parent; (In instances where the caretaker relative is not the parent, these documents can be used to verify the relationship of the caretaker relative to the child's parent. This is a preferred form of verification, but is not required.)

- adoption and legitimation orders that establish the relationship of the child to his/her parent;

- hospital birth records;

- family Bible or other family records which are in ink and have not been altered;

- trust documents and other such instruments and/or records if relationship is specified in the document;

- wills and deeds to property if the individuals and relationships are specified;

- Census Bureau records that list the child belonging to a particular family and showing relationships;

- written statements of physicians or midwives who attended the births and remember the names of the people involved;

- social agency records including those of DHS which are at least one-year old and which consistently specify the degree of relationship of the applicant/recipient to the child;

- Juvenile Court, other court and hospital records which show relationship;

- copies of income tax returns listing the child as a specific relative;

- school records which specify relationship;

- an award letter or other acceptable evidence from SSA that RSDI payments have been awarded to a child based on his/her parent's account;

- military or veterans records which specify relationships;

- INS records, Indian Agency records, other government or local agency records;

- newspaper records, and local histories which specify relationship;

- an Acknowledgement of Paternity properly completed by an alleged natural father of a child is sufficient substantiation of blood relationship; (This document is then routed to the IV-D agency so that they may initiate procedures to have paternity judicially determined to offer the child protections for purposes other Families First eligibility.)
  or

- written materials of other kinds may be used as cumulative evidence of relationship when names and relationship are specified. Such materials include church, daycare and school records, letter and other such written materials.

In the absence of any documentary proof of relationship, the caretaker relative's statement is acceptable as long as it contains the following information:

- the reason there is no proof of relationship;

- his/her detailed statement as to how he/she is related to the child;

- as least one notarized statement from a person in a position to know the facts of the situation in which he/she describes the relationship and how he/she know it to be true.

The notarized statement that is used may be either written by the individuals providing the information or DHS staff can write out the statement and have the individuals' signature notarized. These affidavits may be used to fill in gaps in the information verified by documentary evidence or in lieu of documentary evidence if none exists. An affidavit tracing relationship must be made by a person other than the applicant/recipient. This person may be related or not related to the AR, but he/she must be a person who is in a position to know the facts of the situation. More than one affidavit may be required in order to completely trace relationship.

DOCUMENTATION:

All information regarding relationship must be documented on the appropriate ACCENT screens. Any other pertinent information regarding relationship must be documented on running record comments. For example, once the relationship is verified, it is not necessary to verify relationship again unless the information becomes questionable. If that occurs, the case manager must document the ACCENT case regarding the questionable circumstances and the outcome of the verification.

RELATIONSHIP

PROCEDURES:

The case manager must evaluate the evidence used to establish relationship as to its validity, consistency and the credibility of the person providing the information. Any conflicting information must be resolved before approval of a Families First application. The case manager must obtain any available information necessary to constitute a preponderance of consistent evidence of relationship to determine the relationship of the child to the caretaker. Each step of the relationship between the child and caretaker must be traced and documented. Do not use an affidavit to show relationship when documentary evidence is available or can be obtained.

FAMILY RELATIONSHIP CHART

5° Great-Great-Great Grandparent

4° Great-Great Grandparent

3° Great-Grandfather/ Great-Grandmother

2° Grandfather/ Grandmother

1° Father Mother

* SELF

1° Son Daughter

2° Grandson/ Granddaughter

3° Great-Grandson/ Great-Granddaughter

4° Great-Great-Grandchild

5° Great-Great-Great-Grandchild

2° Brother/ Sister

3° Nephew Niece

4° Grandnephew Grandniece

5° Great-Grandnephew Great-Grandniece

3° Uncle/ Aunt

4° 1st Cousin

5° 1st Cousin Once Removed

1st Cousin Twice Removed

1st Cousin 3 Times Removed

4° Granduncle/ Grandaunt

5° 1st Cousin Once Removed

2nd Cousin

2nd Cousin Once Removed

2nd Cousin Twice Removed

2nd Cousin 3 Times Removed

5° Great-Granduncle/ Great-Grandaunt

1st Cousin Twice Removed

2nd Cousin Once Removed

3rd Cousin

3rd Cousin Once Removed

3rd Cousin Twice Removed

3rd Cousin 3 Times Removed

* ALL DEGREES OF RELATIONSHIP ARE TO SELF

USING THE FAMILY RELATIONSHIP CHART

All degrees of relationship on the Family Relationship Chart are to SELF. For example, a son or daughter, or a father or mother, are in the first degree of relationship to SELF.

When using this chart to determine degrees of relationship between cousins (since these relationships seem to be the most confusing), keep in mind the following guidelines:

- Your first cousin is your parent's brother's or sister's child. This relationship is in the fourth degree, and is a specified relationship for Families First.
- Your first cousin's child is your first cousin once removed. This relationship is in the fifth degree, and is a specified relationship for Families First.
- The child of your first cousin once removed is your first cousin twice removed. This relationship is on the sixth degree, and is not a specified relationship for Families First.
- Your grandparent's brother or sister's grandchild is your second cousin. This relationship is the sixth degree, and is not a specified relationship for Families First.

Example 1:

Joe's Aunt Netta is applying for Families First for him. We look at the chart and see the Uncle/Aunt is in the third degree of relationship for SELF, so Aunt Netta is in the third degree of relationship to Joe, so he is a specified relative for Families First purposes.

Example 2:

Kathryn's father is Ralph. Ralph's first cousin, Ellie, is applying for Families First for Kathryn. The child of the one's first cousin is a first cousin once removed, which is the fifth degree of relationship. Ellie is a specified relative for Families First.

Kathryn has a baby, Margaret. Ellie applies for Families First for Margaret, but is not eligible because she is the first cousin twice removed, which is the sixth degree of relationship.

Remember: Specified relatives also include certain step-relationships, as well as "legal spouses" of the above groups, even though the marriage may have been terminated by death or divorce.

LIVING IN THE HOME WITH A RELATIVE

POLICY STATEMENT:

To be eligible to receive Families First benefits, a child must live in a place of residence maintained by a specified relative as his or her home and the home of the child. For Families First purposes, legal custody is not pertinent to the determination of eligibility and relationship. Where the child actually lives and who has care and control of the child are the determining factors.

A relative is considered to have **care and control** of child when he/she has the major responsibility for parental obligations of day-to-day care, support, supervision and guidance for the child. These responsibilities may be carried out either alone or with another person living in the home. When the child lives with the relative, it is presumed that the relative has care and control of the child. However, there are certain situations when this may be questionable and the case manager must determine who has care and control of the child. The following are examples of instances when care and control must be established:

- joint custody cases;
- when the relative and the child live in different dwellings;
- when temporary absence is claimed; and
- when a relative who is not the parent receives Families First benefits for the child and a parent returns to the home.

The decision as to if the relative has care and control of a child is made on a case by case basis. The case manager/supervisor must evaluate the facts in each particular situation and use their best judgement. If the facts establish that the relative has care and control, then the child is considered to be living with that relative. See Procedures in this section for a guide in determining care and control.

EXCEPTIONS:

When there is a situation of **joint custody**, the case manager must look at each situation on a case by case basis. If the child lives with both parents, then deprivation must exist based on incapacity or unemployed parent policy unless the child lives with each parent for extended periods. In that case, the child may meet the deprivation by absence criteria and would be eligible to be included in the home of the parent with whom he/she resides at the time of application. When the child goes to live with the other parent, eligibility ceases to exist with the first parent.

LIVING IN THE HOME WITH A RELATIVE

Eligibility can continue for Families First during **temporary absences** from the home for either the child or the relative. A temporary absence of the child or relative is of short duration with specific intentions of returning on or about a specific date. In addition, the relative must continue to provide care and control of the child even though either the child or the relative is temporarily absent from the customary family setting. Any absence of either the child or relative which will extend beyond three months must be studied carefully to determine if the relative actually retains care and control of the child for a major portion of each month.

Some examples of when Families First benefits can be granted or continued for a child who is temporarily out of the home are when the child

- is away on a visit;
- is in the hospital temporarily for treatment;
- attends summer camp;
- attends an accredited or approved school away from home for the primary purpose of academic education or vocational/technical training because the school facilities to meet this child's special needs are not available in his/her own community or within commuting distance;
- attends a college, university or other vocational school on a scholarship or other grant that is not available in his own community;
- is temporarily in a psychiatric facility and has not been placed there by a court order; or
- is in a maternity home

A child with special needs includes one who is especially gifted in a particular area such as an academically gifted or artistically gifted child or one who has a physical, mental, emotional or learning disability. A facility that is established primarily for the purpose of providing child care or which is licensed for that purpose does not qualify as an accredited or approved school regardless of what the facility might be called.

Some examples of when Families First benefits can be granted or continued for a relative who is temporarily out of the home are when the relative:

- is away on a visit;
- is providing some care for a spouse or child who is hospitalized;

- is attending a specialized training facility not available in his/her home community such as those through the Services for the Blind or Division of Vocational Rehabilitation;

- is in the hospital for treatment of an acute illness or injury;

- is in a maternity home;

- is in a convalescent care facility for the purpose of obtaining special care that is not available in the home;

- is absent for the purpose of setting up a home to which he/she will move the child; or

- is temporarily in a psychiatric facility and has not been placed there by a court order and will be absent for no more that six months.

A person who resides in a **maternity home** may be eligible for Families First benefits. Eligibility is determined as though she was currently living on her own or in a foster home. The period of time spent in a maternity home is a temporary absence from her usual home and eligibility is established based on the circumstances that exist there. If the home situation is being dissolved, eligibility is determined based on the situation as it currently exists. Residents of a maternity home may apply either in the county of their usual residence or in the county where the maternity home is located.

VERIFICATIONS:

Current school records showing the address of a school age child are the primary evidence that the child in the home of the relative requesting Families First benefits. However, if the child is not school age or the school records are unobtainable for a school age child, use the following sources of evidence:

- Hospital, clinic, or Health Department records

- Statement from a child care provider

- Court support order;

- Juvenile court records.

- Child Welfare agency records.

- Statement from a minister, priest or rabbi.

- Signed statement from a non-relative.

- Signed statement from a non-relative landlord.

- Personal contacts by the case manager with neighbors as to where, to their knowledge, the child lives; or

- Case manager observation that the child lives in the home.

DOCUMENTATION:

All information and verification about where the child lives, temporary absence, joint custody, etc. must be recorded on the appropriate ACCENT screens and in running record comments, CLRC. All extenuating circumstances and/or unusual situations must be fully explained and must include all information used by the case manager/supervisor in making decisions about whether or not the child meets the Families First requirement to live with the caretaker/relative.

PROCEDURES:

The following questions are guides to consider when determining if a relative has **care and control** of a child. The child's age and degree of independence are also factors in making this decision.

- Who has and exercises responsibility for daily physical maintenance of the child such as purchasing/preparing food, purchasing/maintaining clothing, providing a place to sleep and basic shelter, and overseeing daily health maintenance activities?

- Who has and exercise responsibility for securing medical/dental care for the child?

- Who has and exercises responsibility for consenting to major medical treatment procedures for the child?

- Who receives and expends monies for the child?

- How many weeks in a month does the child stay in the relative's home? How many weeks in a month does the child stay away from the relative's home?

- What address is shown for a school age child on the school records?

- If a child is in day care, who takes the child to and picks the child up from the facility? Who does the daycare facility consider the responsible relative?

- Is the child included on the lease in public housing or does the landlord/rental agent know of his/her presence in the dwelling?

LIVING IN THE HOME WITH A RELATIVE

- Do other records indicate where the child lives?

When **joint custody** has been granted, the case manager must:

- obtain a copy of the order or custody order, if possible;
- determine if the order is being followed;
- determine if both parents are functioning as parents;
- determine where the child spends the majority of the time;
- if the child is of school age, obtain from the school records the child's address and the name and address of the person to be notified in emergencies;
- determine if the child receives food stamps in the household in which he/she is included;
- ask neighbors, friends, relatives, etc. with whom they consider the child to be living;
  and
- determine who exercises care and control of the child.

The case manager /supervisor will make their decision about where the child is living based on the information obtained through the sources listed above.

When determining **temporary absence**, the case manager must establish:

- the name and location of the school, camp, maternity home or hospital where the person is;
- the name and address of the friend or relative the person is visiting;
- the date the individual left the home and the expected date of his/her return;
- the reason for the absence and the person responsible for the plans for the person to return to the home;
- the responsibility that the relative has for the child while either of them is away from the home, such as financial responsibility and decision making regarding the child's care; and
- specific arrangements for the individual's return to the home.

LIVING IN THE HOME WITH A RELATIVE

The case manager will use this information to decide whether temporary absence exists or whether the person actually lives elsewhere. If temporary absence exists, an alert must be set to review the case when the individual is expected to return to the home.

DEPRIVATION

POLICY STATEMENT:

To be eligible for Families First a child must be in need according to the Families First assistance standards and deprived of parental support and/or care. Deprivation is due to one of the following:

- continued absence of one or both parents;
- death of one or both parents;
- incapacity of one or both parents; or
- unemployment of one or both parents

I. ABSENCE

POLICY STATEMENT:

To determine that a child is deprived of parental support because of absence, the case manager must establish that at least one natural parent is absent from the home in which the child lives. As a condition of Families First eligibility, the remaining parent or caretaker relative must give required information about the absent parent and cooperate with the IV-D agency as necessary. If the absent parent has a separate living arrangement from the child for which Families First is requested, absence can be considered to exist. Visits from the absent parent need not be based on a court order or other formal arrangement if the absence from the home is established as follows:

Absence from the home may exist because of any of the following:

- divorce of natural parents and only one or neither parent remains in the home with the child;
- separation of parents;
- desertion of one or both parents;
- imprisonment of one or both parents;
- institutionalization of one or both parents;

DEPRIVATION

- one or both parents are serving a court imposed sentence of unpaid public service while residing at home; and/or

- single parent adoptions

Continued absence will be considered to exist when one or both parents is/are out of the home and the nature of the absence:

- interrupts or terminates the parent' s functioning as a provider of maintenance, physical care, or guidance for the child, and

- to know (e.g. institutionalization of parent in medical/psychiatric facilities, incarceration, etc.) or indefinite duration of the absence precludes counting on the parent to perform his/her function in planning for the parental support or care for the child.

Continued absence will be considered to exists when one or both parents is/are <u>out of the home</u> and the nature of the absence:

- interrupts or terminates the parent's functioning as a provider of maintenance, physical care, or guidance for the child, and

- the known (e.g.; institutionalization of parent in medical psychiatric facilities, incarceration, etc.) or indefinite duration of the absence precludes counting on the parent to perform his/her function in planning for the parent support or care for the child.

How do we determine when continued absence exists?

In the great majority of cases, absence exists when one of the parents does not live in the home with the child.

When a parent lives outside the child's home his or her ability to provide maintenance, physical care, and guidance is usually interrupted, and absence can be presumed to exist.

If the child was born out-of-wedlock and paternity has not been subsequently established, absence is presumed to exist.

> In Tennessee, if a father has taken legal action to legitimate a child and lives in the home with that child, the child is NOT deprived of parental support on the basis of continued absence.
>
> By the same token, if a father has acknowledged his blood relationship with the child, and lives in the home with that child, the child is NOT deprived of parental support on the basis of continued absence.

DEPRIVATION

NOTE: If the child is determined not to be deprived of parental support on the basis of absence, and is otherwise, eligible, determine of one of the parents is incapacitated or unemployed.

Both federal and state policy support the maintenance and strengthening of family ties. "Absence" does not preclude the parent who does not live with the child from visiting with the child regularly, taking the child on outings or for visits in his home or otherwise building an ongoing positive relationship with the child. The absent parent can and should be an important influence in the child's life. An absent parent's purchase of small necessary items or items of clothing for a child is by no means evidence that deprivation does not exist. The absent parent may still maintain a relationship with the dependent child and is encouraged to do so.

"Absence " Due to Court Imposed Unpaid Public Service

A child is to be considered deprived of parental support and/or care by reason of continued absence from the home when:

- a parent has been convicted of an offense and is under sentence of a court; <u>and</u>
- the sentence requires-and the parent is performing-unpaid public work or community service during working hours which totally precludes gainful employment; <u>and</u>
- the parent is permitted by the court to live at home while serving the sentence.

The sentence must be verified with the Clerk of the Court which issued the Order. In addition, it must be verified that the unpaid work is actually performed.

Real and personal property belonging to the convicted parent is considered available to the AG.

Should the convicted parent have any form of countable unearned income, except SSI, the excess above his/her own CNS needs should be counted as available to the family.

The convicted offender living at home and performing unpaid work:

- cannot be included in the assistance unit
- cannot be the payee
- is not an FF applicant/recipient so is not required to participate in work
- must not be treated as an absent parent in relation to child support requirements.

DEPRIVATION

Alleged Parent Defined

The natural father of a child born out-of-wedlock whose legal paternity has not been established.

Note: Absence does not exist if both parents, including the alleged parent, live in the home with the child.

The mother or other eligible relative applying for assistance for such a child will be required to provide all the facts known and advised of services available to establish the identity and marital status of the father of the child unless she/he has good cause. (See Sanctions Chapter for consequences of failure to comply with this requirement.)

If the mother states she does not know the father's full name or has not seen him since the child was born, or he was just a casual visitor, in military service, etc., "just passing through", her statements to this effect will be substantiated through other sources of information. In these instances, eligibility will be determined and a referral will be made to the service worker if there is an indication that the children are being harmed by such casual relationships. (Refer to Protection of Children Chapter)

Deprivation on the basis of absence exists even though the parent who remains in the home has remarried and the stepparent is also in the home. For Families First purposes, a stepparent is not considered a legally responsible relative. Therefore, Families First may be approved for the child of the parent's former marriage or for a child born out-of-wedlock who is otherwise eligible regardless of the fact that the child is living in the home with an able-bodied parent and stepparent.

Absence does not exist when a parent is away from the home in which the child is living solely for reason of the parent's employment (long distance truck drivers, traveling salespersons, construction workers on international projects, etc.) or performance of active duty in a uniformed service of the United States (Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Administration and US Public Health Service). This is viewed as an intact family in which the parent is away from home for reason of employment.

The case manager must evaluate the family situation and determine whether or not absence of a parent exists. Generally if a parent was living at home with his/her family prior to leaving in order to work or serve elsewhere, the family will be viewed as intact.

However, absence may be established if:

- the parent was not living at home for reasons other than active service due or employment prior to leaving in order to work or serve elsewhere, and

- divorce proceedings had been instituted or the couple has separated; and

- the AR claims the family is not intact.

In the instance where the parent is in uniformed service, the case manager may assist the caretaker to request an allotment be sent directly to himself, herself or the IV-D agency by writing the appropriate commanding officer/payment center. A referral also may be made to the local chapter of the American National Red Cross for this help.

Absence does not have to exist for a specific period of time. However, the length of time the absence is apt to exist must be considered. When it is evident that the absence will terminate before the application can be processed and payment, the condition of continued absence is not met.

When the absent parent recently left the home and it is not clear that the absence will continue indefinitely, absence must be verified within three months of the date of approval or sooner, if necessary. Set an expected change as appropriate in these situations.

VERIFICATION:

Verification is primarily the responsibility of the AG. Continued absence must be verified at each application, reapplication and review.

DOCUMENTATION:

All pertinent information regarding the absent parent must be documented on the appropriate ACCENT screens. Any additional information not specified on the absent parent screens should be recorded in running record comments, CLRC. The following information should be collected:

- the absent parent's identity
- the absent parent's whereabouts
- length of absence and whether or not there is a possibility of reconciliation or reestablishment of the relationship.
- circumstances regarding the absence
- the absent parent's employment, including the type of work he/she normally does if unemployed
- the absent parent's SSN, date of birth, place of birth and parent's names
- whether or not the absent parent is providing support or adequate support

- whether or not the absent parent is married, divorced, separated, living with a partner etc.

- whether or not the child has been legitimated if born out-of-wedlock or whether or not he/she has a legal parent

PROCEDURES:

Although locating and pursuing child support from all absent parents is the responsibility of IV-D, the case manager must collect all possible information about the absent parent that will assist IV-D, as well as establishing that the child is deprived of parental support. The best method of determining that the child is deprived of parental support based on absence is to interview the absent parent. If the absent parent is in the same county, the case manager should locate and interview the absent parent, whenever possible, to determine:

- whether or not he/she is currently supporting

- the amount and frequency of support

- the method of support payment and any future plans to support the child or establish paternity, if applicable.

In single parent adoptions, absence of one parent exists because there is only one parent. There are no child support requirements on these cases. The fact that an adoption decree states that the adoptive parent is financially able to provide for the child has no bearings on the child or caretaker's eligibility. It is an indication that the worker must thoroughly explore all financial circumstances to determine the facts of the current situation and what has happened to cause the need for AFDC.

Child Born in Wedlock

A child born during a marriage (either a valid legal marriage, an annulled marriage, or a bigamous marriage) is presumed to be the legitimate child of that marriage. Any child born in wedlock or within ten calendar months from the divorce or death of the mother's legal husband is presumed to be the legitimate child of the mother's husband. This presumption can be overcome only with strong and convincing proof that it would have been impossible for the mother and her husband to have cohabited at the time of conception. (For example, if he was abroad in the armed services or if he was in prison at the time of conception.)

DEPRIVATION

Child Born out-of-Wedlock

A child born to an unmarried mother with or without a known father is a child born out-of-wedlock.

Voluntary Legitimation

Voluntary legitimation is accomplished through a petition to the court (usually the Juvenile Court) by the natural father (when he is not married to the mother) with the acknowledgement that he is the child's natural father and that he wishes to legitimate the child. The court then makes a decision as to whether he will be declared the legal father of the child.

Marriage of the Natural Parents to Each Other

If the father of the child born out-of wedlock "holds the child out" as his and the parents are married to each other after the child's birth, the child is legitimated at the point of the parent's marriage. Documentation of the marriage and a notarized request for a new birth certificate must be sent to Vital Records in order to change the child's birth certificate to show his legitimate status. The parents may request legitimation by making application for a new Certificate of Birth to the Tennessee Department of Health and Vital Records.
Both parents must sign the necessary forms in order for the change in records to be made.

Valid Common-Law Marriage

Tennessee does not recognize common-law marriages established in Tennessee, but does recognize common-law marriages established in states which view them as legally binding. Children born of such previously established marriages are considered legitimate and the spouses are obligated to each other financially. Exception: Not valid for deeming stepparent income.

Bastardy Proceedings

A petition by the mother or Department of Human Services or someone acting on the child's behalf is filed in Juvenile Court seeking to have a child's status legally determined. The burden of proof of paternity is on the petitioner. If a child is not voluntarily legitimated, this is the only alternative for establishment of paternity in Tennessee. If the alleged father wishes to contest the action, he may have the case transferred to Circuit Court by demanding a jury trial on the issue of paternity.

DEPRIVATION

Actions Subsequent to HLA Blood Testing

Prior to very recent years, blood testing could only be used as evidence to disprove paternity. However, now that HLA blood testing can include or exclude an alleged father with 95 percent to 99 percent degree of accuracy, courts are accepting these tests in determining the biological father of a child and are issuing orders of paternity based on the results. Thus, these tests, are being utilized with increasing frequency.

Once an order of non-paternity has been issued in a particular case, that man has been legally declared not the father of that child. In such cases, no further attempts should be made to pursue the matter of paternity/child support against that man for that child.

In FF paternity cases handled by IV-D, a copy of the court order issued will be forwarded to FF staff so that the information can be recorded on the absent parent screens in ACCENT. The court order must be checked carefully by the EW when received so that prompt appropriate action can be taken. (within 30 days).

If the order confirms that the alleged parent is the natural/legal parent, the FF family's Circumstances must be determined. If the parent is in the home with the child, the child is no longer eligible unless the parent is disabled. If the parent is out-of-the-home, IV-D will follow up on securing support.

If the court order declares that the named alleged parent is not the natural/legal parent, further action by the worker is required promptly.

- Once such a court order is issued, no further referral to IV-D naming that man as the natural parent of that child can be made.

- The mother (other caretaker or grantee relative) must be interviewed and she must be informed that it is not acceptable for her to continue to name that man as the alleged parent, that she must name the true natural parent, explain why she named the previous man, and /or give a reasonable explanation of the true circumstances of the child's parentage. If she does not do this, sanctions must be applied (see Sanctions Chapter).

- IV-D must be notified of the current status of the case and other appropriate changes (if any) must be made in the assistance group/payment.

Interview held with the child's mother (grantee relative) should always be face-to-face and conducted in privacy. If at all possible, the child in question/other children should not be present.

DEPRIVATION

Sensitive but persistent probe interviewing will probably be required to elicit the kinds of information necessary to enable the worker to make a decision as to whether the client is cooperating in the matter of paternity/child support, whether the client chooses to claim good cause for failure to cooperate, whether good cause exists, and the appropriate action to take.

A glib naming of another man, or a statement of "I don't know" is not acceptable by itself. Information about the circumstances surrounding the child's conception, the mother's life style, why the original man was named, whether the possibility of different parentage exists, and so on must be elicited and recorded.

II. DEATH

Deprivation because of death of one or both parents must be documented on the appropriate ACCENT screens and in running record comments, CLRC. Verification of death may be obtained through any of the following sources:

- death certificate
- physician's report or statement;
- funeral home records;
- cemetery records;
- newspaper notices
- the Division of Vital Records; or
- statements from persons in a position to know.

III. INCAPACITY

POLICY STATEMENT:

The assistance group meets the Families First deprivation requirement when both parents live in the home with the child if one of the parents is incapacitated. "Physical or mental incapacity" of a parent shall be deemed to exist when one parent has a physical or mental defect, illness, or impairment. The incapacity shall be supported by competent medical testimony and must be of such a debilitating nature as to reduce substantially or eliminate the parent's ability to support or care for the otherwise eligible child and be expected to last for a period of at least 30 days. In making the determination of ability to support, the agency shall take into account the limited employment opportunities of handicapped individuals.

DEPRIVATION

Incapacity exists if the mental or physical defect, illness, or impairment reduces substantially the parent's ability either to provide financial support for the child or to provide for the child's day-to-day physical care or guidance. Therefore, "incapacity" exists in either of the following circumstances.

- if the defect, illness, or impairment eliminates or substantially reduced the parent's ability to work, regardless of whether the person retains the ability to perform other parental functions. Examples include cases where there has been a significant reduction in a parent's work-relevant physical or mental capacities, or in earnings (either because of a reduction in hours worked or rate of pay) due to the defect, illness or impairment; or

- if the person's capacity to work is not reduced, but the defect, illness or impairment substantially reduces his or her ability to provide day-to–day physical care or guidance for the child.

In determining whether incapacity exists under either test, the parent's usual or assumed family function is irrelevant, and shall not be considered.

VERIFICATION:

Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information. For example, RSDI or SSI information is available on Clearinghouse. Therefore, it would be more reasonable for the case manager to obtain this information.

The following are acceptable verifications of incapacity determination established by receipt of disability benefits:

- information from Clearinghouse that verification that the RSDI and/or SSI are based on disability or blindness

- written verification that the individual receives RSDI,SSI,VA or Black Lung based on disability or blindness, such as an award letter;

When incapacity is determined by the local office or the MEU, the following verifying documents must be obtained.

- hospital admission and discharge summaries;

- treatment summaries from the individual's treating physicians for the past two years; and

- any other pertinent medical information for the past two years.

DOCUMENTATION:

All appropriate ACCENT screens must be completed regarding the incapacitated individual's circumstances, the verifications obtained to substantiate the incapacity, information sent to the MEU and MEU or appeal decisions that affect the determination of incapacity. In addition, any extenuating or pertinent information must be documented on ACCENT running record comments, CLRC.

PROCEDURES:

An individual is considered to be incapacitated if he/she receives certain benefits (see below). In addition, a determination of incapacity can be made by the Department of Human Services supervisor, the Medical Evaluation Unit in the Department of Human Services state office or a hearing officer as the result of an Appeal for Fair Hearing.

Incapacity exists if the individual receives the following benefits:

- RSDI or SSI based on his/her disability;
- VA benefits based on his/her 100% disability;
- Black Lung benefits based on his/her own condition;

If a recipient whose incapacity was verified by receipt of RSDI,SSI,VA, or Black Lung disability benefits loses these benefits, this is not acceptable proof that incapacity no longer exists for Families First purposes. These recipients will remain eligible for Families First benefits if they continue to claim incapacity, while obtaining and submitting the necessary medical and medical-social information to substantiate their claim. Action to secure this information and submit it for evaluation must be taken promptly. This provision does not apply to applicants. Applicants must follow the normal process for establishing incapacity prior to approval.

Eligibility on the basis of incapacity may be approved or continued at the local level without additional medical evaluation for an individual who received RSDI or SSI disability payments when the payment changes from disability to retirement benefits without a break in benefits. This occurs at age 62 for RSDI and age 65 for SSI. The Department of Human Services Supervisor must approve the incapacity in this situation and there must be verification that the individual was receiving disability benefits prior to the change.

Incapacity Determination at the Local Level:

If the parent does not receive any of the above mentioned benefits, a determination of incapacity can be made by the Department of Human Services supervisor for a period of up to one year based on adequate medical evidence and the staff's observation.

INCAPACITY

In order for the county office or the MEU to determine incapacity, the caseworker must interview the individual and collect and record the data on the Medical Social Information Interview Guide. To obtain the necessary information the caseworker will assist the individual in obtaining the necessary information by making an appointment and authorizing payment for a general physical examination, as well as, obtaining necessary documentary evidence (see the Verification section of this chapter). The caseworker must also obtain all other technical and financial eligibility information.

The caseworker will submit the complete medical and medical-social information to the Supervisor for evaluation and decision on incapacity. The Supervisor may approve incapacity on the basis of adequate medical evidence and medical social information. The Supervisor can approve incapacity, if all eligibility factors are met, for a period up to one year for Families First benefits.

If the Supervisor approved this incapacity for less than one year, the individual may request an extension of approval. If such an extension is requested, additional information from the treating physician must be obtained to substantiate the extension. The Supervisor may decide to submit the medical package to the MEU for decision.

The participant is exempt from the work requirements, as well as the time limits, during this process. The client may not volunteer for any activity or receive support services.

Incapacity Determination by the MEU:

If the Supervisor is unable to reach a decision to approve or believes the application should be denied on the basis of incapacity, the entire medical and medical social information "package" will be submitted to the MEU for a decision on incapacity. This package is sent to:

Tennessee Department of Human Services
Medical Evaluation Unit
Citizens Plaza Building, 12th floor
Nashville, TN 37248-7300

If the MEU makes a decision to either approve or deny incapacity, the case must be resubmitted to the MEU for any further decisions in the year following the MEU decision.. However, if the case has been denied or closed for at least one year, the Supervisor can make the decision for any new application based on incapacity.

The MEU may approve incapacity for any length of time from 30 days or longer. Any period of incapacity approved by the MEU is subsequent to any period approved by the Supervisor. For example, if the Supervisor approves incapacity for three months and the MEU approval is for six months, the total period of incapacity is for nine months. If the incapacity is approved at the local level and is subsequently denied by the MEU, the incapacity approval will end at the end of the period approved by the Supervisor.

The MEU may approve permanent incapacity. In this instance, Families First eligibility will be reviewed periodically for all factors except incapacity.

Incapacity Determination by Appeal:

When an incapacity decision has been appealed, implement the final order as approved by the Director of Appeals.

Review of Incapacity:

Incapacity must be re-evaluated at the end of the approval period following procedures described for applications. If the individual states that he/she is no longer incapacitated and asks for case closure, medical re-evaluation is unnecessary.

The complete medical and medical-social information file and current medical and medical-social information must be submitted for re-evaluation 30 days prior to the end of the approval period. Eligibility continues until a decision on continued incapacity is made.

Collecting medical information for Incapacitated Individuals:

The following is a list of questions that can act as a guide in obtaining the medical Information so that an incapacity determination can be made:

- Has a general examination been performed and does the report follow the prescribed outline?
- If a claim of incapacity is based on recent hospitalization, have hospital admission and discharge summaries, etc., been obtained in lieu of a general examination?
- Have copies of other pertinent medical information, such as treating physicians' treatment notes, information submitted to SSA/SSI for disability determination, other hospital records, etc., been obtained?
- Do all medical reports speak to the individual's primary complaint (the basis for his/her claim to be incapacitated) and most, if not all, of his/her other significant symptoms?
- Is a diagnosis and prognosis given? Does the medical information appear to support the diagnosis?

DEPRIVATION

The Medical-Social Information Interview Guide will help the caseworker in securing the appropriate medical-social information. The Medical Social Information Guide must be completed and submitted in its entirety. However, the following questions should be answered to ensure that the caseworker obtains and submits the needed information to the appropriate individuals for incapacity determination.

- Did the caseworker interview the incapacitated person? If not, why? Who was interviewed? What is the relationship of the interviewee to the incapacitate person?

- Did the caseworker properly document the required information such as name, SSN, grade level attained, birth date, etc.?

- Was complete employment history obtained specifying types of work activities?

- Was information obtained about all of the individual's complaints?

Once the adequacy of the medical and medical-social information is assessed and any available and necessary additional information is obtained, the Supervisor decides whether the medical evidence substantiates that a physical/mental defect, illness, or impairment exists and the period of time the condition is likely to last. The medical and medical-social information is then evaluated together and the Supervisor decides whether the existing physical/mental condition substantially reduces or eliminates this person's ability to provide support or care for his/her child.

Question which the Supervisor must answer affirmatively in order to approve the incapacity include the following:

- Has the physician given a diagnosis of a physical/mental condition?

- Does the medical information reported appear to support the diagnosis?

- Has the physician given a prognosis and recommendation?

- Based on the diagnosis and prognosis, does it appear that the incapacity will last 30 days or more from the month of application?

- Does the diagnosed condition substantially reduce or eliminate the person's ability to work in his/her usual occupation or any other occupation which is within his/her physical/mental competence; or does the diagnosed condition substantially reduce or eliminate the person's ability to care for children (which may be his/her usual occupation)?

DEPRIVATION

Consideration must be given to the limited employment opportunities for handicapped individuals. A high unemployment rate is not decisive in this matter. The decision must be whether this person's physical/mental condition substantially reduces or eliminates his/her ability to provide support or care for his/her child and taking into account general economy for handicapped people. The age and nurturing needs of children being cared for must be considered in determining whether or not the diagnosed condition meets incapacity requirements.

Evaluation of the Treating Physician's Findings and Recommendations

The Supervisor may place considerable reliance on the treating/examining physician's findings/recommendations as whether or not a physical/mental defect, illness, or impairment exists.

The physician's findings should include:

- A diagnosis and clinical/medical evidence to support the diagnosis; and
- A prognosis that appears to be reasonable in light of the diagnosis.

A "prescription pad" statement or a letter from a physician without supporting medical evidence is **not acceptable**.

When the treating/examining physician does not provide a diagnosis/prognosis and/or recommends testing in order to arrive at a diagnosis, submit the entire medical and medical-social package to the MEU.

The decision that incapacity exists according to definition is a programmatic one. The decision must be made based on the medical findings/recommendations as they apply to a particular person and his/her ability to continue his/her current employment/care activities. If after careful consideration of the medical and medical-social information, the Supervisor believes incapacity does not exist, the entire medical and medical-social package must be submitted to the MEU. The staff in the MEU follow the same evaluation procedures as the Supervisor. The MEU decision is binding on the county office.

Reconsideration of Incapacity Decisions

If an individual disagrees with the MEU decision and has additional, new medical information he/she wishes to submit, he/she may request reconsideration of the decision. If the individual has not additional medical information or does not want to request reconsideration, he/she should be helped to file an appeal. To assure that an individual has the opportunity to file and appeal within 90 days of the action to deny or terminate, an appeal request should be filed at the same time as the request for reconsideration is made.

DEPRIVATION

If the individual request reconsideration of an MEU decision, take the following actions:

- explain the reconsideration process;
- secure the new or additional medical information that was not previously reviewed by the MEU;
- update the medical-social information;
- secure the Request for Delay in Fair Hearing to postpone the appeal until the MEU can re-evaluate the case; and
- **promptly** submit the entire medical package including the information previously submitted with a copy of the Request for Delay in fair Hearing and a memorandum explaining that the individual has requested reconsideration and has filed an appeal.

Upon re-evaluation of all information at reconsideration, the MEU may approve or deny incapacity, or may request one or more specialist examinations or other information.

If the MEU approves incapacity, give the individual an opportunity to withdraw his/her appeal request using the Withdrawal of Complaint. If the MEU again denies incapacity, complete the appeal process. If the MEU requests additional information, medical and/or social, **promptly** schedule the requested examinations. Upon receipt of the reports, promptly return the requested reports together with **all** previous medical and medical-social information to the MEU.

Upon notification from the MEU of the decision, promptly notify the individual and his/her legal representative, if any, and take action as shown above for approvals or denials.

IV. UNEMPLOYED PARENTS

POLICY STATEMENT:

When both parents are in the home, the assistance group will meet the deprivation requirement for Families First if the principal wage earner parent:

(Intended to be blank)

- is an unemployed parent, as defined above;
- is not on strike;
- has a labor market connection;
- has not refused, without good cause, a bona fide offer of employment or training for employment; and
- has not refused to apply for or accept UC to which he/she might be entitled.

EXCEPTIONS:

If a families First caretaker marries the parent of an AG child while the caretaker is receiving assistance and the parents income after deducting child support payments is less than 185% of the AG size GIS, the AG is exempt from the unemployed parent requirements. The AG will remain exempt from these requirements until the Families First case closes. If the case closes for any reason and the AG later reapplies, the AG must meet all unemployed parent requirements at that time.

In addition, a PWE who is full-time VISTA volunteer is exempt from the 100 hour rule and the bona fide offer of employment rule. They must meet all other unemployed parent criteria.

GOOD CAUSE:

The PWE must not have refused, without good cause, a bona fide offer of employment or training for employment. Good cause for refusing such employment or training include:

- illness of a more serious nature than a common cold;
- illness of AG parent or child and the PWE is the only available caregiver;
- lack of transportation;
- the job is not within the documented physical or mental capability of the person;
- the wage is less than the minimum wage;
- the job poses an unreasonable risk to the health or safety of the person.

DEPRIVATION

VERIFICATION:

Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information. For example, it would be more reasonable for the case manager to obtain information regarding the bona fide employment offer made through JTPA since the Department of Human Services contracts this service with JTPA.

Verify the parent's status as PWE, his/her employment or lack of employment and labor market connection, good cause information and any other pertinent or questionable information that would affect the AG's eligibility.

Substantiate the amount of earnings of the parents when establishing the PWE by any means accessible. Income tax returns, copies of W-2 forms, employer's records, wage match, check stubs are good sources of verification, but if these are not obtainable use any other means available.

It is not necessary to verify the exact amount of the earnings to determine the PWE's labor market connection. However, it is necessary to verify that the PWE earned at least $50 per quarter when earnings are the basis of this determination.

DOCUMENTATION:

All information regarding deprivation based on unemployed parent criteria must be documented on the appropriate ACCENT screens. Any pertinent information to explain good cause, unusual circumstances or to explain case manager's decisions in the case must be entered in running record comment, CLRC.

PROCEDURES:

To determine deprivation for a Families First unemployed parent, first determine which parent is the principal wage earner (PWE). Follow the steps listed below:

- Determine the total gross income earned by each parent during the 24 month period immediately preceding the application month.

- Consider the total 24 months of earnings for each parent in the home regardless of when their relationship with each other began.

- If only one parent had earnings during the 24 month period, designate this parent as the PWE.

- If both parents had earnings during the 24 month period, determine which parent had the greater amount of earnings during the period. Designate that parent as the PWE.

- If both parents had the same amount of earnings during the period, the case manager and the family will designate the PWE.

The PWE designated at application remains the PWE during each consecutive month that assistance is received. However, if the case is closed and the parents later reapply, the PWE will be determined by the family's circumstances during the 24 months preceding reapplication.

Once the PWE has been designated, he/she must meet all of the following conditions to qualify as the unemployed parent:

- The PWE parent must be unemployed, by definition in this section, and have been unemployed for 30 days prior to receipt of assistance. If employment was lost or terminated less than 30 days prior to application the PWE must complete the 30-day period before an assistance payment can be made. Payment will begin the date eligibility is attained in this instance rather than the date of application. Begin the 30-day count with the first day after the job loss.

- The PWE must not be on strike. If unemployment is caused by participation in a strike, the AG is not eligible for Families First.

- The PWE must not refuse to apply for or accept UC to which he/she might be entitled. If the PWE refuses to apply for or accept UC benefits, the AG is not eligible for Families First.

- If the PWE is working 100 hours or more in the month of application, determine the number of hours worked in each of the two months prior to the application. Then determine the number of hours likely to be worked in the month following the month of application.

    - If the PWE worked fewer than 100 hours per month in each of the two months prior to application <u>and</u> is expected to work fewer hours in the month following application, the 100 hours rule <u>is met.</u>

    - If the PWE either worked 100 hours or more in one or both months prior to application <u>or</u> expects to work 100 hours or more in the next month, the 100 hour rule <u>is not met</u> and the AG is not eligible for Families First.

A labor market connection can be established in either of the following ways:

- the PWE is currently receiving unemployment compensation payments or received at least one UC payment during the 12 months immediately preceding the application month; or

DEPRIVATION

- the PWE earned at least $50 in each of any six quarters within a 13-quarter period ending within one year prior to application. Full-time attendance in an elementary or secondary school or in vocational/technical training or participation in a JTPA project may be substituted for earnings for a maximum of four of the required six quarters.

The case manager must choose one quarter out of the four quarters preceding the quarter in which the application was filed to start the count for the 13 quarters. If the PWE had at least $50 in earned income during six of the those quarters (or was attending an elementary or secondary school or in vocational/technical training, or was participating in a JTPA project for not more than four of those six quarters), then he/she meets the labor market connections for the unemployed parent deprivation requirement. When choosing the quarter in which to start the count, the case manager must choose the quarter that will be to the client's advantage.

The exact amount of earnings does not need to be established, but it must be verified that The earnings were at least $50 for each quarter.

Example: The AG applied for Families First benefits based on unemployed parent Deprivation criteria in the third quarter of 1996. The PWE had $50 earnings in the second quarter of 1996 and the third quarter of 1995. Since both quarters are in the four quarters immediately preceding the quarter in which the application was filed, the case manager must then determine which one to use for the start of the 13 quarter count by looking at the earnings, etc., for the remaining quarters to determine which quarter is to the PWE's advantage. (See chart below)

DEPRIVATION

1996

1	2	3	4
	$50	X	

1995

1	2	3	4
		$50	

1994

1	2	3	4
	$50	$50	

1993

1	2	3	4
			$50

1992

1	2	3	4
	$50	$50	$50

In this example, the PWE had earnings in two of the four quarters prior to the quarter in which the application was filed. When counting back 13 quarters, the case manager discovers that if the 2nd quarter of 1996 is used as the starting quarter, the PWE has only earnings in only five of the 13 quarters. However, if the third quarter of 1995 is used to start the count, the PWE had earnings in six of the 13 quarters and thereby meets the labor market connection requirement. Therefore, third quarter of 1995 should be used to establish the 13-month count. If the PWE meets the unemployed parent definition, then the AG meets the Families First deprivation requirement.

STRIKERS

POLICY STATEMENT:

A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slow-down or other concerted interruption of operations by employees.

An individual is "participating in a strike" if (s)he refuses in concert with others to provide services to one's employers.

If a Families First parent with whom the children live is participating in a strike, the entire aid group is ineligible for as long as the parent is on strike.

If an assistance group member other than a parent is participation in a strike, that individual is ineligible for assistance as long as (s)he is on strike.

If payment of Families First benefits has already been made for any month(s) in which a parent or other assistance group member participated in a strike as of the last day of the month, the payment (or the individual's share) for the entire month constitutes an overpayment subject to recovery.

PERSONAL RESPONSIBILITY PLAN

POLICY STATEMENT:

The Personal Responsibility Plan is an agreement between the Families First participant and the Department of Human Services that is completed for each Families First assistance group. In this agreement, the Families First participant agrees to take certain steps to move the AG to self-sufficiency. In return, the Department of Human Services agrees to provide temporary cash assistance and support services to help the caretaker/parent to gain employment.

The Personal Responsibility Plan development takes place during the eligibility determination process. It is extremely important that the caseworker and the participant discuss the choice of components in the Personal Responsibility Plan in detail to create a realistic, workable plan. The caseworker and the Eligibility Assistant (EA) are responsible for ensuring that the caretaker has an opportunity to receive a clear explanation of each activity on the PRP and how to comply with the plan.

Each assistance group adult must agree to sign and comply with the individualized Personal Responsibility Plan. If there are two adults in the AG, each one must sign his/her own PRP. **The minor parent must sign if he/she is the caretaker of the case.** The minor parent who is a dependent child in an AG is not required to sign a PRP, but one will be presented to him/her. **However, if the minor parent who is a dependent child does not sign a PRP, he/she will be ineligible for support services.**

Signing the PRP

- If an adult or the minor parent who is the caretaker of his/her own AG refuses to sign the Personal Responsibility Plan, the entire AG will be ineligible for Families First benefits. **NOTE:** refusal to sign a PRP **does not** result in a Food Stamp penalty for an applicant. No penalty can be applied if the case was not approved for Families First.

- If an adult refuses to sign the Personal Responsibility Plan at application and there is no minor parent in the AG, the case will fail and will trickle to determine Medicaid eligibility.

- If an adult refuses to sign the Personal Responsibility Plan at application and there is a minor parent in the home, the AG will fail and the case will trickle to create a Families First AG for the minor parent. If the minor parent agrees to sign/comply with the Personal Responsibility Plan, a case can be established with him/her as the caretaker for himself/herself and his/her child.

- If the adult later decides to sign and comply with the Personal Responsibility Plan, he/she can reapply at any time.

- If an adult agrees to sign the PRP and the minor parent in the home (who is not a caretaker) refuses to sign, the AG will not fail. If the adult in an **active** AG refuses to sign the PRP, the AG will be closed and TCC/TM will be set. Minor parents in the AG who wish to apply for Families First for themselves and their children can do so.

- If a participant is completing a two-week compliance period in the same component and for the same number of hours for which he/she was sanctioned, a new PRP does not have to be signed. A new PRP will be required at this time only if a new component is being added.

- If a participant is completing a two-week compliance period in the same component for which he/she was sanctioned but there is a support service that needs to be changed, discuss the change with the participant by phone and send the corrected PRP by mail for a signature. **Do not delay the two-week compliance period while waiting for the PRP to return.** If the PRP is not returned in this situation, there is no penalty as long as the work activity is valid and the necessary support services for the current activity are in place.

- An Authorized Representative cannot negotiate, renegotiate or sign a PRP on behalf of a participant. This activity must be done with each AG adult and minor parent who is caretaker of his/her own case.

The Personal Responsibility Plan Agreements

- The participant agrees to keep immunizations and health checks up to date for all AG children.

- The participant agrees to ensure that all AG children attend school, including kindergarten.

- The participant agrees to cooperate with Child Support Services to establish paternity, locate the absent parent, enforce collection of court ordered child support and assign child support to DHS.

- The participant agrees that minor parents will enroll in and attend school or an approved alternate educational or training program. If the minor parent is not in school during non-traditional school periods, he/she will be encouraged to attend another activity but is not required to do so.

- The participant agrees that minor parents will live in the home with parents or another authorized responsible adult.

- The participant agrees, unless exempt, to participate in work, work preparation, educational or training activities. This agreement applies to eligible adults and/or minor caretakers in the AG.

- DHS agrees to provide support services and child care for the eligible adults and/or minor caretakers who are participating in work, work preparation, educational or training activities.

If the individual is already in compliance with some of the Personal Responsibility Plan requirements, such as immunization, school attendance, employment, etc. at the time of the interview, verification will be required prior to approval. However, the individual will not be assigned to any work component activity or referred for child care and other supportive services until the case is approved. Once the case is approved, the caseworker will notify the Eligibility Assistant that the case has been authorized. The EA will be able to review the plan by inquiry into ACCENT and will assist the caseworker in monitoring and reassigning activities. **EXCEPTION:** Work activities and supportive services will be provided during the application period when the individual must complete a two-week compliance period prior to approval.

An Individual May Need Referrals to:

- Literacy testing;
- Adult Education;
- Training Preparation Education;
- Employment Career Services (ECS) or (ECS Plus);
- Job Skills Training;
- Work Prep;
- Family Services Counseling;
- Vocational Rehabilitation Services;
- Work Experience;
- the child care broker;
- the transportation broker;
- a broker for dental or optical services; and/or
- other support services.

All activities in which the participant is involved and all support services provided must be listed on the PRP.

Renegotiating the PRP Work Plan:

The Personal Responsibility Plan is individualized to meet the specific needs and conditions of the AG and is, therefore, a fluid document. When the AG's needs or circumstances change or an activity is completed, the activities and services associated with the Personal Responsibility Plan will be renegotiated to accommodate these changes.

EXAMPLE: An individual does not have a GED or a high school diploma. The first activity on the Personal Responsibility Plan might be the TABE. In addition, child care and transportation may be needed for the individual to take the test. Once the literacy level has been established, the caseworker will need to talk to the individual **about the results and establish the new activities to be included on the revised Personal Responsibility Plan.**

EXAMPLE: (This example involves **interruptions to previous activities**.) The mother in a two-parent AG begins her 16-week exemption period after the birth of her baby. At the time her exemption begins, the requirements of her prior PRP end, except for immunization, child support cooperation, school attendance, and health checks. A new PRP should be signed removing any work components and related support services. When the participant's 16-week exemption ends, a new PRP based on her current circumstances will be required.

When the caseworker receives any new information that impacts the Personal Responsibility Plan, when work activities end or when activity hours change, begin the renegotiation process as soon as possible, but within a maximum of two weeks (14 calendar days) from the date the information becomes available. Any related eligibility actions will be taken within the usual 10-day time period. It will be critical to keep participants moving through their planned activities without interruptions, if at all possible. To ensure individuals are meeting the requirements of their plan and participating for the appropriate number of hours per week, actions to enroll them in new activities as soon as they complete one activity are critical. **Any time the participant has to wait for an activity, child care or other support service for more than two weeks, the AG's time limit count will be interrupted until the problem can be corrected.** Our goal must be to limit these situations to as few as possible.

The PRP can only be renegotiated for another activity when the participant has completed the activities that are in his/her current plan, except in special situations described in the next section. For example, if Adult Education is on the participant's PRP, he/she must complete Adult Education before that component can be replaced. This policy also applies to the two-week compliance period.

Accommodate the participant's wishes regarding PRP activities as long as they are within the parameters of Families First policy. Discuss fully with the participant all of the available activities, what they encompass and how they fit into the participant's long range plan. Also explain the limits on renegotiation of the PRP work plan. Participants need to make wise choices to ensure that they progress toward self-sufficiency as expeditiously as possible, keeping in mind the reality of time limits. It is important that individuals do not use up their

time limits moving aimlessly from component to component. Their long-range plan can be restructured to include activities that better fit the current situation, needs, and choices of the participants.

Special Situations That May Require PRP Renegotiation

The PRP work plan will need to be renegotiated when changes occur in the participant's personal situation such as those listed below.

- The individual reapplies for Families First after a gap in eligibility.
- The participant progresses to the next AE literacy level in both reading and math.
- The individual who has tested below 9th grade in either reading or math requests AE as his/her component. (These are individuals who have previously taken a literacy test, tested below 9th grade but decided not to go to AE.)
- The participant passes the GED.
- The participant requests Family Services Counseling or Vocational Rehabilitation Services.
- Situations arise that cause the individual to be eligible for a work requirement/time limit interruption/exemption. All activities/support services will be removed during this period unless the individual chooses to "volunteer."
- The activity is unsuitable. There may be instances where an activity is determined unsuitable by the provider resulting in the need for a more appropriate activity. Either the participant or the provider can initiate this determination. If the participant claims that the activity is unsuitable, the provider must agree.
- The individual's activity remains the same, but the hours have changed.
- The individual's support service needs have changed.
- The activity is unavailable. There may be instances where an activity becomes unavailable. This would also apply when an individual loses a job or stops being a full-time college student. If the job or college is no longer available, the PRP work plan can be renegotiated using new activities, even when the participant is in a two-week compliance. This reason would also apply if a participant has been asked to leave a component and is not allowed to return due to inappropriate or unacceptable behavior.
- The participant goes to work. The participant decides to go to work instead of participating in a previously agreed on component. An adjustment may be made to the PRP to reflect the employment and a subsequent change to the activities previously listed.

- The participant is waiting to enter post-secondary education/training. Participants who are in work related activities may choose to go to training or post-secondary education. After choosing training, the training provider's assessment may result in a wait to enter the chosen training program because of financial aid processing, semester scheduling, etc. The participant must continue in 40-hours of component activity, but can change these activities when the training/post-secondary education activity becomes available.

- The caseworker learns about a limitation or barrier to the potential success of the participant. An important part of case management is the ability to:

  - recognize when a serious problem exists;
  - talk to the participant in a non-threatening way;
  - confront the issue; and
  - assist in choosing a solution that is in the individual's best interest.

  If a barrier is identified that can be addressed by Family Services Counseling and/or Vocational Rehabilitation, offer one or both of these activities, as appropriate. If the participant agrees, renegotiate the PRP to include the appropriate component.

  If the barrier is a good cause situation that will affect the individual's participation in a specific activity, the PRP work plan can be renegotiated. Refer to the good cause section of this chapter. (Note: A temporary emergency may or may not be a circumstance that would require renegotiation of the PRP work plan. Each decision must be based on the specific case situation.)

The Personal Responsibility Plan and activities will be printed from ACCENT each time the plan is initiated or renegotiated and the Families First participant will sign the printed PRP.

ACCENT will retain the date the plan is presented to and signed by the individual. Since the plan activities have expected completion dates, it will be important for the Families First participant to retain the printed PRP for his/her records. The caseworker will also retain a copy of the most current paper PRP.

<u>EXCEPTIONS:</u>

There are no exceptions to this requirement for AGs requesting temporary assistance through the Families First program, except for minors who are dependent children in an AG. They are <u>not required</u> to sign a PRP (unless they need support services).

GOOD CAUSE:

There are no good cause provisions for failure to sign a Personal Responsibility Plan. Good cause for failure to comply with specific components of the plan will be evaluated according to the plan requirements and the individual assistance group's circumstances.

VERIFICATION:

The specific components on the Personal Responsibility Plan have different verification requirements. Please refer to the specific policy section for details regarding verification requirements.

DOCUMENTATION:

Information for the Personal Responsibility Plan will be collected and documented through a series of Personal Responsibility Plan screens in the ACCENT case. Additional documentation that is not screen specific will be documented on the ACCENT CLRC screen.

PROCEDURES:

When ACCENT groups a potentially eligible Families First AG, the caseworker must explain the Personal Responsibility Plan requirements, component choices, time limits, and sanctions and penalties to the caretaker, any other eligible adult in the AG, and any minor parent who is the caretaker of his/her own AG. Each of these participants must develop a Personal Responsibility Plan with the caseworker.

The Caseworker's Responsibilities

If the individual agrees to develop the Personal Responsibility Plan, the caseworker will collect information about the individual's:

- circumstances;
- educational and work history; and
- particular supportive service needs, such as child care, transportation, etc.

The caseworker must discuss the Personal Responsibility Plan components with the individual. The caseworker must also work with the individual to determine the best components to be included in the PRP. Using the skills taught in the Case Management Training, the caseworker will help the individual see the importance of choosing components that best fit his/her long-term goals for self-sufficiency. (See the Work Requirements and Work Components Chapter for the work and work preparation components to be used in the

Personal Responsibility Plan.) In addition, the caseworker must help the individual identify the various supportive services that will be needed to make the Personal Responsibility Plan successful.

The authorization of the Families First assistance group will generally occur at some date after the eligibility interview and plan development. When the AG is authorized, ACCENT will notify the AG about their eligibility. The caseworker will notify the EA when the AG is approved. If all of the details of the Personal Responsibility Plan cannot be covered during the initial interview, a subsequent interview may be necessary after the case is approved.

- The caseworker will review the Personal Responsibility Plan with the individual:
  - at each application and review;
  - when an activity is completed;
  - when problems arise;
  - when the individual does not meet a plan requirement;
  - when an interruption in an activity necessitates a change;
  - at the 54th month; and/or
  - when an exemption or interruption ends.
- **The caseworker will ensure that a new Personal Responsibility Plan is signed at each application and eligibility redetermination, even if the activities and supportive services do not change, and that the new PRP date is entered on AEPRP. The caseworker will retain a copy of the most current paper PRP.**
- **A PRP may be renegotiated over the phone at the time of redetermination.**
- The individual does not need to come to the office to sign the PRP, it can be mailed. A changed PRP **cannot** be mailed to the **participant until the caseworker and the participant have discussed the PRP and decided what activities and support services will be included on the new plan,** and the caseworker documents the discussion on CLRC. Changes to the PRP are not valid and referrals cannot be made until the signed copy of the PRP is returned.
- If the participant requests to see the caseworker personally to renegotiate the PRP, the caseworker must set an appointment for renegotiation in person and document the appointment date and time in CLRC.

- When **mailing a PRP** to a participant for signature, the caseworker should include:

  - two copies of the PRP (one for the participant to sign and return, and a second for the participant to keep); and

  - a self-addressed stamped envelope; and

  - a free-form notice that will:

    1. advise the participant to return the signed PRP within 10 days;

    2. instruct the participant to contact the caseworker within 10 days if he/she does not agree with the activities on the plan; and

    3. explain that if the PRP is not returned within 10 days, the Families First case will be closed for failure to sign a PRP. **(This is not a sanction.)**

NOTE: The participant may FAX the signed PRP back to the caseworker as a signed, FAXED, PRP is considered valid.

- Document on CLRC that the above instructions were included on the free-form notice and mailed to the participant.

- When the participant returns the signed PRP, the caseworker must:

  - update all appropriate ACCENT screens with the new PRP information;

  - enter the new sign date (the date the PRP is returned to the office) on AEPRP;

  - enter any needed support services on AEIAS and on AEIPA;

  - enter new activities on AEIPA;

  - make any new referrals needed; and

  - send to the EA to make any necessary changes to the JTPA database.

After updating ACCENT and JTPA, **keep the most current copy of the PRP.**

- When an activity has been completed, begin the PRP renegotiation process as soon as possible but within a maximum of 2 weeks (14 calendar days) from the date information that impacts participation becomes available. Any other related eligibility actions must be taken within the usual 10-day time frame. The caseworker must:

- contact the recipient;
- discuss with the individual the next step needed in the plan; and
- modify the plan with the new component, if any.

- If there is no work requirement for the AG, once the non-work activity is complete there may be no further action necessary. **For example**, the only activity on the Personal Responsibility Plan is to immunize one of the children. Once that is accomplished, no additional activity is necessary until the next series of immunizations are due.

- If the participant has problems that may affect compliance with the PRP, the caseworker and the individual will discuss possible changes that could be made to the Personal Responsibility Plan to correct the problem. If the individual fails to meet any of the Personal Responsibility Plan components, the caseworker must discuss this with the individual to determine if the plan needs to be renegotiated (this may include a referral to FSC or VR) or if sanctions are required. (See the Sanctions chapter for more details.)

The Eligibility Assistant's Responsibilities

The EA is responsible for contacting the adult(s) and/or minor parent(s) in the AG to refer them to the appropriate activities and support services to comply with the Personal Responsibility Plan. In most cases, the plan will call for multiple activities and will require very detailed instructions about where services are located and which class or office is the most convenient to the recipient. To avoid multiple office visits, the meeting with the EA should occur after talking with the caseworker whenever possible. The EA will:

- discuss the plan activities agreed upon by the caseworker and the participant;
- inform the individual how and where to engage in the plan activities;
- inform the participant where and how to obtain the support services that are needed.

- If another visit to the office is necessary for another reason, the EA will give the referral documents to the recipient. Otherwise, the documents will be mailed. If the documents are mailed, the EA will have a telephone conversation with the participant to ensure a clear understanding of what is expected and so that the participant will know:
  - where to report for an activity;
  - when to report;
  - how to access child care and other services; and

- where to obtain other services required by the PRP, i.e., health check-ups and immunizations for the children, school attendance records, etc.

- The EA will provide the participants with paper referrals to all activities and services on the Personal Responsibility Plan.

- **The EA will give the original referral to the participant, retain one copy of all referral forms and send one to the provider agency.**

- Each recipient will need specific and clear instructions on how to comply with the other PRP requirements, such as directions to the health department, hours of operation, and what services are available. Other instructions need to be provided on complying with school attendance requirements. Participants also need clear addresses, names of people to contact and telephone numbers for each referral, as well as directions to classes and other agencies where services are being provided.

Communication To/From Providers/Brokers

Providers have a contractual responsibility to report any information to the DHS office that will impact the Personal Responsibility Plan. Providers have ten working days from the date the client is scheduled to attend the work activity of an initial referral to report. In all other situations, the provider must report within three working days of the non-compliance, including non-compliance during a two-week compliance period. Likewise, the DHS office has a responsibility to report to the provider any information that affects the provision of services to the participant. This exchange of information on work compliance from contract agencies will be available to caseworkers through Infopac.

Local county offices will be responsible for trying to work out a satisfactory arrangement with local health departments and school systems to obtain the best available data.

IMMUNIZATIONS AND HEALTH CHECKS

POLICY STATEMENT:

To receive Families First benefits, caretakers and parents must ensure that all AG children receive their health checks in accordance with the check-up schedule provided by the Department of Health. A chart reflecting this schedule is included at the end of this chapter.

Caretakers and parents must also ensure that AG children receive their immunizations in accordance with the schedule provided by the Department of Health and used by the Department of Education for school enrollment. A chart reflecting this schedule is also included at the end of this chapter.

Review immunizations and health checks as a part of the initial PRP process and at each subsequent review.

If the Families First participant refuses or fails to have an immunization and/or health check for a child, reduce the Families First payment by 20% unless certain circumstances exist. Only one 20% sanction will be imposed, regardless of the number of children who are not immunized or who have not had a required health check. In addition, there will be only one 20% sanction if both the immunization and the health check requirements are not met.

The 20% penalty will remain in place until the AG is in compliance with the immunization and health check requirements. This reduction will be removed the next possible calendar month following the AG's compliance with this requirement. Refer to the Sanctions Chapter.

EXCEPTIONS:

The only children who are exempt from the immunization and health check requirements are those who have been exempted or would be exempted by the Department of Education. Children will be exempt from the immunization or health check requirement if:

- the child's physician or the Department of Health provides a signed and dated statement giving a medical reason why the child should not be given a specified immunization; or

- the child's caretaker/parent makes a clear statement that such immunizations or health checks conflict with A/R's religious tenets and practices.

GOOD CAUSE:

Good Cause for a delay in obtaining immunizations or checkups will be granted for the reasons listed below.

- The child is ill and the health care provider recommends delaying immunization until the child is well.
- A health care provider does not respond to requests for information to document immunization or checkups.
- A caretaker has made a good faith effort to schedule checkups or immunizations within one month, but has not been able to do so because of circumstances beyond the caretaker's control.
- There are other extenuating circumstances that could delay immunization or checkups.

VERIFICATION:

Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the caseworker to obtain the needed information.

- Immunizations and health checks will be verified by the following:
  - Health Department records;
  - "shot" records;
  - medical records; or
  - statement from a physician.

Enrollment in a public school or a licensed child care facility is presumptive verification of immunizations only. Schools and licensed child care facilities require immunizations for enrollment or exempt the child(ren) from the immunization requirement.

Health checks required according to the EPSD&T schedule must be verified by the above methods.

If an exemption for a medical reason is claimed, obtain a statement that explains the medical reason for not giving or delaying a specified immunization or checkup. The statement must be signed and dated by the child's physician or the Department of Health.

DOCUMENTATION:

- Document the appropriate ACCENT screens, including CLRC, regarding:
  - whether or not the immunizations and health checks are current for each child;
  - what specific immunizations or health checks are missing, if any;
  - the verifications used to show that immunizations and health checks are up to date;
  - any exemptions and how they were substantiated;
  - any extenuating circumstances that affect the child's immunizations or health checks;
  - the circumstances of any decisions made based on these circumstances;
  - when the last immunizations and/or health checks were completed; and
  - when the next immunization and/or health check is due for the child(ren). This information needs to be documented at each review so that it will be readily available at the next review.

PROCEDURES:

- When discussing the Personal Responsibility Plan, explain immunization and health check policy. Immunization and health checks are components to be included as part of the Personal Responsibility Plan, unless good cause exists for their exclusion. Address compliance with these requirements at each application and review.

- Evaluate immunizations and health checks at each application, reapplication and at all reviews. If a child does not have the required immunizations and/or health checks and the participant **agrees to have** the child immunized and/or have a health check, then:
  - add the immunization and/or health check activity to AEIPA;
  - enter an expected completion date. One month is generally sufficient but take the individual's situation into consideration. Use prudent judgment when setting the expected completion date and allow the individual adequate time to complete the activities; and

- review the plan and activities immediately prior to the expected completion date to ensure that the AG has complied with the requirement. Follow-up accordingly.

- If a child does not have the required immunizations and/or health checks and the participant claims that there are **medical reasons** for this, then:
  - request the required verification in writing;
  - document the ACCENT case regarding the good cause reason and verification;
  - set an expected change alert for re-evaluation if the reason is of a temporary nature; and
  - continue benefits, without sanction.
- If the participant claims that the child should not be immunized for **religious reasons** document the participant's statement regarding this situation and continue benefits without sanction.
- Apply the 20% sanction beginning the next possible month after the ten-day adverse action notice **if**:
  - a child does not have the required immunizations and/or health checks; **and**
  - the participant does **not agree** to take other action to have the child immunized and/or have a health check; **and**
  - the exception and/or good cause reasons **do not apply**.

PERIODIC SCHEDULE FOR EPSDT CHECK-UPS/SCREENINGS

INFANCY	MIDDLE CHILDHOOD
AT BIRTH	5 YEARS OLD
2-4 DAYS OF AGE	6 YEARS OLD
1 MONTH OLD	8 YEARS OLD
2 MONTHS OLD	10 YEARS OLD
4 MONTHS OLD	
6 MONTHS OLD	
9 MONTHS OLD	
12 MONTHS OLD	
EARLY CHILDHOOD	**ADOLESCENCE**
15 MONTHS OLD	11 YEARS OLD
18 MONTHS OLD	12 YEARS OLD
24 MONTHS OLD	13 YEARS OLD
3 YEARS OLD	14 YEARS OLD
4 YEARS OLD	15 YEARS OLD
	16 YEARS OLD
	17 YEARS OLD
	18 YEARS OLD

Recommended Childhood Immunization Schedule
United States, January-December 2001

Vaccines are listed under routinely recommended ages. **Shaded bars** indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. **Clear boxes** indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Age → Vaccine ↓	**Birth**	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	14-18 yrs
Hepatitis B	Hep B #1											
		Hep B #2									Hep B	
					Hep B #3							
Diphtheria, Tetanus, Pertussis			**DTaP**	**DTaP**	DTaP		DTaP			DTaP	Td	
H. influenza type b			Hib	Hib	Hib	Hib						
Inactivated Polio			IPV	IPV	IPV					IPV		
Pneumococcal Conjugate			PCV	PCV	PCV	PCV						
Measles, Mumps Rubella						MMR				MMR	MMR	
Varicella						Var					Var	
Hepatitis A									Hep A – in selected areas			

An **age range** is given for some immunizations. For instance, the first Hepatitis B immunization can be given anytime from birth through 2 months. A Families First participant would not be out of compliance for not completing this immunization until after the child is two months old.

SCHOOL ATTENDANCE

POLICY STATEMENT:

To receive Families First benefits, all school age children in the AG must attend school, including kindergarten. However, the treatment of the child's school attendance differs depending on the child's circumstances.

School attendance is required for

- a minor child, either married or unmarried, who is **not a parent;**
- a **married minor parent** who is an EC in the AG;
- a **married minor parent** who is a caretaker for his/her own AG; and
- an **unmarried minor parent** who is an EC or an EA.

If **minor children who are not parents or who are married parents** fail/refuse to attend school without good cause, the Families First cash benefits will be reduced by 20%.

If the child is an **unmarried minor parent** who has not completed a high school education or its equivalent, he/she must attend school, prepare for a GED or attend a state approved alternative educational or training program. If an unmarried minor parent fails/refuses, without good cause, to complete the educational requirement, the unmarried minor parent will be removed from the Families First cash payment. This applies to an unmarried minor parent whether he/she is an EC or an EA.

As a parent, the minor parent is required to sign a Personal Responsibility Plan. School attendance is considered a work activity for a minor parent. Therefore, he/she is eligible for appropriate supportive services to meet the Personal Responsibility Plan commitment. (See the Work Requirement chapter for more details.)

When a sanction is necessary only one 20% reduction sanction will be applied for noncompliance with the educational requirement, regardless of the number of children in the AG who do not comply. However, a 20% sanction for a married minor, married minor parent or other AG children who are not parents and the removal of an unmarried minor parent can be applied at the same time, if appropriate.

SCHOOL ATTENDANCE

EXCEPTIONS:

The school attendance requirement does not apply to

- children under age 5;
- a single minor parent whose youngest child is in the home and is under 1 year of age;
- a minor parent who is part of a two-parent household whose child is under 16 weeks of age;
- children who are being educated in a home school or a home bound program that has been approved by the Department of Education; and
- children who have been determined to be severely physically/mentally impaired to attend school.

GOOD CAUSE:

Good Cause for non-attendance will be granted for

- a verified illness that prohibits attendance;
- suspension from school with reentry forbidden and no alternative school available;
- removal of the child from the school by the courts; and
- other verified situations which prevent attendance.

VERIFICATION:

School attendance and good cause must be verified at each application and six months review. If there is a school attendance activity on the AG's Personal Responsibility Plan, this must also be addressed at the anticipated completion date on the Plan.

Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information. For example, in some counties, the Board of Education or the school system may work out an arrangement for the Department to obtain school attendance verification to facilitate access to the needed information. In this case it would be more reasonable for the case manager to obtain the verification of school attendance.

School attendance will be verified by school records. Illness or a severe physical or mental handicap that prohibits school attendance will be verified by a statement from the child's physician or other medical records. If the child claims good cause because of suspension, both suspension and the lack of an alternative school must be verified by the

Department of Education or school. Court records can be used to verify removal of the child from the school by the court.

DOCUMENTATION:

The appropriate ACCENT screens must be documented regarding the school attendance status for each child. In addition, documentation about exemptions, good cause determination, sanction decisions and any other pertinent information about school attendance of any child must be documented on the ACCENT CLRC, running record comments screen.

PROCEDURES:

- The Families First school attendance requirement and penalties must be explained to the applicant/recipient at the time that the Personal Responsibility Plan is presented to him/her.
- The case manager will address and verify school attendance at
  - each application when the Personal Responsibility Plan is first signed,
  - at the six months review; and
  - when compliance with school attendance requirement is due.
- If the application/review occurs during a regular school break and consequently the child is not currently enrolled in school
  - the caretaker/eligible adult must agree to ensure that the child is enrolled and attending school during the next regular session;
  - the Personal Responsibility Plan will include school enrollment as an activity with a target date; and
  - the child's school attendance will be verified at the target date.

Failure to Comply - Married Minor Parents and Minors Who Are Not Parent

For detailed instructions for applying sanctions to the AG when an individual fails to comply with the school attendance requirement, see the Sanctions chapter.

- If the child fails to attend school as required, the case manager will contact the caretaker to determine if the information is correct or if good cause exists.

- If good cause exists and is verified, the case manager will continue the benefits.
- A formal conciliation is not required.
- If good cause does not exist, the case manager will complete the appropriate ACCENT screens to implement the 20% reduction in benefits sanction.
- If the AG later complies, the case manager will remove the sanction the next possible month.

Failure to Comply - Unmarried Minor Parents

For detailed instructions for applying sanctions to the AG when an individual fails to comply with the school attendance requirement, see the Sanctions chapter.

- If an unmarried minor parent fails to comply with the school attendance requirement, the case manager will institute the conciliation process.
- If good cause is established as a result of the conciliation process, the case manager will continue benefits for the unmarried minor parent.
- If good cause does not exist, the unmarried minor parent will be removed from the AG. However, Medicaid coverage will continue for this individual.
- If the unmarried minor parent does not have good cause, but is willing to comply, he/she must attend school for two weeks to be considered in compliance.

CHILD SUPPORT COOPERATION

POLICY STATEMENT:

To be eligible for Families First benefits, the caretaker must cooperate with Child Support to:

- identify the absent parent(s);
- establish paternity, if necessary;
- locate the absent parent(s);
- pursue court-ordered support for each AG child;
- agree to assign all child support, either court ordered or voluntary, past, present and future, to the Department to reimburse the state for Families First and AFDC benefits that the AG receives; and
- assign any spousal support that was ordered at the time of the child support order.

The child support cooperation requirements apply if the Families First payment is not issued because it is less than $10 or is reduced to zero because of a recoupment.

If a caretaker, eligible adult or minor parent who is the caretaker of an AG refuses to assign child support at application, the application will be denied. This does not apply to a minor parent who is an eligible child in an AG who refuses to assign support.

Sanctions will be applied when an AG refuses to cooperate with Child Support (IV-D), except in the case of a minor parent who is an eligible child in an AG who refuses to cooperate with child support. In that instance, the child support sanction does not apply. However, if a caretaker, eligible adult or minor parent who is the caretaker of an AG fails or refuses to cooperate with Child Support Services without good cause or to assign support to the Department, the entire assistance group will be ineligible for Families First benefits until the caretaker complies with the child support cooperation requirement.

The sanction for non-cooperation must not be applied until the child support worker has established that there are no extenuating circumstances that caused the non-cooperation such as illness, delay in mail, misunderstanding, etc., and the Families First caseworker has established that good cause does not exist. (See Sanctions chapter for details.)

If the application is denied for failure to cooperate with Child Support Services, the AG children must be tested for Medicaid eligibility using AFDC rules, but the caretaker is not eligible for Medicaid coverage. Any case closed because of a child support sanction will be referred to the Department of Health for a follow-up visit. (See Visits by the Department of Health chapter.)

The caretaker is also required to submit any child support received for an AG child beginning with the month following the month that the AG is approved for Families First benefits. This is true whether the caretaker receives the child support directly from the absent parent, the court clerk's office or from a third party (e.g., the absent parent's employer).

In addition, if a minor parent is the caretaker of his/her own Families First case, any support paid by an absent parent of the minor caretaker must also be forwarded to the state.

EXCEPTIONS:

The following individuals are exempt from the assignment requirement for Child Support:

- caretakers who receive voluntary payments made for an unborn child; and
- "caretaker only" cases where the dependent child in the AG is not receiving Families First benefits because he/she is receiving SSI.

The following AG types are exempt from the cooperation requirement for Child Support:

- single parent adoptions;
- an AG containing only a pregnant woman (child support cooperation will be required when the new born child is added to the AG); and
- absence is due to court-ordered public service in lieu of incarceration;
- caretakers who have been determined to have good cause for refusal to cooperate with Child Support Services.

GOOD CAUSE FOR REFUSAL TO ASSIGN CHILD SUPPORT:

There is no good cause reason for refusing to assign child support.

GOOD CAUSE FOR REFUSAL/FAILURE TO COOPERATE WITH CHILD SUPPORT:

Good cause can be granted for refusal/failure to cooperate with Child Support Services **only** under the following circumstances:

- It is reasonably certain that there will be physical or serious emotional harm to the

child for whom support is being sought as a result of the caretaker's cooperation. If the good cause claim is made based on emotional harm, an emotional condition must already exist that cooperation would likely result in an emotional impairment that would substantially affect the child's functioning.

- It is reasonably certain that there will be physical or serious emotional harm to the caretaker that would reduce his/her capacity to provide adequate care for the child. If the good cause claim is made based on emotional harm, an emotional condition must already exist that cooperation would likely result in an emotional impairment that would substantially affect the caretaker's functioning.

- Pursuit of the child support would be detrimental to the child because he/she was conceived as a result of incest or forcible rape.

- Adoption proceedings are pending for the child.

- The caretaker is being assisted by a public or licensed private social agency to decide whether to keep the child or relinquish for adoption. This good cause reason will be in effect for only three months.

VERIFICATION:

All good cause claims must be verified. Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the caseworker to obtain the needed information. The following documents are acceptable for such verification:

- birth certificates, medical records, or law enforcement records that indicate that the child was conceived as the result of incest or forcible rape;

- court document or other records that show that adoption legal procedures are pending;

- court, medical, criminal, child protective services, social services, psychological or law enforcement records that show that the absent parent may inflict physical or emotional harm to the child or caretaker if cooperation is required;

- a written statement from a public or licensed private social agency that the caretaker is being assisted by that agency to decide whether to keep the child or relinquish for adoption; or

- notarized statements from individual other than the caretaker that have knowledge of the good cause circumstances. The statements should include what he/she knows about the situation and how he/she is in a position to know about the circumstances.

In some instances, the caretaker may claim good cause for physical harm and there is no documentary evidence. For example, some battered individuals have not reported prior abuse because of fear or embarrassment. In these cases a determination must be made to determine the credibility and reliability of the caretaker. Good cause may be granted in these instances if the physical harm can be reasonably anticipated and the case is fully documented to substantiate this decision. These decisions must be approved by the supervisor prior to granting good cause.

If the caretaker's statements and evidence are insufficient to make a decision about good cause, the caseworker may contact the absent parent if necessary. However, before contacting the absent parent, the caseworker must inform the caretaker so that he/she can provide additional verification, withdraw the application or have the case closed or withdraw the good cause claim.

DOCUMENTATION:

The appropriate ACCENT screens must be documented regarding the absent parent(s) for each AG child. In addition, documentation about exemptions, good cause determinations and procedures, sanction decisions and any other pertinent information about the child support requirements must be documented on the ACCENT CLRC, running record comments screen.

PROCEDURES:

The Families First child support cooperation and assignment requirements, good cause process and penalties must be explained to the applicant/recipient at the time that the Personal Responsibility Plan is presented to him/her. In addition, a Tennessee Child Support Handbook will be given to the caretaker for future reference.

If the individual is receiving child support, the caseworker will enter the amount of child support paid, up to the monthly current court ordered obligation, on AEFMI. The income will remain on that screen as long as the absent parent continues to pay the child support, even after the money is being sent to the state. This will ensure that the income is budgeted properly at application or if an income change is subsequently reported. The Budget Effective Date on the absent parent screens will prevent the income from being counted in the ongoing Families First and Food Stamp budgets.

Upon approval of the Families First benefits, the information provided about the absent parents and good cause is transmitted to Child Support Services by ACCENT when the appropriate information is entered on the ACCENT absent parent screens. Any changes to this information after approval will also be transmitted electronically to Child Support Services. In addition, ACCENT notifies Child Support Services when the Families First case is closed at the end of the adverse action period so that they can notify the caretaker

about the status of the child support case and to notify the court that current child support should be sent directly to the caretaker.

Individuals seeking child support for children who do not receive Families First benefits can obtain child support services through IV-D Child Support Services. The address and telephone number for the appropriate county Child Support Services office must be provided to these individuals upon request.

IV-D Reports to Family Assistance

If Child Support (IV-D) reports any information about the absent parent or the AG to Family Assistance, the caseworker must take prompt action to review the information, determine its impact on the AG and implement any necessary changes to the case. If IV-D reports that a named absent parent has been excluded by a blood test, the caseworker must contact the caretaker to inform her that:

- the man that she named has been excluded as the father of the child;
- it is no longer acceptable for her to name the same man as the absent parent;
- she must name the true natural father;
- she must explain why she named the previous man; and/or
- she must give a reasonable explanation of the true circumstances of the child's parentage.

If she does not do this, without good cause, sanctions must be applied. It is not acceptable for the mother to glibly name another man or merely state that she does not know the father's name.

Failure/Refusal to Cooperate With Child Support

If the caretaker, parent of an AG child or minor parent who is caretaker of his/her own case has failed/refused to cooperate with Child Support, **the child support worker must determine whether there has been willful non-cooperation or if there are extenuating circumstances that caused the problem.** These circumstances may include but are not limited to illness, delay in mail, misunderstanding, etc. If the child support worker reviews the circumstances and concludes that the caretaker had extenuating circumstances, the child support worker will work with the individual to remedy the reason for non-cooperation: schedule a new appointment, court date, etc.

If the child support worker determines that the individual did not have a good reason for non-cooperation, the Families First caseworker will be notified.

Good Cause Determination Procedures

If the caretaker, adult parent or minor parent who is caretaker of his/her own case claims good cause for non-cooperation, the caseworker must determine if the individual meets the good cause criteria for a waiver of the cooperation requirement **(see the criteria listed in the good cause section of this chapter).** If the individual's good cause claim meets our criteria, he/she must provide the required verification within 20 days after the claim is made. This time limit may be extended with supervisory approval in exceptional situations when the individual is having difficulty in obtaining the appropriate verification. A final decision on each good cause claim must be made within 45 days of the date the claim is made. This time standard may be extended only if the information required to verify or investigate the claim could not be obtained within the time limit or if the individual has been given additional time to obtain necessary verification. If the individual has complied with the requirements to establish good cause, Families First benefits will not be denied, delayed or discontinued pending the determination of whether or not good cause exists.

A good cause claim will be denied if

- the individual does not furnish the required verification within the 20-day time limit unless this time frame is extended;
- the evidence submitted does not substantiate the claim and the caretaker/parent does not submit additional evidence;
- the individual has not provided information for an agency investigation, if necessary; or
- the agency investigation establishes that the claim is not valid.

The results of a good cause investigation will be transmitted by ACCENT to Child Support (IV-D) when the pertinent information is entered on the appropriate absent parent screens. In addition, the caseworker must notify the individual in writing about the good cause decision.

If the good cause claim is denied, the individual must be given the opportunity to cooperate, withdraw the application or have the case closed. If the individual continues to be non-cooperative, sanctions will be applied.

Once good cause is established, this decision must be reevaluated at review only if the circumstances on which it is based are subject to change. If the circumstances have changed, the individual must be given an opportunity to provide additional evidence to establish that good cause continues to exist. The same procedures used for the original good cause determination will be used to review the good cause decision. If the good cause determination is reversed, the caseworker will notify the individual that

cooperation with IV-D is now required. The individual can claim good cause at any time if additional evidence becomes available and is presented to substantiate the claim.

Sanctions

See the Sanctions chapter for details on sanction procedures.

Support Collections Which Cause Ineligibility

Child Support Fiscal Services will notify the caseworker when an absent parent pays court ordered current support in an amount that is equal to or exceeds the Families First payment amount. Upon notification, the caseworker must re-compute a prospective budget using the amount of current child support to determine if the case continues to be eligible for Families First. If the AG is ineligible for Families First benefits with the child support included, the Families First case must be closed after the adverse action period. If the AG continues to be eligible, the Budget Effective Date on the absent parent screens will prevent the income from being counted in the ongoing Families First and Food Stamp budgets.

Retention of Direct Support Payments

If the caseworker learns that the AG is retaining support payments, he/she will notify Child Support (IV-D) using the Shared Based document, *IV-D Recovery Retained Support*. If IV-D discovers that the AG is retaining support payments, they will notify the caseworker.

In either instance, the child support will be used to determine if the AG continues to be eligible when the income is included in a prospective budget. If the AG is ineligible for Families First benefits with the child support included, the Families First case must be closed after the adverse action period. If the AG continues to be eligible, the Budget Effective Date on the absent parent screens will prevent the income from being counted in the ongoing Families First and Food Stamp budgets.

Recovery of the retained child support is the responsibility of IV-D and the individual will be required to sign a repayment agreement. If the individual refuses to cooperate with IV-D either in establishing a repayment agreement or in continuing to refuse to assign support, the caseworker will apply the appropriate sanction to the AG.

POLICY STATEMENT:

To receive Families First cash assistance, all adults and minor caretakers, who are not exempt and who are included in the assistance group, must participate in a Personal Responsibility Plan (PRP) that includes 40 hours of work and/or work preparation activities (with some exceptions). These work and work preparation activities are referred to as work components.

The Personal Responsibility Plan will be time-limited, goal-oriented and tailored to each individual's unique needs. Good case management skills and principles will be used in the development of the plan, with the participant being given every opportunity to participate in the decision-making processes. Because the Families First program is time limited, special care and consideration will be used in developing individual work plans. Each participant will go through a pre-plan discussion, orientation, and assessment prior to making a decision on which career path to choose. Once the path is chosen, there may be limitations in activities that DHS will provide if the participant opts to change paths.

- **Limited PRP Work Plan Hours -** An individual may have a temporary impairment that prohibits full participation in a work activity. However, limited participation in a work activity would be feasible. Rather than exempt these individuals, tailor their work activities to meet the hours or kinds of activities in which they would be able to participate. If the individual's impairment limits him/her to 20 hours or less of activities, the time limit must be interrupted. However, non-compliance in the activities without good cause can result in a sanction.

  For example, a woman who is eight months pregnant cannot work or participate in a work preparation activity for 40 hours for medical reasons. However, her doctor will allow her to participate for 20 hours in an activity that is not strenuous. If her doctor provides a statement to this effect, the participant's hours can be adjusted to 20 hours in a work/work preparation activity.

- **Minor Parents –** Minor parents are **parents** (caretakers or eligible children) who are **17 years of age or younger**. The only work requirement for minor parents is that they must stay in school during the school year unless there is a reason for a more appropriate alternative placement. Alternatives could be home study approved by the school system, GED classes, or other education programs. Any alternative placement must be explored to determine if it is appropriate. During the summer months, offer minor parents the opportunity to volunteer to go to summer school, participate in Work Experience, internships, local teen programs, Fresh Start, PACE, Summer Youth or other suitable activities that may be available.

  Note: Any activities during the school year other than school attendance will be treated as voluntary activities. Failure to attend school may lead to sanctions. (See Sanctions chapter.) A minor who has graduated does not have a work requirement until he/she becomes 18.

- **Teen Parents -** Teen parents are **parents** (caretakers or eligible children) **who are 18 or 19 years of age**. They are considered adults for work requirement purposes. However, with regard to work requirements, teen parents who are still in high school school will be treated the same as minor parents until they graduate from high school

or until the class of which he/she is a member when age 18 is attained graduates from high school.

Teen parents who are no longer in high school should be encouraged to return to high school or pursue alternative education courses to attain their diploma or GED. Teen parents who are not in high school will have the same work requirements as any other adult.

DEVELOPING THE PRP WORK PLAN:

Pre-Plan Development Discussion:

The pre-plan discussion encompasses topics that must be addressed with each participant prior to the development of a Personal Responsibility Plan. Part of the discussion will encompass orientation to Families First and evaluation of the individual's current circumstances that will affect his/her PRP. Note: Support services, incentives to work and transitional benefits should be discussed throughout the individual's participation in PRP work plan development, not just at orientation.

Orientation:

Orientation to Families First can be completed one-on-one by the caseworker or can be presented in a group forum. This discussion will help participants to prepare and develop a plan and to begin believing in their own ability to succeed.

Orientation is required for all new Families First applicants (including applicants who have been off Families First for one year) and for current recipients as needed. The manner of presentation is flexible and counties may decide on an arrangement that best fits their needs. A DHS caseworker or supervisor must conduct Orientation. This can be accomplished one-on-one during the individual's eligibility interview. Orientation may also be presented in a group setting on the first day of various PRP component activities or in a pre-authorization group for applicants. Orientation conducted as a group activity will be interactive and include no more than 30 individuals. Every effort should be made to prevent the individual from making multiple visits to the DHS office for Orientation. In addition, the individual cannot be sanctioned or denied for not attending the group orientation.

However the county chooses to present the information, the orientation discussion must include all the information listed below.

NOTE: Be sure to provide all appropriate Families First brochures during the orientation discussion.

- **Individual strengths** – Discuss with the participant and assess the strengths and experiences the individual brings to the work component planning process. Employ a friendly and empowering manner. The goal of this part of the discussion should be to build self-esteem and self-confidence regarding the opportunities presented by the Families First program. *The Case Management Guidebook* gives ideas and examples for these discussions.

WORK REQUIREMENTS AND WORK COMPONENTS

- **PRP Development -** Provide an explanation of the goals of Families First. Discuss PRP development, renegotiations, time limits and sanctions.
- **Work, Education, and Training** – Provide a clear step-by-step explanation of the Families First work requirements. This detailed explanation will include information on possible exemptions, all of the available work components (work, education, and training) and their expectations.
- **Support Services –** Discuss available support services including (but not limited to):
  - child care;
  - transportation assistance;
  - limited vehicle repair;
  - dental and optical assistance; and
  - other services described in the Support Services chapter.
- **Incentives to Work** – Help the participant visualize the possibilities for increased spendable income for his/her family. Emphasize how careers are built through a focus on education, training, and employment. Discuss:
  - the Earned Income Tax Credit;
  - the earned income disregard;
  - the fill-the-gap budgeting method; and
  - public housing income disregard.

  All of these incentives to work should be clearly understood by the participant.
- **Transitional Benefits** – Provide the participant with a preview of the transitional benefits available <u>after case closure</u> (depending on the closure circumstances) which will include:

- Transitional Medicaid for the participant and eligible children;
- continued child care subsidy, if income does not exceed certain guideline limits;
- extended Family Services Counseling after case closure, if requested;
- extended Employment/Career Services when individuals leave Families First with earnings; and

- First Wheels.

- **Family Cap and Marriage During Receipt** – Discuss these aspects of Families First policy and how they might affect the individual's eligibility and benefit amounts.

Evaluation of the Participant's Situation

Evaluate the participant's employability strengths as well as any existing barriers to immediate and long-term employment/training. Use this information to work with the participant to determine the activities and the work components that will be included in the PRP. While we will take into consideration the participant's wishes regarding work activities whenever possible, the choices depend upon several factors, including those listed below.

- **Current Educational Competency Level –** Inform any participant who is not exempt from a work requirement that literacy testing is available for anyone, whether or not he/she has a high school diploma or GED. Also explain how the literacy test scores for math and/or reading will affect the time limits and work requirements. If the individual agrees to take the literacy test, list it as the activity on the individual's PRP.

  Note: Receipt of a Special Education or Attendance Diploma indicate a learning disability or other issues that could be addressed by Vocational Rehabilitation Services or Family Services Counseling.

- **Participant's Goals for Self-Sufficiency -** Explore the participant's ideas and goals regarding self-sufficiency. These ideas and goals must be considered in the development of the work component part. For example, what are the participant's perceived gifts and talents? Can they be developed for specific types of careers? Are these plans realistic given the time limits of the Families First program? The participant's own desires and confidence regarding his/her abilities may overcome many obstacles. The caseworker's role in helping the participant identify personal strengths, develop realistic plans, and promote confidence in self and the program is an important first and ongoing step.

- **Work and Training History -** Determine what work experience, education or training, diplomas, certificates, or other certifications the individual has in preparation for work. The types of previous jobs held and the length of employment will also be important indicators of job readiness and potential for immediate job placement. It will also be an early indicator of the training and/or education needed for successful long-term job placement and/or career planning. The Employment Career Specialist will be available to help the caseworker determine the job readiness of the individual.

- **Current Employment and Training Status -** Do not require an individual to leave a job or an approved educational/training activity to go to another Families First component, DHS interview, or review. However, how the current employment or training affects the individual's assessment and long-term goals should be discussed. There are situations where the number of hours worked do not reflect that the individual is receiving minimum wage for the job. In that instance, the individual would be required to complete other work components to fulfill the 40-hour

requirement or he/she might choose to quit that job. Give the individual enough information to make an informed choice about the available options.

- **The Need for Life Skills and Job Readiness -** In talking with the participant, the caseworker may discover that the individual has low self-esteem, limited parenting and managing skill, little or no training and/or work history. These individuals may benefit from initially participating in components that stress life and job readiness skills (Work Prep, ECS or ECS Plus).

- **Limiting Factors -** Using the techniques introduced in Case Management Training, explore what limiting factors, if any, the participant will face in cooperating with the PRP. This process may reveal how interested the participant is in pursuing employment, or whether there are serious barriers that may hinder or prevent the individual from fully participating. Issues such as drug/alcohol abuse, domestic violence in the family, limited functional ability, or other problems may need to be addressed before the individual can go to work. (See the chapter on Family Services Counseling). In addition, make any reasonable accommodation to the work requirement or activities for a disabled individual as required by The Americans with Disabilities Act of 1990 (ADA).

- **Support Services and Child Care Needs -** Ask what support services the participant can provide, such as transportation, or if he/she will need DHS to assist in securing the service. Explore distance from and location of work or training sites to determine what transportation issues may be present. Discuss child care and transportation fully to determine what problems, if any, may arise in finding child care and/or transportation. Since both are critical pieces to the participant's success, explain that the arrangements must be as stable as possible and that the participant must report changing needs regarding child care and transportation as they occur. (See the Support Services and Child Care chapters for further discussion on these subjects.)

At each step in the development of the PRP, reassess each area listed above. Determine if any changes need to be made in the PRP or if any actions need to be taken to help ensure the success of the participant.

Available Components:

A wide variety of activities, called work components, are available to help participants reach self-sufficiency in the shortest time possible. These activities have been carefully planned and contracted to various community agencies that have valuable knowledge and experience in the fields of education, employment, training, and counseling services. Programs available to Families First in each county have been selected by the local and state DHS administrative staff and contractors are charged with meeting high standards and strict outcome goals.

Most components require that any additional components hours needed to reach the 40-hour requirement must be work-related activities. Work related activities include employment, Employment Career Services (ECS) and ECS Plus, Work Experience, and Community Service. Only Adult Education (AE) for individuals who test below 9.0 grade level in reading or math, literacy testing (Test of Adult Basic Education (TABE), or Basic English Skills Test (BEST), FSC Assessment, and VR Assessment do not require that the individual also participate in work related activities as part of his/her PRP. Some components have restrictions or set conditions that the participants must meet before

entering the component. Certain guiding principles drive the decision-making process in how to structure and combine components.

A list of available activities (components) and the guiding principles that must be observed for the PRP planning process follows.

- **Literacy Testing -** Literacy testing is an available activity designed to determine math and reading proficiency levels. Testing is strongly suggested for:

  - those participants who do not have a high school diploma or a GED; and

  - those participants who appear to be functioning below a 9.0 grade level, regardless of academic credentials.

  (Certificates of Attendance and Special Education Certificates are not the equivalent of a high school diploma or GED. Individuals with these certificates should be encouraged to take the literacy test and may be candidates for Family Services Counseling or Vocational Rehabilitation.)

  The TABE or BEST can be used for this test. While it is recommended that individuals take a literacy test, it is not required. However, literacy testing is a prerequisite for entering Adult Education as a component.

  Note: If an individual leaves AE and returns at a later date, he/she will be given a literacy test again if it has been ninety days or more since the date of their last literacy test.

  Individuals with high school diplomas or GEDs will not be routinely tested for educational competency. However, those academic credentials will not prohibit testing when there is reason to question the person's actual ability. When it appears that a participant may not be functioning at a 9.0 grade level, discuss this with the individual and offer the option to be tested. Information regarding possible difficulties with functional literacy can come from:

  - the participant's own admission;

  - the caseworker's personal observation; or

  - the report of another who may have knowledge of the individual's functioning such as Work Prep facilitators or Employment Career Specialists.

  NOTE: If an individual has already received a GED through the Families First program, this test will not be a viable component choice.

  Individuals with **Limited English Proficiency (LEP)** are given the BEST test. This test will determine the participant's grade level. Based on the test results, the provider can determine the participant's functional level and recommend either ESL or regular AE as a work component. If the provider recommends AE, use the TABE to determine the participant's grade level.

- **Adult Education** – This course is designed to develop basic skills in reading, math, English, and life skills and to focus on preparation for employment. It also includes GED preparation and testing. This activity is generally suggested for those who test below the 9.0 grade level (regardless of degree or certificate). It can also be an additional activity for those who:

  - do not have a GED or high school diploma;

  - function at or above the 9.0 grade level; and

  - are participating in a work-related activity for 20 hours per week.

  NOTE: AE is an appropriate PRP work plan component for individuals who have a **Special Education Diploma** or **Attendance Diploma** and who choose not to go to FSC/VR or for whom the FSC/VR counselor recommends AE.

  Some participants may have had negative schooling experiences that will affect their thoughts about AE. Discuss the AE process so that the participant has a clear understanding about the differences between AE and regular high school. Explain how the results of the scores for math and/or reading will affect the time limits and work requirement.

  English as a Second Language (ESL) – This activity is available to individuals who have Limited English Proficiency and who are not yet ready to participate in regular AE classes. If the provider who administers the BEST literacy test recommends ESL, we can assume that the individual functions below the 9th grade level for program purposes.

  Individuals Who Function Below the 9.0 Grade Level – Offer the opportunity to enter Adult Education for 20 hours per week to anyone who tests below the 9.0 grade level in either math or reading. If the individual chooses to enter AE for 20 hours per week, he/she will be exempt from additional work components and from time limits. This exemption will last until such time as he/she tests at the 9.0 grade level or higher in both reading and math **or** if he/she stops going to AE.

  Individuals who function below the 9.0 grade level may volunteer to participate in other activities in addition to the 20 hours of AE. These individuals will retain their exemption from the time limits and no sanctions would be applied if they fail to participate in the voluntary activities. Likewise, if they are working while attending AE for 20 hours per week, there is no sanction if they voluntarily quit the job. However, if the individual chooses not to attend Adult Education classes, the AG will not be exempted from time limits and voluntary quit sanctions and will be subject to a 40-hour per week work requirement.

  Individuals Without a GED or HS Diploma Who Function at or Above the 9.0 Grade Level - Participants who function at or above the 9.0 grade level in both reading and math have a 40-hour work requirement. If these individuals choose to participate in AE, they must also participate in work related activities for 20 hours/week. Time limits and voluntary quit policies apply to these individuals.

- **Training Preparation Education** - Participants who have a GED or a high school diploma and who function at or above the 9.0 grade level may need some additional basic educational skills to help them enroll in Post-Secondary Education/Training or other training component. Refer these individuals to the local AE class if additional study is needed. The goal of this component is to help the individual achieve a certain level of proficiency, such as a score on the American College Test (ACT). The intent is to eliminate the possibility that the participant will have to take college remedial or development courses. The individual can participate in Training Preparation Education up to six months. This component will be part of a 40-hour work requirement and must be combined with work related activities.

- **FOUNDATIONS Training –** this is an 11-week, 20-hour/week class designed specifically to meet the needs of Families First clients. It is divided into three modules: Customer Service, Basic Workplace Software and Career Preparation Training. This component prepares students to enter the Work Prep and Job Skills Training components.

- **Employment Career Services** – This component provides in-depth, comprehensive job search, job readiness**,** job placement, job retention, career assessment and career advancement activities. It is a ten-week assignment in how to look for a job, actual job search, and job development in a supportive group atmosphere. ECS can be used alone to meet the 40-hour work requirement or it can be used in conjunction with other self-initiated components. ECS used alone to meet the full 40-hour requirement can last up to ten weeks. After ten weeks, limit this component to 20 hours or less and combine it with another component.

  An Employment Career Specialist will:

  - be attached to each participant who is involved in Employment Career Services;
  - work with the caseworker and the participant in developing the participant's PRP work plan and long term career plan;
  - be responsible for classroom work, career assessments, job development and job counseling;
  - follow the participant beyond job placement or other work related activities; and
  - be available to provide post-employment or employment counseling to help with retention and advancement.

  EXCEPTION: The AG will not be eligible for extended ECS if the case is closed due to a sanction or non-cooperation reason.

- **ECS Plus –** In ECS Plus, the component contractors opt to receive incentive payments based on their performance in finding employment for Families First clients. The contractors are offered the freedom to develop and provide activities and training that they feel will help Families First individuals obtain <u>and</u> retain employment.

  ECS Plus is essentially a combination of ECS and Work Prep in addition to any unique activities that the contractor may develop to help with job training, placement or retention. It is not time limited. The contractor's freedom to develop intense activities directed to preparing for obtaining employment will enhance the probability of ECS Plus participants becoming successfully employed.

The ECS Plus contractor must offer some type of assessment prior to developing an activity plan. The caseworker will receive a copy of the Career Assessment Summary report. The Career Assessment results will also be discussed with the participant and a copy will be provided upon his/her request.

In addition to the assessment, the ECS Plus contractor will complete an internal staffing at 90 days and an interdisciplinary staffing at six months. It is suggested that a DHS representative attend the six-month staffing to ensure that the client is progressing and that ECS Plus continues to be an appropriate activity for the individual.

This component will always remain on the PRP (even if it becomes voluntary) because the ECS Counselor and the caseworker share responsibility for the participant's job retention and career advancement.

Though the Families First participant may be involved in various activities in ECS Plus, **ECS Plus will be all that is required to identify the activity on the PRP.**

Job Skills Training – The goal of Families First is to assist the participant in obtaining the best job possible with a career path and benefits. Job skills training includes the types of training listed below (**Indicate the type of training on the PRP**):

- **Vocational Educational Training** – Short-term industry specific training, limited to two training periods, not to exceed a total of twelve lifetime months. All participants are required to complete a screening instrument prior to enrolling in Vocational Educational Training. The instrument will be discussed and signed by the participant and the ECS during a pre-enrollment counseling session. Examples of Vocational educational training include auto repair, phlebotomy technician, Certified Nursing assistant, Medical records Clerk, Clerk, Secretary, Truck driver, Pharmacy Technician, Surgical Technician, LPN, and non-traditional jobs for women in construction or manufacturing.

- **On-the-Job Training** – (Families First funds cannot be used to subsidize these wages.) The employer provides OJT wages. The Local Workforce Investment Areas (LWIA) or another training program may subsidize training. This activity can also include apprenticeship programs that offer a stipend or wage.

- **Employer-Specific Training** – Employer Specific Training is short term training identified by a business or industry as needed in order for the Families First participant to become employed by a specific employer.

- **Self-Initiated Job Skills Training –** training in which the participant makes arrangements for payment for the training. The participant may or may not be in the self-initiated training at the time of application. Individuals who are engaged in a self-initiated training activity can continue in their activities, <u>even training for non-demand occupations</u>. Individuals enrolled in self-initiated training that will result in a certificate, associate degree or bachelor's degree, must meet the conditions set forth in the Post-Secondary Education and Training section below.

NOTE: Any Job Skills Training through the Tennessee Board of Regents (TBR) will be considered a "Job Skills" class.

- **Work Prep –** Individuals with little or no work history, low functioning skills, or low self-esteem are suggested candidates for this activity. Work Prep includes a variety of activities designed to prepare an individual in a general way to go to work or to engage in Job Skills Training. It may include Fresh Start/PACE which includes ***Survival Skills for Women (or Men),*** parenting classes and financial management classes, and the "Work Know How" curriculum. It may also include training activities such as keyboarding or specific employer tasks such as telecommunications and customer skill training. It is the responsibility of the Work Prep contractor to offer a menu of options that will help individuals become successful employees.

  Work Prep is a 20-hour activity that must be combined with work-related activities (or work-related activities and other work components). It can be provided either in a group setting or one-on-one for a period of up to six months. A maximum of two six-month periods of Work Prep is allowed in a 60-month lifetime period of eligibility. The two six-month periods may be back to back, or the individual may participate in work or another activity between Work Prep components.

  NOTE: In ECS Plus counties, Work Prep is part of the ECS Plus component and is not entered on the PRP. In non-ECS Plus counties, Work Prep will be entered on the PRP as a separate activity.

Work Prep and Job Skills Training Participation Limitations

Training choices made by the participant must lead to a specific employment goal. Prior training courses completed by the client should not be duplicated. Training courses should serve as building blocks toward the participant's long range goal. Participants should not be trained for a skill that cannot lead to employment within reasonable driving distance from their home. However, if the participant is willing to relocate and has a feasible plan to accomplish this following the completion of training, the District Program Supervisor can approve exceptions to this requirement.

A transcript of all completed Work Prep and Job Skills courses will be provided to the caseworker upon completion of the Work Prep or Job Skills component.

Effective 10/1/2002, clients are limited to (2) two Job Skills Training courses and effective 7/1/2004, to (2) two Work Prep Training courses during their 60-month lifetime period of eligibility. An exception to this policy may be made if one or more of the circumstances listed below exist and the District Program Supervisor has given approval for the exception to be made.

- The client has been in ECS/ECS Plus and has not been able to find employment in his/her field of training within a reasonable driving distance;

- The employment opportunity pursued no longer exists within a reasonable driving distance from his/her home;

- The client requires more training to reach his/her career goal;

- Circumstances in the client's life have dramatically changed and a new career path must be pursued.

NOTE: Any Job Skills Training completed prior to October 1, 2002 will be excluded when totaling the number of allowable trainings during the 60-month lifetime period of eligibility. The count for the allowable number of Work Prep Trainings will begin effective July 1, 2004.

Failure to complete Work Prep or Job Skills Training

Participants who are referred to Work Prep or Job Skills Training programs who do not complete the course and who do not have good cause may be referred to the same course one additional time only. (Good Cause determination policies can be found in the Good Cause section of this chapter.) Failure to complete the course following the second referral will result in the client's inability to:

- attend the course again;
- enter a different training course for a period of two months;
- include any hours in a training related activity as part of his/her work requirement during the two-month waiting period unless extenuating circumstances prevented completion and the approval of the Program Supervisor is given.

- **Self-Initiated Post-Secondary Education -** Training or education at a post-secondary school or institution which leads to a certificate, associate degree, or bachelor's degree. Participants must be a participant in a work-related activity, arrange for payment of their own tuition (registration fees), and meet other criteria for satisfactory participation, satisfactory progress and the education/training institution's requirements.

  Post-Secondary Education or Training Requirements – Post-Secondary Education or Training is defined as training that:

  - requires a high school diploma or GED;
  - leads to a degree or certificate.

  Participants who wish to enroll in a post-secondary education or training activity must:

  - make arrangements for payment of tuition through federal, state, or other grants, or financial aid through personal loans; and
  - choose a facility which meets state accreditation requirements, maintains a quality program, and meets acceptable placement standards; or
  - the facility must meet standards set by Local Workforce Investment Areas (LWIAs); and
  - maintain a 2.0 collegiate grade point average. (If the participant's grade point average falls below 2.0, he/she will have one academic term to regain the required average.); or

- maintain academic standards equivalent to those of the state's Technology Centers (if the participant chooses a non-collegiate institution) and make satisfactory progress toward completion, as defined by the institution.

Individuals who are enrolled in a college/university must attend **full-time** as defined by the college/university. Individuals enrolled in non-collegiate institutions must also attend full-time as defined by the individual institution. During the summer months, students must either attend full-time, as defined by the institution, or work full-time.

NOTE: Only credit hours are used to determine if the individual is enrolled full-time. Study hours are not considered in this determination.

NOTE: Graduate and post-graduate classes are not approved Families First work preparation/training components.

The caseworker should refer the participant to the Financial Aid Office of the training or the Post-Secondary Education institution to assist in arranging federal, state, or other grants or financial aid to pay tuition. The caseworker or ECS will assist the participant in choosing:

- a facility which meets state accreditation requirements, has acceptable placement standards, and maintains a quality program; and
- a course of study in a "demand occupation."

Post-Secondary Internet studies - Post secondary internet studies will be treated like any other post secondary course of study. All of the same criteria must be met. Internet classes can comprise all or a part of a curriculum of study. To determine PRP work plan hours for Internet studies, count credit hours plus study hours.

Financial Assistance – The caseworker, in conjunction with ECS, is expected to encourage the participant to take advantage of and exhaust all possibilities for financial assistance opportunities for quality training.

Families First funding cannot provide tuition assistance to Families First individuals who are participating in PELL eligible training. This is true even if the individual attending a PELL eligible institution is unable to personally get a PELL grant or if his/her PELL grant has already been exhausted. PELL grants are approved for the duration of the school year. For Technology Centers, this is usually **18** months. PELL grants for colleges and universities are approved for two semesters. A participant who wants to attend school a third semester in the school year may apply for a Wilder-Naifeh grant. If this grant is not approved and the participant is unable to arrange other funding, tuition costs will be the participant's responsibility.

Families First funding may be used for tuition assistance for non-PELL eligible training provided it is in a demand occupation and has been included in the eligible training provider list. However, if funding for the training should end, the individual must renegotiate his/her PRP and access a PELL eligible training or provide his/her own tuition to continue the training.

Families First funding may be provided for necessary training supplies not funded through other sources whether the training is PELL or non-PELL eligible.

The Director of Families First Services must approve any exceptions to the above financial assistance policy.

Study time - Count one hour of study time for each hour of class/credit time when study is required.

Determining Post-Secondary Education or Training hours for the PRP work plan – Combine the class/credit hours with student internships, labs, tutoring hours, and study time to determine the number of Post-Secondary Education or Training hours for the PRP work plan. Individuals who choose the Post-Secondary Education or Training component must participate in work related activities for 20 hours per week. However, if the total Post-Secondary Education or Training hours exceed 20 hours per week, then work-related activity hours will be less than 20 hours so that the total PRP work plan does not exceed 40 hours per week.

If the hours in class and class-related activities are less than 20, the participant must participate in work-related activities at least 20 hours per week. Any additional hours that are needed may be made up in other components.

- **Community Service Programs –** This component includes programs such as AmeriCorps, Job Corp, and VISTA. The hours participants spend in these programs will count toward the 40-hour work requirement. If the position is considered full time by the organization and is 35 hours or more per week, this will satisfy the full-time work requirement.

- **Welfare-to-Work –** WtW competitive grant programs are in operation in some counties. These programs may qualify as allowable components. Area Managers or district offices will determine which grants are applicable.

- **Employment –** Employment is working (either part-time or full time) for wages. Full-time work is defined as:

  – any paid work equaling 40 hours per week;
  – any paid work equaling 35-39 hours per week which the **employer considers to be full time;** and,
  – any paid work in which the hours fluctuate but average 40 available hours a week or 35-39 hours per week **if the employer considers these hours full time.**

  Employment that does not meet this definition is considered part-time employment.

  Paid employment includes on-the-job training where an agency is paying or supplementing the wages.

  In some instances, an individual may be employed for less than minimum wage. If that should occur, divide the earnings by the minimum wage to determine the number of hours allowed on the PRP or for the employment activity. **In-kind payments** cannot be converted to determine PRP hours or employment activity. Monies must actually be exchanged in order to be converted.

  Participants who are working full time by definition are considered to have met their 40-hour work requirement, **UNLESS** their income divided by the number of hours worked does not equal an hourly rate of minimum wage or higher. For participants who meet the 40-hour work requirement, no other activities are required. (The activity on their PRP will be employment.) However, **strongly** encourage them to seek a job with higher wages and to volunteer for ECS for guidance and support. Explain the supportive services that ECS may provide: advocacy, job retention and career advancement. If the participant chooses to volunteer for ECS, add the activity to the PRP. Failure to comply with a voluntary activity is not sanctionable. The participant may also choose to take additional education/training classes or be involved in other Families First components outside their work hours.

  - In order to determine the number of hours allowed for the PRP for individuals whose hourly pay rate is less than minimum wage, use the following calculation:

    Total wages ÷ Minimum wage = Hours allowed on PRP

EXAMPLE: A participant is working as a waitress earning $2.00/hr plus $50.00/week in tips. She is working full time (as considered by the employer) at 35 hours per week. Divide the total earnings per week ($2.00 x 35 = $70.00 + $50.00 = $120.00/week) by minimum wage ($5.15/hr). This calculation results in 23 countable PRP hours. This participant will need an additional 17 hours added to the PRP to meet the 40-hour work requirement.

EXAMPLE: A participant is working for $6.00/hr. She is working full time (as considered by the employer) at 35 hours per week. This participant is meeting her 40-hour per week work requirement since her hourly pay rate is at least minimum wage or greater.

- **Self-employment -** This component can either be part time or full time. To be considered full-time employment, the income after the cost of doing business must be equal to at least minimum wage for 40 hours. If the income after the cost of doing business does not reflect this, divide that income by the minimum wage. This will determine the number of countable hours for the self-employment activity on the Personal Responsibility Plan.

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Note: **Home-based child care providers** are considered self-employed. Their hours will be determined as any other self-employed individual.

Some self-employed individuals receive income less frequently than monthly. In these cases, determine the monthly income as prescribed in the Treatment of Income Chapter. Then use the minimum wage test described above to determine the number of countable hours for the PRP

Participants who are self-employed and whose hours meet the full-time criteria are considered to have met their 40-hour work requirement. No other activities are required for those individuals. (The activity on the PRP will be self-employment.) Again, s**trongly** encourage self-employed individuals making minimum wage to seek a job with higher wages and to be involved with ECS on a voluntary basis. If the individual chooses voluntary ECS, add it to the PRP. These individuals may also volunteer to take additional education or training classes or be involved in other Families First components outside their work hours.

Self-employed participants who are not making minimum wage will be required to make up their hours with other Families First components to meet their 40-hour work requirement.

- **Family Services Counseling (FSC) -** Individuals may be struggling with issues related to mental health, domestic violence, substance abuse, learning disabilities and/or children's health/behavioral problems. Individuals may choose Family Services Counseling in order to remove these barriers to self-sufficiency. This work component can be a part or all of the PRP depending upon the AG's circumstances. (See the Family Services Counseling chapter.)

- **Vocational Rehabilitation Services (VR) –** Vocational Rehabilitation Services is a component available to individuals who have mental, physical or learning impairments but who do not meet Families First disability or incapacity requirements. These individuals may request VR as an activity on their PRP.

  In addition, a Families First provider or the MEU may discover an impairment that they believe is deterring the individual from making progress. They will notify the caseworker of these situations so that a referral to VR can be offered to the participant. VR will accept individuals who meet their program requirements, if the participant wishes to seek employment. (See the Vocational Rehabilitation chapter.)

  If an individual who is participating in VR demonstrates that he/she is not able to work, the VR counselor may determine that the participant is too disabled to work and will release him/her from VR. These persons are exempt from the Families First work requirements.

WORK REQUIREMENTS AND WORK COMPONENTS

- **Department of Children's Services Parenting Plan –** This component is a plan devised by Department of Children's Services (DCS) to help a participant's children stay in the home. The hours and activities will be mandated by DCS and can be verified by the DCS caseworker.

- **Court Ordered Hours –** Participants who are participating in court ordered activity, such as community service, can use these hours as part or all (depending on the number) of their work activity hours.

- **Work Experience –** This activity is an unpaid work experience in a public or not-for-profit agency that provides supervision in a real work environment. (It is one of the work related activities.) This activity is used when all other efforts to find the individual paid employment have been unsuccessful. It may be assigned for a period up to six months. The activity hours will range from one to 40 hours a week, depending upon the need for structured work experience. This activity may be combined with Employment Career Services.

  Note: **Area Managers will use the U.S. DOL six-point test to ensure the placement meets FLSA standards**

  - **DHS Responsibilities** - Work Experience is one of the work components of Families First which requires community involvement of the DHS office with other agencies in the community. This activity places Families First participants in state, local government, or non-profit agencies to gain work experience. These positions are not funded and the participant receives no pay. Child care and other support services are available for the duration of the placement.

    The DHS Area Manager is responsible for ensuring that an adequate number of Work Experience spaces are available to the caseworker. He/She (or an assigned delegate) should solicit the cooperation and continued interest of executive level staff of county government, the school system, state agencies, and non-profit agencies, to create a pool of work experience spaces for use as they are needed.

  - **The Goals of Work Experience -** The purpose of Work Experience is to improve the employability of an individual who is not otherwise able to obtain employment. It is unpaid job training at a clearly defined, well-supervised worksite. The participant should have the opportunity to:

    - develop basic work habits;
    - learn new skills;
    - practice skills already learned in Families First;
    - acquire on-the-job experience;
    - demonstrate skills and work habits to prospective employers;
    - improve interpersonal skills;
    - learn to follow directions and take supervision;

- learn team work and cooperation on the job; and
- have an on-the-job mentor as a role model and support person.

- **Selecting Agencies As Potential Work Sites -** In the past, the following agencies have been willing to provide a work site for Work Experience participants:

DHS Offices	School Systems
Child Care Brokers	Nursing Homes
Board of Regents Schools	Hospitals and VA Institutions
Colleges and Universities	Adult Basic Education Programs
Head Start Programs	LWIA Offices
Community Action Agencies	Public Housing Agencies
Senior Citizen Centers	United Way Agencies
City and State Parks	Legal Aid Organizations
Health departments	Other State Agencies
Mental Health Institutions	Local Government Offices
Hunger Advocates	Other Not-For-Profit Agencies

- **Recruiting Work Site Providers** – The Area Manager will fully inform each potential worksite provider about the expectations placed on the worksite employer. Some of those expectations are as follows:

  - The employer will provide for the health and safety of the individual while he/she is performing on the work site, including any injury claim process.

  - The participant will not be involved in any bipartisan or political activities.

  - The activity to which the individual is assigned will not be of a personal nature for any employee of the agency.

  - The individual will not be discriminated against on the basis of color, race, religion, sex, age, national origin, or disability.

  - All information learned about the individual will be kept confidential by the employer. However, information that may affect Families First eligibility must be reported.

  - Attendance records and Evaluation Forms will be completed on each employee and made available to DHS bi-weekly.

  - DHS will be promptly notified of any accidents, failure to report to work, failure to perform, or failure to cooperate with the agency or supervisor.

- **DHS Responsibilities to the Work Experience Site -** DHS must:

  - provide supportive services and child care as needed by the participant;

- screen work site participants according to the wishes and needs of work site providers;

- furnish the work site provider with reporting requirements and forms

- notify the work site of any change which affects the participant's placement immediately;

- monitor work site placements, compliance by the participant, and the work site's attitude about the placement; and

- maintain the participant's confidentiality.

▪ Examples of information that a worksite employer needs to know are whether or not the participant:

  - has a conviction for child abuse (if children are present at the worksite); or
  - needs accommodation for a mental or physical disability in order to perform the work.

  If the county has difficulty in placing individuals known to the criminal justice system, contact the local Community Corrections or Probation/Parole office and ask for guidance in the types of placements they would recommend. These offices operate community service programs for convicted felons, parolees, and probationers, and might agree to assist by letting the county use some of the worksites they have already developed.

▪ **Participant Work Experience Agreements** – Each participant who enters a Work Experience component is required to sign a Work Experience Participant Agreement. This document specifies the position, the days and hours that the participant agrees to be at the worksite, the duration of the assignment, and the general rules of conduct for this component. The DHS caseworker will sign the form specifying what DHS agrees to do. Keep a copy of this agreement in the worksite file for reference purposes. Give a copy of the agreement to both the participant and the worksite employer.

▪ **Liability** – The following rules apply to liability for injury on the job:

  - All participants are covered by Medicaid and would qualify for medical treatment with their Medicaid MCO.

  - When participants are working on state property and experience an injury that results in a claim not covered by Medicaid, a claim may be filed with the State Board of Claims, if it meets the conditions for such a claim.

- When the participants are working at a local government agency or not-for-profit agency, the agency's insurance must cover any claims not covered by Medicaid.

Satisfactory Participation in the PRP Work Plan:

It is the caseworker's responsibility to monitor the participant's participation in self-initiated activities. It is the service provider's responsibility to monitor participation in Work Prep, Adult Education, ECS, ECS Plus and Job Skills training. Each participant must meet attendance and participation rules to be considered in compliance with the PRP. He/She must also cooperate in providing information that verifies attendance and compliance with the PRP. Providers are required to report to DHS, within three working days, any situation that will affect the PRP. Providers have ten working days from the date the client is scheduled to attend the work activity of the initial referral to report non-compliance. In all other situations, the provider must report within three working days of the non-compliance, including non-compliance during a two-week compliance period. Each component has expectations for set levels of activity, attendance, and compliance. The rules listed below describe the requirements for participation.

- **The 90% Rule** – Each participant is expected to attend the following components for no less than 90% of the time:
  - Work Prep;
  - Adult Education classes;
  - ECS and ECS Plus;
  - Job Skills training;
  - Secondary school classes for minors and teen parents;
  - Foundations;
  - Training Prep.

  The amount of time that constitutes "90%" is dependent upon the length of the activity.

  Activities lasting less than 30 days – Attendance for activities that last less than 30 days will be based on the actual time in the activity. If the activity is:
  - one week in duration, the participant cannot miss more than the equivalent of one-half of an activity day;
  - two weeks long, the participant cannot miss more than the equivalent of one activity day;
  - three weeks long, the participant cannot miss more than the equivalent of one and a half days.

  Activities lasting 30 days or longer – Attendance in activities which last 30 days or longer will be based on 90% of the days in each calendar month. If the first month or last month of the activity is a partial month, follow the criteria listed above for activities lasting less than 30 days. For example, a participant enters AE on March 24. The 90% attendance for the first month will be based on the criteria listed above for a one-week activity. Beginning April 1, attendance will be based on 90% of the calendar month. (The participant can miss up to two days within a calendar month and still be within the 90% attendance rule).

  Providers may grant waivers to this rule for up to three routine absences per month. In addition, extenuating circumstances beyond the control of the participant could result in

additional absences beyond these three. For example, bereavement leave can be granted based on the same regulations and time restrictions as state employee bereavement leave. Providers will ask the participant to provide third party documentation (i.e., physician, court, etc.) to substantiate any extenuating circumstances.

Providers will tally absences in excess of the three excused absences to determine if the participant is meeting the 90% attendance rule. Providers will notify the caseworker within three working days when the participant is not meeting the 90% rule. The caseworker will then determine if the participant had good cause for the absences.

Note: If a participant misses several days of an activity with good cause, it is not necessary that he/she repeat the entire course. The portions that were missed can be "made up." If the participant and provider agree that the course skills have been attained, the provider can determine that the participant has successfully completed the component. In that case, the participant can enter another component.

If the days missed were without good cause and the 90% attendance rule was not met, the participant will have to complete the course.

- **The Employer Rule** – Every employer has his/her own rules about satisfactory participation in work. If an employed individual, who has full or part-time employment as a PRP activity is fired, this constitutes failure to comply with the PRP because of unsatisfactory participation. Consequently, being fired from employment will be treated in the same manner as failure to comply with any other work component. Conciliation and determination of good cause are required. An employer may complain about a participant failing to meet the expectations of their place of employment. In that instance:
  - find out what the problem is;
  - resolve the issue if resources allow; and
  - counsel with the employee to try to address the problem.

  If the participant will not meet the employer's requirements, determine if a sanction is in order for losing the job. (See Voluntary Quit policy in the Sanctions chapter if the individual quits a job.)

- **Secondary Education (High School) Rule** – Monitor secondary school attendance required for minor parents and for teen parents who are still in high school. The 90% rule will apply. One way to monitor secondary school attendance for minor and teen parents is to require them to submit their grade and attendance card every six weeks. If the minor parent is not compliant, follow the appropriate policy in the Sanctions chapter regarding minor parents. If the teen parent is not compliant, sanctions will be applied as for any adult who has not complied with a work plan.

- **Post-Secondary Education and Training Rules – (This component includes individuals who have self-initiated post-secondary education).** Although the attendance rules for colleges and training institutions vary, they will serve as the standard for satisfactory participation in training and post-secondary education. For

attendance rules for colleges and training institutions vary, they will serve as the standard for satisfactory participation in training and post-secondary education. For example, the institution may have a rule that the individual cannot pass if he/she misses more than four classes.

While it is sometimes difficult to get colleges and universities to report attendance when they are not under contract to DHS, the responsibility lies with the participant to ensure that a record of **their attendance is kept and provided bi-weekly**. One method is to have the participant carry an attendance sheet and ask his/her professors to sign it acknowledging that he/she is satisfactorily attending class and making satisfactory progress. The caseworker should follow up at least every quarter or semester to verify ongoing attendance.

When the individual is participating in a training where the training provider contracts with DHS, the training provider must notify the caseworker within three working days, when the participant is **not** attending as required. The provider has ten working days from the date the client is scheduled to attend the work activity to report, if the client has not contacted/participated after an initial referral. During this period, the provider is expected to make every effort to engage the client in the activity.

- **Department of Children's Services Parenting Plan** – DCS will make the determination about whether or not the participant is satisfactorily participating in his/her parenting plan. If the DCS counselor notifies the caseworker that the participant is not in compliance with his/her plan attendance requirement, the caseworker will initiate conciliation/sanction procedures by attempting to contact the individual.

- **Court Ordered Activities** – The court (or its designee) will determine if the participant does not attend these activities.

- **Work Experience Rule** – Work experience is similar to an employment situation in which the employer (or worksite provider) decides what is acceptable work and participation. While worksite providers cannot discriminate against the participant or place them at risk just like any other employer, they have expectations and will decide if a participant is not meeting those expectations. The caseworker or Case Management Assistant (CMA) will monitor these placements carefully to ensure the experience is good for both the participant and the worksite provider. **Attendance for work experience placements will also be provided bi-weekly.**

- **Family Services Counseling Rules –** FSC component activities can be a part of a traditional 40-hour work plan or a modified work plan. Attendance in the FSC activities will be determined based on what the Family Services Counselor and participant have agreed. If the participant is not following the prescribed plan, the Family Services Counselor will notify the caseworker. (See the Family Services Counseling chapter for more details regarding attendance in FSC and other work activities.)

- **Vocational Rehabilitation Services Rules –** Vocational Rehabilitation Services activities are determined by the VR counselor. If the participant is not complying, the VR counselor will notify the caseworker. (See the Vocational Rehabilitation chapter for more details regarding attendance in VR and other work activities.)

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Satisfactory Progress:

Each participant will be measured against the satisfactory progress standard that applies to the activity in which he/she is engaged.

- **Employment Career Services Rule** – The Employment Career Specialist will follow all participants who have ECS as a PRP activity. They are responsible for counseling the participant and assisting them in maintaining career momentum. Satisfactory progress will be determined by the ECS and progress problems will be reported to the caseworker.

- **Adult Education Rule** – In adult education, the teacher will monitor progress by testing the participant every ninety (90) days at minimum. The participant will be tested in the areas of math and reading. The lower of these two scores will be used to determine the participants grade level. The Adult Education work activity will be divided into six levels and progress will be measured against each level. The six levels are:
  - Adult Education below the 2nd grade level (< 2nd grade)
  - Adult Education below 4th grade level (AE 2.0 – 3.9)
  - Adult Education below 6th grade level (AE 4.0 – 5.9)
  - Adult Education below 9th grade level (AE 6.0 – 8.9)
  - Adult Education at or above 9th grade level (AE 9.0 – 10.9)
  - Adult Education at or above 11th grade level (> 11th grade)

    - Individuals who test below a 2.0 on the TABE test must be offered a referral to FSC for a Learning Disability (LD) screening before they enter AE as the activity. If the individual chooses to go to FSC for the LD screening, tests positive for LD and chooses to return to AE, the results of the screening will be shared with the AE instructor. The instructor will then be able to gear the AE material to meet the needs of the LD individual to help ensure that he/she is progressing in AE. If the individual previously tested below 2.0 and he/she chose not to go to FSC for an assessment at that time, he/she will still have up to **9 months** from the date he/she began in AE to progress to the next literacy level or greater.

    - Individuals who test at a level of 2nd grade or above and choose AE as the work activity on their PRP will have up to **6 months** to increase their AE score to the next level of progress or greater.

    - If after 6 months (9 months if TABE < 2.0) in AE, a literacy test indicates that the participant has not made satisfactory progress (scored to the next or greater literacy progress level) the AE instructor will notify the caseworker. At this point, contact the participant to renegotiate the PRP and offer the participant one of the following options:

1.) a referral back to AE for a chance to score at the next literacy progress level within a 3-month period (See Option Descriptions listed below); **or**
2.) a referral to FSC for Learning Disability/Barriers screening (if this option has not already been used previously) See Option Descriptions- FSC Referral Procedures listed below; **or**
3.) an opportunity to change their work component.

- **Option Descriptions:**

- If the participant chooses option 1 to return to AE and he/she does not achieve a score to the next literacy progress level within 3 months, begin the conciliation process. If the participant responds to the AEONC, he/she will have to test at the next literacy progress level or greater in order to correct the non-compliance situation. If he/she fails to test at or above the next level, then he/she will have to renegotiate the PRP (which could include a referral to FSC for assessment, but not for LD screening if that has already been done). At this point, AE is no longer an allowable option. If the clock was stopped while in AE, the clock will begin to count when the PRP is renegotiated (unless another exemption/ interruption is established), since the participant is no longer in the AE activity. If he/she achieves a score at or above the next literacy progress level, he/she could renegotiate the PRP for the next level of AE achievement.

- If the participant chooses option 2, then follow these **FSC Referral Procedures**:

Renegotiate the PRP to reflect FSC Assessment. Complete a referral to FSC Assessment. FSC will complete an assessment that will include a screening for determination of a learning disability. If the screening indicates that the participant is not learning disabled and does not opt to go to FSC, then he/she will be referred back to the caseworker for re-negotiation of the PRP to remove FSC Assessment from the PRP. They may renegotiate for AE or some other activity. If the screening indicates a possible learning disability, FSC will (if agreed upon by the participant) expand the FSC Assessment to include Psycho-Educational testing. This specialized assessment will determine if the participant does have a learning disability. This specialized assessment will provide specific feedback regarding what type of learning disability, which will assist the AE instructor in determining the best way to deliver the AE material to the participant to ensure learning. If the participant is diagnosed by a Psychological Examiner with a learning disability or other barriers that may affect participation, then the FSC Assessment Feedback results will indicate recommendations for the services that the participant should be involved in.

At this point, the FSC will review the results with the participant and may recommend appropriate activities to the caseworker. If needed, the caseworker will then renegotiate the PRP with the participant and make the necessary referrals and changes to the PRP. The recommendations of the Psychologist may be released to the next service provider if the participant signs a release of information so that accommodations can be made.

The Psycho-Educational Assessment is a one-time only test. Once the participant completes the testing, he/she may not be offered another Psycho-Educational test. This assessment does not affect FSC Assessment policy. There are no limits on the number of times a participant may opt for FSC.

For those individuals who choose to go to FSC Assessment for the sole purpose of a screening for a possible learning disability and are already enrolled in AE, enter 2 FSC Assessment hours and 18 AE hours on the PRP. This is the only time that the FSC Assessment activity is not a stand-alone activity on the PRP, as this assessment does not meet the 40- hour work requirement. The time count will be interrupted for 1 month for FSC Assessment. If FSC Assessment has occurred within the last 12 months, the time count will not be interrupted for an additional FSC Assessment. The PRP will remain this way until a feedback form from the FSC counselor is received. If a Learning Disability is discovered in the FSC Assessment, the FSC counselor will issue a FSC Feedback form to the caseworker. The feedback form may suggest any of the following:

- enrollment in FSC activity; or
- return to AE (for full 20 hours); or
- enrollment in another appropriate activity.

NOTE: During this 6/9-month period, the participant will continue to be tested every 90 days for progress. (Code the AEIPA screen with an expected completion date 6/9 months in the future in order for the alert to be generated)

- If the participant leaves the AE activity, for any reason, and returns to the AE activity more than 90 days from the date he/she left, he/she will start the Literacy testing over. If the participant has been out of the AE activity less than 90 days, he/she will enter AE at the previous Literacy level.

Example: A participant tests at 4.8 and enters AE. After 90 days in AE, she is re-tested and scores 5.2. At this point she is in the 3rd month of the 6-month progress period to achieve a literacy score of above 5.9. She leaves AE due to employment. After 2 months, she returns to the Families First program due to loss of job. Since she has not been off the Families First program for more than 90 days, she will return to the previous literacy level. Since she was in the 3rd month of the process, she will have 3 more months to reach a score above 5.9.

- **PRP Re-Negotiation Procedures**:

  The PRP may be re-negotiated by telephone contact as the participant progresses through the levels of AE. There should be no lapse of time with the participant entering to the next level of AE.

- **Fresh Start, PACE and Job Skills** – Satisfactory progress in Fresh Start, PACE or Job Skills will also be assessed by the instructor/facilitator. If the individual appears capable but is not putting forth a good effort, the instructor/facilitator will report to the caseworker with details as to why this decision was made. The caseworker will determine why the participant is not progressing and decide whether a sanction is necessary or if other services would be appropriate.

- **Employment Rule** – Satisfactory progress in paid employment is determined by the employer or the employee's supervisor. If the employee is not making satisfactory progress on the job, termination from the job is a likely possibility. The caseworker may be able to intervene and prevent an employee from being fired if the employer is willing to cooperate in trying to help the employee progress on the job. However, if an employed individual who has full- or part-time employment as a PRP activity is fired without good cause, this constitutes failure to comply with the PRP because of unsatisfactory participation.

- **Secondary Education (High School) Rule** – Minor parents or teen parents in high school must make satisfactory progress by maintaining a passing grade average. If the student is not passing, explore whether or not the student may have a learning disability, or other problem. If one is suspected, offer a referral to Family Services Counseling or Vocational Rehabilitation for further evaluation.

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- **Post-Secondary Education Rule** – An individual participating in post-secondary education must maintain a 2.0 grade average. If the participant falls below this level, he/she will be given one quarter/semester to bring the average up to 2.0. If the grade average does not reach 2.0, begin conciliation/sanction procedures by attempting to contact the participant.

- **Department of Children's Services Parenting Plan** – DCS will make the determination about whether or not the participant is satisfactorily participating in his/her parenting plan. If the DCS counselor notifies the caseworker that the participant is not making satisfactory progress with his/her plan, the caseworker will initiate conciliation/sanction procedures by attempting to contact the participant.

- **Court Ordered Activities** – The court (or its designee) will determine if the participant is non-compliant in these activities.

- **Work Experience Rule** – Satisfactory progress in work experience is determined by the worksite supervisor and reported to DHS if a problem exists. If a problem is reported, the caseworker will initiate conciliation/sanction procedures by attempting to contact the participant.

- **Family Services Counseling Rules –** FSC component activities can be a part of a traditional 40-hour work plan or a modified work plan. The Family Services Counselor will determine progress in the Family Services Counseling activities. If the participant is not following the prescribed plan, the Family Services Counselor will notify the caseworker. (See the Family Services Counseling chapter for more details regarding progress in FSC and other work activities.)

- **Vocational Rehabilitation Services Rules –** Vocational Rehabilitation Services activities are determined by the VR counselor. If the participant is not complying, the VR counselor will notify the caseworker. (See the Vocational Rehabilitation chapter for more details regarding attendance in VR and other work activities.)

Plan Follow-up Responsibilities:

Each county will establish a plan for regular follow-up with participants who have been referred to work components, have gone to work, or have lost cash benefits due to employment. This plan may be customized due to the staffing resources available in each county. However, the plan must ensure that working participants are not interrupted in their employment to come to the DHS office for a review or follow-up discussion. In addition, the follow up does not have to be in person.

County DHS offices will need to determine if extended office hours, employer visits, and adjusted work weeks for employees are needed. The availability of the ACCENT system will be a consideration when planning office hours. These considerations are not unlike many other departments of state government that must provide convenient "customer

services." Area Managers and supervisors will need to consult staff in the development of plans to make the office more responsive to both customers and the employer community.

Follow-up After Referral To Providers - The caseworker has a responsibility to follow up on each participant on a regular basis after assignment to component activities. This contact alert can be set on ACCENT (as an expected systems change) at the time of case approval and should be individualized to the participant. Some participants may need to be contacted every two weeks and some, every two months or less frequently.

The EA can assist the caseworker with the follow-up. Follow-up should occur, at a minimum, when the completion of an activity is expected or when the participant has failed to contact the caseworker at a specified time. However, if the follow up is the result of information from a provider that the participant has completed an activity, has dropped out, has failed to show up, or has some problem that the provider cannot address, the caseworker must attempt the follow up contact. During this contact, the caseworker will:

discuss the reason for non-compliance, if applicable;
try to find a solution to the problem, as the situation demands;
determine good cause; and/or
renegotiate the PRP.

Many follow-up contacts should be made to encourage and congratulate the participant for achievements and successes. These more pleasant contacts will increase the chance of a participant successfully meeting the work plan goals.

Intensive case management follow-up contacts should be made when the participant is nearing the 18-month or 60-month time limit and does not earn enough to leave the Families First program. These contacts prior to the time-limit expiration will help communicate the urgency of time limits and their effect on the participant's benefits. Offer any additional assistance possible to help the participant achieve his/her long-term goal.

Follow-up For Employed Participants Still Receiving Cash Assistance - Every participant who goes to work either part-time or full-time should have follow-up contacts at least bi-weekly for the first six months after the employment begins. The Employment/Career Specialist will make these contacts. The purpose of the contacts is to offer assistance with problems that have developed that the participant may not be able to handle alone. These contacts must not interfere with the job under any circumstance. Keeping individuals on the job, helping them advance to better jobs and pleasing employers are our main objectives in making these contacts. Any problems identified should be addressed immediately. Inform the participant to expect these calls.

Participants should feel that they may call the DHS office and discuss any problem that may develop at work, with their support services, or with child care. Employers should feel they have the same privilege. Respond to both individuals immediately.

Remember that these participants will still be our customers and will still be subject to regular reviews. The review will give the caseworker an opportunity to explore the employment situation in greater depth and to review the rest of the PRP to see if the participant is progressing at a satisfactory rate. Reviews should never interfere with the individual's employment.

- **Follow-up For Employed Individuals Who Had Earnings at the Time of Case Closure -** Employment/Career Specialists will make follow-up contacts for one year with participants who had earnings at the time of their Families First case closure. The purpose of these follow-up contacts is to help the employee with problems that jeopardize continued employment. These individuals may still qualify for:

  - Transitional Child Care;
  - Transitional Medicaid;
  - extended ECS;
  - Family Services Counseling; and
  - the First Wheels program.

  Contacts will continue at least quarterly until it is clear that the family does not want or need our support anymore. If the AG still receives food stamps, these contacts may coincide with the food stamp recertification interviews. However, some individuals will want to break the tie to DHS, and we should honor their privacy.

  Again, these contacts should not interfere with the individual's employment. Contacts with the Employment/Career Specialist at the DHS office should be available at a variety of hours, even on Saturdays, if possible. When an employer has hired a fairly large number of Families First participants, the ECS will offer on-site case management services at least once a month or, as needed. Lunch hours and before or after work sessions could be offered to prevent a trip to the DHS office **if the employer has a room which ensures privacy and confidentiality.**

EXCEPTIONS:

Exemptions from work requirements may be determined at different times in the Families First eligibility process. Some exemptions are determined:

- during the development of the Personal Responsibility Plan;

- after an individual has failed to comply with the plan and has been found to have good cause. Often, these good cause exemptions will occur as a result of the conciliation process; or

- as a result of a change in the AG's circumstances.

When these exemptions are determined, they must be coded on the appropriate ACCENT screens.

After a case is grouped for Families First by ACCENT and found to be potentially eligible, the caseworker must determine if any AG members are exempt from work and/or work preparation activities. Monitor any exemption that is subject to change to determine if the condition or situation still exists. All exemptions should be reviewed at each redetermination of eligibility.

Some exemptions may be of a temporary or time specific nature. **NOTE: The time count exemption/interruption is based on a calendar month, while the work exemption may be**

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only for a portion of the month. Once the exemption ends, take timely action to place the individual in a work activity, regardless of whether or not the time count exemption/ interruption is still in place for that month. For example, the exemption ends on July 15th. The "clock" is stopped for July. However, the PRP must be renegotiated within two weeks of the end of the exemption.

An adult is exempt from the work requirement when:

- the participant has a medically verified disability (refer to verification section of this chapter);
- the participant proves he/she is needed in the home full-time to care for a related child or adult relative who lives in the home (see the Time Limits Chapter for a definition of full-time care);
- the participant is age sixty (60) or older;
- the participant is not included in the AG;
- the participant is determined by Vocational Rehabilitation Services to be too disabled to work after attempting to participate in their program;
- the participant is determined **incapacitated**.
  - When an individual makes a claim of incapacity, follow the same process used to determine incapacity for deprivation purposes (see the Deprivation chapter).
  - Pregnancy is not an automatic incapacity. However, pregnancy may cause a temporary incapacity due to medical problems (see the Good Cause section of this chapter).
  - Both applicants and recipients will be exempt from the work requirement while awaiting an incapacity decision.
  - An incapacity claim **cannot** be denied at the county level. If the MEU denies an incapacity claim, Vocational Rehabilitation Services or Family Services Counseling may be an appropriate referral.

Volunteers

The exempt individuals listed above **cannot** volunteer to participate in Families First activities and cannot receive support services, including child care and transportation.

- Exceptions
  - EA caretakers who are 60 years of age or over and who are employed may access support services necessary to continue employment including child care, transportation, dental, optical, car repair, etc; and

- Single parents caring for a child under the age of 1 or two-parent AGs caring for a child under the age of 16 weeks, who are either currently employed or actively participating in a Families First allowable activity, will also be allowed access to support services including child care, transportation, dental, optical, car repair, etc. This includes high school for minor teen parents.

  NOTE: Remember that these individuals are not required to participate and cannot be sanctioned.

Some individuals are mandatory AG members who are not included in the grant calculation. However, unless they meet other exemption criteria, they <u>are not exempt</u> from the work requirement. These individuals are:

- ineligible aliens;
- convicted drug felons (convicted after 8/22/1996);
- fleeing felons;
- probation/parole violators; and
- disqualified individuals.

NOTE: Because it is illegal for **illegal aliens** to work, they do not have a work requirement.

NOTE: Individuals who home school their children **<u>are not exempt</u>** from the work requirement nor can this home schooling be a component on their Personal Responsibility Plan.

<u>GOOD CAUSE:</u>

There are several good cause reasons for not participating in work/work preparation activities. Some of these reasons may apply to all work activities while others apply only to a particular activity.

Good cause conditions are typically for limited time periods monitored by the caseworker. If the condition lasts for more than two weeks, interrupt the individual from the work requirement and interrupt the time limits until the good cause situation is corrected. The interruption will last as long as the condition exists.

If good cause for failure to comply is the fault of the Department, action should be taken to correct the problem. The participant may be required to take actions to solve a problem that prevents participation if it is within his/her ability.

Good cause may apply during the initial plan development or may need to be considered at any time during the plan implementation. Once an activity is in place, the determination of good cause occurs when:

- the client reports to the caseworker an inability to comply with an activity; or
- the client fails to comply.

When a client fails to comply, good cause will be determined during the conciliation process.

If good cause continues to exist, the caseworker must determine if there is a way to overcome the good cause reason. An interruption in both time limits and work requirements must be given if the good cause reason last more than two weeks.

Remember the following points when determining good cause:

- good cause does not always result in a work or time limits exemption/interruption;
- a good cause reason may become a permanent exemption;
- good cause is determined any time an individual's work activity is interrupted but may or may not result in an exemption;
- a determination of good cause may be made during the application or review process, conciliation or any other appropriate time;
- good cause may be tied to a particular activity and may not automatically apply to all activities.

Good cause exists when:

- The client has a temporary emergency which prevents participation, i.e. family death, disaster, accident, jury duty, etc. <u>There will be a temporary good cause interruption from work requirements and time limits if the situation lasts more than two weeks.</u>
- A two-parent AG has an infant in the home that is less than 16 weeks of age or a single parent AG has a child under the age of one year. There will be a <u>temporary good cause interruption from work requirements and time limits.</u> This interruption will end when the infant becomes 16 weeks (two-parent AG) or one year of age (single parent AG), or is no longer in the home (due to death, adoption, etc.), whichever comes first.
- Neither the client nor DHS can arrange:
  - transportation to the activity;
  - child care; or
  - authorized support services necessary for participation in the current activity.

  There will be a temporary interruption from work requirements if the condition cannot be

corrected within two weeks. The interruption will last as long as the condition exists.

- DHS cannot arrange appropriate work component activities.

- Employment that is offered pays less than the minimum wage and/or equals less than the family's cash assistance grant plus the disregards. (This is good cause for refusing employment. However, the individual in this circumstance is not exempt from a work requirement or time limits and must enter Employment Career Services or other appropriate component to fulfill the work requirement. If voluntary quit is the issue, please see the Voluntary Quit section of the Sanctions Chapter.)

- The health or safety of the individual is a risk using TOSHA standards. The individual is not exempt from a work requirement or time limits and must enter Employment Career counseling or other appropriate component to fulfill the work requirement.

NOTE: The **inability to speak English is not good cause** and does not automatically exempt an individual from work and /or work/preparation components, including literacy testing. However, if no activities are available after exhausting all possible resources, interrupt the participant because DHS could not put him/her in activity and notify the District office so appropriate services can be arranged.

VERIFICATIONS:

Verifications are the responsibility of the participant except when the information is already known to DHS or when access to the information is more easily obtained by the caseworker.

Verify

- employment for any members working, including the number of hours and wages;

- participation in any contracted or self-initiated work component;

- age for all individuals 60 or over;

- age for minor parents and teen parents;

- Family Services Counseling related exemption (the Family Services Counselor will provide this);

- any exemption or good cause claimed by the participant resulting from the conciliation process;

- birth of a child in a two-parent household within the last 16 weeks or birth of a child in a single parent household within the last 12 months, and that the child is in the care of the parent or caretaker relative;

- parent or caretaker relative needed to care full-time for a related child or adult in the home. (A statement from the individual's doctor confirming that the participant is needed in the home to provide full-time care for the relative is sufficient.);

- an incapacitating condition exists for any member claiming such an exemption. (Follow directions for determining incapacity found in the Deprivation chapter in the Families First Handbook);

- limited PRP work plan hours that affect any AG member with a work requirement. A doctor's statement detailing the number of hours, kinds of activities allowed and duration the limitation is expected to last is sufficient verification.

- disability claim by providing one of the following:

  - receipt of SSI under Title XVI of the Social Security Act or disability or blindness benefits under Titles I, II, X, XIV or XVI of the Social Security Act.

  - receipt of interim or presumptive assistance benefits pending the receipt of Supplemental Security Income (SSI);

  - receipt of federal or state administered supplemental benefits under sections 212 (a) of Public Law 93-66;

  - receipt of disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(I) of the Social Security Act;

  - receipt of VA benefits for a service or non-service connected disability rated or paid as total disability, or is considered by VA standards to be in need of regular aid and attendance, or considered permanently housebound;

  - receipt of VA benefits by a surviving spouse of a veteran because he/she is considered by VA standards to be in need of regular aid and attendance and is permanently housebound;

  - receipt of VA benefits by a surviving spouse of a veteran and entitled to VA compensation due to the spouse's service connected death, or VA pension benefits for a non-service connected death and has a disability considered permanent under the Social Security Act. Entitled means the individual is receiving or has been approved for the benefits;

  - receipt of an annuity payment under section 2(a)(1)(iv) of the Railroad Retirement Act of 1994 and is determined to be eligible to receive Medicare by the Railroad Retirement Board;

  - receipt of Railroad Retirement disability annuity under section 2(a)(I)(v) of the Railroad Retirement Act of 1984 and is determined to be disabled based on the criteria used under title XIV of the Social Security Act (SSI);

- receipt of a disability-related medical assistance payment under title XIX (Medicaid);

DOCUMENTATION:

Document the appropriate ACCENT screens and CLRC regarding:

- work/work preparation exemption reasons for all exempt AG members (include the work status code on AEPRP);
- exempt/interrupted individuals who volunteer to participate in work/work preparation activities;
- good cause reasons for not complying with work/work preparation activities;
- reasons for DHS failure to provide services that result in the granting of good cause for the participant (the reasons services were unavailable should be detailed);
- verifications used to prove exemption and good cause status;
- how orientation topics were covered (either one-on-one, in a group setting);
- information obtained during the initial decision-making assessment including long-term and short-term career plans and how they will fit into time limited assistance;
- changes in the assessment and the PRP which may occur as the result of subsequent contacts, reviews, activity completions, or county-to-county transfers;
- work activities chosen and the corresponding number of hours per week in each component;
- potential barriers that may be addressed by VR or FSC, that these activities were offered and the participant's response (see the Family Services Counseling chapter for details);
- all follow-up contacts;
- details that the Work Experience worksite is a placement approved by the Area Manager; and/or
- the brochures that were given (listed in the PROCEDURES section of this chapter).

NOTE: The EA must document the appropriate JTPA screens regarding the components in which the individual is participating, the number of weekly hours, the participant's status in the component, etc.

PROCEDURES:

- Obtain sufficient information during each interview process to determine the exemption/good cause status of AG members.

- Explain to the participant what the exemption/good cause criteria are and how they affect work activities and time limits.

- Evaluate the exemption/good cause reasons at each review/contact with the participant.

- Obtain sufficient information during the pre-plan development discussion to help the participant create an initial work plan. Discuss long-term and short-term goals, barriers and support services.

- Use the results from the ECS career assessment, when available, to assist with the individual's long-term plan.

- Evaluate the work plan activities for progress, completion, or problems at each review/contact with the participant.

- Assist the participant in changing the work plan when necessary.

- Ensure that time limits are considered when developing and renegotiating the PRP work plan.

- Explain that Family Services Counseling and Vocational Rehabilitation Services are possible work activity options (see the FSC chapter for additional procedural details).

- Ensure that the participant has copies of all of the required Families First brochures at both orientation and review. If the participant does not have or remember having any or all of these brochures, provide another copy. This includes, but is not limited to:

  - To get Families First payments, you MAY have to work or go to school. You MUST do certain things for your children. (DHS Authorization No. 345601);

  - Think twice before quitting a job! (DHS Authorization No. 345604);

  - Don't lose your cash payments because you can't do what your Families First plan says! (DHS Authorization No. 345602;

  - Need help? If you have a health, learning or nerve problem, you may have legal rights under the Americans with Disabilities Act (ADA). (DHS Authorization No. 345620); and

  - Life can be tough sometimes. But you don't have to handle it alone. Family Services can help!

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SUPPORT SERVICES

POLICY STATEMENT

Support Services funds are available to assist Families First participants in the elimination of barriers to program participation and to self-sufficiency. The elimination of barriers requires frequent assessment of the participant's status by caseworkers and other Families First service providers. The most common barriers are transportation and child care. But other problems, such as poor vision and dental health may present significant barriers to program completion and self-sufficiency. Caseworkers will ensure that participants access all appropriate Support Services whenever there is a need and the participant meets certain eligibility criteria.

Standard Support Services include:

- Child Care Assistance (refer to Child Care Chapter)
- Transportation Assistance
- Limited Vehicle Repairs
- Vehicle Related Expenses- vehicle registration, county taxes and Tennessee Driver's License
- Dental Assistance
- Optical Assistance

Some participants may need other Work Related Support Services, required by their employer, in order to work. These Work Related Support Services are limited to the following:

- professional or trade licenses
- inoculations, medical tests and/or examinations (not provided by TennCare)

STATE OFFICE APPROVED SERVICES

If a service that is not included in the lists above, but is specifically needed to insure continued program participation, caseworkers should bring the issue to the attention of their supervisor and the District Office. The State office, after consultation with the District Office, may approve a one-time service to help the participant to gain self-sufficiency.

Support services are intended to assist only those individuals who have an urgent unexpected situation that is preventing their full participation in an activity, preventing the acceptance of a bona fide offer of employment or jeopardizing their current employment. Therefore, due to the urgency of the circumstances, it is required that the participant initiate use of the support service within 60 days from the date of the referral. For example, the participant must schedule a dental appointment within 60 days of receiving the referral for dental assistance. If the participant does not initiate the support services within this specified time frame, the referral and subsequent authorization of services, will no longer be valid. However, the caseworker can make the decision to extend the referral beyond 60 days if there are extenuating circumstances that prevent the participant from using the referral.

Explain this policy to the participant at the time that the referral is made. Document CLRC regarding this explanation and enter the referral information on AEIPM for inclusion on the PRP.

The Families First Support Services broker will notify the caseworker if the referral is not used. The caseworker will close the support service on AEIPA, at that time.

If the support services referral expires, a new referral can be issued if warranted. However, reevaluate the need for the referral. If a new referral is issued, enter the support service on AEIPA again, have the participant sign a new PRP with the support service added and document CLRC to explain:

- why the service was not initiated timely; and
- why the service is still needed.

All support services must be initiated prior to the closure of the Families First cash assistance. Services are considered initiated when the participant schedules an appointment with the vendor that will be providing the service.

Verification For All Support Services:

The caseworker will verify the need for support services using any of the following:

- observation, **or**
- information provided by the participant, **or**
- information provided by work component providers, **or**
- information provided by the Families First Support Services broker.

Documentation For All Support Services:

Document CLRC regarding:

- why and when the support service was necessary;
- the authorization of the support service and referral date;
- any problems encountered in providing the service;
- plans for the later provision of service if service was not provided; and
- plans for the restoration of service if service was discontinued.

Also document the date of the referral on AEIPA. Document AEIPM to explain that the referral is only valid for 60 days from the date of the Support Services Referral.
If the Families First Support Services broker notifies the caseworker at the end of the 60-day period that the referral was not used, document CLRC and close the support service on AEIPA.

If a support service referral expires and a new referral is warranted, document CLRC clearly to explain:

- why the service was not initiated timely;
- why the service is still needed; and
- what action was taken regarding the support services referral.

STANDARD SUPPORT SERVICES

TRANSPORTATION ASSISTANCE:

Families First participants are eligible for transportation services. Transportation assistance will be provided to all work component activities, to other authorized support services (e.g., dental and optical appointments). Transportation assistance continues for Families First participants until case closure. The caseworker must evaluate transportation needs and options for Families First participants in conjunction with the work components and support services referrals specified in the PRP.

Transportation assistance may be offered in the form of:

- a reimbursement of $5 per day (when the participant elects to provide their own transportation) and, if one-way travel exceeding 25 miles is required to attend a work component, an additional $1 per day; or
- mass transit passes; or
- broker contracted vans or taxi services.

Authorizing Multiple Forms of Transportation Assistance

In some remote areas of the state, it may be necessary to combine two forms of transportation assistance to meet the participant's needs.

> Example:
> The only form of transportation available to transport the participant to a Families First work activity is a contracted van service. The participant resides in a remote area where the van does not provide services. The participant is not able to arrange for transportation to the work activity, but is able to arrange transportation to the van pick up point. Van transportation and daily reimbursement should be provided.

Authorizing Transportation Assistance for Children of Families First Participants

The children of Families First participants may also need transportation to childcare. Children are eligible to be transported with the caretaker by the mass transit pass or broker contracted van or taxi services.

Broker contracted van and taxi services will be the "last resort" transportation option. These costly fares are difficult for the participant to pay when the transportation assistance is discontinued. Encourage the participant to make arrangements that are safe for the participant and her children. Such arrangements could include car-pooling. When a carpool is utilized, one individual will be reimbursed and the other(s) will be receiving "free" transportation services. They are not to receive a reimbursement. Individuals that elect to walk to their component and do not request transportation services will not receive a reimbursement.

SUPPORT SERVICES

Unless extenuating circumstances exist, the transportation broker will authorize:

1. mass transit as the first option, if available in the area;
2. a cash reimbursement check or gas voucher as the second option; and
3. van pools and/or taxi services as the last option.

Individuals that own a reliable, operational vehicle that is available to them during the hours of a work/training component activity are to provide their own transportation or receive a mass transit pass. They may not receive van or taxi transportation services.

Exceptions to this order of options include, but are not limited to:

- use of van services in rural areas when the participant does not have access to a dependable vehicle and car pooling is not an available option; and
- provisions for reimbursement in urban areas when use of the mass transit system would require frequent and inconvenient transfers.

Transportation will be terminated at the point the individual becomes non-compliant with the PRP (at the point when an AEONC has been issued and the 10 days have expired without the non-compliance situation being resolved, either through good cause determination or by the participant agreeing to correct the non-compliance situation). A referral to reinstate transportation assistance will be issued within three (3) days if the participant agrees to comply. Transportation assistance must be made available as soon as possible, but within 14 days from the date the participant agreed to comply, in order to prevent an interruption in the time count. In non-sanction situations, transportation will be terminated ten (10) days from the date the closure was authorized on ACCENT – matching the end of the adverse action period.

Exception:

Employed individuals will continue to receive transportation assistance for the days they are scheduled to work, until the effective date of closure.

Note: An individual who is working at the time of closure, is considered to be actively enrolled in a work component at the time of closure even if the job is not on the PRP.

Procedures

- The caseworker will discuss or review transportation assistance with the participant during each case action that affects the Personal Responsibility Plan (i.e., approvals, reviews, closure, and/or changes that could affect the participant's continued eligibility for transportation assistance).
- Complete and forward a Support Services referral for transportation services to the Transportation Broker. Explain on the form the transportation needs of the participant and any additional information to assist the broker. Send the referral to the broker within three days from case action.
- If multiple forms of transportation are needed, the supervisor must approve the combination. Document the reason for the need of combining forms of transportation assistance in CLRC.

When no referral is needed

Additional support services referrals are not required when:

- work components change if the participant's participation is continuous;
- the participant's children ride with the participant to child care;

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- the participant needs transportation to and from dental or optical services that DHS has authorized (The dental/optical referral will suffice for obtaining the related transportation);
- the transportation is provided through Rehabilitation Services;

LIMITED VEHICLE REPAIRS:

A personal vehicle in need of repair may be a barrier to the successful compliance with the Personal Responsibility Plan, for some participants. Families First funds, not to exceed $550 per 12-month period, will be used to provide limited vehicle repairs for Families First participants who meet the guidelines. This limit may only be exceeded with the prior approval of State Office, after receiving repair estimate and before any repair work is performed.

If possible, another method of transportation will be provided for the participant while the repairs are being made. All reimbursements for vehicle repairs are to be made directly to the vendor. Under no circumstances will repair reimbursements be made payable to the participant.

Some participants may have access to family or friends who can make repairs but they need assistance to purchase the parts or supplies. The vehicle repairs funds could be used for the cost of these parts or supplies. Only the Support Services Broker is authorized to purchase the replacement parts or supplies, appropriate for the model of vehicle and necessary to render the car operational. When providing a referral for limited vehicle repairs, caution the participant not to begin any repairs without receiving authorization from the Support Services Broker. Participants will not be reimbursed for any out-of-pocket repair expenses.

Misuse of Limited Vehicle Repair Funds

If after repairs are authorized and purchased using Families First funds, fraud is suspected, refer the case to Investigations. A referral to Investigations would be appropriate if it appears that the participant's goal in obtaining the repairs was more for personal gain rather than participation in a Families First component or employment. For example: The participant sells the vehicle immediately after the repairs are completed and ceases continued participation in Families First.

Exceptions:

Only active Families First participants who have been approved for the First Wheels Revolving Loan Program can access Support Service Limited Vehicle Repair Funds prior to the transfer of vehicle title and registration. Upon approval of a loan application submitted by an active Families First participant, the caseworker will assist the participant in accessing any existing Families First vehicle related support services. If minor vehicle repairs are needed prior to the transfer of title and registration, Families First Support Services Limited Vehicle Repair Funds may be authorized.

Procedures

Authorize a referral for limited vehicle repairs for participants who meet the following criteria:

- The authorized repairs, not to exceed $550 per a 12-month period, must make the vehicle operational. Typical of such repairs would be the replacement of parts such as starters, batteries, belts and tires or items required by the Department of Safety. The cost of the needed repairs cannot exceed 80% of the total value of the vehicle unless approved by the FS1; **and**
- The participant is enrolled and in compliance with a Families First component for a minimum of sixty days. (Any exceptions to the sixty day enrollment requirement must be approved by the District Program Supervisor); **and**
- The participant is the owner of the vehicle and is responsible for any loan repayments (document on AERVH); **and**
- Participants requesting vehicle repairs must have owned the vehicle for a minimum of three months and documented on AERVH before repairs will be authorized. (An exception may be allowed when there is no alternative transportation available to required PRP activities. Exceptions require the approval of the District Program Supervisor); **and**
- The participant would use the vehicle in need of repair to provide for his/her own transportation.

Vehicle repairs are limited to $550 per a 12-month period. There are no exceptions in policy for exceeding the limit with supervisory approval. In unique situations, additional funds may be allotted with approval from State Office. Approval must be requested after receiving the estimate and before any repairs are performed.

VEHICLE RELATED EXPENSES

Some Families First participants may need financial assistance in obtaining vehicle license and registration, paying county wheel taxes and emission testing fees, and/or renewing/obtaining a Tennessee vehicle operator's license. Use Families First funds to pay for any and/or all of the vehicle related expenses if it will enable the participant to provide their own transportation to a Families First component. These support services are offered in addition to the limited vehicle repair. Families First Support Services dollars **cannot** be used to pay for car insurance or sales tax associated with the purchase of a vehicle.

Expenses are to be paid directly to the responsible state, county or city government agency. Participants will not be reimbursed for any out-of-pocket vehicle related expenses. **Under no circumstances will Families First funds or state funds be used to pay for fines and/or court costs associated with accidents or traffic and parking violations.**

Procedures

Authorize a referral for assistance for vehicle related expenses. The amount to be paid will be the actual cost levied for the county of residence. The participant must meet the following criteria:

For vehicle license, registration, county wheel taxes and emission fees:

- The vehicle must be registered in the name of the participant (document vehicle on AERVH); **and**
- the participant is enrolled and in compliance with a Families First component for a minimum of sixty days (Any exceptions to the sixty day enrollment requirement must be approved by the District Program Supervisor); **and**
- the participant will use the vehicle to provide her own transportation to a Families First component.

For Tennessee vehicle operator's license:

- The participant is enrolled and in compliance with a Families First component for a minimum of sixty days (Any exceptions to the sixty day enrollment requirement must be approved by the District Program Supervisor); and
- the participant will use the vehicle operator's license to provide her own transportation to a Families First component; and
- the participant lacks a valid Tennessee vehicle operator's license.

DENTAL ASSISTANCE

Some Families First participants may need dental services in order to successfully participate in a Families First component or to obtain/retain employment. Medicaid does not provide general dental insurance to most caretakers. As a result, many participants suffer from dental pain that prevents participation in a Families First activity or dental problems affecting appearance are a barrier to employment for individuals entering the workforce. Families First contract staff may also call dental problems to the attention of the caseworker.

Dental assistance is available only to the extent it is not available through Medicaid, community resources, or other insurance coverage. Families First funds, not to exceed $400 per 12-month period, will be used to provide dental assistance for Families First participants who meet the guidelines. Dental services must be initiated before closure of the Families First cash assistance. . Services are considered initiated when the participant schedules an appointment with the vendor that will be providing the service.

Only maintenance dental work is to be authorized. Examples of maintenance dental work are:

- Routine cleanings (if required as a part of the treatment protocol)
- Extractions

- Bridges (fixed or removable) if they are less costly than partials or complete dentures
- Full and partial dentures
- Amalgam restorations (crowns and fillings)

Procedures

Authorize a referral for dental assistance for a Families First participant when:

- dental pain prevents the participant's full and successful participation in a work component or dental problems affecting appearance are a barrier to employment for individuals entering the workforce; and
- there are no other available resources for payment such as TennCare, other health/dental insurance, or community programs; and
- the participant has been in compliance with a Families First work component for a minimum of sixty days. (A waiver from the criteria may be granted by the District Program Supervisor)

Dental assistance is limited to $400 per a 12-month period. There are no exceptions in policy for exceeding the limit with supervisory approval. In unique situations, additional funds may be allotted with approval from State Office. Prior approval must be obtained on dental work that is estimated to exceed the $400 limit.

OPTICAL ASSISTANCE

Some Families First participants may need glasses or contact lens to participate successfully in a Families First component or employment. Medicaid provides only limited or no optical services to caretakers. Many Families First participants are unable to read or travel safely without glasses.

Optical assistance is limited to $175 per a 12-month period. A new prescription or a change in prescription is required for the authorization or glasses or contact lens. Optical services must be initiated before closure of the Families First cash assistance.

Procedures

Authorize a referral for optical assistance for a Families First participant when:

- a visual problem prevents the full and satisfactory participation in a work component; **and**
- there are no other available resources for payment such as civic clubs (i.e., Lion's Club Eye Bank) TennCare or other health/optical insurance; **and**
- the participant has been in compliance with a Families First work component for at least sixty days. (A waiver from this criteria may be granted by the District Program Supervisor.).

SUPPORT SERVICES

WORK RELATED SUPPORT SERVICES

Work Related Support Services are available to assist those participants who have received a bona fide offer of employment and are ready to enter the workforce and transition to self-sufficiency. Families First participants may need assistance in obtaining one or more of the following additional Work Related Support Services to participate fully in a work component or employment:

- professional trade licenses required by the employer;
- certain medical tests, inoculations and/or examinations required by the employer (not provided by TennCare).

Limits for Work Related Support Services

The allotment for each Work Related support service is limited to the actual cost of the service, or $100, whichever is less. Each Work Related service is limited to a one-time expense. However, if a case closes and re-opens at a later date, the individual may again be eligible for Work Related Support Services. All payments for Work Related Support Services are made directly to the vendor. Under no circumstances will payment or reimbursement be made payable to the participant.

Work Related Support Services Guidelines

- Assistance in obtaining a professional trade license is provided for under Work Related Support Services. Support Services funds are used to pay for the license only. If a licensure examination is administered to determine if a participant may obtain a professional trade license, the examination fees are to be paid by training funds. If the examination fee includes the trade license, only that portion of the fee that would be paid by the general public in obtaining that license may be paid using Support Services funds. Fees for trade licenses may not exceed that charged the general public for the same license.
- No drug testing fees will be paid using Families First funds.
- Work Related Support Services funds may not be used for any graduation related expenses.
- Background checks for employment is **not** a cost covered under Work Related Support Services.
- The purchase of any items allowed under Work Related Support Services must be in process before closure of the Families First cash assistance.

BROKER SYSTEM FOR SUPPORT SERVICES

The majority of Families First Support Services are provided through a broker system. The caseworker refers the participant to the Support Services broker after identifying the participant's need and eligibility according to Families First support services policy. Support Services must be provided in a timely manner, within the time frame specified for the particular services. The broker is to notify the caseworker within three days upon determining that a Support Service cannot be provided.

SUPPORT SERVICES

Broker Responsibility for Service Delivery

- Brokers will contract with all appropriate licensed service providers. Providers should be recognized within the local communities for providing quality services at reasonable rates. The brokers are responsible for the negotiation, the development and the enforcement of any and all contractual agreements made with Families First Support Services providers. Providers may be mass transit systems, van services, bus services, taxi companies, other transportation services, dentists, opticians, garages and mechanics.
- Support Services brokers will develop and maintain a network of transportation and other services providers for Families First participants in each county and/or community. This network should include alternative means of providing transportation to participants residing in remote areas of the state.
- Brokers will provide prompt and timely reimbursements to Families First participants and service providers. Families First participants are to receive transportation reimbursements at 2-week intervals. Providers are to be reimbursed within ten days.
- Upon receiving a referral from the Department of Human Services, brokers will contract Families First participants within three working days to arrange for support services. The broker will notify the Department of Human Services within three working days if services cannot be provided.
- The broker may authorize the transportation provider to transport a Families First participant across county lines if a work component is nearer her home. A child of a Families First participant will not be transported to childcare outside the county unless there is a special need.
- The service broker will notify the caseworker if the use of a support services referral is not initiated within 60 days of the date of Families First Support Services referral.
- Transporters should notify the Transportation Broker of participant "no shows." The Transportation Broker will, in turn, notify the Department of Human Services caseworker.
- Upon receiving notification from the Department of Human Services that a customer is not in compliance with the Personal Responsibility Plan, the Transportation Broker will immediately terminate transportation assistance (i.e., van service, mass transit passes, reimbursement).

RESOURCES

POLICY STATEMENT:

To be eligible for Families First benefits, the assistance group's total countable resources must be less than $2000 at the time of application and reapplication (review). When determining the total countable resource amount, the caseworker will use the equity value of the resource. The equity value is determined by subtracting the amount of encumbrances from the fair market value of the resource.

- **Agent Orange Settlement payments** are **not countable** resources. Veterans who are eligible under the program receive disability payments each year they are disabled during the life of the program. Lump sum payments received by survivors of deceased veterans are also **not countable** resources.

- **Basic maintenance items** that are essential to daily living such as clothing, furniture, appliances, and other similar essential household goods and equipment of limited value are **not countable** resources.

- **Bonds** are **countable** resources.

- **Burial agreements** are **not countable** resources.

- **Burial plots, grave sites, crypts, mausoleums, urns, or other repositories** are **not counted** as resources.

- **Burial policies** are **not countable** resources. A burial policy is different from a burial agreement. It is usually purchased from a funeral home for a certain premium per week or month. These policies pay only for burial costs at the death of the person named on the policy and have no cash value.

- **Cash** on hand is a **countable** resource.

- **Checking accounts** in a bank, credit union or other financial institution **are countable** resources.

- One-time **Crisis Intervention Program** payments to assist with utility costs from the Crisis Intervention Program are **not countable** resources.

- **Disqualified Individual** - Resources of an individual who is disqualified because of an Intentional Program Violation are **countable** resources.

- Payment made through the **Domestic Volunteer Service Act of 1973**, as amended, for volunteer services are **not countable** resources. These programs include Foster Grandparents, Service Corps of Retired Executive (SCORE), Active Corps of Executives (ACE), and other programs under Title II and Title II of the Volunteer Service Act of 1973 (P.L. 93-13, as amended), and VISTA payments.

- **Earmarked Resources** - Any governmental payments that are specifically designated for the restoration of a home damaged in a disaster and rental assistance during the restoration period, are **not countable** resources. Such funds include those made by the Department of Housing and Urban Development through the Individual and Family Grant Program or disaster loans or grants made by the Small Business Administration.

- Payments made under the National Flood Insurance Program (NFIP) for flood mitigation activities shall not be counted as income or resources of the property owner.

- **Earned Income Tax Credits (EITC)** are **not a countable** resource.

- **Energy assistance payments** or allowances made by a federal, state, or local agency or by a charitable organization are **not countable** resources. This exclusion includes payments made through the Department of Health and Human Services, Low Income Energy Assistance Program, and the Community Services Administration's Energy Crisis Assistance and Crisis Intervention programs.

- An **entrepreneurial account** placed with a micro-lending intermediary program with a balance of $5000 or less is **not counted** as a resource. See the Entrepreneurial Account section for details on these accounts.

- **Equipment** used in a self-employment enterprise used to produce income is **not a countable** resource.

- Benefits from **food programs**, including WIC, the value of food stamps and the value of school lunches or other school food programs, are **not countable** resources.

- The **home and lot** owned or being purchased and occupied by the Families First assistance group and the property surrounding the home which is not separated from the home by intervening property owned by others is **not counted** as a resource. Public rights of way, such as roads and/or other public easements, which run through the property surrounding the home do not affect its classification of homestead property. Temporary absences from the home do not affect the classification and/or exemption of the home if the AG has not acquired another home and intends to return to the exempt home at a specified time.

- The value of an **Individual Development Account** (IDA) of **$5000 or less is not counted** as a resource in the 12 demonstration counties. The entire value of an IDA **is counted** as a resource in the non-demonstration counties. See the Individual Development Account Demonstration section for additional details regarding these accounts.

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RESOURCES

- The value of an **Individual Development Account**-WtW (IDA-WtW) of $5,000 or less is not counted as a resource. IDA-WtW's can be disregarded in all counties, not just the 12 IDA Pilot counties. See the Individual Development Account Demonstration section for additional details regarding these accounts.

- Resources of an **ineligible alien** are **countable only** when the ineligible alien is the parent of the AG child(ren).

- **Individual Retirement Accounts** (IRA's) of $20,000 or less are not counted as a resource. IRA's of more than $20,000, minus any penalty for early withdrawal, are **countable** resources.

- **Life insurance policy cash values** are **not countable** resources.

- **Insurance settlements** for casualty/disaster loss to the home are **not countable** as resources for three months following receipt of the payment if the AG intends to reinvest it in a homestead.

- **Keogh plans** minus any penalty for early withdrawal are **countable** resources.

- Payments to **Native American Indians** are **not countable** resources. These payments include:

  - **Alaska Native Claims Payments and Sac and Fox Indian Claim Payments** received under the Alaska Native Claims Settlements Act. P.L. 920203, Section 21 (a) and the Sac and Fox Indian Claims Agreement P.L. 94-189;

  - **Payment for Certain Indian Tribes** that are derived from certain submarginal lands of the United States which are held in trust for certain Indian tribes; and

  - **Payments from Disposition of Funds of Ottawa Indians** under P.L. 94-540.

- **Non-liquid assets used as collateral** for a business loan are **not countable** resources if the lien agreement specifically prohibits the assistance group from selling it.

- **Non-Recurring lump sum payments and retroactive payments** are **countable** resources. Examples of retroactive payments are: RSDI, VA, Unemployment benefits, and Workman's Compensation. Examples of non-recurring lump sum payments are: windfalls, cash gifts, prizes, awards, income tax refunds, tax rebates and credits, refunds of security deposits on rental property or utilities.

- **Pension Funds** that are not accessible to the AG except at retirement or at termination of employment are **not countable** resources. If the employment is terminated and the pension becomes accessible to the AG, it is then a **countable** resource.

- **Property**

  - **Buildings, land and recreational properties**, such as boats, vacation homes and mobile homes that are not homestead property are **countable** resources. (These are called non-exempt properties.) **Income producing real property** is a **countable** resource.

  - **Non-Exempt property,** unless there is a good faith effort to sell the property is a **countable** resource. Real property, that is not homestead property, that the AG is making a **"good faith effort"** to sell is **not a countable** resource if the AG signs an agreement to repay the Families First benefits received during the period of exemption. This exemption will not exceed nine months. If the net proceeds of the sale plus other resources in the AG at the beginning of the exclusion period exceed the resource limit, there is an overpayment of Families First benefits. To qualify for this exemption the AG must :

    – list the property for sale with a real estate agency, or

    – list the property for sale at auction with an auction company, or

    – advertise the property for sale on a continuous basis in the newspaper which serves the area.

  - If the real property is sold during the nine-month exemption period, see the Procedures section for instructions about repaying the Families First benefits. Any proceeds remaining after repayment of the Families First benefits are **countable** resources.

  - If the real property remains unsold at the end of the nine-month exclusion period, reevaluate the state of the property. The county staff must decide whether or not to declare the property as an inaccessible resource on the basis that it could not be sold. Each situation must be given careful consideration and handled on a case-by-case basis. This decision should be based on whether a good faith effort was made to sell the property and if a reasonable offer to buy the property was declined. If the decision is made to count the property as a resource, the benefits that the AG received during the entire period would be an overpayment subject to the usual overpayment collection procedures. If the decision is made that the resource is inaccessible, **do not count** the property as a resource.

  - Payments made under P.L. 104-204 **to children of Vietnam veterans who were born with spina bifida** are **not** counted as a resource.

- **Proceeds from the sale of exempt real and personal property** if there is no intent to reinvest the proceeds in other exempt real or personal property are **countable** resources. If there is intent to reinvest the proceeds in other exempt real or personal property, the proceeds will **not be counted** for three months after the sale. Any exemption extensions for longer than three months require approval from the Families First Policy unit in the state office. Extensions will depend on the factors beyond the AG's control to reinvest the proceeds, such as illness, delays in construction, etc.

- Real property that the AG demonstrates that it cannot sell because it has only a **life estate, use rights, lifetime occupancy or dower rights** is **not a countable** resource.

- **Relocation Assistance Payments** received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 are **not countable** resources. These payments include:

  – payments to persons displaced as a result of the acquisition of real property;

  – relocation payments to a displaced homeowner toward the purchase of a replacement dwelling. Such payments are made only to a displaced owner who purchases and occupies a dwelling within one year following displacement; and

  – replacement housing payments to displaced persons who are eligible for a homeowner's payment.

- **Savings accounts** in a bank, credit union or other financial institution are **countable** resources.

- **Savings certificates** are **countable** resources.

- **Stocks** are **countable** resources.

- **Student grants and loans** are **not countable** resources for Families First AG members, stepparents or parents of a minor in the home.

- **Trust funds -** If a Families First applicant/recipient claims that a trust fund is inaccessible, the individual will have 60 days from the date of application/ reapplication to have the resource made available. If the caretaker is willing to try to have the trust made available, he/she may be included in the assistance group. If the caretaker does not follow through within 60 days, he/she will be removed from the assistance group. If the caretaker is attempting to have the trust made currently available, assistance will continue (if otherwise eligible) pending the court decision.

The court's decision as to accessibility of the trust fund, as written in either a new or amended order, is binding.

The caretaker will not be required to have trust funds made currently available in the following situations and these trusts are **not countable** resources:

- if a trust is established by a will. The terms of the trust will be followed as they stand.

- if a trust is producing regular income which is available to the beneficiary, the body of the trust will not be considered a currently available resource, but the income will be countable income.

- if a trust has been set up for a minor (usually until age 18) and the amount of the trust account is $5000 or less, the caretaker will not be required to attempt to make the trust accessible. In most instances, the legal fees involved in such an attempt would erode the value of the trust to the extent that it would not be cost effective to bring it to a state of availability.

- **Vehicles**

  - The equity value of one vehicle that is under $4600 is **not a countable** resource.

  - The equity value in excess of the $4600 plus the entire equity value of any other vehicle, licensed or unlicensed, is a **countable** resource.

  (See PROCEDURE for the procedures to use to determine the countable resource amount of a vehicle.)

- **Victims Compensation Awards** paid on behalf of minors are **not countable** resources if

  - the minor's parent, caretaker relative or guardian entered into an agreement with the State Claims Commission as to the uses to be made of the funds and signed such an agreement, and

  - the funds are deposited in accordance with the agreement, and

  - the funds remain on deposit or are used only according to the terms of the agreement.

Any funds withdrawn and used for goods/services not specified in the agreement will be treated as income in the month received.

- **Victims Compensation Awards paid to adults** (age 18 or older) in their own behalf are **countable** resources.

VERIFICATION:

Resources must be verified at application and review, if questionable. Verification is primarily the responsibility of the caretaker except when the information is already known to the Department or when it is more reasonable for the case manager to obtain the needed information.

DOCUMENTATION:

All resources will be recorded on the appropriate ACCENT screens as well as verifications used. Any pertinent information about the AG's resources will be documented in running record comments, CLRC. In addition, if verification is required because of questionable information, the case manager must document why it is considered questionable and what documents were used to resolve the questions in CLRC.

PROCEDURES:

Resources are considered available to the AG in the month of receipt. If an AG holds a resource that exceeds the Families First resource limit beyond the month of receipt of the resource and does not report the resource in a timely manner, an overpayment referral will be sent to COTS for a claim preparation.

Ownership of Resources

The owner(s) of a resource is the person in whose name the resource is listed/registered/titled. If the resource is not a type of resource that would be listed/ registered/titled, it belongs to the person who claims ownership. Real and/or personal property belonging to the spouse of a relative other than a parent of an AG child are not countable to the AG. Resources belonging exclusively to an SSI recipient is totally disregarded in determining the eligibility of his/her spouse and the AG in which the spouse is included.

Resources of Individuals

Resources of the following individuals are considered available to the AG only when the individual is included in the AG:

- stepparents;
- the parents of a minor parent;
- a minor child; and
- relatives other than a parent.

Countable resources of an **SSI recipient** is **not counted** in the AG's resource total.

Countable resources of an **ineligible alien** will be **counted** in the AG's resource total only when the ineligible alien is the parent of the AG child(ren).

Countable resources of a **disqualified individual** will be **counted** in the AG's resource total only if the individual is a required AG member.

Treatment of Commingled Liquid Resources

Any liquid resource that is not countable (excluded resource) will retain this status as long as the resource is kept in a separate account and not commingled in an account with countable liquid resources. A resource that has been excluded because it is prorated income and has been commingled in an account with countable resources will not be counted as a resource for the period of time over which it has been prorated. The resource cannot be counted as income and a resource during the same period of time. All other excluded liquid resources that are commingled with countable resources will retain their exemption for six months from the date that the resources are commingled. After six months , the total amount of the commingled account will be counted as a resource.

Jointly Owned Resources

If the Families First AG reports a jointly owned resource (real or personal property that has more than one owner listed), the individual's pro rata share of any countable resource is applied to the AG's resource limit. If the individual can demonstrate that it has access to less than a pro rata share, only the portion to which the individual has access will be counted toward the AG's resource level.

If a jointly owned resource cannot be practically subdivided; and access to the AG's share of the resource is dependent on the agreement of the joint owner; and the joint owner who is not an AG member refuses to comply so that the AG member can obtain his/her share of the resource, then the resource is considered inaccessible to the AG.

The fact that an AG member's name appears on a jointly named asset with that of a non-AG member does not conclusively mean that the resource is "jointly owned." The AG member must be given the opportunity to prove that he/she does not, in fact, have any

ownership rights to the resource. The key to determining ownership is in the written language or oral understanding surrounding the creation of the joint bank account or other jointly named asset. Consider the source of the funds or asset and for whom the use and benefit of the funds/asset are intended and used. This may occur, for example, where an AG member's name is listed on a joint checking account in which all of the funds belong to an elderly or disabled relative so that the AG member can assist the relative with his/her banking transactions, and the AG member does not use any of the funds for his/her own personal use. The burden of proof that he/she has no ownership in the funds is on the AG member.

Sale of Real Property During the Nine-Month Exemption Period

Real property, that is not homestead property, that the AG is making a **"good faith effort"** to sell is not a countable resource if the AG signs an agreement to repay the Families First benefits received during the period of exemption. If the real property is sold during the nine-month exemption period and the sale is reported in a timely manner, a lump sum payment must be used form the sale proceeds to repay the Families First benefits. The caseworker must prepare and send a memo outlining the circumstances of the overpayment to the

Director of Fiscal Services
Citizen's Plaza Building, 5th Floor
400 Deaderick Street
Nashville, Tennessee 37248-3500

The caseworker must remind the AG to submit a lump sum payment to repay the benefits according to the terms of the signed Notice of Excess Property and Repayment Agreement and to include his/her Families First case number on the check or money order before sending the payment directly to Fiscal Services at the above address.

If the real property is sold during the period of exclusion and the sale is not reported in a timely manner, treat the benefits that the AG received during the entire period as an overpayment subject to the usual overpayment collection procedures.

Determining Equity Value of a Vehicle

To determine the value of a vehicle to be counted as a resource, first establish fair market value of the vehicle by determining the "Average Loan value" listed on the Kelly Blue Book website. Do not increase the basic value of the vehicle because of low mileage, optional equipment or special equipment.

Deduct any encumbrances on the vehicle from the fair market value to determine equity value.

If the AG disagrees with the adjusted value, the caretaker may provide verification of the actual value of the vehicle from a reliable source such as a reputable auto dealer, a tax assessment, newspaper advertisements listing the sale price of similar vehicles, etc.
Use the AG's best estimate of the vehicles' value for vehicles no longer listed on the Kelly Blue Book website. If the estimate is questionable or if eligibility is affected, the caseworker must ask for verification from a reliable source (see above paragraph).

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INDIVIDUAL DEVELOPMENT ACCOUNTS

POLICY STATEMENT:

An Individual Development Account (IDA) is a special restricted savings account that a Families First participant can set up to assist in purchasing four different assets. IDAs in the twelve pilot counties (listed below) can be set up with the assistance of the Tennessee Network for Community Economic Development (TNCED), an IDA non-profit sponsor, and a local bank. TNCED is the statewide, non-profit organization that operates the accounts for the IDA pilot Project. An Individual Development Account-WtW (IDA-WtW) can be set up with the assistance of the local Private Industry Council (PIC) through the Welfare-to-Work Program. **IDA-WtWs are available throughout the state.**

An IDA is different from a regular savings account because funds deposited by a participant are matched by a separate entity and there are restrictions on the use of these funds. An IDA will provide an opportunity for a participant to build assets to further support the transition to self-sufficiency.

The funds in an IDA (savings + match + interest), up to $5,000, will not be considered as a resource for Families First participants when computing the resource limit for initial or continued eligibility in the Families First, Medicaid, and Food Stamp programs, as long as the participant complies with IDA eligibility rules below. The amount of an IDA that is over $5,000 is counted toward the $2,000 resource limit.

The IDA can be used only for one or more of the following qualified purposes, as determined and verified by TNCED or the sponsoring PIC:

- Post-secondary education for the participant or the participant's children for career development:
  Payments for tuition, fees, books, supplies and equipment that are required for attendance and instruction courses at a post-secondary educational institution are permissible.

- Small business development:
  Amounts paid directly from an IDA to a financial account for the operation of the individual's business are restricted for use solely on qualified business expenses. These expenses are those specified in an approved business plan including: capital, plant, equipment, working capital and inventory expenses.

- Home ownership:
  Funds can be spent on a principal residence for a qualified first-time homebuyer. This means a taxpayer (and, if married, the taxpayer's spouse) who has no ownership interest in a principal residence during the three-year

period ending on the date of acquisition of the principal residence. The acquisition costs of this residence cannot exceed 100% of the average area purchase price applicable to such residence. Qualified acquisition costs are the costs of acquiring, constructing or reconstructing a residence. This includes any usual or reasonable settlement, financing or other closing costs.

For participants who are in one of the twelve IDA pilot counties, an IDA and an IDA-WtW can be used for one additional use:

- Transportation Needs:
  Permissible purchases for transportation needs are the purchase of a vehicle, necessary car repairs and the purchase of alternative transportation vehicles (e.g. bicycle) to be used for employment or education purposes. If the Saver purchases a vehicle, the value of the new vehicle will then be looked at according to Families First resource policy.

No funds from IDA can be withdrawn for purpose other than those listed above, without penalty. The DHS penalty is that any withdrawal of funds by an IDA group member for unqualified purposes will cause the withdrawn funds to be considered a resource in determining eligibility for Families First. The resource consideration will be for the month of withdrawal and any subsequent months during which the funds may be available to the individual. If the individual is no longer a member of the IDA group, then all funds in the savings account are counted as a resource. The Saver will have the option to retain access to the match dollars (if they are used for qualified purposes) for up to two years. If the Saver takes this option, these match dollars will also be counted as a resource.

Qualified withdrawals will not affect an individual's resources or eligibility unless the withdrawal is for the purchase of a vehicle. The value of a vehicle purchased with IDA funds is considered when determining continued eligibility according to Families First and Food Stamp vehicle resource policy.

If the purchase is deemed unqualified by TNCED or the sponsoring PIC, resulting in the denial of the withdrawal request, the IDA participant may appeal in writing to the sponsoring agency's staff member and TNCED's executive director or the PIC director (whichever is applicable). The staff member and the director will review the appeal to determine if the purchase falls under any of the qualified purposes that are described above. If the purchase is still deemed unqualified, the individual may file an appeal with the Department of Human Services by following usual appeal procedures. The IDA contact is responsible for completing an appeal summary and forwarding the Appeal for Fair Hearing to Hearings and Appeals in the usual manner. Appeals regarding eligibility or benefit level will follow usual appeal procedures.

When a family stops receiving Families First cash grants, funds in the IDA account (savings + match + interest), up to $5,000 are **not counted** as a resource when determining eligibility for the Medicaid and Food Stamp programs.

Eligibility to participate in the IDA Pilot Project

- The individual must be a member of an eligible Families First assistance group.

- The individual must reside in one of the twelve pilot counties for the IDA Pilot Project. The twelve pilot counties are: Campbell, Davidson, Fayette, Knox, Lawrence, Madison, Montgomery, Sevier, Shelby, Tipton, Washington and Williamson.

- The participant must notify the county Department of Human Services office, in advance, that s/he is going to start an IDA. This account must be one with a cosignatory relationship between the Saver and the Tennessee Network for Community Economic Development (TNCED). Applicants must notify the case manager about any individual in the assistance group who has an IDA at the time of application in order for it to be considered a timely notification. For recipients, if the notification of the county office is prior to the recipient attending the first IDA group meeting, it is considered a timely notification. If the Department is not notified prior to the establishment of an IDA or at the time of application, the total funds in an IDA are counted as a resource up to the day that the Department is notified. Starting on the day that the Department is notified, the funds in the IDA will be disregarded.

- A participant does not have to be employed to open an IDA. However, deposits into IDAs must be from earned income.

- The participant must join an IDA group which meets twice a month at an approved non-profit sponsor. An approved non-profit sponsor is one that has agreed to and operates the IDA program in compliance with DHS policies and procedures. At these meetings, the group will receive training, support and technical assistance in maintaining and using this account. Attendance policy is determined by the non-profit sponsor and the IDA group. When the non-profit sponsor contacts the case manager or IDA contact regarding an IDA Saver who is not in compliance with the attendance policy, the participant is not eligible to be in the IDA pilot, and funds in the IDA are counted as a resource.

- The individual (an IDA Saver) must commit to depositing funds to the IDA during these twice monthly meetings (the actual deposits will be completed the next business day by the individual). Deposits to the account must be from earned income. The amount of the twice monthly contributions to the IDA must be decided on beforehand at an amount that is manageable for the participant. If that amount becomes too burdensome, the participant and the non-profit sponsor can

determine another amount that is more appropriate for her/his budget. For times when a participant is unemployed, the contribution amount can be set at zero, but the participant must notify the non-profit sponsor of this change.

Eligibility to participate in an IDA WtW program

- The individual must be a member of an eligible Families First assistance group.

- The participant must notify the county Department of Human Services office in advance, that s/he is going to start an IDA-WtW. This account must be one with a co-signatory relationship between the Saver and the sponsoring PIC. Applicants must notify the case manager about any individual in the assistance group who has an IDA-WtW at the time of application in order for it to be considered a timely notification. For recipients, if the notification of the county office is prior to the recipient attending the first IDA-WtW group meeting, it is considered a timely notification. If the Department is not notified prior to the establishment of an IDA-WtW or at the time of application, the total funds in an IDA-WtW are counted as a resource up to the day that the Department is notified. Starting on the day that the Department is notified, the funds in the IDA-WtW will be disregarded.

- A participant does not have to be employed to open an IDA-WtW. However, deposits into IDAs must be from earned income.

- The participant must join an IDA-WtW group which meets twice a month at a sponsoring PIC. At these meetings, the group will receive training, support and technical assistance in maintaining and using this account. Attendance policy is determined by the PIC and the IDA-WtW group. When the PIC contacts the case manager or IDA contact regarding an IDA Saver who is not in compliance with the attendance policy, the participant is not eligible to be in the IDA-WtW group, and funds in the IDA are counted as a resource.

- The individual (an IDA Saver) must commit to depositing funds to the IDA during these twice monthly meetings (the actual deposits will be completed the next business day by the individual). Deposits to the account must be from earned income. The amount of the twice monthly contributions to the IDA must be decided on beforehand at an amount that is manageable for the participant. If that amount becomes too burdensome, the participant and the PIC can determine another amount that is more appropriate for her/his budget. For times when a participant is unemployed, the contribution amount can be set at zero, but the participant must notify the non-profit sponsor of this change.

Eligibility to Receive Matching Contributions

The money that the participant deposits into the savings account is eligible for a match from a local bank, church, or other donors that contribute through TNCED or through

the sponsoring PIC. The matching fund amount, plus the interest earned on that amount is documented for each IDA participant by TNCED or the sponsoring PIC, on a quarterly basis. An IDA Saver will not have access to the matching funds unless a withdrawal is authorized for a qualified purpose. Even for a withdrawal for a qualified purpose, the matching funds go directly to the vendor. The matching institutions and rates may vary by county and by the non-profit sponsor. However, the match rates are, at a minimum, 1:1 and, at a maximum, 9:1.

The matching funds are available for those account holders who:

- attend the twice monthly meetings;
- deposit the agreed upon amount (as decided by the participant and the non-profit sponsor) into their account twice a month. The deposit must be at least the minimum of the amount agreed upon, but may be a greater amount. If the deposit is a greater amount, the funds will not be matched unless a Deposit Change form has been signed by the designated non-profit sponsor staff member or the sponsoring PIC; and
- are currently employed. Once an IDA holder secures employment, deposits to the account begin to be matched immediately. For the period of time that a participant is unemployed, deposits will not be matched.

The amount of match funds that a participant has in their IDA will be posted quarterly by TNCED or the sponsoring PIC. At the time of a qualified purchase the match funds are paid directly to the vendor, not the participant.

Funds that are withdrawn from unqualified purposes are not eligible for a match.

EXCEPTIONS:

- If an individual in the IDA pilot moves to a county that is not a pilot county, the individual is not eligible to be in the IDA pilot, and the full value of the IDA (savings + match + interest) is counted as a resource, unless they begin participating-in a IDA-WtW program.
- If an individual stops participating in the IDA pilot program or the IDA-WtW program, but continues in another IDA program independent of the pilot or an IDA WtW, the full value of the IDA (savings + match + interest) will be considered a resource.
- If a participant chooses t leave the IDA group, s/he will sign the IDA Departure Form (available from the non-profit sponsor or the sponsoring PIC) indicating plans to use or not use their IDA match for a qualified purpose within two years from the date the participant leaves the group. If it is indicated that the IDA match will be

- used, the matching funds will be considered a resource (savings + match + interest) If the individual does not plan to use the IDA match, the savings account is then considered a resource like any other savings account (savings + interest).

VERIFICATION:

At each eligibility review, the participant must provide the quarterly statements from the bank and TNCED or the sponsoring PIC, that detail the total amount (savings + match + interest) in the IDA. Verification of attendance will come from the non-profit sponsor. A participant who has left the IDA group must present the IDA departure Form to the case manager to determine whether or not the participant has retained the ability to use the matching funds.

In the event of a withdrawal, the participant must provide a receipt and/or other form of verification from TNCED or the sponsoring PIC to the case manager to establish that the withdrawal was used for one of the IDA qualified purposes. In addition, the state office will receive a quarterly statement from TNCED for the IDA pilot programs regarding the IDA activity for Families First Savers. This information will be shared with each of the county offices.

DOCUMENTATION:

Information provided from the participant and the non-profit sponsor or sponsoring PIC regarding IDA start-up, withdrawals, balance amount, qualified purchases, removal from the pilot, etc. must be recorded on CLRC. It should also be noted on CLRC which non-profit sponsor's IDA program the individual has decided to join and whether the program is an IDA pilot or an IDA-WtW program.

The county IDA contact maintains a centralized IDA Program Log. The centralized IDA Program log should be updated with each change in IDA status: referral, opening account, account balance, withdrawals, and departure from the IDA program. Each case manager will fill out an IDA Program Log sheet when a change is reported regarding an individual's IDA. IDA Program Log sheets are available on Shared Base Documents as FA.FF.IDA.PROGRAM.LOG.

PROCEDURES:

- The case manager will explain what an IDA is; how one can participate in an IDA group; and how it affects her/his resources. In the twelve pilot counties, both the IDA-WtW program and the IDA pilot programs should be explained.

- The case manager will be expected to educate the recipient on the incentives and benefits of building savings. The case manager will have a listing of all the non-profit organizations that offer an IDA program and descriptions of each program

- available so that the participant can select the one best suited to her/his needs. Some communities may have only one non-profit that offers IDAs. Some IDA programs will be geared towards a specific service population such as a neighborhood, age or gender grouping. Other IDA programs will focus on a specific IDA use, like small business development. In the event that all the programs available in a county have such specific population requirements that the participant is excluded from every program, the case manager will inform the Department of Human Services county IDA contact of the situation. In turn, the Department of Human Services will notify TNCED and the DHS state office of the circumstances of the person who is not able to open an IDA in the pilot program for service population reasons.

- The Referral form for the IDA pilot program is available to the participant at the Department of Human Services office. The Referral Form can be found on Shared Base Documents as FA.FF.IDA.REFERRAL. If a Families First participant is interested in opening an IDA, the IDA Referral Form should be completed (in triplicate) at the time of the visit. The Saver gives one copy to the non-profit sponsor and keeps another copy. The case manager sends one copy of the form to TNCED at: ATTN: IDA, TNCED, P.O. Box 23353, Nashville, TN 37202-3353., (615) 395-4341. The case manager logs in the referral on an IDA Program Log sheet. This referral information is then given to the IDA Contact in the county office to include in the centralized county IDA Program Log.

- Referrals to an IDA-WtW program should be made on the HS-2619 form with the code, 82-No Impact on PRP. To the right of the activity code, write IDA-WtW.

- The IDA contact will receive a Department of Human Services IDA Saver Notification Form, signaling that a participant is establishing an IDA. The form should be logged into the IDA Program Log, and the information shared with the individual's case manager. The case manager should then send the IDA Saver an IDA Information Letter that explains the DHS IDA Policy. This letter is available on Shared Base Documents as FA.FF.IDA.INFO.LETTER.

- The centralized county IDA Program Log should also be updated with information about account openings, account balance, withdrawals, and departures from the program. The case manager fills in the new information on an IDA Program Log sheet and gives this information to the IDA Contact.

- In the event of a withdrawal, the participant must provide a receipt and/or other form of verification from TNCED or the sponsoring PIC to the case manager to establish that the withdrawal was used for one of the IDA qualified purposes. If the withdrawal was for an unqualified purpose, the Saver should send a Department of Human services-IDA Saver Unqualified Withdrawal Notification Form to the county IDA Contact.

- Questions about a specific IDA should be directed to the designated non-profit sponsor staff. Contact the county IDA contact person regarding any general IDA questions.

LOW-INCOME ENTREPRENEURIAL ESCROW ACCOUNTS

POLICY STATEMENT:

All Families First participants who are self-employed (as defined below) qualify to have a Low-income Entrepreneur Escrow Account administered by a Community Based Organization (COB) in which profits that are not reinvested in their business can be escrowed. These profits and the interest earned, up to $5,000, would not be counted towards a Families First participant's resource limit for the Families First, Food Stamp and Medicaid programs. However, when a participant is no longer in the Families First program, the funds in escrow are then applied to the family's resource limit when calculating continued eligibility for Medicaid and Food Stamps. The escrowed profits are placed in a micro-lending intermediary program.

In order to exempt the escrow profits up to $5,000, a participant must:

- be a Families First participant and be in compliance with the work/work related requirements in his/her Families First PRP;

- be self-employed (if an individual's income, divided by the minimum wage, equals at a minimum twenty hours per week, the individual is considered to be self- employed); and

- be enrolled and participate in a micro-lending program that provides entrepreneurship training, technical assistance and peer support.

Only the amount in escrow over $5,000 is counted as resource for an eligible participant.

VERIFICATION:

The participant must verify the amount in the escrow account, including interest.

DOCUMENTATION:

- The case manager must document on the resource screen and CLRC:

  - the Entrepreneurial Escrow Account number;

  - amount; and

  - the micro-lending program that the participant has joined;

  - the method used to verify the amount; and

- any other pertinent information about the account.

PROCEDURES:

- The case managers will have a list of the organizations in their counties that offer approved micro-lending programs. However, some counties may not have an organization that the participant could join. The case manager will supply the interested participant who is self-employed and meeting the work component of their PRP with a referral form.

- Determine if deferred individual is:

  - enrolled in appropriate micro-lending program;

  - participating in macro-lending program training.

- The case manager is responsible for notifying the CBO that an entrepreneur is approaching ineligibility for whatever reason (time limit, sanctions, income, etc.) so that the participant can plan their finances and their account accordingly.

INCOME

POLICY STATEMENT:

All sources of income must be explored and the gross countable income from all sources must be verified prior to approval or continuation of benefits.

Gross income is tested against a maximum income level which is 185% of the consolidated need standard for the appropriate number of people. If the gross income is greater than this standard by any amount, the assistance group is not eligible for Families First. If gross income is equal to or less than the maximum income level for the appropriate number of people, then net income is computed and this amount is used to determine eligibility and amount of payment. If there is a deficit of $1.00 or more between the need standard and net income, then eligibility on this basis exists. Payment level is determined by testing net income (after appropriate exclusions and disregards, if any) against the standard of need. If there is still a deficit, a payment may be made, not to exceed the standard payment amount for the AG size nor in a monthly amount less than $10.00.

Requirement to Apply for Other Benefits:

As a condition to eligibility for Families First, any person (with the exception as explained below) who is reasonably certain to be entitled to any other case benefit (not SSI) must apply for and accept such benefit for her/himself and/or any member of the assistance group. Failure to apply for or to accept the benefit renders the AG ineligible if the grantee relative is required to be a member of the AG. Failure to apply for or to accept the benefit renders the grantee relative who is not required to be included in the AG ineligible to be included in the AG.

Exception: Applicants for or current recipients of (actual or deemed) Families First benefits who were receiving a VA pension in December, 1978, or prior thereto must not be required to apply for and/or accept improved pension benefits, nor can they be sanctioned in any way for their failure to do so.

I. Earned Income:

Earned income is money derived from an individual's work efforts, such as wages, salaries, commissions, or as profits from a self-employment enterprise.

The following monies are considered earned income:

- Wages, salaries, commissions

- Garnished or diverted wages are considered to be earned income.

INCOME

- Profit from self-employment enterprises such as the following:

  - farming

  - small business enterprises

  - roomers/boarders

  - rental receipts—Rent receipts from property owned/being purchased by an individual/family when the owner/purchaser is actively engaged in the production of the income are earned income; and

  - total gains of any capital goods or equipment related to the business, excluding the costs of doing business.

- Rental income is considered earned if the individual is actively engaged in producing the income. The cost of doing business is an allowable deduction regardless of whether the income is earned or unearned.

- Training and Rehabilitation allowances—count as earned income any wages paid for on-the-job training or public service employment, except JTPA earnings of child applicants/recipients. (See JTPA earnings for children A/Rs later in this section.) Exclude all training allowances and incentive payments in Families First Work projects and JTPA projects.

- Severance Pay and Vacation, Sick, Longevity, Bonus Pay, Maternity Leave Pay, and Jury Duty Pay.

  -Severance pay is counted as earned income.

  - Vacation, sick, longevity, bonus pay, maternity leave pay, and jury duty pay are counted as earned income when mandatory deductions are made.

- JTPA payments to adults and minor caretakers are considered earned income if the payments are wages or compensation in lieu of wages.

- Allowances and Other Benefits under the National and Community Service Trust Act of 1993:

  This Act establishes the Corporation for National and Community Service, which administers national community service programs including Americorps, which provides an individual with an education ward of $4,725 per year of completed national service. There are three programs encompassed in AmeriCorps.

  - AmeriCorps * USA for participants age 17 and over

- AmeriCorps* VISTA for participants age 18 and over; and
- AmeriCorps* NCCC for participants age 16 to 24.

Payments provided to AmeriCorps participants are:

- Living Allowance – Treat this stipend as earned income for Families First participants who were not receiving Families First at the time they joined AmeriCorps VISTA. Apply the earned income disregards EXCEPT in the case of VISTA volunteers. This stipend is disregarded for VISTA volunteers.

  For a participant who receives Families First as a dependent child, treat the living allowance in the same manner as JTPA income (disregard in the GIS test for up to 6 months in a calendar year, and if the family passes the GIS test, disregard it in determining the amount of grant if the child is a full-time student or a part-time student working less than full-time.)

- Child Care Allowances: These allowances paid to participants are disregarded if used to pay child care.

  The basic health insurance policy, child care services, auxiliary aid and services to disabled participants, and the national service education award are treated as in-kind benefits, which are disregarded in Tennessee.

In addition to these basic AmeriCorps programs, the Corporation for National and Community Service oversees the following programs:

- The Senior Corps for participants over age 55;
- The Youth Corps for participants age 14-17; and
- Learn and Serve for participants in grades K-12.

Even though only AmeriCorps participants receive the education award, some of the other Corporation programs provide "stipend" benefits (living allowance, child care allowance, in-kind benefits) to participants.

There is a summer program lasting 8-12 weeks (known by various names, such as Summer of Service, Summer of Safety) in which participants in all six programs are placed in AmeriCorps programs. These participants are eligible for a $1000 education benefit upon completion of the service.

- Reimbursements for normal living expenses such as rent, personal clothing, and food eaten at home, are a gain or benefit. The amount by which a reimbursement exceeds the actual incurred expense is counted as earned income. However, reimbursements are not considered to exceed actual expenses, and the expense amount need not be verified, unless the provider or the A/R indicates the reimbursement amount exceeds (continued on page 176)

the expense. When a reimbursement covers multiple expenses, individual expenses do not have to be separately identified if none of the covered expenses are normal living expenses.

- Welfare to Work payments for work and/or training activities will be considered as earned income. WtW payments for transportation or other services are excluded.

Unearned Income:

Unearned income is any income, which does not meet the definition of earned income. No earned income exclusions or work expense deductions are applied to unearned income. The following monies are considered unearned income:

- Unemployment Compensation and Workers' Compensation.

- Vacation, sick, longevity, and bonus pay are all unearned income when mandatory deductions are not made.

- Rental income is considered unearned if the individual is not actively engaged in producing the income. If the individual carries no specific responsibilities in earning the income, as when rental properties are in the hands of rental agents and the check is forwarded to the individual, or when an individual rents farm land to others and receives a monthly payment, the income is unearned. The cost of doing business is an allowable deduction regardless of whether the income is earned or unearned.

- Interest payments in excess of $60 per quarter (less than $60 is disregarded), dividends, royalties, and all other such direct money payments, which can be construed to be a gain or benefit, are considered unearned income. Convert such income to monthly amounts if received on a weekly, bi-weekly, or semi-monthly basis. Consider these payments as currently available income. If such payments are received quarterly, prorate them over three months; semi-monthly, prorate over six months; annually, prorate over 12 months.

- General assistance payments, pensions, or other countable needs based assistance payments (other than SSI) are unearned income.

- Payments for rehabilitation made under the Services to the Blind, Vocational Rehabilitation, or other such programs are unearned income. Deduct expenses from the gross rehabilitation payment. They may include:

  - transportation costs to and from the training facility, doctor, clinic, etc., based on the current state mileage allowance;

  - books, tools, equipment, etc., not furnished by the facility;

  - supplies such as pens, pencils, etc., not furnished by the facility;

- required occupational clothing;

- noon meals if not furnished by the facility (not to exceed current VA allowance);

- laundry and cleaning expenses related to training;

  - incidental expenses over and above "personal incidentals" such as coffee breaks, grooming aids, some recreation (not to exceed $30 per month) if the person is away from home; and

  - initial outlay items (such as footlockers, suitcases) not furnished by VR or Services for the Blind.

  Costs for items not included in our need standard, but necessary to participate in the program can be excluded as assistance from other agencies.

  Count any remaining rehabilitation payment, after expenses, as unearned income.

- Annuities, pensions, retirement, veterans or disability benefits, military or Job Corps allotments, and other such pensions and benefits.

- Contributions in the form of regular cash payments made to the AG that are over $30 per recipient per calendar quarter.

- Money withdrawn from the body of a trust or interest/dividends paid to an A/R. Such monies are treated as regular income or annualized income as appropriate, depending upon the frequency of receipt.

- **Non-IV-E** Foster Care board payments are considered unearned income for a minor mother in foster care. If the dependent child is on non-IV-E funds, that child's total board rate must also be counted as unearned income. (Individuals eligible for IV-E are not eligible for Families First.)

Payments/Benefits Excluded from All Families First Income Tests (GIS/CNS) and in Calculating Benefits:

- **IV-E** Foster Care and Adoption Assistance payments and Foster Care Board payments.

  - A child for whom Foster care or Adoption Assistance payments are received is excluded from the AG. The child's income and the Foster Care/Adoption Assistance payments are also excluded from the family's income.

  - If a minor parent's foster care payments include the foster care costs of the minor's child, the child is not eligible for Families First.

- If a minor parent is receiving foster care board or adoption assistance payments but his or her child is not, do not count the income(including the board/adoption assistance payment) and resources of the minor parent in determining his/her child(ren's) eligibility for Families First.

- Foster care board payments made to the foster parents for the care of a foster child are not income, but are service fees. (The amount paid to the foster parent in addition to the board payment is income).

  EXCEPTION: If the exclusion of the child for whom adoption assistance is paid would reduce the amount of cash assistance for the adoptive family, the child must be included in the AG and his income, including the adoption assistance payment, must be counted.

- Relocation Assistance payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Act of 1970.

- Funds distributed per capita to or held in trust for members of any Indian tribe under P.L. 920254, P.L. 93-134, or P.L. 04-540.

- Payments received under the Alaska Native Claims Settlement Act (P.L. 92-203, Section 21(a); payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalera Reservation (P.L. 95-443); payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indians Claims Settlement Act of 1980 (P.L. 96-420, Section 5); payments of relocation assistance to members of the Navajo and Hopi tribes (P.L. 93-531).

- Receipts distributed to members of certain Indian tribes referred to in Section 6, P.L. 94-114.

- Payments from the Nutrition Programs for the Elderly (Title VII).

- The value of supplemental food assistance received under the Child Nutrition Act of 1966 (WIC), as amended, and the special food service program for children under the National School Lunch Act, as amended.

- Payments for supporting services and reimbursements of out-of-pocket expenses made to individual volunteers serving as health aids, senior companions, R.S.V.P., Foster Grandparents and any other programs under Title II pursuant to Section 418 of P.L. 93-113.

- AmeriCorps VISTA payments for Families First participants who were receiving Families First at the time they joined AmeriCorps VISTA.

- Income of minor child recipients who are students.

This does not apply to minor caretakers.

Do **not count** the earned income of a minor **full-time student.** Do not count this income in computing the grant or test it against the GIS or CNS during this period.

NOTE: Families First requires that all school age children attend school. If a child is not attending school, see the School Attendance Chapter for details. Also check this section for verification/documentation details.

A student is defined as a minor child recipient attending primary/secondary school, college, university, or a course of vocational or technical training

- A student retains student status during official school vacations and breaks if requirements prior to the vacation/break were met and if the student plans to return.

- A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.

- Participation in apprenticeships, correspondence courses, other courses of home study, and rehab programs other than academic or institutional vocational or technical training do not qualify a child as a student.

- An elementary school is defined as a state approved educational institution comprised of grades K through eight.

- A secondary school is defined as a state approved educational institution offering a curriculum for grades nine through twelve.

  NOTE**: a full time student in a secondary school** is defined as one who is taking an adequate grade level academic load to meet the graduation requirements for the respective school system in which he is enrolled. Generally, this is defined as 25 clock hours/week or 4 Carnegie units per year; **half time** is defined as 12 clock hours/week or 2 Carnegie units per year.

- An equivalent level of vocational or technical training means equivalent to elementary or secondary education. It is not post-secondary education such as that leading to an Associate of Arts (A.A.) degree.

  NOTE: **Full- time attendance** in a trade, technical, or vocational school is considered to be 30 clock hours per week with shop practice or 25 hours a week without shop practice. **A part-time student** is defined as one who attends 15 clock hours per week with shop practice or 12 hours per week without shop practice.

- JTPA Payments for Adults and Minor Caretakers – Exclude as unearned income payments at all steps of the budget calculation if income is identified by JTPA as a supportive services payment and is paid for supportive services such as child care, medical and other services needed to enable the client to work; or if income is identified by JTPA as a "needs based payment" which is income that is paid to meet a basic need that the Families First grant does not cover.

- Guardianship payments come in two types:

  - Kinship care – enables children to be cared for by family members while in the custody of the state; and

  - Subsidized Guardianship – focuses on enabling children, who cannot be adopted, and who do not live with relatives, to have a greater degree of permanency.

  These payments should be treated like Foster Care assistance payments. They are seen as service fees, not income.

- Payments made under P.L. 104-204 to children of Vietnam veterans (male or female) who are born with spina bifida.

- VA payments made under P.L. 106-419, Section 401 of the Veterans Benefits and Health care Improvement Act of 2000 to children with certain birth defects born to female Vietnam veterans. The birth defects identified may not include birth defects resulting from the following:

  - A familial disorder;

- A birth-related injury;
- A fetal or neonatal infirmity with well-established causes; or
- Spina bifida. (Spina bifida is covered by previous legislature (P.L. 104-204). It provides benefits to children with this disability born to either male or female Vietnam veterans.)

- Payments made to individuals because of their status as victims of Nazi persecution are excluded.
- Educational grants, loans, scholarships, stipends and/or college work study Payments made to or in behalf of a Families First AG member or a stepparent in the home or parent in the home of a minor Families First parent are excluded.
- Exclude Agent Orange Settlement payments.
- Earned Income Tax Credits are excluded.
- The costs of doing business such as wages, benefits paid to employees; inventories, supplies, utilities, etc are excluded from income.
- Clothing allowance for disabled veterans for additional clothing needs resulting from the use of prosthetic or orthopedic devices.
- Legally obligated payments otherwise payable to an assistance group which are diverted by the provider to a third party, unless this arrangement is made at the request of an assistance group member.
- Loans provided by an individual or commercial lending institution which represent an obligation and not a benefit such as chattel mortgages and personal notes, are not income.
- Monies received and used for the care and maintenance of a non-assistance group member, who is not the responsible relative of an assistance group member living in the same home, are not income for the AG. If payments are for multiple beneficiaries that include both AG and non-AG members, prorate the payments evenly among the intended beneficiaries to determine individual shares. The individual shares of the assistance group members (their responsible relatives) will be considered income to the assistance group (relative).
- Income belonging to non-assistance group household members is not counted unless the member is a responsible relative or stepparent of an assistance group member.
- Reimbursements for out-of-pocket expenses by volunteers or employees in the performance of their duties are not counted as income.

- Retroactive Families First/AFDC or SSI payments

- Payments that are made either directly to Families First recipients or to a third party for rent or utilities under "Section 8" of the U.S. Housing Act.

- Payments for utilities to or on behalf of Families First recipients through the Department of Health and Human Services' Low Income Energy Assistance Program or other federal, state, or local energy assistance plan. Such payments must be clearly identified as energy assistance by the legislative body authorizing the program and the agency making the payment.

- Support payments (child and related spousal support) received by an assistance group, but transferred to the IV-D agency as assigned support.

- Casual and inconsequential income that is $30 or less per quarter per Families First AG member.

- The portion of the assistance group's income that is withheld by the provider to repay a prior overpayment is not income.

- Any gain or benefit not in the form of money payable directly to an assistance group such as non-monetary or in-kind benefits. Examples are goods and services; food stamps, surplus commodities; rent or mortgage payments paid to a landlord or mortgage holder by HUD or state or local housing authorities or under section 8 of the Housing Act; etc.

- Welfare to Work (WtW)payments made for transportation and other services are excluded as income. WtW payments made for employment and training are considered as earned income.

- Payments made under the National Flood Insurance Program (NFIP) for flood mitigation activities shall not be counted as income or resources of the property owner.

TREATMENT OF INCOME

POLICY STATEMENT:

The amount of income available to meet maintenance needs is to be determined in establishing eligibility in accordance with the definitions of income provided in the Income chapter. Currently available income (as defined) is considered in the determination of eligibility and level of benefit in Families First.

Projecting Income:

In Families First, a prospective method of determining eligibility and payment is used.

At the time of case action a decision is made as to the amount of income to be considered available for a future period. The case manager anticipates monthly income the AG will have in the coming months and uses this figure to calculate the amount of benefits for Families First.

Anticipating Income:

At the time of application/reapplication an AG may expect changes in circumstances to occur in the future; in particular, changes relating to the receipt of income. However, only currently available income will be used to project the amount of ongoing available income unless the amount and date of receipt of expected income is known with reasonable certainty or unless some change has occurred. If the exact amount/month of receipt of the income is not known, only that portion of it which can be reasonably anticipated shall be considered as income.

When any change in AG circumstances is expected, including a change in income, the AG will be required to report the change within 10 days of the change.

Income in Past 30 days:

Income received during the past thirty days will be used as an indicator of anticipated income. However, past income will not be used for any month in which a change in income has occurred or can be anticipated.

If income fluctuates to the extent that a 30-day period alone cannot provide an accurate indication of anticipated income, the case manager and the AG may use a longer period of past time if it will provide an accurate indication of anticipated fluctuations in future income. Similarly, if the AG's income fluctuates seasonally, it may be appropriate to use the most recent season comparable to the time of year, rather than the last 30 days, as one indicator of income for the eligibility period. In no event will the case manager automatically attribute to the AG the amounts of any past income. Past income will not

be used as an indicator of anticipated income when changes in income have occurred or are anticipated to occur.

Cases of Steady Employment:

In cases where the wage earner is steadily employed, income from previous months is usually a good indicator of the amount of income that can be anticipated in the month of application and subsequent months. If information supplied by the AG or a collateral contact indicates that future income will differ substantially from the previous month's income, the case manager will use such information to make a reasonable estimate.

Converting Income to Monthly Amounts:

Since need determination and level of benefit calculation are made on a monthly basis, income and expenses available to an AG must be stated in monthly amounts. The following methods will be used to convert income to monthly amounts for purposes of determining prospective eligibility on active cases and benefit amounts.

- **Hourly or Piece Work Wages:** Estimate the amount of income to be expected as the result of a week's work based on hours/days produced. Use the weekly earnings to determine the monthly income.

- **Weekly Income:** Multiply weekly income by 4.3 to determine monthly income.

- **Bi-Weekly Income:** Multiply amount received each two weeks by 2.15 to determine monthly income.

- **Semi-Monthly Income:** Add the two amounts received to determine monthly income.

- **Monthly Income:** When a wage earner is employed and paid on a regular monthly basis, accept her/his verified monthly/salary as monthly income.

- **Annual Income:** Divide annual income by 12 to determine monthly income.

Rounding Truncating Procedures:

Cents for all types of income will be truncated when used in the budget calculations.

Cents for all types of types of expenses will be included in the budget calculation and then dropped in the final budget step for Families First.

Hourly wages will not be rounded prior to converting gross weekly or gross monthly income.

TREATMENT OF INCOME

Use cents when computing the gross income. The ACCENT system will complete the truncating procedure which drops the cents at the last step of the budget calculation.

Income at Application:

- **Income in application month:** Base the eligibility and benefit level for the AG that is submitting an initial application on its circumstances for the entire calendar month in which the application is filed. Use the income received by the AG members during the application month (i.e., income already received by the day of application plus any that is anticipated, with reasonable certainty, to be received in that month) to determine initial eligibility and benefit level. If the AG's income is averaged, use the averaged amount for each month of the certification period, including the application month.

- **Effects of Changes During the Application Processing Period:** An AG may be eligible in the application month based on circumstances existing in that month, but ineligible in the subsequent month because of changes which occur. The AG is entitled to benefits for the application month even when the processing of the application results in benefits not being paid in subsequent months.

  An AG may be ineligible in the application month based on circumstances in that month, but eligible in the subsequent month because of changes which occur. A new application is not required, however the initial application must be denied for the application month and approved for subsequent months.

Anticipated Changes and Benefit Amounts:

Adjustments in a Families First grant are made on the basis of reported (or discovered) changes. The grant amount for the month of application may differ from the grant amount in subsequent months. If a change in income is reported and the change is ongoing, the new amount is to be used to project future ongoing income and continuing eligibility.

Income at Reapplication:

Families First eligibility and amount of payment at the time of redetermination will be based on circumstances which prevail at that time. Currently available income will be used to determine ongoing eligibility if it is anticipated to be ongoing.

Individuals whose Income Must be Considered:

- **All Assistance group members:**

  Consider the countable gross income, earned and unearned, of all assistance group members and their responsible relatives in the home plus the deemed income of an in-home stepparent and parent of a minor parent, as available. Test the gross amount against the amount equal to 185% of the appropriate consolidated need standard (i.e.,

gross income standard). This procedure screens in families with amounts less than the standard and screens out those with greater amounts. If screened in, the countable net income for the assistance unit is tested against the appropriate need standard to determine eligibility and level of payment.

No income of parents and spouses (i.e., responsible relatives) is diverted to their ineligible dependent(s) living in the home except in the deeming budgets of stepparents and parents of a minor parent.

- **Spouses:**

  Consider the income belonging to one or both members of a married couple as available to each other as long as they are living together.

  Consider the income of a minor's spouse living in the home with the minor as available in its entirety to the minor when the minor is included in an assistance group.

  The income of a spouse who is an SSI recipient is disregarded in determining the other spouse's eligibility and the amount of assistance.

  If the couple presents themselves as married, they are to be considered married. If they later claim to not be married, the burden of proof of their unmarried status will be upon the couple.

  See the Married During the Receipt of Assistance chapter for counting spouse's income when the caretaker marries during the receipt of Families First.

  Note:

  If a Families First applicant or recipient has a spouse in the military and is not receiving sufficient or regular support, the A/R should write the appropriate finance centers (listed below) and request an allotment be sent directly to her/him or the IV-D agency. A letter may also be sent to the military person's commanding officer regarding the matter. In both instances, the letters must give the service person's name, rank, social security number, and complete military address. The local chapter of the American Red Cross may be of assistance to the client in writing, submitting, and following up on the request.

  U.S. Army Finance Accounting Center
  Inquiries Division
  Centralized Pay Operations
  Indianapolis, In 46249

Marine Corps Finance Center
Allotment Division
Kansas City, Mo. 61497

Navy Family Allowance Activity
Anthony J. Clelbrezze Federal Bldg.
Cleveland, Oh 44199

U.S. Coast Guard
Military Pay Center
6501 Lafayette Avenue
Riverdale, Md. 20840

Air Force Accounting and Finance Center
Attention: MPAB
Denver, Co. 80279

- **Income of Children**

  - Do not count the income of a technically ineligible child (i.e., ineligible due to age, deprivation, citizenship).

  - Count the income of a child, who is a minor parent and is sanctioned for failure to cooperate with school attendance requirements or the income of a child sanctioned for enumeration.

  - Do not count a child SSI recipient's income.

  - Do not count the income designated or legally "earmarked" for a child applicant/recipient, but not actually received, in determining eligibility and amount of payment. Although the money will not be counted in the AG, the caretaker must apply to have the money made available to the child. If the caretaker does not do this, the caretaker cannot be included in the AG if the caretaker is a non-parent grantee relative.

- **Parents:**

  Parents are responsible for the support of their dependent children until the children become age 18 (or age 19 if applicable). Parents living in the home with their children must be included in the assistance group and their total income counted as available in its entirety, unless the parent is an SSI recipient. Count the income of parents excluded from the assistance group because of a disqualification or enumeration penalty as available to the assistance group.

Parent(s) of a minor parent who applies for or receives assistance for her/his own children are not pulled into the minor parent's AG. However, if the minor parent's parent receives Families First for the minor's siblings, the minor must be included in her/his parent's AG.

- **Stepparents and Parents of Minor Parents:**

Deem income as available to assistance group members from persons listed below under the given circumstances:

- A stepparent living in the home with stepchildren for whom assistance is requested.

- A parent living in the home with a minor parent who has requested Families First in her/his own right for a child in her/his care.

Do not deem income from a stepparent or a parent who is an SSI recipient.

Determine the amount of income to consider available to the stepchildren /minor parents as follows:

- Determine gross monthly income;

- From earned income only, deduct the flat work expense amount of $150 for full-time or part-time employment;

- Deduct the appropriate Consolidated Need Standard for the stepparent or parent and his legal dependents (for IRS tax purposes) living in the home who are not included in the assistance group. (If the stepparent or parent's income is not taxable, use those individuals (s)he could claim under IRS rules.) NOTE: The natural/legal parent of the dependent child must be included in the assistance group; her/his needs may not then be included again in the deeming budget.

- Deduct amounts actually paid for alimony or child support to individuals not living in the home other than those covered in those mentioned above;

- Show the remainder as income deemed to the stepchildren or minor parent, as appropriate.

- **Applicant/Grantee Relative Other than Parents:**

- Count the income of the grantee relative if the grantee relative is included in the AG. When the grantee relative is included in the AG, all of the income of the relative's spouse is considered available to the AG.

TREATMENT OF INCOME

- **Individuals Whose Income is NOT to be Considered:**

  - SSI recipients (regardless of relationship)

  - Ineligible relatives other than parents/stepparents that are not in the AG

  - Unrelated AG members

  - Individuals living outside the home except for a parent in the uniformed services and out-stationed. Cash contributions from individuals living outside the home are to be counted if more than $30 per quarter per member.

Calculating Income and Benefits:

- A Families First budget is the tool used to determine whether an assistance group is in need according to state standards currently in use, and to determine the amount of payment an eligible assistance group is entitled to receive.

- The ACCENT system calculates the Gross Income Test (AEBAG) budget; Net Income Budget (AEBAN); and the final grant budget (AEBAB).

- The Families First budget sets out the gross income limits, the consolidated standard for the number of people in the assistance group, the gross and/or net income available to the assistance group, any deficit between the net income and the consolidated need standard, and the grant amount for which the assistance group is eligible.

- The Consolidated Standard of Need is :

  - the basis for determining the gross income standard; and

  - to determine eligibility for the $150 earned income disregards at the point of application.

- The Families First payment does not meet 100% of need as defined by the consolidated need standard. A standard payment amount is set for each family size based on available state and federal funds,. Income available to the assistance group (after all appropriate disregards and deductions have been applied) is subtracted from the consolidated need standard to determine the deficit. Payment is the deficit or the standard payment amount for the assistance group size, whichever is less.

  If an assistance group's available income equals or exceed the assistance group's consolidated need, the assistance group is not eligible for a Families First grant.

If there is a deficit of $1.00 to $9.99, no payment can be made, but the assistance group is deemed to be a Families First AG for other purposes, including Medicaid coverage, as long as all other points of eligibility continue to be met.

If the deficit is $10.00 or more and other eligibility requirements are met, payment will be made.

- Families First payment are made on a monthly basis.

  Initial payments are made beginning with the date of application, if all other eligibility factors are met at that time, or at the first of the month in which eligibility is achieved, whichever is later

  The amount of the payment will be the deficit between the need standard and any countable income or the standard payment amount (whichever is less), but not less than $10.00.

- Computing Income and Benefits:

  ACCENT will perform the budget calculations.

  ACCENT will group the filing unit. Countable income will be included. Technically ineligible children and their income will be excluded. Gross income is computed by totaling the gross earnings for all AG members and all countable unearned income plus income deemed from a stepparent/parent/guardian. If the countable gross income exceeds the gross income standard, the assistance group is not eligible for assistance. EXCEPTION: Spouse's income when considering Marriage During the Receipt of Assistance.

  If the gross income test is met, determine net income available to the assistance group and subtract it from the applicable need standard. Net income is the countable gross income less any allowable earned income deductions and/or disregards.

  The need standard less net income (after appropriate disregards) results in a deficit. The payment is the lesser of the deficit or standard payment amount for the appropriate family size. If the deficit is $1.00 - $9.99, the AG is not eligible for a grant, but is eligible for Medicaid benefits only.

- Computing Prorated Income

  When the caseworker must manually determine the amount of income for a partial month payment, the proration calculator at www.sworps.utk.edu/induction/prorate.asp may be used.

Self Employment Income:
Income which is received annually, and/or which is an integral part of annual income, will be totaled and prorated over 12 months, even if the income is received only once or over a period of time shorter than 12 months. Such income usually is derived from farming, but also may apply to other self-employment enterprises.

TREATMENT OF INCOME

Annual Income:

Income which is received annually, and/or which is an integral part of annual income, will be totaled and prorated over 12 months, even if the income is received only once over a period of time shorter than 12 months. Such income usually is derived from farming, but also may apply to other self-employment enterprises. Annual income will be prorated over 12 months even if a person has income from sources other than self-employment. Income received once annually will be prorated over 12 months beginning with the month the income is received.

Income which represents annual income, but which is received periodically during a year, will be totaled and averaged over 12 months. This average figure will be used to project future income (if all other factors remain relatively constant).

If a self-employed person is under contract, the 12-month period begins the first month the person receives payment under the contract.

Income from Migrant Labor, Seasonal Work:

An estimated average monthly income from migrant labor, seasonal farm work and other seasonal employment will be considered during the months it is received.

Monthly Self-Employment Income:

When self-employment income is received monthly, the average monthly income will be estimated based on past income and substantial changes in circumstances which have occurred, such as an increase or decrease in business.

Capital Gains are Income:

The proceeds from the sale of capital goods or equipment are calculated in the same manner as a capital gain for federal income tax purposes. Even if only 50% of the proceeds from the sale of capital goods or equipment is taxed for federal income tax purposes, the case manager will count the full amount of the capital gain as income.

Internal Revenue Service Publications:

IRS Publications 17, 334, and 533 provide detail on taxing self-employment income. They are available form IRS information offices.

Costs of Producing Self-Employment Income:

When a member of the AG receives income from self-employment, (s)he will be required to keep a record of expenses incurred in the production of this income.

TREATMENT OF INCOME

Expenses:

- Identifiable costs of labor (salaries, employer's share of SS, insurance, etc.)
- Stock, raw materials, seed and fertilizer, feed for livestock
- Rent and cost of building maintenance
- Business telephone costs
- Costs of operating a motor vehicle when required in connection with the operation of the business
- Interest paid to purchase income producing property
- Insurance premiums and taxes paid on income producing property
- Costs of feed for work stock
- Costs of meals and equipment for children for whom day care is provided in the A/R's home.

Unallowable Deductions:

- Payments on the principal of the purchase price of income producing real estate and capital assets, equipment machinery, and other durable goods;
- Net losses from previous periods;
- Federal, state, and local income taxes, money set aside for retirement purposes, and other work related personal expenses (such as transportation to and from work). These expenses are accounted for by the flat work expense allowance in Families First;
- Costs of producing home produce intended for family consumption;
- Family living expenses;
- Depreciation.

Determining Monthly Income When Averaged:

For the period of time over which self-employment is determined, add all gross self-employment income (including capital gains), exclude the costs of producing the self-employment income, and divide the self-employment income by the number of months over which the income will be averaged.

Determining Monthly Income When Anticipated:

For those AG's whose self-employment income is not averaged but instead is calculated on an anticipated basis, add any capital gains the household anticipates it will receive in the next 12 months (starting with the date the application is filed) and divide this amount by 12. Use this amount in successive months during the next 12 months, unless the anticipated amount of capital gains to the anticipated monthly self-employment income and subtract the cost of producing the self-employment income. Except for depreciation, calculate the cost of producing the self-employment income by anticipating the monthly allowable costs of producing the self-employment income.

Assistance Groups with Boarders:

AG/s that take in boarders or that operate commercial boarding houses are considered self-employed. Identifiable expenses are allowed as costs of doing business, as in any self-employment.

Determining Income for AG:

The income from boarders (self-employment income) includes all direct payments to the household for room and meals, including contributions to the household's shelter expenses. Shelter expenses paid directly by boarders to someone outside of the household are not counted as income to the AG.

Cost of Doing Business:

After determining the income received from the boarders, exclude that portion of the boarder payment which is a cost of doing business. The cost of doing business is equal to one of the following, provided that the amount allowed as the cost of doing business does not exceed the payment the household received from the boarder for lodging and meals:

- the cost of the Thrifty Food Plan for a household size that is equal to the number of boarders; or

- the actual documented cost of providing room and meals if applicant claims actual costs exceeding the Thrifty Food Plan. If actual costs are used, the only separate and identifiable costs of providing room and board to the boarder are excluded.

TREATMENT OF INCOME

Income of Resident Farm Laborers, Migrant AG's, School Employees, and other Contractual Employees:

Resident Farm Laborer:

The regular monthly income figure will be used to determine the amount of the Families First grant.

Irregular Income - Single Employer:

In some instances, the AG is paid for work done only during the work season, but resides year round on the farm and may receive advance or deferred payments, (sometimes known as "furnish"), during the non-work season. Some difficulty may be experienced in assigning an income figure to the farm worker whose income is high during the work season and correspondingly low during the non-work season when income is only from advance or deferred payments.

Irregular income is to be averaged over a 12-month period.

Regular or Irregular Income - Multiple Employers:

When a farm laborer works regularly for more than one employer, the total income from all employers must be determined an then it is treated in the same manner as that received from a single employer. If work for multiple employers as irregular, the food stamp certification period should reflect actual income or variable basis of issuance should be assigned

Migrant Farm Laborer:

It must be determined whether migrants have out-of-state income from real property in the home base area. A migrant family is permitted one home and lot as an exemption from resources as any other AG.

The income of children in migrant households will be treated as that of any other child for whom eligibility is being determined. If the amount of income belonging exclusively to a child cannot be determined, prorate equally the total income of all household members and treat the child's prorata share as her/his own income.

School Employees:

The average monthly income of school employees will be considered available during the months it is received. Please note that some school employees are paid 9 months of the year, some are paid 10 months, and some receive pay 12 months. The case manager must determine the pay arrangement a school employee may have so that income can be considered in appropriate months.

Income of Other Contractual Employees:

The average monthly income of persons employed on a contractual basis (other than school employees) will be considered as income during the period covered by the contract.

Temporary Employment of Person Under Contract:

In some instances, an employee under contract may accept temporary employment. For example: many teachers and other school employees accept temporary employment during the summer months.

After the appropriate earned income exclusions, disregards and deductions, income from temporary employment will be budgeted as available only in the months received. The same procedures outline in the section below on Unemployment compensation will be followed.

Unemployment Compensation:

Employees with annual contracts such as school employees may be eligible for unemployment compensation when their employment ends.

The A/R must be questioned to determine

- whether or not he/she has filed a claim for unemployment compensation benefits;
- if benefits are being received; and
- the amount of the benefits.

Count unemployment compensation as income only in the months in which it is received. Do not annualize unemployment compensation benefits with income from contractual employment. The monthly amount of the unemployment compensation benefit will be added to the annualized monthly income from employment to determine income available to meet current needs. This will require possible adjustments in the grant both at the beginning and the end of the unemployment compensation benefit period.

When an AG receives Families First benefits because one or both parents are unemployed, if the Principal Wage Earner (PWE) receives Unemployment Insurance Benefits (UIB), also known as "unemployment compensation," determine the family's grant as follows:

- subtract all countable income except the unemployment compensation benefits from the CNS to determine the deficit;

- deduct the unemployment compensation benefits from the lesser of the deficit or the maximum grant for the AG size. The resulting amount is the assistance payment for the Families First AG, so long as the amount is at least $10.00.

Example – Unemployed Parent Budget With Unemployment Compensation Benefits

Mother, father and three children are in the AG. The mother works part-time and we have determined that her net earnings, after applying appropriate deductions and disregards, are $220. The father has been determined to be the PWE. He receives unemployment compensation benefits totaling $250 per month. There is no other income.

CNS for 5	$1,181
Mother's net income	-$220
Deficit	$961
Maximum grant for 5	$264
Unemployment benefits for PWE	-$250
Payment (Grant) amount	$14

TREATMENT OF INCOME

FAMILIES FIRST NEED/PAYMENT STANDARDS:

Number of Persons in AG	1	2	3	4	5	6	7	8	9	10
Gross Income Standard	1197	1515	1782	2002	2185	2337	2466	2575	2671	2758
Consolidated Need Standard	647	819	963	1082	1181	1263	1333	1392	1444	1491
Standard Payment Amount	95	142	185	226	264	305	345	386	425	467
Differential Grant Payment Amount	140	192	232	242	291	305	345	386	425	467

Number of Persons in AG	11	12	13	14	15	16	17	18	19	20
Gross Income Standard	2836	2910	2980	3047	3112	3169	3221	3263	3291	3302
Consolidated Need Standard	1533	1573	1611	1647	1682	1713	1741	1764	1779	1785
Standard Payment Amount	508	549	589	630	670	711	750	790	831	871
Differential Grant Payment Amount	508	549	589	630	670	711	750	790	831	871

TREATMENT OF INCOME
CHILD SUPPORT

POLICY STATEMENT:

The goal of Families First is to assist individuals in moving from welfare to economic self-sufficiency. Using child support to "fill-the-gap" of an assistance group's unmet need is a critical tool to achieve this goal. **An assistance group may be eligible to receive child support pass-through payments and Families First payments simultaneously.**

In order to receive Families First, the applicant/recipient must agree to assign to the state all child support while receiving Families First cash benefits. However, this does not mean that the A/R cannot receive Families First and child support payments at the same time. The AG can receive both Families First and child support if eligible for child support pass-through payments. Eligibility criteria for child support pass-through payments are explained later in this chapter.

Child support Distribution:

Effective October 1, 1998, the child support distribution rules changed for individuals who have received AFDC /Families First cash benefits in the past, but who are not currently receiving Families First cash benefits. Prior to October 1, 1998, if an absent parent made child support payments to a caretaker who had previously received AFDC/Families First cash benefits and the payments exceeded the current court ordered amount, the excess amount would be retained by the state to reimburse the AFDC/Families First benefits. However, effective October 1, 1998, if the absent parent owes child support arrears to a caretaker, the caretaker would receive the current and the arrears payments until those arrears are reimbursed. The state will not be reimbursed until after the arrears owed to the caretaker are paid in full. Arrears owed to the caretaker are called Unassigned Arrears. Arrears owed to the state are called Assigned Arrears.

As of October 1998, child support is distributed to the AG as follows:

- While the AG is receiving Families First cash benefits, eligible AGs will receive child support pass-through payments up to the unmet need. Any child support paid in excess of the child support pass-through payments is used to reimburse the state and federal governments for AFDC or Families First payments that the assistance group receives or received.

- When the AFDC/Families First assistance group is closed, any current child support paid will be issued to the caretaker.

- When the Families First AG is closed and the absent parent makes any arrears payments (with one exception), these payments will be sent to the caretaker if the absent parent owes any child support arrears to the caretaker. However, if the absent parent does not owe any child support arrears to the caretaker, child support paid in excess of the current court ordered amount will be retained by the state until the past

- or current AFDC/Families First grants have been reimbursed. Exceptions: IRS intercepts child support collections are always used to reimburse the arrears owed to the state first.

Counting Child Support in the Families First Budget:

If the absent parent is paying child support to a Families First assistance group or applicant, the case manager must determine if the absent parent owes child support arrears to the caretaker in order to establish the amount of child support to enter on AEFMI. Instructions on how to make this determination and how to code ACCENT are found in the Procedures section of this chapter.

The child support plus any other countable income that the AG has is used to determine Families First eligibility in the GIS and CNS tests. If the assistance group is eligible with the child support included, the child support is removed from the calculation that determines the grant amount. The Budget Effective Date on AEIAC will ensure that the child support is removed from the grant calculation appropriately. Therefore, it is critical that the case manager enter the correct Budget Effective Date. Establishing the correct Budget Effective Date is discussed in the Procedures section of this chapter.

Once the grant amount is calculated after taking into account any earned and/or unearned income, the remaining unmet need for the assistance group can be filled by any child support collected for the children in that month. This is explained in more detail below.

History of Bonus, Supplements and Child Support Pass-Through Payments

Until October 1996, when an absent parent made a child support payment for an AFDC/Families First assistance group, the state issued a bonus child support payment (up to $50 per month) and retained the remaining amount of child support to reimburse any grant paid to the assistance group. At the end of the month following the month in which the child support was paid, DHS would determine if the assistance group was eligible for a supplemental AFDC/Families First payment. If so, the supplement was issued in the amount of the child support payment, less the bonus payment, up to the unmet need in the assistance group's budget. <u>This supplement was an additional grant payment.</u>

Effective October 1996, the federal law changed, eliminating the bonus payment and allowing states to "pass through" the child support that was collected rather than making additional grant payments as supplemental payments, However, until the Tennessee Child Support Enforcement System, TCSES, was modified to handle the child support payments, these payments were still issued as bonus and supplemental payments and they continued to appear on the Cash Issuance History Screen (IQCH) as bonuses (code 103 or 106) and supplements (code 096 or 102).

TREATMENT OF INCOME
CHILD SUPPORT

In February 1998, TCSES was modified to issue child support payments, now called child support pass-through payments, to Families First assistance groups. These payments appear on IQCH with reason code 096. (Any child support payments that are received for a month prior to February 1998, but processed after February 1998, are issued as bonus and supplements, if the assistance group is eligible for a supplemental payment.)

Note: If an overpayment occurs in the Families First case, any supplements issued for a month prior to 10/96 should be included in the overpayment calculations since those payments were grant payments. Any supplements issued for 10/96 or later should not be included in the calculation since those payments were actually child support payments.

If an overpayment occurs because the supplemental grant payment was incorrect, the Supplemental Unit in the State Office will pend the overpayment claim on COTS.

Eligibility Determination For Child Support Pass-Through Payments

Eligibility for child support pass-through payments is based on the AG's unmet need in its Families First budget. (Eligibility for the supplemental payment is determined in the same manner.) The unmet need is determined by subtracting the AG's Net Countable Income and the Families First grant amount from the Consolidated Needs Standard (CNS). This information can be found in ACCENT on the AFDC/AFDC Related Medicaid Benefits Determination Budget screen, AEBAB.

If the AG's unmet need is greater than "0," the AG is eligible for child support pass-through payments up to that amount. The amount of the child support pass-through payment is the amount of support paid during the month (both current and arrears payments) up to the unmet need amount.

Example: A three-person AG has no countable income other than the Families First grant. Child support is collected for 05/06.

CNS	$963.00
Countable Net Income	$0.00
Families First Grant Amount	-$185.00
Unmet Need	$778.00

If the absent parent for this AG pays $400 in child support for 05/06 the child support pass-through payment will be $400 because the unmet need is greater than the child support paid.

Example: The same three-person AG reports receiving countable income that is budgeted for 07/06.

CNS	$963.00
Countable Net Income	-$550.00
Families First Grant Amount	-$185.00
Unmet Need	$228.00

If the absent parent pays $400 for 05/06, the child support pass-through payment will be $228.00 because the unmet need is less than the child support amount paid.

NOTE: If the grant is less than the maximum grant for the AG size, there is no unmet need and no child support pass-through payment will be issued.

Discussion of Child Support With the Caretaker

In discussing child support with the applicant/recipient, the caseworker will fully explain the child support pass-through payment. This discussion should include:

- explaining how the amount of child support pass-through payment is determined (i.e. the amount of child support payments up to the unmet need);
- how the unmet need is determined (the CNS for the AG size minus the amount of net countable income in the Families First budget minus the grant);
- the amount of the AG's unmet need based on the current information in the case; and
- that any changes in the AG's income will affect the unmet need and may, therefore, affect the amount of the AG's child support pass-through payment.

At each application and review, give the applicant/recipient a copy of the handout: "You may get your child support while you are on Families First!"

In order to fully explain the child support pass-through payment policy, the caseworker may provide examples that are specific to the AG's situation to show how changes in income will affect eligibility for child support pass-through payments. This will help the caretaker determine how additional income will affect her eligibility for child support pass-through payments. This will also help show that it may be to her advantage to continue to receive Families First and child support pass-through payments instead of direct child support payments alone. The caseworker can use the format above to set up these examples.

In addition, explain that if the Families First AG is closed, the amount of child support that the AG will receive depends on whether or not the absent parent owes arrears to the caretaker. (See distribution information above.) If the absent parent does not owe the

AG any arrears, payments that exceed the current court ordered amount will be retained by the state to reimburse the AFDC/Families First cash payments that the AG has received in the past.

Determine if the absent parent owes the AG any child support arrears by reviewing the CSFS (Case Financial Summary) screen on TCSES. This is explained more fully in the Procedures section of this chapter.

Refer the AG to the local child support office or the Child Support Customer Service unit for any questions they have about the amount of assigned or unassigned.

DOCUMENTATION:

Document CLRC that

- child support pass-through payment eligibility was explained to the applicant/recipient;
- the AG was informed that they might be able to receive Families First and child support pass-through payments, if eligible. (This is especially important if the caretaker requests that the AG be closed because she/he is receiving child support); and
- the "You may get your child support while you are on Families First!" handout was given to the applicant/recipient. For ease of documentation in CLRC, this can be referred to as the "Child Support Handout."

PROCEDURES:

When the absent parent makes a child support payment for a child who is receiving Families First cash payments, either to the court or directly to the A/R, this money must be sent to the Department of Human Services.

- Enter the appropriate amount of child support paid on AEFMI in the Families First fields with an open End Date.

  - If the absent parent owes arrears to the caretaker, enter the full amount of child support that the absent parent is paying on AEFMI.
  - If the absent parent does not owe arrears to the caretaker but does owe arrears to the state, enter only the amount of child support being paid up to the current court ordered amount on AEFMI since any excess will be retained to reimburse the state.
  - If the absent parent does not owe arrears to the state, enter the full amount of child support that the absent parent is paying on AEFMI.

If the absent parent is paying fluctuation amounts of child support, determine the representative income in the same manner as other fluctuating income is determined. However, the amount used should meet the criteria describe above.

Determine if the absent parent owes the assistance group any child support arrears by reviewing the CSFS (Case Financial Summary) screen on TCSES. If there is an Unassigned Arrears (arrears owed to the caretaker) amount on the screen, the caretaker will receive the current child support and the arrears payment until the Unassigned Arrears have been paid in full. If there are only Assigned Arrears (arrears owed to the state), then any payments that exceed the current court ordered amount will be retained by the state until the Assigned Arrears have been reimbursed.

Note: The one exception to the above distribution rule is child support arrears paid through IRS interception. All IRS interception payments are applied first to Assigned Arrears (owed to the state). However, IRS interception payments are not entered on AEFMI since they are not ongoing child support payments.

- Ensure that the appropriate Budget Effective Date is entered on AEIAC to ensure that the income is budgeted properly.

  - If the AG is receiving child support at the time of application and the AG is approved **before** cut-off, the Budget Effective Date will be the first day of the month following the month of approval.
  - If the AG is receiving child support at the time of application and the AG is approved **after** cut-off, the Budget Effective Date will be first day of the second month following the month of approval.
  - If the AG is **not** receiving child support at the time of application, the Budget Effective Date will be the date of application.
  - If adding an absent parent to an open AG, use the same Budget Effective Date used for the other absent parents for that AG.

- Upon receipt, the Tennessee Child Support Enforcement System, TCSES, processes the child support payment for distribution. TCSES will determine if the AG is eligible for a child support pass-through payment based on the AG's unmet need which has been transmitted to TCSES by ACCENT.

- If the AG is eligible, TCSES will issue the child support pass-through payment. This is reported to ACCENT after the end of the month in which the child support pass-through payment was issued. Child support pass-through payments are posted on ACCENT in two different ways depending on the month in which the payment was issued. Child support pass-through payments issued prior to July 1999 will appear on IQCH with reason code 096. Child support pass-through payments issued July 1999 onward will appear on AEFMI.

- If the child support payment was collected for a month prior to February 1998 but was not issued as bonus/supplement, TCSES will issue a bonus payment up to the amount of the current court ordered amount or $50, whichever is less. If the child support payment was more than the bonus amount paid, TCSES will notify the Supplemental Unit, a special unit in the State Office, about the collection. The Supplemental Unit will determine if the AG is eligible for a supplemental payment. If so, the unit will issue a manual supplemental check through ACCENT. (Note: These supplemental payments are not issued through EBT.) These payments appear on IQCH as bonus (code 106) and manual supplement (code 102) payments.

- The recipient may contact the county about a supplemental payment (102) that has not been issued from child support payments for a month prior to February 1998. In those instances review the case to determine if the AG is eligible for a supplemental payment (has an unmet need for the month in question that is greater than "0"). If so, contact the Supplemental Unit in the State Office to determine why a check was not issued.

  Note: If the grant is less than the maximum grant for the AG size, there is no unmet need and the AG is not due a supplemental payment.

- The recipient may also contact the county about a supplemental check that was issued from child support payments for a month prior to February 1998 that the recipient has not received. In those instances, request a replacement of that check in accordance with the procedures outlined in the Continuing Responsibilities Chapter of the Families First Handbook.

- The recipient may contact the county about a child support pass-through payment or bonus payment that was either not issued or that the recipient did not receive. In those instances, refer the recipient to the Child Support Customer Service unit. Note: If the child support is voluntary (there is no court order), it must still be sent in to the state. However, this money will not be issued until Child Support enters a "voluntary court order" on TCSES.

NOTE: All bonus payments and child support pass-through payments that appear on IQCH show a Warrant Date. This date reflects the TCSES/ACCENT interface date, not the actual issuance date of the check. In addition, all bonus and child support pass-through payments on IQCH show an "RM" Disposition Status, regardless of the actual status of the check. TCSES shows the actual issuance date and status for these checks.

TIME LIMITS

POLICY STATEMENT:

Families First assistance groups have eligibility and grant payment time limits. A time limit is a range of months in which an assistance group will work to achieve self-sufficiency.

- An assistance group has an 18-month time limit for a period of eligibility and a 60-month lifetime limit. There are exceptions to this time limit for certain assistance groups. These exceptions can include exemptions, interruptions, and extensions.

- The 18 and 60-month time limits are maximum time limits. An assistance group may achieve self-sufficiency or become ineligible for other reasons earlier than the maximum time limits.

- Time limit months accumulated in other states will not count toward the 18 and 60-month time limit in Tennessee. In addition, we will only give **COUNTABLE** months accumulated toward the lifetime limit when responding to out-of-state inquiries regarding the number of months of assistance our former customers have received in Tennessee.

- An assistance group that has two eligible adults will have the time limit determined by the caretaker of the assistance group. If the caretaker is exempt, the assistance group will be exempt from time limits. If the caretaker is not exempt, the assistance group will be subject to time limits.

  EXCEPTION: If the AG has two adults and either adult tests below 9.0 in reading or math on the literacy test (e.g., TABE) and is participating in 20 hours of ABE and making satisfactory progress, the AG is exempt from time limits.

- At the point the adult reaches 9.0 on the literacy test (e.g., TABE) or is not enrolled 20 hours per week and making satisfactory progress, the assistance group loses its exemption. The time limit clock will begin the first month following the decision that the recipient no longer meets the exemption status.

- Time limits that apply to an assistance group apply to all members of the assistance group. Therefore, when an assistance group reaches the end of the 18 or 60-month time limits, the entire assistance group is ineligible because of time limits.

  EXCEPTIONS: Children do not have running clocks. A child who was in an assistance group which reached its time limits, can later apply for his/her own assistance group as an adult.

  A child who is living with a particular caretaker (mother, for instance), and loses eligibility due to time limits, may be eligible in the future if they live in the home of

a different caretaker (grandmother, for instance), whose time limits have not expired.

- Time limits apply **to caretakers who are ineligible aliens** in the same manner as they apply to other caretakers. (They are exempt only if they meet the usual exemption criteria.) **Caretakers who are illegal aliens** are exempt from time limits.

- During a period of eligibility, the assistance group will have an individualized PRP defining the personal responsibilities, including work and work-related activities, in which the assistance group will participate.

- During a period of eligibility, the Department of Human Services will also provide specified supportive services.

- If an individual chooses to participate while exempt from a work component (for example, a mother who resumes her PRP component activity before her 16-week childbirth exemption has expired), the volunteered months do not count toward the time limit.

- If a case is being closed for reaching the 18-month time limit and for a voluntary quit and/or subsequent work sanction, the three months "off" for time limits and the sanction will run simultaneously. Both reason codes should be used on AEWAA.

- If a case is ineligible but, due to a client error (either intentional or unintentional), the AG receives benefits in error, the ineligible months would be counted in the accumulation of the 18 and 60 months unless the AG was otherwise exempt or there should have been an interruption (e.g., child under four months, incapacity, lack of activity or support services). This is true even when a claim is being recouped or paid. If the overpayment causing ineligibility was an agency error, the months would not count. The time counter for non-countable months due to agency error should be changed at the time a claim is pended.

- When an individual reports a change or an activity ends requiring a renegotiation of the PRP, begin the renegotiation process within two weeks (14 calendar days) of the reported change. If the PRP process is not begun within that time, interrupt the time count for the month in which the renegotiation should have begun. The time count will resume the month after the month the PRP is renegotiated. If the activity involves a broker, the total time for DHS to initiate the change may be as short as 11 days. This is because the broker must report within three days, leaving 11 days of the two-week period for the caseworker to see the individual and renegotiate the PRP.

- Individuals participating in a self-initiated activity or post-secondary education are solely responsible for reporting changes. If they do not report changes that would affect the number of hours in their activity, those non-reported months **will count** toward the 18/60-month time limit.

TIME LIMITS

- If the individual is participating in an activity in which a broker is involved (AE, for example), and a change occurs which leaves the participant with fewer activity hours that the broker does not report timely, those non-reported months will not count.

- An AG's time limit count will be affected by the county's timely action on a potential sanction. The client contact/attempt and the conciliation notice must be made/sent within three (3) calendar days of learning of the non-compliance.

  NOTE: The county must make every effort to attempt contact and send the conciliation within three (3) calendar days. However, the time count will not be interrupted as long as the client attempt and the conciliation notice are made/sent within 14 calendar days.
  The conciliation notice allows an individual 10 days to respond and establish good cause or agree to comply with the PRP. If good cause/compliance is not established during the conciliation period, the caseworker will close the case within 14-calendar days following the expiration of the 10-day conciliation period.
  If any of the above steps are not completed timely, the time count will be interrupted.
  The caseworker must go back and restart the process at the step following the last completed step. The failure to act timely does not negate the sanction itself (see NOTE on the following page). The first interrupted (non-countable month) will be the month in which a step in the process was not taken timely. The interruption will remain in place until:

- a client contact/attempt is made and/or a conciliation notice is sent; or

- the client participates in a conciliation conference or is exempted or interrupted from the work requirement); or

- a new PRP is signed (and the two-week compliance period begun). A new PRP is not necessary unless the individual is going to comply in a different activity from the one in which he/she was non-compliant; or

- client contact/attempt is made to begin the closure process.

  The time count will resume the month after the month in which one of these actions occurs.

  EXAMPLE: The provider notifies the caseworker 10-6 that the client has been non-compliant. The client contact/attempt is made on 10-7. The caseworker mails a conciliation notice on 10-10 for non-compliance with job search. The 10-day conciliation period expires 10-20. The 14th calendar day following expiration of the conciliation period is 11-3. On 11-18, the caseworker realizes that the client never contacted her and that the closure was not authorized timely. Therefore, the caseworker will restart the sanction process by authorizing the case closure. The caseworker authorizes case closure on 11-18. The end of the two-week conciliation period fell in October. Therefore, October is an interrupted (non-countable) month.

TIME LIMITS

The caseworker restarted the process in November by authorizing the closure. The time limits are also interrupted for November (a non-countable month). December is a countable month because it is the month after the month the closure was authorized. EXAMPLE: A conciliation notice is mailed 10-15 for non-compliance with job search. The 10-day conciliation period expires 10-27 (the actual 10th day is 10-25, a Saturday). The 14th day after the conciliation expiration is 11-10. On 11-10, the caseworker resumes the sanction process. The participant has not responded and the closure process is begun on 11-10. The caseworker is acting in a timely manner because fourteen calendar days have not passed since the 10-day conciliation notice expired.

NOTE: If any steps have been omitted during the conciliation/closure process, the sanction will be invalid and the process must begin again with a client contact/attempt, a second AEONC, etc.

- If the case/cat/seq changes, the current and lifetime counters should not be changed when the FF
benefits are for the same AG.

- In those cases where closure will not occur until the month following the closure month (due to ACCENT cut-off and the 10-day notice requirement), treat the final month in the following ways:

  - if an AG is exempt from time limits at the time of case closure, they will continue to be exempt during the final month of FF participation.

  EXAMPLE: An individual is exempt from time limits because she/he is participating in ABE. The individual fails to continue participation, and the closure is authorized on 11/23. The case cannot be closed effective 11/30 due to 10-day notice requirements. The case will close 12/31. December is an exempt month and not countable.

  - if the AG was not exempt from time limits at the time of case closure, they will continue to be non-exempt during the final month of FF participation (unless reported circumstances occur that change their exemption status).

  EXAMPLE: An individual meets no exemption criteria and is working 40 hours a week. The closure is authorized on 11/23 due to increased income. The case cannot be closed effective 11/30 due to 10-day notice requirements. The case will close 12/31. December is a countable month.

  EXAMPLE: An individual meets no exemption criteria and is working 40 hours a week. The closure is authorized on 11/23 due to increased income. The case cannot be closed effective 11/30 due to 10-day notice requirements. The case will close on 12/31. However, on 12/1, the caretaker has a baby and becomes exempt. December will be an exempt month and not countable.

TIME LIMITS

- Non-exempt individuals generally must participate in a work component for an average of 40 hours weekly. If an individual is only working part-time *(25 hours weekly, for example),* another 15 hours are needed to meet the 40-hour requirement. If the Department does not meet its obligation by providing the other component within two weeks, the clock will be stopped for those months in which the employment is the only component. However, some individuals may be employed full-time *(or part-time*), but not always work a full 40-hour week *(or their agreed upon part-time hours)* for various reasons. In these full-time *(or part-time)* employment instances, the clock will continue to run.

- If an individual is in a full-time component that is different from the component on his/her PRP, the months he/she participates in 40 hours of approved activities **will count** toward the 18/60-month time limit.

  EXAMPLE: An individual has 20 hours of ECS and 20 hours of Work Prep on her PRP. The individual finds a full-time job and begins working but does not renegotiate the PRP for three months. These three months will be countable months because the individual was employed full-time. (Employment is an approved activity.)
- A one-month interruption for a FSC Assessment is only allowed once in a 12-month period. (See the FSC chapter for further information.)

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TIME LIMITS

- FSC will conduct a three-month review for FSC participants with a modified work plan that includes more than 10 hours of FSC. (See the FSC chapter for further information.)

- A two-month (the month of referral and the following month) or 60-day interruption, whichever is longer, for a VR Assessment is only allowed once in a 12-month period. (See the VR chapter for further information.)

When does the time limit count begin?

- Time limits are applicable to assistance groups who make initial application or have a reapplication (review) on or after 9/1/96. At the time of the application or reapplication, the caseworker will present the Personal Responsibility Plan to the applicant/recipient.

- For AGs being approved for the first time, the count of months in the time limit begins the **first <u>full month</u>** (pro-rated months are not countable) **of eligibility after the caseworker:**

  - **presents a Personal Responsibility Plan to the assistance group; <u>and</u>**

  - **the caretaker of the assistance group signs the plan; <u>and if</u>**

  - **the AG is not exempt or interrupted from the time count;**

  - **the mandatory AG adults are enrolled in an activity; and**

  - **were enrolled in the activity within 14 days of case approval.**

    EXAMPLE: An assistance group applies on 9/23/98. The assistance group is interviewed on 9/25/98. During the interview, a PRP is presented to the assistance group and the caretaker signs the plan. On 11/1/98, the assistance group is authorized as an eligible Families First group and put into a work component. The assistance group is not exempt from time limits. The count of the 18 and 60 months will begin 11/1/98, as 11/98 is the first full month of eligibility. October would not have been the first countable month as the A/R was not yet in a work component.

- If a case with a PRP closes and reopens at a later date, the time count will resume with the first month of eligibility if PRP activities and necessary support services are in place.

- A renegotiated PRP date does not affect the time limit count.

TIME LIMITS

- An explanation of both the 18 and 60-month time limits must be presented to all applicants and reviewed with all participants. Remind participants of time limits, and discuss the amount of time left in their current eligibility period and their lifetime limit each time Families First is addressed.

EXCEPTIONS:

Time limits will not apply to assistance groups that meet certain criteria. In some instances, the exception to the time limit is permanent, in others it is temporary. The terms "exemption" and "interruption" refer to time periods when time limits are not applicable to the AG.

An exemption is typically used when the exception to time limits policy is of a more permanent nature, such as age. An interruption is typically provided when the circumstance is short term. In either case, the time limits are not applicable as long as the exemption or interruption is in force. It is critical to code the exemption or interruption in ACCENT correctly since the grant amount depends on proper coding.

NOTE: If an exemption exists for any part of a month, the whole month is excluded from the time count.

An assistance group may have an exemption from the 18 and 60-month count, when:

- the caretaker is age 60 or greater.
- the caretaker is disabled. A caretaker is considered disabled when the individual:
  - receives SSI benefits under Title XVI of the Social Security Act or disability or blindness payments under Title I, II, X, XIV or XVI of the Social Security Act.
  - receives interim or presumptive assistance payments pending receipt of SSI.
  - receives federally or state administered supplemental benefits under section 212 (a) of Public Law 93-66.
  - receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221 (I) of the Social Security Act.
  - is a veteran receiving VA benefits for a service or non-service connected disability rated or paid as total disability, or is considered by VA standards to be in need of regular aid and attendance, or is considered permanently house-bound.

- is a disabled surviving spouse of a veteran and is considered by VA standards to be in need of regular aid and attendance or is permanently housebound.

- is a surviving spouse of a veteran and entitled to VA compensation for a service connected death or VA pension benefits for a non-service connected death and has a disability considered permanent under the Social Security Act. Entitled means the individual is receiving or has been approved for the benefits.

- receives an annuity payment under section 2 (a)(l)(iv) of the Railroad Retirement Act of 1984 and is determined to be eligible to receive Medicare by the Railroad Retirement Board.

- receives an annuity payment under section 2 (a)(l)(v) of the Railroad Retirement Act of 1984 and is determined to be disabled based on the criteria used under Title XVI of the Social Security Act (SSI).

- receives medical assistance based on disability under Title XIX (Medicaid).

- is determined too mentally or physically impaired to work by Vocational Rehabilitation Services.

- the caretaker is providing at-home care for a relative living in the home with the caretaker and the relative requires full-time care as determined by a physician or other health care professional. NOTE: Full-time care is defined as round-the-clock care. Some of this care may be provided by home health care providers or other individuals to give the caretaker assistance/rest, but these services do not negate the exemption. Full time care may be permanent or temporary in nature. Also the individual needing care may or may not be "disabled" as defined above.

  EXAMPLE: A SSI child needing full-time care is enrolled in a special school that meets his needs during the school year. The caretaker would not be exempt during this time. However, in the summer, there is no day care available for the child's special needs. During the summer, the caretaker would be exempt.

  EXAMPLE: The caretaker's child will be in a body cast for a number of months and will require full-time care. The caretaker will be exempt until the child has recovered. This child does not received SSI or SS disability. The injury is temporary.

- the assistance group does not contain an eligible adult for a reason other than an imposed sanction or disqualification.

- the assistance group has an eligible adult who functions below 9.0 grade level in reading or math as determined by the Department of Education; and

- is enrolled at least 20 hours per week in ABE; and

- is making satisfactory progress as determined by the ABE teacher and DHS.

- the caretaker is a minor parent. The time limits will not begin to count for an assistance group when a minor parent is the caretaker until:

  - the caretaker is 18 years of age and has graduated from high school;

  - or the class of which he/she is a member when age 18 is attained graduates from high school.

    EXAMPLE: a minor parent is a sophomore at the time of her 18th birthday and due to graduate in May 2001. She will be exempt from time limits until her class graduates as long as she stays in school. If she graduates in May, her clock will start June 2001. If she drops out, time limits will begin at the time of her 18th birthday or at the time the dropout occurs, whichever is later.

- the caretaker is an illegal alien.

An assistance group may have an <u>interruption</u> in the 18 and 60-month count when:

- the Department of Human Services cannot provide the appropriate education or job training services prescribed in the recipient's Personal Responsibility Plan. If the participant has to wait for an activity for more than two weeks, the AG's time count will be interrupted. The count will not begin again until the month following the month the activity becomes available.

- the Department of Human Services cannot provide essential child care or transportation assistance necessary to comply with the recipient's Personal Responsibility Plan. If the participant has to wait for one of these supportive services for more than two weeks, the AG's time count will be interrupted. The count will not begin again until the month following the month the supportive services become available.

  NOTE: Dental and optical services should be provided when needed. However, it may not be necessary to interrupt the time count while waiting on these services if appropriate activities can be provided until the optical/dental problems are resolved. The severity of the problem will determine whether these services should be considered "essential" to participation.

- A two-parent AG has a newborn that is less than 16 weeks of age. If the newborn leaves the home, the interruption ends. If the child is stillborn, the time count will not be interrupted for this reason. However, this AG may meet another interruption criteria. If the AG fails to report the birth of the newborn, the time clock is only interrupted for the balance of the 16 weeks (if any remains) from the time the birth is reported.

- a single parent AG has a child under the age of 1 year. If the child leaves the home, the interruption ends. If the child is stillborn, the time count will not be interrupted for this reason. However, this AG may meet another interruption criteria. If the AG fails to report the birth of the newborn, the time clock is only interrupted for the balance of the year (if any remains) from the time the birth is reported.

- the caretaker has a temporary incapacity, which will prevent participation in a work plan**.** A claim of incapacity should always be explored. If the FSI cannot determine temporary incapacity at the county level, the case should be sent to the MEU for evaluation. (See the Incapacity Determination section in the Work Requirements and Work Components chapter.) The time limits will also be interrupted during the time the individual has sought an incapacity determination and is waiting for a decision.

- the caretaker is participating in an approved drug and/or alcohol treatment program. Time limits do not apply during the approved time frames for treatment. (See the Work Requirements and Work Components chapter.)

- the caretaker relative is a victim of domestic violence who has been, or is currently, involved in an abusive intimate relationship. The victim may be seeking shelter/safety (in a domestic violence shelter, or other "safe place") from the abuser who may or may not live in the home. **Time limits are interrupted for one month** at the time the domestic violence situation is known, and the customer requests an interruption due to the situation.

  Interruptions will be determined on a case-by-case basis. The caseworker will pursue an interruption when:

  - the participant self-discloses;
  - the caseworker suspects domestic violence; or
  - a third party, i.e., a service provider, reports a domestic violence situation.

  If, after a discussion about the potential interruption, the participant requests an interruption, the caseworker will begin the initial one-month interruption.

  The caseworker may also be alerted by a Family Services Counselor of the need for an interruption in the participant's time limits. In these situations, assessment has already begun, and the caseworker should begin the interruption.

  Time limits for those **individuals who reside in a domestic violence shelter** are interrupted for the duration of their stay in the shelter.

  Time limits for those **individuals who are <u>not</u> residing in a domestic violence shelter** are interrupted for the initial one-month. If a further interruption is needed,

the caseworker should encourage and advise the participant to see the Family Services Counselor for assessment of the domestic violence situation. Assessment by an individual trained in domestic violence counseling (a Family Services Counselor) is mandatory before the time limit interruption can be extended beyond the initial one-month interruption unless the individual is actively fleeing from a threat of immediate harm. Time limits may be interrupted for up to six months at a time thereafter, for as long as necessary, in cases where compliance with work requirements would:

- make it more difficult for such individuals to escape domestic violence;
- place unfair expectations on those who are or have been victimized by such violence;
- endanger the health and well-being of the individual and/or the child(ren).

This exemption applies to individuals who:

- have chosen to stay in the abusive relationship while participating in counseling;
- have filed legal charges, such as assault charges or an order of protection;
- participate in domestic violence shelter activities, such as support groups.

The individual who is not in a domestic violence shelter must provide the Family Services Counselor with existing evidence that will help verify that she/he is in danger. The evidence can include, but is not limited to:

- the caretaker's statement. This can be sufficient verification. However, if other items, such as the ones listed below exist, they should be used to help the counselor with the assessment.
- an order of protection;
- court, medical, criminal, child protective services, social services, psychological or law enforcement records that show the parent/child(ren) have been subjected to abuse and may be in current danger;
- notarized statements from individuals other than the caretaker who have knowledge of the domestic violence situation. The statements should include what the individual knows about the situation and how she/he is in a position to know about the circumstances.

- The caretaker is participating in FSC or VR and has a modified PRP that includes a total of 20 hours or less of activities.

- The caretaker is participating in FSC or VR and the FSC/VR counselor recommends an interruption.

- The caretaker is participating in a Limited Work Plan that, due to his/her impairment, limits work plan activities to 20 hours or less.

Extension in the 18- and 60-Month Count

There are two types of extensions to the time limits: county economic hardship and good cause. Months of assistance under an extension are countable months towards the 60-month lifetime limit.

> If a participant has reached his/her 18th month or is currently in an extension and has an exemption or interruption to the time limit, the time clock will stop. At the time the exemption or interruption is over, the case must again be reviewed for extension criteria.

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TIME LIMITS

In order for the AG to remain eligible the month after the exemption/interruption ends, the AG must be eligible for one of the two extension reasons. If the AG is eligible for an extension, the time clock resumes for that period of eligibility.

EXAMPLE: An AG has reached the 18-month time limit and is eligible for a good cause extension. During month 20, the AG's time count is interrupted for a temporary incapacity. This stops her clock at month 19. The incapacity lasts four months. During the month when the incapacity ended, the caseworker finds that the AG meets good cause extension criteria. The month following the end of the interruption becomes month 20.

If the good cause ceases to exist at a later date, the case is closed for time limits and the AG enters the three-month period of ineligibility.

- An assistance group that resides in an economic hardship county may have an extension to the 18 and 60-month count. An economic hardship county has an unadjusted unemployment rate, as defined by the Department of Labor and Workforce Development, that is twice the unadjusted unemployment rate for the state as a whole. The assistance group will be eligible for this extension on a month-by-month basis, up to six months, as long as the assistance group is in compliance with their Personal Responsibility Plan. The economic hardship county extension applies to AGs at *both* the 18 and 60-month time limit.

- An assistance group that has met the good cause extension criteria may have the eligibility period extended at the end of the 18 or 60-month count or may return to the program after the case has closed following the 60-month limit. (See the Good Cause section of this chapter.)

- An assistance group may have their eligibility period extended after the 18 or 60-month limit when the case is in appeal status, regardless of the reason for the appeal, if the A/R wishes to continue benefits while awaiting the appeal decision.

Time limit counts for assistance groups with two adults

- Because the caretaker's status (with the exception of the literacy level) determines the time limit applicability for the assistance group, the caretaker in a **two-adult** assistance group should not be changed as long as the caretaker remains a part of the assistance group. If the caretaker is exempt, the AG is exempt from time limits. If the caretaker is not exempt, the AG is not exempt.

- The designation of the caretaker in a two-adult AG is the decision of the AG adults.

- The only time that **either** adult will exempt the assistance group from time limits is when either adult has a proven literacy level below 9.0 and is attending ABE and making satisfactory progress.

When an adult who is not exempt from time limits may have more than 60 months of eligibility

- It is appropriate to start a new time limit for the AG if the caretaker is requesting assistance for children who were not or should not have been included in an assistance group that has used all of their 60 months.

- An adult, who previously received assistance for one group of children but now receives assistance for a different group of children, may have a new 18 to 60-month time limit.

  EXAMPLE: A mother receives assistance for her two children. These children reach age 18 and she is no longer eligible for assistance. She used all of her 60 months during the receipt of assistance for her own children. She is currently rearing a grandchild whose mother is not in the home. If the grandmother is eligible to receive assistance for her grandchild, she will have the choice of being included or excluded from the assistance group. If she chooses to be included, a new time limit count, unless exempt, will start for the new assistance group.

- An adult who has received assistance in one assistance group and leaves that assistance group and becomes a second adult in another assistance group will become subject to the time limit requirements of the caretaker in that assistance group.

  EXAMPLE: A man receives assistance for a child and that child becomes 18. The AG is no longer eligible. The man has received assistance with this child for a total of 36 months after signing a Personal Responsibility Plan. He is the father of another child whose mother is receiving assistance for that child. The man does not marry the mother but joins the assistance group and the assistance group is eligible as an unemployed parent group. The mother has only received assistance for 12 months. Her time limit count, as the caretaker, will continue for the assistance group without regard to the months used by the father in the other assistance group.

When a child may have more than 60 months of eligibility

- A child who was in an assistance group that reached its time limits can later apply for their own assistance group as an adult.

- A child who is living with a particular caretaker (mother, for instance), and loses eligibility due to time limits, may be eligible in the future if they live in the home of a different caretaker (grandmother, for instance), whose time limits have not expired.

GOOD CAUSE EXTENSION FOR TIME LIMITS:

Good cause must be evaluated when:

- the assistance group is approaching the 18 or 60-month time limit.

Good cause is granted when reaching the 18 or 60-month time limit if the AG:

- would continue to receive a grant if it were not for the time limits; and

- is in compliance with the Personal Responsibility Plan **work requirement**; and

  NOTE: The following actions are not considered non-compliance with a PRP work requirement:

  - a Voluntary Quit that occurred in the past (prior to the time the good cause extension is being determined);
  - failure to keep an AG child in school;
  - failure to immunize an AG child; and
  - failure to complete an AG child's health check.

- has been in substantial compliance (as defined below) throughout the most recent 18 months of eligibility; and

- has not voluntarily quit a job or refused employment without good cause during the time the caseworker is exploring if time limits good cause exists; and

- has gross income that is **less than** the appropriate income standard for its countable months.

  - if the family cap is applicable to the AG, use the maximum standard grant permitted based on Family Cap rules.

  - if marriage during receipt is applicable to the AG, the maximum standard grant amount would be based on whether or not the spouse is included**.**

  - in determining income on AGs receiving child support, count the amount of child support the family would receive after assistance stops, not the amount of the pass-through payment.

  - in determining income for AGs receiving Foster Care payments, Adoption Assistance payments, or Guardianship payments, disregard the income. The standard grant amount would depend on whether the child/children are included in the grant.

TIME LIMITS

Compliance with the PRP at the end of the time limit exists when:

- an assistance group is meeting the requirements of its plan and sanctions are not being applied.

Substantial compliance with the plan exists when:

- the assistance group has not had more than one three-month sanction for non-compliance with a **work requirement**; and

- the reason for the sanction has been corrected (two-week compliance has been completed OR the individual meets exemption criteria); and

- the assistance group has continued in compliance throughout the evaluation of the good cause extension.

Time Limit Good Cause Process:

- Good Cause will be evaluated when an assistance group reaches the 17th month in an 18-month period of eligibility or the 59th month in the 60-month lifetime limit and, therefore, is subject to termination at the end of the next month. During the evaluation, the caseworker will review the individual circumstances of the assistance group to determine if good cause exists.

- If good cause does not exist, the case is closed and TCC and TM are opened. If the AG has not cooperated with Child Support, the AG is not eligible for TCC and the Caretaker is not eligible for TM.

- If it is determined that good cause does exist (and all other eligibility requirements are met), the assistance group will continue benefits.

- Review the PRP to determine if there are changes that need to be made to the plan that will assist the assistance group in finding employment. Also determine if there are other problems which prevented the assistance group from achieving their goal.

- If appropriate, negotiate a new PRP.

- The assistance group will continue eligibility until the next redetermination review (which must be in at least six months, but can be sooner) provided the assistance group continues in compliance with the PRP and is otherwise eligible.
  Non-compliance with health checks, immunizations or school attendance will reduce the grant amount but will not cause ineligibility.

- At the time of the next redetermination, review the AG's circumstances to determine if good cause to continue their extension of time limits still exists**. Their extension can last as long as the good cause situation exists.**

- **The District Program Supervisor or Family Assistance District Director must approve good cause extensions to the 18 or 60 months eligibility period.**

  EXAMPLE: An assistance group is approaching the 18-month time limit. The assistance group is currently in compliance with their PRP, but they had a sanction six months ago for failure to cooperate with child support. The sanction was corrected two months after failure to comply. During the 17th month of eligibility the caseworker reviews the circumstances of the assistance group and consults with the caretaker regarding the inability to achieve their goal of self-sufficiency. The caretaker states that she has been doing job search for the last month and feels that she is not making progress because she has no work experience. The caseworker and the customer renegotiate the PRP to include some unpaid work experience. With the approval of the District Program Supervisor, the caseworker extends the period of eligibility until the next redetermination, which is 3 months away. At the time of the redetermination, the good cause extension will be reviewed again.

VERIFICATIONS:

When considering time limits, verifications must be provided:

- to establish an exemption such as disability or incapacity. Proof of the individual's disability or incapacity must be provided by the applicant/recipient unless the information is available to the caseworker through an alternative source such as SDX. If a caretaker claims incapacity, the AG's time count will be interrupted while the incapacity is explored.

- to establish an exemption for caring for a relative full-time in the home. The proof must be from a qualified physician or other health care professional and must indicate that full-time in-home care is required. Determine if there are other family members in the home who provide or could provide the care.

- to establish an exemption due to age. The caretaker must have proof that he/she is age 60 or older. Verification can be taken from any document that validates the age or provides supporting evidence that the individual is at least age 60.

- to establish an exemption due to literacy level. The individual must be tested by Adult Education (AE) and the test scores must be provided to the caseworker. The individual has the responsibility to take the test and AE will provide the proof of the

literacy level. In addition, AE will provide proof that the individual is satisfactorily participating in AE for 20 hours per week.

- to establish an interruption in time limits due to an illness. Proof of illness should be from a medical source and should provide the cause and duration of the illness. The illness must also last for more than a two-week period and actually prevent the individual from participating.

- to establish an interruption due to a child under 16 weeks, the parent will present evidence of the birth of the newborn to comply with assistance group policy. This will also suffice as proof for interruption in time limits. The time limit interruption for a newborn for a two-parent AG is only applicable until the newborn is 16 weeks old.

- to establish an interruption due to a child under the age of 1, the parent will present evidence of the child's age to comply with assistance group policy. This will also suffice as proof for interruption in time limits. The time limit interruption for a child under the age of 1year for a single parent AG is only applicable until the child reaches 1 year of age.

- to establish an interruption in time limits due to a failure to provide a work or training activity or supportive service. Examine the claim or finding that the service will not or cannot be provided within two weeks. It is the responsibility of DHS to investigate the lack of service.

- to establish an extension due to good cause. At the review of good cause at the end of the 17th or 59th month of the 18- or 60-month time limit, the case will contain most of the information needed to make the determination. If the recipient disagrees with the findings of the caseworker or has additional information to provide, the recipient will be given an opportunity to present proof to substantiate his or her position.

DOCUMENTATION

The ACCENT case file must contain:

- an initial Personal Responsibility Plan date since the plan date determines the beginning of the first 18-month count and the 60-month count. It must also include all subsequent PRP dates as they are renegotiated.

- the reasons for any sanction or termination of benefits. The factual basis for the adverse action decision must be documented as well as the factual basis for the determination that good cause did not exist. The record should clearly reflect the non-compliance, the conciliation attempts, the review for good cause, and the final action taken. This should be stated on CLRC in narrative form. In addition, the final status for each work component change should be noted on the AEIPA screen of ACCENT.

- the reasons for any determination regarding time limits (exemptions, interruptions, closures, extensions). The factual basis for any determination must be documented as part of the ACCENT file by noting the appropriate code that specifies the reason for

the action (exemption, interruption or extension). If the AG is not entitled to an exemption, interruption, or extension, the specific factual reasons for that determination must be recorded in the CLRC.

- the supporting information to substantiate granting the start of a new time limit when receiving assistance for a different group of children.

- documentation of the findings of the 16-month time count review. This review is required of all cases approaching the 18-month time limit and should include an assessment of each month of assistance for that period of eligibility. The reasons the months were countable or not countable must be recorded on CLRC. CLRC must also have documentation that this review of months was completed prior to a case closure for time limits.

  NOTE: A time limit review needs to be completed prior to any time limit closure. For example, if an extended time limit case is closed at 24 months, the case requires a time limit review.

- documentation of the findings of the 59-month time count review. This review is required of all cases approaching the 60-month lifetime limit and should include an assessment for the most recent period of eligibility.

- data documentation on work activities – these activities must be documented on JTPA and AEIPA for each countable month before case closure.

- an updated AEIPA, as it is the Department's copy of the PRP.

- an updated time count on SFFF. This screen should be updated immediately when a month is not countable.

PROCEDURES:

- Obtain sufficient information during the eligibility and Personal Responsibility Plan interview to establish the time limit exemption status of the assistance group.

TIME LIMITS

- Explain both the 18-month and 60-month lifetime time limits to the applicant/recipient at each application/review. Remind the AG of the number of countable months left in their current 18-month period of eligibility and in their lifetime limit.

- Evaluate reasons for extensions or interruptions; continue eligibility or terminate benefits as appropriate; and, if the AG closes, evaluate for TCC/TM.

- When the Department of Human Services cannot provide an educational, training, or supportive service within two weeks, stop the time limit count and try to obtain the services as soon as possible to avoid delays in accomplishing the Personal Responsibility Plan.

- Review the time limit count at the 16th, 54th and 59th month. If the case is to be closed for another reason in addition to the 18 or 60-month time limit, use both reason codes.

- Evaluate the time count prior to receipt of assistance to determine its impact, if any, on the current request for assistance. When a caretaker requests assistance for a set of children that is different from the AG children for whom the caretaker has previously received assistance, determine if it is appropriate to start a new count of time limits for the AG.

  NOTE: The **general rule about time counters** is that the "current counter" reflects the current period of eligibility. As long as the case stays open, months will accumulate in the current period of eligibility. When the AG reaches 18 or more countable months in a period of eligibility **and** the AG is closed, the counter is reset. If the AG reapplies, a new period of eligibility will start for another 18 months.

TIME LIMITS
AEPRP TIME LIMITS REASONS/CODES DESK GUIDE

TIME LIMITS EXMT (Exempt) REASONS	CODES
Child only AG	A
Caretakers age 60 and older	B
Disabled caretaker	C
Caretaker cares for disabled in-home relative	D
Caretaker's functional literacy below 9.0	E
Second parent's functional literacy below 9.0	F
Caretaker is 18 – has not graduated from high school	G
Caretaker is < age 18	H
Accepted for Vocational Rehab Participation ***(not a selection option)***	J

TIME LIMIT EXTN (Extension) REASONS	CODES
Good cause exists after 18 months	A
Appeal filed	B
GC FOR 1st 6 MTH EXT (LIFETIME)	C
GC FOR 2nd 6 MTH EXT (LIFETIME)	D
GC AFTER 2nd 6 MTH EXT (LIFETIME)	E

TIME LIMIT INTR (interruption) REASONS	CODES
Caring for infant less than 16 weeks	A
Caretaker temporarily incapacitated	B
Child care not available	C
Transportation not available	D
Education services not available	E
Training services not available	F
DHS failed to provide service	G
Caretaker has verified/admitted drug/alcohol addiction or mental health diagnosis – has agreed to treatment/counseling	H
Caretaker is a victim of domestic violence and is seeking shelter/safety	I
Family Services initial assessment interrupt for one month	J
Caretaker in Family Services – FSC recommended interruption	K
Caretaker is an undocumented alien	L
STEPS procedures were not followed at month 16 or greater (valid only prior to July 1, 2004)	M
STEPS procedures were not followed at month 54 or greater (valid only prior to August 1, 2006)	N
VR initial assessment interrupt for 2 mths/60 days	O
Caretaker in VR – VR recommended interruption	P
Caring for infant less than 1 year	Q
Limited PRP – 20 hours or less	R

TIME LIMIT EH (Economic Hardship) REASONS	CODES
Resides in EH county and in compliance with PRP	I
Resides in EH county and out of compliance with PRP	O
Resides in EH county & in compliance @ 60 Months	J
Resides in EH county & out of compliance @ 60 Months	P

TIME LIMITS

COUNTABLE MONTHS CHART

	Y	N
The AG has accumulated 10 months of time limit months in another state before applying in Tennessee. Will these months count (**Time limit months accumulated in other states do not count in Tennessee.)**		**N**
The caretaker reaches 9.0 grade level in June and is no longer exempt from time limits. Is July a countable month? **(The time limit clock begins the 1st month following loss of exemption status.)**	**Y**	
The caretaker (in a two-parent AG) has a baby in May. In July, she chooses to participate in a work activity. Is July a countable month? **(Time Count would not start until the 16-week childbirth exemption has expired.)**		**N**
An AG is ineligible but receives benefits in error for Jan., Feb., and March due to client error. A claim is being recouped. Are these months countable? **(Ineligible months would be counted in this case.)**	**Y**	
An individual reaches 9.0 grade level May 31st. The caseworker does not complete the PRP renegotiation within 14 days. Is June a countable month? **(If the PRP is not renegotiated within 14 days, the month in which the plan was not completed timely would be an exempt month as would each month following until the plan is completed.**		**N**
An AG applies for FF and signs a PRP for the first time on Sept. 1. On Oct. 1, the FF application is approved. Is Oct. a countable month?	**Y**	
In the same example above, is September a countable month? **(The time limit begins the 1st full month after the CM presents a PRP and the caretaker signs the plan.)**		**N**
A non-exempt AG's case was closed effective 11/1. On 1/1, the AG reapplies. Is 1/1 a countable month? **(If a case with a PRP closes and reopens at a later date, the time count will begin the first month of eligibility, if activities and support services are in place.)**	**Y**	
DHS cannot provide CC services to the caretaker beginning June 15th. CC was not continued until August 1st. Are June, July, and August countable months? **(Time count will not resume after an interruption until the month following the month the service becomes available, September in this case.**		**N**

TIME LIMITS
DOCUMENTATION CHART

PRP	Document the initial PRP date on AEPRP and all subsequent PRP dates as they are renegotiated.
SANCTIONS AND TERMINATIONS	**CLRC should clearly reflect the** – non-compliance – conciliation attempts – review for good cause – final action taken – final status for each work component (on AEIPA and JTPA)
TIME LIMIT DETERMINATIONS	Document CLRC regarding reasons for exemptions, interruptions, closures, and extensions. Note the appropriate code on AEPRP. If an AG is not entitled to an exemption, interruption, or extension, the reasons why must be noted on CLRC.
NEW TIME LIMITS	Document CLRC to support the reasons for granting the start of a new time limit when application is made for a new group of children.
WORK REQUIREMENTS	Any work exemptions must be documented on AEPRP
16th/59th MONTH REVIEWS & OTHER **TIME LIMIT CLOSURES (see Bull 18, FA-04-18, 6/22/04)**	Assess each month of assistance for the current period of eligibility. Document on CLRC the results and note which months were countable/not countable and why.
WORK ACTIVITIES	These activities must be documented on JTPA and AEIPA for each countable month before case closure.
TIME COUNT	The time count reflected on AEPRP and SFFF must be updated immediately when the time count is adjusted.
AEIPA	Must be kept up-to-date at all times as it is the Department's copy of the PRP

RE-ENTRY AFTER A PERIOD OF INELIGIBILITY

POLICY STATEMENT:

Assistance groups that are exempt from time limits may re-enter Families First following a closure as long as eligibility requirements are met. Assistance groups that are not exempt from time limits will have to meet eligibility requirements and must meet re-entry provisions.

The AG must complete an application form and have an eligibility interview. The interview will consist of a typical reapplication review. However, the verification procedure may be condensed, when appropriate, using the rules for processing an application within three months of closure. (The rules are discussed in the Application Processing chapter.) A new Personal Responsibility Plan will be negotiated at the time of reapplication.

A Families First assistance group may become eligible once again following a closure or a period of ineligibility if the AG is otherwise eligible and when:

- the AG has corrected a non-compliance sanction for child support;
- the AG has corrected a non-compliance sanction for work requirements (for a second sanction, wait three months and until compliance);
- the AG has closed for a reason other than a sanction, and has not completed their 18-month period of eligibility;
- the AG was working at the time the 18-month period of eligibility ended and subsequently lost employment through no fault of their own;
- the AG has been closed at least three months because the AG has completed the 18-month period of eligibility;
- the AG has good cause for returning to the program after the assistance group has had 60 months of eligibility; or
- the AG has been closed at least three months because the AG has completed the 18-month period of eligibility <u>and</u> sanction requirements have been met. This applies when an AG was closed for both a sanction and time limits.

RE-ENTRY BEFORE COMPLETING A MAXIMUM PERIOD OF 18 MONTHS OF ELIGIBILITY:

- An AG that closes for any reason other than a sanction before completing an 18-month period of eligibility may re-enter the program without any wait when all other points of eligibility are established. The count of the 18-month period of eligibility will resume until the count reaches 18 months.

For example, an AG that has received assistance for 12 months moves out of state and is closed. The AG returns to the state and reapplies and is once again eligible. The AG may resume eligibility for Families First and the count of months will begin at month 13 since the AG has already received 12 months of a period of eligibility.

RE-ENTRY UPON COMPLIANCE WITH CHILD SUPPORT:

- An AG that is serving a sanction for failure to comply with child support will be eligible to re-enter Families First when compliance with child support and all other points of eligibility are established. For child support, agreeing to comply is acceptable as compliance if it is not possible to immediately correct the original non-compliant act.

  For example, an individual may have refused to appear in court for a support order hearing. This cannot be corrected until a new court date is established. Since this may take some time to schedule, the caretaker's agreement to comply is sufficient to meet this requirement. The first date of eligibility will be the date of the application (assuming the AG is eligible from that date) that follows compliance.

RE-ENTRY UPON COMPLIANCE WITH A WORK REQUIREMENT:

- An AG that is serving a first sanction for failure to comply with work will be eligible to re-enter Families First when the AG reapplies and complies with the work requirement. To be in compliance, after the first sanction for work, the applicant must

  - sign a new PRP developed during the eligibility interview; and
  - participate in the original work activity or another activity that has been negotiated by the case manager and the applicant.

  The applicant must participate in the activity for two weeks, during the application process, to be considered in compliance. **(This is an exception to the typical application processing and PRP rules, which state that the applicant will not be required to participate in an activity until the application is authorized.)** This compliance should be completed during the 45-day processing period. However, there are some instances when this is not possible.

  If the application appointment is missed and the client does not contact the case manager, the application can be denied. If the appointment is missed and the individual reschedules but does not have time during the processing period to complete the two-week compliance, interim benefits should be given on the 49th day in order to give the individual time to comply.

RE-ENTRY AFTER A PERIOD OF INELIGIBILITY

If during the period of compliance, a situation occurs that would be considered good cause for non-compliance, the application would be held until the two-week compliance period can be completed. If the delay in beginning the two-week compliance would cause the application to go beyond the 45-day time limit, the individual would be required to complete as much of the compliance period as possible before the 45th day. The application would be approved based on the time spent in compliance, assuming that all other eligibility requirements have been met.

If the "good cause" reason will extend past the 45 days, the application should be approved without a two-week compliance period. Likewise, if the individual is exempt from the work requirement at reapplication, there would be no compliance requirement.

During the application period, the individual will be eligible for child care and transportation, if needed to comply. If the activity, child care, or transportation cannot be made available within the 45-day processing period to the applicant who wishes to comply, the application should be approved, if otherwise eligible.

- An AG that is serving a second or subsequent sanction for failure to comply with the work requirement is not eligible for Families First for three months following the month of closure. In addition, the AG must reapply and comply with the work component for two weeks before the AG can be approved for Families First benefits. The same application processing and PRP compliance rules that apply to an applicant after the first sanction will apply to a second or subsequent sanction.

- Once the applicant has met the full compliance requirement, approve the AG effective the date of application, if otherwise eligible.

- Individuals attempting to correct a sanction during a pending application are referred to as a "sanctioned participant" in the Work, Support Services, and Child Care chapters.

RE-ENTRY FOLLOWING AN 18-MONTH PERIOD OF ELIGIBILITY:

- An AG that has completed 18months of eligibility and does not qualify for a good cause extension or an economic hardship extension will be closed.

- The AG will not be eligible again for at least three months following the month of closure, unless early re-entry provisions, as described below, are met.

- the AG is in sanction status at the time the case is closed for meeting the 18-month time limit, the sanction requirements must be met before the AG will be eligible to return to the program. This is true even if the individual has lost a job through no fault of her own.

Early Re-Entry Due To Loss Of Employment After An 18-Month Period Of Eligibility:

- An AG that is employed at the time their Families First case is closed due to the 18-month time limit may re-enter Families First before the three-month wait if the AG loses employment through no fault of their own. Examples of this include lay-offs, plant closings, or their employment no longer exists.

Individuals who quit or are fired from employment do not meet early re-entry requirements unless they quit or were fired for one of the following **" no fault" reasons:**

- the job paid less than the minimum wage based on the number of hours actually worked;
- discrimination by the employer based on age, race, sex, color, handicaps, religious beliefs, national origin, or political beliefs was claimed;
- a temporary family emergency occurred, such as personal illness, death of immediate family member (follow State of Tennessee bereavement policy), natural disaster, or other traumatic event, and the employer refused to allow time off to attend to the emergency situation; or
- the employee was needed in the home to care for an ill or disabled relative household member for whom it would normally be his/her responsibility to provide care; or
- child care became unavailable and substitute child care arrangements could not be made either by the individual or the child care broker; or
- the individual had a baby and the employer was not required to and did not grant leave in accordance with Family Medical Leave Act provisions; or
- a medically approved incapacity, including complications from pregnancy, rendered the individual unable to work.

- To be eligible for early re-entry, the AG must have been in compliance with the Personal Responsibility Plan at the time the AG closed.

Early Re-Entry Due To Good Cause After An 18-Month Period Of Eligibility:

- An assistance group may re-enter Families First after an 18-month period of eligibility without waiting for three months if the assistance group has "good cause" for doing so. Good Cause exists when:

  - The assistance group was in compliance with their Personal Responsibility Plan at the time the assistance group closed. (**Note**: Non-compliance with health checks, immunizations or school attendance will reduce the grant amount but will not cause ineligibility for good cause.)

AND

- The assistance group was in substantial compliance with their Personal Responsibility Plan for the most recent 18 months prior to the assistance group closure. (**Note: Substantial compliance means the AG has had no more than one three-month work sanction or no more than three child support sanctions** in the most recent 18-month period of eligibility). The AG must have complied with the requirement causing the sanction;

AND

- The AG's gross income is **less** than the appropriate income standard for re-entry;

AND

- The AG has not refused employment or voluntarily quit a job, without good cause, in the two months prior to application or during the application processing period.

NOTE: The "Good Cause" and the "loss of employment through no fault of their own" criteria apply only to early re-entry after an 18-month period of eligibility, where the AG reapplies before the three-month period of ineligibility has ended.

RE-ENTRY DUE TO GOOD CAUSE AFTER A 60-MONTH PERIOD OF ELIGIBILITY:

- An assistance group may re-enter Families First after a 60-month period of eligibility if the assistance group has "good cause" for doing so. Good Cause exists when:

  - The assistance group was in compliance with their Personal Responsibility Plan at the time the assistance group closed. (**Note**: Non-compliance with health checks, immunizations or school attendance will reduce the grant amount but will not cause ineligibility for good cause.)

  AND

  - The assistance group was in substantial compliance with their Personal Responsibility Plan for the most recent 18 months prior to the assistance group closure. (**Note:** Substantial compliance means the AG has had no more than **one three-month work sanction** in the most recent 18-month period of eligibility before reaching the 60-month time limit. The AG must have complied with the requirement causing the sanction.

  AND

  - The AG's gross income is **less than** the appropriate income standard for re-entry.

  AND

  - The AG has not refused employment or voluntarily quit a job, without good cause, in the two months prior to application or during the application processing period.

VERIFICATION:

Verify:

- all eligibility requirements;
- compliance with the sanction, if applicable;
- the reason employment was lost, if applicable; and
- good cause, if applicable

DOCUMENTATION:

- Document the running record comments, CLRC, to support the decision to permit re-entry. Specify why early re-entry or re-entry after using all of the 18 or 60 months is being permitted or being denied.

PROCEDURES:

- Receive applicant's application request to re-enter Families First.
- Determine if AG meets reason for early re-entry.
- If early re-entry is appropriate, establish eligibility and develop a new Personal Responsibility Plan.
- Establish activities needed to gain compliance.
- Authorize and arrange supportive services needed to comply with work activities.
- In the instances when the individual must comply with an activity prior to approval, establish a follow-up to the plan activity within two weeks of the activity start date.

FAMILIES FIRST-RE-ENTRY

Re-entry reasons	Waiting Period	Exceptions	Good Cause
Re-entry Before Completing a Maximum Period of 18 months of Eligibility	No Waiting	If serving a sanction, must comply or Serve the sanction time	N/A
Re-Entry Upon Compliance with Child Support	No Waiting	None	N/A
Re-Entry Upon Compliance with a Work Requirement	1st sanction-must comply for a two-week period 2nd or subsequent sanction-compliance or 3 months, whichever is longer	None None	N/A
Re-Entry Following an 18-Month Period of Eligibility	3 months	If in sanction status at time of closure, Must comply for a two-week period.	N/A
Early Re-Entry Due to Loss of Employment after an 18-Month Period of Eligibility	No Waiting-if meets early re-entry provisions	None	"No fault" reasons must apply
Early Re-Entry Due to Good Cause After an 18-Month Period of Eligibility	No Waiting-if has "good cause"	None	Must meet "good cause" provisions
Re-Entry Due to Good Cause After a 60- Month Period of Eligibility	No Waiting- if meets "good Cause" provisions.	None- NOTE: Loss of employment Criteria does not apply for re-entry After a 60-month period of eligibility.	Must meet "good cause" provisions

GOOD CAUSE

- Not in sanction status at time of closure
- No more than one three- month work sanction and no more than three child support sanctions in the most recent 18-month period of eligibility.
- Income less than the maximum payment standard for the AG's size plus earned income disregard
- Has not quit job or refused employment

"NO FAULT" REASONS

- Job paid less than minimum wage
- Discrimination by employer
- Temporary family emergency
- Needed in the home to care for ill or disabled HH
- Child care became unavailable
- Individual had a baby and employer did not grant leave
- Medically approved incapacity

CHILD CARE

POLICY STATEMENT

The success of Families First in supporting the goal of self-sufficiency for its participants is dependent on the existence of affordable, accessible, quality child care. Care that provides for a child's well-being and development is central to a parent's ability to participate in all work components of the Personal Responsibility Plan, from the individual's first activity to full-time employment and as a support service after the individual leaves the program.

The following types of child care assistance are available to families receiving, or transitioning off of Families First:

- **Families First Child Care (CCDF-FF**) pays for child care while the Families First caretaker, adult or minor parent is participating in work, education, and training activities. This child care includes the participant's travel time to and from these activities.

- **Transitional Child Care (CCDF-TCC)** is available for 18 months after the Families First cash assistance stops. TCC requires the caretaker to contribute to the cost of care.

- **At-Risk Child Care**: families may be eligible for an additional 12 months of child care when TCC ends, based upon funding availability.

- **At-Risk Child Only, or ARCO:** for Families First Child-Only caretakers who meet Transitional Child Care (TCC) and At-Risk policy guidelines. If qualified, a family is eligible for 1 year of assistance.

Certain eligibility criteria determine which children receive child care services**.** Care is available for:

- children under age 13;

- children age 13 and older who are under court supervision;

- children age 13 and over who are physically or mentally incapable of self-care;

- children who live in the home and for whom the caretaker has care and control but who are not in the assistance group; and

- children who would be included in the assistance group except for the fact that they receive SSI.

- Child care payments will not be made to:

  - the child's parent, step-parent, guardian, or any member of the assistance unit; or

  - persons or agencies found guilty or validated as child abuse perpetrators.

- The caretaker relative has certain choices regarding how child care is paid and to whom. The caretaker may choose regulated or unregulated care. Regulated care is licensed by the Department. Unregulated care is not licensed, but is monitored by the Child Care Specialist.

- Effective January 1, 2005, unregulated care may not be provided in the child's home, unless it is also the provider's home.

- Child care is provided in units of care based on the number of hours for which child care is needed per week, i.e., full-time, part-time, or extended time.

  - A full-time unit of care is defined as a weekly schedule of 20 to 60 plus hours of child care needed. Child care can be provided while the parent or caretaker works, goes to class or other educational/training activities such as lab, study, or tutoring; and the traveling time to and from these activities and the child care provider.

  - A part-time unit of care is defined as 1 to 19 hours per week, e.g., for a child who only needs before and/or after school care.

  - An extended time unit of care is only for Families First participants. If a participant is placed in activities that require more hours of child care than allowed by one full-time unit of care, then the participant may receive an extended time unit which provides up to 150% of a full-time unit. Only a DHS supervisor can authorize extended time units. TCC cases are not eligible for extended time units, even if the AG received extended time while they were in the Families First Program.

- Minor parents, who are ECs and have signed a PRP, will also receive Families First child care if the child care is required for them to fulfill the obligations on the PRP. Child care will not be provided if the caretaker (whether EA or NA) is able to provide child care.

Child Care Disregard

- Families First participants who are employed or in a paid work activity and need assistance with child care have two options. They may choose:

  - child care paid by DHS directly to the provider; or

  - a child care deduction used in the Families First budget for the cost of care.

- The DHS caseworker will explain these options to the participant and determine which method of meeting child care expenses is to the participant's advantage. The maximum child care disregard per child is:

  - $200.00 per month for children under two years of age; and

  - $175.00 per month for children two years of age and older.

- The disregard cannot be given in the same month that a direct child care payment is paid by DHS. If the caretaker has received a disregard, payment for child care will begin the month following the removal of the disregard.

Families First Child Care (FF)

In order to receive child care assistance, the child care must be necessary for the caretaker to participate in work, education or training. Child care is not provided if the caretaker can arrange for free care or the children are in school during the hours the client will participate in work, school, or in training. Child care assistance will not be given to a two-parent family (Unemployed Parent case, incapacity or married during receipt of assistance), if one parent is able, willing, and appropriate to provide care in the home. Child care will not be given to a minor parent who is an EC if the caretaker of the AG can provide the care.

- The referral that is sent to the Child Care Specialist is open-ended. Child care eligibility and the eligibility end date must be reviewed during each contact between the caseworker and the participant.

- Child care is available, if needed, on the first day of participation in an activity or employment, or for taking a functional literacy test.

- Child care is available for all eligible adults (even if they are disqualified) if they are in a work component. If the eligible adult is exempt from the work requirements, he/she may still be able to receive child care. For example, if a participant tests at or below 8.9 on the functional literacy test, is in AE for 20 hours, and also decides to work part-time, then child care would be available for the time spent in AE as well as the time spent working.

- Child care cannot be provided prior to the approval for Families First, except when the caretaker is participating in an activity during the required two-week compliance period to cure a sanction.

- Child care assistance will be suspended for Families First participants who are non-compliant with their Personal Responsibility Plan and have failed to respond to the conciliation notice. The suspension date will be the first day following the expiration date of the conciliation notice (AEONC) if there has been no response from the participant or if the participant was contacted and did not agree to comply. (Refer to the PROCEDURES-Suspending Child Care section of this chapter for instruction.)

If the participant makes contact, either during the conciliation process or at a later date, and is determined to have had good cause for the non-compliance situation, or agrees to comply prior to the eligibility termination date, the CW will restart the child care. Prior to restarting child care, the CW must determine that child care is still needed by the participant. Child care will be restarted with no break in coverage if immediate child care is required in order to participate. Otherwise, child care will be restarted effective with the date the individual has agreed to return to the activity.

If the participant fails to comply for the two-week period, the child care will be suspended. The suspension effective date will be equal to the end of the original two-week compliance period.

- In the event the Families First case is being closed for cash benefits, and there is an open FF child care case, the child care case will be suspended effective with the date the adverse action period expires.

  Exception: Families First participants, who are currently employed, will have a child care suspension end date that corresponds with the effective date of case closure. Child care will be provided for hours associated with the employment. This will allow participants to continue to receive child care uninterrupted while they are moved to Transitional Child Care (TCC).

- At the time of approval, child care can be provided back to the date of application for the time that the participant was working or was in an activity that would qualify as a PRP work component. The child care payments may be issued to the participant or the child care provider, as determined by the Child Care Specialist. Retroactive Families First child care will not be provided if:

  - the participant chose the child care disregard for the months in question; or
  - the AG was eligible for TCC during the application period; or
  - the AG was ineligible for cash payment, unless the individual was complying for two weeks to remove a sanction.

- Participants who are referred to Vocational Rehabilitation Services (VR) are eligible for Families First child care as long as they are actively participating in a VR program. Child care is also available for any interim components that the AG may participate in between the required Families First work components and the VR components (e.g., continuing AE as a volunteer until the assessment for VR is complete).

- Child care will be provided, if needed, while a parent is in a drug/alcohol or mental health treatment program.

- Child care will not be suspended when the caretaker is between work/training activities. The provider will retain a child care "slot" for the child for thirty days. If the break between activities will last more than thirty days, the child care should be suspended.

- Retroactive cash reimbursement will be authorized to a caretaker who verifies he/she paid child care costs during a period of Families First eligibility and received no disregard and no direct payment was made to the provider by DHS during that time. This reimbursement cannot exceed the state allowable rate for the type of child care provided. The caretaker will be referred to the Child Care Specialist to request the reimbursement.

Transitional Child Care (TCC)

- An Assistance Group (AG) is eligible for TCC for 18 months beginning the month after the Families First AG is closed. This applies to all case closures, EXCEPT:

  - cases closed for non-cooperation with Child Support;
  - cases closed due to the AG moving out of state;
  - cases closed that have no eligible adult; or
  - cases closed that have no minor parent (EC) who has signed a PRP in the AG.

- The caretaker is required to contribute to the cost of care by paying a weekly co-payment fee based on the family's income and number in the household. The child care income guidelines used to determine if a participant qualifies for TCC are based on 60% of the State Median Income.

- Eligibility for Transitional Child Care (TCC) ends when:

  - the caretaker fails to pay required parent co-pay fees or to make acceptable payment arrangements;
  - the only child in the assistance group leaves the home;
  - the caretaker fails to cooperate with child support requirements as determined by DHS; or
  - the 18-month TCC eligibility period ends.

- To qualify for TCC assistance, the AG's caretaker must:

  - have an eligible child;
  - meet the 60% of the State Median Income guidelines;
  - cooperate with child support requirements; and
  - meet a 40-hour per week work requirement with employment and/or education/training. Further explanation of this qualification follows.

    - Thirty to Thirty-Nine (30-39) hours of work per week will be accepted if this is the best the participant can do, given the area's economic conditions and the participant's skills and capabilities.
    - Individuals who state they work 30-39 full-time hours per week will meet the 40-hour work requirement.
      Individuals who are employed but earning less than minimum wage will have their hours determined by dividing their gross income by the current minimum wage
    - Individuals who are self-employed will have their hours determined by dividing their net self-employment monthly income (gross minus allowable expenses), by the minimum wage.
    - Individuals who are attending a post-secondary institution are not required to be full-time students for their education hours to be considered.
    - Post-secondary credit hours and study hours are countable. If the credit hours + the study hours = less than 40, the difference must be made up with work.

- Paid and unpaid work-study hours are countable.
- Mandatory laboratory hours are countable.
- Tutoring hours received or provided by the participant are countable.
- Teen parents who are in high school and are maintaining satisfactory grades and attendance have no additional requirements.
- Extended FSC or ECS hours are countable with the provision that written verification is provided from the FSC or ECS Counselor.
- Post-graduate cannot be used to determine countable work requirement hours:

The At-Risk and At-Risk Child Only programs have the same qualification requirements as TCC. However, the eligibility period for these 2 programs is 12 months, as opposed to TCC's 18 months.

The Child Care Specialist will determine whether the employment and activity hourly requirements are being met by the participant.

- Qualification for Transitional Child Care (TCC) assistance ends when:

  - eligibility for TCC ends;
  - the family's gross monthly income exceeds 60% of the State Median Income for that size family;
  - the caretaker no longer fulfills the work requirement;
  - a participant who is employed and/or in an education/training program for at least 20 hours at the time TCC eligibility begins, fails to raise his/her hours to meet the requirement within 30 calendar days (of the date he/she qualified for TCC);
  - a participant loses/stops employment and/or education/training and fails or refuses to attempt to regain the required hours within 30 calendar days (of the time his/her hours were reduced).
  - a participant fails to pay late parent fees after attempts by the provider and the Child Care Specialist to collect the fees or to set up a repayment plan. The provider will continue to receive state reimbursement while the provider and Child Care Specialist attempt to collect the fees and while the repayment plan is being developed.

    NOTE: If the participant agrees to try and increase his/her hours but fails, he/she will no longer qualify for TCC. The agreement to make the attempt just gives the individual more time to meet the qualifications. Participants who refuse to attempt to increase their hours will not qualify, at the time of the refusal.

- If the AG does not qualify for TCC at the time of FF closure but later qualifies during the 18-month eligibility period, payments will begin at that time. Child care assistance will continue for the remainder of the eligibility period, as long as the AG qualifies for TCC payments.

- There is no requirement for a set period of time to receive cash assistance prior to case closure in order to be eligible for TCC. For example, if a Families First case is closed after just one month of assistance, the family is eligible for Transitional Child Care.

- If a participant who is receiving TCC re-applies for Families First and is determined to be ineligible for cash assistance, the participant will continue to be eligible for the remainder of the original 18 months of TCC. For example, a participant who has used eight months of TCC re-applies for Families First and is determined ineligible, the participant is eligible for the remaining ten months of the original 18 months of TCC.

- **A Families First AG is eligible for 18 months of TCC each time the AG closes. For example, an AG has used six months of TCC, re-applies for Families First and is approved. At a later date, Families First assistance closes and the AG is again eligible for 18 months of TCC.**

At-Risk Child Care Assistance – Two Types

- **At Risk Child Care (ACC) Following TCC Expiration**

  - TCC recipients who are receiving assistance in the 18th month of their TCC eligibility may receive an additional 12 months of child care assistance under the At-Risk program. These individuals must continue to meet all TCC qualifications.

- **At-Risk Child-Only (ARCO)**

  This type of child care is available to Families First child-only assistance groups.

  - ARCO caretakers must meet TCC qualifications.

  - Child Care certificate agencies will determine ARCO eligibility.

  - ARCO caretakers will be eligible for 1 year.

  - Child Care certificates will be issued for a six-month period at which time continued eligibility will be reviewed.
  - ARCO caretakers must pay a parent fee (co-pay) based on their income.

  - Eligibility for ARCO child care will begin effective the date of the interview with the child care certificate agency.

  - SSI child-only caretakers may receive ARCO child care IF they meet the qualifications.

  - Child-only caretakers who are eligible adults in another Families First assistance group will not be eligible for ARCO. They will receive their child care through the Families First program if they meet Families First requirements.

CHILD CARE

Administrative Responsibilities

It is critical that families in need of child care assistance receive prompt and timely services for the arrangement of child care. Children must be enrolled in a child care program before their parents can report to work, education or training. Good customer service must be available in every county from Certificate Program staff and FA staff, to help parents choose a good quality child care program.

Important: The Families First participant's time limit count will be interrupted if essential child care cannot be arranged within two calendar weeks. The time count will begin the month following the month the child care is made available. If the child care is made available on the first day of the month, the count will resume with that month.

DOCUMENTATION

List the Families First child care effective date, date referred and the completion date on AEIPA, in accordance with ACCENT instructions. The caseworker must document any pertinent information about child care in CLRC. This includes, but is not limited to:

- the caretaker's choice of child care;
- when the Families First child care or TCC referral was made to the Child Care Specialist, if the referral was a manual one;
- any problems that the caretaker might have either finding or keeping appropriate child care;
- the caretaker's decision to choose the child care disregard instead of the Families First child care;
- the begin/end dates of the disregard;
- reasons for suspension/reduction of child care;
- when notification of suspension/reduction in child care and rights and responsibilities sheet was sent to the participant and Child Care Specialist; and
- an explanation of why a TCC referral was not sent for a closed AG.

PROCEDURES:

DHS Caseworker Responsibilities

- DHS caseworkers will determine eligibility for Families First child care and Transitional Child Care.

- The caseworker will complete the child care referral by using the ACCENT Child Care Referral Screens to TCCMS.

CHILD CARE

NOTE: The caseworker must use the form found in Shared Base Documents when making a child care referral for Ineligible Aliens, Drug/Fleeing Felons, and FF/IPV Disqualified Individuals. These participants must be fiated to show a "fail" status. Since these participants are in "fiat" status, ACCENT will not allow the caseworker to select them as caretakers on AEICC. The caseworker will complete each item on the referral form, including the individual's Families First work and work related activities, and the hours involved in the activities. All of the information on the referral form is necessary for the Child Care Specialist to begin the process of arranging child care. The caseworker will e-mail the referral to the Child Care Specialist:

- as soon as the need for Families First child care is identified;
- at the same time that the Families First AG is closed (for Transitional Child Care); and
- anytime there is a change to or suspension of the existing child care.

- The referral for the Families First child care may be needed during the application period if the individual is serving a two-week compliance, at the time of approval, or later during the period of eligibility. It is critical that the referral be made as soon as the need is identified, so that child care arrangements can be made within two weeks.

- The caseworker will give the information sheet that explains basic Families First child care and TCC requirements to the participant. Be sure to include the Child Care Certificate Program agency's name, address and telephone number on the information sheet.

- Both the Families First child care referrals and the TCC referrals are for 18 months. The caseworker is responsible for suspending Families First child care when a need no longer exists or the AG is closed.

- The caseworker will process changes reported by either the caretaker or the Child Care Specialist within five work days.

- The caseworker will notify the Child Care Specialist immediately, but no later than five days, of changes that are reported to DHS that will affect Families First child care eligibility. Such changes include adding a child, a change in the Families First activity, a lapse in a PRP activity, and the length of time before the individual will resume an activity.

- **It is very important for the caseworker to explain that the child care payments do not begin until the participant goes to the Child Care Specialist and gets the child care certificate**. If
  child care arrangements are made before contacting the Child Care Specialist, problems can occur in reimbursing the provider and may impact the participant.

- The caseworker must contact the participant when the Child Care Specialist reports that a child has ten or more absences from child care. An unusually high number of absences may indicate that the individual is not participating in the Families First activity or there may be other problems that impact the AG's Families First eligibility or affect the individual's ability to comply with the PRP.

- When Families First child care hours are reduced or suspended, the caseworker will send a free form notice to the caretaker to explain this action. This notice should be sent as soon as possible after the caseworker becomes aware that the child care will change and before the hours are reduced or suspended. **The caseworker must also include the sheet that explains the individual's rights** and responsibilities with the notice.

- DHS must also inform the Child Care Specialist when the Families First child care hours are being reduced or suspended.

- Caseworkers determine good cause for issues that may result in a suspension or reduction in child care. A good cause determination is necessary when:

  - the caretaker does not provide requested information to the Child Care Specialist; or

  - the caretaker does not cooperate with child support collection.

- Caseworkers will discuss the child care policies regarding the 40-hour TCC work and/or education/training requirement with Families First participants when they report changes that may close the Families First case. Participants will need to be aware of what to expect with TCC. It is important that the caseworker discuss with the participant that TCC is a benefit provided to help the participant prepare for self-sufficiency.

- The caseworker will refer to the Monthly Income and Fee Table to show the participant the income levels that are required to qualify for TCC.

Child Care Specialist Responsibilities

The Child Care Specialist will:

- determine the caretaker's child care needs based on the individual's activities, including the number of hours of care.

- make child care arrangements within seven days after receiving a Families First referral. The Child Care Specialist will make an initial contact (either by phone, in person or in writing) with the participant within three days after receiving a referral. The Child Care Specialist will assist the participant in placing the referred child in an appropriate care arrangement within four work days of the date the Child Care Specialist contacts the participant.

- notify the DHS caseworker when child care arrangements cannot be made for a Families First AG within seven days. The Child Care Specialist will explain what efforts are being made to arrange child care before the AG's time count must be interrupted.

- complete the child care provider enrollment packet. Child care providers who want to participate in the certificate program must also sign a Provider Agreement form. In this agreement, the provider agrees to follow certain rules. This enrollment is required for payment from DHS.

- complete a child care certificate for each child. Families First participants should not place their children in child care before receiving a child care certificate from the Child Care Specialist.

- report changes and respond to notices of change from DHS caseworker and providers within five workdays.

- calculate the parent co-payment fee, which the participant pays directly to the provider. Participants receiving Transitional Child Care and At-Risk programs are responsible for contributing a portion of their income to pay for their child care. The parent co-payment fee is based on a percentage of the participant's gross monthly income. DHS assumes no responsibility for any charges by a provider that are over and above the established state rates for that type of care.

- provide counseling on parental choice for the type of care appropriate for the family's needs; the importance of choosing quality child care; and on the parent's responsibility for monitoring the children's care.

- provide financial counseling to help caretakers plan for full payment of child care costs.

- provide local resource and referral services for locating a provider near the family home or work site.

- notify DHS Fiscal Services to authorize child care payments directly to the providers.

- provide limited mediation between the participant and provider to resolve care problems and the need for emergency care arrangements.

- conduct a review of continued qualification for all TCC/At Risk cases at least every six months. In addition, the Child Care Specialists are encouraged to conduct desk reviews of all cases every three months to provide effective case management.

- monitor child care attendance and provide limited case management to the caretaker. The Child Care Specialist will notify DHS if a Families First child has ten or more unexplained absences.

- give child care providers verbal notice of a child care suspension within 24 hours and a written notice within three days, when they are notified by DHS that a child care case is to be suspended or reduced.

Joint Responsibilities

The DHS caseworker and Child Care Specialist share some responsibilities that require cooperative interaction between the two in order to accomplish specific goals. One of these responsibilities is the suspension of child care when the participant is non-compliant, and the other is the implementation of the appeals process.

Suspending Child Care:

- Suspension of child care for closures requiring conciliation:

  At the time the conciliation (AEONC) notice is generated due to a potential non-compliance situation, the caseworker will suspend the child care case on AEICM. Child care will be suspended effective the day following the expiration of the conciliation notice. This suspension will be communicated to the Child Care Specialist via ACCENT/TCCMS interface. Upon notification, the Child Care Specialist will send written notice of suspension of child care benefits to the participant and the child care provider, using the closure effective date entered on ACCENT.

  EXAMPLE: AEONC notice is mailed on 06/02/04 for failure to attend AE. AEONC provides the participant with 10 calendar days from the date the conciliation notice is mailed to contact the caseworker and resolve the non-compliance situation. Also, on 06/01/04, the caseworker suspends the child care case on AEICM, and enters 06/14/04 as the effective closure date (06/13 falls on a Sunday). This information will be transmitted to TCCMS overnight. Upon receipt of this modification, the Child Care Specialist will send a suspension notice to the participant and to the child care provider, with the effective date of suspension of child care benefits being 06/15/04 (the day following the AEONC termination date of 06/14/04).

  If the participant contacts the caseworker during the conciliation process and has good cause or agrees to comply, the caseworker will restart the child care. This is accomplished by entering a new begin date on the AEICM screen. This will be the day following the previous child care suspension end date or the date the participant is scheduled to return to his/her activity (whichever is later).

  EXAMPLE: An AEONC notice is mailed 06/01/04 and the child care benefits are suspended effective 06/14/04 on AEICM. The participant contacts the caseworker on 06/10/04 and states that he/she is willing to comply. The participant is scheduled to immediately return to Adult Education. The caseworker then goes to the ACCENT AEICM screen and reinstates child care eligibility for every eligible child in the group as of 06/15/04 (the day following the previous child care end date of 06/14/04).

Following conciliation, if the participant fails to follow through and complete the two-week compliance period, the child care will be suspended effective the day the original two-week compliance period was to expire. The child care suspension date will be entered on AEICM, and the Child Care Specialist will receive notification via system interface. Upon notification, the Child Care Specialist will notify the participant and the child care provider that the child care benefits have been suspended.

EXAMPLE: The caseworker learns of non-compliance 06/02/04, attempts to contact the participant on the same day. The caseworker sends an AEONC 06/07/04 (06/05 is on a Sat) and suspends the child care using a date of 06/18/04. On 06/16/04, the participant contacts the caseworker and agrees to comply. She returns to the activity that same day and starts a two-week compliance period that will run from 06/16/04-06/28/04. The child care is restarted using the date of 06/19/04, so there is not a break in service. Then on 06/21/04, the caseworker is notified that the participant has again failed to comply. The child care is suspended with the date of 06/28/04 (end of the two week compliance period).

EXCEPTION: DO NOT suspend child care if the participant is currently employed. For cases in which the participant is employed, the child care will have an eligibility end date corresponding with the effective date of the Families First closure. This will allow the participant to continue to receive uninterrupted child care while they move to Transitional Child Care (TCC), and prevent their employment from being in jeopardy due to a lack of child care.

- Suspension of child care for closures that do not require conciliation:

At the point the DHS caseworker takes action on a case that will authorize closure of the Families First cash case, child care eligibility will be suspended on the AEICM screen. The suspension effective date will be equal to the expiration date of the adverse action period; 10 calendar days from the date the case was closed on ACCENT (begin the count with the day following the mailing date of the notice). If the 10th day falls on a weekend, or a holiday, the adverse action period will be extended until the next working day. Once the Child Care Specialist receives the suspension notification, he/she will follow the same procedures as above to suspend the child care case and will send the participant and the child care provider a suspension letter.

EXAMPLE: The DHS caseworker takes action to close the Families First case on 6/24/04 due to the participant's failure to show for a recertification appointment. The closure is authorized on AEWAA in ACCENT on 6/24/04, with a closure effective date of 7/31/04. The ACCENT mail date is 6/25/04. The DHS caseworker enters the date of 7/5/04 as the suspension end date on the AEICM for the FF child care.

EXCEPTION: DO NOT suspend child care if the participant is currently employed. For cases in which the participant is employed, the child care will have an eligibility end date that corresponds with the effective date of Families First closure. This will allow the participant to continue to receive child care uninterrupted while they move to TCC.

- Contact during Adverse Action:

  If the participant contacts the DHS caseworker during the adverse action period and the Families First case is reopened, the child care case will be restarted if child care is still required by the participant. If child care is required by the participant in order to comply with the work plan, restart the child care on AEICM with an eligibility begin date the day after the previous suspension end date, or the date the participant is scheduled to return to his/her activity (whichever is later).

- Correcting the Funding Stream to TCC:

  Once the DHS caseworker completes the authorization to close the Families First case, the ACCENT system will change the funding stream from active Families First child care to TCC. This date needs to correspond with the first of the month in which the case moves to transitional status.

Implementing the Appeals Process:

Families First participants may appeal any action or failure to act in relation to child care as with any other benefit provided by DHS. The appeal must be filed in a timely manner, that is within 90 days of the action.

- A participant may appeal:

  - failure to take into account a child's special needs;

  - failure to provide the caretaker an opportunity to choose a child care arrangement when more than one type of child care is available;

  - failure to accept a person's refusal of available appropriate child care if she can arrange other child care and can show that her refusal will not interfere with employment or a work activity;

  - failure of the child care provider to allow parental access to the child;

  - unresolved questions about the computation of the TCC income or fee;

  - failure to provide timely and adequate notice of adverse action; and

  - other actions or failures to act which the participant chooses to appeal.

- If a participant wishes to appeal, the Child Care Specialist or caseworker will accept the appeal request, either verbal or written, and immediately notify the other entity that an appeal has been filed. Neither the Child Care Specialist nor the caseworker will refuse to accept an appeal. Decisions regarding the acceptability of an issue or the timeliness of an appeal are made by Administrative Review.

- The procedures for filing an appeal are the same as those described in the Appeals section of this Handbook. A copy of the Appeal for Fair Hearing Form, HS-0008, will be furnished to the Child Care Specialist.

- The caseworker and Child Care Specialist will confer as necessary in preparation for the hearing.

- If the appeal was filed within 10 days of the action and the participant requests that child care continue, TCC payments must be continued pending the appeal decision. If the county action is upheld, the continued benefits become an overpayment subject to recovery.

- Child care payments must also continue pending an appeal if the assistance group requests the benefits to continue, and the individual is employed or continues to participate in a work component activity, such as ECS, AE, training, etc. If the county action is upheld, the continued benefits become subject to recovery.

- The hearing will be conducted by DHS as any other appeal hearing. For example, the appellant has the right to be accompanied to the hearing by whomever the individual chooses.

- The Child Care Specialist and the caseworker will participate as necessary in the hearing and carry out the final order of DHS.

MEDICAID COVERAGE

I. FAMILIES FIRST ASSISTANCE GROUPS:

POLICY STATEMENT:

All members of the Families First cash assistance group receive Medicaid. The coverage is provided when the assistance group is approved for cash assistance.

Families First AGs who are eligible, but do not receive a cash payment because the cash payment would be less than $10, are also eligible for Medicaid coverage.

Families First AGs consisting of a pregnant woman, only, are eligible for both a cash payment and Medicaid in the last trimester of pregnancy. The pregnant woman, who is otherwise eligible, is eligible for Medicaid during the first two trimesters as a Medicaid Pregnant Woman case.

Caretakers of deprived SSI-eligible children are eligible for a cash payment and , therefore, Medicaid, if otherwise eligible.

Eligible assistance groups will be asked to select an MCO that will provide Medicaid coverage for all members of the AG. The MCO will mail a TennCare card to the AG.

EXCEPTION:

There are no exceptions.

VERIFICATION:

The verification that is required to establish Families First eligibility also satisfies the verification requirement for Medicaid.

DOCUMENTATION:

The documentation that is required to support the Families First eligibility decision satisfies the requirements for Medicaid.

PROCEDURES:

- Explain to the applicant that an approved Families First AG will also receive TennCare (Medicaid) coverage for all AG members

MEDICAID COVERAGE

- Have the applicant select the MCO during the eligibility interview or prior to authorization of the AG and record the MCO selection on AEIIM in the ACCENT case file.

- Explain the coverage provided by TennCare.

- Authorize the eligible Families First AG for MA C on AEWAA.

- If an AG does not qualify for Families First and, therefore, is not eligible for Medicaid, explain that the AG members will be evaluated for eligibility for Medicaid in other categories.

II. INELIGIBLE FAMILIES FIRST APPLICATIONS:

POLICY STATEMENT:

Assistance groups who are ineligible for Families First will be evaluated for Medicaid coverage in other Medicaid categories.

EXCEPTIONS:

All applications that are denied for Families First benefits will be evaluated for Medicaid eligibility in other categories except a Families First AG that is making an application but is currently receiving Transitional Medicaid (TM). These AGs will be eligible to continue receiving the remainder of their months of TM if the AG does not re-qualify for Families First. (See the discussion under Transitional Medicaid.)

VERIFICATION:

The verification for the Families First eligibility decision is adequate.

DOCUMENTATION:

The documentation for the Families First eligibility decision is adequate. If the AG is denied Families First and is continuing TM, the running record comments screen (CLRC) should be documented.

PROCEDURES:

- If the Families First application fails for any reason, allow ACCENT to search other Medicaid categories for potential eligibility and deny the Families First AG.

- If the Families First application is denied and the AG is currently in a period of TM eligibility, reset TM eligibility for the remainder of the TM period. If the denied Families First AG does not have any remaining months for TM, ACCENT will evaluate the AG members for Medicaid coverage in other categories.

- If an AG was previously opened for TM reapplies for Families First, but is ineligible for some reason for Families First, let the system evaluate the AG members for MA coverage.

III. TRANSITIONAL MEDICAID:

POLICY STATEMENT:

If a Families First AG is closed for any reason other than the death of all AG members, or all AG members leaves the state, the AG members will be eligible for 18 months of Transitional Medicaid (TM). If the Families First AG is closed because of a sanction for failure to comply with Child Support Services, the caretaker will not be eligible for Transitional Medicaid, but other AG members will be However, if the caretaker is pregnant, aged, blind, or disabled, she may be eligible for Medicaid coverage in MA J, MA A, MA B or MA D, as appropriate.

Transitional Medicaid will begin the first month following the last month of Medicaid coverage under Families First. The AG does not have to meet any requirements for coverage other than having received Families First assistance (including under $10 AGs) and subsequently having the case closed.

Note: Until 09/01/97, Families First cases closed for sanctions or time limits were to be evaluated for ongoing eligibility for Medicaid coverage under the MA c category using pre-TANF AFDC policies. With the 09/01/97 change to give 18 months of TM coverage to all closed Families First AGs, those AGs that were receiving ongoing MA C Medicaid will be opened for a full 18 months of TM at review or at the time that AEABC is run on the case. The 18 months of TM will begin the first month administratively feasible. For example, the AG reports an income change on 09/03/97. When AEABC is run, the case manager will set the TM to begin on 10/01/97 through 03/31/99.

MEDICAID COVERAGE

Once eligibility for TM is established, the AG will continue to receive TM benefits throughout the 18 months period.

The 18 months start again each time a Families First AG is closed. For example, an AG is closed and TM is opened for 18 months beginning in April. In May, they reapply for Families First and are approved for cash assistance. On July 6, the caretaker reports that she started working and this income makes the AG ineligible again. The case will be opened for another 18 months of TM beginning in August.

The AG that is closed because of a sanction will have to meet the compliance rules of the sanction before Families First eligibility can be re-established. The AGs with time limit closures will have to meet the re-entry provisions or the good cause provision before eligibility can be re-established.

Transitional Medicaid does not apply to applications. However, AGs that re-apply for Families First cash assistance during the 18 months of Transitional Medicaid and are not eligible for Families First will continue to receive the remainder of their Transitional Medicaid coverage. For example: An AG is closed on 12/31/96. The Transitional Medicaid coverage begins 01/01/97. In March, the AG reapplies for Families First and is not eligible due to income. The AG's Transitional Medicaid coverage will continue from 03/01/97 through 06/30/98.

When TM is set for a closed Families First AG and a member leaves the home the remaining AG members will continue to receive the balance of the 18 month TM period.
TM eligibility will end for the member who leaves the home. For example, the caretaker and one child receive TM. The child moves out of the home to live with his father. The caretaker will continue to be eligible to receive the remaining months of the 18 month period. TM will end for the child who left the home. Likewise, if the caretaker left the home (moved out of state), the AG children will continue to receive the TM until the end of the l8 months and caretaker's TM coverage would be terminated.

Individuals who move into the home who would be mandatory assistance group members for cash assistance (i.e. minor siblings or a parent of a current AG member) may be added to the TM assistance group or covered under another Medicaid category, whichever is to Their advantage. For example, an AG began receiving TM in 10/96. A minor child, age 15, who is a mandatory AG member entered the home in 01/97. The child was not eligible for MA T because he had no medical bills to meet the spenddown. Therefore, it is to the child's advantage to add him to the current TM assistance group with coverage through 03/98. However, if the same child entered the home in 09/97 and had medical bills to meet the spenddown, it would be to the child's advantage to approve the MA T AG for him since he would receive 12 months extended coverage until 08/98 in that category.

MEDICAID COVERAGE

At the end of the 18 months of Transitional Medicaid, the AG members will be evaluated for eligibility in other Medicaid categories. No additional application is necessary for this determination. If the information available in the case is inadequate for an eligibility determination, the caseworker may request any needed verification from the AG.

EXCEPTIONS:

The only exceptions to automatic receipt of 18 months of Transitional Medicaid coverage, upon closure of the Families First assistance group, are cases closed due to:

- the death of all AG members;
- all AG members leaving the state as described in the policy statement above; or
- a child support sanction.

When an AG is closed because of a child support sanction, the caretaker will not be eligible for TM, but the remaining AG members will. However, if the caretaker is pregnant, aged, blind or disabled, he/she may be eligible to receive Medicaid coverage in MA J, MA A, MA B or MA D, as appropriate.

NOTE: The individual whose case is closed for non-cooperation with child support is not eligible to be added to the TM group if he or she becomes compliant during the TM period. Conversely, an individual who was compliant with child support at the time of case closure will continue to receive TM for an 18-month period even if he/she later becomes non-compliant during the TM period.

If an AG member dies, leaves the state, or becomes incarcerated, end TM for that individual. This action can be taken at any time during the 18-month Transitional Medicaid period. If all the AG members die or leave the state, close the Transitional Medicaid case.

VERIFICATIONS:

No additional verification will be required to establish TM coverage.

DOCUMENTATION:

The ACCENT record should have documentation on CLRC that specifies the reason for the case closure and whether or not the AG is eligible for TM. CLRC should also be documented to explain an AG's circumstances when the AG that is receiving TM applies for Families First, but is determined to be ineligible for cash benefits. This explanation should include whether or not the AG has any remaining months of TM eligibility or, if TM has ended, the AG's eligibility for Medicaid in other categories.

PROCEDURES:

- Determine the reason for Families First closure.

- If closed for any reason other than child support sanction, death of all AG members or all of the AG members move out of state, set the TM switch on AEFPY to "y" and set the TM dates on AEOMT for 18 months beginning with the first month after the Families First case is closed. Authorize the AG on AEWAA.

- If the closure is due to a child support sanction, enter "N" in the Cooperation Field on AEICH to prevent the caretaker from receiving TM. Set the TM switch on AEFPY; establish the dates on AEOMT starting with the first month following the last month of assistance for Families First; and authorize TM on AEWAA.

- if the caretaker who fails to cooperate with child support is pregnant, aged, blind or disabled, ACCENT should trickle to Medicaid categories MA J, MA A, MA B, or MA D, as appropriate. Authorize the appropriate category on AEWAA.

- Do not give TM to a Families First applicant, unless the application is denied and the AG is currently in a period of TM eligibility. If in a current period of TM eligibility, reset TM eligibility for the remainder of the TM period.

- Do not give TM to a Families First AG or member who has died or moved out of state. Be sure to notify TennCare about this individual so TennCare can remove the person from their rolls.

IV. MEDICAID COVERAGE FOR A NEWBORN:

POLICY STATEMENT:

Medicaid coverage is provided beginning with the date of birth of a newborn whose mother is Medicaid eligible at the time of the birth.

EXCEPTIONS:

There are no exceptions.

VERIFICATIONS:

- Date of birth must be verified.

MEDICAID COVERAGE

- A newborn living in the home with the caretaker must be verified. (Hospitalization of the mother and newborn following birth is considered living with the caretaker.)

- An application for a Social Security number has been made for the child to be added for a cash payment. Family Cap provisions may preclude the increase in the cash assistance payment. (Enumeration is not required for Medicaid Only eligibility and authorization for Medicaid Only eligibility must not be delayed because of enumeration.

DOCUMENTATION:

Record the addition of the child to the AG with the appropriate verifications.

PROCEDURES:

- Add the newborn to the AG.

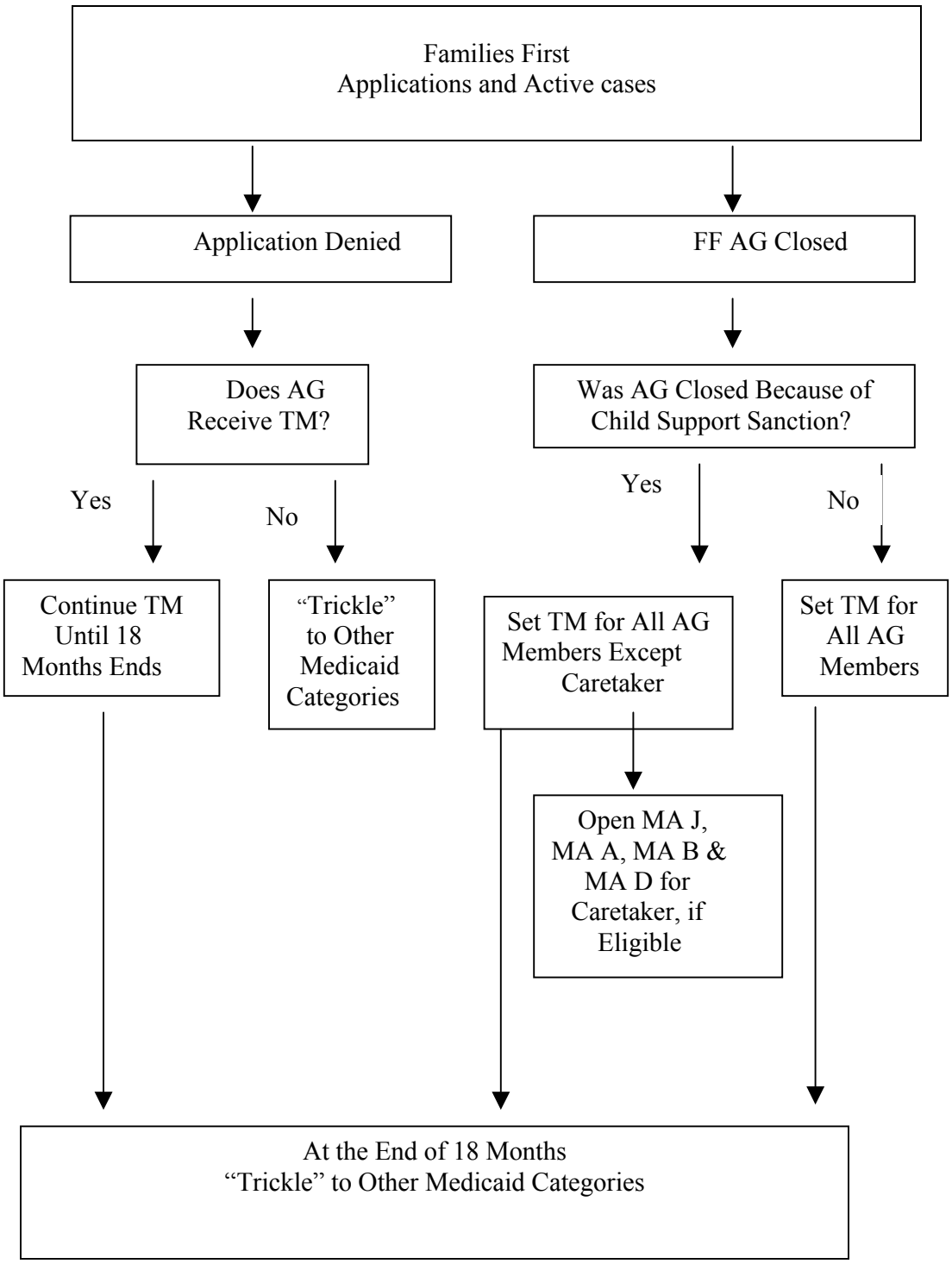
- Verify relationship, living with, birth, enumeration, and any other pertinent eligibility information.

- Authorize the AG after adding the newborn.

V. REPORT ON MEDICAID OVERPAYMENT:

Medicaid overpayments are reported to the TennCare Bureau by completing form HS2029, Over/underpayment form.

FAMILIES FIRST- Medicaid Coverage



SANCTIONS

POLICY STATEMENT

Sanctions are applied to Families First assistance groups when the AG has not complied with the Personal Responsibility Plan and good cause does not exist for the non-compliance reason.

While a sanction is sometimes appropriate or necessary, the caseworker should work with the Families First recipient to avoid sanctions. Sanctions not only limit the individual's ability to benefit from the Personal Responsibility Plan, but also can impact the AG's Families First cash payment and time limit extensions. Every effort to explain the requirements and options to the A/R should be made, as a clear understanding of program requirements can prevent acts of non-compliance.

When it is obvious that an individual is not meeting a PRP requirement, it is the caseworker's responsibility to pursue the reason for non-compliance and evaluate possible good cause reasons for the non-compliance. Skillful interviewing and good case management practices can help the individual overcome the current reasons for non-compliance and prevent acts of non-compliance in the future.

Sanctions are applied to Families First assistance groups for the following reasons:

- failure to cooperate with work or work preparation PRP components;
- voluntary termination of employment (voluntary quit);
- failure to cooperate with Child Support:
- failure of the unmarried minor parent to attend school;
- failure of married minor parents, married minors and other AG children to attend school; and/or
- failure of the AG children to have immunizations and/or health checks.

I. FAILURE TO COOPERATE WITH WORK OR WORK PREPARATION COMPONENTS:

POLICY STATEMENT:

Eligible assistance group adults who are not exempt from work are required to have a work or work preparation component in their Personal Responsibility Plans. Eligible adults must be in compliance with their work components or face possible sanction if good cause for non-compliance does not exist. (In two-adult families, this could affect

either one or both adults). Prior to the application of a sanction, the caseworker must begin conciliation and explore good cause. No sanction will be applied before a conciliation opportunity is given and an adverse action notice is provided to the recipient.

Refusal to Accept a Job:

The ultimate goal of Families First participants is to become self-sufficient, usually through employment. However, the final goal of each work or work preparation component is not necessarily employment. It may be to earn a GED, a college degree, a certificate, etc.

The goal of ECS is employment. Therefore, there are times when refusing a job without good cause can be considered unsatisfactory participation in this component. Otherwise, refusing a job is not a sanctionable act.

However, also keep in mind that the goal of ECS is for the participant to find not just any job but employment that is matched to his/her needs and career goals, employment that the participant is likely to retain and that pays enough to lead to self-sufficiency. Therefore, good cause for refusing a job by an ECS participant could be, but is not limited to, the following:

the participant cannot work the hours the job requires; and/or

based on the most recent career assessment, the job does not match the participant's skills and career goals.

Whether or not good cause exists will be determined on a case-by-case basis. The final decision will rest with the caseworker and the FS1 in conjunction with the ECS counselor.

A Families First sanction for non-compliance with work and/or work preparation components will:

cause ineligibility for the entire AG;

continue, for the first occurrence, until the adult is in compliance;

continue, for the second and any subsequent occurrences, until the adult serves the three months sanction or complies, whichever is greater. An exemption/interruption does not allow for early re-entry to the program in these situations.

not be limited to a period of ineligibility. For example, an AG serves an initial sanction in the first 18-month period of eligibility. During a later 18-month

period of eligibility a second act of non-compliance occurs. As a result, the AG will be sanctioned for three months or until compliance, whichever is greater.

NOTE: If employment is on the PRP when an individual is fired (without good cause), the action should be treated as non-compliance with a work activity.

Conciliation:

When the caseworker is notified that an individual has failed to comply with a work component, the caseworker must attempt to contact the individual personally prior to conciliation. This attempt begins the conciliation process and must be made/attempted within three (3) calendar days of learning of the non-compliance. We will consider that the Department has been made aware of the non-compliance when the change has been documented in CLRC or when the status change is entered on the JTPA system, whichever date is earlier. If the contact attempt is not made timely, the time count will be interrupted and will not begin again until the month after the month an AEONC is sent. If the AEONC is not sent timely, the time count will be interrupted and will not begin again until the month after the month a client contact/attempt is made to start the closure process. Failure to begin the conciliation process timely does not negate the sanction. CLRC must be documented to explain:

when the contact was made or attempted;

what reason the individual gave for non-compliance;

what actions were taken to resolve any barriers to participation that may have arisen.

During the personal contact the caseworker will attempt to:

establish whether there was good cause;

resolve barriers to compliance; and

determine if the individual wishes to comply with the PRP.

After contact has been made or attempted, the caseworker will complete the conciliation process. The AEONC must also be sent within three (3) calendar days of learning of the non-compliance. This is required even if client contact is made, barriers and good cause addressed, and the two-week conciliation period started. Since a Conciliation Notice is required before a sanction, if the client does, in fact, not comply, then the sanction process will have been started. In addition, if the client claims good cause, send a written request for verification.

The individual will have 10 days to respond to the notice and schedule a conference. (This is 10 days from the conciliation notice ACCENT mail date.) The conference

can be either in person or by phone and can be with the caseworker or the caseworker's supervisor. The purpose of a conciliation conference is to determine:

the reason for non-compliance; if the individual is now exempt;

if the individual has good cause for non-compliance;

if the individual has an inappropriate activity assignment;

if the non-compliant individual wishes to comply.

The caseworker must attempt a conciliation conference with the non-compliant individual before an AG is sanctioned. Failure to respond to the request for conciliation will result in implementation of the case closure process. If the participant responds during the 10-day conciliation period and refuses to comply, the caseworker can proceed with the case closure process and does not need to wait until the conciliation period expires. If the individual does not respond, the caseworker must immediately proceed with the closure process within a maximum of 14 calendar days of the date the conciliation period expires. Document CLRC when the closure process begins. If the action is not taken timely, the time count will be interrupted and the closure process restarted following the step that was not taken timely. Again, the sanction itself will not be negated. (See the Time Limits chapter for a discussion on the timely application of sanctions.)

NOTE: In a two-parent household, the AEONC notice would be sent to the adult who failed to comply with the PRP. If either parent in a two-parent AG is sanctioned, the entire AG will be ineligible.

GOOD CAUSE:

Good cause for non-compliance may be established when:

the work activity is no longer available;

the supportive service needed for the individual to engage in the work activity is not available;

there is proof the individual is/was sick or hospitalized;

the individual is caring for a sick child or other adult relative in the home and there is proof;

there is/was some temporary emergency; or

the individual presents a reason for his/her inability to comply and the caseworker determines that the reason is an appropriate reason for non-compliance.

Good cause reasons should be evaluated to determine if the individual is now exempt, either permanently or temporarily, or interrupted temporarily from the work component of the PRP. **Exemptions or interruptions constitute good cause.** The caseworker should always evaluate the situation, use prudent judgement, and consult with the recipient, to determine if the recipient understands:

- his/her commitment;
- whether he/she has been granted good cause and why; and
- that the work requirement will resume when the exemption/interruption ends.

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The sanction for an applicant or recipient who meets an exemption/interruption criterion before he/she can complete a two-week compliance period will remain on the record. When the exemption/interruption expires, the PRP will be renegotiated but the two-week compliance period will not need to be completed. If a subsequent non-compliance occurs, it will be treated as a second or subsequent sanction.

- **Compliance:**

If it is determined that the individual does not have good cause for non-compliance, the individual will have to participate in the original activity or *FSC/VR for two weeks at a 100% participation level to "cure" the sanction. If the original activity is not available, the participant may participate in an alternate activity. The individual cannot change activities during the two-week compliance period unless the activity becomes unavailable.

***If an individual chooses to comply in FSC or VR and barriers are identified at assessment and he/she agrees to ongoing FSC or VR and VR is able to serve the individual, then the two-week compliance period is satisfied.** However, if the individual agrees to FSC or VR assessment but no barriers are found or VR cannot serve the individual, then the participant must complete the two-week compliance in the original component (or another, if there is good cause for not participating in the original). The same holds true if the participant **opts not to continue** in FSC or VR.

If the individual fails to comply (without good cause) during the two-week compliance period, begin the closure process (sanction). If the individual has good cause for non-compliance, the participant would not have to start the entire two-week compliance period over. He/she would have to make up the missed time so that the total time served would equal a two-week period.

When an individual agrees to comply in a component that lasts less than two weeks, the two-week compliance period must be completed in an additional component. This will require a renegotiation of the PRP during this period. If the individual fails to renegotiate the PRP to add the additional component, a sanction for non-compliance with the work plan will be applied.

- **Two-parent AGs**
  - When both parents in a **two-parent AG** have been sanctioned, both must comply before anyone in the household can be eligible for any Families First category (ADCI, ADCU, ADCR), unless either parent becomes exempt. NOTE: This only applies to two-parent AGs that have a child in common.

- In his children/her children situations where each parent could potentially be eligible for a separate grant, only the sanctioned parent who is applying for benefits must comply.

- **Two-week compliance during the application period:**

  - Failure to comply

    - If an individual who has completed a two-week cure for a sanction stops participating in the activity prior to approval, there is no sanction for his action. The individual should be encouraged to comply in the interim period but must return to the activity within two weeks of approval. If the individual is not eligible and not approved after curing the sanction, the caseworker must ensure that the sanction cure is documented.

    - If the Department did not allow time for the A/R to complete the two-week compliance period during the 45-day application processing time frame, approve the AG on the 45th day and base the 100% component attendance on the time the customer was able to participate prior to approval.

    - If the participant failed to complete the two-week compliance period during the 45-day processing time frame due to a good cause reason (illness, for instance), issue interim benefits and request that the A/R complete the two-week compliance period.

  - Employment during compliance

    - Employment does not "cure" a sanction for a work-related activity. If the **individual gets a job during the two-week compliance period**, renegotiate the PRP to add the employment as a work activity and require that the remainder of the two-week period be completed in that component. If the income from the employment will be enough to cause ineligibility and the participant does not have enough time in the application processing time frame to complete the two-week compliance period, the sanction will remain on the case record.

    - If an individual gets a job during the compliance period, and loses it through no fault of his/her own before the compliance period is up, renegotiate the PRP again and require that the participant comply in the new activity for the remainder of the two-week period.

SANCTIONS

VERIFICATION:

The caseworker must determine that the individual has not complied with the work or work related component. Verification may be established through the service provider, the recipient's statement, or other information from a source in a position to know.

DOCUMENTATION:

- Document CLRC to show the date the caseworker became aware of the non-compliance.
- Document CLRC to show the date the conciliation notice (AEONC) was sent.
- Document CLRC to show clear explanation of the conciliation outcomes and any good cause findings.
- The conciliation request screen (AEONC) must reflect the request for a conciliation conference.
- The Personal Activity screen (AEIPA) must reflect the compliance status.
- If the AG is sanctioned, the case record must reflect the sanction. AEOIE will contain documentation of the first and subsequent occurrences and the dates of the sanction.

PROCEDURES:

- Attempt to contact the individual personally (by phone) if he/she has not complied.
- Caseworker will request the conciliation notice by completing the AEONC on ACCENT.
- Caseworker will schedule a conciliation conference if the individual responds to the AEONC. This conference can be either in person or by phone.
- Caseworker will explore good cause for non-compliance during the conciliation conference.
- The caseworker will determine if the individual should reenter the previous activity if there is no good cause, or if another activity is more appropriate. Remember that, generally, participants should complete an existing component prior to beginning a new one. A new component would be appropriate if the previous one is unavailable or the participant wishes to participate in FSC or VR. Monitor the activity for compliance over the next two-week period.

SANCTIONS

- Begin the closure process if the individual does not have good cause and/or does not wish to comply.

- Begin the closure process if the individual does not respond to the conciliation request. This must be done within two weeks after the 15-day conciliation period expires.

- Establish the sanction on AEOIE.

- Give 18 months of Transitional Medicaid (TM). (See the Medicaid chapter for more details.)

- Give 18 months of Transitional Child Care (TCC). (See the Child Care chapter for more details.)

- The AG will not be eligible for extended ECS or First Wheels if the case closure is due to a sanction or non-cooperation reason.

II. VOLUNTARY TERMINATION OF EMPLOYMENT (VOLUNTARY QUIT):

POLICY STATEMENT:

- Voluntarily quitting a job, without good cause, by an eligible adult in a Families First AG will result in ineligibility of the AG for three months.

- The voluntary quit provision applies to applicants or recipients.

- The voluntary quit provision applies to both full and part-time employment.

- A Families First application with an adult member who voluntarily quits a job without good cause two months prior to applying for assistance or during the application processing months will not be eligible for three months, starting with the month the quit occurred. For example, the AG applied 12/20/01 and the individual quit 11/2/01 and did not have good cause. The AG will not be eligible until 2/01/02.

- The AG that files an application for Families First, and is otherwise eligible except for having voluntarily quit a job without good cause, will have a home visit from a health professional.

- A Families First AG that is receiving benefits and has an eligible adult member who voluntarily quits a job without good cause, will not be eligible for three months

starting with the first possible month of eligibility following the case closure. For example, the quit occurs 12/3/01. The case is closed effective12/31/01. The AG will not be eligible again until 4/1/02.

NOTE: This policy also applies to EAs who have been disqualified.

- An individual who voluntarily quits a job without good cause, and leaves one Families First assistance group and joins another Families First assistance group as an eligible adult, will carry any remaining months of the sanction to the new assistance group. The sanction will no longer apply to the AG with whom the individual previously resided.

EXCEPTIONS:

The voluntary quit provision does not apply when:

- the individual who quit is an ineligible (NA) member of the AG;
- the individual is exempt from a work requirement according to the work exemptions listed in the Work Requirement and Work Components chapter; or
- the individual is a minor.

GOOD CAUSE:

Good cause for voluntarily quitting employment may include:

- acceptance of employment with at least comparable gross wages;
- the job paid less than the minimum wage based on the number of hours actually worked;
- the employee left a job in connection with patterns of employment in which workers frequently move from one employer to another, such as migrant farm workers;
- the individual left employment to attend an educational or training program full-time (as defined by the institution) that is consistent with allowable Personal Responsibility Plan work components;

  NOTE: Leaving employment for the purpose of applying for Families First and entering a training program through FF is not good cause.

- the work demands or conditions rendered continued employment unreasonable, such as working without being paid on schedule, work conditions were hazardous to health, or expenses for child care (not paid by DHS) and/or transportation exceeded the individual's net earnings;

- discrimination by the employer based on age, race, sex, color, handicaps, religious beliefs, national origin or political beliefs;

- occurrence of a temporary family emergency, such as personal illness, death of immediate family member (follow State of Tennessee bereavement policy), natural disaster or other traumatic event, and the employer refused to allow time off to attend to the emergency situation;

- responsibility for the care of an ill or disabled spouse, parent, child or relative household member;

- transportation became unavailable and substitute arrangements could not be made (evidence of efforts to arrange transportation will be required);

- child care became unavailable and neither the individual nor DHS could find substitute child care arrangements;

- the employer was not required to grant Family Medical Leave Act provisions for the birth of a child; or

- a medically approved incapacity, including complications from pregnancy, that renders the individual ineligible to work.

VERIFICATIONS:

The following information must be verified for voluntary quit:

- the date of the voluntary quit; and

- the good cause reason for quitting.

DOCUMENTATION:

- Document the CLRC with:

  - the circumstances of the voluntary quit;

- the attempt(s) to contact the individual to discuss good cause and the outcome of the attempt(s);
- any good cause reasons claimed by the individual; and
- the outcome of the good cause evaluation.

- Document AEOIE indicating the date and any other appropriate ACCENT screen, if the AG is sanctioned.

PROCEDURES:

- When the A/R reports a voluntary quit, evaluate good cause.

  NOTE: AN AEONC notice and conciliation is not required for voluntary quit.

- When a voluntary quit is identified by another source, contact the individual who quit either by telephone or mail to discuss the reason for the quit and determine if the individual had good cause. The contact must be attempted by mail if the individual cannot be reached by phone. Use a free form notice to request that the A/R contact the caseworker to discuss the quit. Allow 10 days for the A/R to respond. If the recipient does not respond by the end of that time or if the A/R does not have good cause, sanction the AG and send the appropriate closure notice. A formal conciliation is not required to evaluate voluntary quit.

- When good cause exists, document the case and continue eligibility.

- When good cause does not exist, initiate a closure and a Notice of Adverse Action.

- Begin the **ineligibility date** for an **application** with the month in which the quit occurred. Begin the **ineligibility date** for an **active case** the month following the month the case closure is effective.

- Send a referral to the Department of Health for a health visit on all applications that are denied by the caseworker for voluntary quit. Referrals on active cases that are closed because of voluntary quit will be sent as part of the closure process.

III. CHILD SUPPORT COOPERATION:

POLICY STATEMENT:

The Families First AG must cooperate with Child Support Services. Cooperation includes:

- identifying the absent parent;
- establishing paternity, if necessary;
- assisting in the location of the absent parent;
- pursuing court-ordered child support for each AG child; and
- agreeing to assign all child support, either court ordered or voluntary, past and future, to the Department of Human Services to reimburse the state for Families First benefits that the AG receives. Any spousal support that was ordered at the time of the child support order must also be assigned to the state.

Failure to cooperate with any of the child support requirements, without good cause, will result in a sanction of ineligibility for the entire AG. The sanction will continue until the caretaker agrees to cooperate. The sanction will be considered "fixed" when either the A/R:

- complies with the Child Support request; or
- agrees to comply in the future if the action that cannot be taken until a later date (a court hearing, for example).

Therefore, if the participant contacts the caseworker within ten days of the Child Support sanction closure notice and agrees to comply, reopen the case based on the participant's intent.

NOTE: If the case is reopened because the A/R states that he/she will cooperate with Child Support but does not, proceed with the previous sanction. This could happen quite some time after the first closure notice depending on what the participant had failed to do.

For example: The A/R does not go to court and her case is sanctioned. She contacts the caseworker within 10 days and says that she will go. The case is reopened based on the participant's intent. However, when the next court date is scheduled a month later, the A/R fails to go again. At that point, proceed with the previous sanction, following the prescribed closure process.

EXCEPTIONS:

All Families First caretakers who are requesting assistance based on absence must cooperate with Child Support Services, unless good cause is claimed.

Failure of a minor parent, who is a child in her parent's AG, will not result in a sanction to the AG, but the caseworker should work with the caretaker and the minor parent to overcome the non-cooperation. The fiscal and social advantages of cooperation with Child Support should be explained. A minor parent, who is the caretaker of her own AG and who fails or refuses to cooperate, will have an AG sanction, unless good cause is granted.

GOOD CAUSE:

The caretaker must agree to:

- assign all child support to the state; and
- cooperate with CS in gathering information about the absent parent for the purpose of pursuing child support.

There is **no good cause for failure** of the caretaker **to assign** to the state **all child support** received by any member of the AG.

However, **there is good cause for failure or refusal to cooperate with other child support requirements**. These Good Cause reasons are defined in the Child Support Cooperation chapter.

VERIFICATION:

A claim of good cause for failure or refusal to cooperate with a child support requirement must be accompanied by proof of the good cause.

- Acceptable documents of proof are defined in the Child Support Cooperation chapter. The caseworker should not limit the verifications if the applicant/recipient can produce other acceptable forms of verification to substantiate a good cause claim.

DOCUMENTATION:

The child support absent parent screen in the ACCENT file must clearly indicate that the caretaker is cooperating or not cooperating. If good cause is claimed, the screen must

indicate whether or not good cause has been granted. CLRC should also be documented to indicate that good cause was claimed, whether or not it was granted, and why the caseworker arrived at a particular conclusion.

PROCEDURES:

- When an applicant refuses to assign his/her rights to child support, the application will be denied.

- When the caseworker provides an explanation of the responsibilities to cooperate with child support, it is assumed that the caretaker will cooperate with Child Support. If the caretaker acknowledges at the application that he/she will not cooperate with Child Support requirements, the caseworker must pursue good cause.

- If it is determined that the applicant has good cause, the AG will be approved.

- If it is determined that the applicant does not have good cause and the applicant continues to refuse to cooperate, the AG will not be approved.

- An application that is denied for failure to cooperate with Child Support without good cause will be tested for Medicaid eligibility using AFDC rules. If eligible under AFDC rules, the children will receive Medicaid in MA C. If ineligible in MA C, ACCENT will search for other potential eligible categories of Medicaid. The caretaker who refuses to cooperate with Child Support, without good cause, will not be eligible for Medicaid in the MA C category but may be eligible in another category.

- The caretaker may re-apply at any time, but must agree to cooperate to be determined eligible.

- If the Child Support Office reports that the caretaker in an active AG is refusing to cooperate and they have determined that there are no extenuating circumstances that caused the problem, the caseworker will make a good cause determination for a waiver of the child support cooperation requirement. (See the Child Support Cooperation chapter for further discussion.)

- If good cause is granted, the AG will continue eligible.

- If good cause is not granted, the AG will be closed the first month following the end of the Notice of Adverse Action.

- The AG will remain ineligible until the AG re-applies and agrees to comply.

SANCTIONS

- The caretaker will not be eligible for Transitional Medicaid, but the other AG members will be. If the caretaker is pregnant, aged, blind, or disabled, she may be eligible for Medicaid coverage in MA J, MA M, MA B OR MAD D, as appropriate.

- The AG will not receive Transitional Child Care when closed for failure to cooperate with child support.

- An AG that is closed for cash assistance will be referred to the Department of Health for a health visit.

III. FAILURE OF AN UNMARRIED MINOR PARENT TO ATTEND SCHOOL:

POLICY STATEMENT:

An unmarried minor parent, under the age of 18, whose child is over the age of 1 year and who does not have a high school diploma or equivalent, must stay in school or an alternative education/training program during the school year. Alternatives could be home study approved by the school system, GED classes, or other education programs approved by the Department.

Unmarried minor parents who do not meet the above requirement, and do not have good cause, **will be sanctioned by having their needs removed from the AG budget**. This requirement applies to the unmarried minor parent who is a child (EC) or a caretaker (EA). Income and resources of the excluded unmarried minor parent are considered available to the AG.

NOTE: An unmarried minor who is pregnant is not considered an unmarried minor parent for policy purposes until the child is born.

Failure of a married minor parent to attend school is considered in the school attendance requirement that is discussed in the next section of this chapter.

Conciliation:

Before an unmarried minor parent is sanctioned, the caseworker should attempt a conciliation conference with the minor and the caretaker of the AG (if different). The caseworker will send the Request for Conciliation Notice and the AG will have 10 days to respond to the notice and schedule a conference. The conference can be with the caseworker or the caseworker's supervisor. The purpose of the conciliation conference is to determine:

- the reason for non-compliance;

- if the minor has good cause for non-compliance; and
- if the minor who is in non-compliance wishes to comply.

Failure to respond to the request for conciliation will result in removal of the minor's needs from the budget when determining the Families First assistance payment. A Notice of Adverse Action will be sent to the AG prior to the implementation of the sanction.

EXCEPTIONS:

A sanction is applicable unless the minor has good cause.

GOOD CAUSE:

Good Cause for failure to attend school or an alternate educational or training activity will be granted when:

- the minor parent has a verified physical or mental medical reason that prevents attendance in an educational or training activity;
- the minor parent's child has a verified illness that requires the presence of the minor parent to care for the child;
- the supportive services, such as child care, are not available and the Department cannot make them available;
- the child of a minor single parent is less than 1 year of age;
- the child of a minor parent in a two-parent AG is less than 16 weeks of age;
- the minor parent is participating in a drug or alcohol counseling program that prohibits their participation in school or other educational activities; or
- the minor parent has a documented emergency or catastrophe that the caseworker determines is sufficient to interrupt school attendance or educational/training activity. The caseworker should work with the caretaker and/or the minor parent to ensure that the minor re-enters school or the educational/training activity as soon as possible

Compliance:

If it is determined that the minor does not have good cause for non-compliance, but the minor parent states that he/she is willing to comply, he/she must attend school for two weeks to be in compliance.

VERIFICATION:

- Verify that the minor is engaged in the activity.
- If the minor is participating in another educational or training activity, investigate the activity to determine if it qualifies as a substitute for school attendance.
- Verify good cause if it is claimed for failure to participate in school or other approved educational or training activity.
- Verify compliance if the minor agrees to comply.

DOCUMENTATION

- Document the minor's participation or failure to participate in school, educational activity or a training activity.
- Document the alternate activity if not in school and how the activity qualifies as a substitute for school attendance.
- Document failure to attend school or an alternate activity as non-compliance on the Personal Activities screen and record any additional information on CLRC.
- Document the results of the conciliation conference or the failure to respond to the request for conciliation.
- If the minor agrees to comply, document the minor's agreement to comply and the compliance completion (after two weeks) on CLRC.
- Document the claim of good cause, the caseworker's decision, and how the caseworker arrived at the decision on CLRC.

PROCEDURES:

- Verify school attendance.
- If not in school, determine if the minor is in an alternate educational or training program.
- If in an alternate program, determine if the alternate activity satisfies the requirement.

SANCTIONS

- If the minor is not in school and does not have an approved alternate activity, attempt to contact by phone.
- Send a request for a conciliation conference.
- If the conference is not attended, initiate a reduction in benefits. ACCENT will send a Notice of Adverse Action. Continue Medicaid coverage for the minor.
- If the conference is attended, determine if good cause exists.
- If good cause exists, do not sanction.
- If good cause does not exist, determine if the minor is willing to comply.
- If the minor is willing to comply, monitor the compliance for two weeks to determine if compliance is being met.
- If compliance is met, do not sanction.
- If good cause does not exist and the minor is not willing to comply or does not comply during the two-week compliance period, initiate a reduction in benefits and a Notice of Adverse Action. Continue Medicaid for the minor.
- If the removal of the minor's needs result in AG ineligibility, begin the closure process.
- The caseworker should work with the AG to encourage the minor to attend school. The caseworker should also work with the AG to provide the supportive services necessary for the minor to attend school.

IV. FAILURE OF MARRIED MINORS, MARRIED MINOR PARENTS AND OTHER AG CHILDREN TO ATTEND SCHOOL

POLICY STATEMENT:

Assistance group children, including married minors and married minor parents (and SSI children), must attend school, unless good cause is established (see the previous section (IV) for a discussion about unmarried minor parents).

Failure of any or all AG children, including married minors and married minor parents, to attend school, without good cause, will result in a 20% sanction to the AG cash payment.

SANCTIONS

The sanction will remain in effect until the AG is in compliance with the school attendance requirements. The budget will have the 20% reduction removed the first possible month following compliance.

If other sanctions are imposed on the AG at the time the 20% sanction is imposed, the 20% sanction will be applied to the net grant payment. For example, if the AG has an IPV disqualification or a minor parent sanction, the school attendance sanction will be applied to the net grant after the other disqualifications or sanctions. If the AG also has a 20% sanction for immunizations/health check, the AG will have two separate reductions, or 40%, from the net grant.

EXCEPTIONS:

Sanctions will be applied to all AGs that have school age children who are not attending school and do not have good cause.

GOOD CAUSE:

The good cause reasons for failure to attend school are listed in the School Attendance chapter.

VERIFICATIONS:

If it is determined by the caseworker that a school age AG child is not in school, it is the responsibility of the caretaker to verify school attendance or good cause for failure to attend school.

DOCUMENTATION:

The caseworker must document:

- the reason the caretaker states the child is not in school;
- whether or not good cause is claimed or granted, the reason for the caseworker's decision regarding good cause; and
- the month compliance with school attendance is met on the Personal Activities screen.

PROCEDURES:

- When information is received that a school age child is no longer in school, the caseworker will contact the caretaker to determine if the information is correct or if there is good cause for failure to meet school attendance requirements**. A formal conciliation is not required in this instance.**

- If the caretaker provides supporting information to establish good cause, the grant will not be reduced.

- If the caseworker is not able to get in touch with the caretaker or if the caretaker does not provide proof of good cause, the caseworker will rerun AEABC to recalculate the budget, initiating the reduction in benefits and send the Notice of Adverse Action.

- The grant will be reduced the first month following the month of adverse action.

- If the school attendance requirement is later met, the 20% sanction will be removed from the budget calculation the first possible month following compliance. This would be the next month for all changes made prior to recurring month processing and the second subsequent month for all changes made after recurring month processing. If the compliance is verified before the recurring processing and the caseworker fails to recalculate the grant amount, the caseworker will issue an auxiliary payment for the month(s) the cash payment is in error.

V. FAILURE TO HAVE IMMUNIZATIONS AND/OR HEALTH CHECKS:

POLICY STATEMENT:

Children in Families First AGs (including SSI children) are required to have immunizations and health checks unless there is a good cause reason not to have them.

An AG that fails to meet this requirement for one child or all children in the AG and does not have good cause will have a 20% sanction applied to the assistance group cash payment. The 20% sanction will apply when the AG fails to comply with either or both the immunizations and health check requirements. The sanction will remain in effect until the AG is in compliance with the immunization and health check requirements. The budget will have the 20% reduction removed the first possible month following compliance with the requirements.

If other sanctions are imposed on the AG at the same time the 20% sanction for immunization and health checks is imposed, the 20% sanction will be applied to the net grant payment. For example, if the AG has an IPV disqualification or a minor parent sanction, the immunization and health check sanction will be applied to the net grant after

the other disqualifications or sanctions are applied. If the AG also has a 20% sanction for failure to comply with the school attendance requirement, as well as a 20% immunization/health check sanction, the AG will have two separate sanctions, or 40%, reduced from the net grant.

EXCEPTIONS:

Sanctions will be applied to all AGs that have children who are not immunized and are not getting health checks and do not have good cause.

GOOD CAUSE:

The good cause reasons for failing to have immunizations and health checks are discussed in the Immunizations and Health Checks chapter.

VERIFICATION:

It is the responsibility of the caretaker to verify immunizations and health checks or good cause for failure to have children immunized and given health checks.

DOCUMENTATION:

The caseworker must document:

- the attempt(s) to reach the caretaker to discuss non-compliance;
- the reason the caretaker did not have the child(ren) immunized or given health checks;
- whether or not good cause is claimed, the decision on that claim, the reason for the caseworker's decision; and
- the month compliance with the immunization and health requirement is met.

PROCEDURES:

- When it is determined that a child is not receiving immunizations or health checks, the caseworker will contact the caretaker to determine if the information is correct or if there is good cause for failure to meet the immunization and health check requirements. **A formal** conciliation conference is not required.

SANCTIONS

- If the caretaker provides supporting information to establish good cause, the grant will not be reduced.

- If the caseworker is unable to contact the caretaker or if the caretaker does not provide proof of good cause, the caseworker will take action to reduce the cash grant and notify the AG of the adverse action.

- The grant will be reduced the first month following the month of the adverse action.

- If the immunization and health check requirement is later met, the 20% sanction will be removed from the grant calculation the first possible month following compliance. This is the next month for all changes made prior to recurring month processing and the second subsequent month for all changes made after recurring month processing. If the compliance is verified before the recurring processing and the caseworker fails to recalculate the grant amount, the caseworker will issue an auxiliary payment for the month(s) the cash payment is in error.

FAMILIES FIRST SANCTIONS DESK GUIDE

Sanction	Type of Sanction	First Occurrence	Subsequent Occurrences	Conciliation
Work	**Total AG Ineligibility**	**Until Compliance**	**Until compliance or 3 months, whichever is greater**	**Yes**
Voluntary Quit	**Total AG Ineligibility**	**3 Months or until individual is exempt, has replacement employment at equal wages or leaves AG**	**3 Months or until individual is exempt, has replacement employment at equal wages or leaves AG**	**No**
School Attendance Unmarried Minor Parent	**Remove needs of minor parent from AG**	**Until Compliance**	**Until Compliance**	**Yes**
School Attendance Married minors, Married minor parents, and other AG children	**20% reduction in assistance payment**	**Until Compliance**	**Until Compliance**	**No**
Immunization	**20% reduction in assistance payment**	**Until Compliance**	**Until Compliance**	**No**

DEPARTMENT OF HEALTH VISITS

POLICY STATEMENT:

Assistance groups that lose eligibility for any reason other than the successful transition to self-sufficiency will have a home visit by a nurse, medical social worker or other health professional from the Department of Health. The purpose of the visit is to determine if the health and/or safety of the assistance group children is in jeopardy.

ACCENT daily and monthly closure information will create a single file of all closures that require a DOH referral. This file will populate the DOHT database at the beginning of each month. The DOHT database will electronically send notices to DOH offices on cases requiring a DOH home visit referral. The home visit by the health professional will occur within 30 days of the Families First closure/denial and DOH will mail a copy of the DOH activity form documenting the home visit to the DOHT Team and to the DHS caseworker. During the home visit, the health professional will determine whether or not the assistance group is in an "at-risk" situation and in need of financial assistance in order to prevent:

- the removal of a child from the custody of her/his parents; or
- the loss of shelter or utilities.

In making the "at-risk" determination, the Department of Health professional will consider circumstances such as:

- the family's receipt of an eviction or utility (heat, light or water) cut-off notice due to lack of payment;
- unpaid shelter and/or utility bills that exceed the family's monthly income; or
- lack of food.

If the family has one of the above characteristics, then the family will be determined to be "at-risk." If the health professional determines that the assistance group is "at-risk," he/she will advise the assistance group that temporary assistance may be available from the Department of Human Services.

- If the AG is determined to be "at-risk" because of an eviction, utility cut-off notice or lack of food in the first month after Families First case closure, the Department of Health professional will complete a DOH activity form and mail a copy to the DOHT Team and to the DHS caseworker within 48 hours. The DOHT Team will enter the results of each home visit into the DOHT database within three working days. The caseworker will immediately issue an auxiliary payment on cases that DOH has determined to be "at risk." The caseworker will enter action taken into CLRC and also into the DOHT database. The caseworker will schedule a follow-up interview, to occur within 30 days, so that the AG can present the eviction or cut-off notice. The DOHT Team at the state office will track the county office action for timely completion.

DEPARTMENT OF HEALTH VISITS

No further auxiliary payments can be issued to this family for this month or any subsequent months if this documentation is not provided.

- If the assistance group's unpaid shelter and/or utility bills exceed their current income in the first month after Families First closure, the Department of Health will complete and mail a copy of the DOH activity form to the DOHT Team and to the DHS caseworker. The caseworker will set up an appointment for an interview to verify the unpaid shelter and/or utility bills and establish the AG's eligibility for an auxiliary payment. The caseworker will schedule the appointment so that, if the assistance group is eligible, the auxiliary payment will be issued within seven days of notification by DOH. The action taken will be the same if the AG contacts the caseworker before the DOH visit.

- The Department of Health professional may identify circumstances that warrant a review of the family's circumstances by the Department of Children's Services. This review must be completed before a conclusion can be reached that the children are in jeopardy of being removed from the home. If the Department of Health and the Department of Children's Services conclude that an auxiliary payment will prevent the removal of the children from the home, the Department of Human Services will be notified to issue an auxiliary payment. The DHS caseworker will wait for a determination from the Department of Children's Services that the child is "at-risk" before an auxiliary payment is issued. At that time, the caseworker will immediately issue an auxiliary payment.

All such auxiliary payments will be made in the amount of the assistance group's Families First grant prior to closure.

Auxiliary payments will be made for any additional month that the AG remains closed, if proof is provided that they meet the eligibility criteria. NOTE: A visit by a Department of Health professional is not required prior to issuing an auxiliary payment for these additional months (even if the AG is in an "at risk" situation).

The DOH and DHS staff will encourage the assistance group to reapply for Families First when discussing the auxiliary payment. The Department of Health and Department of Human Services staff may also suggest that the assistance group apply for Food Stamps if they are not already receiving them. An emergency appointment for Food Stamps may be necessary in these instances.

NOTE: The closure notices refer to the auxiliary payments as "special cash payments." Therefore, if an individual requests a "special cash payment," he or she is referring to an auxiliary payment.

DEPARTMENT OF HEALTH VISITS

EXCEPTIONS:

A Department of Health visit and auxiliary payment cannot be made when the assistance group is closed because:

- the assistance group's income or resources exceed Families First limits;
- the assistance group requested a closure in writing;
- there are no children within the age limits;
- the family has moved out of the state;
- all children in the assistance group reside with a different caretaker; or
- the only child in the assistance group has died.

AGs closed at the caretaker's written request or because the AG children are in the care and control of another caretaker do not require a DOH referral, even if the children are in the same residence. AGs closed because the children are in the care and control of another caretaker will not be referred to DOH and are not eligible for an auxiliary payment.

VERIFICATION:

If the AG has shelter/utility expenses that exceed their current income, verification of these expenses must be provided prior to the authorization of the auxiliary payment.

NOTE: During the first month after closure, if the DOH home visit has not been accomplished at the time of the auxiliary request, obtain the appropriate verification for these auxiliary payments while awaiting the home visit. Do not wait until the home visit is made to request the verification.

The AG must provide verification of eviction or utility cut-off due to non-payment within 30 days of the issuance of the auxiliary payment.

DOCUMENTATION:

ACCENT will populate the DOHT database at the beginning of each month with closures requiring a DOH home visit referral. The DOHT database will electronically send referrals to DOH offices on cases requiring a DOH home visit. The DOH office will complete an activity form and will mail a copy to the DOHT Team and a copy to the caseworker. The DOHT Team will enter the information from the activity form into the DOHT database. The caseworker will enter the information from the activity form onto CLRC. The caseworker will take action as requested by the DOH and enter action taken onto CLRC and the DOHT database. The DOHT Team will track the county office action.

Any additional contacts and/or auxiliary payments made while the case is in closed status must be documented on CLRC and must be entered into the DOHT Database.

PROCEDURES:

- When a Families First assistance group is closed for any reason other than those listed in the EXCEPTIONS portion of this chapter, ACCENT will populate the DOHT database at the beginning of each month.

- The DOHT database will electronically send DOH home visit referrals to the local County Departments of Health on closures requiring a home visit referral. Referrals must be sent to local County Departments of Health, even if the AG states that they do not want to have a health visit.

- The DOH Referral will include the following information:
  - the case name;
  - -case/cat/seq;
  - -the caseworker's name; and
  - -the date of the referral.

- When the AG is denied for Families First because of voluntary quit, the caseworker will submit a referral to the Department of Health. Referrals for homeless AGs should include as much information as possible to assist DOH in contacting the family in the absence of an address. Referrals must be sent to DOH, even if the AG states that they do not want to have a health visit. Referrals will be sent to the local DOH offices by the caseworkers via e-mail. The DOH home visit referral from the caseworker will include the following information:

  .- the case name;
  - -case/cat/seq;
  - -the caseworker's name; and
  - -the date of the referral.

- The Department of Health professional will make three attempts to call assistance group by telephone to schedule a home visit. If these attempts are unsuccessful, the health professional will mail a letter to the AG advising them of the scheduled visit. If DOH is successful in completing the home visit, the health professional will make a general assessment of the health and safety of the AG children through verbal contact and observation.

- The DOH will report all home visit findings, refusals of home visits and contact attempts. The DOH will mail a copy of the DOH activity form to the DOHT Team and to the DHS county office within three working days of its completion, unless the DOH is requesting the caseworker to issue an auxiliary. In this case, the DOH must mail a copy of the DOH activity form to the DOHT Team and the DHS caseworker within 48 hours.

DEPARTMENT OF HEALTH VISITS

- If the health professional determines that the assistance group is "at-risk, he/she will advise the assistance group that temporary assistance may be available from the Department of Human Services in the form of an auxiliary payment.

- The DHS county office will enter information from the DOH activity form into CLRC. The DHS office will take action requested by DOH and will enter this information into CLRC and also into the DOHT database.

- The DOHT Team will track the action taken by the DHS county office for timely completion of necessary documentation.

- When an AG that is "at-risk" because of an eviction, utility cut-off notice or lack of food requests an auxiliary payment during the first month that the Families First case is closed, contact DOH immediately. DOH will attempt to visit these AGs as quickly as possible. However, it is the responsibility of DHS to issue the auxiliary payment within 48 hours of the request whether or not DOH is able to provide feedback within that time. Prior to issuing the auxiliary (but within 48 hours), attempt to determine if the rent or delinquent utility bill has been paid. If payment has been made, and risk of utility cut-off and/or eviction no longer exists, DO NOT issue the auxiliary. If payment cannot be determined, issue the auxiliary.

- When an AG that is "at risk" because of **verified** unpaid shelter and/or utility bills that exceed their current income requests an auxiliary payment during the first month that the Families First case is closed, issue the auxiliary payment within seven days of the auxiliary payment request. This action should be taken whether or not the DOH home visit has been made. The AG must provide appropriate verification of their income/expenses prior to the issuance of the auxiliary payment. If the DOH home visit has not been accomplished at the time of the request, **make an appointment** (within 7 days) for an interview and obtain the appropriate verifications. Do not wait until the home visit is made to request the verification

- Process requests for auxiliary payments received after the first month of closure within appropriate time frames depending on the reason for the auxiliary payment (eviction, unpaid shelter/utility expenses exceeding income, etc.). (As is the case for the first month after closure, do not require a home visit by a DOH professional prior to issuing an auxiliary payment for a month beyond the first month after closure).

- If an AG determined to be "at-risk" because of an eviction or utility cut-off notice or lack of food requests an auxiliary payment after the first month of closure, issue an auxiliary payment within 48 hours of the request. Prior to issuing the auxiliary (but within 48 hours), attempt to determine if the rent or delinquent utility has been paid. If payment has been made, and risk of utility cut-off or eviction no longer exists, do not issue the auxiliary. If payment has not been made or cannot be determined, issue the auxiliary. Schedule a follow-up interview, to occur within 30 days, so that the assistance group can present the eviction or cut-off notice. NOTE: Verification can occur prior to auxiliary issuance but do not delay past the 48-hour time frame.

DEPARTMENT OF HEALTH VISITS

- If an AG determined to be "at risk" because of verified unpaid shelter and/or utility bills that exceed their current income requests an auxiliary payment after the first month of closure, set up an appointment for an interview to establish the AG's eligibility for an auxiliary payment. Schedule the appointment so that, if the assistance group is eligible, the auxiliary payment can be issued within seven days of the request.

- If there are indications of endangerment to the health and safety of the child, the DOH professional will make a referral to the Department of Children's Services. If the Department of Health and the Department of Children's Services conclude that an auxiliary payment will prevent the removal of the children from the home, the Department of Human Services will be notified to immediately issue an auxiliary payment. In this instance, the DHS caseworker must wait for the determination from the Department of Children's Services that the child is "at risk" before an auxiliary payment is issued. An auxiliary payment will not be issued based on the Department of Health determination alone when endangerment is the issue.

- When discussing the auxiliary payment with the AG, the caseworker will also encourage the AG to reapply for Families First benefits. If the AG was closed because of time limits, the AG will be evaluated for early re-entry to Families First in accordance with policy found in the Re-Entry Chapter of the Families First Handbook. Likewise, if the AG was closed because of a sanction, the caseworker should discuss compliance with the AG and encourage the AG to comply and reapply. If the AG is closed because of a second or subsequent sanction or voluntary quit, the caseworker must provide guidance to help the AG avoid such sanctions once the sanction period is served.

- If an auxiliary payment is appropriate, the caseworker will issue the payment in the amount of the Families First grant the AG received at the time of closure and will document CLRC the action taken.

- If the AG has a pending Families First application when the Department of Health notifies the caseworker that an auxiliary payment is required, the caseworker will issue the auxiliary payment. If the case is approved, the eligibility begin date will be the month after the month the auxiliary was issued.

- If the AG has been reopened at the time that the Department of Health notifies the caseworker that an auxiliary payment is required, the caseworker will not issue the auxiliary payment.

- If the caseworker becomes aware that an AG has moved to another county after the DOH referral has been generated, the caseworker should enter this information into CLRC and the DOHT database comment section. The caseworker should send an e-mail to the DOHT Team and the DOH office advising them that the AG has moved. The caseworker should transfer the case to the new county of residence. The local DOH should send their home visit referral to the DOH office in the county where the AG moved. The new DOH office should take action on the home visit referral, complete a DOH activity form and

mail a copy to the DOHT Team and to the new DHS office. The new DHS office is responsible for taking action as requested by the DOH, and entering all actions taken on CLRC and the DOHT database.

DEPARTMENT OF HEALTH TRACKING TEAM PROCESS FOR REQUESTING DOCUMENTATION/ACTION FROM DHS

If the DOHT Team worker cannot complete action needed on the DOH home visit referral until the DHS caseworker (CW) clarifies record documentation, the DOHT Team worker may contact the CW via e-mail. It is imperative that the CW respond within three working days to resolve the clarification issue. The CW will update CLRC with the needed clarification and e-mail the DOHT Team worker explaining that CLRC has been updated with the needed clarification. If the CW cannot clarify the documentation within three working days, the CW will e-mail DOHT Team worker within three days explaining this. If more than one request for information is necessary, the CW will be given three working days between each request to respond. The escalation order for requests is listed below:

1st Request – From the DOHT Team worker to the CW and a copy to the FS1.

2nd Request – From the DOHT Team worker to the CW and copies to the FS1, the Program Supervisor, the Family Assistance District Director, and the DOHT Team Unit Supervisor.

3rd Request – From the DOHT Team Unit Supervisor to the CW and copies to the FS1, the Program Supervisor, the Family Assistance District Director, and the State Office, and the DOHT Director.

If the CW has questions on a DOHT home visit referral, the CW may communicate with the DOHT Team worker via e-mail. A response to the CW will be expected within three working days of the date the e-mail was sent. If a response is not received within the required time frame, the following procedures will be applied. A response is expected within a maximum of three working days of each request.

1st Request – From the CW to the DOHT Team worker and the DOHT Unit Supervisor and a copy to the DHS FS1.

2nd Request – From the CW to the DOHT Team worker, the DOHT Unit Supervisor, and copies to the DHS FS1 and the DHS Program Supervisor.

3rd Request – From the CW to the DOHT Team worker, the DOHT Unit Supervisor, the DOHT Director, and copies to the DHS FS1, the DHS Program Supervisor, and the State Office.

GENERAL ADMINISTRATIVE PROCEDURES

POLICY STATEMENT:

Case Record Management:

- All families First cases are maintained in an electronic file.

- The one page paper application form that is signed by the applicant/recipient is maintained in the county office in an alphabetical file by month of application or reapplication. These forms must be maintained in a manner that allows then to be retrieved as necessary.

- The Families First assistance group is a part of the case file for all of the members of a common residence group. There may be multiple assistance groups in a single case. The application or reapplication for assistance is completed on a single one-page application form for all types of assistance- Families First, Food Stamps, and Medicaid for all members of the common residence group.

- case numbers and individual recipient ID numbers are assigned by ACCENT.

- The case number contains a 10 digit number that is a common number for the residence group. The case number will also have a 4 digit alpha category type which defines the type of assistance for which the assistance group potentially qualifies. The case number also contains a 2 digit sequence number that identifies the assistance group when there is more than one of that category contained in the case file.

- case records will maintain their case number as long as the case is in active or historical status on ACCENT. When a closed case reapplies, the old case number should be selected to reopen an application. Individuals that leave an existing case and apply in their own right will have a new case number assigned, but will retain their existing recipient identification number.

Content of the Case Record:

- The application and reapplication interviews are conducted in an on-line interactive process. If the system is not available or if the interview must be conducted in a remote site where the system is not available, the interview shall be recorded on a paper application and shall immediately be entered in the ACCENT system upon return to the office.

- The date of the application/reapplication will always be the date the signed and dated application form is received in the county office or if the interview is conducted in a remote sight and the form is provided at this time, the date will be the date the case

manager receives the form. The application date is entered on AEFPY and is used to track the case for the timeliness and establish the start date of benefits.

- The electronic file will contain responses to all interview questions.

- The file will contain verifications of all eligibility components. The verification will be entered on the appropriate screen using the appropriate code to describe the source of the verification. The date of the information is recorded on the screen and the system date will reflect the date the information is entered.

- Comments, additional verification information, and any other pertinent information to the eligibility of the case will be recorded on the running record comment screen (CLRC). It is not necessary to document additional information about every piece of information where a code is used to verify information, but CLRC should be used to provide details of the verification that may be unclear otherwise. When recording information on CLRC, the case manager should always indicate her/his name on the recording.

- Verification that is provided by the application/recipient or secured by the case manager should be recorded on the correct screen and/or CLRC and should be returned to the applicant/recipient or destroyed as appropriate.

- The case manager may request the expected change screen to remind her/him of potential changes that may occur in a case.

- The ACCENT system will issue alerts to the case manager on the case when an action is needed to update the file or review certain information.

Security of ACCENT Case Files:

- All individuals requesting access to the ACCENT system must have a RCAF number and must complete an ACCENT enrollment form. Upon appropriate authorization, the individual will be given access to ACCENT. The individual's security profile will define the type of access (update or inquiry) and the screen's that may be accessed.

- The access to ACCENT in the county office if approved by the Area Manager or the District office. Access at the state level is approved in the state office by the Program Director or Assistant Commissioner. The Security Coordinator (in the county office, known as the AAA) sets the security profile.

- The caseloads in the ACCENT system has a primary case manager and there may be a total of 5 case managers (EC profile) that are attached to a case. This profile will permit inquiry and update. The county and district supervisor will have inquiry and update access to the cases that are managed by the case managers that are in their administrative structure.

- Security must be maintained at all times. Staff must never share their system sign-on password and must sign-off of the system when away from their work station.

Confidentiality of Case Record Information:

The Department of Human Services in Tennessee, in accordance with the laws of this State and the Federal statutes pertaining to this subject, has adopted the policy of maintaining the confidential nature of Family Assistance, including Families First, information. The confidentiality objectives are:

- develop a relationship of confidence between the department and the applicant/ recipient.

- define and protect the right of applicants and recipients by safeguards which prevent their identification as a special group; their exploitation for commercial, personal, or political reasons; and which prevent information to be made available solely as a basis for prosecution and other proceedings except as directed by General Counsel.

- Provide a basis for recognition by the Court of the right of the Department to protect its records.

- Develop a relationship of confidence between the Department and the public at large by protecting information made available to the department by representatives of the public and by utilizing such information only for the purpose of the proper functioning of the Department's programs.

Information Considered Confidential:

- case record information

- Lists of Families First recipients

- Reports of investigations and medical investigations

- Information contained on applications and in the electronic file

- Names and addresses of Families First recipients and all other information known to the agency in connection with Family Assistance and other services.

Exceptions to Confidentiality:

- Release to law enforcement officials to assist in prosecuting fraud against the Department or child abuse.

- release to appropriate agencies assisting in collection of child support in the Families First program.

- Release to service providers, such as mental health professionals, providing services to abusive or neglectful parents.

- Release to contracting agencies working with the department who are providing Families First work services.

- Release to the child's guardian ad litem in child custody and guardianship cases.

- Release disbursement reports, total expenditures of funds, number of recipients and other statistical information, social data, and reports on surveys. Disbursement reports cannot be copied.

- Release to agencies where the information operates to the welfare of the individual and will not be used for embarrassment or exploitation and the agency assures that confidentiality will be protected and the agency gives assurance that the information will be used only for the purposes it was requested.

- Information may be released to appropriate law enforcement officials as may be needed in the apprehension and/or conviction of a felon. This information will not be released to process servers or for civil reasons.

- Information that is requested through a valid subpoena or court order will be provided. The court will be asked to limit the scope of discovery if it appears that this gives the Attorney an opportunity to review information that is not part of the intended request.

- Release to the applicant or recipient.

Release of Information to the Applicant/Recipient or her/his Representative:

- The A/R or representative can request information be printed from her/his ACCENT record. A charge of 10 cents per page may be made except when being secured for a fair hearing.

- Upon proof that the attorney has been secured by the A/R, the attorney or an authorized non-lawyer employee will have access to examine, request print, or copy information in the file. The file should be documented by the case manager when this occurs.

- If an A/R or representative is viewing the record on-line, the case manager must be present.

- Information considered "Confidential" by the provider and potentially damaging to the A/R should be provided after DHS informs the individual or her/his attorney that it is inadvisable and the individual or attorney continues to want access to the information.

Applications by Department Employees and Their Relatives

The FS 1, Area Manager, the District Family Assistance Director, or the District Administrative Director must be made aware as appropriate of applications, reapplications, or changes to assistance groups containing an employee or a relative of an employee.

Applications made by an employee or a relative of an employee of the Department should be processed by a county or district supervisor.

The case should be maintained in a "Confidential Caseload" on ACCENT.

The county office should maintain a plan to ensure that confidential procedures are followed for employee and relative applications, reapplications, and changes.

Families First State-Only Program

In the Families First program, there are some assistance groups whose grants are paid for out of only state funds rather than with both state and federal (TANF) funds. There are four types of assistance groups that make up Tennessee's state-only program:

all ADCU assistance groups;

assistance groups that meet the married during receipt of assistance criteria when the spouse is <u>included</u> in the AG; and

assistance group members whose caretaker or second parent do not meet the requirements to allow inclusion in the grant or whose caretaker or second parent has been convicted of a Class A drug-related felony offense, which occurred after August 22, 1996.

All other Families First assistance groups are in the TANF funded program.

All Families First assistance groups are subject to the same Families First policy, regardless of whether they are paid from state-only or TANF funds. State-only assistance groups are eligible for the same services, benefits and supports as TANF AGs. They are also subject to the same time limits, work requirements, and sanctions.

RIGHT TO APPLY FOR FAMILIES FIRST

POLICY STATEMENT:

- Any person wishing to do so shall have the opportunity to apply for Families First.
- Information about the Families First program administered by the Department of Human Services shall be provided to any person requesting it.
- Applications must be filed in the DHS Office in the county of the applicant's residence and must be on a form prescribed by the agency. The application must be filed by the applicant, his/her authorized representative or designated agent, or someone acting responsibly for him/her.
- An applicant may be assisted by any individual of his choosing in the various aspects of the application/redetermination of eligibility process. However, it is unlawful for any person/agency to charge or receive anything of value, either directly or indirectly, for providing such assistance to a person requesting Families First.
- A person found eligible for Families First cash payments is eligible for Medicaid (Tenncare) benefits without filing a separate application.
- Proof of eligibility is not required of a person prior to his filing an application.
- The right to file an application shall not be denied to any person even though it is apparent to the case manager that eligibility for Families First benefits does not exist.
- The applicant (or designee) must complete an interactive interview with the case manager whereby the application will be completed through on-line entry of information into the ACCENT system. In the even the ACCENT system is unavailable the information will be collected via a paper application and will be entered into the ACCENT system at a later time to complete the electronic case file.

RIGHTS AND RESPONSIBILITIES

POLICY STATEMENT:

The Tennessee Department of Human Services, at all administrative levels, will not discriminate against any applicant, participant, employee or contractor in any program aspect, for reasons of age, race, color, sex, disability, religious creed, national origin, or political belief.

Since the advent of the Families First Program, the services provided by the Department of Human Services have expanded. The Department works with agencies in every part of the community in an effort to help our participants become self-sufficient. It is, in part, because of our extended reach, that our responsibilities have increased. We are responsible for knowing about the civil rights laws that ensure equal and fair treatment for our participants in every aspect of the Families First Program and in those supporting programs that provide services to our participants.

Federal Nondiscrimination Laws that Apply to TANF Programs

- **Federal laws that prohibit discrimination in federally funded programs apply to the Families First Program and the actions of our contractors and service providers, just as they do other federally funded programs and their providers. An overview of the federal laws that prohibit discrimination in any federally funded program, including the Families First welfare program (and state-only funded Families First) is listed below.**

  - Title VI of the Civil Rights Act of 1964 **– prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal funds or other federal financial assistance.**

  - **Title VII of the Civil Rights Act of 1964** – prohibits private, state, and local government employers with 15 or more employees, and employment agencies from discriminating on the basis of race, color, sex (including pregnancy), religion or national origin in all aspects of an employment relationship. This includes hiring, discharge, compensation, assignments, and other terms, conditions, and privileges of employment.

  - **Section 504 of the Rehabilitation Act of 1973** – prohibits discrimination on the basis of disability by employers and organizations that receive federal financial assistance.

  - **The Americans with Disabilities Act of 1990 (ADA)** – prohibits discrimination on the basis of disability by both public and private entities, whether or not they receive federal financial assistance.

- **The Age Discrimination Act of 1975 (ADEA)** – prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance.

- **Title IX of the Education Amendments of 1972** – prohibits discrimination on the basis of sex in educational programs and activities that receive or benefit from federal financial assistance.

  - **The Equal Pay Act (EPA)** – requires payment of equal wages to men and women performing substantially the same work unless the pay discrepancy is based on a seniority or merit system (a system that measures quantity or quality of production, or a factor other than sex). The EPA applies to employers of any size.

Other related regulations include:

- **Titles VII and VIII of the Public Health Service Act** – bars sex discrimination in admissions to health training programs.

- **Hill Burton Community Service Assurance Act** – requires that hospitals or other health care facilities assisted under the Act provide services to persons residing in the community without discrimination based on race, color, national origin, or method of payment. Hill Burton hospitals may not refuse emergency services because of a person's inability to pay.

- **Drug Abuse Office and Treatment Act of 1972** – hospitals may not refuse to admit or treat anyone needing emergency care solely because that person is dependent on or addicted to drugs.

- **Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970** – hospitals may not discriminate in admissions or treatment against alcoholics solely because of alcohol abuse.

- **Multi-Ethnic Placement Act of 1994 (MEPA)** – prohibits placement of children for adoption and foster care on the basis of race.

Coverage by Federal Nondiscrimination Laws

- The **nondiscrimination statutes** listed above prohibit discrimination on the basis of race, color, national origin, age, and disability in programs or activities that receive or benefit from federal financial assistance. These same statutes prohibit discrimination on the basis of sex in education and training programs that receive federal assistance. Discrimination on the basis of disability is prohibited in all programs, services, or activities of public entities. ADA (Americans with Disabilities Act) coverage does not depend on the receipt of federal funds.

RIGHTS AND RESPONSIBILITIES

- The **employment discrimination statutes** prohibit discrimination on the basis of race, color, religion, national origin, citizenship status and unfair documentary practices regarding employment verification, sex, age, and disability in private and public sector employment. Depending on the circumstances, the Department may be subject to coverage under both the nondiscrimination statutes and the employment discrimination statutes.

These laws apply to:

- state agencies that receive federal money through a block grant to conduct welfare programs;
- county and city agencies that assist in job training as part of a welfare program;
- private contractors and service providers that help welfare participants find jobs or training;
- county offices that determine eligibility for food stamps;
- offices that operate federally funded child nutrition programs (for example, National School Lunch Program and the Women, Infants and Children program);
- state agencies that refer welfare recipients to businesses or public agencies for employment; and
- private contractors and businesses that contract with the state to provide job referral services for welfare participants.

Family Assistance Accommodations Requirements

- DHS is required to provide reasonable accommodations to applicants/recipients to ensure that they have equal access to benefits and services. *"Reasonable accommodation"* includes, but is not limited to:

- modifying existing facilities to make them accessible;
- acquiring or modifying equipment;
- providing readers or sign language interpreters; and/or
- offering modified work plans for Families First AGs.

Accommodations are designed and granted on a case-by-case basis to address special needs and to guarantee that every applicant/recipient has full access to Family Assistance Programs.

At each client contact, ensure that the individual has all of the information and assistance from the Department that is needed to complete the application, interview or other action, prior to ending the conversation. If an accommodation is requested but it is questionable whether or not the request can or should be fulfilled, contact the Area Manager or FS1 for a final decision.

- Accommodations should be offered when:

  - the client requests accommodations based on a disability or impairment that will prevent access to our services;
  - the DHS staff member (counselor, front desk staff, contractor, etc.) is concerned that the individual may not understand the application, verification or recertification instructions;
  - the DHS staff member is concerned that the individual may not complete the application or recertification review without these accommodatons;
  - the program's policies dictate that a waiver from the office interview is appropriate; or
  - other circumstances or information lead DHS staff to think that accommodations are needed.

  All clients must have access to our standard services. While accommodations must be offered to those in need of them, these specialized services are a client option, not a requirement.

County Office Accommodations Procedures

Written procedures must be in place in each county to ensure that all staff who directly serve clients are aware of how to arrange for accommodations and know who must be consulted to make these arrangements.

Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency (LEP)

In order to ensure compliance with Title VI, DHS must take steps to ensure that LEP persons who apply for or receive Families First and our related programs have meaningful access to those programs. The most important step in meeting this obligation is to provide the language assistance necessary to ensure such access, at no cost to the LEP person.

- The type of language assistance provided depends on a variety of factors, including:

  - the size of the organization providing the service;
  - the size of the LEP population it serves;
  - the nature of the program or service;
  - the objectives of the program;
  - the total resources available to the organization providing the service;
  - the frequency with which particular languages are encountered; and
  - the frequency with which LEP persons come into contact with the program.

- The key to providing meaningful access for LEP persons is to ensure that the Department and the LEP person can communicate effectively. The steps taken must ensure that the LEP person:

- is given adequate information;
- is able to understand the services and benefits available;
- is able to receive those benefits and services for which he/she is eligible; and
- is able to effectively communicate the relevant circumstances of his/her situation to the Department.

- In order to ensure that persons are not excluded from equal program participation due to limited English proficiency (LEP), the Department must provide trained and competent interpreters and other oral language assistance services to accommodate our LEP clients. We may:

  - hire bilingual staff;
  - hire staff interpreters;
  - use volunteer staff interpreters;
  - use volunteer community interpreters;
  - contract with an outside interpreter service; or
  - use a telephone interpreter service.

Friends and family members may be used as interpreters at the request of the LEP customer provided the use of such a person would not compromise the effectiveness of the services, violate confidentiality, and the customer is first advised that a free interpreter is available. The LEP customer's declination of the offer of free interpreter services must be documented. Also suggest that a trained interpreter (in addition to the friend/family member) sit in during the interview to ensure reliable and correct interpretation of information. Minor children cannot be used as interpreters.

- Written materials that are routinely provided in English to applicants, recipients, and the public must be made available in regularly encountered languages other than English. We must ensure that communication tools are provided to LEP customers. The following is a list of the minimum requirements for written documents that should be in the language of the customer:

- any documents that have to be signed;
- documents that describe the eligibility requirements to participate in a program;
- notifications of changes in status;
- documents informing customers of rights; and
- communications informing customers of meetings and reviews for the purpose of recertification.

- OCR (Office for Civil Rights) will consider the Department to be in compliance with its Title VI obligation to provide written materials in non-English languages if for:

- **LEP language groups that constitute ten percent or 3,000** (whichever is smaller) of a service area, the Department provides translated written materials, including vital documents, for each eligible person to be served or likely to be directly affected by the FF program;

- **LEP language groups that constitute five percent or 1,000** (whichever is smaller) of a service area, the Department ensures that, at a minimum, vital documents are translated into the appropriate non-English languages for each eligible person to be served or likely to be directly affected by the FF program;

- **LEP language groups that constitute fewer than 100 persons** in a service area, the Department does not translate written materials but provides written notice in the primary language of the LEP language group of the right to receive competent oral translation of written materials for each eligible person to be served or likely to be directly affected by the FF program.

  The "service area" is defined as the county served by each DHS office. The LEP population in each county would determine how individual offices apply the Title VI directives.

Title VI Prohibition on Discriminatory Conduct In Federally Funded Programs and Activities

DHS may not discriminate against people on the basis of race, color, national origin, disability, or age in how we administer our programs or activities.

DHS may not indirectly discriminate on these bases through contractors or by means of any other arrangement. The Department is responsible for ensuring that our contractors administer their programs in a nondiscriminatory manner. *Public entities and private contractors that contract with the state to administer welfare programs are subject to the nondiscrimination statutes because they act as agents of DHS in carrying out the program or activity, not because they are recipients of federal assistance.*

- DHS **may not exclude or deny welfare benefits** to persons based on their race, color, national origin, disability, or age, or on the basis of sex in education programs.

  Examples:

  - DHS caseworkers may not reject an applicant for benefits because he/she is or appears to be an African-American, Hispanic, Asian, American Indian, Alaskan Native, or a member of another racial or ethnic group. If an applicant declares that he/she is a U.S. citizen, no further verification is required unless there is reason to question the statement.

  - Caseworkers may not reject an application based on the assumption that a person with a foreign-sounding last name is not a citizen and therefore not eligible.

  - Neither DHS caseworkers nor the employees of a Families First contractor may deny benefits to persons who are not fluent in English because they assume

- persons who are, or appear to be, from other countries and are not English proficient, are not eligible for such benefits.

- DHS **may not impose different standards or procedures to determine who may receive benefits** on the basis of race, color, national origin, disability, or age, or on the basis of sex in education programs.

  Examples:

  - A Families First caseworker may not accept a self declaration of qualified immigration status requiring verification from applicants who appear to be of African origin, yet require all immigrants from Spanish speaking nations to submit INS documentation because of an assumption that these applicants are illegal aliens.

  - Families First personnel may not report suspected illegal aliens to the INS on the basis of race, color, or national origin. Independent evidence supporting illegal alien status is necessary.

  - An employee of a contractor hired by the state may not delay a review of referrals from older individuals until after she evaluates referrals from younger persons.

- DHS **may not provide different benefits** to persons on the basis of their race, color, national origin, disability, age, or on the basis of sex in education programs.

  Examples:

  - Do not reject applicants for job training programs because they are or appear to be Hispanic.

  - Do not assume that a single mother with four children would be unable to complete a rigorous training course because of her family responsibilities.

  - A DHS office located in an area consisting of Hispanic immigrants with limited English proficiency must provide written materials or other communication services in both English and Spanish that describe all of the benefits and services offered to applicants and participants.

Type of Conduct Prohibited in Employment Settings

- Employment discrimination laws protect workers and prospective workers from discrimination based on race, color, national origin, citizenship status and unfair documentary practices related to employment eligibility, religion, sex, age, or disability. These laws cover both individual employers and employment agencies, including DHS and contractors that provide job placement services for our program participants. The laws prohibit discrimination in all aspects of the employment.

process: hiring and discharge, compensation, assignments, and all other terms, conditions, and privileges of employment.

Examples:

- Employers or those referring welfare participants to employers may not discriminate on the basis that a person looks "foreign" or has an accent.

- Employers must accommodate an employee's or welfare participant's religious practices unless doing so would create an undue hardship. For example, people must normally be permitted to wear religious attire unless doing so would create a safety hazard. Furthermore, a welfare agency may not refuse to refer an individual for employment because of his or her need for religious accommodation.

- Employers may not place female Families First participants in office positions while male Families First participants are placed in manual labor positions based on assumptions of the individual's skills and strengths.

Discriminatory Conduct on the Basis of Handicap/Disability That Is Prohibited in Programs and Services

- **DHS may not discriminate against any qualified individual with a disability in providing services or administering any program or activity, whether or not the program receives federal financial assistance**. In general, an individual with a disability is "qualified" if that person meets the essential eligibility requirements for receipt of services or participation in the program or activity. DHS may not refuse to allow a person with a disability to participate because the person has a disability. We must eliminate unnecessary eligibility standards or rules that deny an individual with a disability an equal opportunity to participate. DHS may not harass a program participant or applicant based on a disability.

  Examples:

  - The director of a day care program which includes children of Families First participants who are attending employment training programs may not refuse to accept children who have emotional problems or who take medication for a disability.

  - Families First recipients with disabilities may not be prohibited from work activities, education, or training opportunities based on assumptions that such individuals are not qualified to participate in training or work.

  - A community college offering job-training for Families First participants may not require students with disabilities to provide medical histories if such histories are not required of all students.

RIGHTS AND RESPONSIBILITIES

- DHS is required to make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration in the program would result.

  Examples:

  - A job-training course for Families First participants must extend testing time when a person with a learning disability requests extra time to complete the test because of his/her disability. The course provider may ask the individual who is seeking extra time to provide reasonable documentation of the learning disability and the additional time that is required.

  - A Families First applicant with a mental disability who is unable to complete the application must be assisted.

  - If an individual with a disability, with or without reasonable accommodation, is unable to perform the essential functions of any available job, a state welfare agency should seek alternatives to the work participation requirement.

- DHS must ensure that programs and services are provided in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity for individuals with disabilities. Programs that provide special benefits to people with disabilities are permitted, but people with disabilities cannot be compelled to participate in those programs.

  Examples:

- A county DHS office may offer an alternate site for an eligibility interview at the Community Mental Health Center for those with mental disabilities. However, the office may not require people with mental disabilities to go to an alternate site for an interview.

  - A county DHS office may not require people with HIV to be served in a separate room from the other participants.

  - A county vocational training program may offer special training opportunities for people with vision impairments. However, it may not require people with impairments to participate in the special program or refuse to permit them to participate in courses open to other program participants.

- DHS must ensure effective communication with individuals who have hearing, speech, or vision impairments. Programs must provide auxiliary aids and services when necessary to ensure effective communication. However, they are not required to provide auxiliary aids that will result in undue financial and administrative burdens. Examples of auxiliary aids are Braille material, sign language interpreters, readers, or text telephones (TTYs).

Examples:

- A job placement program that makes information about job openings available by telephone must ensure that the information is available to users of TTYs.
- Printed information for applicants/participants about welfare eligibility requirements must also be provided on audiotape or in Braille for people who have vision impairments, or materials must be read to them.
- Job training programs for Families First participants must provide sign language interpreters for deaf students when it is necessary to ensure effective communication for those students.

- DHS may not exclude individuals with disabilities from programs and activities because buildings are inaccessible. However, the providers are not required to take any action that would result in a fundamental alteration in the nature of the program or activity, or in undue financial and administrative burdens. This means that providers need not remove physical barriers such as stairs in existing buildings as long as the programs are made accessible to individuals with disabilities in other locations or through other methods such as home visits.

  Examples:

  - A DHS office that is located on the second floor of a building that has no elevator may make its services available to an applicant who uses a wheelchair by meeting with that applicant in an accessible ground floor office.
  - A job-training program that usually offers classes in an inaccessible second-floor classroom may make its program accessible by relocating the class to an accessible classroom in another building.
  - An applicant with a physical disability who cannot be accommodated at the county office must be offered an alternative to the office interview that will accommodate his/her needs and, at the same time, satisfy program requirements.

Conduct on the Basis of Disability That Is Prohibited in Employment

- Employers and those referring Families First participants to employers may not impose qualification standards that screen out any individual with a disability or a class of individuals with disabilities unless such standards are shown to be job related and consistent with business necessity.

  Example:

  - An employer may want to require that all job applicants have a driver's license. If driving were an essential function of the position, for example, a bus driver's job,

no change in policy would be required. If the job could be done with accommodation (a personal driver, for instance), then the policy would have to include this accommodation. However, if an applicant were seeking a position for which having a driver's license is merely convenient (such as a secretarial position), the employer would be prohibited from applying this requirement to an applicant who does not have a driver's license because of a disability.

- The ADA limits an employer's ability to ask questions of applicants and employees regarding the existence, nature, or severity of a disability and to require medical examinations. Employers may not ask disability related questions of applicants or require medical examinations before an offer of employment is made. If an applicant has a known disability that may prevent the individual from performing the essential functions of the job, the employer may ask how, with or without reasonable accommodation, the applicant would perform the specific tasks required.

  Example:

  - A Families First recipient has just applied for a job as a data entry clerk. As she is filling out a personnel form, she mentions this is the first job she has had since she developed Carpal Tunnel Syndrome. The personnel manager cannot ask her for the name of her doctor so he can determine if she is currently under treatment. However, the personnel manager may ask her to demonstrate or describe how she would perform her job-related duties.

- Employers are required to provide reasonable accommodations to employees to enable them to perform the essential functions of the job unless the employers can demonstrate that providing a reasonable accommodation would cause an undue hardship to the employer. *"Reasonable accommodation"* includes, but is not limited to:

  - modifying existing facilities to make them accessible;
  - acquiring or modifying equipment;
  - providing readers or sign language interpreters;
  - offering part-time or modified work schedules; and/or
  - restructuring the duties of the job.

  In determining whether an accommodation would impose an *"undue hardship"* on an employer's business or program, the following factors should be considered:

  - the overall size of the business or program with respect to the number of employees, number and type of facilities, and size of the budget;
  - the type of the employer's operation, including the composition and structure of the workforce; and
  - the nature and cost of the accommodation needed.

Examples:

- A Families First recipient who uses a wheelchair obtains a job on the clerical staff of an employer whose offices are in a building that has two steps at the entrance. The employer may be required to provide reasonable accommodation for the employee by providing a ramp at the building entrance. A job training program offered by an employer may be required to provide sign language interpreters for deaf employees when it is necessary to enable them to participate in the training.

- DHS hires an accountant with vision impairment. The Department may be required to provide reasonable accommodation for the accountant by obtaining computer equipment to enable the accountant to read printed material.

Accommodations Procedures

- **Waiver of office interview** for Families First applicants/recipients:

- If the client has named an authorized representative for the AG, the representative can come to the office in lieu of the AG. The authorized representative may answer basic questions needed for eligibility determination but may not negotiate a PRP or provide other selected information, e.g. child support cooperation. The PRP and child support discussion must be with the A/R.

- the office interview **must** be waived upon request by any AG which is unable to appoint an authorized representative and:

  1. has no AG members able to come to the county office because they are 60 years of age or older or are handicapped/disabled;

  2. lives in an extremely remote location;

  3. has no AG members able to come to the county office because of transportation difficulties or similar hardships which the county determines, on a case-by-case basis, warrants a waiver of the office interview. These hardship conditions include, but are not limited to:

     a) illness;
     b) care of a household member;
     c) prolonged severe weather;
     d) hardship associated with living in a rural area; and/or
     e) employment or training hours that prevent an applicant/recipient from participating in a face-to-face interview.

     NOTE: if needed, the county office should try to accommodate working/training hours by scheduling appointments outside of traditional business hours.

- Telephone Interviews

  The county office may offer a telephone interview in lieu of a face-to-face interview for an AG for whom the face-to-face interview has been waived.

- Out-of-office interviews

  For those clients who are unable to come to the office or participate in a phone interview, interviews may be held in a mutually agreed-upon site (e.g. Community Mental Health Center, client's workplace, DHS satellite offices, community agencies, or other locations).

- alternate interview examples
  - when a client is hospitalized, a telephone interview or an authorized representative interview should be offered;
  - a home-bound disabled client who is unable to be served through a telephone interview or authorized representative should be offered a home visit;
  - if a handicapped/disabled client indicates that he/she needs a home visit because of transportation problems, consult with the Area Manager for additional guidance as to whether the accommodation should be made. A home visit is not necessarily the mandated accommodation if other arrangements, e.g. telephone interview or alternate transportation, can be made.

Filing Discrimination Complaints:

Any individual or his/her representative may file a discrimination complaint with the County, District, or State Office of the Department of Human Services, or with the U. S. Department of Health and Human Services. Complaints may also be filed with the Tennessee Human Rights Commission. A complaint may be filed at both the state and the federal levels, separately or concurrently, at any time during the process. The complaint may concern discriminatory practices or actions on the part of DHS. The complaint may also involve practices or actions by other agency related institutions, organizations, contractors, medical care vendors or practitioners that participate in the Families First program by providing aid, care, or services. DHS will investigate each complaint promptly to determine whether or not it is justified and, if justified, what corrective action is appropriate. Following the receipt of a complaint, the following actions should be taken:

- **Instruct the complainant to submit the complaint in writing**, preferably on Form HS-2631, *Complaint Under Civil Rights Act of 1964.* The complainant, his/her representative, or a Title VI Coordinator may complete the form. A verbal complaint may be taken, but must subsequently be written up on Form HS-2631. Unless a complaint is already being filed at the state or federal level, it is preferable that all

complaints be filed initially at the local level within thirty (30) days of the alleged discriminatory act.

If the complainant is not willing to complete the official form, he/she may write a letter setting forth his/her grievance and a staff member will complete the form. If the complainant refuses to file an official written complaint, record the complaint in the ACCENT case running record comments (CLRC).

- **Record the complaint in the Title VI Complaint Log.** List complainant identification and type/status of the complaint.

- **Send the original copy of the complaint to the DHS Title VI Coordinator** in Nashville (include all pertinent information). Give a copy of the complaint to the complainant and retain one for local files. The local Title VI Coordinator must notify the DHS Title VI Coordinator immediately when any complaint is filed.

- **Mail a letter to the complainant** acknowledging receipt of the complaint within five (5) calendar days of the date that the complaint was received.

- **Conduct a fact-finding investigation within thirty (30) calendar** days of the receipt of the complaint. The local Title VI Coordinator is responsible for this initial investigation. When the complaint applies to discriminatory actions on the part of contracting agencies, individuals, or institutions from which assistance or service is purchased or secured by the Department, the complainant will be interviewed to secure as much information as possible. The interview will examine the nature of the complaint, the precipitating circumstances, and identify the date the alleged act occurred.

- **Report investigation findings to Department management** within five (5) days of completion of the investigation. If the report includes a finding of violation of Title VI, include any proposed remedial action in the *Report of Investigation*, Form HS-2632.

- **Give the written findings to the complainant** within five (5) calendar days after the above report is completed. At this time, inform the complainant of his/her right to appeal at the state or federal level if there is disagreement with the investigation findings or the proposed remedial action (include appeal form and instructions for filing).

Filing an Appeal

- **Instruct the complainant to complete Form HS-2634,** *Appeal from Finding.* The local Title VI Coordinator must forward a copy of the complaint, the findings, the proposed action, and the request for an appeal to the DHS Title VI Coordinator within ten (10) calendar days after the date of the appeal. Forward the form to the Tennessee Human Rights Commission (THRC) or the complainant may mail the form directly.

Tennessee Human Rights Commission
530 Church Street, Suite 400
Nashville, TN 37243-0745
Phone: (615) 741-5825

Complaints (for Medicaid/Tenncare and Families First) filed with federal agencies should be sent to:

U.S. Department of Health and Human Services
Office of Civil Rights
Atlanta Federal Center
61 Forsyth St. S. W., Suite 3B70
Atlanta, GA 30303
Phone: 1-800-368-1019

Public Notification of Nondiscrimination Compliance:

- The Civil Rights pamphlet will be given to each applicant/recipient at each application and review. The application form will contain information about rights and responsibilities.

- All Tennessee Department of Human Services offices will permanently display the nondiscrimination poster provided by USDA, Food and Nutrition Service.

- The Department will ensure that applicants/recipients and other low-income families/individuals have access to information regarding nondiscrimination statutes and policies, complaint procedures, and the rights of participants within 10 days of the date of a request for such information.

Availability of Information:

- The following will be available to all staff involved in eligibility determination for Families First benefits:

  - Tennessee Family Assistance Plan of Operation (includes waiver information);
  - Federal Procedures;
  - Tennessee Department of Human Services Families First Handbook; and
  - supplemental instructions (bulletins and memos) issued for use in serving households applying for Families First.

  These program guides will be maintained in the county and State Office of the Department of Human Services for examination by the public on regular workdays during regular office hours.

- Copies of the Families First Handbook are made available to public custodians. Public custodians are those who:

- request the manual or handbook for use by the public;
- are centrally located and publicly accessible to a substantial number of the recipient population; and
- agree to accept responsibility for filing amendments and changes forwarded to them by DHS.

- Initial copies are issued to public custodians without a charge and when the handbook is reprinted in its entirety. All other requests have a charge related to the cost of reproduction.

- Groups or individuals, other than those mentioned above, who request a handbook and agree to use it for informational purposes, may be furnished a copy at the discretion of the Commissioner or his/her designee. There may be a charge related to the cost of reproduction. Upon request, specific policy materials necessary for an applicant/recipient or his/her representative to determine whether a fair hearing should be requested or to prepare for a hearing may be made available to the applicant/recipient and/or representative without charge.

- An up-to-date copy of the Families First Handbook is maintained in the county, district, and state DHS offices. Copies of portions of the manual will be made available upon request to students, researchers, and other agencies at cost of reproduction of the materials.

Use of Families First Cash Payment (Grant):

The Families First cash payment (accessed through the use of an EBT card), is designed to provide a subsistence payment for a dependent child and caretaker in conjunction with other income and support already available to the assistance group. It takes into consideration the resources and income conditions existing in each case and is issued in compliance with state rules and regulations.

- The Department is not at liberty to determine for the recipient what use he/she will make of the Families First benefits. Staff may counsel with a recipient about the use of their benefits, but must be careful to avoid activity or instruction that would limit the recipient's freedom of choice. However, vendor and protective payments may be made under certain circumstances.

Right to Apply for Families First:

- Any person who wishes to apply for Families First has the right to do so. He/she will not be required to provide proof of eligibility before doing so. Proof of eligibility will be required before assistance is granted.

- Families First individuals will be required to provide proof of eligibility circumstances. In instances where the information is readily available to the

- Department or where it is more reasonable for the Department to secure the information, the Department will do so.

Right to Information or to File Informal Complaints:

- Persons or agencies who desire program information or wish to file an informal complaint about Families First may contact any or all of the following:

  - The Area Manager or FS I at the local county office. The phone number and address may be found in the telephone directory for the town designated as the county seat.

  - The District Administrator or District Family Assistance Director,
    Families First Policy
    400 Deaderick Street
    Nashville, Tennessee, 37248-7200

  - Assistant Commissioner, Adult and Family Services
    400 Deaderick Street
    Nashville, Tennessee, 37248-0002

  - Commissioner
    400 Deaderick Street
    Nashville, Tennessee 37248-0001

POLICY STATEMENT:

Any applicant for, or recipient of, Families First may file an appeal through the county office, District Office, State Office or the Family Assistance Service Center when dissatisfied with an action on his/her case. Complaints must be given prompt and careful attention and corrective action, when indicated, must be taken immediately. The county office or the Family Assistance Service Center must provide whatever assistance the complainant requires in appealing for a fair hearing. The county office staff must provide the Families First participant with a Tennessee Department of Human Services Appeal form or complete the form on his/her behalf.

If an individual files an appeal because he/she is dissatisfied with an action or lack of action by the county office, the county office will offer the complainant the opportunity to have a conference, with either the caseworker or the supervisor, to discuss the issue. The caseworker will inform the appellant that the conference is optional and will not delay or replace the fair hearing. The individual may also question the Department's interpretations of the law and the validity and applicability of the policies to his/her situation. Group hearings may be conducted where the sole issue is one of state or federal law, regulations or policy.

If the individual is not willing to discuss his/her grievance with local staff, he/she may request an appeal without a conference with the caseworker or supervisor. However, he/she should be encouraged to resolve the issue through the informal conference. If the individual files an appeal, it cannot be delayed or canceled without his/her consent because of the outcome of any subsequent informal conference.

Right of Appeal

Every applicant/recipient must be informed of his/her right to appeal if he/she is aggrieved by an action or lack of action by DHS. Anyone who applies or wants to apply for Families First benefits must be given the informational pamphlet that explains the right of Appeal and Fair Hearing, the method by which a hearing may be obtained and that his/her case may be presented by a household member or a representative. All applicants/ recipients must be informed about these rights:

- verbally at the interview when he/she applies for benefits;
- in writing on the notice regarding the action taken on his/her application; and
- when he/she indicates disagreement with an agency action.

In addition, the appellant must be informed of any free legal representation that is available. DHS staff will refer the appellant to any legal services available in the community.

All Department hearing records and decisions are available for public inspection and copying, subject to the disclosure safeguards provided by federal regulation. In addition, the names and addresses of appellants and other members of the public must be kept confidential.

APPEALS

Appeals may arise from conflicts or dissatisfaction related to an action or lack of action by DHS such as, but not limited to:

- a decision regarding eligibility for Families First such as amount of assistance, the manner of payment, restrictions on the payment or the amount of payment for services;
- reduction or termination of Families First benefits;
- failure to act on a request for Families First benefits within 45 days;
- state or federal laws, policies or regulations considered unfair or unreasonable;
- discriminatory treatment or practices on the basis of race, color, age, sex, handicap, religious creed, national origin or political belief (in the case of a discrimination complaint, see Rights and Responsibility chapter);
- the content of the Personal Responsibility Plan;
- the activities or support services provided which are related to the Personal Responsibility Plan.

EXCEPTION: If the appeal is regarding an action of a Title XX Third Party agency, that agency is responsible for responding to the complaint. If the complaint is not resolved informally by the Third Party agency, the complainant can bring his/her case to the Department of Human Services for further review through the appeal process.

Complaints by an interested individual on behalf of an applicant/recipient must be handled within the limits of confidentiality. When an appeal is filed, every effort must be directed to resolving the appeal promptly and, if possible, to the complainant's satisfaction.

Division of Appeals and Hearings Functions

FAX all county office Families First appeals to the Division of Appeals and Hearings. The county office may continue to take action to resolve the issues in the appeal informally. If the informal hearings result in resolution, the county office must fax a Withdrawal of Appeal form to the Division of Appeals and Hearings. At that time, the appeal process will cease.

FAX all Family Assistance Appeals to:

Jo Murphy, Director of Intake and Conciliation
Tennessee Department of Human Services
Division of Appeals and Hearings
P.O. Box 198996
Nashville, TN 37219-8996
Fax: 1-866-355-6136 (Long Distance) or 313-5013 (Nashville or 615 Area Code)

The Family Assistance Service Center will accept appeal forms or file a verbal appeal on behalf of the Families First participant. The Family Assistance Service Center will document the request for an appeal on CLRC and enter the request for an appeal into the ARTS system. The responsibilities of the Division of Appeals and Hearings will be divided among the three units described below and organized according to the action needed on each case.

- The Intake Unit is the initial receiving point for appeals and miscellaneous mail. Intake Unit Staff will enter the appeals that have been faxed or mailed to them into the Appeals Resolution Tracking System (ARTS);

  NOTE: When an appeal is entered into ARTS as complete, it automatically goes to the Conciliation Unit.

- The Conciliation Unit staff will be responsible for conciliation attempts concerning appeals. They will:

  - determine if the appeal was filed timely;
  - make an initial determination of whether it is fair hearable;
  - determine benefit continuation/reinstatement pending the appeal decision;
  - send a letter of acknowledgment of the appeal and information attachments to the Families First participant;
  - resolve as many appeal issues as possible through communication with the appellant and the county office;
  - ensure that the due process rights of the appellant are upheld;
  - review the appeal to determine if the case action relative to the appeal was appropriate;
  - make changes on items relative to the appeal;
  - reinstate benefits if the case was closed because of caseworker error;
  - contact the county office caseworker and FS1 to make the case correction if the Conciliation Unit is unable to do so;
  - forward the appeal to the Case Preparation Unit if unable to resolve the issue.

  NOTE: The Conciliation Unit will not have the authority to make changes on the PRP, on Child Care information or on Refugee Cash Assistance cases.

- The Case Preparation Unit will:

  - prepare the case for a hearing with the Hearing Official;
  - schedule the hearing and notify individuals needed to testify;
  - write to the appellant and schedule the hearing; and
  - give the appellant notice that will include the date, time, place and issue of the hearing.

  After the hearing, the Hearing Official will issue an order. The Hearing Official will send the order to the appropriate county office that will take action to implement the order. The Case Preparation Unit will monitor implementation of the orders.

Timeliness for Filing Appeals

Families First appeals must be filed within 90 days after the mailing date of the written notice sent as a result of the case action. If an appeal is filed within ten days of the notice of adverse action on an active case, Families First benefits can be continued at the previous level, pending the final decision of the Hearing Official. However, the individual must be informed that if the county's decision is upheld, the AG will be responsible for repaying the benefits paid pending the decision. If benefits are to continue pending the outcome of the appeal, the Conciliation Unit will authorize the benefits on ACCENT.

When benefits are continued, the Hearing Official may determine at the hearing if the issue being appealed is one of law, regulation or policy or if the issue is a matter of fact or judgment. If the Hearing Official issues an oral decision that the issue being appealed is one of law, regulation or policy, the Families First benefits must be reduced or terminated immediately, as indicated in the original notice of adverse action. The Hearing Official will notify the appellant and the county office in writing that benefits must be reduced or terminated immediately pending the final hearing decision.

Once benefits have been continued, they cannot be reduced or terminated prior to the final hearing decision unless:

- the Hearing Official issues an oral and written decision that the issue being appealed is one of law, regulation or policy and that the appellant's claim that the county improperly computed the benefits, misinterpreted or misapplied such law or regulation is invalid;

- another change occurs while the hearing decision is pending that affects eligibility or benefit level, and the appellant does not request a hearing on that issue during the ten-day adverse action period; or

- a mass change occurs while the hearing decision is pending.

The 10- and 90-day counts for filing an appeal will begin the day after the notice is mailed. If the 10th or 90th day falls on a weekend or holiday, the time limits will be extended to the next working day. An appeal filed on the 10th or 90th day is considered timely.

Good Cause for Filing a Late Appeal

Appeals may be accepted after the 90-day time limit if the appellant can show good cause as to why the appeal could not be filed within 90 days. In addition, benefits can be continued if the appellant can show good cause for failing to file the appeal within ten days. The decision regarding good cause is made by the Commissioner or his/her designee.

Filing an Appeal

An individual can file an appeal either orally or in writing. The appellant should give a clear statement about the issue of the grievance and his/her mailing address on the appeal form if the appeal is in writing. If the issue is unclear, the caseworker or the Family Assistance Service Center should clarify the issue prior to submitting the appeal. The caseworker or the Family Assistance Service Center must assist the appellant in filing the appeal in any way necessary.

The caseworker will explain on the appeal form the action taken or delay in action that is the issue of the appeal. This explanation should include:

- the date the appeal was requested (either orally or in writing);
- a clear statement of the action taken or delay in action taken on the case;
- the date(s) the action was taken on the case; and
- the state rule numbers of the policy in question. The state rule numbers are located in the Families First handbook, pages 2-4.

The appeal form must be faxed to the Division of Appeals and Hearings on the date the appeal was filed. The caseworker will not wait for the appellant to sign the appeal form before submitting it to the Division of Appeals and Hearings if the appeal was filed orally or if the individual refuses to sign the form. If the appellant requests the appeal orally or refuses to complete the form, the caseworker will complete the form and fax it to the Division of Appeals and Hearings.

Appeals that are requested verbally through the Service Centers must be entered directly into ARTS. Information must include:

- the case name and case number;
- the date the appeal was requested; and
- a clear explanation of the reason for the appeal.

If the individual first contacts the State Office to request an appeal, the State Office staff will get the pertinent information regarding the issue of the appeal and the appellant's name and address will be faxed immediately to the Division of Appeals and Hearings. The Division of Appeals and Hearings will treat this as any other oral request and process in the manner described above. All procedures described above will be followed for appeals initiated in the State Office.

The Responsibilities of the District Family Assistance Director

Copies of correspondence between the District Family Assistance Director, the county office, the Medical Evaluation Unit and others will be sent to the Division of Appeals and Hearings to inform them of the status of the appeal. Copies of correspondence coming from the appellant or others in the community about the facts of the case should also be sent to the Division of Appeals and Hearings.

The responsibilities of the District Family Assistance Director may be delegated to the District Program Supervisor.

Interim Adjustments

While the appeal is pending, the county office or the Division of Appeals and Hearings will take any action on the case needed to correct an error or which results from changes in the AG's circumstances or in agency policies. Written notice of each change and advance notice, if required, must be given prior to the change.

In an appeal case where medical disability is the issue, the supervisor, the appellant or his/her representative and the caseworker must hold a conference to determine if more medical and/or social information can be obtained. If no new information can be obtained, the caseworker will then process the appeal form.

If more pertinent social and/or medical information is obtained, the appellant may request that his/her medical file be re-evaluated by the MEU prior to the hearing. The appellant must sign an original and three copies of the Consent for Delay form. The original copy should be held by the county office, one copy will be sent to the District Family Assistance Director, one copy will be sent to the Division of Appeals and Hearings, and one copy attached to the medical record that is sent to MEU. The case should include a letter explaining that the case is in appeal status. The MEU will then give prompt attention to the request for review and will respond with a decision.

If the MEU decides in favor of the appellant, the appellant will be asked to sign a Withdrawal of Appeal form. If the MEU does not decide in the appellant's favor, then the appeal process will continue.

In an Appeal case where medical incapacity is the issue, the supervisor, the appellant or his/her representative and the caseworker must hold a conference to determine if more medical and/or social information can be obtained. Any new information should be acted upon. The appellant may choose to continue or discontinue the appeals process regardless of whether or not new information is presented at the conference.

If more pertinent social and/or medical information is obtained, the appellant may request that his/her medical file be re-evaluated by the MEU prior to the hearing. The case should include a letter explaining that the case is in appeal status. The MEU will then give prompt attention to the request for review and will respond with a decision.

If the MEU decides in favor of the appellant, the appellant will be asked to sign a Withdrawal of Appeal form to withdraw the appeal. If the MEU does not decide in the appellant's favor, then the appeal process will continue.

Withdrawing an Appeal

If the appeal is resolved in favor of the appellant, the appellant will be informed of the same and will not have to withdraw the appeal in writing. If the appellant is satisfied with an adjustment or explanation of the reason for the action by local or district staff, or the Division of Appeals and Hearings Conciliation Unit, he/she will be given the opportunity to withdraw the appeal at any point during the appeal process. The appellant should complete and sign a Withdrawal of Appeal form, giving the reasons for the withdrawal. This should be done in his/her own handwriting and words, if at all possible. If the appellant wishes to withdraw the appeal, but does not want to sign the form, the caseworker or Division of Appeals and Hearings worker will complete it and attach the appellant's written statement.

The caseworker or Division of Appeals and Hearings worker will complete the Withdrawal of Appeal form giving the reason for the withdrawal. The caseworker or Division of Appeals and Hearings worker must:

- explain any action being taken on the case;
- the dates of the action;
- the facts upon which the action was based;
- cite applicable laws or regulation; and
- any admissions, stipulation or agreements between the appellant and the agency.

If benefits are being restored, the amount and effective dates of those benefits must be included, as well as copies of budgets if there were changes in income, need or AG composition.

Hearing Process

All hearings will be tape-recorded. Recordings will not be transcribed routinely. However, any party may request, at his expense or by the Division of Appeals and Hearings' expense, a transcript of all or any part of the recording. If the Division of Appeals and Hearings elects to transcribe the proceedings, any party will be provided a copy of the transcript upon payment of a reasonable fee. All recordings will be kept on file for no less than three years and then destroyed if there have been no further developments in regard to the appeal.

The Hearing Official will enter an Initial Order in writing, which will contain a report of the hearing and a preliminary decision regarding the hearing. The Initial Order will be sent to the appellant and the county office. The report of the hearing will include the following information:

- the names and identities of the persons present at the hearing;
- a statement of the issues;
- summary of the substance of the hearing that includes:
  - a citation of oaths administered;
  - a statement of the evidence presented;
  - exhibits, stipulations, admissions, and matters officially noticed;
  - questions and offer of proof, objections, and rulings on any objections; and
  - attachments, which include the appeal form, the Withdrawal of Complaint (if applicable), the appeal summary prepared by the county office, acknowledgment notices, budget screens, and all documents or correspondence pertaining to the appeal.
- The recommendation of the Hearing Official which will include:
  - a concise statement of the issues;
  - the facts brought out in the hearing;
  - citation to the applicable law or regulation;
  - the reasoning that led to the conclusion; and
  - the recommendation to the Commissioner or his/her designated representative.

The recommendation is based exclusively on the evidence obtained in the hearing. Confidential or other information which the appellant or his representative does not have an opportunity to hear, see, respond to or consent to will not be introduced at the hearing nor become a part of the hearing record, since due process requires that all parties must have the opportunity of cross-examination and rebuttal.

The appellant and/or his/her representative, and the Case Prep Unit worker who attended the Hearing will receive a copy of the initial order. This will allow the parties to examine the order for completeness and accuracy. Any party to the hearing may file a Petition for Reconsideration and/or Appeal of the Initial Order by submitting written comments, arguments and exceptions to the order within fifteen days of the mailing of the report. In accordance with due process, it is not permissible to add new evidence that was not presented at the hearing.

The following information will be submitted to the Commissioner or his/her designated representative for the final decision:

- the report of the hearing;
- all exhibits and documents which were made part of the hearing record;
- a recording of the hearing or transcription, if one was made;
- Hearing Official's recommendation; and
- any additional comments, arguments and exceptions filed within fifteen days of the Hearing Official's decision.

The Final Order entered by the Commissioner or his/her designated representative shall either:

- adopt the decision of the Hearing Official as set forth in the Initial Order;
- modify and/or reverse the decision of the Hearing Official as set forth in the Initial Order, specifying the basis of the modification or reversal; or
- remand the case to the Hearing Official for a specified reason.

While the Final Order is binding upon all parties to the appeal, either party may file a Petition for Reconsideration of the Final Order within fifteen days of the date of the Final Order. This petition must be in writing, stating the specific grounds for the request. Filing a Petition for Reconsideration of the Final Order shall not supersede or delay the effective date of the Final Order. The Final Order will take effect on the date entered and will continue in effect until the Petition for Reconsideration of the Final Order is granted or until the Final Order is superseded, modified or set aside in a manner provided by law.

However, if a change affecting the recipient's benefits occurs while the reconsideration is pending, action to implement that change will not be delayed pending the decision on the petition.

Implementing the Decision

If the decision is in favor of the appellant and benefits had not been continued, the benefits will be reinstated and any lost benefits will be issued in accordance with the final decision. If the case was closed, an application is not necessary to reopen a case because of an appeal final decision.

If the final decision upholds the county's action and the Families First benefits have been continued, the AG's benefits will be reduced effective the first possible month after receipt of the decision. No advance notice is required to implement a hearing decision. An overpayment claim will be referred to COTS to recover any benefits that the AG received pending the final decision of the hearing.

Time Limits for the Appeal Process

The maximum time limit for processing appeals is 90 days for the Families First Program. The hearing can be delayed if the appellant is ill or if there is a delay in obtaining medical evidence because of circumstances beyond the control of the appellant or DHS.

Judicial Review

If the individual disagrees with the final decision in a fair hearing, he/she has the right to request a judicial review. The appellant must file a petition for review in the chancery court for the county in which the appellant lives or in the chancery court in Davidson County within 60 days of the date of the Final Order.

DOCUMENTATION:

A full explanation of the circumstances surrounding the appeal must be clearly explained in ARTS and in ACCENT CLRC running record comments. This should include:

- all of the issues in question;
- the reason for the county's decision;
- the outcome of any conferences regarding this matter;
- the outcome of the preliminary and final decisions of the hearing; and
- the action taken as a result of the final decision.

PROCEDURES:

Processing Fair Hearing Requests

When an individual requests a fair hearing, the county office will fax the appeal to the Director of Intake and Conciliation, Division of Appeals and Hearings.

All pertinent information regarding the appeal, such as what action was taken on the case that caused the individual to request the appeal, the program for which the appeal is being filed, and an explanation of the issue of the appeal, must be included on the form. The completed form must be faxed to the Division of Appeals and Hearings. on the same day that the hearing request is received in the county office.

- original faxed to the Director of Intake and Conciliation, Division of Appeals and Hearings;
- one copy to the District Program Supervisor;
- one copy to the appellant and/or his/her representative;
- one copy to be retained by the county;
- one copy to the Commissioner's office, if discrimination is an issue; and
- one copy to the District Director of Investigation, if the action was based on an investigative report.

Routing of a Withdrawal of Complaint

The county office, or Service Center, will send the Withdrawal of Appeal form to the Director of Intake and Conciliation, Division of Appeals and Hearings, the day it is received. The distribution for the Withdrawal of Appeal form is the same as for an appeal form, except that the original is sent to the Division of Appeals and Hearings, Director of Intake and Conciliation.

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APPLICATION PROCESS

POLICY STATEMENT:

- Make applications available to individuals who request an application in person.
- Mail the application on the same day an application request is received by mail or phone.
- The Families First application process begins with a signed request for assistance on the Department's Family Assistance application form HS-0169.
- DHS will accept signed, dated applications received in the county office. The application may be received in person, by mail, or by FAX. The application file date will be the date the application is received in the county office, either by FAX, mail or person. The file date for a FAXED application includes holidays and weekends. FAXED applications that contain the applicant's name, address and handwritten signature are acceptable. Receipt of an original application to the fax is not required.
- The application is a request for **all** Family Assistance programs unless the applicant indicates that he/she does not wish to apply for a particular program.

The Application Process Consists of:

- making applications available;
- assisting in completion of the one page application, if necessary;
- conducting an interactive interview with the caretaker. If interviewing outside of the office, use a paper application form, maintain the application date and record the information on ACCENT as soon as possible.
- obtaining necessary verification;
- developing a Personal Responsibility Plan;
- authorizing the assistance group; and
- providing individuals who are disabled and require additional assistance reasonable accommodations in accordance with the Americans with Disabilities Act. For example, the caseworker may provide, upon request, enlarged print notices to an individual who has a visual problem and difficulty reading the notice.

APPLICATION PROCESS

Filing an Application:

- The application should be filed in the county of residence. If the assistance group should move out of the county during the application process, the application will be transferred and the application date is protected.

- Any person making an inquiry about an application should be advised of their right to same-day filing to protect their application start date.

- Any person requesting to file an application will be given the opportunity to do so and will not have to provide proof of any eligibility criteria prior to doing so.

- if an application is requested by mail, it must be mailed the same day the request is made.

- If a county has designated offices to serve specific areas of the county, applicants may contact the wrong office. When this occurs, the applicant must be advised of the correct office at which (s)he should apply and given the address and phone number. The applicant must be given information about same-day filing. An offer should be made to forward the application to the correct office. If the application is received by mail in the wrong office, the application must be mailed to the correct office the same day.

- The assistance group may voluntarily withdraw its application at any time prior to the determination of eligibility. The case manager will document in running record comments (CLRC) the reason for withdrawal and that contact was made with the assistance group to confirm the withdrawal. The AG will be advised of the right to reapply at any time.

Promptness of Applications:

- The standard of promptness for completing Families First applications will be 45 days following the date the signed and dated application is received in the county office.

- The Department is under Federal Court order to process all applications timely. Any application for Families First that is not processed and authorized on the 49th day will be issued interim benefits based on the information that is available in the case record.

APPLICATION PROCESS

- The authorization action will consist of approval or denial. Denial will be based on ineligibility for the program, failure to develop and sign a Personal Responsibility Plan, loss of contact, withdrawal of the application, or death of the applicant.

- The assistance group is authorized on AEWAA. When the authorization occurs, the case is processed in the overnight ACCENT system batch and the appropriate notice and benefit (if any) are mailed to the assistance group on the next working day.

Eligibility Determination:

The following must be established during the application process:

- Age

- Residence

- Citizenship and alien status

- Relationship

- Deprivation
- Enumeration
- School Attendance
- Incapacity or Unemployed parent status if two parent home
- Immunization and Health Checks
- Income
- Resources
- Minor Parent's school attendance
- Cooperate with Child Support
- development of Personal Responsibility Plan

Families First Application when case closed or denied less than 3 months:

- The applicant must complete the one page paper application.
- The applicant must be interviewed and have all points of eligibility reviewed.
- All matches must be resolved.
- Verify the following factors of eligibility:
  - that the point(s) of eligibility which caused the previous denial or closure no longer exists; (If the assistance group was closed due to the time limit or a second work sanction that requires a 3 month ineligibility period, the ACCENT record will contain this information.)
  - assistance group composition;
  - income;
  - deprivation;
  - deductible expenses; and
  - resources if questionable

The ACCENT system will require that all eligibility factors be verified. Unless the information is questionable at the time of the interview, accept the previous verification and the statement of the applicant for the verification other than those listed above.

- Renegotiate a new Personal Responsibility Plan

Apply the Preceding Application Procedure When:

- the AG is applying after serving a 3 month closure due to ending an 18 month time limit without good cause to continue eligible; or

- the AG is applying within 3 months after closure due to a child support or work sanction; or

- the AG was closed due to excess resources, but re-apply within three months and are now within the resource limits; or

- persons fail to submit required verification(s) within specified time frames, but do so at a reapplication within three months of the denial; or

- cases that were closed due to income from employment, but the affected person is now unemployed (and did not voluntarily quit a job without good cause) and re-applying within three months of closure.

Applying for Families First and Appearing Potentially Eligible for SSI:

- When the parent or other caretaker relative who is making application for Families First appears to be potentially eligible for SSI, the applicant will be asked whether application for SSI has been made. If application has not been made, a brief explanation of the program will be provided to the applicant.

- The parent will be included in the AG and if (s)he chooses to apply for SSI and becomes eligible, (s)he will be removed from the AG at the time eligibility for SSI is attained.

- If the parent or other caretaker wishes to relinquish SSI and be included in the Families First AG, the case manager will explain the differences in benefits. If the individual chooses to be in the Families First budget, the case manager will ask the individual to talk to a Social Security Office representative. When the SDX verifies that the individual no longer receives SSI, the individual may be added to the Families First AG.

TIMELINESS STANDARDS

POLICY STATEMENT:

The standard of completing applications for Families First will be no later than 45 days From the date the AG or its representative files the application.

An opportunity to participate in the Families First Program consists of providing eligible assistance groups with a cash payment within 45 days after the completed application is filed. An opportunity to participate has been provided if the AFDC check is mailed prior to or on the 45th day after the application is filed. A check is mailed the first work day following the day the authorization is completed.

Providing Notices:

- The ACCENT will generate a notice to the applicant on the first work day following the day the Families First AG is authorized.

- The reason codes on AEWAA will generate the text for the approval or denial notice of the Families First AG.

- The Notice will contain:

  - the amount of benefits for each month of the application period and for the on-going monthly benefit;

  - the month the cash payment will begin;

  - a statement to inform the AG of its right a fair hearing and of the name and telephone number of the person to contact for additional information. If there is an individual or organization that provides free legal representation, the AG will be advised of the availability of that service.

  - a reminder to report changes in circumstances within 10 days.

INTERVIEWING FOR ELIGIBILITY

POLICY STATEMENT:

Interviewing plays a vital role in applicant, recipient, and agency communication. Interviews provide an opportunity for the applicant and recipient to communicate on a more substantive level.

The skillful use of interviews permits the caseworker to obtain accurate, reliable information which is used to determine eligibility and develop the Personal Responsibility Plan.

Most interviews for eligibility and PRP development will be completed in an on-line, interactive mode. The interviews will be integrated so that information is collected to determine eligibility for all programs being applied for at the same time. The caseworker should strive to use the computer in a positive manner which helps gain efficiency and organizes information, but the caseworker must also use skill and judgement in knowing what to pursue outside of the questions on the ACCENT screens.

Purpose of an interview:

- The interview helps the A/R gain an understanding of the agency and its programs, clarifies questions about eligibility and gives the A/R an opportunity to present her/his information in her/his own words.

- For the caseworker, the interview permits an opportunity to gather information needed to determine eligibility in an organized fashion and assist the A/R with a better understanding of the requirements of the program.

- The interview permits the Families First A/R an opportunity to communicate goals and supportive services needed to move to self-sufficiency.

- The interview gives the caseworker an opportunity to discuss goals and specific needs of the A/R that will help the family move to self-sufficiency.

- The interview provides the opportunity to discuss the rights and responsibilities of the A/R.

- The interview provides an opportunity to discuss other resources that may be of assistance to the A/R.

Mandatory Interviews:

All Families First applicants will have a face-to-face interview prior to the initial authorization of eligibility and at six month intervals to redetermine eligibility unless the face-to face interview has been waived as a result of a special needs accommodation.

- The interview will usually be with the applicant/ recipient. However, if the A/R has a guardian or authorized representative, this person may be interviewed in lieu of the A/R if special needs accommodations are necessary. The authorized representative may not renegotiate the PRP or provide child support cooperation information.

- A Families First AG must have a Personal Responsibility Plan. If the AG contains two adults and both adults are required to have a work component, both adults must be interviewed to establish the PRP. If the AG has a minor parent, the minor parent must have a PRP activity plan also and must, therefore, be interviewed.

Scheduling Interviews:

- The county will schedule an interview as promptly as possible after the filing of the application in order to ensure that an eligible assistance group has a check mailed by the 45th day after the application is filed.

- An applicant who misses an interview is notified via the interview notice mailed from the ACCENT client scheduling system that an appointment can be rescheduled if necessary. A second interview is not automatically scheduled. An application that is pending will be denied by the 45th day if the applicant does not reschedule a missed interview.

- An active assistance group will have a reapplication review at six months or sooner if the residence group contains a Food Stamp group with earned income. The client scheduling module of ACCENT provides an appointment notice to the AG the month before the AG reapplication is due. If the recipient fails to appear for the interview or contact the caseworker, the caseworker must send a 10-day Notice of Adverse Action closing the AG.

Single Interview:

A single interview is conducted for Medicaid, Food Stamps, and Families First. If there are other assistance groups within the residence group, the caseworker must interview the head of each assistance group.

Waiver of Office Interview:

- An office interview is required unless extenuating or hardship circumstances exist which prevent one.

- Telephone contacts are not acceptable for application and reapplication interviews unless the face-to-face interview has been waived due to a special needs situation, but are acceptable as contacts between reviews.

- Home visits are not required but may be used when no alternative accommodations can be made or no other accommodations are appropriate for the situation.

Information Provided During the Interview to the Applicant/Recipient

- The applicant/recipient is responsible for supplying verification to establish eligibility. However, the caseworker will obtain information that is available to the agency or when it is more feasible for the agency to obtain the information. The individual should be given information as to what sources are acceptable. Never deny a case for failure to provide a particular source of verification when another source of verification is acceptable. The caseworker will accept the applicant/recipient 's statement as verification if:
  - the individual tries but is unable to obtain the information; and
  - the information is not available to and cannot be made available to DHS.

- Give the applicant/recipient an explanation about what information is needed and what proofs are acceptable.

- Inform the applicant/recipient that DHS will contact some individuals or organizations to establish proof of her/his eligibility. The applicant/recipient must be given an opportunity to refuse to give the caseworker the right to secure information from the individual or agency. If it is determined that this particular person or organization is the only acceptable source for certain required information, and the applicant/recipient continues to refuse permission to contact, then deny or terminate eligibility.

- The Department will assist individuals who are hearing or visually impaired or otherwise in need of special assistance by providing a reasonable means of communication about the program and their case activity.

- Discrimination because of age, race, color, sex, handicap, religious creed, national origin or political belief is unlawful. The Civil Rights pamphlet must be provided to each applicant.

- Inform the applicant/recipient that information about her/his circumstances will be held in confidence.

- The applicant/recipient has the right to appeal any Department action that he/she believes to be discriminatory or unfair or when action on a request for assistance is not taken with reasonable promptness.

- It is unlawful for anyone to charge, either directly or indirectly, for help to the applicant/recipient in filing the application with the agency.

- A request for assistance must be completed within 45 days. Approval can be made only after all eligibility requirements are met.

- Each assistance group member who is applying for Families First cash assistance must furnish or apply for a Social Security number.

INTERVIEWING FOR ELIGIBILITY

- Applicants/recipients are entitled to be referred to the Department of Children's Services, if requested. Individuals must be referred if evidence of child neglect or abuse is observed.

- The AG must have a Personal Responsibility Plan. The requirements of the Personal Responsibility Plan must be discussed in detail and the individual must participate in the development of the work plan. The individual must be given information about supportive services to assist during participation in work or a work activity.

- Unless exempt, the time limits for receipt of assistance must be explained to the assistance group.

- Regarding child support, explain to all applicants/recipients:
  - that the AG's rights to child support must be assigned to DHS;
  - that the caretaker must cooperate with Child Support Services to
    - identify all absent parents;
    - locate an absent parent; and
    - establish court-ordered support;
  - that the applicant/recipient can claim good cause for failure to cooperate and what that entails. (See Child Support Cooperation Chapter for details.); and
  - how the AG may be eligible for child support pass-through payments.

  Give a copy of the Child Support Handbook to the applicant/recipient.

- The individual can register to vote at the DHS office.

- If the applicant is approved, the AG will receive a cash assistance payment and Medicaid benefits.

- The cash assistance may be used as the applicant sees fit to meet the needs of the family.

- If the A/R is eligible for other benefits (<u>other than SSI</u>), the A/R **must** apply for and accept the benefits. SSI is a potential benefit when age or disability is a factor. Applying for SSI is optional, not required.

- Individuals under age 21 are eligible for Early Periodic Screening, Diagnosis and Treatment, EPSD&T, provided as a service of the Department of Health.

- At each application and review interview, give each applicant/recipient:

• The Privacy Act pamphlet	• The "You may get your child support while you are on Families First!" handout
• The Civil Rights pamphlet	• The information sheet on family planning

Failure to Cooperate in the Eligibility Process:

- An adverse action to close a case for failure to cooperate will be initiated when the AG fails without good cause to provide requested information needed to establish eligibility for assistance. If the AG fails to comply with a **written** request for information or completion of specific action, send a 10-day adverse action notice. If the AG complies prior to the expiration with the 10-day notice requirement, assistance will be continued if eligibility is reestablished.

  An application will be denied for failure without good cause to provide requested information prior to the 45-day time limit. The case record must be documented to show that the information was requested **in writing** from the applicant and that the information was not available or could not be readily made available to the agency.

- The Families First applicant/recipient has the primary responsibility for obtaining required verification; however, the case manager must assist the individual when a good faith effort has been made and difficulties were encountered. The case manager will rely on automated verification such as data exchange matches whenever possible. Obviously, if the information is readily available to the case manager, the customer should not be requested to obtain the verification. In any instances where the customer is having difficulty obtaining the information, the case manager must offer assistance in securing the verification. When it becomes known to the Department that an A/R has a disability which is causing difficulty in providing verification, the CM will assist the individual as indicated, The assistance could include, for example, providing for the individual a reasonable means f communication, or soliciting the required verification document directly.

  If the applicant notifies the case manager that he/she is unable to provide the information within the 45-day time limit, the case manager should attempt to obtain the needed information. If neither the case manager nor the Families First participant can obtain the information, the case manager can accept the individual's statement as verification.

- If an applicant is denied prior to the 45th day for loss of contact and returns before the 45th day and provides the required verifications, the original application date is protected and benefits will be provided retroactive to the application date or the eligibility date (if later than the application date).

Refusal to Cooperate in the Eligibility Process:

- Refusal to cooperate is **not** evident until the case manager has explored the situation with the A/R in an attempt to help him establish eligibility, and to determine whether there is acceptable reason for any failure to provide needed information.

- If it is determined that the AG is refusing to cooperate, the assistance case will be closed or denied. Once denied or terminated, the AG will not be determined eligible in subsequent application until there is cooperation with the Department. This policy applies to application and any subsequent review of eligibility, including regular redeterminations , reviews resulting from reported changes, and reviews by Quality Control staff.

VERIFICATION PROCEDURES

POLICY STATEMENT:

Verification is the process of confirming or substantiating information provided by the applicant/recipient.

Any decision made before the end of the standard of promptness period must be based on a clear determination of eligibility or ineligibility.

Verification is the responsibility of the applicant/recipient for Families First. The case manager should secure verifications when the information is known to the Department through automated data interfaces or when it is more reasonable for the Department to secure the information.

For a finding of ineligibility, the case manager may render a decision based on the AG's unverified statement. For example, an AG reporting resources over the program's resource limit would be determined ineligible. However, to render a decision of eligibility, the worker must be able to make a firm determination of eligibility based on verified points of eligibility. Therefore, the verification process is central to the eligibility counselor's ability to certify an AG for benefits. If there is any doubt of eligibility, the case manager must resolve it using the best evidence including documentary evidence, collateral contacts, and home visits.

The applicant/recipient's statement of the facts can be accepted as verification when:

- the AG has tried, without success, to obtain the needed verification and

- the case manager has exhausted all means of securing documentary evidence, without success; and

- the documents needed are other than those required by another agency, as in unemployment benefits.

The record must be documented in running record comments (CLRC) the efforts that have been made and the results.

The purpose of verification is to establish as accurately as possible that the AG meets defined eligibility criteria, and that the benefit amount is correct.

Documentary Evidence:

- Documentary evidence is written that is relied on as the basis, proof, or support of information provided by the AG and may be official or unofficial

- Official documents are those that are prescribed or recognized as authorized and are most commonly provided by business, agencies, and organizations engaged in specific enterprises or service delivery. A social security card, utility bill, or award letter is an example of official documents.

- Unofficial documentary evidence may include such items as hand-written notes from employers, baby-sitters, etc.

- Documentary evidence is considered the primary source of verification. When it is not available, collateral contacts, or home visits will be used.

- When using documentary evidence, record the title or type of document, document number, date of document, date seen, and contents.

Collateral Contact:

- A collateral contact is a verbal confirmation of the AG's circumstances by an individual outside of the home and who is knowledgeable of the facts being verified for the AG.

- The contact may be made in person or by telephone.

- The case manager may select the collateral or may ask the A/R to provide a collateral. The case manager does not have to accept the collateral named by the A/R. The case manager should interview the collateral thoroughly enough to ascertain the relationship and reliability of the collateral so that a decision can be made that the collateral's statements are acceptable.

- When using a collateral, CLRC must be documented stating the date of the contact, whether it was in person or by telephone, or in writing; document the name of the collateral contact; document the relationship of the collateral to the AG; and the content of the collateral contact.

Home Visits:

- A home visit may be scheduled to verify the AG's circumstances when there is no documentary evidence or collateral contacts.

- CLRC should be documented with the date the home visit schedule and the date the visit was made and the information obtained during the visit.

Verification Required at Initial Application:

- Residence in state

- Alien Status

VERIFICATION PROCEDURES

- Social Security Number or application for a Social Security Number
- Assistance group composition
- Age
- Relationship
- Living with a specified relative
- Marital status
- Reason for Deprivation
- School attendance for children age 5 and older and all minor parents
- Immunizations of children and Health Check-Ups for children
- Income, both earned and unearned, and from self-employment
- Resources
- How expenses are being met when expenses exceed income
- Dependent Care expenses
- Loans
- Striker status when a strike is in the employment area and there is a history of employment.
- Incapacity for purposes of deprivation
- Disability or incapacity for work requirement exemption
- Inconsistent information provided by the A/R or questionable information
- Pregnancy conception and expected delivery date if no other children in the AG

Verification Required at Reapplication:

- Residence
- Composition of AG
- School attendance

VERFICATION PROCEDURES

- Immunization and Health Check-Ups
- Deprivation of parental support- has an absent parent returned to the home
- Living with a specified relative
- Enumeration- verify Social Security Number of any members who have previously applied for a number and have not reported the number
- Pregnancy for family cap decision
- Gross income- earned, unearned, self-employed
- Deductible expenses
- Resources
- Striker status
- Compliance with work plan requirements

Verification of reported Changes:

- Recipients are required to report changes within 10 days of the date the change becomes known to the AG.
- Changes are subject to the same verification procedures and requirements that apply to initial applications or reapplications.

Verifications may be requested using forms contained in the Verification Subsystem of ACCENT in the default library on Groupwise or through electronic data exchange available through ACCENT and Clearinghouse.

AUTHORIZATION OF GRANTS

POLICY STATEMENT:

Families First grants are received through an Electronic Benefit transfer system (EBT). This is an on-line system in which the recipient, or other designated payee (protective Payee), can electronically access assistance benefits with the use of a Benefit Security Card.

The grant is authorized by the case manager assigned to the case, or other case manager or supervisor in the administrative structure who has update access to the case.

The grant is authorized by entering the appropriate reason codes on AEWAA screen in the ACCENT case file.

After the case manager authorizes the benefits, they are transmitted nightly to the EBT processor. The processor sets up the individual debit accounts, which allow participants to access their benefits.

Families First benefits can be accessed on the first day of each month for active participants. For new applicants, the benefits will usually be available the day after the grant is authorized.

The Benefit Security card is mailed to the participant at the mailing address listed on the AEICI screen. If there is a protective payee, a Benefit Security card will be mailed to the address listed on the AEFAR screen. The address for the participant and the protective payee (if any) must be a legitimate address and cannot be "General Delivery".

The Benefit Security Card will be mailed only to the caretaker relative named on AEFPY unless a protective payee is named on AEFAM.

Refer to the EBT handbook for more detail.

Refer to the Treatment of Income Chapter for grant amounts.

Authorization of Differential Grants

Certain Families First AGs, with one to five individuals, who are exempt from the time limits and work requirements, are eligible for larger Families First grant amounts. These increased grant amounts are called differential grants. The following AGs will receive differential grants:

- child only cases- cases in which the caretaker is not included in the AG; these are cases where the caretaker is an "NA"

- disabled caretakers- caretaker has a medically verified disability (not an incapacity)- refer to the verification section of the Work Requirement Chapter for definitions of which person fall under the disabled category.

- caretakers caring full time for a disabled relative living in the home; and
- caretakers age 60 and older.

Exception: AGs are not eligible for a differential when the caretaker is:

- an NA because he/she is an illegal alien; or
- a minor parent.

The case manager must enter the correct exemption codes in the "Time Limits-Exmt" field on the AEPRP screen to ensure that ACCENT will properly compute the differential grant amount.

Designation of Protective Payee

The protective Payee is an individual who has access to the AGs cash benefits. He/she is responsible for and expected to use the cash grant for the benefit of the child(ren) and to act for the caretaker in relation to the child. The protective payee may be related or unrelated and may live in the home or apart from the AG.

- If an assistance group has a protective payee, Benefit Security Cards are mailed to both the payee and the caretaker. However, only the protective payee will have access to the cash benefits.
- No employee of DHS may serve as a protective payee.
- It is also not possible for a business to be designated as a protective payee. This is because the Benefit Security Card must be issued in an individual's name, and that individual will be responsible for activating the card and accessing the benefits.

A Protective Payee will be named:

- if the individual applying for Families First has a guardian, the guardian will be named payee for the grant;
- if a child who has a legal guardian is living in the home with a relative within the specific degree of relationship, the guardian will be named payee for the AG;
- when the caretaker is a minor under age 14, or is a minor deemed in need of a protective payee;
- in emergency situations that will not exceed a three-month period. When an emergency situation becomes known, the case manager will:

- determine the nature of the emergency, the whereabouts of the caretaker and the children, and the name, telephone number, and address of the person reporting the emergency;

- secure the name of a protective payee (from the caretaker, if possible);

- determine continued eligibility for the AG and make any necessary changes;

- refer the case to Child Protective Services, if appropriate; and

- set an expected change within three months to determine the circumstances of the AG.

Authorization of retroactive Assistance and Auxiliary Payments

- When it is determined that the applicant is eligible for the current month and subsequent months prior to approval, a single payment is made to the AG beginning with the date of application. The ACCENT system will compute current month and retroactive payments when the case is authorized on the AEWAA screen.

- When an applicant is currently eligible, but would have been ineligible during the application month, deny the application for the application month. Enter a new application date on AEFPY for the month the AG is eligible. Payment will be made for the current month and any eligible future months.

- Deny an applicant who has had a change in circumstances during the application processing period that causes the AG to be ineligible for the current and future months. Issue an auxiliary payment for the month(s) of eligibility. Authorize the auxiliary payments on the BICS screen.

- Auxiliary payments are made to correct an underpayment of at least $1.00 per month.

CONTINUING RESPONSIBILITIES

I. REDETERMINATION OF ELIGIBILITY

POLICY STATEMENT:

Every Families First case must be reviewed once every six months. The review will be a face-to-face review unless the face-to-face has been waived to accommodate a special needs situation. In that situation, other options may be used. See the Accommodations for Special Needs section of the Rights and Responsibilities Chapter for further discussion.

A review becomes overdue when six months have passed without a redetermination. The six-month period for a new application begins with the month of the first check. For active cases, the six months begins with the month following the completion of each review. The review is considered timely if the review is completed by the last day in the month in which it is due. A review is completed every time a case is closed. However, because of the ten-day adverse action period, the review might be considered complete as many as two months prior to the effective date of the closure.

- In accordance with the Americans With Disabilities Act, if it becomes known to the Department that an individual is disabled and requires additional assistance, staff should provide reasonable accommodations. For example, if the individual has a visual problem, has trouble reading the notices and requests copies of the notices, the caseworker should provide enlarged print copies.

EXCEPTIONS:

There are no exceptions to the redetermination of eligibility requirement for Families First AGs. If the recipient is visiting out of the state or county at the time of the review, a contact must be made with him/her through correspondence or by the Department of Human Services in the community in which he/she is visiting. If the recipient is too ill to be interviewed or is otherwise unable to participate in an interview, information regarding the situation must be obtained from the person who is responsible for the recipient's care or from the legally appointed guardian or conservator.

VERIFICATION:

Follow the verification procedures for review/redetermination of eligibility as described in the chapter on Verification.

CONTINUING RESPONSIBILITIES

DOCUMENTATION:

All appropriate ACCENT screens must be completed during the redetermination of eligibility. In addition, all pertinent information regarding the AG's circumstances and anything that affects its eligibility must be documented on running record comments, CLRC. The information in the case must substantiate continuing or reducing benefits or closing the case. Any questionable or unusual circumstances must be explained as well as the progress or lack of progress in the AG's Personal Responsibility Plan.

PROCEDURES:

The six-month review will consist of:

- a face-to-face interview with the grantee relative, unless the face-to-face interview has been waived due to a special needs accommodation; or
- a face-to-face interview with the caretaker, if a different person; a contact with each child, if possible; or
- a face-to-face interview with an Authorized Representative appointed by the A/R; or
- a home visit, alternate site visit or telephone interview if necessary; and
- any other contacts that are necessary to determine continuing eligibility on all factors subject to change.

When investigating continuing eligibility, the caseworker will:

- analyze all of the information in the case so that changes in the AG's circumstances will be readily identified;
- carefully question the recipient about the AG's circumstances and any changes that have occurred since the last application/review;
- obtain all the facts available to substantiate the AG's continuing eligibility;
- obtain any additional information/verification needed to establish eligibility;
- explain any circumstances that are pertinent to eligibility; and
- authorize the case when all points of eligibility are clarified.

CONTINUING RESPONSIBILITIES

When determining continuing eligibility, the case manager will

- establish whether or not the AG continues to meet income and resource standards;
- determine if there have been any changes to the AG composition. Individuals should be added to or removed from the AG as appropriate (See the Family Cap and Marriage During the Receipt of Benefits chapters in particular.)
- establish that the AG continues to reside in the state. If a recipient leaves the state, the case manager must determine if the absence is permanent or temporary;
- determine the institutional status of any member of the AG that is in an institution to determine if a child's stay in the hospital is temporary and that the grantee-relative continues to have responsibility for the AG;
- determine whether or not anyone in the AG has transferred or acquired property since approval or since the last review;
- determine if the period of incapacity established by the supervisor or MEU has expired and needs to be reestablished;
- determine if the AG is receiving court ordered or voluntary support from an absent parent, make any necessary referral to Child Support Services, and update any information in the ACCENT case about the absent parent; and
- review the Personal Responsibility Plan and work requirement with the individual and re-negotiate the Plan, if necessary. (See Personal Responsibility Plan and Work Requirement chapters for more details.)

The case manager will instruct the recipient that he/she must report any changes in the AG's circumstance that may affect eligibility within ten days. Examples of such changes are:

- birth of a child;
- marriage;
- an absent parent returns to the home;

- an AG member leaves the home;
- a substantial change in income or resources.

The case manager will provide a Change Report form for the A/R to use to report changes.

II. ACCRUAL RIGHTS TO A CHECK

POLICY STATEMENT:

Once an applicant is found to be eligible for Families First benefits and benefits are authorized, he/she has a right to the initial payment provided that he/she is alive on the date on which the application was filed. If the Families First payment is authorized for the calendar month in which the application was made, the AG has the right to the Families First payment from the date of application through the month in which the case is authorized. If the AG is ineligible for Families First benefits in the month of authorization, but is eligible in the following month, the AG has the right to the payment for the month following authorization. The right to a continuing Families First payment accrues on the first day of a calendar month for which payment is made as long as the recipient is alive and eligible for payment on that day.

EXCEPTIONS:

If the A/R or legally responsible relative in the home was on strike as of the last day of the month, the AG is not eligible for an assistance payment made for that month.

III. CHANGES BETWEEN REVIEWS

POLICY STATEMENT:

Some cases may need more frequent contact than every six months because of changes in the AG's circumstances that can be expected. In those instances, the case manager should set an "expected Change" alert to ensure that the changes are investigated and acted on in a timely manner.

CONTINUING RESPONSIBILITIES

The following are cases that might require more frequent contact.

- Cases in which the record shows that the recipient has failed in the past to give accurate information and/or has failed to report promptly when changes occur in the AG's circumstances.
- Cases in which one or both parents do not have the mental/physical ability to act responsibly and/or to give accurate, reliable information.
- Cases in which the recipient has a pattern of sporadic employment. Frequently, the employment or unemployment is not reported to the Department causing an erroneous payment.

Case Adjustments

When changes occur between reviews that affect the AG's eligibility or benefit level, the caseworker must adjust the case. The AG's and the county office's responsibilities regarding changes are listed below.

- Client Responsibilities

  The AG must report the following changes within 10 days of the date that the changes become known to the AG:

  - all changes in source and/or amount of income;
  - when cash on hand, stocks, bonds, and money in a bank account or savings institution reaches or exceeds the resource limit;
  - when the AG obtains a vehicle;
  - all changes in household composition; and
  - changes in residence.

Changes may be reported by telephone, in person, or by mail using the Change Report Form, HS-047. The ten-day period will begin with the date the change becomes known to the AG. The change will be considered as reported by the AG on the date the report of change is received by the county or, if mailed, the date the envelope is postmarked. Each Change Report Form will be date stamped immediately when received in the county office. The date that the change was reported or post-marked must be documented in the running record comments, CLRC.

If the AG failed to report a change and received benefits to which it was not eligible, the case manager will refer the case to COTS so that an overpayment claim can be prepared.

- Caseworker Responsibilities

  - The county office will not impose any reporting requirements on the AG.
  - The caseworker will not treat the submission of changes as a waiver of the AG's right to a ten-day Adverse Action notice unless the recipient indicates in writing that he/she understands that the report will reduce or terminate assistance.
  - The caseworker will provide a Change Report Form and "postage paid" envelope to each AG at approval, at review and when a Change Report form is returned by the AG. A Change Report form will be provided to the AG more often if necessary. The case manager will encourage the AG to use the Change Report Form when a change is being reported.
  - The caseworker will act on the changes reported by telephone and in person in the same manner as those reported on a Change Report Form.
  - The caseworker must inform the AG of its responsibility to report changes within ten days at application and at each review.
  - The caseworker will take prompt action on all changes to determine if the change affect the AG's eligibility or benefit level.
  - In accordance with the American With Disabilities Act, if it becomes known to the Department that an individual is disabled and requires additional assistance, staff should provide reasonable accommodations. For example, if the individual has a visual problem and has trouble reading the notices, the caseworker should provide enlarged print notices.

Increasing Families First Benefits

The caseworker will take prompt action when an AG reports a change that increases the Families First benefits. Once eligibility has been established, the increase in benefits will be made effective with the month following the reported change. A change reported during recurring processing will be effective the second subsequent month, except when the change is to add an individual. When adding an individual who is required to be included in the AG, the benefits will be increased effective the date the individual entered the home or date of birth for a newborn. If the individual is an optional AG member, the effective date of eligibility will be the date the request was made to add the individual to the AG.

Terminating Families First Benefits

- When the caseworker identifies a potential case closure he/she will attempt to contact the caretaker by telephone to:

  - discuss the reason for the potential closure;
  - establish good cause, if applicable; and
  - attempt to correct any problems or misunderstanding that may have occurred.

NOTE: If the caseworker attempts a call and the line is busy, the caseworker must attempt another contact for each time the line is busy. If the line is out of order, then no further attempt to contact by telephone is necessary. In addition, if the client does not have a telephone but a message number is listed on AEICI, the caseworker should attempt to reach the participant at a contact number, leave a message and give a reasonable amount of time (not less than 24 hours) for the participant to respond.

EXCEPTIONS: The following closure reasons do not require a telephone call prior to closure, and do not require a DOH referral.

- The caretaker requests the closure by a verbal request to the DHS supervisor or in writing.
- The caretaker requests the closure by a written request and a DHS supervisor has reviewed it.
- The AG's income or resources exceed the Families First limits.
- The entire AG has moved out of state.
- There are no children in the AG within the age limits.
- All AG members have died.
- The only adult in the AG has died or left home.
- All AG children are eligible for benefits in another AG.
- All AG children are in foster care or have been adopted.
- All AG members receive SSI.

- Prior to closing the Families First case:
  - check the case to ensure that there have been no changes that would affect the case status;
  - read previous CLRC documentation to be sure that there is not a potential sanction closure reason; and
  - check the SFFF screen to ensure that the case has not reached a time limit.

  Do not close a case if a sanction or time limits are potential closure reasons even if the closure reason is for a reason other than sanction or time limits. Sanction and time limit closures take precedence over other closure reasons.

  Example: A client is a "no show" for a review appointment. The caseworker checks SFFF, and finds the case to be at 18 months. The Time Count Review Team must complete a time count review and close the case with reason codes 717 and 404.
- Document CLRC regarding:
  - the circumstances causing case closure;
  - the attempt to contact the caretaker by telephone (if appropriate);
  - the outcome of the attempt (if the AG has no telephone, document this also);
  - the appropriate ACCENT reason codes;
  - the date the case is closed and closure effective date; and
  - the DOH referral (if needed).

CONTINUING RESPONSIBILITIES

Written and Verbal Requests for Case Closure

DHS staff must not advise individuals about whether or not to close their AGs. Instead, staff is to provide accurate policy information so that the caretakers can make informed decisions about the status of their Families First.

- Written case closure requests made to individuals other than a DHS supervisor can be closed if a DHS supervisor has reviewed the case. Whether the closure request is written or verbal, the DHS supervisor will document in CLRC.
  the reason for the closure request; and
  - that the DHS supervisor discussed the closure with the caretaker, if the request was verbal; and
  - that the DHS supervisor reviewed the written request; and
    that the client's decision was based on accurate Families First policy, without instruction from DHS staff.

  NOTE: Check the time count prior to authorizing closure based on a verbal or written request. If the case is over the time limit, review the time count prior to closure. If the count holds, close the case for time limits and at the client's request.

  NOTE: If the client contacts the caseworker during conciliation and requests case closure, close the case for the work sanction and at the client's request. The request for closure does not negate the sanction. The same holds true for voluntary quit and child support sanctions.

Advance Notice of Adverse Action

If the AG reports a change that will reduce or terminate the Families First benefits or remove a person from the AG, then action cannot be taken until the ten-day adverse action notice has expired. The adverse action notice period will allow the AG to provide any information/verification that will alter the decision to reduce/terminate the benefits or request an Appeal for a Fair Hearing and continue the benefits pending the outcome of the hearing. If the AG presents evidence during the ten-day period that establishes that the AG is still eligible, benefits will be reinstated without a new application.

The ten-day adverse action period count begins the day after the day that the Notice of Adverse Action is mailed to the AG. If the tenth day falls on a weekend or holiday, the tenth day will end at the close of business on the next working day. The Notice of Adverse Action must be mailed to the AG at least ten days prior to the effective date of the action. If the recipient requests an appeal of an adverse action within ten days of the notice, he/she must be given the option of continuing the benefits pending the outcome of the appeal. If the recipient opts to continue benefits, the caseworker must authorize the benefits at the pre-change level. The caseworker must inform the recipient that if the county is upheld in the

appeal decision, the benefits paid during the period between the hearing request and the decision are subject to recovery.

If the client contacts the caseworker within the 10-day adverse action period **indicating** a willingness to remedy the reason for closure, the case must be reopened **immediately** and benefits authorized at the pre-closure level. A new application is not required. The reason for closure will be "remedied" after the case is reopened. If appropriate, good cause should be verified and/or the recipient should be given another opportunity to comply. If the client fails to correct the problem after the case is reopened, the case will be closed again with a Final Closure Notice. After the Final Closure Notice has been issued, the case will not be reopened until the client reapplies and takes whatever steps are necessary to correct the closure reason. In addition, the caseworker must send an email to the CRT advising them that the case has been reopened and the reason why. The client will not get another 10-day adverse action period.

If the recipient reports a change in circumstances or presents additional evidence during the advance notice period that changes the decision on the case, the benefits should be continued at the appropriate level based on the new information. If the new information does not affect the decision, the reduction or termination of benefits should become effective as specified in the notice originally.

EXCEPTIONS:

There are no exceptions to the requirement to report changes within ten days of the date the change became known to the AG. However, there are exceptions to the requirement that the caseworker give a ten-day notice of adverse action. A ten-day notice of adverse action is not required when:

- DHS has factual information confirming the death of the recipient or of a Families First payee and no person can be named as alternate payee;

  Note: DHS staff must not advise individuals about whether or not to close their AG's. Instead, staff will provide accurate policy information so that the caretakers can make informed decisions about the status of their cases.

- the recipient has been admitted or committed to an institution where he/she is not eligible receive Families First benefits;
- the recipient has entered a skilled nursing home or intermediate care facility and vendor payments will be authorized through Medicaid;
- the recipient's whereabouts are unknown and agency mail directed to him/her has been returned by the Post Office indicating no forwarding address (if the individual's whereabouts become known during the payment period, however, the recipient's checks to which he/she is entitled will be made available);

CONTINUING RESPONSIBILITIES

- the recipient moves out-of-state and DHS has established that he/she has been accepted for assistance in another state;

- a Families First child is removed from the house as the result of a judicial determination or is voluntarily placed in foster care by his/her parents or legal guardian;

- DHS has received notification that a member of the AG has been approved for SSI; assistance is to be discontinued or reduced as the result of an appeal decision which upholds the county office; or

- the AG fails to show up for a review appointment.

VERIFICATION:

The caseworker is not required to obtain verification when the AG reports changes that terminate the Families First benefits. However, any reported change that increases or decreases the benefits or that is reported by someone other than an AG member must be verified in accordance with the policies detailed in the Verification chapter.

DOCUMENTATION:

The caseworker must record all changes on the appropriate screens and give full explanation of the changes in running record comments, CLRC. This documentation should include:

- when the change was reported;
- how the change was reported;
- what was used to verify the change;
- what action was taken on the change; and
- if the AG filed an Appeal for Fair Hearing during the ten-day notice period and whether or not continued benefits were requested.

When closing a case, document CLRC regarding:

- the circumstances causing case closure;
- the attempt to contact the AG by telephone and its outcome (if the AG has no telephone, document this also);
- the appropriate ACCENT reason codes;
- the explanation that the AG can receive child support and Families First at the same time, if the caretaker verbally requested case closure because of child support; and
- the DOH referral (if needed)

When a case is closed based on the client's request, the DHS supervisor must document CLRC explaining:

- the reason for the closure; and
- that the DHS supervisor discussed the closure with the caretaker, if the request was verbal; or
- that the DHS supervisor reviewed the written request and the decision was based on accurate Families First policy, without instruction from DHS staff.

PROCEDURES:

When a change is reported, the caseworker must:

- determine if the change affects the AG's Families First eligibility or benefit level;
- record all pertinent information on the appropriate ACCENT screens and running record comments, CLRC;
- obtain all necessary verifications; and
- rerun AEABC and authorize the new benefit level or case closure so that a notice will be sent to the AG.

IV. COUNTY TO COUNTY TRANSFER

POLICY STATEMENT:

Families First recipients may move from county to county within the state and remain eligible for benefits. The case manager must inform the A/R at each application and review to:

- report any plan to change residence;
- provide the approximate date of the move; and
- provide the new address with directions to the residence.

CONTINUING RESPONSIBILITIES

The county offices are responsible for:

- transferring the case to the new county as quickly as possible;
- ensuring that benefits are not interrupted if the recipient provides all necessary information; and
- reviewing the transferred case within 30 days of receipt.

VERIFICATION:
When the AG is transferred from county to county in the state, the AG is responsible for providing verification for all points of eligibility during the review in the new county.

DOCUMENTATION:
When the recipient reports a move, the case manager in the old county of residence will update the address and directions to the residence on the appropriate ACCENT screens and document the circumstances of the transfer in running record comments, CLRC. When the case manager in the new county of residence reviews the case, he/she will update the appropriate ACCENTS screens and document any pertinent information in running record comments, CLRC, just as with any other review.

PROCEDURES:

- When a Families First AG moves from one county in the state to another, the case manager in the "old" county will transfer the case on ACCENT to the new county.
- If the AG is in an ACCENT case with other AGs, the case manager will delete the members of the AG that have moved and set up a new ACCENT case for these members before transferring them to the new county.
- If the recipient reports the move to the new county first, the case manager in that county will notify the case manager in the old county who will either transfer the case or remove the individuals, as appropriate.
- The case must be reviewed in the new county within 30 days of receipt. When the case is assigned to the case manager in the new county, he/she will:
  - schedule a review appointment with the recipient;
  - determine continuing eligibility; and
  - authorize the case.

V. BANKRUPTCY

POLICY STATEMENT:

A bankruptcy order can affect the Families First grant amount. Usually, the bankruptcy order will specify that all or a part of the Families First grant amount be paid directly to the bankruptcy court for disbursement to the individual and his/her debtors.

During the period the bankruptcy order is in effect, the Families First grant cannot be reduced due to an overpayment. Even though benefit reduction cannot be imposed on a bankruptcy case while the bankruptcy order is in effect, claims must continue to be completed on any overpayments that occur after the bankruptcy order is issued. Once the bankruptcy is discharged, recovery can be attempted on any post-petition overpayments that have occurred.

Other appropriate actions, such as a grant increase or decrease due to changes in income or AG size, can still be made. In addition, disqualifications and sanctions can be imposed and cases may be closed, if appropriate.

VERIFICATION:

The county will receive a bankruptcy order from the court Bankruptcy Trustee.

DOCUMENTATION:

Document CLRC that the A/R's case has a reduction in the grant amount due to a bankruptcy.

PROCEDURES:

When the Department is notified that a Families First recipient has filed for bankruptcy protection:

- Stop any collection activity to resolve a claim.
- Notify Investigations immediately to ensure the debt to the Department is included in the bankruptcy filing so that it can be discharged through the bankruptcy order.
- Forward the bankruptcy order immediately to FA/Bankruptcy, Fiscal Services, in the State Office. Following the receipt of the order, the FA/Bankruptcy worker will contact the caseworker regarding the appropriate amount to be fiated for the bankruptcy.

CONTINUING RESPONSIBILITIES

- Contact the FA/Bankruptcy worker regarding any change in the grant amount (including case closure). The FA/Bankruptcy worker will contact the Bankruptcy Trustee. Prompt communication between the field and the FA/Bankruptcy worker in the State Office is essential, since there is no automated link for this part of the process. **NOTE:** When a case with a bankruptcy order is closed for any reason (including failing to appear for a review), the individual is responsible for the payment to the bankruptcy court in the month following closure.

- Contact the FA/Bankruptcy worker if the case is reapproved so that he/she can determine that the bankruptcy order continues to remain in force and can act appropriately.

FAMILIES FIRST DENIAL/CLOSURE ACTIONS

Medicaid

Applications Denied:	DOH Visits	MA C	TM	Trickle	TCC
Refusal to Sign PRP	No	No	No	Yes	No
Voluntary Quit	Yes	No	No	Yes	No
Refusal to Cooperate with Child Support	No	Yes for EC	No	Only if ineligible for MA C	No
Denied for Other Reasons	No	No	No	Yes	No

Medicaid

Active Case Closed:	DOH Visits	MA C	TM	Trickle	TCC
Refusal to Sign PRP	No	No	Yes	No	Yes
Work Sanction	Yes	Yes	Only if ineligible for MA C	No	Yes
Voluntary Quit	Yes	Yes	Only if ineligible for MA C	No	Yes
Child Support	Yes	Yes	Only if ineligible for MA C	No	Yes
Closed for Other Reasons	No	No	Yes	No	Yes

FAMILIES FIRST OVERPAYMENTS AND UNDERPAYMENTS

POLICY STATEMENT:

Title IV-A, Section 402 (a) (22) of the Social Security Act and federal regulations 45 CFR 233.20 (a) (13) require prompt recovery of overpayments and correction of underpayments. TCA 14-8-120 provides for criminal penalty against individuals who fraudulently receive Families First benefits to which they are not entitled.

The Department of Human Services must correctly determine eligibility for Families First benefits and provide the correct grant to each assistance group.

I. FAMILIES FIRST UNDERPAYMENTS

POLICY STATEMENT:

A Families First underpayment occurs when an AG receives less assistance than they were entitled to receive. Corrective action must be taken promptly to restore benefits retroactively any time an underpayment for any prior period is discovered when the AG is currently eligible for and receiving benefits, or would be if the error causing the underpayment had not occurred. The amount of the underpayment is the difference between the grant the AG received and the amount of benefits they were entitled to receive.

Retroactive payments cannot be used to offset an overpayment.

VERIFICATION:

The case manager must verify pertinent information to establish the amount of benefits to be restored to the AG, such as loss or decrease in income, etc., in accordance with normal verification requirements. See the Verifications chapter for details.

DOCUMENTATION:

Running record comments, CLRC, must be documented fully to explain the circumstances causing the underpayment, the specific months involved and the steps taken to correct the error. In addition, the case manager must update any appropriate ACCENT screens.

FAMILIES FIRST OVERPAYMENTS AND UNDERPAYMENTS

PROCEDURES:

Prompt action must be taken to correct the ongoing grant, if applicable. When calculating the amount of the underpayment, the case manager will:

- establish the entire period of incorrect payment;
- use the policies, procedures, budgeting methods and payment standards in effect during the period of underpayment;
- work a Families First budget off-line to determine the amount of benefit that the AG should have received for each month of the period;
- subtract the amount received from the amount that should have been issued for each month in question;
- authorize a retroactive corrective payment for each month involved in the following manner.

The case manager will enter information on the Supplemental Cash Request (BISC) screen, if the current and/or recurring month's benefits are being corrected for the addition of an individual (reason code 97) or a decrease in income (reason code 98), but because of time frames the changes could not be made effect for the current or next calendar month.

If retroactive payments are being made for reasons other than those listed above and/or the retroactive payment are for past months, the case manager will enter information on the Cash Auxiliary (BICS) screen.

If child support was collected and there is any remaining unmet need after the retroactive corrective payment has been authorized, the case manager must notify the Supplemental Unit in the AFDC/FF/FS Policy Section about:

- the months involved;
- the correct CNS;
- the correct Families First payment; and
- any net countable income.

II. FAMILIES FIRST OVERPAYMENTS

POLICY STATEMENT:

A claim must be established when any AG receives more Families First benefits than it was eligible to receive, regardless of the reason for the overpayment. An overpayment must be established for any prior period if the circumstances and overpayment can be determined. The first-line supervisor has full responsibility for ensuring that all claims are accurately and promptly established.

Overpayment may occur as a result of:

- administrative (agency) error (AE);
- inadvertent client error (ICE);
- improper payment error (IPE) for AFDC claims prior to 9/1/96 only; and
- suspected intentional program violation (SIPV).

If a change, either reported or unreported, results in ineligibility and the payment is not correctly adjusted the next month, then a claim reporting the overpayment must prepared When an overpayment is discovered, it must be pended on the Claims On-Line Tracking System (COTS).

For all overpayments beginning on or after 2/1/85, the period of Medicaid ineligibility must be determined for each recipient and reported to the Department of Health if an AFDC/FF ineligible was also ineligible for Medicaid.

Any individual who has been convicted in a state or federal court of having made a fraudulent statement or misrepresentation with respect to the place of residence in order to receive AFDC, Families First, Food Stamp, Medicaid (including TennCare) or Supplemental Security Income (SSI) benefits from two states simultaneously will be ineligible for Families First assistance for a period of ten years. This disqualification will be implemented using the same procedures that are used to implement any other disqualification.

EXCEPTION:

Claims that occur when excess real property is sold during a period of exclusion and the sale is timely reported are not pended on COTS. Follow the collection procedures outlined in the Resources chapter.

Collection will be pursued for overpayment claims. However, collection will not be pursued on cases that are technically ineligible or overpaid solely because of a procedural error (i.e., failure to enumerate an assistance group member).

GOOD CAUSE:

The earned income disregards are not allowed when calculating overpayment cause by the A/R's failure, without good cause, to timely report income. Good cause includes the following which might prevent a timely report:

- severe illness;
- accident;
- hospitalization;
- natural disaster; or
- other extenuating circumstances beyond the A/R's control.

VERIFICATION:

All information used to establish the overpayment should be verified. However, if the employer fails or refuses to provide verification or has gone out-of-business or cannot be located, the case manager should still pend the claim. The claims writer should attempt to verify the actual income of the AG, document the result. Only the income that is verified by the employer or established by the A/R's statement or any other available source such as wage match, Clearinghouse, etc., can be used in calculating the claim.

DOCUMENTATION:

The case manager will document the circumstances regarding the overpayment claim and the COTS claim number in the ACCENT case in running record comments, CLRC. In addition, the decision to suspend collections must be fully documented in the running record comments, CLRC, in the ACCENT case.

PROCEDURES:

The procedures for processing claims in each county are established by the district and county administrative staff. The following guidelines have been developed to ensure that all claims are identified and process timely.

- Each District Family Assistance Director, Area Manager or Family Assistance Program Supervisor will assign claims responsibility to either:
  - a specialized claims unit; or
  - a specialized claims worker; or
  - the AG's case manager.
- The case manager who discovers the overpayment must pend the claim on COTS using the instructions in the COTS procedural manual.

Establishing the Period and Amount of the Overpayment

An overpayment must be established for any prior period if the circumstances and overpayment can be determined. The policies and need/payment standards that were in effect during the time the overpayment occurred must be used to establish the period and amount of the overpayment.

If the period of overpayment begins on or after 2/1/85, Medicaid eligibility for any AFDC/FF ineligibles must be determined. If an individual is ineligible for Medicaid:

- determine the period of ineligibility for **each** recipient; and
- enter this information in the appropriate section of the Family Assistance Claim Determination report.

This information will be transmitted to the Department of Health.

To determine the amount of the overpayment:

- use prospective budgeting to calculate the claim amount;
- establish the difference between all IV-A benefits (AFDC/Families First cash assistance and supplemental payments) the AG received and the corrected benefits they were entitled to receive; and

- COTS will calculate the net overpayment by reducing the gross overpayment by any IV-D reimbursements of the grant. The claim may be reduced to zero if IV-D collections have reimbursed the state for the AFDC/Families First payment.

Start Date of Claim

If the claim where the first month of overpayment or ineligibility was prior to 9/1/96 and error caused by non-financial changes, whether reported or unreported, begin the claim during the month following the month the change occurred. If income changes, either reported or unreported, causes prospective ineligibility, begin the claim the month of the change. The month the change occurred is considered to be the month income was actually received by the applicant/recipient.

To establish the begin date of the claim when the first month of overpayment or ineligibility is 9/1/96 or later:

- allow ten days to report the change from the date the change became known to the AG;
- allow ten days for the case manager to have acted on the change;
- allow ten days for the advance notice of adverse action.

The begin date of the claim will be the first month after the adverse action period ends.

Earned Income Penalty

When calculation the amount of the overpayment because of the A/R's failure, without good cause, to timely report income, do not allow any of the earned income disregards (i.e. $75 work allowance and $30 & 1/3 or $30 for months prior to 9/1/96 and $150 for months 9/1/96 or later; and child care in either instance). See the Good Cause section for details.

Collection of AFDC/Families First Overpayments

Federal regulations mandate that recovery be initialed by the end of the quarter following the quarter the overpayment was identified. However, collection will not be pursued on cases that are technically ineligible or overpaid solely because of a procedural error (i.e., failure to enumerate an assistance group member).

COTS will generate a "Notice of Benefit Reduction/Request for Repayment" to the AG when the claim is complete. This notice will:

- inform the AG that they received more benefits than it was eligible to receive;

- include the amount of the overpayment;
- include the months of the overpayment; and
- advise the AG to contact the agency to negotiate a repayment agreement.

Detailed instruction are provided in the COTS Procedural Manual.

The case manager/investigator is responsible for negotiating the Repayment Agreement with the AG. The Repayment Agreement is to be completed for each claim. This form serves as a contractual agreement between the Department of Human Services and the AG and will remain in effect until the claim is repaid in full or another Repayment Agreement is negotiated.
DHS must attempt to recover the overpayment from:

- the assistance group that was overpaid; or
- after consultation and concurrence with departmental legal counsel, any AG of which the caretaker and/or other adult member of the overpaid AG has subsequently become a member.

Examples

- The AG consisted of grandmother and her two grandchildren. The AG was overpaid because the grandmother failed to report her earnings. She requested that she be removed from the AG, but she still received assistance for her two grandchildren. The grandmother refused to repay the overpayment. Since we must recover the overpayment from the AG that was overpaid, grant reduction must be invoked from the children's AG.
- Mrs. James received assistance for herself, her disabled husband and their child. Mrs. James failed to report that she had started working and the AG was overpaid from February through June.

  In July, Ms. James left the state and DHS could not locate her. Mr. James applied for assistance for his nephew and was approved. This AG consists of the Mr. James and the nephew.

  Since Mrs. James' whereabouts are unknown, we must get departmental legal counsel's opinion of the feasibility of attempting recovery from Mr. James' current AG. If our legal counsel is in agreement, then we will recover the overpayment from Mr. James' grant.

Methods of Repayment

The net overpayment will be collected through:

- grant reduction (active money payment cases only);
- lump sum repayment; or
- installment payments.

Non-IPV overpayments for active money payment cases must be recovered through grant reduction. Grant reduction may be used for IPV overpayments unless other payment plans are decreed by the court. Federal regulations require that recipients subject to grant reduction must be allowed to retain income (Families First payment plus other income) equal to at least 90% of the payment standard for their AG size.

If the grant is reduced to zero because of grant reduction, the AG continues to be considered Families First recipients. They remain eligible for Medicaid. However, they must continue to meet all Families First eligibility requirements (i.e. deprivation, resources, enumeration, etc.).

If a former recipient reapplies and the AG has an outstanding claim, grant reduction must be invoked at the point of approval. If the recipient had agreed to a monthly repayment, the monthly repayment must be discontinued and grant reduction must be initiated. A revised Repayment Agreement should be pursued, but is not required to initiate the grant reduction.

Initiate grant reduction for active money payment cases as soon as a claim has been established and calculated. However, do not initiate grant reduction on a claim that been referred to Investigative Services unless and until advised to do so by Investigative Services.

ACCENT will generate a COTS alert to run AEABC to initiate benefit reduction. This will cause ACCENT to compute the monthly amount to be withheld for the Families First check and generate a Notice of Disposition to the advise the AG of the effective date of the grant reduction and the grant amount they will receive. If the net grant amount after grant reduction falls below $10, a check will be issued for the appropriate amount.

If the recipient appeals the grant reduction within ten days, the appeal should be processed as normal. The AG must be informed that they have the option to either accept the adverse action or continue benefits pending the outcome of the appeal.

If the case with grant reduction closes or the grant falls below $10 before the claim is repaid, the case will appear on the COTS report, Benefit Reduction to Repayment. A

request for Repayment, HS-200, should be sent tot he AG advising them of the outstanding balance of the claim and requesting that they come in to sign a new Repayment Agreement. COTS will continue to send monthly statement to these inactive AG in accordance with COTS Procedural Manual.

Other Repayment Methods

A lump sum payment is a one-time payment for the entire net balance of the overpayment or a partial payment on the claim. This type of repayment is to be used on inactive cases or active cases when the recipient request this option.

An installment payment is a regular monthly payment made on the balance of the overpayment. Installment payments may be accepted as the repayment method for inactive cases if total repayment by lump sum is not possible.

Other methods and/or schedules or recovery may be used as ordered by a court for IPV claims.

Procedures for Lump Sum or Installment Payments

After the claim has been completed, collection activities will be initiated and COTS will generate the Notice of Grant Reduction/Request for Repayment. The Request for Repayment will instruct the individual to contact the agency to set up a repayment plan.

If the individual responds

- the Repayment Agreement will be negotiated;
- the appropriate COTS change will be submitted in accordance with the COTS Procedural Manual; and
- the individual must be given a preaddressed, postage-paid envelope and advised to send payment to:

  Tennessee Department of Human Services
  Fiscal Services Section
  P.O. Box 198980
  Nashville, Tennessee 37219

- Fiscal Services will continue collection effort if payment is not made in accordance with the Repayment Agreement.

If the individual fails to respond to the Request for Repayment or complete the Repayment Agreement:

- Section R (Repayment section on COTS) must be completed placing the claim in repayment status; and

- Fiscal Services will send monthly statements and preaddressed, postage-paid envelopes to the overpaid AG; and

Collection activities will automatically be suspended after six monthly statement have sent to the AG if there have been no payments. However, collection activities can be initiated in the future if the AG's circumstances change.

Receipt and Deposit of Direct Payments

Recipients should be instructed and urged to send all payments directly to Fiscal Services in the State Office. However, the county office must accept payments from anyone who insists on making a local, direct payment.

Each county office is responsible for designating an individual to assume responsibility for receiving overpayment collections and making deposits as follows:

- Repayments in the form of cash, checks of any type or money orders will be accepted.

- A Families First check may only be accepted as payment when it is for the same month and the same amount as the overpayment thereby preventing an overpayment.

- If the recipient gives the Families First check as payment the recipient must endorse the as follows:

  Signature of Recipient
  For Deposit Only
  by the Tennessee Department of Human Services

- **Do not accept a Families First check as payment for a prior period of overpayment.**

- Procedures outlined in the COTS Procedural Manual should be followed in crediting the client's account and depositing county office collections.

- All collections must be deposited within 24 hours after being received.

- Any repayment that cannot be deposited in the local bank the same day it is received must be stored overnight in a secure area (preferably a vault).

- The client must be given a receipt when a collection is accepted by the county office.

Monthly Statement

Individuals who have received a Families First overpayment will receive a computer-generated statement each month giving the information shown below. Each overpaid AG, regardless of whether repayment is current or delinquent, will receive a statement until the claim(s) is paid off or until collection activities are suspended.

- claim number(s);
- previous balance(s);
- the amounts and dates of payments and credits;
- current balance (if the AG has multiple claims, the statement will show the total of all overpayments;
- past due amounts;
- monthly amounts due;
- amounts currently due; and
- any special message to the individual.

For more a detailed explanation and instructions, refer to the COTS Procedural Manual.

COTS will automatically suspend collection activities on all claims after six monthly statements have been generated if no payment is received. The county office can suspend collection activities on inactive cases at any time after the claim has been prepared if:

- the agency loses contact with the AG;
- the agency determines that future collection activities would not be cost effective and the outstanding balance is less than $1; or
- the agency is prohibited by the court form initiating collection.

See COTS Procedural Manual for instructions on suspending collection activities.

The decision to suspend collections must be fully documented in the running record comments, CLRC, in the ACCENT case. The suspension can be lifted if there is a change in the individual's circumstances.

FAMILIES FIRST OVERPAYMENTS AND UNDERPAYMENTS

Federal regulations **prohibit** a Families First (AFDC) claim from being deemed uncollectible. Do not deem a Families First claim uncollectible.

Procedures for Families First AGs With Overpayments That File for Bankruptcy

Individuals who file for bankruptcy can list the Department of Human Services as a creditor if they have an outstanding claim. The Notice of Bankruptcy should be submitted to the State Office. Any bankruptcy document submitted that are sent to the county office by mistake should be forwarded immediately to:

Bankruptcy Administrator
Attorney General's Office
Tax Division
Bankruptcy Unit
404 James Robertson Parkway
Suite 2121
Nashville, Tennessee 37243

Record Keeping Requirements

The official records of claims and repayments will be maintained for federal reporting and audit purposes by COTS and the Fiscal Services AFDC Claims Unit in the State Office. Investigative Services staff are responsible for maintaining case files that contain thorough documentation substantiating the overpayment. Case files containing documentation of a claim are to be retained until the total of any and all claims is paid in full.

III. ADMINISTRATIVE DISQUALIFICATION FOR FAMILIES FIRST

POLICY STATEMENT:

An intentional program violation (IPV) is an action by a person for the purpose of:

- establishing eligibility for Families First; or
- maintaining eligibility for Families First; or
- increasing the amount of a family's Families First grant; or
- preventing a decrease in or termination of a Families First grant.

which is intentionally:

- a false or misleading statement; or
- a misrepresentation ; or
- a concealment or withholding of facts; or
- any act intended to mislead, misrepresent, conceal or withhold facts, or propound a falsity.

Families First applicants must be given written information ("Fraud, the Law and You") about disqualification penalties at the time of application. Families First recipients will be given this information each redetermination of eligibility.
Prior to conducting an administrative disqualification hearing, an investigation of an allegation that a person committed an intentional program violation must conducted. All suspected IPVs must be referred to Investigative Services after the overpayment claims have been pended. Investigative Services will conduct a separate investigation to prepare a case for an Administrative Disqualification Hearing or to pursue court action.

Case Maintenance

Pending the outcome of disqualification proceedings, the case manager may take any necessary action to discontinue, terminate, suspend or reduce assistance, or change the manner or form of payment to a protective, vendor or two-party payment for reasons unrelated to the reasons for the disqualification hearing. The case manager will also continue to take any necessary action on a case awaiting investigation, administrative hearing or court hearing. The case manager will make changes including

- the addition of individuals to the AG;
- the removal of individuals from the AG;
- grant changes;
- redetermination of eligibility; and
- all other necessary case maintenance activities.

FAMILIES FIRST OVERPAYMENTS AND UNDERPAYMENTS

Disqualification Penalties

An individual who, on the basis of a plea of guilty, nolo contendere (no contest) or otherwise is found to have committed an intentional program violation as a the result of an administrative disqualification hearing (ADH), or by a state or federal court, will be disqualified from participating in the Families First program. This disqualification penalty is limited to the individual(s) found guilty of having committed an IPV.

An individual found to have committed an IPV will not have his/her individual needs taken into account when determining the AG's eligibility and the amount of assistance, but any resources and income of the disqualified individual will be considered available in their entirety to the AG. This penalty is applied during the entire duration of the penalty period.

The individual will be disqualified for

- for six months for the first IPV;
- for 12 months for the second offense; and
- permanently for the third or a subsequent offense.

In cases where a disqualification penalty and other sanctions or penalties apply;

- the disqualification penalties imposed under this chapter will be in addition to, not be substituted for, any other sanction or penalties which may be imposed by law for the same offenses.
- The disqualification penalties affect the individual concerned and cannot be substituted for other sanctions under the Families First program (e.g., failure to participate in the Personal Responsibility Plan or to cooperate in obtaining child support), but may run concurrently with other sanctions which are in place. After the disqualification period expires, the person will have to meet all eligibility requirements before being added to the Families First AG.

Imposition of the Disqualification Penalty

A disqualification penalty will be imposed only after the issuance of a Final Administrative Order finding the individual guilty of committing an intentional program violation. The period of disqualification starts no later than the second calendar month following the date of the final order.

In the event that a state of federal court finds an individual guilty of having committed an IPV, impose the penalty according to the terms of the court order. If the penalty, begin the penalty no later than the second calendar month following the date of the court order, usually the next recurring month.

When the individual's disqualification results from a prior receipt of AFDC and/or Families First and the case is closed, the disqualification will run as if the person is an active recipient.

A notice will be sent to an individual who has been found to have intentionally violated the Families First program by a final order or has entered into a consent agreement (as discussed later in this chapter). This notice will include:

- the period of disqualification;
- the amount of payment the AG will receive during the disqualification period; and,
- if the Families First case is closed, information that the disqualification will run as if the person was an active recipient.

Stay of Penalty

Once an ADH has been held and a disqualification penalty is imposed, there is no further administrative remedy available. If a disqualification penalty is imposed by either an ADH or by court order, it will remain in effect unless and until the finding on which the penalty was based is subsequently reversed by a court of appropriate jurisdiction. The period of disqualification will continue even if the Families First case is closed.

The period of disqualification is not subject to administrative stay or review. Therefore, the only way for the disqualification period to be altered is for a court to issue an order to change the period. If a disqualified individual petitions for a judicial review of the period of the disqualification, any orders issued by the court must be followed.

Consent Agreements

The Department of Human Services may enter into an agreement with the local district attorney's office allowing said district attorney to enter into consent agreements with accused intentional program violators. The agreement will be filed with a court of competent jurisdiction and approve the court. Before entering into a consent agreement with the accused individual, the district attorney's office must send advance written notice to the accused explaining the consequences of entering into such an agreement.

The advance written notice, prepared by the Department of Human Services, will contain, at a minimum, the following:

- a statement for the accused individual to sign that he/she understands the consequences of signing the agree;
- a statement that the caretaker relative must also sign the agreement if the accuse individual is not the caretaker relative;
- a statement that signing the agreement will result in a reduction in payment for the appropriate period; and
- a statement of the length of the disqualification period that will be imposed as a result of the accused individual signing the agreement.

After the court confirms the agreement, a written notice will be sent to the case manager specifying the period of disqualification and the amount of Families First payment, if any, the AG will receive during the disqualification period.

Court Referrals

Investigative Services is responsible for referring appropriate cases suspected of IPV for court prosecution. When the court finds the individual guilty of IPV, but does not impose a specific disqualification period, the pre-defined period will be used. If the court finds the individual not guilty, the individual will not be disqualified. Investigative Services will reclassify the claim and initiate collection procedures.

Multiple Overpayments

- When multiple overpayments were combined into one IPV claim, only one disqualification penalty per guilty individual.
- Multiple individuals in the same Families First AG can have disqualifications running concurrently.
- If a separate IPV claim is established at a later date, a separate disqualification will apply.
- If the individual is serving one disqualification period and subsequently commits a second IPV, the disqualification periods must be served based on the date of decision. Therefore, there may be some overlapping disqualification periods.

- If the individual is found guilty of an offense that occurred prior to an existing IPV, do not impose a disqualification for that prior offense unless it has been specified in a court order.

Once the disqualification period starts, it continues until it is completed. This is true, even if the remaining eligible AG members become ineligible for any reason at a later date. If the disqualified individual leaves the AG, the disqualification follows that individual.

EXCEPTION:

When an optional AG member is the person found guilty of an IPV, that person is disqualified and removed from the AG. However, the person's income and resources are **not** considered available to the remaining members of the AG.

DOCUMENTATION:

All appropriate ACCENT screens must be completed to implement the disqualification. In addition, running record comment must contain all pertinent information regarding the disqualification, such as how the disqualification was ordered, the period of the disqualification, etc.

COTS

After either a waiver, consent decree, court order or ADH, Investigative Services will complete sections E, D, and R on COTS. Section E contains an explanation of the action taken. Section D contains identifying information about the disqualified individual and pends the disqualification. Section R initiates the request for repayment that is sent to the individual.

COTS connections have been modified to include AFDC/ Families First disqualifications.

COTS CONNECTION	EXPLANATION
0	No Outstanding Claims at This Time (Have Had a Claim in Past)
1	Food Stamp Claim
2	AFDC/Families First Claim

3	Food Stamp & AFDC/Families First Claim
4	Deferred Food Stamp Disqualification
5	Active Food Stamp Disqualification
6	Deferred Food Stamp Disqualification with AFDC/ Families First Claim
7	Active Food Stamp Disqualification with AFDC/ Families First Claim (Possible Deferred Food Stamp Disqualification Pending)

COTS CONNECTION	EXPLANATION
A	AFDC/ Families First Deferred Disqualification
B	AFDC/ Families First Active Disqualification (With Possible Deferred AFDC/ Families First Disqualification)
C	AFDC/ Families First Deferred Disqualification With Food Stamp (With Possible Active AFDC/ Families First Disqualification)
D	AFDC/ Families First Deferred Disqualification With Food Stamp Disqualification (With Possible Deferred AFDC/ Families First Disqualification)
E	AFDC/ Families First Deferred Disqualification With Deferred Food Stamp Disqualification
F	AFDC/ Families First Active Disqualification With Deferred Food Stamp Disqualification (With Possible Deferred AFDC/ Families First Disqualification)
G	AFDC/ Families First Deferred Disqualification With Food Stamp Active Disqualification (With Possible Deferred Food Stamp Disqualification)
H	AFDC/ Families First Active Disqualification With Food Stamp Active Disqualification (With Possible Deferred AFDC/ Families First/Food Stamp Disqualifications

PROCEDURES:

All suspected IPVs must be referred to Investigative Services after pending the claim. Investigative Services will conduct a separate investigation to prepare a case for an ADH or pursue court action.

If legal action is being planned, Investigative Services will schedule an appointment for the individual to come in for an interview. The individual will be given an opportunity to make a statement or present facts to clear up any possible discrepancies.

If legal action is not being pursued, Investigative Services will notify the individual

- that it appears a member of the AG has committed an intentional program violation;
- about the basis of the violation (e.g. unreported income);
- that an appointment has been scheduled with an Investigative Services staff member to discuss the overpayment;
- that the individual may either sign a waiver or proceed with the ADH;
- explain about the disqualification periods for the first, second and third IPVs;
- about the methods of repayment of the overpayment; and
- about the availability of free legal representation.

If the individual does not respond to the requests to come in to discuss the overpayment, Investigative Services will notify Administrative Review to schedule the hearing.

All referrals for an ADH will be made by Investigative Services to Administrative Review. A person accused of an IPV may waive his/her rights to an ADH. The notice concerning the right to waive an ADH is sent by the investigator and the waiver itself is secured by the investigator.

Imposing a Disqualification

Investigative Services will notify the case manager by E Mail message about the date of adjudication and length of disqualification. Family Assistance must notify the individual and remaining AG members of the disqualification using the Free Form Client Notice from CNVR.

Determining Eligibility With Disqualifications

All income and resources of the disqualified individual count to the remaining AG members. (See Exceptions in this section.)

Apply the appropriate earned income disregards to the earnings of the disqualified individual unless the earned income penalty is applicable. Determine the AG's eligibility and grant without including the disqualified individual's needs.

Starting the Disqualification

The case manager must begin the disqualification:

- based on the terms of a written court order; or
- the first month possible based on timely notice requirement and computer month-end deadlines after the ADH waiver or Consent Order was signed; or
- the first month possible based on timely notice requirement and computer month-end deadlines after final order from Administrative Review is received; or
- the first month possible based on timely notice requirement and computer month-end deadlines after court order is received

The disqualification must start no later than the second month following the date of the waiver or order, usually by the next recurring month and the disqualification must be imposed regardless of whether or not the individual is an active recipient. If there are multiple disqualifications or overpayments, the disqualifications will be imposed in accordance with the Policy Statement regarding multiple disqualifications in this section.

In addition, the case manager must:

- notify Investigative Services by E Mail message about the disqualification begin date (Investigative Services will then enter that information on Section D on COTS.);
- authorize the ACCENT case and update CLRC;
- set up an expected change for the month the disqualification is due to end; and
- send the appropriate notice using the verification notice sub-system (free form).

Ending the Disqualification

A computer report is produced around the 15th of the month and is accessible through Infopac. This report, Disqualification Due to Expire Report, lists all AFDC/ Families First and Food Stamp disqualifications that are expiring for the current month. This report serves as an alert that the disqualification has ended.

In order to prevent an underpayment, the case manager must take the actions listed below during the month the eligible individual first appears on the report.

- add the individual back into the AG if the individual is currently eligible;
- recompute the budget; and
- notify the individual of the change using the free form Client Notice on the verification notice sub-system.

If the case is closed because of the disqualification, the AG must apply after the disqualification has ended.

POLICY STATEMENT:

The Mid-Century White House Conference on Children and Youth defined the rights of all children which must be preserved and protected. These rights of children and rights and responsibilities of parents are detailed in the Department of Children's Services policy. However, the following information must be made available to all Family Assistance staff so that they will be fully aware of the Department of Human Services' responsibility in protecting children.

Federal regulations and state law require that Family Assistance staff be alert to possible signs of neglect, abuse or exploitation of the children we serve and to make appropriate referrals. Every child has the basic right to have parents and a home in which he/she receives the necessities for sustaining life. Therefore, Families First benefits may preserve a home and the necessities for the child when he/she is in jeopardy of losing these. When assistance is requested, the Family Assistance staff must determine eligibility as quickly and objectively as possible to ensure that income is made available to purchase these necessities (if all eligibility requirements are met regardless of the strengths or weaknesses of the home situation. When there is reason to believe that a home is unsuitable because of neglect, abuse or exploitation, the condition is to be brought to the attention of the Department of Children's Services staff with the facts which support this belief. Family Assistance staff must also cooperate with the Department of Children's Services in planning and implementing any action which is in the best interest of the child.

The Family Assistance staff must report and refer any observations of neglect or abuse of children immediately to the Department of Children's Services so that that staff can proved any needed protective services. The following are examples of neglect if the child is

- malnourished, ill-clad, dirty or without proper shelter;
- physically abused or cruelly treated;
- without proper supervision and is left unattended or is allowed to wander about without parental direction;
- overworked or exploited;
- seriously ill and the parents neglect or refuse to provide the necessary medical care and treatment;

- emotionally disturbed and his disturbance appears to be the result of physical, mental or emotional incapacity of his parents or of other manifestation of family breakdown, such as severe marital conflict;

- denied normal exercise that produce feelings of being loved, wanted, secure and worthy.

The following information has been provided from the Child Protective Services manual for the case manager to use in evaluating whether child abuse/neglect might exist and/or whether a referral to Department of Children's Services for further evaluation is in order.

Conditions of a Child Indicating Possible Abuse/Neglect

- Physical injuries including fractures, burns, bruises, welts, cuts and/or internal injuries in various stages of healing.

- Impaired psychological growth and development as evidenced in infants by lack of positive operant behaviors such as smiling, mobility, exploration, vocalization and manipulation of objects.

- Impaired psychological growth and development as evidenced in childhood and adolescence by poor self-esteem and lacking interpersonal skills necessary for adequate performance in nonfamiliar contexts such as schools, peer groups, etc.

- Impaired cognitive development including awareness and judgment.

- Child has a dull, "vacant" stare.

- Signs of extraordinarily poor hygiene.

- Emaciated appearance and/or distended abdomen; height and weight below average or normal for age.

- Pallor which suggests anemia.

- Wasting of subcutaneous tissue and/or untreated skin lesions.

- Dehydration.

- Maggot infestation of wounds or infestation of lice and/or other body vermin.

PROTECTION OF CHILDREN

- Lack of basic survival needs such as food, clothing, shelter or supervision taking into account the amount of time the child is unsupervised, the child's age and competence, and time of day.

- Impaired physical growth and development

- Obviously very poor teeth, recurrent toothaches.

- Lack of positive social values as evidenced by stealing, harming other, other anti-social behavior.

- Apparently undue fear of their parents.

- Behavioral extremes. For example, crying often or crying very little and showing no real expectation of being comforted; being excessively fearful; or seeming fearless of adult authority; being unusually aggressive and destructive, or extremely passive and withdrawn.

- Wariness of physical contact, especially that initiated by an adult; apprehensive when an adult approaches another child, particularly one who is crying.

- Hungry for physical contact, yet may have difficulty relating to children and adults.

- Sudden changes in behavior on a frequent basis. For example, displaying regressive behavior such as pants wetting, thumb-sucking, frequent whining; becoming disruptive; or becoming uncommonly shy and passive.

- Take over the role of the parent, being protective or otherwise attempting to take care of the parent's needs.

- Learning problems that cannot be diagnosed.

- Habitually truant or late to school.

- Always tired and often sleeps in class.

- Inappropriately dressed for the weather on a regular basis, too much or too little clothing.

- Sexual involvement with an adult, particularly in young children or at any age with a relative.

PROTECTION OF CHILDREN

Conditions of a Parent Indicating Possible Abuse/Neglect of Children

- Isolation from family supports such as relatives, friends, neighbors, and community groups.
- Appearance of trusting no one.
- Reluctance to give information about the child's condition or injuries. Unable to offer an explanation or the explanation is far-fetched, contradictory, or plausible but unlikely.
- Responds inappropriately to the seriousness of the child's condition either by overreacting (hostile or antagonistic) or by under-reacting (exhibiting little concern or awareness and seeming more preoccupied with their own problems).
- Refusal to consent to diagnostic studies of the child.
- Failure or delay in taking the child for medical care for routine checkups, optometric or dental care or for treatment of injuries or illness.
- Overly critical of the child and seldom, if ever, discusses the child in positive terms.
- Unrealistic expectation of the child, expecting or demanding behavior that is beyond the child's years of ability.
- Belief in the necessity of harsh punishment for children.
- Seldom touches or looks at the child; ignores the child's crying or reacts with impatience.
- Keeps the child confined, perhaps in a crib or playpen) for overlong periods of time.
- Seems to lack understanding of child's physical, emotional and psychological needs.
- Appears to be misusing alcohol or drugs.
- Cannot be located.
- Appears to lack control, or fears losing control, of children or self.
- Lacks knowledge of parenting skills.
- Appears to be borderline in intelligence, psychotic or psychopathic.

Exhibits generally irrational behavior.

Gives child inappropriate food, drink or medication.

The above lists are not all-inclusive, but are some indicator that conditions are conducive to abuse/neglect. As in any situation involving human beings, a particular observable condition must be viewed in relation to other conditions existing in a family. However, if a child and his parent both exhibit any one of the listed conditions, a referral will be made to the Department of Children's Services for the protection of the child.

Statutory Rape

All Family Assistance staff are required to report knowledge of possible statutory rape, as they are required to report any kind of child abuse or neglect. In Tennessee, statutory rape is defined as:

Consenting sexual penetration when the victim is at least 13 but less than 18 years old and the person she/he consented to have sexual penetration with is at least four (4) years older. **Statutory rape** is a class E felony. Punishment for a class E felony is a prison sentence ranging from 1 to 6 years.

Contact your local Department of Children's Services (DCS) office and notify the Child Protective Services intake worker of a possible occurrence of statutory rape when a Families First applicant or recipient is:

a minor at least thirteen (13) years of age but less than eighteen (18) years of age, and is pregnant or has children; **or**

a parent, legal guardian or custodian on behalf of such a person; **and**

the father of the minor's unborn child or the father of her child(ren) is at least four years older than the minor.

NOTE: **Do not question the pregnant minor regarding the age of the A/P as this is not information we normally gather prior to a child's birth. However, if information presented during the interview reveals that statutory rape is a possibility, contact DCS. Otherwise, A/P information can be collected when the child is born.**

Either caseworkers or supervisors may report suspected statutory rape to DCS. **Do not** document your report in ACCENT.

Follow up the verbal report by documenting:

the case name
the case number;
the victim's name;
the suspected perpetrator;
the date the report was made to DCS;
the name of the person who made the report to DCS; and
the name of the DCS Child Protective Services intake worker to whom the report was made.

PROVIDE THE STATUTORY RAPE PAMPHLET TO YOUR CLIENTS AT ORIENTATION AND EACH APPLICATION AND REVIEW AND MAKE THEM AVAILABLE TO YOUR CONTRACT PROVIDERS FOR DISTRIBUTION TO YOUR PARTICIPANTS.

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FAMILIES FIRST
RENEWAL HOUSE DEMONSTRATION PILOT

The Renewal House Demonstration Pilot will spend $100,000 per year for two years to test whether welfare families, at risk of being broken apart due to the addiction of the mother to crack cocaine, can be preserved through a residential treatment program where the children and mother live together. This facility is designed to provide treatment, a safe drug-free environment, along with support and housing for the family for a 6 to 12 month period. Education, job training and employment will also be critical components.

Services will include: Assessment, evaluation and diagnostic services; impatient medical detoxification; intensive outpatient substance abuse treatment; outpatient counseling; recovery programs; and aftercare services. Families First employment, education, training and case management services will be available along with any support services which the mother may need such as child care or help with transportation. Life skill classes, parenting training and classes in infectious diseases and general health will be included.

The Davidson County Juvenile Court has documented during a brief period in 1995 that out of 659 neglect/dependent cases filed in that court, over 60% involved cocaine addicted mothers. Over 50% of the children in these cases were 6 years of age or younger. Placing these children in Foster Care costs the state $11,084 per child. Renewal House is modeled after a similar program in Knoxville where 2 out of 3 mothers admitted to the residential program graduated while just 3 out of 10 admitted to a day treatment program graduated. Also, 75% of those who graduated retained custody of their children. While 50% of those who graduated have relapsed at least once, only 1 out of 10 has returned to the addict lifestyle. Residential programs appear to offer a substantially increased chance for a successful long term healthy lifestyle for the family.

This pilot program will be operated by the Davidson County Juvenile Court in collaboration with numerous local agencies already providing many of the kinds of services needed at but not which are not offered in a residential setting. The residence will be provided by the metropolitan Development and Housing Agency. An advisory board is being named to oversee the demonstration pilot.

Twelve Families First families will be served at Renewal House at any one time. They will represent approximately 36 family members. The Families First funding will provide operating expenses, services coordination, counseling for both mother and children, case management, and other necessary expenses of a residential program. Additional funds are being sought from foundations and other state agencies.

Admission to Renewal House will be voluntary based on an agreement between the mother and the court that she will participate fully in treatment. An evaluation of the Renewal House concept will be conducted by the University of Memphis. A report will be submitted to the Legislature by January 1 of each year of the pilot program.

WELFARE-TO-WORK

POLICY STATEMENT:

Welfare-to-Work (WtW) is a program created by the Balanced Budget Act of 1997. Under this Act, the US Department of Labor is authorized to provide funds to states to create additional job opportunities for the hardest to employ Families First recipients, non-custodial parents and individuals who no longer receive Families First cash benefits because of the 18 or 60-month time limit. The program is administered through the Private Industry Councils in each area of the state. Each WtW participant will probably have a WtW case manager at the PIC office who will coordinate with the DHS case manager.

The Welfare-to-Work (WtW) program will provide pre and post employment services, transitional employment, job placement and other support services which assist Families First recipients to move into long-term unsubsidized employment. The goal of WtW is to provide services to individuals that go beyond and do not duplicate Families First services. This program compliments Families First by filling potential gaps in services and providing long-term follow-up and support. Not all Families First or former Families First participants will meet WtW eligibility guidelines.

Welfare-to-Work as a Families First Work Component

Welfare-to-Work is available as a 20 or 40-hour Families First component for the Personal Responsibility Plan depending upon the needs of the participant. An individual who is eligible for WtW and who has a 40-hour work requirement can choose WtW as a component for the full work portion of the Personal Responsibility Plan or to supplement other Families First work activities to equal 40 hours. If the participant only needs 10 or 20 hours to complete the 40 hours of activity, WtW can fill that gap.

When WtW is added to the PRP as a Families First work component, the individual is required to satisfactorily participate in that component, just as in any other component for the number of hours assigned at WtW. If the hours in the WtW activities do not equal the number of hours needed, the individual's Personal Responsibility Plan must be amended to include another Families First work component to total the 40-hour requirement.

Welfare-to-Work as a Voluntary Activity

If an individual member of an assistance group is exempt from a work requirement, he or she may volunteer for WtW, just as for any other work component. Individuals whose cases are about to be closed or have been closed due to time limits may volunteer for WtW. This is a way to continue any education, training and perhaps support services after they leave Families First. In addition, if an individual has a barrier which Families First can not address, he/she may volunteer for WtW for help with that barrier while they continue to participate in Families First activities. For example, if an individual is enrolled in Adult Basic Education for 20 hours and wants to volunteer for additional activities, he/she may enroll in WtW. If an individual has a

unique barrier to participation which Families First can not address the participant may volunteer for counseling or treatment under WtW.

Note: Individuals who volunteer for WtW will not be sanctioned if they fail to cooperate in any way. It is important for the DHS case manager to carefully document voluntary participation in the case file and to carefully explain to the recipient that this is a voluntary activity.

The following are some specific examples of when individuals may volunteer for WtW:

- An individual who has scored 8.9 or lower on the TABE in either reading or math and is participating in a 20 hour Adult Basic Education activity can also volunteer for WtW as an additional component. However, in order to continue to be exempt from a 40-hour requirement and time limits, that individual must continue to satisfactorily participate in ABE for 20 hours per week.

- Individuals whose Families First assistance group is being closed may volunteer for WtW. Those who are being closed because of time limits would be eligible after closure. However, those being closed for other reasons would not and must be referred before closure.

- Individuals who are working 40 hours per week, but who are still eligible for Families First cash benefits.

- Individuals who have unique barriers beyond those that Families First can address, such as mental health problems, transportation problems, child care problems, etc.

Who Should Be Referred to Welfare-to-Work:

Individuals referred to WtW may include: Families First recipients, former Families First participants who have lost benefits due to time limits, non-custodial parents, and minor parents. Non-custodial parents of child only cases are eligible for WtW if they meet the eligibility criteria.

If the families First recipient and the DHS case manager agree on WtW as a work component or as a voluntary support need, then WtW will be entered on the Personal Responsibility Plan (PRP) at the time of the negotiation and the PRP must be signed by the participant. If the WtW case manager at the PIC determines that the individual cannot be enrolled in WtW, he/she will notify the DHS case manager. **At that point, the PRP must be renegotiated with the recipient to take WtW activities off and add new FF components.**

NOTE: A referred participant is considered to be enrolled in WtW for DHS purposes when DHS is notified by the WtW case manager. If the PIC subsequently notifies DHS that the individual was not enrolled, the DHS case manager must interrupt the time clock (adjust the time counters in ACCENT) retroactively if more than two weeks lapse between the referral to WtW and placement in another work component.

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Individuals who are suitable referrals to WtW include, but are not limited to, those who:

- Test at or below 8.9 in reading or math and are attending ABE for 20 hours per week. These individuals may volunteer for WtW without affecting their time count or work requirement if they continue to satisfactorily participate in ABE for 20 hours/week. These individuals may receive special tutoring to help them progress in ABE or may identify a career that does not require a GED and may move into employment.

- Are working full-time, but who are still eligible for cash assistance. Training or special assistance in finding a better paying career may be provided in WtW.

- Have attended all classes and activities Families First has to offer and still have not found a job. These individual may need special attention, job experience or more intensive job placement training.

- Are working part-time and cannot find a full-time job.

- Are having difficulty with attendance and participation in a component. WtW may be able to provide more intensive case management services.

- Are known to have dysfunctional family situations which involve substance abuse, domestic violence or mental health problems.

- Are trying hard to succeed in families First, but who have low functional skills that indicate a need for more individualized services.

- Need special tutoring to pass the GED or succeed in a training program.

- Could benefit from on-the-job training because they have not been successful in prior work situations or have not been able to obtain a job.

- Have unique child care, transportation, housing or other barriers which cannot be resolved by Families First.

- Are about to lose Families First benefits because of time limits.

- Want to open an Individual Development Account savings to start a business, buy a home, buy a car or go to school.

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Welfare-to-Work Eligibility:

Welfare-to-Work is intended to serve hard to employ individuals but, because of federal requirements, not all Families First recipients, former recipients or non-custodial parents are eligible for WtW activities. At least 70% of Welfare-to-Work funds must be spent on Families First recipients, former recipients who have lost benefits due to time limits and non-custodial parents (absent parents). Non-custodial parents may be served in child only cases.

All parents must have specific labor market deficiencies. Custodial parents and Non-custodial parents are also eligible when the other parent meets the labor market deficiencies.

The remaining 30% may be spent on Families First recipients or those who have lost benefits due to time limits and on non-custodial parents, who must have the state defined characteristics of long term welfare dependency. DHS case managers and local child support offices both have a responsibility to make referrals to WtW.

Custodial parents qualify in the *70% category* if they:

- are receiving cash assistance, and

* are long-term welfare recipients who have received AFDC,TANF (Temporary Assistance for Needy Families) or Families First cash benefits for 30 months or more in Tennessee or any other state (whether or not consecutive); or * may be terminated from Families First within 12 months because of either the 18- or 60-month time limits

or

- are no longer receiving Families First cash assistance because of either the 18 or 60-month time limit

AND

- meet at least two of the following labor market deficiencies:

  - lack a high school diploma or GED and test at or below 8.9 in reading or math;
  - require substance abuse treatment to become employed
  - have not been employed full-time for more than three consecutive months out of the last 12 months.

Non-custodial parents are also eligible if the custodial parent is receiving cash assistance and either parent meets the labor market deficiencies. If either parent meets these deficiencies, the other parent is eligible under the 70% provision.

If the caretaker stops receiving Families First cash assistance **after the referral**, the absent parent remains eligible for WtW under the 70% category.

If the non-custodial parent is associated with a child only case, the length of stay on assistance eligibility criteria can be met by looking at the length of time that the recipient or the children received assistance.

Individuals qualify in the *30% category* if they:

receive Families First cash assistance or have become ineligible for Families First cash assistance because of the 60 month time limit;

AND

- meet any of the following characteristics of long term dependence:

  - is a school dropout;
  - tests below 8.9 in reading or math;
  - was or is a teen parent;
  - is disabled or incapacitated;
  - has a poor work history;
  - needs drug/alcohol treatment;
  - is a victim of domestic violence;
  - has a mental health condition;
  - is a convicted felon;
  - lives in a remote area and transportation or jobs are limited;
  - lives in an inter-city high poverty area;
  - lacks reliable transportation;
  - needs additional child care assistance;
  - is homeless or faces eviction from housing;
  - has lost a job through no fault of his/her own; or
  - other criteria as defined by the PIC.

The non-custodial parent of the assistance group children will also fall under the 30% category if the caretaker, at the time of the referral, and/or the absent parent meet the characteristics of long-term dependence described above. If the caretaker stops receiving Families First cash assistance **after the referral**, the absent parent remains eligible for WtW under the 30% category.

The DHS case manager is responsible for marketing Welfare-to-Work (explaining the services available in a way that encourages participation), for determining if the Families First recipient who would like to participate in WtW is eligible for referral, and for making the referral. Once the Families First case manager makes the referral, the WtW case managers at the PIC will determine if the participant can be helped by WtW and whether or not to accept him/her into

WtW. The PIC staff will also make the final determination as to which eligibility category they belong. If the PIC does not accept a Families First recipient into WtW, a status change notice will be completed which indicates non-acceptance. PIC staff are also responsible for documenting why an individual was not accepted.

Welfare- to-Work Activities:

When adding Welfare-to-Work as an activity to the Personal Responsibility Plan, the case manager will list which WtW activity is being used in the referral. There are three different WtW activity levels (and codes,) each of which indicate different levels of hours needed for the PRP. These are:

SHOWING ON AEIPA		SHOWING ON CUSTOMER'S PRP
82	WtW No Impact	WtW/No Penalty for not Attending
87	WtW 20 hours on PRP	WtW/Meeting a 20 Hour Work Requirement
89	WtW 40 hours on PRP	WtW/Meeting a 40 Hour Work Requirement

The 40 hours, the 20 hours, and the "no impact" activity levels can be made up of several activities. For the 40 and 20 hour levels, the PIC may place the recipient in pre or post-employment activities which enhance what Families First is able to provide.

The "no impact" activity code will be used when a support service not available through Families First is needed; when the individual is not required to have a work component in the PRP; or when the recipient volunteers for WtW. A message to the customer will be printed by ACCENT on the customer copy of the PRP stating "WtW/No Penalty for Not Attending". **We must fully inform the participant that this activity is not required and this it will have "No Impact" on their work requirement or benefits status.** To adequately inform the recipient, the Case manager should enter free form text on AEIPM stating that the activity is optional.

The DHS case manager should be able to explain the various types of activities the individual may be enrolled in as a part of WtW. Once an individual is accepted, she/he will be given individualized services that are tailored to his/her specific needs to get and keep a job that will lead to self-sufficiency. A Families First recipient's activities can include any combination of available WtW activities.

The following is a list of activities available in WtW. Remember, one of the three Welfare-to-Work activities (WtW 20-hours, WtW-40 hours, or WtW-No impact) is to be entered on ACCENT screen AEIPA to generate the PRP. If the PIC does not enroll the participant, the Case Manager must renegotiate the PRP whether or not the activity is mandatory. The following information is for discussion purposes only and is not to be entered on the PRP. The PIC Case manager will determine which activities will be assigned based on their assessment and the number of hours that the DHS case Manager states is needed to meet the work requirement.

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- Apprenticeship- An on-the-job employment and training program in which the individual earns a wage while learning a specific skill which is transferable and credential.

- Community Service- An employment activity in which participants are placed with Community based Organizations to gain employment experience. These participants are paid Minimum wage for this activity.

- Individual Development Accounts- Welfare-to-Work staff may work with local not-for-profit agencies and Families First participants in establishing an IDA in any county in the state. However, all IDAs are subject to Families First policy as defined in the Individual Development Account Chapter.

- Internship- After completing certain classroom and/or OJT programs, individuals may be required to participate in mandatory activities that will make them eligible to complete testing for certification/licensing requirements before they can obtain permanent employment.

- Job Readiness and Job Placement- Creative pre-employment strategies designed to prepare individuals for work, to help place them in jobs, and to help keep them employed and moving up the career ladder. This may even include assisting a participant to start his/her own business.

- Job Retention Services-Post-employment services provided to enable the individual to stay in a job and merge successfully into the work force. Some examples of these services are:
  - Substance Abuse Treatment
  - Domestic Violence and Mental Health Intervention
  - Parenting Skills and Case Management for absent parents (available in at least one county in each SDA)
  - Job Skills Training (only available for working WtW participants)
  - Entrepreneurial Training (to allow individuals to start their own businesses)

- On the Job Training (OJT)- An on-the-job employment activity which the employer provides training in exchange for payment of up to one-half of the wages. The training periods should not exceed the amount of time necessary to learn the basic skills of the specific job or six months, which ever is shorter.

- Post-Employment Services- Services offered after an individual has been placed in employment either through Families First, another WtW activity, or self-initiated job seeking efforts by the individual. These services include, but are not limited to, Basic Education, English as a Second Language, Job Skills Training and Mentoring.

- Work experience-This activity is similar to Community Service in that it gives the participant an opportunity to gain employment skills through a position created for training purpose at a public or non-profit agency. These participants are also paid minimum wage.

- Work place Training- This activity will provide basic skills related to the workplace while the participant is on the job.

Support Services Under Welfare-to-Work:

Welfare-to-Work may also provide supportive services, not available through Families First, that are needed for individuals to participate in and continue successfully in employment. These services may be offered after an individual is placed in employment or job readiness. Examples of support services are:

- Specialized Counseling for barriers such as domestic violence, mental health, or substance abuse problems.

- Transportation during a transitional period or in an emergency, when it is not covered by Families First.

- Housing advocacy in the form of counseling, making referrals to housing providers, payment of back rent, and training on first home purchases.

- Specialized child care assistance over and above those offered through Families First or TCC. This may occur when an individual has exhausted TCC, when child is ill, when child care is not available through Families First and other child care costs that are not covered by Families First.

- Other support services such as automobile repair, tools, and uniforms if they are not being provided by Families First.

Note: Families First services will always be used first. However, Welfare-to-Work may also provide some support services such as transportation, housing advocacy, specialized child care assistance, automobile repairs, etc. when these services are not available from Families First.

Refer to the Welfare-to-Work Handbook for additional information on these activities and services.

Coordination With the PIC:

Once the Families First recipient is referred to Welfare-to-Work, this WtW activity becomes a component on the PRP just as any other component. A WtW 40-hour or WtW 20-hour activity on the PRP means the individual must continue to meet her/his work requirement (either 20 hours or 40 hours, as appropriate). For a WtW "no impact" activity, the PRP would need to be renegotiated if the participant is not enrolled by the PIC. If the participant is enrolled by the PIC they will consider them to be volunteers and will not update, unless they exit the program. The DHS case manager will ensure that enough activities are entered on the Personal Responsibility Plan to meet these requirements. Consequently, if the WtW activity is for only 20-hours per

week and the individual has a 40-hour requirement, the case manager must ensure that an additional 20 hour Families First component is also included on the plan.

The WtW case manager from the PIC will notify the DHS case manager via the HS-2619 if a Families First recipient is no longer satisfactorily participating in the WtW activity by circling the appropriate Status Codes. At that point, the DHS case manager will determine if the individual is a voluntary participant or a "mandatory" participant in WtW (i.e. the individual is an active Families First participant with a 20 or 40-hour work component requirement.) If the individual is a voluntary participant, no penalty action will be taken. However, the DHS case manager should contact the recipient to determine if she/he is willing to continue in WtW. If not, the PRP must be renegotiated to remove the WtW component.

If the individual is a "mandatory" participant in WtW, the case manager will follow the Procedures and policies in the Sanction Chapter of the Families First Handbook.

If after conciliation procedures are completed, the participant is willing to continue in Welfare-to-Work, either as a volunteer or mandatory participant, a new referral should be made. The WtW case manager at the PIC will make the decision as to whether or not the individual will be allowed to return to WtW.

DOCUMENTATION:

ACCENT

If agreed to by the participant, one of the three Welfare-to-Work activities should be listed on the Personal Responsibility Plan as a work component, just as any Families First component. The appropriate code should be entered on AEIPA. DHS will make referrals to the PIC which will help the participant select specific WtW activities. The DHS case manager will be informed of these specific activities through an INFOPAC Report (GRP943W) which list the WtW activities in which the PIC case manager placed the individual. The CLRC (running record comments) should be documented regarding the type of activity in which the recipient is participating in WtW and the number of hours per week this involves. The recipient's status as mandatory or voluntary should also be documented.

Families First/JTPA Database

Once the Welfare-to-Work activity is determined on the PRP, the participant should be enrolled in the Families First WtW Activity on the HS-2619. As discussed in the Work Component Tracking Alert Memorandum (WCTA, 98-02), the HS-2619 has been revised to accommodate the WtW program. The participant will be enrolled at the top portion of the form and they will be referred by completing the bottom portion of the form, the WtW referral. This is a form of eligibility verification for the PICs. Therefore, the Case Manager will need to sign at the bottom and **date** beside the signature. In order to accurately complete this process, the Eligibility section of the *Welfare-to-Work Handbook* has been attached for your review. Once a participant

has been referred, the DHS Case Manager will receive updates on INFOPAC Report Number GRP943.

Once the participant is referred to the PIC, they will document the participants progress in WtW by tracking the participant in Program Code 85, Welfare-to-Work. The DHS Case Manager will receive updates regarding this program on INFOPAC Report Number GRP943W.

PROCEDURES:

It is the responsibility of the DHS case manager to use the Welfare-to-Work program to enhance and improve the resource base available to each individual customer who may qualify for WtW services, This is one more "tool" in the "tool box" to help families reach independence. Case managers must know the program well enough to "sell" it to their customer; whether they have mandatory Families First work plans or whether they are potential volunteers for WtW.

The first step to getting a customer to accept WtW as an activity for their PRP is to be able to explain it to them clearly, giving the reasons why this will enhance their existing plans. This program is designed especially for the hard-to-serve. It provides many support options not available under Families First and is a good addition to other Families First components.

- The case manager will determine whether or not the recipient is potentially eligible for participation in Welfare-to-Work in accordance with the eligibility screening criteria. If so, the case manager will explain WtW to the recipient to determine if she/he will agree to have that component added to her PRP>

  These individuals are the hardest to employ and generally their time "clocks" are running. Therefore, the case manager should encourage them to take advantage of the services and activities that are available through WtW so that they can expedite their movement to self-sufficiency through employment. The case manager will also explain that if the individual is referred to WtW, the WtW case manager at the PIC will determine if she/he meets the final criteria for the program.

- If the individual agrees to be referred to WtW, the DHS case manager will complete a Families First Work and Training Tracking and Welfare-to-Work Referral (HS-2619) with as much information as possible about the recipient's situation. This will assist the WtW case manager at the PIC in making an eligibility determination.

The instructions for completing the (HS-2619) are attached in the Work Component Tracking Alert Memorandum (WCTA 98-02) and are also included in the *Technical Assistance Guidebook, Data Management for Work and Training Components.* The DHS case manager should pay particular attention to using program code 83 in the FF/JTPA System for Families First participants. In addition, when documenting the activities code, the case manager should use:

- 82 (No impact) for individuals who are volunteers or who need support or other services only;
- 87 (WtW – 20 hour PRP0 for individuals who require 1-20 hours of WtW activities to complete the PRP requirement; or
- 89 (WtW-40 Hour PRP) for individuals who require 21-40 hours of WtW activities to complete the PRP requirement.

The DHS case manager must include the exact number of hours needed to complete the customer's Families First PRP by writing in the number of hours next to the "Activity Code" entry (Note: This is not a "blank" on the form. Therefore, the case manager will need to write the hours in. Ample space is provided.) of the HS-2619 so that the PIC case manager will know how many hours of activities are needed. For example, if the individual is working 30 hours per week, the case manager will use activity code 87 and will explain that 10 hours of WtW activities are needed.

- The following will be attached to/enclosed with the HS-2619 when sent to the PIC:

  - a copy of the PRP, including past activities and their status;
  - any assessment results; and
  - any details about the individual that would be needed to assist the recipient in achieving self-sufficiency.

The case manager will monitor the recipient's participation in WtW in the same manner as with any other component. If the WtW case manager at the PIC reports any changes/non-compliance with the WtW component via the Status Codes on the HS-2619, the DHS case manager will take the appropriate action on the case (renegotiate the PRP, initiate conciliation, etc.)

FAMILY SERVICE COUNSELING

POLICY STATEMENT:

Beginning February 1, 2000, statewide, Families First will have new services to offer participants who may need treatment or counseling in order to progress to self-sufficiency. The purpose of Family Services Counseling (FSC) is to provide help to participants who are not making progress and to those who may have barriers to their progress. In addition, Family Services will help the caseworker who may be struggling with situations where customers are not making progress or not following through with the requirements of Families First. Family Services will provide immediate assistance to customers struggling with issues related to any of the following:

- Mental health
- Domestic violence
- Substance abuse
- Learning disabilities
- Children's health or behavioral problems

Family Services can help with a range of services that may make the path to self-sufficiency easier for some participants. Family Services include:

- A preliminary assessment;
- An in-depth assessment, if needed;
- A family assessment;
- Individual and family counseling;
- Advocacy;
- Help with PRP development;
- Follow-up;
- Referrals and access to treatment facilities or other appropriate services;
- Access to treatment for drug and alcohol abuse;
- Access to treatment for mental health disorders;
- Access to domestic violence shelters and counseling resources;
- Access to services to help with learning disabilities;
- Identification of multiple and co-existing barriers;
- Services to children;
- Follow-up;
- Assistance with applying for Supplemental Security Income and Social Security benefits for individuals with learning and/or mental disabilities.

Family Services Counseling is a new work plan component for Families First that can be a part or all of the Personal Responsibility Plan. Family Services are tailored to address the specific concerns or problems of an individual participant and/or the family. These

services may allow for an alternate work requirement and/or a time limit interruption to accommodate special circumstances.

These Family Services are available to all Families First assistance groups that contain an eligible adult, who faces any of the issues listed above. This includes both individuals who are required to work and some individuals who are exempt from the work requirement (see the Work Requirements and Work Components chapter under "Volunteers," for a discussion of work exempt individuals who may volunteer). Children of eligible adults can also receive Family Services. Former Families First assistance groups that contain an eligible adult are eligible for Family Services for twelve months after they leave the Families First cash program. Child only assistance groups are not eligible for Family Services.

Family Services Counselors from local mental health, treatment and/or counseling programs will be available to all county offices. Some counselors may cover more than one county, making them available to each county on a rotating basis.

All Families First assistance groups must be informed of the availability and content of Family Services. This includes child only assistance groups, even though members of a child only assistance group are not eligible for the services. When informing child only AGs about the services available, it is important to explain clearly that they may be able to access Family Services only if the caretaker is included in the assistance group. However, if they need these kinds of assistance, refer them to other resources in the community.

Caseworker – Family Services Counselor Relationship

Information needed to complete the Personal Responsibility Plan for work and time limit provisions is shared between the caseworker and the Family Services Counselor. However, due to the sensitive nature of the subject matter and the confidentiality of the client/counselor relationship, some information related to Family Services will not be shared with the caseworker.

Federal law on substance abuse and mental health treatment contain rigid confidentiality rules that must not be violated. There will be some information on activities and barriers that will not be shared with the caseworker, unless the participant allows it. All Family Services Counselor related activities will be referred to by the caseworker and on the PRP as "Family Services". For example, a participant needs treatment for a mental health condition. The caseworker will know that the participant has 10 hours a week of "Family Services" in the work plan and may know that the person is in treatment but will not know that the treatment is for a mental health condition.

Exceptions:

There are exceptions to the confidentiality relationship of the counselor with the participant:

- incidents or suspicion of physical and/or sexual abuse or neglect of a child will be reported, by law, to the appropriate authority;
- incidents of direct threats of harm to self or others may be reported to the appropriate agency or persons;
- information may be disclosed as a result of a court order or subpoena; and/or
- information may be disclosed to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Note: Information relating to Families First eligibility that is shared with the Family Services Counselor during the course of counseling is considered confidential. The only information that FSC is required to report is the participant's active/failed participation in counseling when the PRP mandates counseling in the plan, and information directly related to an individual's eligibility for Families First.

When the Family Services Counselor discusses confidentiality during the initial assessment, he/she will present a consent form for the participant to sign stating that he/she agrees with and understands these exceptions to the confidentiality policy. Family Services cannot be provided to a participant who will not sign the consent form. If the participant refuses to sign the consent form, the Family Services Counselor will notify the caseworker about this refusal. The caseworker will then contact the individual to renegotiate the Personal Responsibility Plan and remove Family Services Counseling as an activity. This is not a sanction situation.

PRP Development with Family Services:

When someone is referred to Family Services Counseling, the caseworker will renegotiate the Traditional Work Plan on an individual's PRP to reflect the Family Services Assessment. During the assessment period, no other PRP activities are required of the participant. However, the participant may continue any activities they were in at the time of the referral on a volunteer basis while the assessment is conducted.

Note: Individuals who are not exempt from the work requirement and who quit a job without good cause are subject to Voluntary Quit policy. This is true even if they are participating in FSC Assessment or ongoing Family Services Counseling. If the Family Services Counselor has identified that work is not an appropriate component at this time and the individual voluntarily quits the job, this would be considered good cause. In the event of voluntary quit, follow the procedures in the Sanctions Chapter of the Families First Handbook.

FAMILY SERVICES COUNSELING

If a barrier is identified by the initial or in-depth assessment, the Family Services Counselor will suggest the best work plan for the individual. If needed, the Family Services Counselor will recommend FSC as a part of the Traditional Work Plan or of a Modified Work Plan. At this time, the individual will decide whether or not to agree to FSC in the work plan and whether or not to have a Traditional or Modified Work Plan. The negotiation of the Family Services activities is between the Family Services Counselor and the participant.

- FSC Three-month Review

  In addition to having Family Services Counseling activities in the work plan, a participant may also have a Modified Work Plan that is recommended by the Family Services Counselor. A Modified Work Plan is a work plan with hours or activities outside of the standard FF work plan. This plan may also include modified sanction procedures and/or time limit interruptions. Many times, the reason for a Modified Work Plan will not be shared with the caseworker.

  When a work plan has been modified to include more than ten hours of FSC (fewer than 30 hours of work activities), or the participant has a special sanction criteria plan, the FSC supervisor will review the plan after three months. The purpose of this review is to determine if the modified plan continues to be appropriate for the participant.

- After the Three-month Review

  Clients may continue to participate in FSC after their three-month review. Whether or not their modified work plan and/or time limit will continue depends upon the results of the FSC review. If the FSC supervisor determines that a modified plan is no longer appropriate, it will be necessary to renegotiate the PRP to reflect the changes in the individual's work plan. The FSC activity (if continued) must have 10 hours or less of FSC coupled with enough hours of another activity to equal 40 hours. When an activity ends, the renegotiation process must begin within two weeks to be timely and the client must be in a new activity as soon as possible after the renegotiation.

  The FSC supervisor may also recommend that the modified PRP or time limit interruptions continue until he/she determines that the participant is able to handle a full-time work requirement with no time limit interruption. When the modified work plan ends, clients may continue to participate in FSC. However, their PRP must be renegotiated to reflect the hours and sanction criteria of a traditional work plan and the time limit interruption must be ended.

After the Family Services hours and services are agreed to by the participant, the remaining hours of Families First work components will be negotiated between the (cont. on page 356).

caseworker and the participant. The Family Services Counselor will inform the case-worker if there is available information on the appropriateness of some work components that the caseworker will use during this negotiation. This will help lead the participant to the most effective work plan to accommodate barriers and to achieve his or her career goals.

REFERRALS

The DHS caseworker is the central point for any case where a Family Services referral is made. The caseworker is the link to both the standard Families First services and Family Services Counseling.

A referral to a Family Services Counselor can occur:

- at the initial signing of the PRP,
- at the time of PRP renegotiation, or
- at any time when a condition or situation indicates a special need exists.

In an emergency situation, a Families First service provider will refer a participant directly to the Family Services Counselor. The provider will notify the caseworker about the emergency referral immediately. In emergency referral situations, the caseworker will renegotiate the PRP to include Family Services as a component.

For individuals who are no longer receiving Families First but whose AGs have closed within 12 months, a referral can be made by the Employment Career Counselor directly to the Family Services Counselor.

There are seven groups of appropriate referrals to Family Services. The referral group that the individuals fit into may determine what expectations the caseworker will have for their continued involvement with the Family Services Counselor.

If there is a special circumstance that warrants a Family Services assessment but does not fall under any of the seven referral categories, a referral to the Family Services Counselor can be made with approval from the Family Assistance District Director or their designee.

1. Individuals Who Are Non-Compliant With The Work Requirement

Individuals who are non-compliant with the work requirement must be offered a referral to the Family Services Counselor to begin the two-week compliance period. The participant has a choice of whether or not to go to the Family Services Counselor for assessment as a preliminary part of the two-week compliance period. The Family Services referral can be made at any step in the conciliation/closure process when compliance is offered (e.g. conciliation, phone contact, indicating to the caseworker a wish to comply, or reapplication after a sanction). However, once a component has been chosen, the individual cannot change during the two-week compliance period.

FAMILY SERVICES COUNSELING

If Family Services assessment is selected for the two-week compliance, the individual must cooperate with the Family Services Counselor. If the assessment and/or other Family Services are not available when the two-week compliance is to begin, recipients and applicants will not be required to go into another component to show compliance.

The compliance period will begin when the Family Services are available. However, the recipient can choose to go into another component for the two-week compliance period.

If barriers to employment and/or compliance are found in the assessment, the participant will choose whether or not to accept Family Services Counseling as a component in their work plan. In addition, if a Modified Work Plan is recommended by the Family Services Counselor, the participant will choose between the Modified Work Plan and the Traditional Work Plan. If, however, the Family Services Counselor does not find any barriers or the participant does not choose to go with Family Services, the participant must then agree to and comply with a standard two-week compliance period in order to come into compliance with Families First.

2. Those Who Are Compliant With The Work Requirement But Who May Be Experiencing Difficulty Or Showing Signs Of Obstacles That Could Be Addressed By Family Services

This group includes all those with a 40-hour work requirement and those who test below ninth grade and are in ABE. For some individuals in this group, the offer of the referral is mandatory, for others it is recommended. This does not mean that the participant must agree to the referral, but the referral must be offered.

A Family Services referral must be offered to individuals who:

- exhibit signs (either through interview or visual observation) of one of the obstacles mentioned above; or
- are identified by a Families First service provider (AE teacher, Employment Career Specialist, etc.) as having obstacles that could be addressed by the Family Services Counselor. The caseworker may request that the individual come in to renegotiate the PRP. This may include those with suspected learning disabilities that prevent their progress in education or training.

A Family Services referral is recommended for the following:

- Those who make frequent requests to re-negotiate the PRP. This may indicate difficulty with PRP activities or other barriers that may inhibit completion or follow-through.
- Assistance groups with children who have behavioral problems. These problems may impede the adult's participation in the work requirement or result in a school attendance sanction for the AG. Services can be provided for both the children and the caretaker.

- Assistance groups that have relatives (children, spouse, or other live-in relatives) with health problems that cause difficulties in complying with the Families First work requirements.

3. Requests From The Individual For A Referral

Individuals who think that counseling or treatment through a Family Services referral may help them may be referred without meeting one of the above criteria. The caseworker must refer individuals or the appropriate family member to the Family Services Counselor, upon request**. The individual does not need to give the caseworker a reason for the referral request. The caseworker may not ask the participant why he or she is asking for the referral to FSC.**

4. **Participants in Self-Initiated Treatment or Domestic Violence Programs**

If an individual informs the caseworker that he/she is in a treatment program or has initiated a safety plan to escape domestic violence, the caseworker will offer an FSC referral. **The participant in a self-initiated treatment or domestic violence program can only receive a Modified Work Plan and interruptions to the time limit if he/she accepts and participates in the referral to the Family Services Counselor**. The Family Services Counselor will not change the participant's treatment or safety plan but will assess the individual's situation to determine if there are other services that are needed. The Family Services Counselor will also recommend adjustments to the work plan and time limits, if needed. The intent is to fit the participant's self-initiated services into the Families First work plan without interrupting the service/treatment plan that the individual has begun.

If the participant wishes to have any of the treatment hours, time spent with a domestic violence counselor, or other like activities count toward the work requirement, the participant must cooperate with the assessment process and the Family Services Counselor. The hours spent in self-initiated treatment or counseling will be referred to as "Family Services Counseling" on the PRP. If additional non-FSC hours are needed for the participant's work plan, the Family Services Counselor will follow through with the participant and the caseworker as is done with other FSC referrals**.**

<u>Exception:</u>
If the participant is in a domestic violence shelter or a full-time residential treatment program, good cause can be granted for work plan compliance. An interruption or exemption to the time limit can be given without referring the participant to the Family Services Counselor. However, the caseworker can ask the Family Services Counselor for assistance in acquiring the needed verification of the treatment program.

5. Self Referrals

Individuals who are informed about FSC may contact the Family Services Counselor directly. If this occurs, the Family Services Counselor will proceed with working with the participant. The Family Services Counselor will then send a referral form to the caseworker to serve as an alert that the PRP may need to be renegotiated. If the participant initiates a referral, the participant has the responsibility to inform the caseworker in order to renegotiate the PRP.

6. **Eligible adults who are fulfilling their work requirement in other activities and want to participate in FSC as a volunteer.**

Individuals who are exempt or interrupted from the work requirement due to any of the following reasons **cannot** volunteer to participate in FSC:

- caretaker over 60 years of age;
- disabled caretaker;
- caring for an in-home disabled relative;
- incapacitated;
- caring for a child under the age of 1 year; or
- caring for a child under 16 weeks of age; **unless** the individual meets one of the following **exceptions:**

✓ caretakers 60 years of age or over (exempt code B) **<u>who are included in the AG;</u>**

Individuals in this category **who are employed** will be allowed to access support services necessary to continue employment. Such services include child care, transportation, dental, optical, car repair, etc. The caretaker must be included in the AG to access services; and

✓ a parent in a two-parent AG who is caring for a child under the age of 16 weeks (interrupt code A);

Individuals in this category **who are either currently employed or actively participating in a Families First allowable activity** (including high school for minor parents) will be allowed to access services. Services may include either the Families First funded activity itself or support services necessary to continue employment or participation in an activity. Such support services include child care, transportation, dental, optical, car repair, etc.

✓ single parents caring for a child under the age of 1 year (interrupt code Q)

Individuals in this category **who are either currently employed or actively participating in a Families First allowable activity** (including high school for minor parents) will be allowed to access services. Services may include either the Families First funded activity itself or support services necessary to continue

Individuals, who are exempted or interrupted from the work requirements for any reason other than those listed above, may request FSC and participate as a volunteer.

Note: Child-Only assistance groups cannot receive any services since the caretaker is not an eligible member in the assistance group.

The caseworker will send a referral to Family Services for participants who wish to volunteer and who meet the above criteria that allows them to be a volunteer.

7. Transitional Participants who have received cash assistance in the past 12 months.

The caseworker will make a FSC referral for an individual who has received Families First cash payments within the last 12 months and shows signs of a barrier or who wishes to be referred. There are four different ways that a transitional participant can be referred: the caseworker; the Employment Career Specialist; the DOH professional that conducts a post-termination visit; and a self-referral.

Non-compliance with Family Services

Individuals in referral groups 1-5 who are non-compliant can be subject to a sanction for non-compliance with Family Services, as is the case with other Families First work components. The Family Services Counselor will notify the caseworker regarding the non-compliance. Individuals in referral group 6 and 7 are volunteers and no sanction or renegotiation action is taken for non-compliance with Family Services Counseling for this group.

If a child in the AG is seeing a Family Services Counselor or receiving services through a provider arranged through Family Services, no action is necessary if the child stops going. If the child's involvement is tied to the adult's ability to work or participate in other activities, the Family Services Counselor will advise the caseworker on the action needed.

FSC and Time Limits

A referral to the Family Services Counselor results in a one-month interruption (the month of referral) to the time limit for assessment. However, based on the findings of the counselor, additional months may be interrupted if needed.

The one-month interruption for assessment will be limited to once in a 12-month period. This will be true whether or not the individual:

- has barriers;
- agrees to ongoing FSC;
- keeps the assessment appointment(s);
- becomes non-compliant;
- changes components; or
- loses eligibility and the FF AG is closed.

The 12-month count will begin the first month following the month the participant:

- began FSC Assessment; or
- was given an FSC assessment appointment date (whether or not he/she went to the appointment).

When an individual requests FSC within twelve months of a previous FSC assessment, another assessment can be completed but the clock will not be stopped.

Coordination With Other Services For Those With Family Services:

There are two other entities in the Families First Program that are specifically designed to diagnose and/or treat those with more difficult obstacles to self-sufficiency: the Medical Evaluation Unit (MEU) and Vocational Rehabilitation Services. It is important to note how these programs interact with FSC.

Determining Incapacity:

When incapacity is claimed or suspected, the caseworker will follow the incapacity determination procedures for either county approval or MEU referral. The Family Services Counselor cannot take the place of this procedure.

Rehabilitation Services:

Vocational Rehabilitation Services can help many participants with barriers get the training needed to find success in the workplace. A person with physical ailments or disabilities that prevent compliance with or exempt the individual from a Traditional Work Plan may need a referral to VR. A person who is referred to VR can also get a referral to Family Services at the same time or whenever the referral is needed.

Welfare-to-Work:

The Welfare-to-Work program also targets services to those with barriers to employment. It is important to ensure that services are not duplicated between Family Services and

WtW. Family Services should be viewed primarily as a source for counseling and treatment service. If Welfare-to-Work also offers counseling and treatment, Families First related services should be used first.

Priority Referrals

In order to serve those in the greatest need for Family Services first, the different groups of referrals are given different levels of priority. Those who are non-compliant; are in the required referral category; or are self-initiated referrals are given top priority. Those who are recommended referrals and transitional participants are given next priority. Those who are exempt from the work requirements or interrupted from time limits due to incapacity are given the next priority.

Priority for referrals and treatment will be given to anyone in danger or at risk of harming themselves or someone else. Every effort should be made by the Family Services Counselor to see a person who is in this type of danger on the same day that the situation is known or to make arrangements for the individual to see another professional who can help.

If a Families First service provider sees that a Family Services Counselor is needed immediately, the Families First service provider will make the referral to Family Services Counseling instead of referring the participant to the caseworker first.

OUTCOMES FROM FAMILY SERVICES ASSESSMENT

The Family Services Counselor will provide an assessment of the participant for the services and treatment that she or he may need to become self-sufficient. The Family Services Counselor recommendations will be individualized. Some recommendations may include Family Services Counseling as a part of the Traditional Work Plan. Others may have an exemption or interruption from the time limits and/or work requirements or may require a simple modification of the PRP or service delivery method to accommodate an individual's circumstances.

The Family Services Counselor will submit information, within two-weeks of the referral date, indicating what activities and modifications, if any, are recommended for the PRP, based on the initial assessment. If needed, a more in-depth assessment will be conducted by the Family Services Counselor before PRP recommendations are made or if the initial recommendations are no longer appropriate. The participant and the Family Services Counselor will discuss what the Family Services activities will include. Based on this information, the participant will choose whether or not they wish to include Family Services in the Traditional Work Plan or to agree to a Modified Work Plan (if needed).

If Family Services Counseling is chosen, the caseworker will use the Family Services Counselor's recommendations to revise the PRP to appropriately reflect what activities

are needed/required. A Modified Work Plan can only be offered to a participant if the recommended Family Services components, if any, are accepted as a part of the work plan. The PRP will be renegotiated when additional or different activities or services are warranted

For example, the first work plan with Family Services may require only cooperation with the Family Services Counselor or it may require counseling sessions over a period of time, in conjunction with other activities. The Family Services Counselor will consult with the caseworker to ensure that the PRP is reflective of the participant's needs, based on the initial assessment.

The following are the outcome categories that the Family Services Counselor will use to guide the caseworker and the participant in the PRP development**:**

Category A - No barriers to participation are present. Participant is referred to caseworker to renegotiate the PRP.

Category B - Slight barriers are present that require continued work with Family Services Counselor and related services, but do not affect the participant's ability to participate in Families First work components. The Family Services Counselor will assist, as needed, in the development of the PRP. Some hours may need to be spent with the Family Services Counselor. These hours will count as a part of the Traditional Work Plan on the Personal Responsibility Plan. The participant may spend part of the time usually devoted to classroom activity with the Family Services Counselor. Standard time limits, work requirements, and sanctions apply to this category.

Category C – Major barriers to participation are present that require a Modified Work Plan. This may result in fewer hours or different activities**. A participant in this category who wants to take advantage of the Modified Work Plan must continue to work with the Family Services Counselor and the related services as a part of the PRP**. The Family Services Counselor is responsible for determining the number of hours and setting up any activities that are different from the standard work activities found in a Traditional Work Plan. If there is a Families First component that is not appropriate for this customer at this time, the Family Services Counselor will ensure that the caseworker knows not to include this activity on the PRP.

The Modified Work Plan can include periods of time when no activities are required at all due to the individual's circumstances. When this occurs, the Family Services Counselor will notify the caseworker to exempt the individual from the work requirement, for the needed period of time. For times when no activity at all is required, the time limit is also interrupted.

Time limits may also be interrupted for individuals in this category**. For an individual with a modified PRP that includes a total of 20 hours or less of activities, the time limit <u>must</u> be interrupted**. For an individual with more than 20 hours of activities, the

Family Services Counselor will determine if the time limits should be interrupted based on the individual circumstances of the participant.

This category of participation may also allow special sanction criteria that are customized to the individual, if needed. The Family Services Counselor will need the help and involvement of the caseworker in order to monitor the case properly. The Family Services Counselor determines what the compliance provisions will be. However, the FSC will not alter the sanction process once the case gets to conciliation. The sanction modifications are allowed prior to the point of conciliation.

For example: A participant who has bi-polar illness may have the symptom of not following through on plans she has made. The Family Services Counselor may allow non-compliance with the work requirement three times before asking the caseworker to start the formal sanctioning process. Instead of conciliation for these first three instances of non-compliance, the caseworker will inform the Family Services Counselor so that the failure to follow-through is addressed as part of the **treatment.**

The Family Services Counselor may determine that Rehabilitation Services is an appropriate referral in this category. If so, the FS Counselor will contact the caseworker about renegotiating the PRP with the individual in order to make a referral to Rehabilitation Services.

Category D – The individual has already been determined to be either disabled or incapacitated and has been exempted/interrupted from time limits and work requirements. FF participants who meet this requirement may be served by FSC in the following ways. These individuals:

- may access FSC for the sole purpose of assistance in either applying for SSI/SSA or assistance with a pending SSI/SSA application;
- will not require an FSC assessment but will be referred directly to the FSC activity;
- will not be eligible for support services;
- will not receive FSC-funded counseling but may receive an initial review and/or referrals to outside resources;
- will have voluntary FSC as their only allowable activity.

Individuals who request FSC and have <u>not</u> been determined disabled or incapacitated will:

- be referred to FSC Assessment; and

- be assessed as a Category C, provided the barriers are severe.

If, during the assessment process, the individual makes a claim of disability, the Family Services Counselor will provide the information to the caseworker via a feedback form. The caseworker will:

- contact the client to initiate the incapacity determination process.
  If the client does not agree to an incapacity determination, he/she will remain subject to the work requirement and time limits, unless otherwise exempt, and may opt to have FSC included on the PRP. If the client wants to apply for SSI/SSA, the FSC counselor may still offer assistance with the application as part of their work with the client.

NOTE: Individuals who are reasonably certain to be entitled to other cash benefits (with the exception of SSI) must apply for and accept such benefits for themselves or any member of the AG as a condition of eligibility.

The evaluation for incapacity by the county/MEU and the eligibility determination for SSI may occur simultaneously. As always, the time limits will be interrupted while awaiting the determination of incapacity. The individual will be exempt from the work participation requirement as well, until incapacity is determined or until the participant has been approved for SSI/SSDI.

While incapacity can be approved at the county level, the county cannot automatically approve incapacity based solely on the Family Services Counselor's referral for incapacity determination. Instead, the county will follow standard procedures to either approve the incapacity or to refer to the MEU.

FAMILY SERVICES COUNSELING

VERIFICATION:

No verification is needed from the participant to receive a Family Services referral. The Family Services Counselor will provide verification of the individual's participation in the Family Services activities and appointments.

DOCUMENTATION:

- Document CLRC to show that Family Services were discussed with the participant, that the Family Services information sheet was read and explained to the customer and the customer's response.

- Update CLRC to reflect the reasons around the Family Services referral. The details about the barrier that are not necessary for eligibility determination should not be included because of the confidentiality issue. However, documentation would include the circumstances around the referral, where it originated, when it was sent, etc.

- When an assessment referral is made, update AEPRP to reflect the one-month interruption to the time count. Update AEIPA to show FSC assessment as the activity on the work plan. Update JTPA to show FSC assessment enrollment.

- If the Family Services Counselor determines that an interruption to the time limit is necessary for the participant, update AEPRP to reflect the Family Services interruption.

- Update AEIPA to reflect any new activities as decided by the caseworker, the participant and the Family Services Counselor. Document CLRC to reflect any work components that the Family Services Counselor has identified as inappropriate or appropriate for the participant.

- If the Family Services Counselor determines that a Modified Work Plan with varying hours or a customized sanction is necessary, document the requirements for the hours or specialized sanction procedures in detail in CLRC.

- If the Family Services Counselor determines that the individual's barrier is such that an exemption from the work requirement is needed, then update AEPRP to include this work exemption.

- Update CLRC to include all information that the FSC shared regarding the initial assessment, the complete assessment and any progress reports. This information includes the details that are shared regarding any barriers and any details necessary to case manage the Modified Work Plan.

- Update JTPA regarding FSC assessment and ongoing Family Services Counseling component using the appropriate JTPA codes.

- For transitional participants who are referred to Family Services Counseling, update CLRC to show that a referral was made and the circumstances around the referral. Update CLRC to reflect all the information shared with the caseworker after the initial assessment and any change in status.

PROCEDURES:

- Inform all assistance groups about the availability of Family Services Counseling. Give a copy of the Family Services Counseling Information Sheet to each customer at the initial or redetermination interview and at each renegotiation of the PRP. Explain Family Services Counseling, how it may affect the individual's PRP and who may be eligible to receive these services.

- Ask applicants who have received Families First in the last twelve months if they are currently receiving Family Services Counseling. If so, contact the Family Services Counselor to determine if he/she can provide any information that would require a Modified Work Plan or impact the activities on the PRP, the sanction procedures or time limits.

- If a participant meets any of the referral criteria, offer a referral to Family Services Counseling.

- If the individual agrees to an FSC referral, enter FSC assessment as the only mandatory component on the PRP. Enter the FSC assessment interruption code on AEPRP for the one-month interruption. If the individual wants to continue to participate in other Families First components, enter these as voluntary components. Be sure to include any necessary supportive services such as child care and transportation on the PRP. Enter FSC Assessment on the JTPA system.

- Complete the DHS Families First Work Component Provider Referral form. This can be completed either by the caseworker or the Case Management Specialist. If the form is completed by the CMS, the caseworker **must** sign the referral.

  NOTE: If the individual does not volunteer the reason for the referral, **do not ask** for the reason. If the individual volunteers the information about the reason for the referral, the **caseworker** will complete this portion of the referral form. Document any observations that might be helpful to the Family Services Counselor in the comments section of the referral form.

- Self-Referrals: If a participant makes a self-referral directly to the Family Services Counselor, the Family Services Counselor will complete as much identifying information on the referral form as possible and the portion of the referral form that is reserved for the Family Services Counselor. The Family Services Counselor will send the original referral form to the caseworker.

  The caseworker will then contact the individual (either by telephone or in writing) to determine if he/she wants to renegotiate the PRP to include FSC. If the individual chooses to participate in FSC, the caseworker will renegotiate the PRP, complete the referral form and return it to the Family Services Counselor. If the individual does not choose to participate in Family Services, the caseworker will notify the Family Services Counselor so that the Family Services Counselor can terminate the Family Services case.

- Barrier Identified by Families First Service Providers: If a Families First service provider identifies barriers that indicate that the participant may be a candidate for Family Services, the Families First service provider will notify the caseworker. The Families First service provider will use the normal procedures that are used to notify the caseworker about any other changes or pertinent information.

  Upon receipt of this information, the caseworker will contact the individual (either by telephone or in writing) to explain Family Services and to determine if he/she wants to renegotiate the PRP to include FSC. If the individual chooses to participate in FSC, the caseworker will renegotiate the PRP, complete the referral form and return it to the Family Services Counselor. In addition, the caseworker will notify the Families First service provider about the change in the PRP activity. If the individual wishes to volunteer to participate in an additional activity while in FSC assessment, the caseworker will notify the Families First service provider that the participant has changed to a volunteer status. Unless the Families First service provider is notified otherwise, they will continue to provide the activity to the volunteer participant in the regular manner.

  If the Families First service provider identifies an **emergency** situation where the participant is in danger of self-harm or of harming others, the Families First service (Cont. on pg. 367)

provider will take the appropriate steps to assist the individual (calling the police, contacting the local crisis support agency, etc.). In addition, the Families First service provider will send an FSC referral directly to the Family Services Counselor. (The Family Services Counselor will begin assisting the individual based on the information contained on the referral sent by the Families First service provider. The Families First service provider will complete all of the pertinent information on the referral form that is possible. The Families First service provider will send the original Family Services referral to the caseworker and a copy of the form to the Family Services Counselor.

Upon receipt of an emergency referral form from the provider, the caseworker will contact the individual (either by telephone or in writing) to explain Family Services and to determine if he/she wants to renegotiate the PRP to include FSC. If the individual chooses to participate in FSC, the caseworker will renegotiate the PRP, complete the original referral form and send it to the Family Services Counselor.

- Within two weeks of a referral, the Family Services Counselor will report preliminary information based on the initial assessment to the caseworker using the Family Services Counseling Feedback form.

- The Family Services Counselor will also use the Family Services Counseling Feedback form to notify the caseworker about:

  - additional information or participation changes that will require changes in the participant's activities or outcomes after the initial assessment;
  - changes or pertinent information for ongoing FSC cases;
  - whether or not the individual should have a Modified Work Plan (including modified hours, sanctions, time limits, etc.); and
  - each failure to cooperate with Family Services (even for those with modified sanctions).

- Upon receipt of the feedback form, either after the initial assessment or on an ongoing Family Services case, the caseworker will use this information to:

  - renegotiate the PRP
  - discuss non-compliance; or
  - begin sanction procedures, as appropriate.

  In addition, the caseworker will update all pertinent ACCENT screens:

  - AEIPA to reflect all appropriate work components;
  - AEPRP to update the time limit interruption code AEPRP, if necessary; and

- CLRC to explain the information reported by the Family Services Counselor and the subsequent actions taken on the case.

- The caseworker will notify the Family Services Counselor of any incidents of non-compliance in standard Families First work components that are included on the individual's PRP, including those where participation is voluntary. The caseworker will also notify the Family Services Counselor if sanction procedures have begun as a result of the non-compliance. **NOTE:** If sanction modifications apply to the participant, the caseworker will notify the Family Services Counselor of each incident at the time of non-compliance.

- Participation in Family Services Counseling for Individuals With a Work Requirement - If a participant who has a work requirement wants to change from a Modified Work Plan to a Traditional Work Plan or stop participation in Family Services Counseling, the caseworker will renegotiate the PRP. The caseworker will also take appropriate measures to accommodate any known barriers to fulfilling the Traditional Work Plan, if needed.

  However, if the Family Services Counselor notifies the caseworker that the participant has stopped participating in Family Services **without** requesting a renegotiation of the PRP, the caseworker will initiate regular conciliation and sanction procedures by attempting to contact the participant.

- Voluntary Participation in Family Services Counseling - Update the PRP for individuals who are exempt from a work requirement, but who want to participate in Family Services with Family Services Counseling as a voluntary activity. If a volunteer wishes to stop the Family Services, the activity will be removed from the PRP, with no further action necessary. The individual must sign the revised PRP.

- Transitional Family Services Participants - An individual can request Family Services from the caseworker within 12 months after Families First cash payments end. In these instances, the caseworker will complete the Family Services Counseling Referral form and send it to the Family Services Counselor. The CMS can also complete the form based on the caseworker's input, but the caseworker must sign the referral form.

  If the Employment Career Specialist makes the referral, he/she will complete the DHS Families First Work Component Provider Referral form, send it directly to the Family Services Counselor and notify the caseworker about the referral.

  If the DOH professional identifies the need for a referral, he/she will indicate the need on the Department of Health Families First Activity Report. Upon receipt, the caseworker will contact the individual either in writing or by telephone to complete (cont. on pg. 368.1)

the referral and send it to the Family Services Counselor. If the DOH professional identifies the need as an emergency, he/she will complete the referral, send it directly to the Family Services Counselor and notify the caseworker about the emergency referral on the Department of Health Families First Activity Report.

The Family Services Counselor will notify DHS if an individual makes a self-referral within 12 months of end of the Families First cash payments. In addition, the Family Services Counselor will notify DHS of any changes in an individual's FSC status.

The caseworker will update CLRC regarding any Family Services referrals and changes in status.

- Transfers to another county: If an AG that contains an FSC participant moves from one county to another, the Families First caseworker will follow the normal Families First transfer procedures. Notify the Family Services Counselor about the move as soon as possible. When the Family Services Counselor is notified, either by the caseworker or the participant, he/she will notify the Family Services Counselor in the new county and transfer the FSC case. This will ensure that Family Services will continue without interruption. If the participant notifies the Family Services Counselor before notifying the caseworker, the Family Services Counselor will also let the caseworker in the old county know about the move as soon as possible.

Pages 369-374 - Intended to be blank

(Completion Bonus Chapter eliminated effective 07/01/03)

FIRST WHEELS REVOLVING LOAN PROGRAM

POLICY STATEMENT

Current and transitional Families First participants will be given the opportunity to apply for an interest free loan to purchase a vehicle needed for transportation to work. The goal of the First Wheels Revolving Loan Program is to address significant barriers to transportation and to provide an opportunity to purchase a reliable vehicle so caretakers can continue to pursue self-sufficiency and continue to improve the quality of life for their families.

Loan amounts and repayment periods will be limited. The loan amounts will be determined by the participant's ability to make the monthly installments. The participant must submit a monthly budget for the family that accurately reflects the family's allowable income (defined later in this chapter) and monthly expenses, including fuel, insurance, and maintenance costs for the First Wheels vehicle. If the Families First cash grant is included as income, only the number of months remaining in the current eighteen (18) month period of eligibility will be considered in the First Wheels budget. The loan amortization period will never exceed 36 months. Amortization periods will be based upon price, condition, and the effective life of the vehicle.

All monthly installment payments and placement fees will be deposited into the First Wheels Revolving Loan Program, to sustain the program and to provide loan opportunities for future First Wheels loan participants.

The First Wheels Revolving Loan Program is available to eligible participants, to the extent that funds are available. If funds are not available at the time of loan approval, eligible participants will be placed on a waiting list, based upon the date of approval. The first approved applicant on the waiting list will be offered the first available vehicle. The Loan Committee will not consider pending applications until funds for vehicle purchase become available. As new applications are submitted they will be placed on a waiting list, according to application date, for future consideration by the Loan Committee when funds become available.

If the participant rejects an acceptable vehicle that is at or below their approved loan limit, the vehicle will be offered to the next participant on the waiting list. A participant may only reject an offered vehicle within their approved loan limit once. After the second rejection, the participant must reapply for the First Wheels Revolving Loan Program. Upon approval of the new loan application, the individual will be processed in the same manner as other new approvals.

Caseworkers and case management assistants will inform current and transitional Families First participants of the availability, eligibility criteria, program criteria and requirements for the First Wheels Revolving Loan Fund Program and assist applicants in comprehending and completing the loan application process. First Wheels Revolving Loan Fund Program information shall be included in all Families First orientations.

Application Process to Apply for a First Wheels Loan

The application is a three- (3) part process.

1. Determination of basic eligibility;
2. Determination of eligibility according to First Wheels Program Requirements; and
3. Loan Committee determination.

An application form to apply for a First Wheels loan and Information Consent Form must be completed/submitted by each applicant. Caseworkers or case management assistants will provide applicants with the forms necessary to obtain a driver's safety record from the Tennessee Department of Safety. The applicant must submit a copy of his/her Tennessee driver's safety record, obtained from the Tennessee Department of Safety, with the application. Loan applicants must meet basic and program eligibility requirements to be approved for a First Wheels loan. DHS caseworkers or case management assistants will help applicants who are eligible for Part I based on the First Wheels Revolving Loan Program requirements to prepare for each of the subsequent parts of the program.

First Wheels Application Process: Part I

Within two (2) weeks of the receipt of the First Wheels loan application, the Information Consent Forms and Driver's Safety Record, a Centralized Eligibility Worker will determine eligibility and the appropriate notices will be issued by the DHS caseworker. The First Wheels applicant must meet all of the program eligibility requirements before the loan application is sent to the First Wheels Loan Committee**.**

There are two categories of eligibility:

1) Parent/Caretakers who are receiving Families First cash payments;
2) Parent/Caretaker off cash assistance;

To be eligible, a parent/caretaker **who is receiving Families First cash payments:**

- must meet all eligibility requirements for Families First; **and**
- must be residing in Tennessee; **and**
- must be eighteen (18) years of age or older; **and**
- must be employed, either part-time (20 hours or more) or full-time; **or** have unearned income (child support and/or social security benefits) **and**
- must have dependent children in the home; **and**
- must be an active eligible assistance group member who has been receiving Families First for sixty days preceding the date of loan application; **and**
- must be in compliance with all aspects of their Personal Responsibility Plan (including health checks, immunizations and school attendance) for the last three months on assistance or the total time on assistance (since the most recent application), whichever is shorter. If the applicant is not in compliance with the PRP,

without good cause, the compliance requirement has not been met, even if the individual complies for two weeks to prevent a sanction; **and**

- must not have a Families First Intentional Program Violation (does not include a Suspected Intentional Program Violation, SIPV) claim either outstanding or paid in full; **and**
- must have continued to be eligible and in compliance throughout the three-part application process; **and**
- must have no serious violations (reckless driving, personal injury accidents) on her/his driver's safety record within the past three years, (If any of these violations appear on the safety record, applicant must provide proof of having completed a driver's education course); **and**
- must have a demonstrated transportation need (i.e., lack of transportation, does not own an automobile, an inoperable automobile, an inoperable automobile that cannot be repaired using Families First Support Services funds, two-parent household where both parents are employed and one vehicle does not suffice for two commutes).

To be eligible a parent/caretaker off cash assistance must:

- have lost Families First cash assistance within the eighteen (18) months preceding the date of loan application; **and**
- be a current resident of Tennessee; **and**
- be eighteen (18) years of age or older; **and**
- have dependent children in the home; **and**
- have been an assistance group member who met all eligibility requirements for Families First and received Families First for a minimum of sixty (60) days prior to case closure; **and**
- have been employed for thirty-five (35) or more hours per week for sixty (60) days preceding the date of loan application; **or,** must be employed at least twenty (20) hours per week and satisfactorily participating in full-time post-secondary education for the sixty (60) days preceding the date of loan application; (note: self-employment income must equal at least the minimum wage for the hours worked per week, in accordance with Families First policy): **and**
- not have had a Families First Intentional Program Violation (does not include Suspected Intentional Program Violation, SIPV) claim either outstanding or paid in full; **and**
- have no serious violations (reckless driving, personal injury accidents) on her/his driver's safety record within the past three years, (if any of these violations appear on the safety record, applicant must provide proof of having completed a driver's education course); **and**
- have a demonstrated transportation need (i.e., lack of transportation, does not own an automobile, an inoperable automobile that the applicant cannot afford to repair, two-parent household where both parents are employed and one vehicle does not suffice for two commutes).

The assistance group must continue to be eligible and in compliance throughout the entire First Wheels loan application process (Parts I, II and III) and, if approved, to the point of vehicle placement.

In addition, the assistance group must have been in compliance with all aspects of the Personal Responsibility Plan (including health checks, immunizations and school attendance) for the last three months on assistance, or total time, whichever is shorter. **The assistance group must continue to be eligible and in compliance throughout the entire First Wheels loan application process (Parts I, II and III) and, if approved, to the point of vehicle placement.**

Parents/Caretakers who lost cash assistance, due to earnings, at some point during the First Wheels Application process, have more flexibility in becoming eligible during the first two months after the case closed due to earnings. Individuals are eligible if they:

- were in an eligible assistance group that received Families First cash benefits for the sixty (60) days preceding the date of loan application; **and**
- were employed 20 hours or more per week, prior to the date of loan application (note: the self-employment income equals at least the minimum wage for the hours worked per week, in accordance with Families First policy); **and**
- maintain or increase their level of employment (hours and wages) during the application processing period; **and**
- were not disqualified for a Families First Intentional Program Violation (does not include a Suspected Intentional Program Violation, SIPV).

In these instances, the assistance group **must** continue to be eligible for and in compliance with all First Wheels eligibility requirements throughout the application process (Parts I, II and III) and, if approved, to the point of vehicle placement.

EXCEPTIONS:

An applicant is ineligible for a First Wheels loan when:

- the individual has no allowable income other than Families First cash assistance; **or**
- the individual is in an assessment or orientation as the only activity in the month of the loan application; **or**
- a Families First case was closed due to a work sanction, voluntary quit sanction or child support sanction within the past eighteen (18) months; **or**
- the Families First case is a “child only” case ; **or**
- there were no eligible children present in the home at the time of case closure; **or**
- there are no dependent children in the home after case closure; **or**
- the parent/caretaker moved out of state at the time of closure; **or**
- the individual has an outstanding balance on a current automobile loan; **or**
- he/she resides in a one-parent household with one or more operational vehicles; **or**
- he/she resides in a two-parent household, where both parents are employed, with two or more operational vehicles; **or**
- the applicant or the identified adult drivers, have received a DUI and/or DWI charge on their driver’s safety record within the past twenty-four (24) months.

The Centralized Eligibility Determination Worker will have two (2) weeks, from the date the application is submitted, to review applications to determine that all eligibility criteria have been satisfied and to issue notices. Caseworkers will issue a notice to applicants indicating whether the applicant is eligible or ineligible based on Part I basic eligibility requirements.

DHS caseworkers, case management assistant or a designee appointed by the Area Manager will prepare applicants, who are eligible based on Part I criteria, for Part II of the application by:

- reviewing the required forms with the applicant;
- referring the applicant to an authorized financial management and vehicle maintenance class, if needed;
- assisting the applicant in obtaining documentation verifying completion of financial management and/or vehicle maintenance classes.

Applicants may need an advocate to assist with Part II. The advocate may be any individual of the applicant's choosing or the DHS caseworker. The advocate may assist the applicant in assembling the documents for the loan application package and in meeting the program requirements. Advocates may accompany the applicant to the Loan Committee interview.

First Wheels Application Process: Part II

The Centralized Eligibility Determination Worker will make a determination of eligibility according to First Wheels Revolving Loan Program Requirements. Each loan applicant must meet all of the following program requirements prior to the individual's application being submitted and or approved by the Loan Committee.

- The applicant must provide documentation of having completed a personal financial management class of five (5) or more hours, which includes instruction on the preparation of a monthly household budget. (Modules provided through Families First, such as Fresh Start, the PACE program, Adult Education, or other recognized local agencies, will suffice for this requirement. However, PACE is the recommended curriculum.
- The applicant must provide documentation of having completed a vehicle maintenance class of one (1) or more hours. (Viewing the DHS provided instructional video on maintenance will suffice for this requirement.)
- The applicant must provide a copy of the applicant's current, valid State of Tennessee vehicle operator's license.
- The applicant must identify all other drivers in the home at the time of application and agree to limit drivers to the applicant and adult members (age twenty-five (25) or older) of the assistance group/household or a spouse who resides in the home. Each identified driver must also submit a copy of their Tennessee Vehicle Operator's License and driver's safety record, obtained from the Tennessee Department of Safety.

- The identified drivers in the home may not have any serious driving violations on her/his driver's safety record within the past three years. Serious driving violations would include reckless driving and personal injury accidents. If any of these violations appear on the safety record, applicant must provide proof of the identified drivers having completed a driver's education course.
- Only individuals who are insurable may be considered for a First Wheels Revolving Loan. No automobile will be placed with an individual until their Liability Insurance is in force. The First Wheels Program Manager can assist the applicant in determining insurability and applying for Liability Insurance.
- The applicant must document and demonstrate the ability to:
  a) afford monthly payments toward the purchase of the car; **and**
  b) afford the expense of regular vehicle maintenance items (i.e., oil and filter changes, chassis lubrication, etc.); **and**
  c) afford basic automobile liability and uninsured motorist insurance coverage; **and**
  d) afford to pay for the First Wheels Placement fee.

The estimated costs of the above-mentioned items shall be included in the written monthly budget submitted in the application package. The income portion of the monthly budget should only reflect countable gross income, unearned income of child support received, and social security benefits, as allowable in First Wheels policy, and the Families First cash grant, if applicable. If including the cash grant as income, time limit counter information must be included within the budget. The cash grant income can only be counted for the number of countable months remaining in the current eighteen (18) month period of eligibility. If the case has an extension to the time limits, the grant should only be counted for the current month's income.

Application Package

A First Wheels application package will be assembled by the applicant or, if an advocate was selected, the applicant's advocate. Verification is the responsibility of the First Wheels applicant. The caseworker should secure verifications when the information is known to the Department through automated data interfaces or when it is more reasonable for the Department to secure the information. When it becomes known to the Department that an applicant has a disability which is causing difficulty in providing verification, the caseworker will assist the individual as indicated. The assistance could include, for example, providing for the individual a reasonable means of communication, or soliciting the required verification documents directly.

The application package will include:
- The signed application form
- The monthly household budget (developed by the applicant)
- Copies of a current Tennessee vehicle operator's license for all identified adult drivers
- Copies of driver's safety records for all identified adult drivers
- A signed First Wheels "Authorization for Release of Information" form (HS-2699)

- A signed statement by the caseworker and the applicant that the applicant is:
  1. Eligible according to Part I requirements
  2. Eligible according to Part II requirements
  3. Verification that the participant has continued to meet the eligibility qualifications required in Part I up to the point of the Loan Committee meeting (Only for the packages being sent to the Loan Committee).
- A statement from the District Program Supervisor, that the application has been reviewed and approved. Upon receiving the application, the District Program Supervisor will have two weeks in which to review the application, and approve or deny.
- The number of months remaining in the current eighteen (18) month period of eligibility, (for those currently receiving cash assistance), as of the date it was approved by the District Program Supervisor.

Procedures for Processing the Loan Application Package

The Centralized Eligibility Determination Worker will utilize the "First Wheels Eligibility Checklist" (Part I-HS2698, Part II–HS2697) that includes the eligibility criteria, to determine and to substantiate that all basic and program eligibility requirements have been satisfied. If an applicant does not meet both basic (Part I) and program (Part II) eligibility requirements, upon receiving notification from the Centralized Eligibility Determination Worker, the caseworker will issue a "Notice of Denial of Part II" citing the eligibility deficiencies and the right to appeal information. The notice will be documented on CLRC. Caseworkers will provide the District Office and the First Wheels Program Manager with a copy of the notice and the "First Wheels Eligibility Checklist."

<u>Verification of Allowable Income and Expenses for First Wheels Monthly Household Budget:</u>

The First Wheels Monthly Budget, submitted by the applicant, must accurately reflect countable gross income unearned income of child support received and Social Security benefits as allowable in First Wheels policy and the Families First cash grant for the months remaining (if applicable), fixed and ongoing monthly expenses, other liabilities, and estimated expenditures for placement fee, vehicle operation, maintenance, license, registration, liability insurance or, if required, comprehensive insurance. The DHS caseworker or Centralized Eligibility Determination Worker will verify the income and expenses reflected in the budget against the information documented on ACCENT. The applicants must provide verification for any income or expenses not documented on ACCENT. For applicants in an open Families First assistance group, the caseworker will provide the Loan Committee with the countable months remaining on the participant's current eighteen (18) month period of eligibility.

All loan packages will be date stamped and the name, case number and the date received in the county office recorded on the Application Log Sheet.

FIRST WHEELS REVOLVING LOAN PROGRAM

The Centralized Eligibility Determination Worker will be responsible for ensuring that the loan applicant has continued to meet the eligibility qualifications required in Part I and II.

- The Centralized Eligibility Determination Worker will be responsible for reviewing each loan application package within two (2) weeks of receipt to ensure all requisite forms have been completed, the program requirements have been met, and to review the package for accuracy of information (compatible with information on ACCENT).

- Inform each applicant, including his/her advocate, if applicable, either in person, by phone contact, or by written correspondence of incorrect or incomplete loan application packets. When notification is either in person or by telephone, caseworkers should follow up with written notification citing the incorrect or incomplete information. The applicant will have ten (10) working days in which to provide the requested information or verifications. If the information is not received within the ten (10) days, issue a "Notice of Denial of Part II" citing the reasons and right of appeal information.

- The applicant must submit a new application to re-establish the application process.

- Applications that meet both the Part I and Part II eligibility requirements will be forwarded to the District Office for approval. The Centralized Eligibility Determination Worker will attach a copy of the "First Wheels Eligibility Checklist" to the application. The District Office will have two (2) weeks to review the package. Upon receiving written approval (either by e-mail or official District procedure) from the District Office, caseworkers will issue a "Notice of Approval of Parts I and II." The notice will be issued, by the DHS caseworker, within three (3) days of District approval and documented on CLRC. The caseworker will provide the First Wheels fiscal agent with a copy of the "Notice of Approval of Parts I and II," by attaching to the loan package.

- If an applicant does not continue to meet eligibility criteria set forth in Parts I and II, up to the time of the Loan Committee decision, the DHS caseworkers will issue a "Notice of Denial," (HS-2692) citing eligibility reasons and right of appeal information. The notice will be issued within three (3) days upon determination of ineligibility, and documented on CLRC. The caseworker will provide the District Office and the First Wheels Program Manager with a copy of the notice.

First Wheels Application Process: Part III

The caseworker will submit all complete First Wheels loan packages to the First Wheels Loan Committee. In addition to eligibility requirements, the Loan Committee will consider the following items in arriving at their decision:

- household budget;
- countable income (earned and unearned);
- fixed expenses and any other liabilities; and

- demonstrated transportation need.

Loan applications will be denied when:

- the applicant is unable to show evidence of the ability to afford fixed and ongoing monthly expenses, other liabilities, and the estimated expenditures for owning, operating, and maintaining a vehicle; and/or
- other eligibility requirements are not met.

Loan Committee

All loan applications must be either approved or denied within thirty- (30) calendar days of the Loan Committee receiving the reviewed applications from the DHS caseworker. The Loan Committee may deny or approve the application or postpone a decision pending additional information. The applicant, the DHS caseworker (or a DHS representative) and the applicant's advocate, when applicable, will attend the meeting of the loan committee to respond to any questions put forward by members of the Loan Committee. The Loan Committee should review the "First Wheels Eligibility Checklist" with the applicant to ensure no changes have occurred since the application package was submitted. The Loan Committee will evaluate the loan application to determine suitable repayment terms, the applicant's ability to afford monthly payments, and the severity of transportation need. Each applicant will receive a notification (provided by the loan committee), from the DHS caseworker explaining the outcome of the Loan Committee meeting: approval, pending, or denial.

Postponement Of A Decision

The loan committee may delay action on a loan application if additional information or documentation would assist the committee in arriving at a decision. The applicant will have ten (10) days to provide verifications or information needed to complete the decision-making process. If the information is not provided in ten (10) days, then the application will be denied. The ten- (10) day delay by the loan committee should not exceed the thirty- (30) day timeframe for taking action on an application, unless there are extenuating circumstances that are approved by the District Office.

Denial

If a loan application is denied, a written notice to the applicant, issued on behalf of the Loan Committee, by the caseworker, stating the reason(s) for the denial will be sent no later than two (2) weeks following the committee meeting. The caseworker will retain a copy. An individual who has resolved the circumstances cited in the denial may reapply, through the regular three- (3) step application process, at anytime.

FIRST WHEELS REVOLVING LOAN PROGRAM

Approval

The Loan Committee will authorize the First Wheels Program Manager to contact the participant and initiate the process of locating an appropriate vehicle, based on the terms of the loan approval. The Loan Committee will provide the participant with the name of the local First Wheels Program Manager. The First Wheels Program Manager must initiate any negotiations regarding vehicle purchase. Participants must be cautioned not to enter into any agreements, cash deposits or sales contracts on their own, to purchase a vehicle using First Wheels Program funds and cautioned to remain eligible and in compliance through the time of vehicle placement.

Only vehicles that meet the First Wheels Programs specifications (i.e., loan to value guidelines, safety inspection, appropriate for family size and use, low maintenance and repair cost) will be purchased. Due to the high cost of maintenance and repair, and/or the inappropriateness for family size and use, the following vehicles will not be purchased with First Wheels funds:

- convertibles
- sports cars
- two passenger cars
- luxury vehicles
- sports utility vehicles (except under special circumstances and with the approval of the First Wheels Program Director).

Upon locating an appropriate vehicle, the First Wheels Manager will:

- carry out a pre-release inspection;
- complete any essential repairs identified by the inspection;
- assist in transferring the title and registration to the participant;
- ensure that the lien-holder information, identifying the First Wheels Fiscal agent, is recorded on the title and registration;
- obtain a duplicate set of ignition keys to the First Wheels vehicle, to be retained by the First Wheels Program Director until the time that the lien is released;
- review the loan repayment plan with the participant and ensure that all required signatures are obtained for all the mandatory loan and program documents;
- review vehicle maintenance requirements with the participant;
- review all program violations with the participant;
- release the vehicle to the First Wheels Program participant.

NOTE: Upon approval of a loan application submitted by an active Families First participant, the caseworker will assist the participant in accessing any existing Families First vehicle related support services (vehicle license and registration, wheel taxes, emission testing fees, etc.). A Support Services Referral, authorizing transportation assistance, in the form of reimbursement, should be issued. If minor vehicle repairs are needed prior to the transfer of title and registration, Families First Support Services Automobile Repair Funds may be authorized. **Only active Families First participants that have been approved for the First Wheels Revolving Loan Program can access Support Service Automobile Repair Funds prior to the transfer of vehicle title and registration**.

Approved Applicants Relocating To Another County

When an individual relocates to another county, after receiving approval for a loan but prior to receiving the vehicle, the application package will be transferred to the county office where the applicant has moved. Subsequent to receiving the application package, the DHS office in the county of residence will reconfirm all information, determine eligibility, and submit the application to the District office for approval. The DHS caseworker will issue the appropriate notice, denial or approval, upon receiving the information and document on CLRC. The District office will forward the approved application to the residence county's Loan Committee for further action.

The participant should be aware, that by transferring the case to another county, there is the potential that the application may not be approved by the Loan Committee, or that they may be placed on a waiting list or placed in a position further down on the waiting list.

The First Wheels Loan

Terms

The Loan Committee will make the decisions regarding the recommended vehicle loan amount, term of the loan, and the monthly payments (excluding insurance premiums). The applicant's ability to repay and the family size will be considered when establishing loan terms.

The maximum approved loan amount for a First Wheels vehicle may not exceed $4,600. Participants obtaining a vehicle valued over $3000 must obtain a full-coverage (liability, uninsured motorist, collision and comprehensive) insurance policy. Only exceptional applicants, those off Families First cash assistance, employed full-time with a stable work history of six (6) months or more and with ample earnings, should be considered and/or approved for vehicle loans exceeding $3000.

GOOD CAUSE:
Good cause can be granted for not obtaining a full-coverage (liability, uninsured motorist, collision and comprehensive) insurance policy for vehicle valued over $3,000 when:

- it is necessary to purchase a more expensive vehicle in order to accommodate the number of children in the household or
- it is necessary to purchase a more expensive vehicle in order to accommodate an adult or a child with special needs.

Conditions of the First Wheels Loan

- Down payments are not required but will be accepted.
- The automobile full-coverage or liability insurance may be included in the monthly payment.
- The minimum monthly payment will be no less than $50 for all individuals.

- For individuals receiving cash assistance, the maximum monthly payment should not exceed $100, unless there is sufficient evidence of the ability to repay a higher monthly installment.
- The loan amortization period will never exceed 36 months. Amortization periods will be based upon the participant's financial ability to repay the loan in the least amount of time, and the price, condition, and effective life of the vehicle.

Pre-payment Options

- If circumstances change, a participant may elect to increase the amount of their monthly installment payment. Participants may pay higher installments without effecting the established minimum installment payment reflected in the signed loan agreement.
- There is no penalty for repaying the loan ahead of schedule. Individuals may use IRS tax refunds, Earned Income Tax Credits, or other sources to reduce the loan balance or pay the loan balance in full.
- If the individual desires to trade the First Wheels automobile for a different automobile, the loan balance must be paid before release of lien. The payoff amount may be obtained from the local First Wheels Program Manager.

Terms of the Agreement

The loan terms of agreement include requisites that will cause the loan to be revoked if a customer violates the agreement. The loan can be revoked if an individual:

- fails to make the installment payments for two consecutive months and/or fails or does not meet the criteria for an extension of payments; **or**
- fails to maintain the required automobile insurance (either full-coverage, if loan exceeds $3000, or personal liability and uninsured motorists) causing a lapse of coverage; **or**
- has their Tennessee vehicle operator's license revoked; **or**
- is found to have been approved for a loan due to administrative error, fraud, or misrepresentation; **or**
- fails to cooperate in their Families First Personal Responsibility Plan by the end of the fifteen (15) day conciliation period and no "good cause" reason exists.

The First Wheels Program Manager and the DHS caseworker will make every effort to caution a loan customer, prior to a serious violation, and encourage the customer to remedy the situation. Arrangements to remedy any of the above-cited situations will be accepted if corrections are made within fifteen (15) days from the violation notification.

A failure to cooperate with the Personal Responsibility Plan will be handled in the same manner as with other aspects of the loan agreement.

The following options are available to the participant when a violation in the terms of agreement occurs and the participant wants to avoid repossession of the vehicle;

- comply within fifteen (15) days if in non-compliance with the PRP; **or**

- correct the violation(s) immediately; **or**
- return the vehicle to the First Wheels fiscal agent; **or**
- pay the loan balance in full.

Late Payments

Failure to make a payment by the due date will not incur a late charge. However, chronic late payments will be a factor for consideration when a participant desires a "Request for Extension."

Extension Requests

Individuals experiencing hardship situations (i.e., temporary loss of employment, illness, financial and/or personal problems, etc.) should contact the First Wheels Manager or DHS caseworker and request a "Request for Review and Extension" form. Following submission of the form, the participant may be asked to reappear before the Loan Committee for review and consideration of the extension request. In reviewing the request, chronic late payments, failure to perform routine maintenance, voluntarily quitting employment, or intentionally reducing the number of hours worked per week will be justification for denying an extension.

- The Loan Committee must act on a "Request for Extension" within thirty (30) days. In the event the Loan Committee does not have a meeting scheduled within that thirty- (30) day time period, the Area Manager may send the "request" information to the Loan Committee members, and poll the members for their decision. The polling of the members may be by telephone, e-mail or by fax.
- The Loan Committee may extend the payment period by a maximum of three (3) months, not to exceed the original amortization period. No more than two extensions, regardless of the number of months granted in either extension, will be approved during the term of the loan.

  Example: A participant received a First Wheels loan, amortized over a twenty-four (24) month period. With sixteen (16) months remaining on the loan, she experienced a hardship situation. After receiving the "Request for Review and Extension," the Loan Committee approved a two-month extension. The participant now has eighteen (18) months remaining on the loan. Therefore, since the eighteen (18) months remaining is less than the twenty-four (24) month amortization period, the extension is approved.

Automobile Repair Loan Requests

- Participants who do not receive Families First cash assistance, or active Families First participants who have depleted the Support Services Limited Automobile Repair funds, may petition the Loan Committee for an automobile repair loan. The Loan Committee may approve a request for funds from the First Wheels Revolving Loan fund if
  - the individual cannot immediately afford the cost to have the vehicle repaired; and

- the repairs would be reasonable to extend the life of the vehicle.

The amount of the repair loan will be added to the vehicle loan principle. The additional repair loan may extend the number of months in the amortization period, but may not exceed the original amortization period. As provided in the pre-payment options, the participant may elect to increase the amount of their monthly installments, in order to repay the repair loan.

- A request for an automobile repair loan should be considered an emergency situation that could result in the loss of employment. If a meeting of the loan committee is not scheduled within the week, the Area Manager will provide all loan committee members with the necessary information. The Area Manager will poll the committee members for their opinion. The poll may be performed by telephone, e-mail or fax machine.

Return of a First Wheels Vehicle

A participant may voluntarily return a vehicle to the First Wheels Program Manager after providing advance notification and making arrangements for the vehicle's return. A participant who returns a vehicle to the First Wheels Program has revoked the terms of the loan agreement and will relinquish any and all rights to any payments that were made toward the loan and may be liable for any repair expenses, vehicle depreciation, any resale expenses, deficiencies incurred and the remaining loan balance, according to the terms of the loan agreement.

Insurance

- All First Wheels loan participants must obtain the required automobile insurance, either full-coverage, if loan exceeds $3000, or personal liability and uninsured motorist coverage, **prior** to taking possession of the vehicle.
- Approved loan applicants may opt to have the insurance premiums included in the monthly loan installment. The First Wheels Program, on the behalf of the participant, would pay the premiums with funds collected from the monthly payments.

Insurance premiums will be more expensive for individuals who have not maintained continuous automobile insurance coverage for the last six months and individuals that never had automobile insurance. Other factors affecting the premium price are moving violations, driver safety record, residing in high accident areas, teenage drivers and the make and/or model of automobile. Prior to meeting with the Loan Committee, applicants must determine if they are eligible for automobile insurance coverage and obtain an estimated cost of the premium. The First Wheels Manager or the local Families First Councils will provide assistance in locating insurance companies offering competitive rates that may be beneficial to the loan recipient.

After taking possession of the First Wheels vehicle, participants must notify the First Wheels Manager of any circumstances involving the vehicle, such as an accident,

vandalism, and/or theft. The participant must also notify their automobile insurance company of any accident and may proceed with the claims process, **only,** after consulting with the First Wheels Program Manager. Any and all cash proceeds from an insurance claim are to be either applied to vehicle repair costs (when there is a full-coverage policy) or toward the repayment of the First Wheels loan.

REQUIRED ROUTINE MAINTENANCE FOR PROGRAM PARTICIPANTS

Each First Wheels participant must agree to be personally responsible for regular routine vehicle maintenance, and provide verification of such to the First Wheels Program Manager, throughout the life of the loan. The First Wheels Program will regularly monitor the routine maintenance of every participant's vehicle. Routine maintenance should include the following items:

- oil and filter changes, as recommended;
- maintain proper fluid levels (brakes, transmission, antifreeze, coolant, etc.);
- check head and tail lights, and replace when needed;
- check tires and maintain recommended level of pressure.

CREDIT REPORTING

At application, program participants may elect to have their loan payment history reported to the local credit bureau. DHS caseworkers will counsel each applicant on the importance of building and maintaining a good credit history. However, if an individual chooses not to have their payment history reported, that decision will be honored. A loan customer may decide to discontinue having their credit reported at a later date; however, history already reported cannot be changed or withdrawn. Someone who initially did not want credit reported may change that decision at a later date.

VERIFICATION

- The First Wheels applicant has the primary responsibility for obtaining required verifications; however, the caseworker, case manager assistant or Centralized Eligibility Determination Worker must assist the individual when a good faith effort has been made and difficulties are encountered. The caseworker will rely on automated verification such as data exchange matches, whenever possible. Obviously, if the information is readily available to the caseworker, the customer should not be requested to obtain the verification. When it becomes known to the Department that an applicant has a disability that is causing difficulty in providing verification, the caseworker will assist the individual as indicated. The assistance could include, for example, providing the individual a reasonable means of communication, or soliciting the required verification documents directly.

- On the applicant's budget, the caseworker or Centralized Eligibility Determination Worker will verify only income, earned and unearned, allowable under First Wheels policy, and the countable months remaining in the current eighteen (18) month period

of eligibility.

- The participant will provide verification of employment, completion of a personal financial management class, completion of a vehicle maintenance class, current valid Tennessee vehicle operator's license, Tennessee driver's safety record, ability to obtain the required automobile insurance coverage, and if applicable, documentation of completion of a driver's education course. If requested, the caseworker or case management assistant will assist in obtaining verification.

- The Loan Committee will provide verification of any action taken on a loan application: postponement, denial, approval, repair loans and requests for extension. A copy of the verification is to be provided to the First Wheels Program Manager.

- The First Wheels Program Manager will provide verification vehicle make and model, Vehicle Identification Number (VIN), title and registration, to the local DHS office.

DOCUMENTATION

- Application log sheets will be maintained for progress summary reporting.

- Document the following in CLRC for both active and closed Families First AG:
  - the application date;
  - all notices (approvals and denials) sent regarding the application process:
  - eligibility decisions;
  - reasons for denial at any stage of the process;
  - verifications needed for the process; and
  - other pertinent information regarding the First Wheels loan.

- Document the vehicle make, model, and the First Wheels Program as lien holder AERVH.

- Document referral for Limited Automobile Repairs, authorized for the First Wheels vehicle, on AEIPA for active Families First AGs.

PROCEDURES

- Inform current and former Families First participants of the opportunity to apply for an interest free loan to purchase a vehicle needed for transportation to work.

- Explain the three (3)-step application process to the participant.

- Assist the applicant in understanding the First Wheels Revolving Loan Program.

- Issue a "Failure to Meet Eligibility Criteria" notice to ineligible applicants within two (2) weeks of receiving the individual's application.

- Issue all First Wheels notices on the same working day of approval or denial and documented on CLRC, for both active and closed Families First assistance groups.

- Review completed loan application packages within two (2) weeks of receipt.

- Complete "First Wheels Eligibility Checklist" within two (2) weeks of receipt.

- Issue "Notice of Denial" for ineligible loan application packages within two (2) weeks of receipt of application package.

- Issue "Notice of Approval" for eligible loan application packages within two (2) weeks of receipt of application package.

- Forward the decision of the Loan Committee to the applicant, the First Wheels Program Manager and the Centralized Eligibility Determination Worker upon receipt of information.

- Inform the First Wheels Program Manager if a customer fails to cooperate in their Families First Personal Responsibility Plan by the end of the fifteen-(15) day conciliation period and no "good cause" reason exists.

- Inform the First Wheels Program Manager if a customer relocates to another county or state.

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VOCATIONAL REHABILITATION SERVICES

POLICY STATEMENT:

The purpose of Vocational Rehabilitation (VR) services is to provide help to participants who are not making progress toward employment and to those who may have barriers to their progress due to a qualifying disabling condition. In addition, VR services will help the caseworker that may be struggling with situations where customers are not making progress or not following through with the requirements of Families First. VR may be able to provide assistance to customers and their children (of working age) struggling with issues related to any of the following:

- Mental health/limitations
- Physical limitations
- Learning disabilities

Individuals potentially eligible for VR services are those who:

- have a physical or mental limitation or learning disability which constitutes or results in a substantial impediment to employment; **and**
- can benefit from VR services in terms of employment outcome; **and**
- will require VR services to prepare for, secure, retain, or regain employment.

The above listed limitations/disabilities must fall within the VR definition of **"qualifying disabilities"** in order to be eligible for VR. These "qualifying disabilities" include anyone who:

- is receiving SSI/SSDI Social Security benefits and wants to work (these individuals are automatically eligible for services);
  - SSI recipients do not have a work requirement and are not referred to VR via a FF referral. They can choose to go to VR on their own. Caseworkers will discuss VR and provide a VR flyer to these individuals. The flyer has a self-referral form attached.
- has an obvious permanent physical disability such as a missing limb, is in a wheelchair, or permanently on crutches;
- has recently had a stroke or heart attack;
- is blind or has difficulty seeing even with glasses;
- has difficulty with communication because of hearing or speech problems;
- has epilepsy or a seizure disorder;
- appears to be mentally slow or cannot understand simple concepts or has severe memory problems. (Individual could have a learning disability, have attention deficit disorder, or have had a head injury); or
- is mentally handicapped. The person may have a representative acting on his/her behalf.

VOCATIONAL REHABILITATION SERVICES

The following list includes **those who do not meet the VR definition** of having a qualifying disability. Anyone who:

- has a literacy problem not related to a learning disability;
- has only a broken limb;
- is recovering from surgery and should have no residual problems that would interfere with working;
- has an illness in an irreversible, terminal state;
- is HIV positive but is still healthy and has no secondary disabling condition.

For eligible individuals, VR can help with a **range of services** that may make the path to self-sufficiency easier. VR services include:

- a preliminary assessment;
- a vocational evaluation;
- individual counseling and guidance;
- advocacy;
- trial work experiences to determine eligibility for the most significantly disabled;
- supported employment for the most significantly disabled;
- development of an individual plan for employment;
- referrals and access to treatment facilities or other appropriate services;
- access to services to help with learning disabilities;
- identification of multiple and co-existing barriers;
- training (work adjustment or academic) and job placement;
- follow-up for 90 days after securing employment;
- post-employment services;
- assistance with applying for Supplemental Security Income and Social Security benefits for individuals with physical disabilities (FSC will assist those with learning and/or mental disabilities);
- special services for the deaf and hard of hearing;
- special services for the blind and visually impaired; and
- rehabilitation technology and physical aids.

VR is a work plan component for Families First that can be a part or all of the Personal Responsibility Plan. VR is tailored to address the specific concerns or problems of individuals who have a qualifying disabling condition. These services may allow for a modified work requirement and/or a time limit interruption to accommodate special circumstances.

VR services are available to all Families First assistance groups that contain an eligible adult who has a mental or physical limitation or learning disability **(see further discussion in Priorities section of this chapter)**. This includes both individuals who are

required to work and those who are exempt from the work requirement. Children of eligible adults who are of working age (16 years old or older) and meet the VR definition of a qualifying disabling condition can also receive VR services.

VR Counselors from the DHS Vocational Rehabilitation program will be available to all county offices. Some counselors may cover more than one county, making them available to each county on a rotating basis.

All Families First assistance groups must be informed of the availability and content of VR services. This includes child only assistance groups. Even though members of a child only assistance group are not eligible for the services through a Families First referral, they may apply on their own.

Caseworker – VR Counselor Relationship:

Information needed to complete the Personal Responsibility Plan for work and time limit provisions is shared between the caseworker and the VR Counselor. Because VR is a part of the Department of Human Services, information related to the reasons for the VR referral can be shared with the FF caseworker. The VR application also has a release of information to service providers. If this is signed and understood, contractors who assist the VR participant could have knowledge of the kinds of barriers VR is helping the individual overcome.

All VR related activities would be referred to on the PRP as "Voc Rehab Services". In addition, a participant may also have a Modified Work Plan that is recommended by the VR Counselor. A Modified Work Plan is a work plan with hours or activities outside of the standard FF work plan. This plan may also include modified sanction procedures and/or time limit interruptions. Sometimes, the reason for a Modified Work Plan will not be shared with the caseworker.

VR Counselor Responsibilities: First, the counselor must inform the FF caseworker of information that pertains to continued eligibility for Families First (for example, income, deprivation, and children in the home). Second, the VR counselor has the same responsibilities as any other DHS counselor to inform the Department of Children's Services of situations where a participant's children may be at-risk for abuse or neglect.

PRP Development with VR services:

To make a referral to VR, the caseworker will renegotiate the Work Plan on an individual's PRP to reflect the VR Assessment. During the assessment period, no other PRP activities are required of the participant. However, the participant may continue any activities they were in at the time of the referral on a volunteer basis while the assessment is conducted. The exception to this statement is when VR assessment is part of an FSC plan or FSC assessment is included in a VR plan. The exception is that the individual would be required to continue in FSC.

NOTE: Individuals who are not exempt from the work requirement and who quit a job without good cause are subject to Voluntary Quit policy. This is true even if they are participating in VR Assessment or ongoing VR services. If the VR Counselor has identified that work is not an appropriate component at this time and the individual voluntarily quits the job, this would be considered good cause. In the event of voluntary quit, follow the procedures in the Sanctions Chapter of the Families First Handbook.

If a barrier is identified by the initial or in-depth assessment, the VR Counselor will suggest the best work plan for the individual. If needed, the VR Counselor will recommend VR as a part of the Traditional Work Plan or of a Modified Work Plan. At this time, the individual will decide whether or not to agree to VR in the work plan and, if applicable, whether or not to have a Traditional or Modified Work Plan. The negotiation of the VR activities is between the VR Counselor and the participant.

After the VR hours and services are agreed to by the participant, the remaining hours of Families First work components will be negotiated between the caseworker and the participant. The VR Counselor will inform the caseworker if there is available information on the appropriateness of some work components. The caseworker will use this information during the negotiation. This will help to lead the participant to the most effective work plan to accommodate barriers and to achieve his or her career goals.

REFERRALS:

The DHS caseworker is the central point for any case where a VR referral is made. The caseworker is the link to both the standard Families First services and VR.

A referral to a VR Counselor can occur:

- at the initial signing of the PRP;
- at the time of PRP renegotiation; or
- at any time when a condition or situation indicates a VR referral would be helpful.

There are five groups of appropriate referrals to VR. The referral group that the individual fits into may determine what expectations the caseworker will have for his/her continued involvement with the VR Counselor.

If there is a special circumstance that warrants a VR assessment but does not fall under any of the five referral categories, a referral to the VR Counselor can be made with approval from the Family Assistance District Director or their designee.

1. Individuals Who Are Non-Compliant With The Work Requirement and Exhibit Signs of a Disability

Individuals who are non-compliant with the work requirement and exhibit signs of a disability must be offered a referral to VR (see note below) to begin the two-week compliance period. The participant has a choice of whether or not to go to the VR Counselor for assessment as a preliminary part of the two-week compliance period. The VR referral can be made at any step in the conciliation/closure process when compliance is offered (e.g., conciliation, phone contact, indicating to the caseworker a wish to comply, or at reapplication after a sanction). However, once a component has been chosen, the individual cannot change during the two-week compliance period.

NOTE: FSC instead of VR may be a viable option here. The individual must be offered the option of both services, if appropriate for their circumstances. If VR has no service that applies to a particular individual's situation, an FSC referral can be made.

If VR assessment is selected for the two-week compliance, the individual must cooperate with the VR Counselor. If the assessment and/or other VR services are not available when the two-week compliance is to begin, recipients and applicants choosing VR will not be required to go into another component to show compliance (unless FSC would be an option). The compliance period will begin when the VR services are available. However, the recipient can choose to go into another component for the two-week compliance period.

If barriers to employment and/or compliance (that are VR eligible disabilities) are found in the assessment, the participant will choose whether or not to accept VR as a component in their work plan. In addition, if a Modified Work Plan is recommended by the VR Counselor, the participant will choose between the Modified Work Plan and the Traditional Work Plan. If, however, the VR Counselor does not find any barriers or the participant does not choose to go with VR, the participant must then agree to and comply with a standard two-week compliance period in order to come into compliance with Families First.

2. Those Who Are Compliant With The Work Requirement But Who May Be Experiencing Difficulty Or Showing Signs Of Obstacles That Could Be Addressed By VR Services

This group includes all those with a 40-hour work requirement and those who test below ninth grade and are in AE. For some individuals in this group, the offer of the referral is mandatory. This does not mean that the participant must agree to the referral, but the referral must be offered.

VOCATIONAL REHABILITATION SERVICES

A VR referral must be offered to individuals who:

- exhibit signs (either through interview or visual observation) of a mental or physical limitation or learning disability; or
- are identified by a Families First service provider (AE teacher, job search counselor, etc.) as having obstacles that could be addressed by VR services. The caseworker may request that the individual come in to renegotiate the PRP. This may include those individuals with suspected learning disabilities that prevent their progress in education or training.

3. Requests From The Individual For A Referral

Individuals who think that counseling or services through a VR referral may help them may be referred without meeting one of the above criteria. The caseworker must refer individuals or the appropriate family member to the VR Counselor, upon request. **The individual does not need to give the caseworker a reason for the referral request. The caseworker will not ask the participant why he or she is asking for the referral to VR.**

4. Self-Initiated VR Participants

If an individual informs the caseworker that he/she is in VR, the caseworker will need to make a VR referral in order for their participation to fulfill some or all of the FF work requirement. The referral is also necessary to inform VR that the individual is a Families First participant and, as such, is eligible for Families First accompanying services such as child care, standard support services, or participation in other work components. If the individual agrees to the referral, the caseworker will add VR to the PRP. The hours spent in the self-initiated program will be referred to as "Voc Rehab Services" on the PRP. **The participant in a self-initiated program can only receive a Modified Work Plan and interruptions to the time limit if he/she accepts the referral to the VR Counselor and subsequently participates.**

The VR Counselor will not change the participant's VR program but will assess the individual's situation to determine if other services are needed. The VR Counselor will also recommend adjustments to the work plan and time limits, if needed. The intent is to fit the participant's self-initiated services into the Families First work plan without interrupting the plan that the individual has begun.

If the participant wishes to have any of the VR activities count toward the work requirement, the participant must cooperate with the assessment process and the VR Counselor. If additional non-VR hours are needed for the participant's work plan, the VR Counselor will follow through with the participant and the caseworker as is done with other VR referrals.

5. With An Eligible Adult Who Is Exempt From The Work Requirement But Who Wishes To Volunteer For VR

Individuals (EAs) who are exempt or interrupted from the work requirement and time limits and who meet VR criteria may take advantage of VR on a volunteer basis. The caseworker will send a referral to VR for participants who wish to volunteer. Individuals who are NAs, dependant children of working age and individuals receiving transitional benefits may also apply but they will not be referred through Families First.

Non-compliance with VR:

Individuals in referral groups 1-4 who are non-compliant can be subject to a sanction for non-compliance with VR, as is the case with other Families First work components. The VR Counselor will notify the caseworker regarding the non-compliance. Individuals with a modified work plan, however, may also have modified sanctions. (See further discussion on this in the Outcomes from VR Rehabilitation Services Assessment section of this chapter, Category C.) Individuals in referral group 5 are volunteers and no sanction or renegotiation action is taken for non-compliance with VR for this group.

No action is necessary if a child or minor parent (of working age) in the AG stops going to see a VR Counselor or stops receiving services through a provider set up **through VR.**

VR and Time Limits:

A referral to VR will result in a **two-month** (the month of referral and the following month) **or 60-day interruption, whichever is greater**, to the time limit for a VR assessment. Based on the findings of the counselor, additional months may be interrupted if needed.

The initial two-month/60-day interruption for assessment will be limited to once in a twelve-month period. If a Families First case closes and the AG requests VR at a subsequent application within 12 months of the previous closure, they will be assessed, but the clock will not stop again.

If a participant makes a self-referral to VR, the time count will be interrupted at the time the PRP is renegotiated to reflect the VR assessment.

Coordination with Other Services for Those In VR:

There are two other entities in the Families First Program that are specifically designed to work with those individuals who have more difficult obstacles to self-sufficiency: the Medical Evaluation Unit (MEU) and Family Services Counseling. It is important to note how these programs interact with VR.

VOCATIONAL REHABILITATION SERVICES

Determining Incapacity:

When incapacity is claimed or suspected, the caseworker will follow the incapacity determination procedures for either county approval or MEU referral. VR does not take the place of this procedure. However, an individual can be referred to VR while awaiting MEU determination. In this case, the participant would be a volunteer and time limits would be interrupted.

Family Services Counseling Services:

Family Services Counseling can help many participants with specific barriers obtain the services needed to find success in the workplace. A person with certain barriers that prevent compliance with or exempt the individual from a Traditional Work Plan may need a referral to Family Services Counseling. A person who is referred to VR can also be referred to Family Services at the same time or whenever the referral is needed.

Priorities:

In the event VR has insufficient funding to serve all individuals who apply for services, Federal VR law mandates that an Order of Selection and Priority Categories will be used to give priority to eligible individuals who have the **most significant disabilities**.

VR has established four Priority Categories (PC) that help determine which individuals may be served. The Priority Categories are listed below:

- Priority Category 1 - eligible individuals who are **most significantly disabled**;
- Priority Category 2 - eligible individuals who are significantly disabled;
- Priority Category 3 - eligible individuals who are not significantly disabled whose vocational rehabilitation is expected to require multiple services; and
- Priority Category 4 - eligible individuals who are not significantly disabled and who cannot be classified into a higher priority category.

All other individuals, who cannot be served due to insufficient funding, will be referred to a career center for services and/or will be placed on a waiting list for VR services. Families First individuals will need to choose another component until funding problems are resolved.

An eligible individual in PC1 and identified as having a **most significant disability** will:

- have a severe physical or mental disability that creates serious limitations in at least two functional capacities such as:

  - mobility;
  - communication;

- self-care;
- self-direction;
- interpersonal skills;
- work tolerance; or
- work skills.

- Have one or more physical or mental disabilities resulting from:

  - amputation;
  - arthritis;
  - autism;
  - blindness;
  - burn injury;
  - cancer;
  - cerebral palsy;
  - cystic fibrosis;
  - deafness;
  - head injury;
  - heart disease;
  - hemiplegia;
  - hemophilia;
  - respiratory or pulmonary dysfunction;
  - mental retardation;
  - mental illness;
  - multiple sclerosis;
  - muscular dystrophy;
  - Musculoskeletal disorders;
  - neurological disorders (including stroke and epilepsy);
  - paraplegia;
  - quadriplegia and other spinal chord conditions;
  - sickle cell anemia;
  - specific learning disability;
  - end-stage renal disease; or
  - another disability or combination of disabilities which, determined on the basis of an assessment for determining eligibility and vocational rehabilitation, causes comparable substantial functional limitations; and

- require multiple services lasting 6 months or longer.

The above determination must be made by a VR Counselor.

VOCATIONAL REHABILITATION SERVICES

OUTCOMES FROM VOCATIONAL REHABILITATION ASSESSMENT:

The VR Counselor will complete an assessment of the participant for the services and treatment that she or he may need to become self-sufficient. The following are the outcome categories that the VR Counselor will use to guide the caseworker and the participant in the PRP development:

Category A – Individual doesn't meet VR eligibility criteria or is not in a VR Priority Category that VR is currently able to serve. Participant is referred to caseworker to renegotiate the PRP.

Category B - Slight barriers are present that require continued work with the VR Counselor and related services, but do not affect the participant's ability to participate in Families First work components. The VR Counselor will assist, as needed, in the development of the PRP. Some hours may need to be spent with the VR Counselor. These hours will count as a part of the Traditional Work Plan on the Personal Responsibility Plan. The participant may spend part of the time usually devoted to classroom activity with the VR Counselor. Standard time limits, work requirements, and sanctions apply to this category.

Category C – Major barriers to participation are present that require a Modified Work Plan. This may result in fewer hours or different activities**. A participant in this category who wants to take advantage of the Modified Work Plan must continue to work with the VR Counselor and the related services as a part of the PRP.** The VR Counselor is responsible for determining the number of hours and setting up any activities that are different from the standard work activities found in a Traditional Work Plan. If there is a Families First component that is not appropriate for this customer at this time, the VR Counselor will ensure that the caseworker knows not to include this activity on the PRP.

The Modified Work Plan with VR can include periods of time when no activities are required at all due to the individual's circumstances. This is called "interrupted status." When this occurs, the VR Counselor will notify the caseworker to exempt the individual from the work requirement for the needed period of time. For times when no activity at all is required, the time limit is also interrupted.

Time limits may also be interrupted for individuals in this category. For an individual with a modified PRP that includes a total of 20 hours or less of activities, the time limit must be interrupted. For an individual with more than 20 hours of activities, the VR Counselor will determine if the time limits should be interrupted based on the individual circumstances of the participant.

This category of participation may also allow special sanction criteria that are customized to the individual, if needed. The VR Counselor will need the help and involvement of the caseworker in order to monitor the case properly. The VR Counselor determines what

the compliance provisions will be. However, the VR Counselor will not alter the sanction process once the case gets to conciliation. The sanction modifications are allowed prior to the point of conciliation.

For example: A participant with a physical disability may have problems related to the disability that prevent follow-through on plans he/she has made. The VR Counselor may allow non-compliance with the work requirement a specific number of times (to be decided on a case-by-case basis) before asking the caseworker to start the formal sanctioning process. Instead of conciliation for these first instances of non-compliance, the caseworker will inform the VR Counselor so that the failure to follow-through is addressed as part of the treatment.

Category D – Severe disability barriers to participation are present. If the VR Counselor finds that the individual may have a significant disabling condition or incapacity, the counselor will pursue an exemption or interruption.

The VR Counselor can also refer an individual to the caseworker for a determination of incapacity or may suggest that the individual apply for SSI/SSA. The evaluation for incapacity by the county/MEU and the eligibility determination for SSI may occur simultaneously. As always, the time limits will be interrupted while awaiting the determination of incapacity. However, the time count can be interrupted while awaiting a SSI determination only if:

- the individual is also awaiting an incapacity determination by the county or MEU; or
- the VR Counselor has determined that the time limits should be interrupted.

While incapacity can be approved at the county level, the county cannot automatically approve incapacity based solely on the VR Counselor's referral for incapacity determination. Instead, the county should follow standard procedures to either approve the incapacity or to refer to the MEU.

The VR Counselor may determine that the individual should apply for SSA or SSI. The VR counselor can assist a physically disabled person with the SSI/SSA application. If the individual is mentally disabled or has a learning disability, Family Services Counseling is the appropriate referral for the SSA/SSI application assistance. The VR Counselor will contact the caseworker about renegotiating the PRP with the individual in order to make a referral to Family Services Counseling.

Volunteers – Individuals who are EAs but exempt from the work requirement are volunteers. Individuals who have volunteered for VR may fit under any of the outcome categories. However, regardless of their category in VR, the individuals will remain exempt and retain their volunteer status, unless the exemption status changes.

Accommodations to Disabilities versus VR Modification:

A Families First participant who may or may not meet the Families First or VR definition of disabled and has not been approved incapacitated by the MEU may inform the caseworker of a physical or mental limitation. If accommodations must be made in order for the participant to comply with program requirements, the caseworker is obligated to seek reasonable accommodations. However, if accommodations are needed but the participant does not agree to participate in VR or is not eligible for VR, it remains necessary for the caseworker to make accommodations based on the Americans with Disabilities Act. In other words, a person with physical or mental limitations does not have to choose VR as their work component, even though it appears it may be the best option. An individual needing accommodations can choose any component and reasonable adjustments must be made to assist them in participating in the component.

VERIFICATION:

No verification is needed from the participant to receive a VR referral. The VR Counselor will provide verification of the individual's participation in VR activities and appointments.

DOCUMENTATION:

- Update CLRC to reflect the reasons around the VR referral. The details about the barrier that are not necessary for eligibility determination should not be included because of the confidentiality issue. However, documentation would include the circumstances around the referral, where it originated, when it was sent, etc.

- When an assessment referral is made, update AEPRP to reflect the two-month/60-day interruption to the time count. Update AEIPA to show VR assessment as the activity on the work plan.

- If the VR Counselor determines that an interruption to the time limit is necessary for the participant, update AEPRP to reflect the VR interruption.

- Update AEIPA to reflect any new activities as decided by the caseworker, the participant and the VR Counselor. Document CLRC to reflect any work components that the VR Counselor has identified as inappropriate or appropriate for the participant.

- If the VR Counselor determines that a Modified Work Plan with varying hours or a customized sanction is necessary, document the requirements for the hours or specialized sanction procedures in detail in CLRC.

- If the VR Counselor determines that the individual's barrier is such that an exemption from the work requirement is needed, then update AEPRP to include this work exemption.

- Update CLRC to include all information that the VR Counselor shared regarding the initial assessment, the complete assessment and any progress reports. This information includes the details that are shared regarding any barriers and any details necessary to case manage the Modified Work Plan.

- Update JTPA regarding the VR assessment and ongoing VR component using the appropriate JTPA codes.

PROCEDURES:

- Inform all assistance groups about the availability of VR. Give a copy of the VR Information Sheet to each customer at the initial or redetermination interview. Explain VR, how it may affect the individual's PRP and who may be eligible to receive these services.

- If a participant meets any of the referral group criteria, offer a referral to VR.

- If the individual agrees to a VR referral, enter VR assessment as the only mandatory component on the PRP. Enter the VR assessment interruption code on AEPRP for the two-month/60-day interruption. If the individual wants to continue to participate in other Families First components, enter these as voluntary components. Be sure to include any necessary supportive services such as child care and transportation on the PRP. Enter VR Assessment on the JTPA system.

- Complete the VR Referral Form. This can be completed either by the caseworker or the Case Management Assistant. If the form is completed by the CMA, the caseworker must sign the referral.

- Self-Referrals: If a participant makes a self-referral directly to the VR Counselor, the VR Counselor will complete as much identifying information on the referral form as possible and the portion of the referral form that is reserved for the VR Counselor. The VR Counselor will send the original referral form to the caseworker.

  The caseworker will then contact the individual (either by telephone or in writing) to determine if he/she wants to renegotiate the PRP to include VR. If the individual chooses to participate in VR, the caseworker will renegotiate the PRP, complete the referral form and return it to the VR Counselor. If the individual does not choose to participate in VR, the caseworker will notify the VR Counselor so that the VR Counselor can terminate the VR case.

- Barrier Identified by Families First Service Providers: If a Families First service provider identifies a mental or physical problem or a learning disability that indicates a participant may be a candidate for VR, the Families First service provider will notify the caseworker. The Families First service provider will use the normal procedures that are used to notify the caseworker about any other changes or pertinent information.

  Upon receipt of this information, the caseworker will contact the individual (either by telephone or in writing) to explain VR and to determine if he/she wants to renegotiate the PRP to include VR. If the individual chooses to participate in VR, the caseworker will renegotiate the PRP, complete the referral form and return it to the VR Counselor. In addition, the caseworker will notify the Families First service provider about the change in the PRP activity. If the individual wishes to volunteer to participate in an additional activity while in VR assessment, the caseworker will notify the Families First service provider that the participant has changed to a volunteer status. Unless the Families First service provider is notified otherwise, they will continue to provide the activity to the volunteer participant in the regular manner.

- Within 30 days of a referral, the VR Counselor will report preliminary information based on the initial assessment to the caseworker using the VR Initial Feedback form.

- The VR Counselor will use the VR Change Feedback form to notify the caseworker about:

  - additional information or participation changes that will require changes in the participant's activities or outcomes after the initial assessment;
  - changes or pertinent information for ongoing VR cases;
  - changes in Priority Category status;
  - whether or not the individual should have a Modified Work Plan (including modified hours, sanctions, time limits, etc.); and
  - each failure to cooperate with VR (even for those with modified sanctions).

- Upon receipt of the feedback form either after the initial assessment or on an ongoing VR case, the caseworker will use this information to:

  - renegotiate the PRP;
  - discuss non-compliance; or
  - begin sanction procedures, as appropriate.

  In addition, the caseworker will update all pertinent ACCENT screens:

- AEIPA to reflect all appropriate work components;
- AEPRP to update the time limit interruption code, if necessary; and

- CLRC to explain the information reported by the VR Counselor and the subsequent actions taken on the case.

- The caseworker will notify the VR Counselor of any incidents of non-compliance in standard Families First work components that are included on the individual's PRP, including those where participation is voluntary. The caseworker will also notify the VR Counselor if sanction procedures have begun as a result of the non-compliance. NOTE: If sanction modifications apply to the participant, the caseworker will notify the VR Counselor of each incident at the time of non-compliance.

- Participation in VR for Individuals with a Work Requirement:

  - If a participant with a work requirement is assessed by VR and does not fall within a VR Priority Category that VR is able to serve, the caseworker will renegotiate the PRP and help the participant choose an alternate component to fulfill the work requirement. If the individual claims incapacity at this point, he/she will be exempt from the work requirement until an incapacity determination is made.

  - If a participant who has a work requirement wants to change from a Modified Work Plan to a Traditional Work Plan or stop participation in VR, the caseworker will renegotiate the PRP. The caseworker will also take appropriate measures to accommodate any known barriers to fulfilling the Traditional Work Plan, if needed. However, if the VR Counselor notifies the caseworker that the participant has stopped participating in VR **without** requesting a renegotiation of the PRP, the caseworker will initiate regular conciliation and sanction procedures by attempting to contact the participant.

- Voluntary Participation in VR: Update the PRP for individual EAs who are exempt from a work requirement, but who want to participate in VR as a voluntary activity. If a volunteer wishes to stop VR, the activity will be removed from the PRP, with no further action necessary. The individual must sign the revised PRP. If an NA individual wishes to participate, send them to VR but do not complete a Families First VR referral.

- Transfers to another county: If an AG that contains a VR participant moves from one county to another, the Families First caseworker will follow the normal Families First transfer procedures. Notify the VR Counselor about the move as soon as possible. When the VR Counselor is notified, either by the caseworker or the participant, he/she will notify the VR Counselor in the new county and transfer the VR case. This will ensure that VR services will continue without interruption. If the participant notifies the VR Counselor before notifying the caseworker, the VR Counselor will also let the caseworker in the old county know about the move as soon as possible.

CLOSURE REVIEW TEAM

POLICY STATEMENT

The goal of Families First is to provide Families First applicants and participants with an opportunity to become financially self-sufficient through employment and child support. It is the intent of the Families First program to provide Families First families with every opportunity to achieve self-sufficiency. The Closure Review Team (CRT) was created in July 2006 to make sure that cases are correctly sanctioned and closed.

- The Closure Review Team will conduct a review of Families First cases within the 10-day adverse action period following case closure. The sole purpose of the CRT is to ensure that:

  - the case record reflects the appropriate outcome;

  - each individual receives appropriate and timely service;

  - the correct notice is mailed to the client; and

  - the conciliation process is followed correctly.

Closures Requiring Review by the CRT

- The CRT will review Families First closures for:

  - child support non-cooperation;

  - voluntary quit;

  - non-compliance with work requirements; and

  - time limits

  NOTE: If the Families First participant contacts the caseworker regarding a potential sanction and requests his/her case to be closed, the case will be closed for the work sanction, voluntary quit or non-cooperation with child support, and at the customer's request. The request for closure does not negate the possible sanction.

INTERRUPTION/EXEMPTIONS THAT OCCUR DURING THE CLOSURE REVIEW TEAM PROCESS

Although the CRT will not be interviewing or contacting clients, if they discover during their review process that a client had good cause at the time of the closure, or during the sanction process due to circumstances that will cause an exemption/interruption from the work requirement, the case will be returned to the caseworker. The interruption/exemption will not negate the sanction, but the client will not be required to complete a 2-week compliance period when the exemption/interruption ends.

CLOSURE REVIEW TEAM

CLOSURE REVIEW TEAM RESPONSIBILITIES

The CRT will complete an ACCENT case record review within the 10-day adverse action period after case closure. This review is to determine if all actions and information needed to substantiate a closure are clearly documented in the case record and if the closure was appropriate. The CRT will also determine if Families First policies and procedures were followed correctly.

If the case was closed inappropriately, the CRT will reopen the case, reinstate benefits, and return the case to the county caseworker.

Note: Cases closed with the incorrect reason code will be reopened by the CRT and returned to the caseworker to close with the correct reason code.

If there is not enough information in CLRC to determine if the closure is appropriate, the case will be reopened, benefits will be reinstated, and the case will be returned to the caseworker.

If the case appears to be closed appropriately, but lacks documentation, the case will not be reopened. The county caseworker will be required to make corrections/additions to running records. The CRT will monitor the progress on the corrections.

The CRT will not contact clients.

OUTCOME OF THE CLOSURE REVIEW TEAM REVIEW

When the CRT process is completed, the caseworker will be notified via email only if corrective action is needed.

CASE ACTIONS DURING THE CLOSURE REVIEW TEAM PROCESS

When the client contacts the caseworker during the 10-day adverse action period, the caseworker will be responsible for notifying the CRT about any pertinent contacts or actions taken on the case. Depending on the contact made, the CRT may hold the review, discontinue the review or proceed with the review taking into account the new information.

The caseworker will send a final closure notice on cases that are reopened and fail to cooperate. The case will be sent to the CRT and the 10-day review process will begin again. After receiving a final closure notice, the client will have to reapply to have the case reopened.

CLOSURE REVIEW TEAM PROCESS FOR REQUESTING DOCUMENTATION/ACTION FROM DHS

The CRT cannot complete their case review until the caseworker takes the appropriate steps to correct the cases needing documentation. Therefore, it is imperative that the caseworker respond to the CRT within three (3) working days to resolve documentation issues. If more than one request for information is necessary, the caseworker will be given three (3) working days between each request to respond. The escalation order for requests is listed below:

- 1st Request – From the CRT to the CW and a copy to the FS1.
- 2nd Request – From the CRT to the CW and copies to the FS1, the Program Supervisor, the Family Assistance District Director, and the CRT Unit Supervisor.
- 3rd Request – From the CRT Unit Supervisor to the CW and copies to the FS1, the Program Supervisor, the Family Assistance District Director, and the State Office Families First Policy Director.

If there are problems obtaining the needed information or taking the required action within the three (3) days, notify the CRT as soon as possible.

NOTE: The above listed channels are also used to resolve any question on policy involving cases reviewed by the CRT.

DHS CW PROCESS FOR REQUESTING DOCUMENTATION AND ACTIONS FROM CLOSURE REVIEW TEAM

When the CW sends an email to the CRT, resolution of the issue, documentation of the action taken, and a response to the CW will be expected within three (3) working days of the date the email was sent. If a response is not received within the required time frame, the following procedures will be applied. A response is expected within a maximum of three (3) working days of each request.

- 1st Request – From the CW to the CRT and the CRT Supervisor, and a copy to the FS1.
- 2nd Request – From the CW to the CRT and the CRT Supervisor, and copies to the FS1 and the Program Supervisor.
- 3rd Request – From the CW to the CRT, the CRT Supervisor, and the State Office Families First Policy Director.

TIME LIMIT CLOSURES

Prior to closing a case due to time limits, the time count must be validated. In addition, the caseworker must determine whether or not the AG is eligible for an extension to the time limit and whether there is a sanction situation that needs to be resolved prior to closure. If the case is closed without the counter review validation or extension determination, the CRT will return the case.

CASES CLOSED FOR MULITPLE REASONS:

A case that is closed for at least one closure reason code that requires a CRT review plus a closure reason code that does not require a CRT review must be reviewed by the CRT.

TRANSFER CASES:

The CRT will complete the review on cases that transfer to another county during the post closure review process. The CRT will forward the results of the review to the new county and that county will take any corrective action needed.

APPEALS:

The CRT will provide any requested documentation/data if requested for an appeal/hearing.