

Division of Family Support  
OPERATION MANUAL  
Volume I

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MS 0001 FAMILY SUPPORT MANUALS AND PROGRAM INSTRUCTIONS (1)

The Division of Family Support is responsible for developing, writing and publishing operations manuals, forms, and memorandums for eligibility programs administered by the Department for Community Based Services. Information and procedures in the manuals conform to federal and state laws and regulations and must be applied in a like manner in all counties.

- A. The following manuals, manual cover letters, and forms are located online and available to staff at <https://chfsnet.ky.gov/dcbs/dfs/Pages/resources.aspx>.
  1. Operation Manual that includes volumes devoted to:
    - a. General administration of all programs and claims;
    - b. Supplemental Nutrition Assistance Program (SNAP);
    - c. SNAP work provisions;
    - d. Cash assistance programs (K-TAP, Kinship Care, FAD, WIN);
    - e. Kentucky Works;
    - f. Family Medicaid programs;
    - g. Adult Medicaid programs and State Supplementation; and
    - h. Clarifications;
  2. Forms Manual that includes forms and procedural instructions and:
    - a. Forms Workbook tool to pre-populate selected fields on some forms;
    - b. Calculator workbook containing tables for all programs, and tools to assist in the:
      - 1) Completion of form FS-103 for SNAP purposes;
      - [2) Calculation of self-employment to be considered for KWP participation; and
      - 3) Determination of the KAMES codes for denial/discontinuance, disqualification and member status.]
  3. Computer Manual instructions for KCD (Kentucky Claims Debt Management System);
  4. Transmittal letters that accompany new or revised manual material and summarize changes in:
    - a. The Operation Manual;
    - b. Forms and procedural instructions; and
    - c. The Computer Manual;
  5. Family Support Memorandums (FSM);
  6. Tip Sheets; and
  7. User Guides
    - a. Bendex User Guide



- b. Best Practices Handbook
  - c. ECF User Guide
  - d. e-Forms User Guide
  - e. ETP EX-EZ System Guide
  - f. FAD User Guide
  - g. KAMES User Guide
  - h. KEUPS User Guide
  - i. RDS System Guide
  - j. SDX User Guide
  - [k. OTIS User Guide ]
  - l. Web 117 Case Review System Guide
- B. The general public can access the Operation Manual at [http://manuals.chfs.ky.gov/dcbs\\_manuals/DFS/index\\_dfs.asp](http://manuals.chfs.ky.gov/dcbs_manuals/DFS/index_dfs.asp). Other material is not accessible at this site. The local office makes material available for review at the request of a client or any interested party. To avoid copying an entire volume of information for manuals appearing in PDF format, use the file function for printing and enter the desired range of pages.
- C. Field staff is alerted on KAMES when new or revised material is added to the intranet site. Review all newly issued or revised material. Staff can locally print information.

MS 0010\*

## CABINET STRUCTURE

The Cabinet for Health and Family Services (CHFS) consists of several agencies with various functions that include the provision of direct services to individuals, families and businesses. The list of CHFS agencies and a brief description of each is located at <http://chfs.ky.gov/agencies>

- A. The Department for Community Based Services (DCBS) is an agency within CHFS that administers adult and child protection/permanency and family support programs. There are DCBS offices in every county that provide direct services to individuals and families. DCBS consists of the following Divisions:
1. Service Regions;
  2. Child Care;
  3. Violence Prevention Resources;
  4. Protection and Permanency;
  5. Administration and Financial Management;
  6. Program Performance; and
  7. Family Support.
- B. Field staff located in the counties is attached to the Division of Service Regions and managed by a Service Region Administrator. Information regarding the counties in each Service Region is located at <http://chfsnet.ky.gov/dcbs/ServiceRegions.htm>.
- C. The Division of Family Support, located in Frankfort, is responsible for developing policies and procedures relating to the administration of income support programs and providing technical support to field staff. Additional information about the Division is located at <http://chfs.ky.gov/dcbs/dfs>.

\*MS 0015            ETHICS POLICY FOR FAMILY SUPPORT EMPLOYEES            (1)

The Department for Community Based Services (DCBS) and its employees must recognize the vulnerability of their clients and the serious responsibilities associated with the provision of public assistance. The behavior of human service professionals shall reflect an emphasis on integrity, professional trustworthiness, and on the values of respect for persons, competence, loyalty, diligence, honesty and confidentiality.

DCBS professionals have a duty to be familiar with their responsibilities under this manual section and to consider which ethical principles apply in a particular situation. If there is a conflict between two or more ethical principles and/or responsibilities in a particular case, staff should consult with his or her supervisor in choosing a proper course of action.

**Family Support employees:**

- A. Adhere to standards of ethics, confidentiality, and security agreements;
- B. Execute their responsibilities on behalf of the citizens of the Commonwealth. As such, they do not use their positions for personal gain or influence;
- C. Strive to improve the quality and efficiency of services rendered by Kentucky state government;
- D. Are honest, objective and diligent in the performance of their duties and responsibilities;
- E. Avoid leading or coaching program applicants or recipients into making statements or taking any other action in order to gain benefits to which the individual or household is not entitled;
- F. Avoid participation in any activity they know to be illegal or improper;
- G. Are continually aware of the public trust they hold and their obligation to maintain a high standard of integrity, competence, and dignity in the performance of their duties;
- H. Do not enter into any activity which may be in conflict with the interest of the citizens of Kentucky;
- I. Refrain from entering into any activity which may prejudice (or give the appearance of such) their ability to objectively perform their duties and responsibilities;

- J. Do not solicit or accept directly or indirectly, any gift, gratuity, favor or other economic consideration from any person, group, private business or public agency, or from members of their immediate families, which may affect the impartial performance of the employee's duties;
- K. Are prudent in the disclosure or use of information acquired in the course of their duties;
- L. Shall not disclose information that may infringe upon another's right to privacy;
- M. Shall not use confidential information for any personal gain or in a manner which may be detrimental to the welfare of the citizens of the Commonwealth;
- N. Do not use state resources, including time, facilities, equipment, supplies or uniforms for private benefit or advantage;
- O. Shall secure prior approval of their Cabinet's management before using state time, facilities, equipment, supplies or uniforms for community projects;
- P. Strive for improvement in the proficiency and effectiveness of the service and products they deliver;
- Q. Extend respect, honesty, fairness, and cooperation to citizens, colleagues, and members of other agencies;
- R. Document their professional work accurately, truthfully, and according to agency policy and/or legal requirements in order to ensure proper accountability;
- S. Act in the best interest, promote the welfare, and avoid harming those they serve.

MS 0020

GENERAL CASE PROCESSING

(1)

- [A. Eligibility determinations for K-TAP, Kinship Care, Family Medicaid, AFDC related Medicaid, Adult Medical Assistance (AMA), and SNAP are completed on the Kentucky Automated Management and Eligibility System (KAMES). MAGI Medicaid, which will take the place of Family Medicaid and AFDC related Medicaid, is processed on kynect. In the transition period, some Family and AFDC related MA will be continued to be processed on KAMES until they are converted to MAGI Medicaid on kynect.
- B. When a worker processes a case, the worker documents in KAMES comments any and all actions taken within the case.]
- C. All individuals contacting the local office requesting assistance are entered into the Agency Contact File on KAMES by designated staff.
- D. Workers cannot take or process an application of an individual who is a relative or close acquaintance. This includes family members related by birth or marriage, through first cousins. The worker is responsible for advising supervisory staff if an applicant is a relative or close acquaintance. The worker cannot provide case status information or inquire the case for a relative. In addition, Family Support employees may not act on behalf of a payee by receiving, cashing, or co-signing checks.
- E. Supervisors or designated persons accept and process applications filed by DCBS employees.
- F. All applications or reapplications must be acted on promptly. No longer than 30 days should elapse between the application date and authorization for action date, with the exception of unusual case situations. If the time frames required by the specific program are not met, document the reason for the delay in KAMES comments. For IM cases when an application cannot be processed timely due to a reason beyond the control of the worker or applicant, enter the applicable good cause reason code on KAMES. This will pend the action for supervisory approval. Management reports will reflect the number of cases not processed within 30 days that had good cause.
- G. To ensure authorizations are completed promptly, cases processed by workers without case decision must be reviewed immediately.
- H. Ongoing eligibility is reviewed periodically as required by specific program guidelines.
- I. Deny an application for assistance or discontinue benefits if:
  - 1. An individual withdraws the application or requests discontinuance;
  - 2. It is established a technical or financial factor is not met; or
  - 3. An individual fails to verify eligibility factors.

- J. When entering a reapplication for a K-TAP or MA case that has been previously entered on KAMES, do not enter the alpha identifier. A SNAP case number does not contain an alpha identifier. If a case has been entered using the same SSN, a Case SSN/Name Match screen appears. Each matched case will have a separate screen. The questions on the Case SSN/Name Match screen must be answered correctly. Give special attention to the case number, program code, and case identifying information that appears. Assigning a different alpha identifier can create multiple problems. If KAMES does not allow selection of the appropriate case, contact the Help Desk. To resolve case SSN/Name Match, do the following:
1. Enter "Y" to "Is the member in your case and the member in matched case the same person?" if the individual listed on the screen has the same name, SSN, and birthday as the person that is applying. All three elements do not have to match exactly for "Y" to be answered; however, workers must ensure KAMES is matching with the correct person before answering yes. An "N" response returns you to the Application/Recertification Menu screen and displays an error message, "TWO MEMBERS CANNOT HAVE THE SAME SSN, PLEASE CORRECT". Resolution of member matches will take place at the time of occurrence, one member at a time.
  2. If a SNAP case has been previously entered on the system or there is a K-TAP or MA application pending for that individual, the "Select" field is protected and uploaded with "N" for these cases on the Case SSN/Name Match screen.
  3. Enter "N" to "Do you wish to start a new case...?" to select the previous case. Then a "Y" must be entered to the question "Do you wish to select this case?".
- K. Some screens are used for both SNAP and IM cases and require indication of which program's policy is to be applied. Enter "FS" for SNAP, "IM" for K-TAP, MA, and Kinship Care, or "JT" for both SNAP and IM so that KAMES will apply the appropriate policy. These entries are not limited to the program being updated. When a specific type of income is only countable in one program, use "FS" or "IM" as appropriate; otherwise use "JT". The correct code must be entered for KAMES to accurately calculate income and determine eligibility. Certain actions taken on a member in a case can affect benefits received in another case if "JT" is entered.

EXAMPLE: Sam is a member in both an IM and SNAP case. At his SNAP recertification, Sam reports they are taking an overpayment out of his Social Security check. Worker would enter the actual amount of Social Security received, and then enter the amount of the overpayment under "other unearned income". On the other unearned income screen an "IM" would be entered by the question, "JT/IM/FS\_\_". Entering "IM" allows KAMES to calculate the full amount of Social Security for the IM case and only the actual amount received for the SNAP case.

MS 0021                      GENERAL OVERVIEW OF KAMES INQUIRY                      (1)

[The following information is regarding inquiry of cases processed on KAMES. Cases processed on kynect cannot be inquired on KAMES. Use Function B on the Main Menu to access the Inquiry Menu. NEVER use the Case Change function for inquiry purposes. The following is a brief summary of the information available on the Inquiry Menu.]

- 1 - E-Forms/Scanning and Imaging – This option is used to access forms that can be populated with case specific data and caseworker information from KAMES into pre-defined templates on forms. This option also allows access to the Knowledge Lake Capture program to scan, index and search for documents stored in the Electronic Case File (ECF).
- A - Case/Pending Inquiry Menu - Use this option to inquire any case or member segment on active, inactive or pending cases.
- B - Agency Contact - This option contains the agency contacts entered on the system. Agency contacts are retained for 90 days.
- C - Appointment Sched. - Use this option to find a recipient's appointment. It is possible to find the recipient's appointment time by entering "Case Number" only. Leave "Worker" and "Date" blank. The appointment calendar for the date of the scheduled appointment displays. Appointments can be viewed 10 days in the past and 50 days in the future.
- D - Management Reports - This option includes Application/Caseload Activity, Caseworker Production and the Application/Reinstatement Register. A worker has access to reports through this file. The Field Services Supervisor and some clerical staff can access the reports for their unit/county.
- E - Eligibility Tables - This option contains the eligibility tables for all programs. When you select a table, the most current table for that program displays. To view prior or future tables, change the effective date. This option also contains case load weight table, benefit proration calculations, and LIS designated persons by county.
- F - Caseload Assignment - Use this option to inquire the worker assigned to a caseload, or the caseloads and workers in a given county or unit. In counties with multiple units, inquire the caseloads by unit. Use caseload code, not worker code.
- G - SSN Cross Reference - To inquire if an individual has been on KAMES with another SSN, enter the current SSN on the system. This option displays only SSN changes completed through Function V on the Case Change Menu.
- H - Exparte/Extended MC – This option is used to inquire Exparte and extended managed care coverage dates. It is also used to issue a replacement Medicaid card, if requested, during the Exparte/Extended MC limited coverage time. Enter the SSN to access.

I - Provider File - Use this option to inquire:

1. LTC providers;
2. PCH/FCH providers.

Enter "X" by the file you wish to inquire and enter the county code.

LTC –Enter the provider number.

Active LTC field - To inquire an inactive provider enter an "X" in the LTC field and an "N" in the Active LTC field. To inquire only active providers enter a "Y". If a value is not entered in the active LTC field, the inquiry will display all active and inactive providers.

Note: Out-of-state LTC providers can be inquired by entering an "X" in the LTC field and entering the county code of the state needed. If the county code is not known, enter a question mark in the county field. F8 until the desired state and county code is displayed.

L - Special Circumstance - Use this option to inquire any special circumstances issued for a case. Enter the case number.

[M - MC Organization - Use this option for MA cases processed on KAMES to inquire Managed Care Organization information by county code or region.]

N - School Listing - Inquire by county number to view all schools, their addresses, school numbers and districts.

P - Pro Certifications – To inquire an individual's certification for LTC. The PRO Cert will include the date of admission, level of care, and the date the level of care was met. Select option "P" and on the next screen that appears enter the case number.

Q - Vital Statistics Death Information – To inquire information regarding a household member who has an SSN matched with a record on the Vital Statistics database. Enter the deceased member's SSN.

R - LIS Referrals – To inquire LIS referrals matched to KAMES that do not have a current case or are not active in any other case (other than a "Z" case). Designated staff assigns referrals to workers for processing. Enter the member's SSN.

S - New Born Database – To inquire information regarding a newborn whose MA eligibility was automatically issued through the newborn's first birthday. Workers add the newborn to the appropriate case on KAMES by inquiring the newborn's information on this database. The newborn information can be found by entering the mother's SSN, the mother's name or the child's name.

[T – Out of State IPV on DRS – To inquire information regarding out-of-state IPV for a SNAP case.]



MS 0030

CASE RECORD

(1)

The case record is the official document of the Department that establishes accountability for the expenditure of state and federal funds. Local management staff is responsible for ensuring case records are properly maintained, purged of obsolete material, and accessible to staff. This includes hard copy case records and the electronic case file (ECF).

A. [Each hard copy file and ECF contains pertinent information about each applicant and recipient and supporting documentation for every decision made regarding eligibility. At a minimum, this includes: ]

1. Date of application;
2. Date and type of action (approval, denial, interim, special circumstances, restoration, etc);
3. Documentation sufficient to support the eligibility determination;
4. Verification used in the determination of initial and continuing eligibility;
5. The basis for denial or discontinuance of assistance;
6. The condition that prompts a need for special accommodation to ensure access to benefits and services by individuals or families with a physical or mental condition;
7. Accommodation offered and accepted by an individual or family;
8. Signed applications;
9. Copies of notices manually prepared and provided to the client;
10. Forms completed and/or provided by the client;
11. Maintaining a single archival case file folder per case;
12. Annotating in red on the hard copy case record if an overpayment is identified regardless if the overpayment is pending or is established if the overpayment occurred prior to the implementation of ECF.
13. The Kentucky Works Program (KWP) material is scanned into the ECF into the appropriate category for the specific verification or form received.

The KWP material retained in the case file includes:

- a. Participation verification records;
- b. Payment vouchers and verification of expenses;
- c. Forms WIN-1 and WIN-2, if appropriate; and
- d. All manually sent notices, such as form PA-105, Notice of Ineligibility.

- B. Case records are readily accessible to staff at all times. Each region has a plan for maintaining archived active and inactive hard copy cases which includes:
1. The location of active and inactive case record files;
  2. A designated individual responsible for maintaining archived active and inactive case record files;
  3. A method for tracking case records that are removed from files; and
  4. Procedures for sending and maintaining records in offsite storage, if applicable, to ensure they can be easily located and retrieved.
- C. Hard copy case records contain confidential material. To ensure information is not lost or misused, records are:
1. Opened one at a time except for comparative study;
  2. Purged of obsolete material that is disposed of by shredding or burning. For additional information on purging, refer to [MS 0040](#);
  3. Arranged in proper order;
  4. Never stored in desks;
  5. Returned to the case record storage area on a timely basis; and
  6. [Never removed from the local office except to transfer to another county, the Division of Administrative Hearings, Quality Control, or Central or Regional Office, offsite storage or archives.]
- D. Discontinued case records are retained as a record of the expenditure of funds for audit purposes.

MS 0040 PURGING OBSOLETE MATERIAL (1)

Hardcopy case records are required to be retained for a length of time specified by each program. With the implementation of the Electronic Case File (ECF), existing hardcopy case records are retained following normal purging procedures. Any form or verification scanned into ECF will become a permanent record.

To ensure records contain only relevant material, case records are purged of all outdated material. Material not directly related to eligibility or benefit authorization is not retained. Purged material is shredded or burned prior to disposal.

[Any claim established after the implementation of the Electronic Case File (ECF) must have the corresponding documentation noted as part of the claim case record in ECF.

- A. DO NOT PURGE a case record involved in an audit until the audit is completed, a response to the audit has been filed and the audit is closed.
- B. For benefit programs except the Supplemental Nutrition Assistance Program (SNAP), material retained permanently in an active case is:
  - 1. Case history sheet(s), PAFS-116;
  - 2. Application and need determination forms;
  - 3. All forms used to establish technical eligibility;
  - 4. All forms relating to Long Term Care;
  - 5. Hearing decisions on which eligibility is based; and
  - 6. All forms and material related to fraud or overpayment claims.

Kentucky Works Program (KWP) material is not purged from case records. It is retained indefinitely or until the K-TAP is inactive for 5 consecutive years.

Form PAFS-706 Voter Registration Rights and Declination is retained as part of the case record for 3 years from the date of completion.

All other material including the PA-10 series, MA-105 or PA-105, not required to substantiate a period of eligibility, is purged from active K-TAP or Medicaid cases after 5 years.

- C. For SNAP cases, maintain all local office records related to certification and issuance such as monthly reports, application registers and issuance listings, for a period of 3 years from the month of origin.

Hard copy files that are marked "DO NOT PURGE" prior to ECF are maintained as a hard copy case record. Scan into ECF any part of a hard copy case record that applies to a newly discovered claim. Before a hard copy case record is purged inquire KAMES to determine the status of the case, inquire KCD to determine if there is a pending or established claim. DO NOT PURGE a claim case unless the claim is paid-in-full for 3 years. IPV claims should never be purged.

Purge the following from the case record by burning or shredding:

1. Material which is older than 3 years except claims-related material.
    - a. DO NOT PURGE Intentional Program Violation (IPV) claims records or any case file records which substantiate either pending disqualifications or disqualifications which are being or have been served.
    - b. This includes documents such as signed disqualification consent agreements, court determinations, signed statements waiving the right to an administrative disqualification hearing, a hearing decision, and the notification of disqualification.
    - c. Retain IPV claims records indefinitely as long as the records can be used (i.e., the records are accurate, relevant, up to date and complete) to respond to requests from another State which is participating in the Disqualified Recipient Subsystem (DRS). Refer to [MS 1210](#).
  2. Irrelevant material.
- D. All purged material must be shredded or burned. Local offices may place the purged material in lockable recycling containers. For assistance with disposal of records, contact the Cabinet Records Coordinator, Division of Facilities Management.

When purging the case records, remove all binder clips and spirals. It is not necessary to remove paper clips and staples.】

MS 0045\*

## ARCHIVING CASE RECORDS

Archiving is the act of sending case records for storage to the Department of Libraries and Archives (DLA) when the entire case record can be destroyed after a certain time period. Only inactive case records can be archived.

DO NOT archive cases involving pending or established claims. When the established claim has been paid in full for three years, the case can be archived.

DO NOT archive cases involved in an audit until the audit is completed and the response to the audit is filed.

Because local offices utilizing off-site storage facilities must provide case record material within 48 hours of the request by a Quality Control analyst, do not select cases to be archived that have been inactive for less than one year.

When sending cases to be archived, indicate on each box the date the case records can be destroyed.

MS 0050

COUNTY OF CASE RESPONSIBILITY

(1)

[An application/reapplication for assistance, recertification, change report, or any information provided by or in behalf of a recipient is accepted by staff without regard to the county of residence of the individual. Scan the documents into ECF for the specific case. Enter the application/reapplication, recertification or change into KAMES.

K -TAP/KWP and Adult Medicaid (AMA) cases that are active or pending can be transferred to another county or to another caseworker in the same county. All other cases do not have one specific county or worker that has ongoing responsibility.

There are two exceptions:

- A. Cases handled by a Department of Juvenile Justice (DJJ) worker are carried in the county where the DJJ worker is located; and
- B. SAFE cases are carried in Central Office.

Ongoing responsibility for K-TAP/KWP and AMA cases belongs to the county where the recipient lives. This includes cases with a statutory benefit payee, committee, or guardian regardless if the payee, committee or guardian is located in or outside of Kentucky.]

MS 0055 KENTUCKY ENTERPRISE USER PROVISIONING SYSTEM (KEUPS) (1)

[The Kentucky Enterprise User Provisioning System (KEUPS) provides for a single sign-on to most systems used by staff and automates the request process management staff uses for system access. For detailed information, refer to the website: <https://chfsnet.ky.gov/dcbs/dfs/Pages/KEUPSUserGuide.aspx> for the KEUPS User Guide.

- A. KEUPS provides a single sign-on for the Kentucky Network (Mainframe Applications, including KAMES), DCBS Case Review, Kentucky Physicians Care, KVETS (Birth Index), E-Forms and Electronic Case Files. Users can log in once using a single user name and PIN and access multiple systems.]
- B. The KEUPS User Agreement must be accepted on the first use of KEUPS and may be required again if the User Agreement changes.
- C. KEUPS automates the process for requesting, approving, and granting access to the applications on KEUPS. Supervisors use KEUPS to request access for employees, modify access, and update employee information. KEUPS provides e-mail notification regarding approval and other tasks in KEUPS.
- D. Employees may make some changes to their contact information in Account Management in KEUPS. Employees may also change their security questions.
- E. The KEUPS Help Desk in the Cabinet's Office of Administrative and Technology Services (OATS) assists with users' access to KEUPS and other applications. KEUPS provides automation of some Help Desk tasks previously done through manual processes.
- F. The Help Desk can be contacted by phone toll free at 866-231-0003, locally at 502-564-0104 or by email at [CHFSOITSecurityHelpdesk@ky.gov](mailto:CHFSOITSecurityHelpdesk@ky.gov) or [CHFSNetworkHelpdesk@ky.gov](mailto:CHFSNetworkHelpdesk@ky.gov).
  1. The Security Help Desk handles the following issues: access revoked on KYNET, KEUPS issues with most KYNET related applications, exceeded maximum security violations on KAMES, KYNET Passwords, KAMES application passwords, etc. The Security Help Desk is option 2 when calling.
  2. The Network Help Desk handles the following issues: logging onto the workstation, KEUPS issues related to a user's account, server issues, anything Network related for PC users, Email issues, printer issues, etc. The Network Help Desk is option 5 when calling.

MS 0060 CASE TRANSFER PROCEDURES (1)

[The following procedures are used to transfer K-TAP/KWP and Adult Medicaid (AMA) cases between counties: ]

A. When a household reports moving to another county, the sending county:

1. [Enters the new address and county code and previous verification code. For K-TAP and AMA, cases household composition must be verified.
2. Must remove the household composition verification source for the K-TAP/KWP and AMA. The individual is provided with a "Request for Information" (RFI) instructing the individual to return the verification to the address listed on the RFI.
3. Ensures that any documents/verification received in the sending county are scanned into ECF before the case is transferred out.]
4. Documents case comments regarding any outstanding issues relating to the case.
5. Transfers the case to the appropriate county caseload code. This code is located by entering "?" in the New Code field on the Case Reassignment screen. Online help displays the designated caseload codes for county transfers.
6. Enters "Y" in the Transfer into County column.
7. Mails any archival case material to the appropriate county office. The addresses for all DCBS offices are located at: [https://prd.chfs.ky.gov/Office\\_Phone/index.aspx](https://prd.chfs.ky.gov/Office_Phone/index.aspx).
8. Inquires on Kentucky Claims Debt (KCD) Management System for any related active claims and notifies the claims worker of the household's new address. The claims worker will update the county and worker code on KCD.

[If any documents/verification are received in the sending county after the case has been transferred, the sending county scans the material into ECF.

B. In the receiving county of residence:

The designated caseload staff person receives a spot check "Case Transferred into County" the first work day after the sending county makes the caseload change.

C. If a recipient reports the change of address to the new county of residence or a worker otherwise becomes aware that an active case exists in another county:



1. Advise the recipient to notify the post office in the old county of residence so mail can be forwarded.
  2. Conduct or reschedule a recertification interview if it is the final month of the certification period and no recertification interview has been completed.
- D. Accept applications, changes, and verification from an individual or representative regardless of the individual's county of residence. DCBS staff is responsible for entering the information on KAMES and scanning any documentation into ECF.
- E. Designated staff in a county reassigns a K-TAP/KWP case from one case manager to another in the same county by selecting function "R – Case Reassignment" on the KAMES Main Menu. Complete the screen, from left to right.

For temporary assignment of a KWP case for the purpose of OTIS access, the reassignment is completed on OTIS by the designated individual using the Administration option.]



MS 0080

CASELOAD WEIGHTS

(1)

Each case is assigned a designated weight based on case types. Weights are as follows:

Program	Weight
NA SNAP	2.0
PA SNAP	1.4
SF (SAFE) SNAP	.5
K-TAP	2.5
KWP Case Management with K-TAP (For each additional KWP Participant add 2.5)	5.0
K-TAP- UP	5.0
Kinship Care	2.5
Work Incentive (WIN)	1.5
Family Alternatives Diversion (FAD)	3.0
Family MA/KCHIP	1.6
TMA	1.0
Non-Supplementation ABD/FGH	.5
State Supplementation ABD/FGH.	1.0
SSI/MSE Child, SSI Only/SSI Alert Cases	.5
State Supplementation ABD/FGH with QMB dual eligibility	1.2
Adult Medically Needy JKM.	1.8
Adult Medically Needy JKM with QMB dual eligibility	2.0
Qualified Medicare Beneficiaries (QMB)/Qualified Disabled Working Individuals (QDWI)/Specified Low-Income Medicare Beneficiaries (SLMB) Z category/Qualified Individuals group 1 (QI1)	1.0
Family MA and J, K, or M Spend Down	3.0

MS 0090

RETURNED MAIL

(1)

[Ensure the correct mailing address is entered on KAMES. If the address is different, send the returned mail to the new address listed on KAMES.]

If the address listed on KAMES matches the returned mail, do the following: ]

- A. Call the household in an attempt to obtain the correct mailing address.
  1. If able to contact the household by phone, correct the address to ensure written correspondence is delivered.
  2. [If unable to contact the household by phone, generate an RFI requesting that verification of residency be provided within 10 days.]
- B. If verification is provided, correct the case address and mail all returned correspondence to the household.
- C. If the household does not respond to the request, take action on KAMES to discontinue the case.
- D. Scan the returned envelope and document the nature of the contents on KAMES. If the contents are notices originating from DCBS, shred the envelope and the contents. If the returned mail contains sensitive material such as, original birth certificates or check stubs, store in the hard copy file (if one exists) until the client is due to return to the office. If there is not a hard copy file, file the returned mail based on local office procedures, until the client is due to return to the office.
- E. Document in case comments regarding action taken.]

MS 0100

RETURNED CHECKS

(1)

Checks can be returned to Central Office or to the local office by the payee.

[A. Checks, including K-TAP, Kinship Care, The Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program, KWP supportive services, State Supplementation, and FAD, which cannot be delivered are returned to Central Office. The designated regional contact will receive notification via e-mail about returned checks and respond via e-mail within 5 work days. The response authorizes the appropriate action to:]

1. Cancel a check if:
  - a. The recipient of the check died prior to the first day of the month for which the check was issued; or
  - b. The recipient has moved and cannot be located, and mail sent to the recipient by the local or Central Office has been returned to the local office. A check is not cancelled until procedures for returned mail in [MS 0090](#) are completed and the recipient cannot be located. If, after the check has been cancelled but prior to the last day of the month covered by the cancelled check, the location of the recipient becomes known, the check must be made available to the recipient.
  - c. The recipient voluntarily returned a check to avoid an overpayment.
  - d. A supportive services provider returns a duplicate payment.
  - [e. A supportive services payment is returned due to an incorrect amount or provider on the check. In this instance, the correct payment is issued on OTIS by the caseworker/case manager.]
2. Remail a check if return was due to an incorrect address and the current mailing address is established. Take action to correct the address to ensure delivery of subsequent checks.
3. Reissue a K-TAP, Kinship Care or State Supplementation check for the original amount if there has been a change in payee and the new payee is eligible for the original amount.

[Do NOT change the payee for FAD or supportive services. Cancel the erroneous payment on KAMES or OTIS and issue a new payment to the correct individual/provider.]
4. Reissue the check, if a recipient of K-TAP or State Supplementation dies on or after the first day of the month for which the check was issued, to:
  - a. The widow, parent, or guardian; or
  - b. The executor or administrator of the estate. If the check is reissued to an executor or administrator, obtain a copy of the executor or administrator appointment order as verification.

- B. For mutilated checks, request the payee bring the remains of the mutilated or defaced check to local office. Return the check with form PAFS-61, Notice of Returned Check and Authorization for Disposition, to:

Division of Family Support  
Family Self-Sufficiency Branch  
K-TAP Section  
275 E. Main St., 3E-1  
Frankfort, KY 40621

[Annotate the envelope as to the type of check being returned, (e.g., Attention: K-TAP, Kinship Care, SNAP ETP, and State Supplementation.]

Request the original check be replaced and mailed to the payee.

- C. Once the cancelled K-TAP, Kinship Care or State Supplementation check has been redeposited on the system, "CA" will appear in the benefit status field on inquiry. Workers adjust the YY tracking screen on KAMES for the number of months of K-TAP receipt.

MS 0110 REPORT OF NONRECEIPT OF BENEFITS ISSUED BY CHECK (1)

If a payee reports nonreceipt of a check or that a check has been lost or stolen, the payee may request a replacement of a check (K-TAP, Kinship Care, the Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program, supportive services, FAD, WIN and State Supplementation). If the check has been cashed, follow procedures found in [MS 0115](#).

A payee must report nonreceipt, loss or theft of a check within 12 months of the intended receipt in order to receive a replacement check. Replacement checks are not issued for requests made after 12 months.

Example: The issuance date of the check is 6/6/11. The individual may request replacement of the K-TAP check until 5/31/12. If the individual reports nonreceipt, loss or theft of the K-TAP check on 6/1/12 or after, the replacement request is denied.

A. When a payee reports nonreceipt, loss, or theft of a check:

1. Inquire the appropriate system to determine if and when the check was issued;
2. Explain the following to the payee:
  - a. [Wait 10 business days from the daily check issuance date before completing form PAFS-60, Affidavit, requesting the replacement; and]
  - b. The original check cannot be cashed once a stop-payment is called in and form PAFS-60 is signed;
  - c. If the original check, which is issued in a self-sealed envelope known as thermo-bond, is received after form PAFS-60 is signed, it must be returned to the DCBS office. The replacement check has a different check number and date of issuance.
3. Determine if:
  - a. The payee recently moved and failed to provide a forwarding address to the Post Office or a change of address was submitted too late to redirect mailing of the check;
  - b. The check was lost or stolen and if the check was signed before the loss or theft; or
  - c. The theft was reported to the police.
4. Contact the Division of Family Support (DFS), K-TAP Section at 502-564-3440 to determine if the check has been returned or cashed.
  - a. If the check has not been returned or cashed, verbally schedule an appointment within 3 days to complete form PAFS-60.
  - b. If returned, the check is remailed to the correct address.
  - c. If cashed, follow procedures in [MS 0115](#).

- B. At the time of the appointment to complete form PAFS-60, contact the DFS, K-TAP Section at 502-564-3440, to request a stop payment be placed on the check.
1. The worker completes all portions of the "Agency Use Only" section of form PAFS-60 which pertain to the type of replacement check being requested. Omitting information will delay processing of the replacement check because incomplete forms are returned to the field for corrections. The worker must complete Parts I and III for replacement check requests.  
  
Part IV must be signed by the payee and Field Services Supervisor (FSS).
  2. Once form PAFS-60 is completed and signed, forward to:  
  
Division of Family Support  
Family Self-Sufficiency Branch  
K-TAP Section  
275 East Main St., 3E-1  
Frankfort, KY 40621  
  
Annotate the envelope as to the type of check (e.g., Attention K-TAP, Kinship Care, SNAP ETP, WIN, State Supplementation, etc.)
  3. When form PAFS-60 is received by DFS, if the check has not been cashed, a replacement is issued. If the check has been cashed, follow procedures found in [MS 0115](#).
- C. If the payee is a supportive services provider, send form PA-64, Provider Appointment Letter, to document the appointment to discuss nonreceipt, loss, or theft of a check. Form PA-64 also provides instruction for the provider to return form PAFS-60 signed and notarized to the office.



MS 0115                      REPLACEMENT OF A CHECK THAT IS CASHED                      (1)

If the original check is cashed before the stop payment is in place:

- A. The Division of Family Support (DFS) obtains a copy of the cancelled check and mails a copy to the Field Services Supervisor (FSS) or the designated individual.
- B. The supervisor or designated individual schedules a face-to-face interview with the individual within five work days to view the endorsement of the cashed check. Complete form PAFS-60, Affidavit, Parts II, III, and IV if the individual states the signature is not his/hers. If the payee is a supportive services provider, send form PA-64, Provider Appointment Letter, to complete form PAFS-60.

Form PAFS-60 is evidence in the event legal action is initiated for false swearing or fraud. Advise the individual that the form may be used as evidence and extend to the payee the opportunity to consult legal counsel, if desired, before signing the form.

Inform the individual that the Kentucky State Treasury has the final decision regarding the replacement of a check that has been cashed. There is no time frame in which Treasury has to make the decision to issue the replacement.

Part IV of form PAFS-60 MUST be signed by a Notary Public. The form cannot be signed by a staff person who is not a Notary Public. If a Notary Public does not sign the form, the form is returned by Treasury requiring the signature on a new form. A new form PAFS-60 must be completed with all signatures. This will cause a delay in the replacement check.

1. If the individual states he/she signed the check, send an e-mail to DFS at [FSSBK-TAP@ky.gov](mailto:FSSBK-TAP@ky.gov) explaining that the individual no longer claims nonreceipt of the check.
2. If the individual denies the endorsement is his/hers, the individual's signature on form PAFS-60 must be notarized. Have the individual and the notary sign form PAFS-60. File a copy of the signed PAFS-60 in the case record. Send the original signed PAFS-60 to the Family Self-Sufficiency Branch (FSSB) at:

Division of Family Support  
Family Self-Sufficiency Branch  
K-TAP Section  
275 East Main Street, 3E-1  
Frankfort, KY 40621

Form PAFS-60 is forwarded to the Treasury. The Treasury has the final decision regarding the replacement of a check that has been cashed. There is no time frame in which Treasury has to make the decision to issue the replacement.

3. If the individual fails to view the endorsement, send an e-mail to FSSB at [FSSBK-TAP@ky.gov](mailto:FSSBK-TAP@ky.gov) explaining that the individual failed to view the endorsement.

Failure to view the endorsement or sign form PAFS-60 does NOT affect the eligibility of the case.

- C. The FSS or designated individual must respond to FSSB within 10 calendar days from receipt of the request to view the endorsement.
- [D. If, within six months of the first replacement check, a second replacement check is requested by the client, follow the procedures for replacement check requests. In addition, change the mailing address for the checks to the local office address and require the individual to pick up checks at the local office for the next six months.]**

MS 0120                      CHECKS RECEIVED BY THE LOCAL OFFICE                      (1)

Checks may be mailed to the local office for the recipient to pick up. However, this should be done rarely and only with good cause.

- A. A log is maintained of all checks received in the local office. This log includes:
  - 1. Month of check;
  - 2. Check number;
  - 3. Payee name;
  - 4. Case number;
  - 5. Amount of the check; and
  - 6. Recipient signature, when the check is picked up by the recipient.
- B. Annotate the log to indicate the disposition of each check (i.e., cancelled or delivered to the recipient) and the date. It is extremely important that this log is updated daily with accurate information.
- C. If at the end of the month, the recipient has not picked up the check:
  - 1. Complete form PAFS-61, Notice of Returned Check and Authorization for Disposition, to cancel the check.

- [2. Forward form PAFS-61 and the check to:

Division of Family Support  
Family Self-Sufficiency Branch  
K-TAP Section  
275 E. Main Street, 3E-I  
Frankfort, KY 40621]

Annotate the envelope: DO NOT FORWARD

MS 0130

DOCUMENTATION

(1)

A Case Summary/System Comments screen is available on the KAMES Case/Pending Inquiry Menu. The purpose of this summary is to capture relevant case information and also reduce the amount of documentation staff is required to enter on the comments screen.

If verification in the case record does not conflict with system entries, further comment is not required. However, if verification in the case record conflicts with system entries, an explanation must be provided on the comments screen. Comments also need to address any unusual circumstances regarding the individual's situation.

The following is a list of items that should be addressed in case comments.

A. Documentation for all programs:

1. At application or recertification case comments **MUST** contain a statement that rights and responsibilities were explained and understood by the client and that all required forms were given to the client;
2. Resolution of Batch Matches and Spot Checks;
3. Unusual circumstances pertaining to:
  - a. The reason a request for a telephone or out-of-office interview is granted or denied;
  - b. Deviation in normal office operating procedures;  
  
Example: Individual applies on 7/1/08, but KAMES is down. A hardcopy application is taken and the action is not entered until 7/2/08.
  - c. Technical eligibility, program type, citizenship, household composition, or deviation from normal calculation procedures for income allocations (earned/unearned, countable/excluded);
  - d. A statement explaining persons included or excluded in the household;
  - e. A statement explaining the status of non-household and ineligible members and the consideration of their income and resources;
  - f. **[Clarifications and Program Inquiries from Central Office that address issues present in the case;]**
  - g. Reasons for any delays in case processing;
  - h. The reason for determining information is questionable and how this was resolved;

- i. Income verification and calculations that conflict with KAMES entries;
  - j. Inaccessible resources;
  - k. The household's voluntary request for a denial or discontinuance;
  - l. The contact number(s) used by households without telephone service;
  - m. The joint custody of children within the household;
  - n. The need for accommodation in the provision of services due to a mental or physical disability of a household member; or
  - o. A statement that an eligible member does not have any out-of-pocket medical expenses or chooses not to provide verification of the expenses, when a medical deduction is not considered.
- B. Additional documentation requirements relevant to particular programs are found in the appropriate volume.
- C. **[For ALL PROGRAMS, DO NOT editorialize, offer personal opinions or air disagreements in case comments. Case comments are a part of the official case record, which is subject to review by supervisory staff, Central Office, Quality Control, Management Evaluation staff, the Division of Administrative Hearings, Department of Medicaid staff, clients and their legal counsel.]**

\*MS 0131 ELECTRONIC INCOME VERIFICATION (EIV) (1)

Electronic Income Verification (EIV) is a method of obtaining verification of a client's earned income online. An online service may be used to assist clients when verification of earned income is not readily available and the client advises the worker that verification of the income is available by a free on-line service.

- A. It remains the client's responsibility to provide verification of earned income if information provided on an online service is incorrect or incomplete.
- B. EIV online services may have hidden fees that workers may not be aware of without completing additional research. Therefore, the online services must meet all of the following criteria:
  - 1. The online service must be free;
  - 2. The online service must not lead to a charge of any kind; and
  - 3. The information must be accessible to the caseworker directly.

If the EIV online service meets all of the criteria above, it can be used as an acceptable method of obtaining verification of a client's earned income. If the EIV online service does not verify the client's wages or is incomplete, follow normal verification procedures.

- C. DO NOT utilize or set up individual accounts on EIV online services that do not meet the criteria listed above. DO NOT use a client's username and password to logon to the client's online account to verify earned income OR allow a client to use state computer equipment to do so.

MS 0140

ACRONYMS

(1)

Following is a list of acronyms and the programs utilizing the term.

Initials	Meaning	Program
ABD	Aged, Blind, Disabled	MA, State Supp.
ABE	Adult Basic Education	KTAP
ABI	Acquired Brain Injury (Medicaid) Waiver Program	MA
ABAWD	Able-Bodied Adults Without Dependents	SNAP
ADA	Americans with Disabilities Act of 1990	All Programs
ADH	Administrative Disqualification Hearing	SNAP, Claims
AE	Administrative Error	Claims
BENDEX	Beneficiary Data Exchange	All Programs
BOW	Birth Out-of-Wedlock	KTAP, MA
BUA	Basic Utility Allowance	SNAP
CAA	Community Action Agency	KTAP, SNAP
CAN	Child Abuse/Neglect background checks	Kinship Care
CCAP	Child Care Assistance Program	All Programs
CCR&R	Child Care Resource and Referral Agencies, sometimes referred to as R&R	All Programs
CE	Categorical Eligibility	SNAP
CHFS	Cabinet for Health and Family Services	All Programs
CMS	Claims Management Section	All Programs
COLA	Cost of Living Adjustment	All Programs
COM	Community Service	KTAP
CSE	Child Support Enforcement	All Programs
CSV	Cash Surrender Value	MA
DCBS	Department for Community Based Services	All Programs
DCSR	Daily Case Status Report	All Programs
DDS	Disability Determination Services	MA
DFS	Division of Family Support	All Programs
DMS	Department for Medicaid Services	MA
DPP	Division of Protection and Permanency	KTAP, Kinship Care, MA
DOB	Date of Birth	All Programs
DVO	Domestic Violence Order	KTAP
EBT	Electronic Benefit Transfer	SNAP, KTAP, Kinship Care
ECF	Electronic Case File	All Programs

EEO	Equal Employment Opportunities	All Programs
EITC	Earned Income Tax Credit, also known as EIC	All Programs
EIV	Electronic Income Verification	All Programs
EPO	Emergency Protective Order	KTAP
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	MA
ESI	Employer-Sponsored Insurance	MA
ESL	English as a Second Language	KTAP
ETP	Employment and Training Program	SNAP
FAD	Family Alternatives Diversion	KTAP
FCH	Family Care Home	MA, State Supp.
FEIN	Federal Employer Identification Number	KTAP
FFY	Federal Fiscal Year	All Programs
FICA	Federal Insurance Contributions Act	All Programs
FLSA	Fair Labor Standards Act	KTAP
FMV	Fair Market Value	MA
FNS	Food and Nutrition Service	SNAP
FPL	Federal Poverty Level	All Programs
FRYSC	Family Resource and Youth Services Center	KTAP
FSSB	Family Self-Sufficiency Branch	All Programs
FTI	Federal Tax Information	All Programs
GED	General Equivalency Diploma	KTAP
HCBS	Home and Community Based Services (waiver program)	MA
HHS	Health and Human Services	KTAP, MA
HIPAA	Health Insurance Portability and Accountability Act of 1996	All Programs
HUD	Department of Housing and Urban Development	All Programs
HW	Homecare Waiver	MA
ICF/MR/DD	Intermediate Care Facility/Mental Retardation/ Developmentally Disabled	MA
ICPC	Interstate Compact on the Placement of Children	KTAP, MA, Kinship Care
IDA	Individual Development Account	KTAP
IEVS	Income and Eligibility Verification System	All Programs
IHE	Inadvertent Household Error	SNAP
IMD	Institution for Mental Diseases	MA
IPV	Intentional Program Violation	SNAP
IRS	Internal Revenue Services	All Programs
JRA	Job Readiness Training	KTAP
KAMES	Kentucky Automated Management and Eligibility System	All Programs



KAR	Kentucky Administrative Regulation	All Programs
KASES	Kentucky Automated Support and Enforcement System	All Programs
KC	Kinship Care	[KC, KTAP, SNAP]
KCD	Kentucky Claims Debt Management System	Claims
KCHIP	Kentucky Children's Health Insurance Program	MA
KCTCS	Kentucky Community and Technical College Systems	KTAP
KEUPS	Kentucky Enterprise User Provisioning System	All Programs
KMA	Kentucky Medical Association	MA
KMP	Kentucky Medicaid Program	MA
KPC	Kentucky Physicians Care Program	MA
KRS	Kentucky Revised Statutes	All Programs
K-TAP	Kentucky Transitional Assistance Program	All Programs
KWP	Kentucky Works Program	KTAP
LEP	Limited English Proficiency	All Programs
LIHEAP	Low Income Home Energy Assistance Program	[SNAP]
LOC	Level of Care	MA
LTC	Long Term Care	MA
MA	Medicaid/Medical Assistance	All Programs
MAID	Medicaid Identification Card	MA
MCO	Managed Care Organization	MA
MRT	Medical Review Team	KTAP, MA
MSBB	Medical Support and Benefits Branch	MA, State Supp.
[NAB	Nutrition Accountability Branch	SNAP]
NCLEX	National Council Licensure Examination	KTAP
NCP	Non-custodial Parent	KTAP, MA
NEMT	Non-Emergency Medical Transportation	MA
OAG	Office of Attorney General	All Programs
OATS	Office of Administrative and Technology Services	All Programs
OIG	Office of Inspector General	All Programs
OJT	On-the-Job Training	KTAP
OTIS	Online Tracking Information System	KTAP
OVR	Office of Vocational Rehabilitation	KTAP
PA	Public Assistance	All Programs

PAPS	Public Assistance Program Specialist	All Programs
PASS	Plan for Achieving Self-Support	MA
PCA	Personal Care Assistance	MA, State Supp.
PCH	Personal Care Home	MA, State Supp.
PL	Public Law	All Programs
PRO	Peer Review Organization	MA
PRO-Cert	PRO-Certification	MA
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996	All Programs
PRTF	Psychiatric Residential Treatment Facility	MA
QC	Quality Control	All Programs
QDWI	Qualified Disabled Working Individuals	MA
QIT	Qualifying Income Trust	MA
QMB	Qualified Medicare Beneficiaries	MA
QP	Qualifying Parent	KTAP, MA
R & R	Rights and Responsibilities	All Programs
RAP	Relocation Assistance Program	KTAP
RDS	Report Distribution System	All Programs
RFI	Request for Information	All Programs
RN	Registered Nurse	KTAP
RSDI	Retirement, Survivors, or Disability income	All Programs
RTW	Ready-to-Work Program	[KTAP, SNAP
SAFE or SF	Simplified Assistance for the Elderly	SNAP]
SAVE	Systematic Alien Verification for Entitlement	All Programs
SCL	Supports for Community Living Waiver Program	MA
SDX	State Data Exchange	All Programs
SFU	Standard Filing Unit	KTAP, MA (E&T only)
SLMB	Special Low Income Medicare Beneficiaries	MA
SNAP	Supplemental Nutrition Assistance Program	[SNAP]
SOLQ	State On-Line Query	All Programs
SP	Second Parent	KTAP, MA
SR	Specified Relative	KTAP, MA
SR	Simplified Reporting	[SNAP]
SRA	Service Region Administrator	All Programs
SRAA	Service Region Administrator Associate	All Programs
SSA	Social Security Administration	All Programs
SSI	Supplemental Security Income	All Programs
SSN	Social Security Number	All Programs

SST	Short-term Training	KTAP
SUA	Standard Utility Allowance	<b>[SNAP]</b>
SYETP	Summer Youth Employment and Training Program	All Programs
TAA	Transitional Assistance Agreement	KTAP
TANF	Temporary Assistance for Needy Families	KTAP
TAP	Targeted Assessment Program	KTAP
TDD/TTY	Telecommunications Device for the Deaf and Hard of Hearing	All Programs
TMA	Transitional Medical Assistance	KTAP, MA
TOP	Treasury Offset Program	Claims
TPL	Third Party Liability	KTAP, MA
TPR	Termination of Parental Rights	KTAP, MA
UI	Unemployment Insurance	All Programs
UIB	Unemployment Insurance Benefits	All Programs
UP	Unemployed Parent	KTAP, MA
USC	United States Code	All Programs
USDA	United States Department of Agriculture	<b>[SNAP]</b>
VA	Veterans Administration	All Programs
VISTA	Volunteers In Service To America	All Programs
VR	Vocational Rehabilitation	KTAP
WEP	Work Experience Program	<b>[KTAP, SNAP]</b>
WIA	Workforce Investment Act	All Programs
WIC	Women, Infant, and Children	All Programs
WIN	Work Incentive Reimbursement	KTAP

MS 0150

CONFIDENTIALITY REQUIREMENTS

(1)

Disclosure of information concerning applicants and recipients of assistance or services from the Department is limited to purposes directly connected with the administration of the program. Such purposes include establishing eligibility, determining amount of assistance, and providing services.

- A. Recipients must be protected from harassment and exploitation for political or commercial purposes. Case records or listings of recipients may not be open for public inspection or used in any manner so as to become a part of public record.
- B. Respect the recipient's right to privacy.
  - 1. Do not conduct interviews with other individuals present unless the recipient consents.
  - 2. Do not discuss or disclose information about the recipient with a collateral contact.
  - 3. Do not discuss case situations informally or outside the office setting.
  - [4. Do **not** provide any information by e-mail to the recipient. If you receive an e-mail from a recipient, respond with the following message: "I am not allowed to respond to e-mails regarding confidential information. Please call 1-855-306-8959 or come in to the local office to discuss your request for information." Before sending the e-mail, remove all confidential information, such as client name, SSN, or address, from the original e-mail including the subject line.
- C. All e-mail communication must be **encrypted before** it is sent outside of the state government e-mail system. Case information, including Personal Health Information (PHI), **cannot** be sent via unencrypted e-mail to agencies outside of the state government e-mail system. Encrypted communication is not sent to a recipient.
  - 1. All e-mail messages should include the following confidentiality notice:

"This electronic message is intended to be for the use only of the named recipient, and may contain information that is confidential or privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above, and delete and destroy all copies of this message. Thank you."

This notice can be added to the signature block of the e-mail if an automated signature is used.

2. Prior to the release of case information:
    - a. The recipient must complete form DCBS-1A, Informed Consent and Release of Information and Records Supplement, before PHI can be released by DCBS.
    - b. Before an outside agency can release PHI to DCBS, the outside agency must have the form DCBS-2, Informed Consent and Release of Information and Records, by the recipient.
  3. Do not send PHI in the subject line of any e-mail message whether encrypted or not. This includes the name or any corresponding record number.
  4. Before attaching a document to the message, double check the document to determine that it is the correct one.
  5. Before sending the e-mail, check to ensure no unintended information is included.】
- D. Forms and/or information utilized in the voter registration process are to remain confidential and be used only for voter registration purposes.
- E. Any person who violates requirements regarding confidentiality is subject to a fine of not less than \$50 and not more than \$200, or imprisonment for not more than 6 months, or both.

For additional information regarding HIPAA, refer to MS [0160](#).

For additional requirements regarding safeguarding IRS information, refer to [MS 0680](#).

MS 0160\* HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY  
ACT COMPLIANCE REQUIREMENTS

The Department for Community Based Services (DCBS) must comply with provisions of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA information is available on the internet at <http://www.hhs.gov/ocr/privacy/index.html>

- A. The HIPAA component which impacts DCBS staff administering Family Support programs is the safeguarding of an individual's health information.
- B. The term "health information" relates to any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse. Health information relates to the past, present or future physical or mental health or condition of an individual; to the provision of health care to an individual; or to the past, present, or future payment for the provision of health care to an individual.
- C. Examples of safeguards that apply to covered entities and that are mentioned in the preamble to the HIPAA Privacy Rule are;
  1. Shredding documents prior to disposal;
  2. Locking doors or cabinets where medical records are kept;
  3. Limiting access to the keys or combinations of the locks for these doors or cabinets;
  4. Turning computer screens away from public view;
  5. Locking or logging off computer monitors when they are not being used;
  6. Never giving health information to a third party who is not an authorized representative;
  7. Monitoring the duplication and transmission of health records on fax machines, photocopiers, and printers;
  8. Keeping records containing health information face down on desks and tables;
  9. When sending a fax containing health information, first call the recipient so the fax will be picked up immediately; and
  10. Speaking softly so that others do not overhear health information.

MS 0170

SUBPOENAED INFORMATION

(1)

Never give case record information from any program as testimony in court without a court order or subpoena unless certain provisions exist.

A. The provisions that allow case record information to be shared as testimony are:

1. Court action involves an appeal of an Agency decision to circuit court; or
2. The Cabinet or the Department for Community Based Services (DCBS) is the initiator of court action, including but not limited to fraud or unsuitable home actions initiated by Protection and Permanency, or child support actions initiated by Child Support Enforcement.

[B. There are several types of requests for information used by our judicial system. Guidance regarding what can or cannot be disclosed based on the type of subpoena may be obtained from the Regional attorneys or, if the Regional attorney is unavailable or cannot help, the Cabinet's Office of Legal Services (OLS) in Central Office. A list of Regional attorneys is found at <https://chfsnet.ky.gov/ols/Pages/home.aspx>.

1. Contact the Regional attorney or OLS at (502) 564-7905 immediately upon receipt of a subpoena. If time permits, the Regional attorney/OLS will assist. If time does not permit OLS assistance, take the following action:
  - a. If the subpoena requests a Family Support worker to appear in court, the worker must appear in court with the requested information as directed. In addition, the worker should take a copy of KRS 205.175 found at <http://www.lrc.ky.gov/KRS/205-00/175.PDF> and explain to the judge that all Family Support case records are confidential pursuant to KRS 205.175 and can only be released by court order. If the judge orders the release of the information, the worker must comply.
  - b. If the subpoena requests a Family Support worker to appear in a setting other than the courtroom or in the presence of a judge, the employee must appear as directed and advise that all DFS case information is confidential pursuant to KRS 205.175 (<http://www.lrc.ky.gov/KRS/205-00/175.PDF>) and can only be released to a judge by a court order. (See Vol. III, MS 2040 if the individual presents a court order);
  - c. If the subpoena requests release of information contained in the case file and the individual requesting information is acting on behalf of the Cabinet, such as a county attorney involved in child support activities, provide the requested information.

2. Grand jury subpoenas are not court orders and while a judge is not present at the proceeding, information may be released to the grand jury only if the investigation involves alleged fraud in benefits programs administered by the Cabinet. Use the following information when a grand jury subpoena is received.
  - a. The requested information can be provided to the prosecuting attorney or given during the grand jury appearance.
  - b. ALL information, requested by and provided to the grand jury, is confidential. NO aspect of any case is to be discussed with anyone outside the grand jury proceedings.
  - c. If the investigation is for other criminal actions, contact OLS for guidance prior to the grand jury hearing.
  - d. Failure to follow these instructions will cause the individual named in the subpoena to be held in contempt.]
- C. For specific information regarding the requirements relating to the general release of Supplemental Nutrition Assistance Program (SNAP) material see Volume II, [MS 7200](#).
- D. For specific information regarding the requirements relating to the general release of K-TAP, Medicaid, and other federally funded programs material, see Volume III, [MS 2040](#) for K-TAP and other TANF funded programs and Volume IV, [MS 1100](#) and Volume IVA, [MS 1235](#) for Medicaid.



MS 0180                                      VIEWING OF CASE RECORD MATERIAL BY                                      (1)  
RECIPIENTS AND REPRESENTATIVES

- A. [The following portions of the case record may be viewed at any time by the client or a representative designated by the recipient on form DCBS-1, Informed Consent and Release of Information and Records, or the DCBS-1A, Informed Consent and Release of Information and Records Supplement:
1. Forms completed or provided by the client;
  2. Worksheets used in the eligibility determination;
  3. Correspondence to and from the client;
  4. Decisions from the Medical Review Team;
  5. Non-confidential medical records of the client;
  6. KASES print-outs verifying child support payments. (Option 21)
- B. The following portions of the case record cannot be viewed unless the client obtains a court order:
1. Medical records marked as “confidential – not to be viewed or shared with the patient”;
  2. Names of individuals who provided information regarding the client;
  3. The nature or status of criminal proceedings;
  4. Records subject to HIPAA procedures. For more information regarding HIPAA see Volume I, [MS 0160](#);
  5. Child support screens which contain the absent parent’s tax refund information.
- C. Case record inspection is conducted in any local office with care taken that no part of the record is lost. Electronic case file (ECF) documents must be printed for viewing. The client, POA, authorized representative, or attorney cannot view the case material from the computer screen. If requested, copies of the record pertinent to the issue are prepared for and provided to the client or representative at any local office. Case material cannot be provided through e-mail or mail. The only exception to sending case material via mail is for a telephonic hearing.
- D. Information needed for settlement of a deceased client’s affairs may be released to a bona fide representative or administrator of an estate but are still subject to HIPAA requirements, see Volume I, [MS 0160](#).]

MS 0190

AGREEMENT TO SAFEGUARD INFORMATION

(1)

An agency, organization, or school may obtain recipient information if a Memorandum of Understanding (MOU) Safeguarding Information in Public Assistance Programs and Business Associate Agreement has been completed with the Department for Community Based Services (DCBS). These are confidentiality agreements that are negotiated and maintained by staff in the Division of Family Support (DFS).

- [A. To qualify to enter into an MOU, a requesting agency must meet the following criteria: ]
1. The agency must be federally funded;
  2. The agency must provide needs-based services, where eligibility is based on an income test; and
  3. Staff of the agency must be subject to the same confidentiality requirements as Cabinet employees.
- B. Examples of agencies that meet the above criteria include public housing authorities and public Boards of Education.
- C. Organizations which do not meet the criteria include churches, associations sponsored by religious groups, civic clubs, United Way, the Red Cross, individuals such as temporary help in the local offices, custodians, guards, repairmen, summer workers, landlords, or students working on research papers. Case information can only be released to these groups/individuals if the recipient completes form DCBS-1, Informed Consent and Release of Information and Records, or DCBS-1A Supplement.
- [D. If an agency/organization/school meeting requirements in item A, requests client information and does not have a current signed MOU agreement with DCBS, contact the Policy Development Branch (PDB) at [PolicyDevelopment@ky.gov](mailto:PolicyDevelopment@ky.gov).
- E. Staff in PDB:
1. Will initiate completion of the MOU directly with the agency; and]
  2. Send out renewal agreements every two years to agencies which have an existing MOU.
- F. A listing of all currently active confidentiality agreements is maintained with DFS. To inquire about the status of a confidentiality agreement, contact the PDB at [PolicyDevelopment@ky.gov](mailto:PolicyDevelopment@ky.gov).

MS 0200 [COMPLAINT MODULE ON WORKER PORTAL (1)

The Complaint Module is a method by which the Cabinet for Health and Family Services (CHFS) complies with a Food and Nutrition Service mandate to track client contacts and complaints. Entries are made on the module for all individuals who contact the cabinet for assistance concerning an issue with a case. All field staff within CHFS with user access to Worker Portal (WP) have access to the Complaint Module.

Access the Complaint Module by signing onto WP and navigating to the Case Summary Screen. From Tools, select 'Complaints' from the drop down. Options for a new Complaint entry or a Complaint Search are available.

The complainant is defined as the person making contact. The complainant can be making a formal complaint or may be inquiring about his/her or another person's case. Before a complainant is entered into the Complaint Module, conduct a thorough search in the Complaint Module via the Complaint Search selection to determine if the same complaint has been previously entered.

It is critical that all users strive to keep the data that is entered into the Complaint Module current at all times. There may be duplicate entries for a complainant if they have made different points of contact or called multiple times.]

MS 0210

CIVIL RIGHTS OVERVIEW

(1)

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policies, the Department for Community Based Services and contracted vendors can not discriminate against any person in the provision of services and benefits on the basis of political beliefs, race, color, national origin, religion, age, mental or physical disability or sex.

A. Policies and practice must conform to the following statutes:

1. Title VI of the Civil Rights Act of 1964 which protects individuals from discrimination on the basis of race, color, or national origin in any program or activity that receives federal funding. Specific discriminatory actions prohibited under Title VI include:
  - a. Providing services more limited in scope or lower in quality; or
  - b. Limiting participation in a program.
2. Section 504 of the Rehabilitation Act of 1973 protects a qualified individual with a disability from discrimination in the provision of any benefit or service provided under any program or activity receiving federal funds. Discriminatory actions prohibited under this authority may include:
  - a. Denying a qualified individual with a disability an aid, benefit or service that is provided to others.
  - b. Providing a different or separate aid, benefit or service to a qualified individual with a disability, unless such action is necessary to ensure that the aid, benefit or service is equally effective as those provided to others.
3. Title II of the Americans with Disabilities Act of 1990 prohibits discrimination on the basis of disability in programs and activities of all state and local governments. Specific discriminatory actions may include:
  - a. Imposing eligibility criteria that screens out or tends to screen out an individual with a disability from fully or equally enjoying any program or activity, unless such criteria is shown to be necessary.
  - b. Providing a qualified individual with a disability with an aid, benefit or service that is not as effective in affording equal opportunity to gain the same result or reach the same level of achievement as that provided others.
  - c. Administering programs, services, and activities in the most integrated setting that is not appropriate to the needs of qualified individuals with disabilities.

4. The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance.
  5. Discrimination on the basis of religion is prohibited by a number of Federal laws and regulations.
- B. Ensure the following general requirements are met in the provision of all services and benefits to applicants and recipients:
1. Do not discriminate against any individual for reasons of age, race, sex, disability, religious creed, national origin or political belief in any aspect of program operation, including but not limited to the application process, benefit or claims determination, hearings, employability assessments, or work program components.
  2. Explain and provide the Civil Rights pamphlet at application and any time the individuals question or do not understand their rights. The pamphlet can be accessed at: <https://chfsnet.ky.gov/ohrm/Pages/ClientCivilRights.aspx>.
  3. Provide assistance to an individual needing accommodation due to a physical or mental disability he or she or another household member currently has or had in the past. A disability is a physical or mental impairment that substantially limits one or more of an individual's major life activities, having a record of such impairment, or being regarded as having such an impairment. Definitions of common disabling conditions and suggested accommodation, as well as other information relating to Title II of the Americans with Disabilities Act, can be found at [www.ada.ky.gov](http://www.ada.ky.gov).
  4. Document the need for and provision of any accommodation in the case record. If appropriate, mark "Y" on the KAMES disposition screen to "Are Special Interviews Required?" and enter the appropriate code.
- C. Accommodation in the provision of benefits and services may include, but is not limited to:
1. Visiting an individual's home to conduct interviews.
  2. Scheduling interviews that do not conflict with disability related appointments of the applicant/recipient or a disabled member of the household.
  3. Rescheduling interviews if notified a conflict exists with disability related appointments.
  - [4. Making reminder calls regarding appointments or needed information. For special interviews coded 'VI'-Visually Impaired/Blind, the code appears on the appointment calendar for cases due for recertification reminding workers to call the individual. Document case comments when the call is made.]

5. Reading and/or explaining letters and forms to an applicant/recipient.
  6. Providing a sign language interpreter for a deaf or hard of hearing applicant or recipient. See [MS 0220](#).
  7. Allowing flexibility in the required hours of participation and component placement in work activities.
  8. Providing extra space in the interview area to allow for medical equipment such as a walker, oxygen tank, wheelchair, etc.
  9. Providing an interpreter for an individual who does not speak or understand English. See [MS 0230](#).
  10. Providing other individualized assistance on a case-by-case basis to ensure the applicant/recipient is provided equal access to benefits and services.
- D. Assist applicants and recipients who feel discriminated against in filing a complaint. Refer to [MS 0240](#).

MS 0220

INTERPRETER SERVICES FOR DEAF AND  
HARD OF HEARING INDIVIDUALS

(1)

- A. All staff is required to make reasonable accommodations to ensure all services are accessible to individuals with a disability. A deaf or hard of hearing individual applying for program benefits must have interpreter services made available, at no cost to the individual, upon request. If interpreter services cannot be provided at the time requested, arrange for program services to be provided as soon as an interpreter is available.

When interpreter services are needed for a deaf or hard of hearing individual, do the following:

1. Document the case that the individual requires interpreter services and indicate how these services were provided. Mark "Y" on the KAMES disposition screen to "Are Special Interviews Required?" and enter the appropriate code.
2. [At application, reapplication and recertification, provide the individual with forms CHFS-OHRM-EEO-2, Your Right to Effective Communication, and CHFS-OHRM-EEO-3, Waiver of Interpreting Services. Document in the case record that the forms were sent/given to the individual. Additionally, if completed, scan form CHFS-OHRM-EEO-3 into the Electronic Case File (ECF) and provide the individual with the original.]
3. If available, use qualified on-site personnel. A qualified interpreter is an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary. There are three types of interpreters:
  - [a. Certified Deaf Interpreter (CDI) – used for a deaf or hard-of-hearing individual, who is able to assist in providing an accurate interpretation using sign language. This includes Video Relay Services (VRS);]
  - b. Deaf/Blind Interpreter – used for a deaf and blind individual who places her/his hands over the hands of the interpreter in order to read signs through touch and movement; or
  - c. Oral Interpreter – used for a deaf or hard of hearing individual who can lip read.
4. Request interpreter assistance from a local school or social service agency; or
5. Request services from the Kentucky Commission for the Deaf and Hard of Hearing (KCDHH) Access Center. The Access Center is a language interpreter referral service for state agencies. Information about services available from the Access Center is located at <http://www.kcdhh.ky.gov/oea/access.html>.

- [a. The client may have the telephone equipment to use VRS. VRS is a qualified interpreter service. Form CHFS-OHRM-EEO-3 is not completed for this service.]
- b. To request an interpreter go to <http://www.kcdhh.ky.gov/forms/> and click on "interpreter/captioner". Complete the request form and submit. Notification is sent once the Access Center has received the request. Another notice is sent within a few days to confirm that an interpreter has been scheduled. Because it may take up to two weeks to schedule an interpreter, the worker should request the interpreter when scheduling appointments.

When requesting an interpreter from KCDHH, provide the following information:

- 1) Your name, address and phone number;
  - 2) The date services are needed;
  - 3) The time (beginning and estimated end time);
  - 4) The location of assignment;
  - 5) Type of assignment (application, meeting, etc.)
  - 6) Name of individual needing services;
  - 7) Individual's preferred mode of communication, if known; and
  - 8) Billing information (name, address and phone number).
6. At application, reapplication and recertification, or at any time an interpreter service is used, have the individual performing the interpreter service complete the confidentiality form, Business Associate Agreement. Scan a copy into ECF.
- B. In situations when a service is performed by a licensed interpreter and a fee is charged, each interpreter has his/her own billing statement. State employees and unlicensed interpreters provided by the individual (e.g., family members, friends, etc.) are not paid for their interpretation services.
1. Obtain a signed billing statement from the licensed interpreter which includes:
- a. Name of interpreter;
  - b. Social Security number or federal identification number;
  - c. Address, telephone, and email, if available;
  - d. Purpose of the assignment;
  - e. Date the service was provided; and
  - f. Amount of fee. The fee includes:
    - 1) The hourly rate includes time spent in travel, time spent interpreting, and mealtime. Mealtime cannot exceed one hour. Interpreters shall also be paid for at least two hours of service which can include waiting time due to delays in appointments and when an individual does not appear for the appointment.
    - 2) The number of miles traveled to and from the assignment and the mileage rate. Mileage is paid at the state rate.
    - 3) The cost for lodging, if appropriate.
  - g. The grand total;
  - h. Contact information of the worker to verify the service was provided; and



- i. Signature of the interpreter
2. A prevailing hourly rate for interpreter fees is:
    - a. \$40 to \$50 for services provided between 8:00 am and 5:00 pm Monday through Friday; and
    - b. \$45 to \$55 for services provided between 5:00 pm and 8:00 am Monday through Friday and 5:00 pm Friday through 8:00 am Monday or on state holidays.

If the interpreter's fees exceed the prevailing rate, determine if there is another interpreter available. If none is available, contact the Family Self-Sufficiency Branch through Regional office.

- [3. After service is rendered, scan the signed billing statement with a completed CHR-101 stamp or form CHR-101, and e-mail to Joann Hatcher in General Accounting, Accounts Payable Branch at [joann.hatcher@ky.gov](mailto:joann.hatcher@ky.gov).]

MS 0230 LIMITED ENGLISH PROFICIENCY (LEP) (1)

The Cabinet must ensure all individuals with Limited English Proficiency (LEP) have access to all programs and services administered by the Cabinet. LEP individuals are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. Each local office must post notices in multiple languages in the reception and waiting areas to inform the public of the availability of free interpreter services.

Use the following policy and procedures to identify LEP individuals and to provide LEP services to those individuals.

A. When an individual comes into the local office to apply:

1. Ask the individual what his/her primary language is. Based on the individual's statement, enter the appropriate code for the language block on KAMES Member General Information screen. Do not assume an individual does not speak or understand English or assume the individual's primary language based on appearance. If the individual does not speak or understand English, use the "I Speak" language identification posters to determine the primary language; and
2. Inform the LEP individual that interpreter services are available at no cost to the individual using the "I Speak" posters.
3. [If the individual indicates a primary language other than English and refuses interpreter services provided by the agency, have the individual complete the form, Waiver of Interpreter Services – Limited English Proficiency (LEP). This form can be accessed at <https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.]

B. If an individual cannot understand verbal or written English, use one of the following options to access interpreter services:

1. Language Access Section. If a Spanish-speaking interpreter or document translation is needed, contact the Language Access Section (LAS) at (502) 564-7770. LAS staff are available during regular work hours and can be scheduled in advance. For example, if a Spanish-speaking individual needs to be recertified, the worker should schedule a LAS interpreter for the recertification appointment.

When no Spanish speaking interpreter is available through LAS, use the Language Services Associates, Inc., item 4 of this section.

2. CHFS Qualified Interpreter Service. If LAS staff is not available, choose an interpreter from the CHFS approved list of Cabinet employees who are qualified to provide interpreter services. The list can be accessed at: <https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>
3. CHFS Qualified Community Based Partner Interpreters. If neither a LAS interpreter nor a CHFS qualified interpreter is available, contact a qualified non-CHFS interpreter. This resource can provide interpreter services for a variety of languages, including Spanish. The list can be accessed at: <https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.

These services usually involve a cost. To pay for these services, scan a signed billing statement from the interpreter with a completed CHR-101 stamp or form CHR-101, and e-mail to the [CHFSPayablesBranch@ky.gov](mailto:CHFSPayablesBranch@ky.gov).

4. Language Services Associates, Inc. (LSA). If none of the resources in items 1, 2 or 3 can provide interpreter services for the LEP individual, use the LSA. Contact staff in the local office designated to access LSA to arrange for the service. The instructions for the LSA may be accessed at <https://chfsnet.ky.gov/ohrm/Pages/LanguageAccessSection.aspx>.
- C. If the individual wants to use another individual to interpret for him/her, contact a Cabinet approved interpreter, if available, to sit in on the interview. Explain to the individual that an approved interpreter is used even though he/she has another interpreter to ensure all the information, questions and responses are interpreted correctly and without bias.
- D. If a form is identified as needing translation into another language, forward the request for translation of the form to the Division of Family Support through the Regional Office.
- E. Document in the case record and on KAMES or OTIS when interpreter services are needed and used. Documentation should include:
1. Flagging the case that special interviews are required on the KAMES disposition screen.
  2. Date when services are requested and provided;
  3. What option is used; and
  4. Reason for the service, such as application or recertification interview, interim communications, or translation of forms or other written material.
- F. Each contact which requires LEP services is entered on the online LEP Interaction form according to the Region's monitoring plan. This information is used to identify what LEP services are needed for the region. Access the tool at: <https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.
- G. Make copies of "Know Your Rights" and have them available in the local waiting area. This brochure is available in ten languages and can be found at <https://chfsnet.ky.gov/ohrm/Pages/LanguageAccessSection.aspx>. The brochure must be downloaded from the website with copies made for distribution.

MS 0240

CIVIL RIGHTS COMPLAINTS

(1)

Any individual who feels discriminated against may file a complaint. Assist the individual in filing a complaint with any or all of the entities listed below. Retaliation against an individual who submits a complaint or assists in the investigation of a complaint or interference in the investigation of complaint is prohibited by law. An employee who is determined to be in violation is subject to disciplinary action, up to and including dismissal.

- A. Use the Fair Hearing process if the individual alleges denial of eligibility because of agency policy or a discriminatory application of agency policy.
- B. Use form [CHFS-OHRM-EEO-1](#), [CHFS Client Civil Rights Complaint Form](#), if the individual alleges discrimination in the manner in which services are provided or refusal of access to services.
- C. If form [CHFS-OHRM-EEO-1](#) is submitted to the local office forward it to the local Equal Employment Opportunities (EEO) counselor. The local EEO counselor routes to the DCBS, EEO Counselor Coordinator, the Service Region Administrator, and:

EEO/Civil Rights Compliance Branch  
275 East Main Street, 5C-D  
Frankfort, Kentucky 40621  
Telephone: (502) 564-7770  
Fax: (502) 564 3129

- [D. In addition to or in place of filing a complaint with the Cabinet, when discrimination is alleged in the provision of Supplemental Nutrition Assistance Program (SNAP) benefits the individual may file a complaint with the U. S. Department of Agriculture by writing or calling: ]

USDA, Director, Office of Civil Rights  
1400 Independence Avenue, S.W.  
Washington, D.C. 20250-9410  
(800) 795-3272 (voice) or (202) 720-6382 (TTD)

The complaint should be filed within 180 days of the alleged discriminatory action. Only the U. S. Secretary of Agriculture can extend the time frame under special circumstances.

- E. In addition to or in place of filing a complaint with the Cabinet, when discrimination is alleged in the provision of TANF funded programs (K-TAP, FAD, WIN, Kinship Care, Kentucky Works) or Medicaid, the individual may file a complaint by writing or calling:

U.S. Department of Health and Human Services  
Region IV Office for Civil Rights  
61 Forsyth Street, SW.-Suite 3B70  
Atlanta, Georgia 30323  
(404) 562-7886 (voice) or (404) 331-2867 (TTD)

- F. Civil rights complaints may also be filed by writing or calling the:

Kentucky Commission on Human Rights  
The Heyburn Building  
Suite 700, 332 W. Broadway  
Louisville, Kentucky  
(800) 292-5566 (voice) or (502) 595-4084 (TTD)

- G. When the individual chooses to file a complaint with entities other than the Cabinet, recommend that the following information be included in the complaint in order to help in the investigation:
1. The name, address, and phone number of the person alleging discrimination.
  2. The name and location of the office or contractor where the discrimination took place.
  3. The nature of the incident, action, or aspect of program administration that led to the complaint.
  4. The reason for the alleged discrimination i.e. age, race, sex, disability, religious beliefs, national origin, political beliefs.
  5. The names, titles, and addresses of witnesses or persons who have knowledge of the alleged discriminatory acts.
  6. The date(s) when alleged discriminatory actions occurred.
- H. Advise the EEO/Civil Rights Compliance Branch, referenced in item C, of any discrimination complaints filed with agencies outside the Cabinet.
- I. Complaints are investigated and resolved by the agency where the complaint is filed.

MS 0260

OVERVIEW OF EBT

(1)

[The method used by the Department for Community Based Services to make benefits and payments available to eligible households is the Electronic Benefit Transfer (EBT) card.

- A. The EBT card is used to access the following:
  - 1. SNAP benefits;
  - 2. K-TAP benefits;
  - 3. Kinship Care benefits;
  - 4. KWP transportation payments; and
  - 5. WIN reimbursement payments.
  
- B. Acronyms used in relation to the EBT system are: ]
  - 1. ATM - Automated Teller Machine
  - 2. CSR - Customer Service Representative
  - 3. EBT - Electronic Benefit Transfer
  - 4. FNS - Food and Nutrition Service
  - 5. IVR - Interactive Voice Response
  - 6. PIN - Personal Identification Number
  - 7. POS - Point of Sale

MS 0270

REQUIRED EXPLANATIONS OF EBT

(1)

During the certification interview, provide the household with the following explanations about EBT and the use of the EBT card and PIN:

- A. EBT is the system used to deliver SNAP, K-TAP and Kinship Care benefits and KWP transportation and WIN payments in Kentucky. EBT provides a safer, more secure method for recipients to receive benefits. EBT also eliminates the need to mail or have the recipients pick up benefits each month. Benefits are simply added to the recipient's EBT account when an issuance is processed and are automatically available on the EBT card.
- B. EBT cards are the size and shape of typical bank credit cards. The card is red, white and blue with an American flag design. The EBT card contains the recipient's name and the EBT card number.
- C. All EBT cards are mailed with an inactive status. The card should be received in approximately 7 days. When the recipient receives the EBT card, a sticker is attached to the card, advising the recipient to call the Customer Service Representative (CSR) to activate the card. THE CARD DOES NOT WORK UNTIL IT IS ACTIVATED.
- D. Only one EBT card is issued per individual regardless of the number of cases in the individual's name and SSN. Individuals who have an active EBT account for one type of benefit will not have a separate EBT account or be issued a separate EBT card for other types of benefits. The same EBT card is used to access SNAP, K-TAP and Kinship Care benefits and KWP transportation and WIN payments.

For KWP transportation and WIN payments, if there are two individuals in the K-TAP case who are receiving either payment, each individual will have an EBT account.

Example 1: Mom has a K-TAP, SNAP and Kinship Care case. All three cases are in her name and SSN. Mom is issued one EBT card for all benefits.

Example 2: Mom and Dad have a K-TAP and SNAP case in Dad's name and SSN. Mom has a Kinship Care case in her name and SSN. Dad is issued an EBT card for the K-TAP and SNAP benefits. Mom is issued an EBT card for Kinship Care benefits.

Example 3: Mom and dad have a K-TAP and SNAP case. The cases are in mom's name and SSN. Both mom and dad are working and receive transportation payments. Mom's payments are posted to the EBT account along with the K-TAP and SNAP benefits. Dad has his own EBT account and card for his transportation payments.

- E. The EBT card is mailed in a card carrier, which is a two-sided heavy paper folder with slots cut to hold the card in place during mailing. Supplemental

EBT educational information is printed on the card carrier covering such subjects as:

1. How and where to use the card;
  2. How and when to use the CSR;
  3. How to protect the card;
  4. The need for PIN security; and
  5. A non-discrimination statement.
- F. SNAP households may designate a representative to receive and use the EBT card. Naming an EBT representative allows that person to contact the Customer Service Representative on the recipient's behalf. If the household designates two representatives, one to apply for benefits and the other to use the EBT card, have the household specify which representative is to use the EBT card. The representative who applies for the benefits is entered first on the KAMES screen and the EBT representative is entered second on the screen. Authorized representatives are not issued their own EBT card.
- G. The EBT system distributes benefits to recipients through POS terminals located in authorized retailers. EBT system problems are handled by customer service support 24 hours a day, 7 days per week for recipients and retailers.

Cash benefits on the EBT system can be accessed as follows:

1. [The EBT card cannot be used for any cash benefit transactions or withdrawals from ATM's in liquor stores, adult-oriented entertainment establishments, or any casino, gambling casino or gaming establishment.]
  2. The individual can withdraw cash at an Automatic Teller Machine (ATM) which displays the Quest logo. The individual gets one free withdrawal per month. The individual is charged a fee of 85 cents per withdrawal for subsequent withdrawals. The individual will also be assessed normal bank charges if the ATM charges a processing fee. The fee is deducted from the EBT account.
  3. The individual can withdraw cash at a retailer's point of service (POS) terminal at authorized retailers with no charge at the time of a retail purchase. Individuals cannot request cash back from the SNAP benefits portion of the EBT account.
- H. Give all households authorized to receive benefits the toll-free telephone number when problems arise with their card and/or PIN. The CSR telephone number is 1-888-979-9949. The number is printed on the back of the EBT card and on the training material the recipient receives in the mail.



- I. The CSR is operational 24 hours a day, 7 days a week and is voice automated. Recipients may call from a touch-tone phone or a rotary dial phone. If calling from a rotary dial phone, the recipient is instructed to stay on the line to speak with a representative.
- J. All certified retailers are provided with a toll-free telephone number for use when problems arise with their equipment or completing a transaction. These numbers are:

Retailer HELP DESK	1-800-230-0179
EBT only Integrated	
Call your Third Party Processor	
Manual Voucher Approval	1-866-340-9520
Retailer General Questions	1-800-350-8533

These numbers are printed on the training material the retailers receive.

- K. Recipients contact the CSR to:
  - 1. Report their EBT card lost, stolen or damaged and request a new EBT card;
  - 2. Activate their EBT card. To activate the EBT card, the individual must provide the 16-digit EBT card number and the individual's date of birth MMDDYY;
  - 3. Check their benefit balance;
  - 4. Review their last 10 transactions; and
  - 5. Select and/or change a PIN.
- L. Explain the use of SNAP benefits as follows:
  - 1. SNAP benefits may be saved from month to month, but the account must be used at least once within a 12-month period.
  - 2. The household has the right to designate an authorized representative to use its SNAP benefits.
  - 3. SNAP benefits can be used **ONLY** to purchase eligible food for their household, including seeds and plants to grow fruits and vegetables.
  - 4. SNAP benefits **CANNOT** be used to pay on any kind of credit account even if it is for eligible food.
  - 5. SNAP benefits **CANNOT** be used to purchase items such as tobacco, alcoholic beverages, pet foods, soap or other household products, and medicines.
- M. **[Explain that the Kentucky EBT card can be used in all states.]**

MS 0280 LOCAL OFFICE RESPONSIBILITIES (1)

Each local office is responsible for providing all households with an explanation of the EBT issuance process. The Family Support Supervisor is responsible for ensuring that these procedures are followed in the local office.

- A. Maintaining security and control of EBT cards which are sent to the local office for pickup.
- B. Retaining all issuance records for audit purposes for at least five years from the month of origin or for a longer period of time if requested in writing by FNS or for five years if Kentucky Transitional Assistance Program or Kinship Care benefits are included on the card.
- [C. Ensuring that case information is accurately entered on Worker Portal.

Worker Portal transmits the information required to issue EBT cards, and/or authorize benefits to the EBT system during nightly batch processing.

- D. Reviewing the adhoc report monthly to confirm the EBT cards remaining in the local office at the end of each month.
- E. Annotating the report and emailing the report to [CHFS.FoodBenefitsPolicy@ky.gov](mailto:CHFS.FoodBenefitsPolicy@ky.gov)
- F. Contacting the Community Support Section at [policydevelopment@ky.gov](mailto:policydevelopment@ky.gov) inbox with questions concerning issuance of EBT cards, the selection of the four digit PIN, or benefits on the account.]

MS 0290

SECURITY OF EBT CARDS

(1)

[Worker Portal tracks Electronic Benefits Transfer (EBT) cards from the initial request through the final process, eliminating the need for hardcopy logs that were previously used. The system has edits in place to ensure separation of duties.

EBT cards are sent to the household's mailing address entered on Worker Portal. However, if the household has issues receiving mail, the EBT card can be mailed to the local office.

When a new card is requested, the worker selects the office location where the household wants to pick up the new card. When received in the mail, the receiving worker or OSA updates the system to show the card as received in the local office. The same worker that made the EBT card request is not allowed to log the card as received in the local office.

Additionally, when the client comes in to pick up the EBT card, neither the worker that made the card request, nor the worker that logged the card as received by the local office, are allowed to give the card to household. The system requires the card to be updated as given to the household by a third, separate worker/OSA. This individual verifies the identity of person picking up the card, obtains a signed Affidavit of EBT Card Receipt (EBT-29), gives the card to the household and scans the EBT-29 into the electronic case record.

The client has 30 days from the date the card was received to pick up the EBT card. If the client fails to pick up the EBT card by close of business on the 30th day, a task is generated to the supervisor to destroy the card the following business day. If the client comes into the local office to pick up the card and the EBT card has been destroyed, request another card.

When EBT cards are received in the local office and the envelope has been opened or a card is found and returned to the local office, update the Worker Portal to show the card as received in that office. The FSS and another employee destroys and/or witnesses the destruction of the EBT card if the card is returned to the local office, received damaged or not picked up within 30 days, and updates Worker Portal at the time of destruction.

To maintain the security of EBT cards in the local office:

A. The Field Services Supervisor (FSS):

1. Maintains overall responsibility for secure storage of EBT cards and logging each card into Worker Portal;
2. Ensures EBT cards are NEVER left unsecured;
3. Routinely inspects the secure storage area;
4. Destroys or witnesses the destruction of EBT cards as the cards are returned to the local office, received damaged, or not picked up by close of business on the 30th day;

5. Updates information on Worker Portal at the time of destruction;
6. Creates and reviews an adhoc report at the end of each month to reconcile the number of EBT cards remaining in the local office; and
7. Annotates the report and emails it to [CHFS.FoodBenefitsPolicy@ky.gov](mailto:CHFS.FoodBenefitsPolicy@ky.gov).

Regional Staff (SRAA and/or PAPS) will ensure the EBT cards are being stored securely with limited access. They may also run adhoc reports to check the count of on-hand cards at any point in time.

EBT cards are not to be mailed between local offices.

M & E will continue to check the status on how and where the EBT Cards are secured when they do the local office reviews.

Disciplinary action is initiated with the FSS and/or the employee, if procedures to secure and distribute cards are not followed which results in a loss of cards.]

MS 0300                                      CENTRAL OFFICE RESPONSIBILITIES                                      (1)

**[The Division of Family Support (DFS) has responsibility for all Central Office issuance activities. DFS is responsible for the following: ]**

- A. Ensuring that EBT cards are mailed to all eligible households in a timely and accurate manner;
- B. Reconciling all benefit issuances; and
- C. Retaining all issuance records for audit purposes for a period of three years from the month of origin or for a longer period at the written request of the Food and Nutrition Service (FNS) or the Department of Health Service (DHS).

MS 0310 TIME LIMIT FOR USING EBT BENEFITS (1)

- A. An EBT account must be debited by the recipient at least once every twelve months, or benefits will be removed. If the recipient fails to debit their EBT account at least once every twelve months, some or all of the benefits in the account are expunged. When the benefits are expunged, they are deducted from the recipient's EBT account and are no longer available to the recipient. The recipient CANNOT, under any circumstances, get expunged benefits back.

When the oldest benefit in the EBT account has not been used within twelve months, the EBT system checks each individual benefit in the account to determine if it should be expunged. In order for an individual benefit to be expunged, the "available date" for that benefit must be at least twelve months in the past.

1. The EBT system sends KAMES a file of all EBT accounts that have not had any debit activity for twelve months. To ensure that the recipient is aware that they have had benefits removed from their EBT account, KAMES sends the household an expungement notice. This notice advises the recipient that they have not used their EBT account in the last twelve months, the benefits listed on the notice have been expunged from their EBT account and they cannot get these benefits back. If they owed benefits on a claim, these expunged benefits will be applied to that claim.

When benefits are expunged, KAMES updates the benefit segments with the amount expunged and the date. This information is available on the benefit inquiry screen.

NOTE: If the case is inactive due to the only household member deceased, a notice will not be issued.

2. **[For active cases, every time a notice is sent to the recipient, a spot check stating EBT Benefits Have Been Expunged will appear on the DCSR.]**
- B. The discontinuance of the case has no impact on the EBT account. As long as there are benefits in the account and the recipient is debiting the account at least once every twelve months, they have access to the EBT account.
- C. Access the EBT System, at each reapplication to determine the status of an individual's EBT card.
- D. If the EBT card status is anything other than active (01) or inactive (00) or if the EBT card number is blank, do the following:
1. Answer yes to the question "Does the household need a new EBT card?"
  2. Tell the recipient their old EBT card will not work.
- E. **[The worker needs to check the EBT system to verify EBT card status at every reapplication. This will prevent confusion when the applicant tries to access**

current benefits with a card that has been deactivated and allows recipients access to their benefits in a timely manner. Workers cannot assume that a card from an earlier eligibility period is still a valid card. If the worker cannot determine the status of a card, contact the Nutrition Assistance Branch (NAB) at [CHFS DFS FOOD BENEFITS POLICY inbox.](#)】

The EBT account will always remain active on the EBT system. The EBT card will remain active unless reported as lost, stolen, or damaged or has otherwise been deactivated.

MS 0320 RECONCILIATION OF ISSUANCES (1)

[The Division of Family Support (DFS) verifies and reconciles all EBT issuances.]

Retailers have the right to request a debit to a recipient's EBT account when it is discovered that the EBT transaction did not debit the recipient's account correctly.

When this occurs, KAMES will generate a notice to the recipient advising the recipient that the EBT account will be adjusted to pay the retailer for the purchase.

[If the recipient contacts a worker and requests that the funds not be debited from their account and to request a fair hearing, take the following action: send, by e-mail, the recipient's name, SSN, EBT account number, amount being debited, and the date the notice was sent to the recipient, to the [CHFS DFS FOOD BENEFITS POLICY inbox](#).]



MS 0330

EBT INQUIRY

(1)

[A. Information concerning the EBT account, client, and card information is maintained on the EBT system. To obtain access to the JP Morgan Kentucky EFS Security system, staff must complete a Kentucky User ID Form (link is below). E-mail or scan a copy of the signed form to the e-mail address on the bottom of the form. To complete the application, follow these steps:

1. Download the [PDF FORMAT KENTUCKY USER ID FORM](#).
2. Open the PDF format Kentucky User ID Form using Adobe Acrobat Reader.
3. Complete all fields on the form electronically (do not handwrite entries). Once all fields are completed, print the form.
4. Sign the form and obtain any other necessary local signature.
5. Supervisor will e-mail a scanned copy of the signed form to the Commonwealth Security Office (CSO) at the e-mail address on the bottom of the form.

CSO will process your request and you will receive an e-mail from the JP Morgan EFS Security System when the request has been processed.

B. To review EBT account information, go to the web and type in <https://ebtadmin.jpmchase.net>. After selecting the appropriate option, you will be asked to log on. Enter "KY" then your '7-digit HR user ID' and password.

1. The EBT System is used to:
  - a. Determine if an EBT card has been issued;
  - b. Determine if a PIN has been selected;
  - c. Determine if there is a discrepancy between demographic data on KAMES and the EBT system; and
  - d. Review benefits information in order to assist the client in resolving any problems that could not be handled by the Customer Service Representative (CSR).
2. To view the above information:
  - a. Enter the client's Social Security Number;
  - b. Enter the EBT card number;
  - c. Enter the EBT case number; or
  - d. Enter the client's name.

For problems signing on to the EBT system, contact Commonwealth Service Desk by e-mail at [CommonwealthServiceDesk@ky.gov](mailto:CommonwealthServiceDesk@ky.gov) or by phone at (502) 564-7576 or toll free at (800) 372-7434.]

- C. In addition to having access to the EBT system for inquiry, staff also has an EBT inquiry screen on KAMES. This screen displays when option "X" is selected on the Case/Pending Inquiry Menu.

The information displayed on this screen is:

1. EBT Case Number. This is a 14-digit number that is used to transmit data to the EBT system;
  2. The latest demographic data sent to the EBT system and the date the data was sent;
  3. Case status on the EBT system;
  4. The date(s) an EBT card was returned in the mail; and
  5. The "Issue EBT Card" field on this screen indicates if an EBT card was requested on the last action that was transmitted to the EBT system by KAMES. An "N" in this field does not mean that an EBT card has not been issued; only that a card was not requested on the last action transmitted.
- D. In addition to having inquiry capability, designated staff at the Central Office level perform the following activities:
1. Debit the EBT account as the result of a claims repayment or returned KTAP or Kinship Care benefits;
  2. **[Add/update client's EBT account; and]**
  3. Issue an EBT card.

MS 0340 REPLACING EBT CARD (1)

[All EBT cards are mailed with "Card Status" of "00" (not activated). When the recipient receives the card, the recipient calls the CSR to activate the card. Once this is done, the "Card Status" changes to "01" (active card). In most instances, when a recipient needs a replacement EBT card, he/she should call a CSR at 1-888-979-9949.

If an EBT card is returned by the Post Office, the card status is changed by the EBT Contractor to "11" (undelivered). If the client calls the CSR to request a replacement card, the CSR can replace the card ONLY if the address that the client gives the CSR matches the address that is on JP Morgan. If the address does not match, the client must contact a DCBS office to request a replacement card.]

A. Customer Service Responsibility

Customer Service is responsible for issuing replacement cards except in the following situations:

1. Current card status is not "01" or "00".
2. [Recipient advises Customer Service that his/her address is different than the most recent address on the EBT system. If the recipient uses a mailing address, the mailing address MUST be given to the CSR when calling (not his/her home address).
3. Recipient advises Customer Service that his/her name is different than the name on the EBT system.
4. Recipient wants his/her replacement card sent to his/her local office. These replacements must be issued by a DCBS office.]

B. Local Office Responsibility

[In the above situations, the CSR refers the recipient to a DCBS office. Replacement cards are requested through "Option 1" on the "Case Change" menu.]

1. If the current card status on the EBT system is "11", determine why the card was returned. If the current card status is "09", that card has been deactivated and a new card must be issued.
  - a. [If the case is active or pending: ]
    - (1) If there is a new address for the case, update the address through the address change function or update the pending case before requesting the card;
    - (2) Enter the case number and select "Option 1" on "Case Change Menu";
    - (3) Enter a 'Y' for the question "Issue EBT Card", and enter. 'C' or 'O' for the question, "DO YOU WANT EBT CARD MAILED TO THE

CLIENT OR LOCAL OFFICE?" and press enter. (The case address will be uploaded and cannot be changed on this screen.); and

- (4) When the message 'REQUEST PROCESSED' is received, PF3 to return to the 'Case Change Menu'.

[If the case is active, the card will be sent to the recipient's mailing address if a 'C' was entered for the 'mailed to client or local office' question. If an 'O' was entered, the card will be sent to the client's DCBS office.]

- b. If there is no active or pending case in the head of household's Social Security Number:

- (1) Enter the case number and select "Option 1" on the "Case Change Menu".
- (2) Enter a "Y" for the question "Issue EBT Card?"
- (3) Enter the mailing address and press enter.
- (4) When the message "REQUEST PROCESSED" is received, PF3 to return to the "Case Change Menu".

[If the case is inactive, the card will be sent to the mailing address. If the card should be mailed to his/her local DCBS office, enter the office address as the mailing address.]

2. If the recipient's address has changed and their EBT card has been lost, stolen or damaged, follow steps as outlined in item 1.

3. For name changes, determine if the recipient wants to have a new card issued immediately. Explain to the recipient that if a new card is requested through KAMES, the current card becomes invalid that evening. Benefits will be inaccessible until the new card is received. Advise the recipient that, if requested, the card replacement can wait until the current month's benefits have been used or until access to benefits is not needed for several days. The recipient could call CSR to have the card replaced at a more convenient time. The advantage to waiting is the worker can make the name change on KAMES and KAMES can update the EBT system. This enables the CSR to authorize the replacement once the recipient calls.

- a. Procedures for Delayed Card Replacement

- (1) If the case is active:
  - (a) Make the name change on KAMES and end session. The name change will be sent to EBT that night.
  - (b) Advise the recipient to call the CSR when they do not need to use their card for several days and request a new card. Advise the recipient that once a request for a replacement card is made, the old card becomes inactive and cannot be used.
- (2) If the case is inactive, NAB will make the name change on the JP Morgan website and issue a replacement card.

- b. Procedures for Immediate Card Replacement

- (1) If the case is active:

- (a) Make the name change on KAMES.
  - (b) Request a replacement request through KAMES.
- (2) If the case is inactive, NAB will make the name change on the JP Morgan website and issue a replacement card.
- 4. **[If the recipient requests the replacement card be sent to his/her local Office, do the following:**
  - a. If the case is active, request a replacement card through KAMES by entering 'O' for the question, "DO YOU WANT EBT CARD MAILED TO CLIENT OR LOCAL OFFICE?"
  - b. If the case is inactive, enter the office address as the mailing address;
- 5. If the recipient contacts a local office to report a lost or stolen card, encourage the recipient to call the CSR at 1-888-979-9949 and request immediate deactivation of the card.]

MS 0360 THE QUALITY CONTROL SYSTEM (1)

The state is federally required to provide a system of quality control (QC) to assure Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits are issued correctly. Penalties are imposed on any state that does not substantially reduce the error rate as determined by the QC process. The review is carried out by department QC staff with some re-reviews performed by federal personnel. QC staff also review K-TAP cases to determine if appropriate action is taken to ensure KWP participation.

A. Sample cases are chosen by means of systematic random sampling on a monthly basis and are reviewed in depth to substantiate the worker's determination of eligibility and computation of the grant amount.

B. A QC review consists of:

[1. Analysis of the case record including adequacy of each of the steps taken by the agency in the process of determining eligibility and the amount of payment; ]

2. Face-to-face interviews;

3. Other investigation, including any collateral contacts necessary to assure documentation of all eligibility factors and accuracy of payment; and

4. Preparation of QC-343, Review Findings Notifications, as appropriate to list errors and related observations, if any.

a. A positive QC error is when the household was eligible for benefits but the incorrect amount was issued—an over issuance or under issuance. A positive QC error, also, includes a household that is totally ineligible for benefits.

Example: The household received \$300 in benefits for the month of March. A QC review found that the incorrect amount of wages was used in calculating the benefits and the household was actually entitled to receive \$250.

b. A negative QC error is when a case was denied or discontinued incorrectly.

Example: The household applied for benefits on 8/27/12 and the worker manually denied the application on 9/25/12 for non-cooperation of client.

C. Findings on individual cases are reported on the QC-343 by the QC Branch Manager for corrective action. When in the course of the review, the QC analyst learns of changes occurring in a case subsequent to the review date, information is transmitted to the office supervisor.

MS 0380 LOCAL ACTION ON QC FINDINGS (1)

[To ensure that the Division of Program Performance and local office staff meet time standards for responding to Quality Control (QC) reviews, QC-343, Review Finding Notification, is uploaded to the QC SharePoint and a notification, with a link to the review, is sent to the appropriate DCBS Regional contacts and Central Office staff. The notification will either request a PAFS-343.1, Response to Quality Control Errors, be completed or notify staff that no errors were found.

NOTE: It is the responsibility of the Program Specialist to forward to the appropriate Field Services Supervisor and to track the timeliness of the PAFS 343.1 when required.]

These procedures apply to all Supplemental Nutrition Assistance Program (SNAP), K-TAP/KWP, Kinship Care and MA reviews.

[Immediately upon receipt of the electronic QC-343 in the local office, review the case record in relation to the findings reported on the QC-343 and take the following action: ]

A. If the case is cited in error:

1. [If the reported case findings are correct, take action to correct the case within 10 calendar days from the date of the Electronic form QC-343.]
2. If necessary, schedule an interview with the recipient.
3. [If the recipient disputes the information as reported on the QC-343, additional collateral contacts may be necessary to substantiate or refute the QC findings.]
4. Issue a restoration of lost benefits, if appropriate.
5. The Claims Management Section (CMS) will notify the region when a claim is suspected. Within 20 calendar days of the date on the QC-343, review the case and enter a claim on KCD, if appropriate. If "NO CLAIM" is determined enter the reason on KAMES and notify CMS of the action taken.
6. File the QC-343 in the electronic case file (ECF).
7. [After corrections have been made to the case, but no longer than 20 calendar days from the date of the QC-343, the Field Services Supervisor (FSS) completes the electronic form PAFS-343.1, Response to Quality Control Errors. The PAFS-343.1 is an E-form and can be accessed through KAMES or by using the KAAAP E-forms link located in KEUPS. This form identifies the error, what caused the error and what corrective action has been taken to correct the case.

**NOTE: A copy of the PAFS-343.1 must be filed in ECF.]**

8. Ensure that the findings are shared with all staff in efforts to prevent the same type of error in the future.

B. If the case was cited as correct, review the QC-343 for "Related Observations" for a possible claim and take the appropriate case action. Refer for a claim and follow policy by placing the case on KCD within 20 calendar days from the date on the QC-343.

**Form PAFS-343.1 must be completed for related observations on all Adult Medicaid and SNAP reviews.**

C. If the QC-343 indicates the recipient "refused" to cooperate with QC, take action to impose the disqualification. Please reference Volume I, [MS 0390](#) to determine the appropriate action to take for each program.

D. If, as a result of the investigation, it is clearly established that the findings reported on the QC-343 are erroneous as of the review date, take the following actions to dispute the QC decision:

1. Within 15 calendar days from the date on the electronic QC-343, the Field Services Supervisor provides the Service Region Program Specialist with the following information to take exception to the QC error as cited:

- a. Case Name;
- b. Case Number;
- c. Region;
- d. County;
- e. Review Number;
- f. Review Month; and
- g. Explanation of why an exception to the error is taken and why the case is believed to be correct.

2. If the Service Region Program Specialist agrees with the exception, within 20 calendar days from the date of the electronic QC-343, the Program Specialist forwards the request to the applicable program branch in the Division of Family Support.

NOTE: Any requests forwarded after the 20 calendar day timeframe WILL NOT be re-reviewed by QC.

E. Hearings Based on Findings: If the recipient requests a hearing and the hearing officer rules that, as of the review date, the QC finding was in error, take appropriate action as indicated based on the Final Order. HOWEVER, THE HEARING DECISION DOES NOT CHANGE THE QC DECISION. Follow procedures in item "D" when taking exception to the QC error.



MS 0390 REFUSAL TO COOPERATE WITH QC (1)

[If QC-343, Review Finding Notification, indicates the individual refused to cooperate with Quality Control (QC) take the following action: ]

A. For Medicaid:

In Medicaid programs, there are no sanctions placed against a recipient who refuses to cooperate with a QC review. However, IF a QC analyst specifically requests that the recipient be contacted in an attempt to gain the recipient's cooperation, send form PAFS-2, Application Letter or Notice of Expiration to the recipient to schedule an interview. Notify the QC analyst of the interview date and time. If the recipient fails to keep the appointment scheduled on form PAFS-2, send form MA-105, Notice of Eligibility/Ineligibility, to propose discontinuance for failure to keep the interview appointment in the local office.

B. For K-TAP and KWP:

The QC analyst conducts a desk review of K-TAP and/or KWP cases. No client interview is required, therefore the cooperation of the recipient is not required and no sanctions are imposed.

C. For KINSHIP:

The QC analyst contacts the household to request certain verifications and acquires independent verifications. There are no sanctions placed against a recipient who refuses to cooperate with the KINSHIP Care QC review.

D. For Supplemental Nutrition Assistance Program (SNAP):

1. If a household **refuses** to cooperate with the QC analyst in completing the case review, disqualify the household from further participation until the household cooperates with QC and provides the necessary information to complete the review.

a. [When notified by QC that a household has refused to cooperate, enter a disqualification on the individual who refused to comply with QC. QC will identify this person on the QC-343. If QC cannot determine which member refused to cooperate, apply the disqualification to the head of household. Document this in comments. Take the following steps to enter the disqualification.]

- 1) Select "Q" on the Main Menu.
- 2) Enter the SSN of the individual.
- 3) Enter disqualification type "319" (Cooperate with Quality Control) on the Disqualification Menu.
- 4) Complete the Member Disqualify screen entering "999" in "Number of Months Disqualified" field.

- b. Once the disqualification has been applied KAMES discontinues the case and issues form KIM-105, General Notice of Action, to the household, indicating the household's refusal to cooperate as the reason for termination or denial of benefits and states the actions the household must take if it wishes to reapply and cooperate.
- c. If the household disbands and members reapply within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the penalty follows the person who refused to cooperate and the new household will be disqualified. The new household, containing the disqualified person, must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Follow the steps outlined in d1 and 2 below.
- d. If the household remains intact and reapplies within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the household must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Enter the application on KAMES and take the following steps:
  - 1) If the household states that it is unwilling to cooperate with the QC analyst, the disqualification remains on the system and the reapplication will be denied for that reason.
  - 2) If the household states that it is willing to cooperate with the QC analyst, hold the reapplication pending and take the following action:
    - (a) [Notify the original QC Analyst or QC Branch Manager by email or phone at (502) 564-1908 within 3 working days of the date of reapplication, of the household's intention to cooperate with the QC analyst. Provide current identifying case information with the QC review number and review date from the QC-343.]
    - (b) Upon notification that the household intends to cooperate, the QC analyst schedules an appointment with the household. After the QC interview is conducted, the analyst forwards a memorandum advising the local office either of the household's decision to cooperate or of the household's refusal to cooperate.
      - (1) If the QC notice indicates the household's refusal to cooperate, deny the reapplication.
      - (2) If the QC notice indicates the household's willingness to cooperate, delete the disqualification and process the reapplication.
      - (3) If the reapplication is approved, and QC later determines the household is no longer cooperating with the review process, follow steps in D, 1, a above.
- e. If the household reapplies more than 125 days after the end of the annual QC review period (September 30 of every year) cooperation with the state QC analyst for the prior review period is not required.

- However, the household must verify all eligibility requirements prior to being determined eligible.
- f. If the household is terminated for refusal to cooperate with a federal QC analyst and reapplies after 9 months from the end of the annual QC review period (September 30 of every year) cooperation with the federal QC analyst for the prior review period is not required. However, the household must verify all eligibility requirements prior to being determined eligible.
  - g. If an individual does not want to reapply for SNAP but states they will cooperate with the Quality Control review, refer them to the Quality Control Section to ensure the completion of the review so the disqualification can be deleted once the household has cooperated.
2. If the QC analyst did not have any contact with the household, (the household failed to respond to the appointment letters, did not contact the QC analyst personally or verbally, or contact their worker concerning the appointment) it is considered as **failure** to cooperate and no disqualification is applied.
- a. However, if a QC analyst specifically requests that the local office contact the recipient in an attempt to gain the recipient's cooperation, do the following:
    - 1) Mail form PAFS-2 to the recipient to schedule an interview; notifying the QC analyst of the interview date and time.
    - 2) If the recipient fails to keep the appointment scheduled on form PAFS-2, manually discontinue the case no later than close of business the day after the scheduled appointment, using the reason 'UNABLE TO LOCATE FOR QC REVIEW'.
  - b. When the household reapplies for SNAP benefits and the last discontinuance reason was reason code '685' 'UNABLE TO LOCATE FOR QC REVIEW', the prompt 'NOTIFY QC-LAST ACTION WAS 685-UNABLE TO LOCATE FOR QC REVIEW' will appear. Instruct the household to contact QC and explain to the client that he/she must cooperate with the QC process as a requirement of receiving SNAP benefits.

MS 0400\*

## AUDITS

The United States Department of Agriculture, Department of Health and Human Services, and the Government Accounting Offices periodically conduct audits to evaluate all phases of program operations. These evaluations emphasize financial accountability and compliance with federal laws and regulations.

The audit process includes the following procedures:

- A. The Division of Family Support (DFS) notifies the Service Region Administrator (SRA) and the appropriate local office supervisor of a scheduled audit.
- B. An exit conference is held at the conclusion of the audit to discuss deficiencies. The SRA and local office supervisor and/or designee will participate in the conference.
- C. The local office supervisor is responsible for ensuring that any deficiencies identified during the exit conference are corrected immediately.
- D. Official audit findings and corrective action recommendations are forwarded to the SRA and local office supervisor.
- E. The local office supervisor replies within 30 calendar days to the findings and recommendations, responding to each detail of the audit specifically. Submit responses, with any required claims information attached, to the Director of Family Support and the SRA.
- F. If the established timeframe cannot be met, an interim report on the progress is submitted to the Director of Family Support and the SRA.
- G. DFS notifies the SRA and local office supervisor when the audit is officially closed.

MS 0410 THE DCBS CASE REVIEW WEB 117 APPLICATION (1)

All case reviews are completed on the DCBS Case Review Web 117 Application available through the Kentucky Enterprise User Provisioning System (KEUPS). Supervisory staff can request that a user be granted access to the Web 117 Application through KEUPS. Reviews are used to assess the correctness of casework processing and to identify error trends and training needs so that they can be addressed on a local, regional or statewide basis.

A. The purpose of a case review is to ensure that:

1. A case is processed correctly;
2. Case decision is made according to Agency policy;
3. All information is obtained, reviewed and evaluated to substantiate a case decision;
4. Impending changes are identified and spot checks are set up and processed appropriately;
5. Computer matches are acted upon timely and appropriately;
6. All required forms are incorporated into the case record and all inconsistent information is clarified;
7. All areas of eligibility are documented on the appropriate computer system;
8. All elements affected by an error are identified; and
9. All computations are correct.

B. Reviewer Functions.

1. Reviewers follow the guidelines issued by the Service Region Administrator's (SRA) office which establishes the required number of cases to be reviewed on a monthly basis. Special reviews may be included in the case review quota.
2. Reviewers use the different levels of reviews available. Each level of case reviews contributes to the assessment of case work and identification of the need for coaching, mentoring, training, policy support, practice supports and system changes.

C. Review Process

At each level of case review, these general procedures are appropriate:

- [1. Reviewers follow procedural instructions available on the web-based online 117 Case Review System as a "Help" function. These

instructions can be viewed by opening the link right below the "Review Section" of a 117 case review or by clicking "Help" on the menu at the left of the page.

2. Reviewers must read cases and review all elements.
3. The reviewer prints a copy of the review for the worker.
4. When there are errors, the reviewer cites specific policy for the error identified:
5. If the case requires corrections, the reviewer indicates on the Web 117 Application, that further action is necessary and leaves the review "incomplete".
6. The worker makes the necessary corrections and returns the case to the reviewer within the allotted timeframe.
7. When the reviewed case is returned to the reviewer, the reviewer ensures that the necessary corrections are made. After all the necessary corrections are made, the reviewer accesses the incomplete Web 117 review and enters a "NO" on the "Action Needed" tab to show that the case review is complete.
8. If the worker disagrees with the error cited, a conference with the reviewer may be requested.
9. Reviewers may use the "Detailed Activity by Reviewer" report to track the status of case reviews.
10. Although the worker is given a copy of the review, the copy is retained for work purposes use only. The completed review is confidential and a part of the Agency's records.
11. The review outcomes are used in the performance evaluation of an employee to identify the caseworker's policy strengths and training needs.

D. Central Office Functions.

1. DCBS Case Review Web 117 Application responsibilities within the Division of Family Support (DFS) are divided by program area. Program specific questions and suggestions for changes to the system are e-mailed by the Web 117 Regional Administrator to that program's designated Central Office Web 117 administrator.

Designated Regional Administrator's can delete a review meeting the criteria in item F.

All other Case Review system related issues are handled by the KAMES Helpdesk at (502) 564-0104 or (866) 231-0003, option 1.

2. Central Office staff will complete 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> level reviews. Cases from every region are reviewed.
3. When an error is identified, local staff has 10 work days to make corrections. In some instances case records or other material may be needed by Central Office in order to complete the review. In the event that material is needed from a case record, the Program Specialist will be contacted to provide the information to Central Office within 5 work days from the date the information is requested if not already scanned into Electronic Case Files (ECF).]

E. 117 Reports

The information gathered by the Web 117 Reports is used as a tool to monitor error rates by:

1. Identifying regional trends that suggest the need for targeted training;
2. Requesting additional statewide training when necessary;
3. Clarifying policy which is error prone;
4. Identifying needed changes in policy, procedures or systems that could address errors;
5. Identifying areas for best practice tip sheets, checklists and news messages;
6. Supporting and measuring achievement at the regional level; and
7. Identifying errors and their root causes.

For more information on the Web 117 reports see [MS 0420](#).

[F. Deleting Web 117 Case Reviews

Prior to deletion of a Web 117 Case Review all users must validate the reason for the request. This is necessary for reviews deleted by 117 Regional Administrators.

The following instructions apply to all Web 117 Case Review deletion requests:

1. Pending Reviews:

The pending review is deleted by a supervisor or program specialist when the deletion request meets one of the following criteria:

- a. Incorrect Entry of Case Decision (CD)/ Non Case Decision (NCD)
- b. Incorrect case name/number/program code
- c. Review marked complete in error (this is a Central Office function only)
- d. Name of worker incorrect

- e. Wrong review level indicated
- f. Wrong error cited.

These 6 options populate in the "reason for deletion" dropdown box at the bottom of the review. If the deletion request does not meet one of these requirements, the review is not deleted.

2. Complete Reviews:

The 117 Regional Administrator is responsible for deleting completed reviews.

Send the deletion request to the 117 Regional Administrator. The Regional Administrator screens the request to determine if the request is past the 10<sup>th</sup> day of the month following the review month.

- a. If the request is made after the 10<sup>th</sup> day of the month following the review month, Regional Administrator denies the deletion request as this skews reporting data history.
  - b. If the request is made prior to the 10<sup>th</sup> day, the Regional Administrator screens the request to make sure it meets one of the six criteria in section "A" above. If the request is appropriate, the Regional Administrator deletes the review.
3. If the denied request is to delete a review that failed to identify an error, another review must be completed to ensure case accuracy.
4. If the denied request is to delete a review for any other reason, a new review is not entered.]



MS 0420 [THE DCBS CASE REVIEW WEB 117 REPORTS (1)

The DCBS Case Review Web 117 Application captures the results of case reviews and compiles various reports. The reports summarize the reviews completed by each worker, unit, county and region.

A. The Web 117 reports are used to:

1. Capture the results of case readings;
2. Provide summarized reports identifying trends in case work;
3. Determine error-prone areas and identify training needs;
4. Track case record actions to determine if policy and procedures for all programs are applied correctly;
5. Provide an orderly method for case reviews; and
6. Compile data identifying strengths and weaknesses of individual workers or counties.

B. The following is a list of the reports and description available on the Web 117 Application. Employees and management at all levels are to use the data found in the reports to improve accuracy and performance and initiate corrective plans as needed.]

1. Case Actions: This report compiles totals for all case decision actions taken on KAMES. The total number in error is divided by the total number of reviews and the result is the percentage in error. Each category has a subtotal that reflects the following error types:
  - a. Verification Error: Occurs when a case lacks required verification or substantiating evidence to justify an action that conflicts with KAMES.  
  
Example: A self employed applicant does not provide copies of his Schedule C tax return yet the worker has entered self employment income deductions without obtaining any personal records to substantiate the deductions allowed.
  - b. Documentation Error: Occurs when a case lacks sufficient documentation to fully explain actions taken that conflict with KAMES data.
  - c. System Entry Error: Occurs when computer system entries are not correct or timely.
  - d. Issuance Error: Occurs when an action taken on a case resulted in an incorrect benefit issuance.
2. Case Actions by Region: This report breaks down the case decision/non-case decision action totals by region and county. The percentage totals are computed the same as case action totals.

3. **Cases in Error:** This report is used to identify the programs in which the most errors occur. It summarizes all of the cases in error and breaks the reviews down by worker, case decision, case number, date of the KAMES action, review date, corrections due, review level, review type and error categories.
4. **Detailed Activity by Completed By:** This reports allows the ability to look at the cases read by the 2<sup>nd</sup> or higher level reviewer. It provides the total number of reviews read and the number of reviews in error. The report breaks the reviews down by case decision, case worker, case number, date of the KAMES action, review date, review level, review type, review status and error categories
5. **Detailed activity by Region, and Detailed Activity by Reviewer:** These reports are used to obtain an overall total of reviews completed by region and reviewer. These reports give the current status of all reviews for the region, and for a reviewer. The report breaks the reviews down by case decision, case worker, case number, date of the KAMES action, review date, review level, review type, review status and error categories
6. **Employee Cases:** This report gives an account of employee cases reviewed statewide. This report monitors the level of review, the status of the review, the program type and identifies the caseload.
7. **Excel Dump of Reviews:** This is a report only available to Central Office.
8. **Review and Summary Sheet by County and Program, Review and Summary Sheet by Region and Program and Review and Summary by Worker and Program:** These three reports break reviews down by the review elements. It gives an overall total for the review period specified on elements cited in error.
9. **Review Summary by Unit:** This report is used to obtain an overall total of reviews by unit. The report breaks the reviews down by unit, case decision, case worker, review type, review counts, number in errors and error categories
10. **Deleted Reviews:** This report tracks the reviews which are deleted by the 117 Regional Administrators. It gives an account of the type of review, the date the review was deleted and by whom. Other information such as the case name, case date, case number, worker code and name is provided.
11. **Statewide Review Summary:** Provides a statewide summary of the number of reviews completed and the totals for reviews in error for all regions.

MS 0430\*

PROFILE SELECTION

(1)

Profile selection is used to assist staff in selecting cases to review, which have had any action taken on them in the current or prior month, based on specific criteria. These criteria can be accessed through Online Help or in RDS report HRKRMR52, IM Codes List. The profile entered for each worker is used to select these cases. This option can be used by Supervisors, Principals, Regional Office, and DFS Central Office Staff.

- A. To select cases for review based on established profiles, complete the following:
1. Select function "E", Profile Selection, from the main menu, and;
  2. Enter up to 15 caseworker's KAMES User ID's and indicate the appropriate profile codes in the FS and IM columns.
- B. Cases generated by the Profile Selection Option will post to the Daily Case Status Report (DCSR) of the requestor under Option J, Sample of Cases, on Mondays. The cases that are posted will remain on the DCSR until new cases are selected the next week. If the criteria have not changed, the same case will be selected again each week until the matching action is no longer in the current or prior month.

To display cases to be reviewed, complete the following:

1. Select "F", Daily Case Status Inquiry, from the main menu, then;
  2. Select "J", Sample of Cases.
  3. KAMES will display the worker code, case number, case name, review profile and date selected.
- C. If the profile selection must be changed for a caseworker, re-enter the worker code and change the profile selection code as appropriate.
- D. When the profile for a particular worker is no longer required, select Option "E", Profile Selection, re-enter the worker codes that are no longer needed and enter a "Y" under delete.

MS 0440 ADMINISTRATIVE HEARING OVERVIEW (1)

Any applicant or recipient of any type of assistance from the Department for Community Based Services (DCBS) has the right to request a hearing before an impartial hearing officer, if dissatisfied with an action or inaction on the part of the Department that adversely affects his/her case.

- A. At the time of application and at the time of any adverse action affecting his/her status with the Department, inform the individual in writing of the right to discuss the situation with a worker and/or to request a hearing. Such information is included on various Agency forms mailed or given to the individual. In addition, applicants are provided the pamphlet, PAM-PAFS-326, Division of Family Support Administrative Hearing Procedures.
- B. The hearing process consists of:
  - 1. The request;
  - 2. Preparation for and scheduling of the hearing;
  - 3. The hearing itself;
  - 4. Review of the recommended order; and
  - 5. The final order.

Additional recourse for the recipient following an adverse hearing decision is available through appeal to the Appeal Board or Judicial review.

- C. For SNAP:
  - 1. [An AGENCY CONFERENCE is offered to households adversely affected by an agency action. The household is advised that an agency conference is optional and in no way delays or replaces the fair hearing process. The worker, supervisor and the household member and/or representative attend the agency conference. An agency conference may lead to an informal resolution of the dispute. However, a Fair Hearing must still be held unless the household makes a written or verbal withdrawal. If the client requests a withdrawal verbally, complete form PAFS-277, Hearing Withdrawal Confirmation Notice. Form PAFS-277 is to be scanned into the Hearings Module as part of the withdrawal process and a copy mailed to the client and representative if applicable.]

An agency conference for households contesting a denial of expedited services is scheduled within 2 working days unless the household requests it be scheduled later or states no agency conference is wanted.

- 2. The Agency must expedite hearing requests from households, such as migrant farm workers, who plan to move from the jurisdiction of the hearing official before the hearing decision would normally be reached. Hearing requests from these households are processed faster than others if

necessary to enable them to receive a decision and a restoration of benefits, if the decision so indicates, before they leave the area.

3. Employment and Training Program (ETP) activity that may be appealed includes any denial, reduction, or termination of benefits due to a determination of nonexempt status or a determination of failure to comply with a work requirement. Individuals or households may appeal actions such as exemption status, the type of requirement imposed, or refusal to make a finding of good cause, if the individual or household believes that a finding of failure to comply has resulted from improper decisions on these matters.

When a fair hearing on these actions is scheduled, the caseworker must request ETP records from the ETP worker. The caseworker handles all local office activities prior to the hearing. The ETP worker and caseworker both attend the hearing.

- D. The Division of Administrative Hearings (DAH), conducts hearings, upon request, for Kentucky Works participants. A participant is eligible for KWP supportive services while a hearing regarding a penalty is pending. Refer to Volume IIIA, [MS 4750](#) and [MS 4770](#).
- E. Group Hearings. The Agency may respond to a series of individual requests for fair hearings by conducting a single group hearing if there is a single common issue in question. Hearing cases are consolidated only if the sole issue is related to a federal law, regulation or policy.

In all group hearings, the policies governing hearings must be followed. Each individual is permitted to present his own case or be represented by legal counsel or other spokesperson.

Each individual has the opportunity to withdraw from the group if in the opinion of the hearing officer, the dissatisfaction results from actions in the individual's case.

- F. Telephonic Hearings. Hearings conducted via special telephone equipment may be held at the discretion of the DAH. During a telephonic hearing, the hearing officer is at one location and the agency representative, recipient, and representative, are at different locations.

The recipient is notified by the DAH that a hearing will be telephonic. If the recipient objects to a telephonic hearing, a face to face hearing is scheduled by contacting either the DAH or the local office in writing, prior to the scheduled hearing date.

Regarding evidence to be submitted for consideration at the hearing, the recipient may either bring the evidence with them to the local office where it will then be copied and sent to the DAH, or they may mail copies directly to the hearing officer themselves.

MS 0450 THE HEARING PROCESS (1)

The following procedures for administrative hearings are in accordance with the Kentucky Revised Statute KRS 13B, Administrative Hearings. If the hearing request involves a Medical Review Team (MRT) determination, refer to [MS 0465](#).

[A. Upon receipt of a request for a hearing:

1. Complete a Request for Hearing, Appeal or Withdrawal through the Worker Portal by accessing the Hearing tab at the top of the navigation page.
  - a. When hearing requests are received by call services, the call services worker completes the request through the Worker Portal, then sends an email referral to the client's county of residence indicating that the client is requesting a hearing.
  - b. The supervisor in the county of residence should try to resolve the issue before it goes to a hearing by offering the client an opportunity to have an Agency Conference (see [MS 0440](#), C. 1.). In addition, the Division of Administrative Hearings (DAH) will conduct a telephonic prehearing conference with the client and agency to explain the administrative hearing and ensure they are conducted in a fair manner. However, if a hearing is required, a staff member (Refer to item A.1.c.) must attend the hearing.
  - c. A case decision worker, principal, or supervisor from the client's county of residence should attend the telephonic prehearing conference and the hearing. Depending on the individual county, who attends may vary. Do not ask DAH to reschedule a hearing because the designated person cannot attend the hearing and/or due to travel to another county. Another worker will have to attend the hearing in the event that the designated worker is unavailable.]
  - d. The telephonic prehearing conferences on claims are held to determine the matter of the claim and to resolve any issue with the claim. The worker needs to thoroughly review the claim to be able to explain why the claim exists. The claims worker has the ability to ask for a dismissal of a hearing due to an untimely request, if an issue relates to another agency, or no issue. If the hearing request is outside of the valid timeframe for receiving a fair hearing, it is appropriate to ask the hearing officer for a pre-hearing conference to discuss this. If the issue is not resolved and a hearing is scheduled, the agency must submit the evidence to DAH by email and to the client by mail at least 8 days prior to the scheduled hearing. If Kentucky Claims Debt Management System (KCD) and Worker Portal Notices are a part of the evidence that is being presented, be sure to include the back of the notice to show the client has been advised of his/her rights to request a fair hearing. As RDS does not include the back page of a notice, it is advisable to have a back page in the office and make a copy to include with the notice. Worker Portal notices are not available on RDS. Prior to sending the evidence to DAH and the client, ALL evidence must be labeled as: Exhibit 1, 2, 3

or Exhibit A, B, C, etc. During the hearing process if the agency is asked to waive the timeframes of hearing procedures, the agency's answer is always "NO". Additionally, if another worker had input in the case or gathered collateral information during the time at issue, include that worker(s) as a witness. Attendance by a DCBS worker is mandatory under these circumstances so evidence is not considered "hearsay".

- e. Attending staff should have a summary written (may use form PAFS-78.1, Administrative Hearing Summary) and be prepared to represent the agency.

Note: The DCBS representative should re-verify any collateral contact used as verification in the case to overcome the hearsay issue once the referral is received in the home county. If the contact is not willing to attend the hearing and testify, ask for a signed statement addressing the issue to be presented at the hearing.

2. [If the hearing issue involves a negative action, include a copy of the negative action notice (i.e., KIM-105 series, FS-105, MA-105, or PA-105), including the back page and forward to DAH. The KAMES-generated notices are maintained on RDS and may also be accessed through DocumentDirect. As RDS does not include the back page of a notice, it is advisable to have a current back page in the office and make a copy to include with the notice. The system-generated notices for Worker Portal are available in the Correspondence Module. The back page is included with the notices in the Correspondence Module. If the notice is not available at the time of the request, request the hearing through the Worker Portal within 24 hours and forward the copy of the notice as it becomes available.]
3. If the request is from an individual who has limited English proficiency and requires interpreter services or has a physical or mental condition which requires accommodation in order to participate in the hearing, annotate the hearing request with this information.
4. [All requests must be sent to DAH, through the Worker Portal, within 24 hours of receipt, with exception of a hearing related to Medicaid payments or covered services, in one of the following ways:
  - a. E-mail to: [Hearings.BranchFC@ky.gov](mailto:Hearings.BranchFC@ky.gov);
  - b. Fax to: (502) 573-1014; or
  - c. Mail to:  
  
Cabinet for Health and Family Services  
Division of Administrative Hearings  
Families and Children Administrative Hearings Branch  
105 Sea Hero Road, Suite 2  
Frankfort, KY 40601
5. A request for a hearing related to Medicaid payments or covered services is heard by the Department for Medicaid Services (DMS).

- a. Annotate a short description in Notes when requesting the hearing request through the Worker Portal.]
  - b. Forward the hearing request within 24 hours to:  

Department for Medicaid Services  
Administration & Financial Management  
Administrative Service Branch  
275 East Main Street, 6C-C  
Frankfort, Kentucky 40621-0001
  - c. DO NOT send the case record to DMS.
  - d. The DCBS worker does not attend the DMS hearing.
6. Clients can also request DMS hearings by calling the Administrative Services Branch directly, at (502) 564-8196, ext. 3175.
- B. [Prepare for the hearing by reviewing the case record and writing a summary of the issue/action that prompted the request. If the hearing involves a claim issue, it may be necessary to contact the claims worker for additional information about the case record and give a copy of the summary to the supervisor.]
1. Include in the summary all information, documentation, notices, forms, comments, etc., that support the action taken by the agency. Be clear and concise; but, include pertinent information with the explanation in the case when you are unable to attend the hearing and the supervisor or another worker must represent the agency's position.
  2. If the issue involves proper notification, make multiple copies of any manual or system-generated notices that are related to the issue to present at the hearing. Ensure that the back page of every notice is included. As RDS does not include the back page of a notice, it is advisable to have a back page in the office and make a copy to include with the notice.
  3. Make copies of all manual sections that relate to the issue/action. Include any pertinent policy clarifications that support the agency.
  4. DO NOT include unprofessional language or comments in the summary.
- C. Upon receipt of the hearing request, the DAH schedules the hearing and may need to contact the client for clarification of the reason for the hearing. The DAH notifies the client, field staff, and appropriate Regional Contact of the issue to be heard, along with the date, time and place of the hearing. The Regional Contact is responsible for notifying the field staff of the hearing if the Hearings Branch does not know the identity of the field staff.

The worker and supervisor notify any witnesses of the scheduled date of the hearing. The worker, supervisor or designated individual, MUST prepare, attend and actively participate in the hearing. A review of the case record must be completed to determine if a worker verified information by collateral



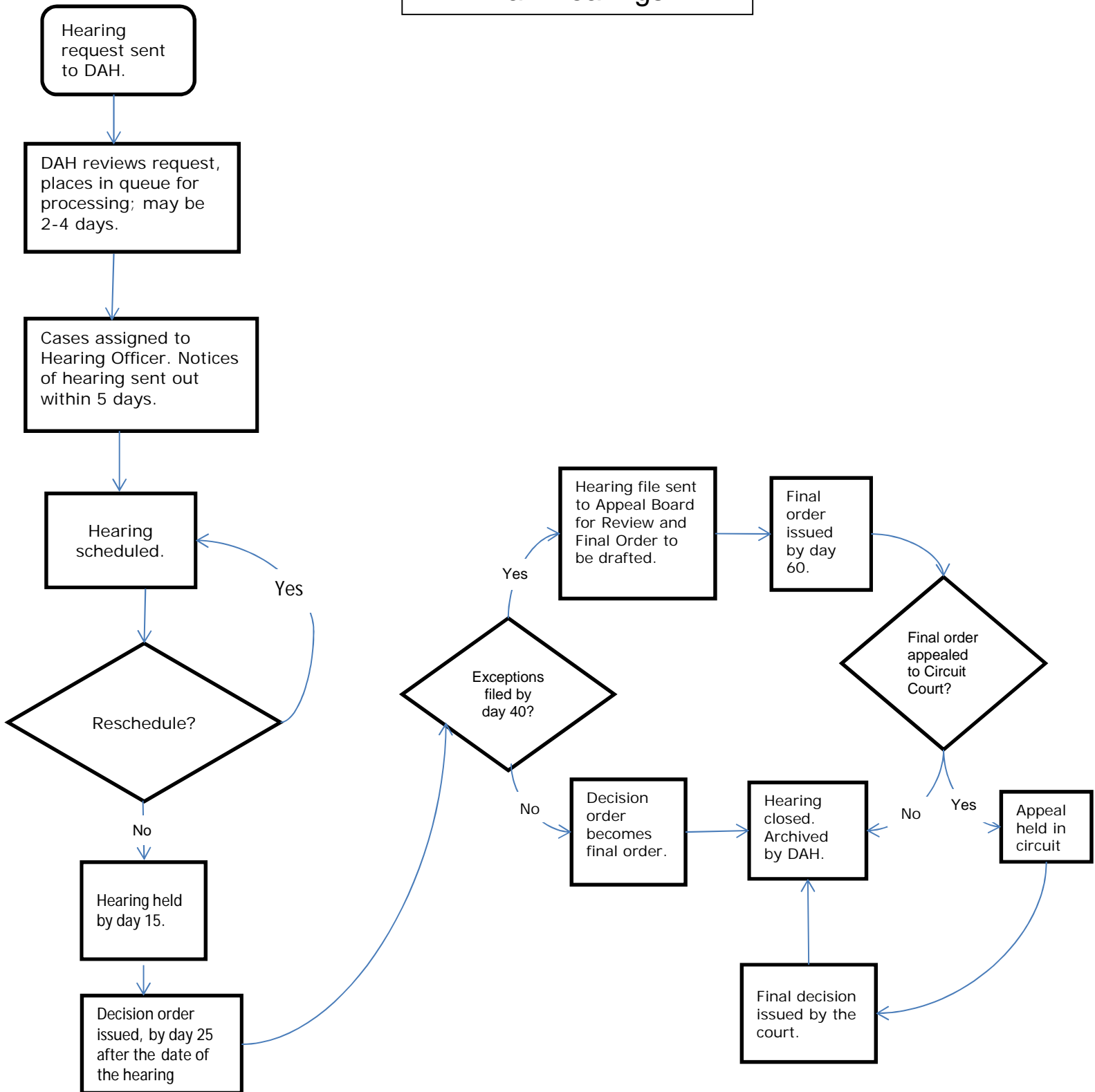
contact. If the case record reflects that this occurred, the worker who made the collateral contact "MUST" attend the hearing in order to avoid any "hearsay issues" that may arise. The Hearings Public Assistance Program Specialist is responsible for ensuring the Agency representative is fully prepared. Claims Management Section (CMS) staff will attend Administrative Hearings which involve claim compromise.

- D. At the hearing, the agency representative worker or individual attending the hearing must be prepared to present the facts surrounding the issue/action. Preparation is important because the hearing officer cannot consider any information or documentation not presented at the hearing. The burden of proof for the case action is the responsibility of the Agency.
- E. After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is not a final order. DO NOT take any case action based on the recommended order. The recommended order is sent for review to:
  - 1. The client and/or representative;
  - 2. The Regional Contact person;
  - 3. The local office;
  - 4. Central Office; and
  - 5. The Department for Medicaid Services, if the issue involved patient status in a skilled nursing home.

If any of the parties disagree with the recommended order, an exception can be filed with the Cabinet for Health and Family Service (CHFS) Appeal Board for Public Assistance within 15 calendar days of the date of the recommended order. For detailed procedures, refer to [MS 0510](#).

- F. Staff reviews all timely exceptions to the recommended order and drafts a final decision for submission to the CHFS Appeal Board for Public Assistance.
- G. The CHFS Appeal Board for Public Assistance signs the final order and sends copies to the client, representative, if any, the local office, and to the appropriate SRAA.
- H. Once the final order is received in the local office, the case worker takes the appropriate action indicated by the final order. Refer to [MS 0520](#).

Fair Hearings



MS 0460

THE HEARING REQUEST

(1)

A hearing request is a clear expression, either oral or written, to review a decision made by the Agency.

- A. The request must be made by the client, a household member, his/her counsel, or an individual acting on behalf of the household or recipient.
- B. Requests for a Hearing, Appeal or Withdrawal, either written or oral are requested through Worker Portal for the client.
  1. When requesting a hearing through Worker Portal for an ETP/KWP work program related issue, indicate that the hearing request involves an ETP/KWP issue.
  2. If received by phone or through the mail, indicate this in the comments section when requesting the hearing.
  3. When a client has moved out-of-state and subsequently requests a hearing, tell the individual they may request a hearing to be held telephonically.
- C. When completing a request for a hearing, be specific when describing the client's reason(s) for the hearing request. Use statements like: "The client does not agree with the amount of earnings counted in her KTAP case". Avoid vague statements such as "client request", or "client disagrees with denial". In addition, if the hearing involves an emergency situation, clearly annotate on the Note screen that it is an emergency.
- D. A request for a DCBS hearing may be submitted by the client or their representative directly to the Administrative Hearings Branch.
- E. [The client may voluntarily withdraw the hearing request any time prior to the hearing. If the client wishes to withdraw the request, complete a hearing request search through Worker Portal, locate the client's hearing request and update the fields and re-submit to the Hearings Branch. Complete and attach form, PAFS-277, Hearing Withdrawal Confirmation Notice and attach in the Hearings Module as part of the withdrawal request. Form PAFS-277 should then be mailed to the client and their representative, if applicable, for their records.]
- F. A request for a hearing related to Medicaid covered service issues is heard by the Department for Medicaid Services (DMS). DCBS staff are not responsible for these hearings. Furthermore DCBS staff does not attend these hearings.
  1. Hearings may include, but are not limited to:
    - a. Patient level of care status determinations in any type of vendor payment case;
    - b. Denial of payment for services;

- c. Services provided through EPSDT; and
  - d. Issues related to managed care services or participation.
2. Clients can also request DMS hearings by calling the Administrative Services Branch directly, at (502) 564-8196, ext. 3175.
  3. The only appeal process which applies to DMS hearings is a judicial review. The Appeal Board does not review these cases.
  4. DCBS staff is responsible for hearings on Medicaid eligibility and follow the regular procedures for requesting an administrative hearing.
  5. There are no fair hearing procedures for managed care as the delivery method of Medicaid is not a qualifying event for a fair hearing. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider assignment. This is explained in more detail in the member handbook.

MS 0465 HEARING REQUESTS INVOLVING MEDICAL REVIEW TEAM DETERMINATIONS (1)

A client may request an administrative hearing if he/she disagrees with a determination made by the Medical Review Team (MRT), only after negative action is taken on his/her case based on that determination.

- A. At the point of the original request for a hearing, ask the client if there is new medical evidence or a change in the client's condition to justify resubmitting the case to MRT for redetermination.
1. If the client states there is new evidence or the condition has worsened, ask if the client has been to a doctor or medical facility or had tests run since the last MRT determination was submitted.
  2. If there is new evidence or a worsened condition not considered by MRT, ask the client if he/she would like to resubmit the case to MRT. Advise the client that if he/she disagrees with the result of the redetermination, he/she can ask for a hearing based on the new action or inaction in the case. Resubmitting the case to MRT could eliminate the need for a hearing and provide benefits to the client in a more timely manner. It is the client's choice to resubmit to MRT or to request the hearing.
  3. If the client agrees to submitting the new information to MRT:
    - a. Take a new application if the application or extension request was denied or reinstate the benefits of a discontinued case (other than an extension to 60 months of K-TAP benefits);
    - b. Complete form PA-601T, Referral for Determination of Incapacity/Disability, to include the new information provided by the client and annotate in red on top of the form that it is a redetermination based on new information;
    - c. Have the client sign an original form MRT-15, Authorization to Disclose Information to the Cabinet for Families and Children, for each medical source (doctor, hospital, lab, clinic, etc.) plus two additional forms MRT-15. Sign the forms as a witness; and
    - d. Upon completion of forms PA-601T and MRT-15, immediately forward to MRT the forms along with:
      - (1) The last MRT determination packet, including:
        - (a) Medical information;
        - (b) The last form PA-601T,
        - (c) PA-6, Incapacity Determination; or
        - (d) PA-610, Certification of Permanent and Total Disability; and
      - (2) Any new information/documentation the client may have provided.

MRT will make a determination considering the new information provided by the client. Upon receipt of MRT's determination, take appropriate action on the case. If the client disagrees with the action

taken on the case, based on the new determination, the client can request a hearing.

- B. [If there is no new evidence or worsened condition or the client does not want to resubmit information for an MRT determination, submit a Request for Hearing, Appeal or Withdrawal through the Worker Portal by accessing the Hearings tab at the top of the navigation page. Advise the client of his/her right to request continuation of benefits pending the hearing and the obligation to repay benefits if the hearing officer does not rule in his/her favor.]
- C. At the hearing, the client may present new medical information such as hospital records, new test results, a new specialist's report or appointment to support his/her claim of incapacity/disability.
- D. When a hearing involves an MRT determination, take a copy of the last packet of medical information, including form PA-601T and PA-601T, Sup. A, Supplement to Referral for Determination or Redetermination of Incapacity/Disability, if appropriate, that MRT used to make the determination along with several blank forms MRT-15 that can be completed, if needed, and form PA-6, Incapacity Determination, or form PA-610, Certification of Permanent and Total Disability, to the hearing. If this is done, and the client presents new medical information, the hearing officer can submit the information along with the interim order directly to MRT. Otherwise, the worker is responsible for submitting the information to MRT.
- E. At the hearing:
  - 1. If the client does not provide any new evidence, the hearing officer drafts a recommended order based on the information presented by both parties.
  - 2. If the client provides new medical evidence, the hearing officer drafts the interim order to remand the case to MRT for a redetermination. The interim order lists the new medical evidence to be considered by MRT.
    - a. If all the information is available at the hearing, the hearing officer can send the redetermination request and interim order directly to MRT.
    - b. If all the information is not available at the hearing, the worker is responsible for obtaining the information needed and submitting it to MRT. The worker must submit the request for redetermination to MRT within 7 calendar days of the hearing.
- F. Once the request for redetermination is submitted to MRT, MRT has 30 calendar days from the date of the interim order to make a determination. If MRT needs additional time, it can request a 30-day extension.
- G. MRT will send form PA-6/PA-610 to the hearing officer. If it is a denial, MRT will also send the new information on which the redetermination was

made. The hearing officer makes a decision based on additional information.

- H. After 30 days, or 60 days if an extension was granted, if the hearing officer has not received the MRT determination, a recommended order can be drafted without MRT input. If the Agency is upheld in the final order, the client can request an appeal.
- I. The interim order process is designed to facilitate the process for cases that are remanded to MRT. Workers are not to act on recommended orders, until 16<sup>th</sup> day from the mail date, and then it becomes the final order.

MS 0470

MEDICAID HEARING REQUEST  
DUE TO THE LOSS OF SSI

(1)

In Kentucky, the Social Security Administration (SSA) determines Medicaid eligibility for individuals who receive a Supplemental Security Income (SSI) payment. Any individual who applies for SSI is also applying for Medicaid. If SSI is approved, the individual is also approved for Medicaid. If a recipient's SSI is discontinued and a hearing is requested, the recipient can continue to receive Medicaid during the hearing process only when they continue to receive the SSI payment.

- A. [Individuals who contact the local Department for Community Based Services (DCBS) office to appeal the termination of their SSI benefits must be referred to the SSA. Individuals approved by SSA for a continuation of SSI benefits while they are in the appeal process will receive Medicaid coverage automatically and have a payment status code of C01, M01, or M02. Refer to SDX User Guide Payment Status Codes.
- B. If the SSI individual contacts the local DCBS office requesting a hearing due to the loss of their Medicaid, the DCBS office handles the hearing request through the Worker Portal.
- C. Upon receipt of a Medicaid hearing request, the worker should become familiar with the situation and be able to give the reason why Medicaid benefits ended. Review and take the following information to the hearing:
  1. PA-10-SSI notices which are located in the Worker Portal Correspondence Module; ]
  2. SDX screens (pages 1 and 2 of the discontinuance action) showing the pay status code and MA discontinuance date; and
  3. An explanation of the discontinuance reason which is located in the SDX manual under pay status codes.

Copies of the SDX screens are presented at the hearing and may be viewed by the other attending parties to document the reason for the discontinuance. To ensure that IRS information is kept confidential, black out the wage information on page 2 of the SDX screen before other parties view the screen. Prior pages of the SDX record may need to be reviewed to find the correct discontinuance reason. However, a copy of the screens is NOT to be given to the hearing officer or the appellant. Once the hearing is over, shred the SDX screens.

Provide a verbal explanation of the information contained on the SDX screens during the hearing.



MS 0475 HEARING TIME FRAMES (1)

- A. [For IM programs (KTAP, Kinship Care, Medicaid, FAD, WIN, State Supplementation), a hearing request is considered timely if received by the Department:]
1. Within 40 calendar days from the date form KIM-105 or MA-105 is sent on a proposed action;
  2. Within 30 calendar days from the date form KIM-105 or MA-105 is sent on an action already taken; or
  3. Whenever the hearing issue is a delay in action on the case and the action is still pending.
- B. For SNAP, a household or member is allowed to request a hearing on any action by the Department or any loss of benefits which occurred in the prior 90 days.
1. The household may request a hearing any time within the current certification period, only if disputing its current level of benefits.
  2. Action by the Department shall include a denial of a request for restoration of any benefits lost more than 90 days but less than a year prior to the request.
- C. The Division of Administrative Hearings (DAH) acknowledges all hearing requests, conducts a hearing, and issues a recommended order within 60-90 days from a request for a hearing, the Cabinet for Health and Family Services Appeal Board for Public Assistance shall consider the record.
- D. [If the hearing request is untimely, forward the request and any information concerning why the request was untimely to the DAH through the Worker Portal. The hearing officer determines from the information provided whether the household had good cause for submitting an untimely request.]
- E. Individuals whose SSI is discontinued and who request a hearing must be referred to the Social Security Administration (SSA) to appeal the termination of their SSI benefits. Individuals requesting a continuation of Medicaid benefits must make that request with the SSA agency. If SSA approves the continuation of SSI benefits while they are in the appeal process then the individual will receive MA coverage automatically and they will have a payment status code of C01, M01, or M02.

MS 0480

SCHEDULING THE HEARING

(1)

- A. A hearing request is acknowledged by the Hearings Branch by form AR-2, notifying the client the request has been received and entered on the docket of pending requests.

The acknowledgement letter also contains information regarding the hearing process, including the right to case record review prior to the hearing, the right to representation, and a statement to the effect that the local office can provide information regarding the availability of free representation by legal aid or welfare rights organizations.

- B. The Hearings Branch notifies the client of the date, time, and place the hearing will be held via form, "Notice of Hearing".

The form also contains information regarding:

1. The client's right to bring an attorney and/or witnesses if desired.
  2. An explanation that if the client or a representative does not appear for the hearing, the client will have a period of ten days to advise the Hearings Branch of the reason for not appearing. The Hearings Branch considers the reasons and determines if good cause exists. The request is considered abandoned and dismissed unless good cause for the absence can be shown.
  3. All parties to the hearing are provided at least 10 days timely notice of the hearing to permit adequate preparation of the case except for TANF related, LIHEAP or State Supplementation hearings. TANF related, LIHEAP, or State Supplementation hearings require at least 20 days timely notice. However, the household may request less timely notice to expedite the scheduling of the hearing.
- C. The client may request and is entitled to a postponement without good cause if the request is made BEFORE the hearing. The postponement cannot exceed 30 days and the time limit for action on the decision is extended for as many days as the hearing is postponed. For example, if a hearing is postponed by the household for 10 days, notification of the hearing decision is required within 70 days for SNAP or within 100 days for IM from the date of the request for a hearing. The worker notifies the hearing officer of the postponement.
- D. [Before conducting a claim hearing, review the Worker Portal, Fraud Referral Overview SIPV Screen to determine if the claim location code is "Court". If the claim is being prosecuted, contact the hearing officer or ask for a pre-hearing conference to inform the hearing officer that the court holds jurisdiction over the matter and request the hearing to be dismissed. The Claims Management Section can be contacted at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov) to verify if the claim has been referred for prosecution.]

- E. For IM programs, a client or his/her representative may request a delay of the hearing for reasons beyond the control of the client. The decision to grant the delay is made by the hearing officer.

MS 0485

PROGRAM PARTICIPATION  
PENDING THE HEARING – IM PROGRAMS

(1)

- A. When the client requests a hearing within 10 days of the date on the timely notice, the benefits remain reduced or inactive pending a hearing decision unless the client specifically requests that the benefits continue, including supportive services.

Explain to the client that if the Agency's decision is upheld, any overpayments resulting from continuation of benefits will have to be repaid.

If the request is received within 20 days of the date of the timely notice, and the client claims good cause for not reporting within 10 days, determine if the reason for the delay meets the following good cause criteria:

1. The client was away from home during the entire timely notice period;
2. The client was unable to read or comprehend the timely notice and the right to request a fair hearing;
3. The client moved which resulted in a delay in receiving or failure to receive the timely notice;
4. The client had a serious illness; or
5. The delay was no fault of the client.

[If good cause is determined and the client requests continuation of benefits, reinstate the case within 5 work days.]

Accept the client's statement for good cause unless there is reason to doubt.

- B. If the case is active and benefits are reduced and the client requests a hearing within 10 days of the date on the timely notice, benefits remain reduced unless the client specifically requests benefits continue. If the client requests benefits continue, reinstate benefits within 5 work days at the level prior to the timely notice.
- C. If benefits are discontinued and the client, within 10 days of the date on the timely notice, requests a hearing and continuation of benefits:
1. [Complete a Request for Hearing, Appeal or Withdrawal through the Worker Portal by accessing the Hearing tab at the top of the navigation page.
  2. If reason for discontinuance is "failure to keep recertification interview," complete a recertification.

3. For all other reasons for discontinuance, complete form PA-1.1C Supplement B, Interim Notations, or annotate comments on the Worker Portal, as appropriate.]
  4. On the day of the hearing request, authorize approval of benefits at the level prior to timely notice with the current month as effective date.
- D. For checks received in the local office, follow procedures found in Vol. I, [MS 0120](#).

A monthly printout of all checks with a local office address is generated for reconciliation purposes. The supervisor is responsible for ensuring each check on the printout was cancelled or delivered to the recipient.

- E. A client may reapply for discontinued or denied benefits during the hearing process. Accept and process a reapplication based on a change in circumstances.

Approval of a case based on a change of circumstance does not affect the hearing status unless the client voluntarily withdraws the hearing request.

MS 0490

PROGRAM PARTICIPATION  
PENDING THE HEARING – SNAP

(1)

Depending upon the circumstances of the case, the recipient is entitled to participate during the hearing process. The worker explains to the recipient that:

A. PARTICIPATION IS CONTINUED IN THE FOLLOWING CIRCUMSTANCES:

1. If the recipient requests a hearing during the 10-day timely notice period, participation is continued on the basis authorized immediately prior to the timely action notice unless the recipient specifically waives continuation of benefits. The recipient is advised that if the hearing finds the agency decision was correct and the household was ineligible for all or part of the SNAP benefits received pending the hearing officer's decision, a claim is established against the household for the value of extra benefits received.
2. If benefits are reduced or terminated as a result of a mass change without individual notice of timely action, benefits are reinstated on the prior basis only if the issue contested is that eligibility or benefits were improperly computed or that federal law or regulations were misapplied or misinterpreted by the agency and if the household requests the continuation.

B. ONCE CONTINUED OR REINSTATED, BENEFITS ARE NOT REDUCED OR TERMINATED UNLESS:

1. The certification period expires. Upon expiration of the certification period, the recipient can reapply and have eligibility redetermined.
2. A change affects the household's eligibility or basis of issuance while the hearing decision is pending and the household fails to request a hearing after the subsequent notice of adverse action.
3. A mass change affects the household's eligibility or basis of issuance while the hearing is pending.
4. The hearing officer makes a preliminary determination in writing, and at the hearing, that the sole issue is one of federal law or regulation and the household's claim that the State Agency improperly computed the allotment or misinterpreted or misapplied such law or regulation is invalid. The household is notified by form KIM-105 General Notice of Action, when benefits are reduced or terminated pending the hearing officer's decision.
5. [The household fails to appear for the hearing, and the Division of Administrative Hearings notifies the local office that the hearing request has been abandoned. If the household fails to appear, reduce benefits effective with the next monthly issuance. The household is notified by form KIM-105.]

MS 0495 DENIAL/DISMISSAL OF HEARING REQUEST (1)

- A. The Division of Administrative Hearing (DAH) may dismiss a hearing request if:
1. The request is untimely;
  2. The issue relates to a determination by another agency;
  3. There is no issue; or
  4. The request is abandoned.
- B. [The client may withdraw a request for a hearing at any time prior to the release of the hearing officer's decision. Withdrawals are formalized by the completion of form PAFS-277, Hearing Withdrawal Confirmation Request, if the client is verbally requesting a withdrawal to an agency representative. A client can also request withdrawal via written statement with notation of the reason for withdrawal. The withdrawal process completed through the Hearings Module with all documentation scanned to that case record. In all instances in which the client has a representative or attorney, the client should be advised to consult with the representative before signing a withdrawal statement. If a representative made the original request, the worker must verify that the representative concurs in the withdrawal. Indicate if the representative does not concur with the withdrawal request on the comments screen when submitting the request to withdraw from the hearing. Form PAFS-277 is completed any time the client does not provide a written request to withdrawal.]
- C. If the client or representative fails to appear for a hearing and the reason is unknown, a notice is mailed by the DAH. The notice advises the client to contact the hearing officer, in writing or by telephone within 10 days, if he/she wishes to continue the hearing and can present good cause for failing to keep the appointment. If the client replies but does not show good cause, or fails to reply, the request is considered abandoned. If good cause is shown, the hearing is rescheduled.

MS 0497\*

CLIENT'S HEARING RIGHTS

A client not only has the right to request a hearing, but also has additional rights.

- A. Explain to the client or his/her representative the following rights:
1. To present the case himself/herself or to have it presented by legal counsel or another representative. Inform the client of the availability of free legal services;
  2. To review the case record relating to the issue;
  3. To bring witnesses to support his/her case in the hearing;
  4. To present arguments without interruption;
  5. To question any testimony or evidence and cross-examine witnesses; and
  6. To submit evidence establishing pertinent facts and circumstances in the case.
- B. Explain to the client that the Department does not provide payment for legal counsel but, if available, will refer him/her to a legal aid agency.
- C. Provide the client and the client's representative or legal counsel adequate opportunity to examine all documents and records to be used at the hearing a reasonable time before the date of the hearing as well as during the hearing. The contents of the case file, including the application form and documents of verification used by the agency to establish the household's ineligibility or eligibility and allotment, are made available. Confidential information, such as names of individuals who have disclosed information about the household without its knowledge or the nature or status of pending criminal prosecutions, is protected from release. If requested by the household or its representative, the agency provides a free copy of the relevant portions of the case file. Confidential information protected from release and other documents or records which the household will not otherwise have an opportunity to contest or challenge are not presented at the hearing, and do not affect the hearing officer's decision.
- D. If the client, after requesting a hearing, is dissatisfied with medical evidence used in making the case decision, the client may request an examination from another medical examiner. If an examination by an internist or specialist was received within three months prior to date of hearing request, the client must specify the reason for the additional examination.



1. The request for another medical examination is submitted to the Hearings Branch and includes the type of examination requested. If the hearing officer considers the additional medical assessment necessary, an appointment is made by the Hearings Branch after Departmental approval for payment of a specified fee. No payment will be made without prior authorization, and payment for unauthorized examinations is the responsibility of the recipient. The examination is made by an internist or specialist in the field of the client's major ailment.
2. The client, and, as appropriate, the client's attorney, are notified of the date of the appointment by the Hearings Branch. If represented by legal counsel, a copy of the client's new medical report is mailed to the attorney by the Hearings Branch.
3. If a request for additional examination at Department expense is denied, the hearing officer sets forth the reason for denial in writing. The hearing officer may request additional medical examinations at no expense to the client.

MS 0500 CONDUCT OF THE HEARING (1)

- A. Hearings are conducted by an impartial hearing officer who is knowledgeable of the Department's law, policy and procedures. The Division of Administrative Hearings operates independently and recommended orders are based only on information presented at the hearing.
- B. Hearings are privately conducted at a place convenient to the client and:
  - 1. Are orderly but informal;
  - 2. Conducted without the use of strict technical rules of evidence and procedure;
  - 3. Provide a method by which the client can speak freely regarding facts and circumstances of the situation, refute testimony and examine all papers and records introduced as evidence;
  - 4. Provide the client the opportunity to submit additional evidence and to cross examine witnesses; and
  - 5. Concluded when the hearing officer is satisfied that sufficient evidence has been introduced to resolve the issue.
- C. The hearing is attended by the worker and/or supervisor and by the client or his/her representative or both. The hearing may also be attended by friends and relatives of the client if the client so chooses. However, the hearing officer has the authority to limit the number of persons in attendance at the hearing if space limitations exist.
- D. At the hearing, the worker or individual must be prepared to present the facts surrounding the issue/action. Preparation is important because the hearing officer cannot consider any information or documentation not presented at the hearing. The preparation includes:
  - 1. Reviewing the case record to become familiar with the case situation.
  - 2. Drafting a presentation that is clear and concise. The written presentation can be entered into evidence after the oral presentation, if needed.
  - 3. For hearings involving a Medical Review Team (MRT) determination, the medical information used by MRT for the determination must be presented in chronological order for each provider. The MRT packet contains a form titled "Case Development Sheet". This form provides names and dates of requested medical information and contacts. In the MRT packet, the form follows the MRT decision.
  - 4. [Making at least two copies of any forms, notices, documentation and system screen prints (including the Worker Portal or KAMES comments) that are to be presented as evidence to support the issue or action. One copy is for the hearing officer and the other is for the client.]

5. Making two copies of all pertinent manual sections that support the issue/action – one for the hearing officer and the other for the client. Use only Operation Manual Sections including updates, Family Support memorandums and policy clarifications issued by the Division of Family Support Central Office. Do not submit training materials, forms or items not issued or sanctioned by the Division of Family Support as evidence at the hearing.
  6. Contacting individuals that may be witnesses for the Agency to notify them of the time and place for the hearing. Witnesses, if available, may agree to testify telephonically. These witnesses may include an individual from the Medical Review Team (MRT), Medicaid, Targeted Assessment Project (TAP), Claims Management Section, Determining Eligibility through Extensive Review (DETER), etc. Witnesses should be briefed on the issue or action in order for them to testify effectively. When an individual agrees to testify as a witness for the Agency, information from the case record pertinent to the hearing issue is copied and forwarded to that individual. This will allow the individual to be prepared to testify.
  7. [If a collateral contact was used to verify a household situation and an administrative disqualification hearing is to be held, contact the persons who provided statements about the case to ask if they will attend the hearing. If the person will not attend, ask for a signed written statement supporting verbal information indicated in the Worker Portal comments. The Worker Portal comments alone are not acceptable sources of verification in a hearing. The worker who spoke to the collateral contact must also attend the hearing to verify statements made on the Worker Portal and should be notified well in advance of the hearing date to ensure their attendance.]
  8. Taking the case record to the hearing to assist in responding to questions asked during the hearing.
  9. Dressing professionally.
  10. Using professional language when presenting the summary and evidence. When called upon to present the Agency's position, speak clearly. Explain the policy and procedure used in terms that everyone attending the hearing can understand. If unsure of a response to a question, advise those present that the information is not available at the hearing but will be provided if necessary.
- E. If conclusive evidence is not produced at the hearing, the hearing officer may continue the hearing. If the hearing officer continues the hearing, the hearing process must still be completed within 60 calendar days of the hearing request for SNAP or 90 calendar days for IM. If the hearing is continued, the client and workers are notified 10 days in advance of the time and place of the continued hearing.

A client or representative may request the hearing officer to delay the recommended order for a reason beyond the control of the client. The decision to grant the delay and continue the hearing is made by the hearing officer.

MS 0510

RECOMMENDED ORDER

(1)

After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is not the final order; therefore, action is not taken on the case.

A. The hearing officer:

1. Reviews all evidence and drafts a recommended order. A recommended order:
  - a. Summarizes the facts of the case;
  - b. States the reason for the recommended order;
  - c. Identifies the supporting evidence and the pertinent Operation Manual sections; and
  - d. Cites pertinent state and federal regulations.
2. Ensures that the recommended order complies with federal and state law or regulation and is based on the hearing record.
3. Mails a copy of the recommended order for review to the following:
  - a. The client;
  - b. The client's representative if one was present at the hearing;
  - c. The Regional Contact;
  - d. The local office;
  - e. The Division of Family Support (DFS) Central Office; and
  - f. The Department for Medicaid Services (DMS) if the issue involved patient status in a skilled nursing home.

B. If at the hearing, the client presents new medical evidence which may affect the determination of incapacity, disability or good cause the hearing officer will issue an Interim Order sending the case back to the Medical Review Team (MRT) for a redetermination using the new medical information. The hearing record will be held open for 30 days. Refer to [MS 0465](#).

C. The recommended order is reviewed by the parties listed in item A.3. The parties have 15 calendar days from the mail date indicated on the recommended order to review and file any exceptions and/or rebuttals. Exceptions or rebuttals filed after the 15<sup>th</sup> calendar day are disallowed.

1. [If there are no exceptions or rebuttals to the recommended order received within the 15-day period, then on the 16<sup>th</sup> day the recommended order becomes the final order for Supplemental Nutrition Assistance Program cases, any type of Claim, and Medicaid. The recommended order is reviewed to ensure that it is in accordance with regulations. A final order will be issued for the Kentucky Transitional Assistance Program and Kentucky Works Program. ]

Note: Central Office will no longer receive notification of the recommended orders from DAH or final orders from the Appeals Board for Public Assistance. Field staff will receive notification through the Worker Portal and be responsible for reviewing the RO's to determine if an exception is required. If an exception is required,

follow instructions below and follow the hearing procedure process for administrative disqualification hearings through the Worker Portal:

2. Exceptions by the Agency are filed by DFS Central Office staff.
  - a. Use the following procedures to file an exception;
    - 1) Upon receipt of a recommended order, the worker and his/her supervisor have 7 calendar days from the date it was mailed to determine if an exception is needed. An exception can only be based on the facts and evidence presented at the hearing. New information or evidence may not be used to take exception.
    - 2) The region drafts an exception outlining why the recommended order should be changed. Specify the policy or evidence you are referring to when writing the draft.
    - 3) Forward the written exception to the Regional Program Specialist who will review the request. Valid exception requests are sent via email within 10 calendar days to the appropriate program branch in DFS Central Office:
      - SNAP Hearings  
Nutrition Assistance Branch at [CHFSFoodBenefitsPolicy@ky.gov](mailto:CHFSFoodBenefitsPolicy@ky.gov);
      - Medical Assistance Hearings  
Medical Support and Benefits Branch at [DFS.Medicaid@ky.gov](mailto:DFS.Medicaid@ky.gov); or
      - KTAP, Kinship Care, FAD, KWP, WIN Hearings  
Family Self-Sufficiency Branch at [fssbk-tap@ky.gov](mailto:fssbk-tap@ky.gov);
      - Claims Hearings  
Claims Management Section at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov).
    - 3) After review, Central Office staff submits the exception, if appropriate, to the CHFS Appeal Board for Public Assistance. A copy of the exception is sent to the client and representative, as appropriate. Field staff are required to scan a copy of the final filed exception to the electronic case file on the Worker Portal
      - a) If an exception is filed timely by either party, the other party can file a rebuttal to the exception within the 15-day period. If the 15 days have elapsed, no rebuttal can be made.
      - b) The CHFS Appeal Board for Public Assistance office staff reviews all timely exceptions to the recommended order and drafts and signs a final order.

3. If no exceptions to a Recommended Order of Dismissal are submitted to the CHFS Appeal Board for Public Assistance by the 15<sup>th</sup> calendar day, then on the 16<sup>th</sup> day, the recommended order becomes the final order and the agency can take appropriate action on the case.

MS 0515

THE FINAL ORDER

(1)

[The Cabinet for Health and Family Services (CHFS) Appeal Board for Public Assistance issues the final order for the hearing.

- A. The final order accepts the recommended order, rejects or modifies the recommended order, or returns the issue back to the hearing officer for further action before a final order is issued.
- B. The CHFS Appeal Board for Public Assistance has 60-90 days to issue a final order from the date the Hearing Request is received.
  1. Receives the official record of the hearing in which a recommended order is not submitted; or
  2. Receives the recommended order.
- C. The CHFS Appeal Board for Public Assistance signs the final order and mails a copy of the final order to the following:
  1. The recipient;
  2. The representative;
  3. The Regional Contact;
  4. Central Office;
  5. The local office; and
  6. If the issue involved patient status in a skilled nursing home, to the Department for Medicaid Services.】
- D. The final order becomes part of the record and approves or rejects the recommended order, and provides the available appeal rights.
- E. A final order is followed until the next time the household's eligibility is redetermined.

MS 0520 LOCAL OFFICE FOLLOW-UP TO A FINAL ORDER (1)

[When the final order signed by the Cabinet for Health and Family Services (CHFS) Appeal Board for Public Assistance is received in the local office, the final order and recommended order are reviewed by the supervisor and worker for any reference to future action in the case.]

- A. For reversals of denials or discontinuances of IM cases, take case action to approve or reapprove the case and return the case record to active status.

For reversals involving reduction of IM benefits, take case action within 10 days to restore benefits effective the date of the reduction action on which the hearing was held and authorize supplemental benefits, if appropriate.

- B. Final orders which result in an increase in the household's ongoing SNAP allotment or the issuance of a supplemental or restoration must be reflected in the benefit allotment within 10 days of the receipt of the final order.

If the final order is a result of a request for a casualty replacement that was denied, the casualty replacement must be issued within 10 days of the receipt of the final order.

Determine if the recipient has an existing claim. If so, offset benefits, if appropriate.

- C. When a final order is received that instructs the worker to resubmit a case to MRT for a determination of incapacity, disability or good cause for the Kentucky Works Program (KWP), do the following:

1. Within 2 days of receipt of the final order, send an appointment letter to the client to complete a new form PA-601T, Referral for Determination of Incapacity/Disability. Request the client bring in new or updated medical information.
2. At the appointment, complete form PA-601T and include any new or updated medical information the client presented at the hearing or has been received since the hearing. Also, have the client sign an original form MRT-15, Authorization to Disclose Information to Cabinet for Families and Children, for each medical source (doctor, hospital, lab, clinic, etc.) plus two additional MRT-15 forms. Sign the forms as a witness.
3. Annotate in red on the top of form PA-601T the following: "Case remanded to MRT by an administrative hearing final order".
4. Upon completion of forms PA-601T and MRT-15, immediately forward to MRT the forms along with:
  - a. A copy of the final and recommended orders;
  - b. The MRT determination packet which was used in the hearing, including:



- (1) Medical information;
  - (2) The last form PA-601T;
  - (3) PA-6, Incapacity Determination; or
  - (4) PA-610, Certification of Permanent and Total Disability;
- c. The new medical information/documentation the client presented at the hearing; and
  - d. Any new information/documentation the client may provide at the appointment.

MRT will make a determination considering the new information provided by the client. Upon receipt of MRT's determination, take appropriate action on the case. If the client disagrees with the action taken based on the new determination, the client can request a hearing.

- D. If the issue pertained to a medical determination, enter a spot check for any recommendation for a reexamination for a calendar month sufficiently in advance of the recommended action to provide for timely reexamination. If the final order includes recommendations for referrals to, for example, Rehabilitation Services, immediately follow up such recommendations.
- E. In cases when the Agency is upheld, the notification advises the client of the right to file an appeal with the Appeal Board. In cases in which assistance has been continued during the hearing process, the worker takes action based on the final order to correct the case and the amount of benefits.

Do NOT continue benefits pending an appeal to the Appeal Board.

If appropriate, initiate a claim and collection action against the household for any overpayment caused by a continuation of benefits pending the hearing. Initiate claims action even if the case is inactive.

- F. The hearing officer's responsibility ends with the issuance of the final order. If pertinent records or facts of substantive value become available after the final order, this additional information is considered as a basis for reapplication. If the case is pending review by the Appeal Board, the Board is notified of additional evidence by memorandum from the local office.
- G. Enter a brief statement of action, including the issuance date of the final order on KAMES "Comments" screen.
- H. Volume IVA, [MS 3680](#), and Volume IVA, [MS 3690](#), contain specific procedures relative to hearings in which the issue relates to patient status in a Long Term Care facility.

MS 0530 APPEAL TO THE APPEAL BOARD (1)

[An appeal to the Appeal Board is the final administrative review available to a recipient dissatisfied with the decision of the hearing officer. The Appeal Board consists of the Secretary of the Cabinet for Health and Family Services (CHFS), or authorized representative, and two other members.]

- A. Requesting an Appeal. If the recipient disagrees with the hearing decision, the recipient must appeal within 20 days of the date the hearing decision was mailed. The mailing date is the date on the hearing decision. The Appeal Board, if requested by the recipient, may grant a 10-day extension to the 20-day time standard, if good cause for the delay is established according to [MS 0475](#).

Whenever an appeal is not made within the 20-day time standard, submit a memorandum with the appeal explaining the cause of the delay and request the Appeal Board to determine if good cause for the delay exists.

The recipient's request for appeal may be either a verbal or written request. The date of the verbal request is the date of the appeal; however, any verbal request must be confirmed in writing by the recipient. The written request is either a letter from the recipient or completion of form PAFS-78, Request for Hearing, Appeal or Withdrawal. The date the letter is received or the date on form PAFS-78 establishes the date of the request for appeal. Encourage the recipient to make the appeal in the local office to avoid delay in requesting the appeal within the prescribed time frame.

- [B. Forwarding the Appeal Request. Forward the appeal request by email to the CHFS Appeal Board for Public Assistance at [CHFSAppealBoard@ky.gov](mailto:CHFSAppealBoard@ky.gov). Do not send the case record unless it is requested. The Appeal Board for Public Assistance will have necessary material and the tape of the hearing.]
- C. Action after Submitting Request. The Appeal Board will send the recipient an acknowledgement of receiving the appeal request. The recipient may request permission within 7 days from the date on the acknowledgement to submit written arguments or new evidence regarding the appeal.

When the Appeal Board orders a special examination, the recipient is notified of the date, time and place of the examination with a copy of the notification sent to the local office.

The recipient notifies the local office if unable to keep the appointment and the supervisor calls the Appeal Board to advise and schedule a new appointment.

- D. Reapplication before Appeal Board Decision. If the recipient reapplies during the appeal process, before a decision is reached, process the application.

MS 0535\*

## HEARING OF APPEALS

The Appeal Unit in the Department of Law will present the appeal to the Appeal Board. All appeals are heard based upon the records of the Department and evidence and exhibits introduced before the hearing officer unless the recipient specifically requests an additional hearing. Such additional hearings are only granted for the purpose of introducing new and additional proof not available for introduction at the original hearing.

The Appeal Board may direct the taking of additional evidence if needed to make a decision. Such evidence will be taken by the Board after 7 days notice to the parties, giving the parties the opportunity to object to the introduction of additional evidence or to rebut/refute any additional evidence.

MS 0540

THE APPEAL BOARD DECISION

(1)

[The Appeal Board decision is mailed to the recipient and the recipient's legal counsel by the Appeal Unit. Appeal Board decisions are confidential case information and may be released only to the recipient, the recipient's power of attorney or legal representative, or the recipient's attorney. Whenever the hearing officer's decision is upheld, the letter of transmittal advises the recipient of the right to appeal to the Circuit Court in his home county within 30 days of the date the decision is mailed.]

The decision of the Appeal Board is mandatory and irrevocable except by judicial action, until such time as investigation or reapplication establishes that facts surrounding the issue have altered to the extent that the decision is no longer appropriate.

- A. Retroactive Payments. If the Appeal Board reverses the decision of the hearing officer, payment and/or medical entitlement retroactive on a month-by-month basis is authorized in the local office, along with authorization for continuing action provided it is established that the recipient is currently eligible.
- B. Field Action. Field Action on Appeal Board decisions corresponds to hearing decisions in that:
  - 1. The case record is annotated;
  - 2. Reversals are set up for appropriate redetermination; and
  - 3. If the decision contains recommendation for referrals, treatment, etc., follow-up on the recommendation is made immediately.

MS 0545                    JUDICIAL REVIEW OF APPEAL BOARD DECISIONS                    (1)

The recipient may request the Circuit Court in the county of residence to review any Appeal Board decision.

- A. A request for review must be filed within 30 days from the date of the Appeal Board's decision.
- B. **[The Division of Administrative Hearings certifies the official hearing record and forwards it to the court.]**
- C. The court reviews the record as certified by the Secretary, Cabinet for Health and Family Services, and no other evidence can be admitted.
- D. The court reviews the case to determine if:
  - 1. There was sufficient probative evidence to support the Appeal Board's decision;
  - 2. The regulations on which the decision was based are reasonable; or
  - 3. The Appeal Board acted arbitrarily, unlawfully, or in a manner that constitutes an abuse of discretion.
- E. If the court upholds the decision of the Appeal Board, the case record is returned to the local office with appropriate notation.
- F. If the court reverses the decision, the Appeal Unit reviews the record and judgment to determine whether appeal on the part of the Cabinet is justified.

If no further appeal is needed, official notification of reversal is issued by the Appeal Board.

- G. See [MS 0520](#) for local office procedures after the appeal decision is received.

MS 0560 DOCUMENTATION OF ALIEN STATUS (1)

Verify the status of an alien through the U.S. Citizenship and Immigration Services (USCIS) documentation.

Aliens who left their homelands under emergency situations may not have all the required documentation for eligibility such as verification or documentation of birth, marriage, divorce or relationship. In the absence of the regular sources of verification, use form I-94, I-151, I-551 or other entry documents to verify required information (e.g., age, relationship or alien status). Review and accept any documents the alien brought from his/her homeland that verifies the alien's situation. The alien's statement may be accepted for verification of marriage, divorce, relationship and prior labor market attachment. USCIS documents may be used to verify date of birth. The alien's statement is NOT acceptable to verify alien status. Alien status MUST be verified by USCIS documents.

Use the following chart as a guide to the USCIS documentation. This is not an inclusive chart. An alien may have a different USCIS document that identifies the alien status and date of entry. Accept any USCIS documentation provided by the alien that verifies status and date of entry unless it is questionable. Have the alien resolve any questionable status through USCIS.

NOTE concerning form I-94, Arrival/Departure Record: On 4/30/13, Customs and Border Protection (CBP) automated the I-94 process at air and sea ports only. Most non-immigrant visitors entering the country via air and sea ports will no longer be issued a paper I-94. Instead, the admission information generally provided in the paper I-94 will be stamped on the traveler's foreign passport (i.e. COA, date of entry and expiration date), with the exception of the I-94 admission number. Aliens have to visit [www.cbp.gov/I94](http://www.cbp.gov/I94) to print their I-94 admission number. Also, if an alien is unable to provide a passport with the admission stamp, a copy of their record of admission can be printed by the alien at this website.

[Beginning 9/7/15, refugees will no longer receive the paper I-94 card at Ports of Entry (POE) and will need to obtain the I-94 record online. CBP will stamp the refugee's transportation boarding letter upon admission to the U.S. which is provided to the Principal Applicant of each refugee case. Beginning 9/1/15, the transportation boarding letter will be the only document provided to the refugee with an official CBP refugee stamp.

Derivative asylees and parolees will continue to receive a paper I-94. CBP will strike out the pre-printed number and hand-write the true I-94 number on the document. Use the hand-written I-94 number when verifying alien status.]

The I-94 has a letter that indicates the entry status. The letter will have a number after it such as A-2, H-3, etc. Letter codes A through L indicate the alien entered the U.S. for a temporary reason.

The following list defines the specific letter codes:

- A – Foreign government official;
- B – Visitor for business or pleasure;

- C – Alien in travel status;
- D – Alien crewman;
- E – Treaty trader and investor and family;
- F – Alien student;
- G – Representative and personnel of international organizations;
- H – Temporary worker;
- I – Members of foreign press, radio or other information media;
- J – Exchange visitor;
- K – Fiancé or fiancée of U.S. citizen and their children; or
- L – Intra-company transferees and their families.

If the I-94 has an entry other than codes A through L, the alien has entered the U.S. for permanent residence. The entry indicates the status of the alien such as refugee, asylee, victims of human trafficking and eligible relatives, etc.

Status of Alien	USCIS Document
Permanent resident alien before August 22, 1996	I-151 (Green card) was replaced with the I-551 (Alien Registration Receipt Card, commonly known as the "green card") in March 1996
Permanent resident alien on or after August 22, 1996 If veteran of US Military If active duty US Military	I-551 (Valid for 10 years)  DD-214 Discharge Certificate Any document showing active status
Refugee	I-94 marked with "admitted under INA 207", "Refugee", or "Refugee - Conditional Entrant"
Asylee	I-94 marked with "admitted under INA 208" or USCIS letter
Deportation Withheld	I-94 marked with "admitted under INA 243(h)" or letter from immigration Judge
Amerasians	I-94 or I-551 marked with an identifier in comments - AM1, AM2, AM3, AM6, AM7 or AM8
Parolees	I-94 marked with "admitted under INA 212(d)(5)" The date will read "Indefinite"
Conditional Entrants	I-94 marked with "admitted under INA 203(a)(7)"
Cuban/Haitians	I-94 may be marked "admitted under INA 207", "Refugee" or "Refugee - Conditional Entrant"
Battered Aliens	I-94 admitted under INA 204(a)(1)(A) or (B), or whose deportation is suspended under INA 244(a)(3)
Victims of Human Trafficking and Eligible Relatives	I-94 or visa with "T-1" category. Eligible relatives of the victims have T-2, T-3, T-4 or T-5 category designations.

Afghan/Iraqi Special Immigrant	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SI1; Department of Homeland Security (DHS) stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SI6.
Spouse of Afghan/Iraqi Special Immigrant	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SI2; DHS stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SI7.
Unmarried dependent child of Afghan/Iraqi Special Immigrant	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SI3; DHS stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SI9.
Iraqi Special Immigrant under Section 1244	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SQ1; DHS stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SQ6.
Spouse of Iraqi Special Immigrant under Section 1244	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SQ2; DHS stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SQ7.
Unmarried dependent child of Iraqi Special Immigrant under Section 1244	Passport with an immigrant visa (IV) stamp noting the individual has been admitted under IV category SQ3; DHS stamp or notation on passport or form I-94 showing date of entry, or form I-551 (green card) SQ9.
Native Americans born in Canada	Form I-181, Memorandum of Creation of Record of Admission for Lawful Permanent Residence, form I-551 with the code S13, an unexpired I-551 stamp in a Canadian passport, form I-94 with the code S13 or a letter or other tribal document certifying at least 50% American Indian blood combined with a birth certificate or other satisfactory evidence of birth in Canada.
Form I-185	Canadian border crossing card.
Form I-186	Mexican border crossing card.
Form SW-434	Mexican border visitor's permit.

Aliens who have limited English language skills may need interpreter services. When requesting additional information, make every effort to ensure that the alien understands the request. If the alien is in the office with an interpreter or has a relationship with a refugee resettlement agency, discuss the possibility of signing



form DCBS-1, Informed Consent and Release of Information and Records, to allow the sharing of the request for information with the appropriate entity or individuals.

MS 0562\* DOCUMENTATION FOR ALIEN VICTIMS OF TRAFFICKING

Traffickers force young women and children into prostitution, slavery and forced labor through coercion, threats of physical violence, psychological abuse, torture and imprisonment. It is not necessary for the worker to determine whether someone is a victim of a severe form of trafficking or to contact the U.S. Citizenship and Immigration Service (USCIS) or any division of the Department of Justice to consult on these issues.

The Trafficking Victims Protection Act of 2000 (Public Law 106-386) provides that "victims of a severe form of trafficking" are eligible for benefits and services DCBS administers. Individuals identified as victims and their eligible relatives are treated as an alien who is admitted to the United States as a refugee and are not barred from receiving benefits during their first five years in the United States. Eligible relatives include the spouse and dependent children of the victim and if the victim is a child, the child's parents and siblings. This eligibility is without regard to the actual immigration status of such victims.

The Office of Refugee Resettlement (ORR) is designated to certify that an adult is a victim of a severe form of trafficking. Children under 18 years of age do not need to be certified. However, the child must still be determined eligible for benefits as a minor victim of a severe form of trafficking. ORR issues a certification letter for adults and a letter, similar to the adult certification letter, for children. These letters serve as the verification that the individual is a victim of trafficking.

Use the following policy and procedures when processing cases that contain a member who is a victim of human trafficking.

- A. Applications for K-TAP, Medicaid, or food benefits who are victims of a severe form of trafficking must present their letter from ORR to the worker.
  1. Accept the ORR letters in place of INS documentation. Victims of a severe form of trafficking are not required to provide proof of their immigration status. Do not complete a SAVE inquiry on the victims.
  2. Call the Trafficking Verification Line at (202) 401-5510 to confirm the validity of the ORR letter and to notify ORR of the type of benefits for which the individual has applied.
- B. The entry date for the individual is the certification date that appears in the body of the ORR letter.
- C. If the individual does not have documents to verify identify, contact the Trafficking Verification Line for assistance.
- D. If the individual does not have or cannot obtain a social security number (SSN) for work purposes, assist the individual in obtaining a SSN for non-work purposes by providing the individual a letter for the Social Security

office that includes:

1. The Cabinet's letterhead;
2. The individual's name;
3. The reason a non-work number is required; and
4. A statement of eligibility for the program benefits. This means that all the eligibility factors are verified and entered on the system for approval.

The letter cannot be a form letter, photocopied or generic.

Do not delay, deny or discontinue assistance pending the receipt of the SSN.

- E. Determine technical and financial eligibility for the program and issue benefits, and if eligible, to the victim in the same manner as refugees.

If the application includes a member who is not a victim of a severe form of trafficking, this member is subject to the 5-year ban for receipt of benefits unless his/her immigration status meets one of the statutory exceptions.

- F. Once victims of a severe form of trafficking are determined eligible, either at disposition or after disposition, enter a spot check "I" for the food benefits case and/or "87" for the IM case, for the eighth month starting with the month of ORR certification, or eligibility letter for children. When the spot check "TECH ELIGIBILITY FACTOR CHANGE" appears on the DCSR, contact the Trafficking Verification Line to verify recertification.

1. If it is verified that the victim of a severe form of trafficking is recertified with ORR, take no further action until the next recertification.
2. If it is verified that a victim of a severe form of trafficking is not recertified with ORR, take action to have the recipient come into the office and determine if on-going benefits are appropriate in another alien status.

- G. At this time, there are no procedures to de-certify victims of severe forms of trafficking. The recipient should have an original updated letter of certification or similar letter for children, at recertification. The recipient's ORR certification period is eight months and, in most cases, will not correspond with a given program's certification period. If the household does not have an original updated letter from HHS, contact the Trafficking Verification Line for assistance.

If during an interview it is determined that the applicant/recipient is not or is no longer eligible based upon information from the Trafficking Verification Line, determine eligibility using other criteria for aliens.

- H. Anytime an applicant or recipient believes he/she may meet the definition

of a victim of "severe forms of trafficking", provide the individual the phone number of the Department of Justice, Division of Civil Rights, (888) 428-7581, or the Refugee State Coordinator with Catholic Charities of Louisville, (502) 636-9263.

If it is believed that a child has been subjected to a severe form of trafficking, the worker is to make a referral to Protection and Permanency (P&P). P & P makes the decision if the alleged maltreatment meets the adult or child eligibility criteria for intake.

MS 0565\*                      ALIENS SPONSORED ON OR AFTER 12/19/97

Privately sponsored aliens must meet additional income and resource requirements. A private sponsor is an individual, not an organization or group.

A. Some aliens are not required to have a private sponsor as a condition of entry into the U.S. on or after 12/19/97. These aliens are:

1. Refugees under Section 207;
2. Asylees under Section 208;
3. Individuals whose deportation is being withheld under Section 243(h);
4. Cuban/Haitian entrants; or
5. Amerasians.

These aliens can be publicly sponsored by an organization or group. Publicly sponsored aliens are NOT subject to income deeming.

B. Privately sponsored aliens who enter the U.S. on or after 12/19/97 must complete and sign before a notary public, a sponsorship agreement, INS form I-864, Affidavit of Support.

Form I-864 shows that an alien has adequate means of financial support and is not likely to become a public charge. Signing the form constitutes a legally binding contract between the sponsor and the U.S. Government in which the sponsor agrees to support the alien and any spouse and/or children immigrating with the individual. The sponsor's obligation continues until the sponsored alien:

1. Becomes a U.S. citizen;
2. Can be credited with 40 qualifying quarters of work. For 40 quarters determination, see Volume II, [MS 2900](#) A. 2;
3. Departs the U.S. permanently; or
4. The sponsor dies.

An alien may have joint sponsors if one sponsor cannot meet the income requirement. The joint sponsor must also complete form I-864.

C. Immigrants currently in the U.S. who previously completed sponsor agreements are NOT subject to the new affidavit requirements. Forms I-134, Affidavit of Support, or I-361, Affidavit of Financial Support and

Intent of Petition for Legal Custody, were not obsoleted. These forms were used as sponsor agreements prior to 12/19/97.

- D. Sponsored aliens entering the U.S. on or after 12/19/97 and completing the new affidavit of support are responsible for:
1. Providing forms I-864 and I-864A as appropriate, and verifying the income and resources of the sponsor and the sponsor's spouse. The sponsor's total income and resources, as well as the spouse's, are deemed available to the sponsored alien;
  2. Obtaining cooperation from the sponsor's household necessary to process the application;
  3. Reporting all changes concerning the sponsor's household which affect the sponsorship of the member, such as income changes; and
  4. Reporting a change in sponsor or termination of the sponsorship agreement.

MS 0566\*      CONSIDERATION OF THE SPONSOR'S INCOME AND RESOURCES

The income and resources of the sponsor and the sponsor's spouse are deemed as available to a sponsored alien who completed the affidavit of support on or after 12/19/97.

- A. Deeming the sponsor's income applies to all aliens sponsored by individuals. Deeming continues until the alien gains citizenship.
  - 1. The total income and resources of the sponsor and spouse are considered available to the alien's household. Consider the deemed income as unearned income.
  - 2. If a change in sponsorship occurs during the recertification period, verify and recalculate the deemed income and resources.
- B. There are exceptions for deeming a sponsor's income. Do not deem the sponsor's income to the alien if one of the following exceptions applies:
  - 1. If the alien is determined indigent. Apply the following conditions to determine indigence:
    - a. The amount of the sponsor's income and resources given to the alien does not exceed the amount agreed to in the affidavit; AND
    - b. Without the assistance from the Cabinet, the alien would be unable to obtain food and shelter. In determining if the alien is indigent, take into account the alien's own income, plus any cash, food, housing or other assistance provided by other individuals including the sponsor.

Count only the amount actually provided by the sponsor for a 12-month period. The 12-month period for the indigent exception starts with the month the determination is made.

If an alien is determined indigent, forward the names of the sponsor and sponsored alien involved to the appropriate program branch in the Division of Family Support.

- 2. If the alien or alien's child has been subjected to extreme cruelty or has been battered in the U.S. by:
  - a. A spouse or parent; or
  - b. A member of the spouse or parent's family living with the alien or alien's child and the spouse or parent allows the cruelty or battery; or
- 3. If the alien is a child who lives with a parent who has been battered or subject to extreme cruelty in the U.S. by:
  - a. A spouse; or

- b. A member of the spouse's family living in the same household and the spouse allows the battery or cruelty.

In order to claim this exception, the alien child and parent may not be living with the individual committing the battery or extreme cruelty. This exception lasts 12 months unless the child and parent move back into the abusive situation.



MS 0570

SAVE

(1)

[Federal law requires that the immigration status of aliens applying for benefits be verified. The Systematic Alien Verification for Entitlement (SAVE) is the U.S. Citizenship and Immigration Services (USCIS) system of verification for this purpose. SAVE is used to reverify the initial documentation of alien status received from the alien. Any applicant who is not a U.S. citizen or national is required to carry immigration documentation that contains an Alien Registration Number (A-Number) or an I-94 Admission Number. These numbers are used to access SAVE.]

For aliens who have permanent resident status, the SAVE process is completed only once. For all other aliens, the SAVE process is repeated at every recertification or until the alien is granted permanent resident status.

[Do not complete a SAVE inquiry on victims of human trafficking. However, do complete a SAVE inquiry on eligible family members of trafficking victims.]

Use the following procedure when an alien applies for benefits.

A. [Initiate a request for verification by SAVE. Send a memorandum with the following information to the Regional Office:

1. Case name and number;
2. For each alien member: name, the corresponding alien number, birthdate, the type of documentation provided, and if available, the social security number and the I-94 admission number; and]
3. Worker name, code and phone number.

[For SNAP, **DO NOT** delay processing the case for the receipt of SAVE information. For Medicaid and other programs, which include issuance of Medicaid, **WAIT** for the SAVE information before processing the case.

B. Within 3 work days from receipt of the request, the Regional contact person accesses the web-based program to obtain SAVE information and:

1. In response, the Verification Information System (VIS) assigns a verification number which is used as a reference number if further verification from USCIS is needed.
2. VIS also provides the name, alien number, birthdate and social security number, if available, which is retained by the VIS database.
3. Regional Office compares the information provided in the original memorandum to the information provided by VIS, and decides whether further verification by form G-845, Document Verification Request, is necessary.

4. Regional Office annotates the original memorandum with the SAVE information and their decision, and returns the memorandum to the local office.】

C. When the SAVE information is received from Regional Office:

1. 【If SAVE verifies alien status: document the SAVE response in comments and scan into ECF.
2. If SAVE does not verify alien status and requests additional verification:
  - a. Regional Office completes form G-845, Document Verification Request. The form along with a scanned copy of the alien's document with or without additional information for verification is submitted electronically to USCIS.  
  
DO NOT deny or discontinue the case based on alien status until a response is received.
  - b. If the USCIS response on form G-845 indicates the alien status document is valid, document the response in comments and scan into ECF.
  - c. If the USCIS response on form G-845 indicates the alien status document is not valid, deny or discontinue benefits for the unverified alien.】

MS 0590 FEDERAL BENEFIT CHANGES (1)

RSDI, SSI, Railroad Retirement (RR), Black Lung, and designated Veterans Administration (VA) beneficiaries periodically receive a change in the benefit amount.

A. FEDERAL BENEFIT CHANGES

1. Medicaid and K-TAP:

All IM recipients who get these benefits are affected, and are responsible for reporting the change.

Note: Individuals in Long Term Care (LTC) who only receive SSI are not affected by the conversion.

2. SNAP:

These changes in federal benefit income are known to the agency and are not required to be reported by SNAP recipients/households.

- a. The federal increase is considered a mass change.
- b. A notice of action taken is required, but a timely notice of a reduction or discontinuance of benefits is not required.

B. KAMES generates all required notices for any case action taken as a result of the conversion.

C. Verifying Benefits

During the first week of December, request verification of benefits as follows:

1. RAILROAD RETIREMENT (RR)

[Benefits for these individuals may increase or decrease. Use form PAFS-54, Letter to Verify Railroad Retirement Benefits or the "KAMES-IM Active Cases with RR Benefits", listing to send ONE ALPHABETICAL LIST of claimants per local office to the appropriate RR District office shown below. List the claimant's name, wage earner's name and the claim number as it appears on the Medicare card. The Louisville District Office serves most Kentucky counties except those listed below:

Counties:

Boone, Bracken,  
Campbell, Gallatin,  
Grant, Kenton,  
Mason, Pendleton  
and Robertson

Send to:

Cincinnati District Office  
CBLD Center, RM. 201  
36 East 7th Street  
Cincinnati, Ohio 45202  
Telephone: (877) 772-5772

Boyd, Carter, Elliott, Floyd, Greenup, Johnson, Lawrence, Lewis, Martin and Pike	Huntington District Office New Federal Bldg., RM. 145 640 4TH Ave. Huntington, WV 25721 Telephone: (877) 772-5772
Henderson and Union	Indianapolis District Office The Meridian Centre 50 South Meridian, Ste. 303 Indianapolis, IN 46204 Telephone: (877) 772-5772
All other counties	Louisville District Office 629 South 4 <sup>th</sup> Street Suite 301 Louisville, Ky. 40202. Telephone: (877) 772-5772

The RR Board enters the new benefit amount on form PAFS-54 or the KAMES listing and returns the form to the local office sometime in the month following the change.

The recipient will receive an IBM card from the RR Board showing the benefit amount. If the recipient is contacted for another reason before verification is received from the RR Board, verify the new amount from the recipient award letter.】

## 2. VA BENEFITS

Use form PAFS-53, Letter to Verify Veterans Benefits or "KAMES-IM Active Cases with VA Benefits" to send ONE ALPHABETICAL LIST of claimants per local office to:

- a. Department of Veterans Affairs Regional Office  
321 West Main Street, Ste. 390  
Louisville, KY 40202.  
Telephone: (800) 827-1000
- b. List claimant's name and VA claim number.

The VA indicates the new basic benefit amount plus aid and attendance, if any, on form PAFS-53, Letter to Verify Veterans Benefits, or the KAMES listing and returns the verification to the local office. Not all VA beneficiaries receive an increase. VA beneficiaries that will receive an increase will receive an award letter no later than the month before the change occurs. If the recipient is contacted for another reason before verification is received from the VA, verify the new amount from the recipient benefit verification letter.

### 3. BLACK LUNG BENEFITS

Send a request for information to the recipient requesting verification of entitled benefit and convert as appropriate. Use the "KAMES-IM Active Cases with Black Lung Income" listing to identify KAMES cases. Black Lung recipients usually receive a cost of living increase; this can be verified through the annual Federal Benefit Rate (FBR) for Black Lung.

### 4. SOCIAL SECURITY BENEFITS

If an increase in benefits is authorized by the Social Security Administration, the increase becomes effective January 1<sup>st</sup> of each year. Verify RSDI entitlement amount by IMS Inquiry program HR39 (BENDEX) or benefit verification letter at the next recertification. When program HR39 is accessed to obtain the RSDI benefit amount, use the amount shown as "NET". "NET" is the amount before the SMI deduction. DO NOT round. Enter the actual NET RSDI amount on KAMES. If there is an overpayment of RSDI retained in order to pay back an RSDI claim, for SNAP cases, subtract the current overpayment amount from the "Net" amount to calculate the amount of RSDI to be counted in the case. Contact the client for verification if unable to verify benefit amount from these sources.

D. Use the following timeframes for completing manual conversions:

1. When a household applies in January, consider the new amount for issuances in January and thereafter.
2. Reflect the increased benefit amount in an active case as follows:
  - a. IM cases no later than January.
  - b. FS cases no later than the March issuance.
3. For any cases not converted to the new Federal benefit level by the due date, complete a claim.

MS 0610 OVERVIEW OF THE CHILD CARE ASSISTANCE PROGRAM (1)

The Child Care Assistance Program (CCAP) is operated by service agents who are contracted by the Cabinet. The list of the service agents and counties each serve is located at <http://chfs.ky.gov/dcbs/dcc/apply.html>.

- A. Eligibility for CCAP is determined by service agents for all individuals except for those who are:
  1. Participants in the Kentucky Works Program (KWP) including sanctioned individuals participating in order to cure a penalty;
  2. Employed KTAP recipients who are KWP work eligible individuals;
  3. Receiving child protective services from the Division of Protection and Permanency; or
  - [4. KTAP teen parents attending high school or pursuing a general equivalency degree (GED).
- B. Eligibility for a single parent employed an average of 20 hours per week or a couple employed a combined average of 40 hours per week is determined by the service agents.
- C. Eligibility for CCAP for employed KTAP recipients and KWP participants is determined by the KWP case manager or KTAP worker. Medicaid and Supplemental Nutrition Assistance Program (SNAP) recipients and Kinship Care relatives needing CCAP are referred to a service agent for an eligibility determination.]
- D. The CCAP serves:
  1. KTAP recipients, including teen parents, who need child care while employed or participating in KWP;
  - [2. KTAP recipients who need child care in order to work when KTAP is discontinued and income remains at or below the CCAP gross income limits. These individuals may be eligible for CCAP until the next redetermination after the KTAP discontinuance;
  3. Families with children receiving protective services and are referred for child care by Protection and Permanency; or
  4. Low income families.]

- E. To receive CCAP payments, a child care provider must be:
1. Licensed;
  2. Certified; or
  3. Registered. Persons living in the same household as the child needing the services CANNOT receive CCAP payments for caring for that child.
- F. Family Support staff may address the child care needs of applicants and recipients by:
1. Approving child care benefits for KTAP recipients using form DCC-85A, KTAP Approval for Child Care Assistance. Refer to Volume IIIA [MS 5270](#) for specific instructions for approval of CCAP for KWP participants and employed KTAP recipients; or
  - [2. Referring recipients of SNAP, Medicaid, child only KTAP cases without a work eligible adult, or Kinship Care benefits who request child care assistance to the designated service agent staff for an eligibility determination. Form DCC-86, Referral for Low-Income Child Care Assistance, is used for this purpose.

Field staff send referrals and exchange information with the service agents by e-mail to the Division of Child Care centralized mailbox at CHFS DCBS DCC 85 or by typing the e-mail address, [DCC85@ky.gov](mailto:DCC85@ky.gov).]

- G. A summary of the CCAP for workers is contained in form DCC-113, Child Care Assistance Program (CCAP) Information for Workers. This information is accessible at <https://chfsnet.ky.gov/dcbs/dcc/Pages/DCCFormsLibrary-ListView.aspx>

MS 0620 CHILD CARE ASSISTANCE PROGRAM ELIGIBILITY REQUIREMENTS (1)

Applicants and recipients of any program who need financial assistance in order to pay for child care costs should be screened for eligibility for the Child Care Assistance Program (CCAP). CCAP is administered by the Division of Child Care in the Department for Community Based Services. In order to be eligible for the CCAP, the following criteria must be met.

- A. The parent or responsible adult must be:
  - [1. Working an average of 20 hours per week for a single parent or working a combined average of 40 hours per week for a couple; ]
  - 2. Receiving KTAP and working or participating in the Kentucky Works Program;
  - [3. A teen parent (through age 19) attending high school or pursuing a general equivalency degree (GED); ] or
  - 4. The caretaker for a child determined by the Division of Protection and Permanency (P&P) to be in need of care due to safety or neglect issues present in their home. P&P makes these determinations.
- B. The household includes a dependent child needing care who is:
  - 1. Under age 13;
  - 2. Under age 19 and physically or mentally incapable of caring for oneself (verified by a physician's or certified/licensed psychologist's statement) or under court supervision.
- C. [The household's income is at or less than CCAP gross income limits. The income of all responsible adults in the household is considered in the eligibility determination completed by the service agent. Income of a child is excluded.
- D. A family that continues to work and is discontinued from KTAP will remain eligible for CCAP services if the household's income remains at or below the CCAP gross income limits until the redetermination for CCAP.]
- E. Families receiving child care assistance are responsible for a co-payment paid to the child care provider. Failure to pay the co-payment can result in loss of child care benefits. No co-payment is assessed if:
  - 1. Protection and Permanency staff elects to waive the co-payment for a family receiving child protective services; or
  - 2. The family's income is below \$900 per month.



- F. CCAP payments are not made when child care is available and accessible through programs free to the recipient such as Head Start or public preschool /kindergarten.

MS 0640

VOTER REGISTRATION

(1)

Federal and state law requires the Department to distribute voter registration forms, assist individuals in the completion of forms, and ensure the completed voter registration forms reach the appropriate state election office for processing.

- A. Staff is subject to fines, imprisonment up to five years, or both, if convicted of:
  - 1. Seeking to influence political preference or party registration;
  - 2. Displaying any political preference or party allegiance; or
  - 3. Making statements or acting in a way that implies that a decision to register or not to register to vote will have any bearing on the availability of program services or benefits.
- [B. At application, recertification, and when an address change is reported, the head of household/applicant meeting the following criteria is provided the opportunity to complete an application to register to vote or update voter registration: ]
  - 1. Be included in the assistance application or case;
  - 2. Be age 17 or over;
  - 3. Be a citizen of the United States;
- C. Hard copy versions of the voter registration forms, SBE-1 Commonwealth of Kentucky Mail-in Voter Registration Form, are made available to the general public in the reception area.
- D. Other household members may complete form SBE-1 if wishing to register to vote.
- [E. Staff must provide the same level of assistance to individuals wanting to register to vote as is provided for other applications. This includes providing assistance in completing the application to register to vote, unless the applicant/head of household refuses help.]
- F. Completion of the Voter Registration Form is only an application to register to vote. The State Board of Elections approves or denies the application and sends a notice to the applicant.
- G. General information regarding the voter registration process in Kentucky can be found at [www.elect.ky.gov](http://www.elect.ky.gov)

MS 0650

VOTER REGISTRATION PROCEDURES

(1)

- [A. At application, recertification and address change for the applicant/head of household (HOH) age 17 years or over:

FOR FACE TO FACE INTERVIEWS:

Enter the individual's response to the question, "If the head of household is not registered to vote where they live now, would the head of household like to apply to register today?" field on the KAMES General Information (HRKIMA02) screen. Permitted entries are "Y" (Yes), "N" (No), or "U" (Unknown). If the individual is already registered to vote where he/she lives, answer "N" (No).

Form PAFS-706, Voter Registration Rights and Declination, is system generated and uploaded with the case name and case number before printing when "Y", "N" or "U" is entered. Form PAFS-706 is read by or to the individual who signs and dates the form.

The Voter Registration Application, is generated when the applicant/HOH, age 17 or older and a US citizen, answers "Y" or "U" to "If the head of household is not registered to vote where they live now, would the head of household like to apply to register today?"

If the applicant/HOH is not present, the authorized representative is given form PAFS-706 and/or the Voter Registration Application, depending upon the response to the question to be completed by the applicant/HOH.

FOR PHONE INTERVIEWS:

Follow the instructions for face to face interviews and mail form PAFS-706 and/or the Voter Registration Application, depending upon the response to the question, to the household. Inform the applicant to return the forms along with other verification to the local DCBS office.

FOR MAIL-IN APPLICATIONS AND RECERTIFICATIONS:

The system generates and mails a letter of explanation, form PAFS-706, and the Voter Registration Application to I case mail-in applicants if "Y" is answered to, "KCHIP MAIL-IN APP?" and to Z case applicants when "Y" is answered to, "Z MAIL-IN? or LIS referral?". All SAFE cases are mailed the explanation letter, PAFS-706, and the Voter Registration application.

FOR ADDRESS CHANGES:

Anytime a home address is changed on the address case change screen, if the HOH is age 17 or older, a letter of explanation, form PAFS-706, and the Voter Registration Application will be system generated to the household.

- B. If the individual wants to register to vote, the individual completes the Voter Registration Application by checking the party affiliation, reads or is read the voter declination statement on form PAFS-706 and signs and dates the Voter Registration Application and form PAFS-706. The individual's name, SSN, date of birth, sex, county of residence and address is uploaded on the Voter Registration Application. The individual must be provided the opportunity to complete the Voter Registration Application in private. Provide an envelope for the completed Voter Registration Applications.
- C. If the individual does not want to register to vote, form PAFS-706 is completed by the HOH.
- D. If the applicant/HOH refuses to sign the form PAFS-706, enter "refused" in the client signature space, sign and date the form and provide a copy to the applicant/HOH.
- E. Form PAFS-706 is maintained with the case and purged per program policy. See Volume I, MS 0040, Purging Obsolete Material.
- F. For a hard copy application or recertification (including FS-1, Application for SNAP, or PA-100, Application/Recertification for K-TAP, Kinship Care, and Family/AFDC Related MA), provide the applicant/HOH form SBE 01, Commonwealth of Kentucky Mail-In Voter Registration Form and a hardcopy form PAFS-706. Form SBE 01 can be obtained at <http://www.elect.ky.gov/register.htm>. If the individual chooses to register to vote, form SBE 01 is completed and form PAFS-706 is read and signed. Provide an envelope for the completed SBE 01.
- G. Any person entering the local office can fill out a voter registration form if he/she so chooses. Provide the interested individual with form SBE 01.
- H. Instruct the individual to deposit the sealed envelope containing the system-generated Voter Registration Application or form SBE 01 (Mail-In) in the locked voter registration box in the local office.
- I. Completed registration applications must be transmitted to the local County Clerk's office every Friday. For applications completed within 5 days before the last day to register to vote in an election, ensure the applications are transmitted to the county clerk prior to the deadline.
- J. Form PAFS-706 is completed by the HOH at every application, recertification, and when a change of home address is reported.]

MS 0670 INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) (1)

IEVS is a federally mandated system designed to identify case discrepancies by means of various computer matches. IEVS compares the social security numbers of K-TAP, MA, and SNAP applicants/recipients with SSN's contained on the computer files of other state and federal agencies. A hit or exception is generated when a discrepancy is identified between case record data and computer file information. Compare "hits" with income and resource information in the case record.

[Resolve any discrepancies between IEVS data and case record information. If required, verify information. Any potential claims discovered through IEVS matches are resolved separately from the IEVS process and timeframes.]

Member information is entered on KAMES at application or member-add. The system performs two processes which are designed to meet IEVS requirements. These are the on-line computer match and Batch Match.

- A. On-line computer matches are uploaded by the system at application, recertification and member add. On-line match information appears on the appropriate income screens while the case action is pending. Match data must be reviewed and resolved prior to processing.
- B. The Batch Match process matches computer file data against case and member information currently on the active KAMES data base. This includes all ineligible and disqualified household members with a status code not prefaced by "N" (non-member) or "O" (out-of-household). Resolve Batch Match hits through the Batch Match function.

Information obtained through IEVS matches is subject to the confidentiality provisions as detailed in [MS 0150](#) in addition to IRS safeguarding procedures detailed in [MS 0190](#).

MS 0675 [RESOLVING MATCH DISCREPANCIES] (1)

Use the following verification procedures when an IEVS discrepancy is identified in any program.

A. Match Data Requiring NO Independent Verification

1. Matching data from SNAP, Unemployment Insurance, SDX and BENDEX (Unearned Income) files require no independent verification UNLESS the data is questionable.
2. [If the matching data is questionable (i.e., conflicts with previously verified case information), document the reason on KAMES. Resolve the discrepancy and take appropriate case action within 30 days of the match date.]
3. If the matching data is not questionable (i.e., does not conflict with previously verified information), resolve the match within 30 days after the match date.
4. For data received from these sources which is not considered in the case record, adjust benefits within 30 days after the match date.

B. Match Data Requiring Independent Verification

1. [Matching data from Wage Records, IRS (Computer Matching Data) and BENDEX (Wage and Pension) files require independent verification since the data obtained in the match is several months old and may not reflect current household circumstances. Match Data can be found on the following KAMES screens:
  - a. HRKIMA17, Batch Match, shows wages, the types of BENDEX earned income data, and the types of IRS data at application, recertification, and case change;
  - b. HRKIMA19, CM and/or BXE, shows details for IRS matching Data and BENDEX earned income data at application, recertification, and case change;
  - c. HRKIMK1W, Inquiry – Batch Match, shows wages, the types of BENDEX earned income data, and the types of IRS data at inquiry;
  - d. HRKIMK0A, IRS and/or BXE, shows details for IRS matching Data and BENDEX earned income data at inquiry. This screen is accessed by pressing "enter" when on screen HRKIMK1W; and
  - e. HRKIMA0X, Unearned Income, shows IRS (computer match) income type at application and recertification.]

Attempt to resolve 100% of matching data requiring independent verification within 30 days after the control date/match date; however, on

an individual worker basis, 20% may remain unresolved for up to 90 days pending verification from the data source. This remaining 20% must be resolved within 90 days after the control date/match date. The 30 and 90-day timeframes DO NOT apply if the case is due for recertification prior to those timeframes. Resolve all hits before the recertification is processed.

## 2. General Procedure for Independent Verification

- a. [When a Match requiring verification is received the month prior to the recertification month, do not take action (issue an RFI) AFTER the date of Cut-Off or Negative Action. Document the case that a match has been received, the reason for not acting on it at that time, and that it must be acted on during recertification.
- b. For Matches acted on during the month of recertification, discuss the match during the interview and request the client provide the required verification to resolve the match before the recertification due date. Explain to the client that the verification must be provided before the recertification case can be approved. Document the case thoroughly to ensure the worker processing the recertification is aware of the match and the requested verification.
- c. For cases not due for recertification, enter the information on KAMES and allow the system to issue an RFI requesting the necessary verification. If the requested verification is not returned timely, the system will take appropriate action. If there is not enough information to enter it on KAMES, answer "Y" to "Is contact needed to verify unclear information?" within 5 work days after receipt of the match to request the necessary information. Allow the household 10 calendar days from the date of the notice to provide the requested verification. Follow the below procedures and if the client does not return the information, discontinue the case.

When requesting verification by RFI, **DO NOT** list Federal Tax Information (FTI) on the form. FTI is data derived from the IRS such as:

- (1) BENDEX earned income;
- (2) IRS matching data; and
- (3) Other unearned income IRS computer matches.

KAMES screens containing FTI are listed in B. All screens containing FTI can be easily identified by the banner which states, "This screen contains IRS data – do not print."

The RFI must only request general information. **NEVER** list any specific information found on batch match or computer match screens, such as the employer's name or the amount of income.

For example: A batch match shows that Bob earned wages of \$3,000 from Wal-Mart in the 3<sup>rd</sup> quarter. In the 'Notes' section of the RFI,

the caseworker requests that the client contact DCBS to discuss the income. The worker does not specify the name of the employer, amount of the wages, or any other information obtained from the batch match screens. When Bob contacts DCBS the worker asks if he works at Wal-Mart and requests his check stubs. No information from the match is listed on the RFI; therefore, no FTI is shared. The RFI and the check stubs are scanned into ECF.

- d. When verification, other than what was originally requested, is required as a result of contact with the recipient prior to expiration of the 10-day period, prepare another RFI, as appropriate and allow 10 calendar days for the recipient to return the additional verification.
  - e. Upon receipt of verification, send the appropriate notice of eligibility/ineligibility, if required, and adjust benefits timely.
  - f. Document all actions thoroughly and completely.
  - g. Resolve the exception through the Batch Match function.】
3. Wage Records. Use the following criteria to determine when a match requires independent verification.
- a. The matches which determine whether independent verification is required are the last available Wage Records quarter and the quarter prior to the last available Wage Records quarter.  
  
EXAMPLE: If the last available Wage Records quarter is the third quarter of 2010 (shown as 3/10) the quarter prior to the last available Wage Records quarter would be the second quarter of 2010 (shown as 2/10).  
  
    - (1) 【If there are no matches for either of these quarters, no independent verification is required to resolve the Wage Records match. Resolve the exception through the Batch Match function.
    - (2) If a match is shown for either or both of these quarters, determine whether the income is currently being received by the member.
      - (a) If the case record contains adequate verification for resolution, document accordingly and resolve the Batch Match.
      - (b) If independent verification is required, refer to item B. 2.】
  - b. After IEVS resolution, process any possible claim in accordance with this volume, chapter Claims.
4. Computer Matching Data Information. Should recipients inquire about the source of Agency information, indicate the data was secured through computer matches made by the Agency. Use the following criteria to determine when a match requires independent verification.



- a. [Independent verification is not required if the match data is currently considered in the case record or the case record contains adequate verification for resolution. Document accordingly and resolve the Batch Match.
- b. Independent verification is required if the case record does not contain adequate verification. Refer to item B. 2. Additionally, if a bank account has been closed, a statement from the bank or source is required to verify the closure.]
- c. After IEVS resolution, process any possible claim in accordance with this volume, chapter Claims.

### [C. PARIS Veterans Match – Individual Summary

Report HRKMR5E, PARIS Veterans Match – Individual Summary, is a quarterly report that matches the Social Security Number (SSN) of KAMES members receiving Veteran's Administration (VA) benefits against the Public Assistance Reporting Information System (PARIS) Veterans File. The report lists the KAMES case information, member information, and the VA matched data.

The report includes a two character Entitlement Code (ENT CODE) that identifies the payment type of the award. The first character indicates the type of service and the second character indicates if the payment is Pension or Compensation (ex: ENT CODE '71' is 'Vietnam Service Compensation').

NOTE: ENT CODE '51' indicates a one-time Compensation payment for the Month-of-Death. It is not identified in the key.

Use the key below to determine the payment type.

<b>First Position</b>	<b>Second Position</b>
0 - Gulf War Service	1 - Compensation
1 - WWI Service	2 - Protected Pension (veteran)
2 - WWII Service	4 - Section 306 Pension (veteran)
3 - Korean Conflict Service	5 - Death Compensation
4 - Peacetime Service	6 - Protected Pension (survivor)
7 - Vietnam Service	7 - Dependency Indemnity Compensation
9 - Philippine Service	8 - Section 306 Pension (survivor)
	D - Improved Pension (survivor)
	L - Improved Pension (veteran)

The gross, net, and check amounts in the VA data portion are shown in whole dollars only (no cents). Therefore, if the client receives a VA amount that includes cents, then the amount shown on the report will be less than the actual amount received.

1. If the VA income is already counting in the case for the member and the amount on the report differs **within \$0.99 cents**, no change is required to the case except documentation of the match.

2. If the VA income is already counting in the case for the member and the amount on the report differs **more than \$0.99**, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.
3. If the VA income is not counting in the case, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.

Take appropriate action on cases requiring correction and determine if an over-issuance has occurred. Identified claims are to be entered on KCD within 10 days.]

MS 0680

IRS SAFEGUARDING ISSUES

(1)

The Internal Revenue Service (IRS) requires that measures be taken to protect or safeguard confidential information. The IRS audits the Cabinet for Health and Family Services annually for compliance with these safeguarding requirements. The following procedures have been developed as a result of these requirements.

GENERAL SAFEGUARDING PROCEDURES

A. Staff should take all precautions necessary to protect information that must be safeguarded, such as the following:

1. All Federal Tax Information (FTI) – including Batch Match, IEVS, BENDEX earned income, and any other information that comes from the IRS. KAMES screens containing FTI are identified by the banner stating, "This screen contains IRS data – do not print." FTI must NEVER:
  - a. Be copied, e-mailed, printed or faxed; or
  - b. Be filed in the case record.

Two barrier security is required for FTI. This means access to the material is locked by two locks.

Place form DTA-FTI-1 (included as attachment to the annually issued FSM "IRS Safeguarding Procedures") to the front of all file drawers or locked boxes (with two barrier security) where any potential FTI is held identifying that those files contain FTI. Also attach form DTA-FTI-1 to the front of any file folders within the file so that it is visible to anyone who looks at those records.]

2. Any material containing an individual's Social Security Number, such as case records must be safeguarded. Limit access to the case record and other recipient-related information.

Store all case records and recipient information in locked file cabinets in a secure location (a locked file cabinet in a locked room, if possible) when not working on them;

Do not leave case records on chairs, the floor, the top of file cabinets, etc;

- a. Secure case records when absent from your desk; and
- b. Ensure that all records are inaccessible before leaving the office.

B. Minimize public access to confidential information:

1. Secure work areas against unauthorized and unsupervised access;

2. Ensure that during an interview, only the case record pertinent to that individual is visible on the desktop or surrounding areas;
  3. Ensure that computer terminals only display information related to that individual during interviews; and
  4. Sign off or lock computer terminals when not in use or when leaving the work area.
- C. Keep mailed information secure:
1. Check mail trays for recipient information regularly; and
  2. Do not leave recipient information in mail trays overnight.
- D. Properly dispose of case record material and other recipient information as follows:
1. Shred the material into 5/16 inch or smaller strips; or
  2. Place in a designated box:
    - a. Seal the designated boxes and store in a secure location, preferably one which can be locked; and
    - b. Complete the Certificate of Disposal form.

#### PROCEDURES FOR SAFEGUARDING IRS INFORMATION – BATCH MATCH

- A. [When an IRS hit is received on the computer and independent verification is required, complete form PAFS-2, Application Letter or Notice of Expiration, to schedule an appointment for the recipient to come in for an interview and/or provide verification of the income or items in question. Do not print any KAMES screens containing IRS data. These screens can be identified by the banner which states, "This screen contains IRS data – do not print." Do not specify the IRS data on form PAFS-2 or in case comments. For example, the name of the employer or the amount of the wages should not be entered on form PAFS-2.
- B. The original form PAFS-2 is mailed to the recipient. No FTI is entered on form PAFS-2; therefore it and the provided verification may be filed in the case record.
- C. If verification is returned concerning the request made on form PAFS-2 and no claim is established, file the information in the case record. Allowable comments in the case concerning the resolution of the hit would be "Batch Match hit dated 'mm/dd/yyyy' resolved.
- D. If verification returned as a result of the request indicates the need for establishing a claim, follow normal procedures in establishing a claim.

NOTE: Form PAFS-7, Notification of Appointment/Request for Verification, is obsolete effective 5/1/11; however, the log used to track FTI is kept in a locked file and maintained for 5 years after the last item on the log is destroyed, at

which point it is destroyed per procedures found in General Safeguarding Procedures, item D.]

#### PROCEDURES FOR BENDEX INFORMATION

- A. [Do not file any BENDEX information in the case record. BENDEX information is:
  - 1. Earned income data found on KAMES screens identified by the banner which states, "This screen contains IRS data – do not print;" and
  - 2. RSDI income data and earned income data found on KYIMS Job Menu, program 39, New BENDEX.
- B. Do not mention BENDEX in case comments. Document that the income amount was verified by system inquiry on mo/day/year.
- C. If it is necessary to print and keep any BENDEX screen information, it must be stored under two barrier security in a folder or file labeled with form DTA-FTI-1. The case record may only reference where verification is filed.
- D. Do not copy, fax, or e-mail BENDEX information.]

#### PURGING IRS FEDERAL TAX INFORMATION FOUND IN CASE RECORDS

Case records cannot contain any BENDEX information, IEVS information, or KASES screens containing IRS data.

- A. Check all active and inactive case records for BENDEX information, IEVS information, and KAMES and/or KASES screens containing IRS data.
- B. Purge BENDEX information, IEVS information, and KAMES and/or KASES screens containing IRS data found in the active and inactive case records. The purged information must be disposed of following the procedures in General Safeguarding Procedures, item 1.D.

#### PENALTIES FOR FAILURE TO SAFEGUARD IRS INFORMATION

- A. Unauthorized inspection or disclosure of Federal income tax returns or return information may be punishable by a \$5,000 fine, five years imprisonment, or both, plus the cost of prosecution, per Internal Revenue Code Section 7213(a);
- B. A taxpayer may bring suit for civil damages in a US District Court for unauthorized disclosure or unauthorized inspection of returns and return information, per Internal Revenue Code Section 7431. This Section allows for punitive damages in case of willful inspection or disclosure or gross negligence, as well as the cost of the action; and
- C. These civil and criminal penalties apply to the individual worker even if the unauthorized disclosures or unauthorized inspection were made after employment with the Agency terminated and if the individual is no longer an employee of the Commonwealth of Kentucky.

IMPROPER INSPECTION OR DISCLOSURE

- A. If an improper inspection or disclosure is discovered or witnessed, report the violation to the Service Region Administration Associate (SRAA) for your Region. The SRAA forwards the report to the Director of Service Regions. The SRAA takes action to ensure the violation does not occur again.
  
- B. Additionally, if an improper inspection or disclosure has occurred, notify the Internal Revenue Service (IRS) by calling the Chicago Field Division at (312) 886-0620 or 1-800-366-4484 or by writing to:

Treasury Inspector General for Tax Administration  
P.O. Box 589, Ben Franklin Station  
Washington, DC 20044-0589

MS 0722

COMPUTER MATCH CODES

The IRS Computer Match displays the type of earnings towards the bottom of the Batch Match Screen. The following are definitions of computer match income. These are also located on RDS under report HRKMR52 IM CODES-LIST.

The INCOME INDICATOR reflects the type of income reported.

Form #	Income Indicator
<b>Form 1099-Q</b>	<b>Qualified Tuition Program Payments</b>
	<b>107</b> Earnings - earnings part of qualified tuition program payments made to the designated beneficiary or account owner. Qualified tuition program includes programs established and maintained by private eligible educational institutions.
<b>W-2-G</b>	<b>Statement of Gambling Winnings</b>
	<b>003</b> Gross Winnings - income resulting from wagers.
	<b>033</b> Winnings from Identical Wagers -income from identical wagers.
<b>1065-K1</b>	<b>Partners Share of Income, Credits, Deductions, etc.</b>
	<b>008</b> Dividends - distribution of money, stock, or other property from partnership.
	<b>002</b> Interest - income from or credited to: accounts (including certificates of deposit and money market accounts) with banks, credit unions and savings and loan associations; building and loan accounts; notes, loans and mortgages; tax refunds; insurance companies if paid or credited on dividends left with the company; bonds and debentures; also arbitrage bonds issued by State and local governments after October 9, 1969; gain on the disposition of certain market discount bonds to the extent of the accrued market discount; U.S. Treasury bills, notes and bonds; U.S. savings bonds which include: total interest when bond is cashed or when bond reaches maturity and no longer earns interest; or yearly increase in the bond(s)' value.
	<b>025</b> Royalties - income from oil, gas, mineral properties, copyrights and patents.
	<b>115</b> Ordinary Income - share of income (loss) from trade or business activities of partnership.
	<b>116</b> Real Estate - income (loss) from activity in which partner did not materially participate.
	<b>117</b> Other Rental - income (loss) activity in which partner did not materially participate.

			<b>118</b>	Guaranteed Payments – partner’s share of income for services.
			<b>151</b>	Short Term Capital Gain - income (loss) from partnership of less than 1 year.
			<b>152</b>	Long Term Capital Gain - income (loss) from partnership of more than 1 year.
	<b>1041-K1</b>	<b>Beneficiary's Share of Income, Credits, Deductions, Etc.</b>		
			<b>008</b>	Dividends - distribution of money, stock, or other property from an estate or trust.
			<b>002</b>	Interest - beneficiary's share of taxable income from accounts with banks, credit unions and thrifts (e.g., certificates of deposit and money market accounts).
			<b>050</b>	Business Income and Other Nonpassive Income - beneficiary's share of annuities, royalties, or any other income not subject to passive activity limitation.
			<b>144</b>	Passive Income - Rental income from trade or business activities in which beneficiary did not materially participate.
			<b>151</b>	Short Term Capital Gain - income from installment sales, like-kind exchanges and/or other partnerships and fiduciaries of less than 1 year.
			<b>152</b>	Long Term Capital Gain - income from installment sales, like-kind exchanges and/or other partnerships and fiduciaries of more than 1 year.
	<b>1120S-K1</b>	<b>Shareholder's Share of Undistributed Taxable Income, Credits, Deductions, Etc.</b>		
			<b>008</b>	Dividends - distribution of cash; value of stock, property or merchandise received as a shareholder (e.g., mutual fund).
			<b>002</b>	Interest - income from or credited to: accounts (including certificates of deposit and money market accounts) with banks, credit unions and savings and loan associations; buildings and loan accounts; notes, loans and mortgages; tax refunds; insurance companies if paid or credited on dividends left with the company; bonds and debentures; also arbitrage bonds issued by State and local governments after October 9, 1969; gain on the disposition of certain market discount bonds to the extent of the accrued market discount; U.S. Treasury bills, notes and bonds; U.S. savings bonds including total interest when bond is cashed or when bond reaches maturity and no longer earns interest; or yearly increase in the bond(s)' value; income received or credited to an account that may be withdrawn.
			<b>025</b>	Royalties - income from oil, gas, mineral



				properties, copyrights and patents.
			<b>115</b>	Ordinary Income - shareholder's pro rata share of ordinary income, loss, deductions, credits and other information from all corporate activities.
			<b>116</b>	Rental Real Estate - net income (loss) in which shareholder did not materially participate.
			<b>117</b>	Other Rental - net income (loss) from other rental activity in which shareholder did not materially participate.
			<b>151</b>	Short Term Capital Gain - income from sales and exchanges of capital assets, including stocks, bonds, etc. and real estate held for less than 1 year.
			<b>152</b>	Long Term Capital Gain - income from sales and exchanges of capital assets, including stocks, bonds, etc. and real estate held for more than 1 year.

	<b>1099-CAP</b>	<b>Changes in Corporate Control and Capital Structure</b>		
			<b>109</b>	Cash Received (may be negative amount)
			<b>110</b>	Fair Market Value of Stock Received (may be negative amount)
			<b>111</b>	Fair Market Value of Property Received (may be negative amount)
	<b>1099-S</b>	<b>Statement for Recipients of Proceeds from Real Estate Transactions</b>		
			<b>080</b>	Real Estate Sales - gross proceeds from sale or exchange of real estate.
	<b>1099-B</b>	<b>Statement for Recipients of Proceeds from Real Estate Brokers and Barters Exchange Transactions</b>		
			<b>097</b>	Stocks and Bonds - gross proceeds from disposition of securities (including short sales), commodities, or forward contracts.
			<b>099</b>	Aggregate Profit and Loss - total profit (loss) from regulated futures or foreign currency contracts.
			<b>100</b>	Realized Profit or Loss - profit (loss) realized on closed regulated futures or foreign currency contracts.
			<b>155</b>	Unrealized Profit or Loss (may be negative amount) – unrealized profit (loss) on open contracts held on account but considered sold as of year-end.
	<b>SSA-1099</b>	<b>Social Security Benefit Statement</b>		
			<b>004</b>	Total Benefits Paid - gross amount of benefits the individual is entitled to for the current tax year. This amount is prior to subtracting the

				amount of any benefit checks returned, adjustments for disability payments, work, overpayments and/or cash repayments.
	<b>1099-G</b>	<b>Statement for Recipients of Certain Government Payments</b>		
			<b>020</b>	Unemployment Compensation - payments of unemployment compensation including Railroad Retirement Board payments.
			<b>084</b>	Agricultural Subsidies - agricultural subsidy payments
			<b>085</b>	Prior Year Refund - refunds, credits, or offsets of State or local income tax.
	<b>1099-DIV</b>	<b>Statement for Recipients of Dividends and Distributions</b>		
			<b>035</b>	Capital Gains - amount of total capital gain distributions (long-term).
			<b>036</b>	Nontaxable Distribution - amount of nontaxable distribution.
			<b>039</b>	Cash Liquidation Distribution - amount of cash distributed as part of a corporation's partial or complete liquidation.
			<b>040</b>	Noncash Liquidation Distribution - fair market value (at time of distribution) of non-cash distributions made as part of partial or complete liquidation of a corporation.
			<b>065</b>	Ordinary Dividend - amount of ordinary dividends, including those from money market funds and net short-term capital gains from mutual funds, and other distributions on stock.
			<b>044</b>	28% Rate Gain - any amount of capital gains (IND 23) that is 28% rate gain.
			<b>045</b>	Unrecaptured Section 1250 Gain - any amount of capital gains (IND 23) that is section 1250 gain from certain depreciable real property.
			<b>046</b>	Section 1202 Gain - any amount of capital gains (IND 23) that is section 1202 gain from certain qualified small business stock.
	<b>1099-INT</b>	<b>Statement for Recipients of Interest Income</b>		
			<b>002</b>	Interest - amounts paid or credited by: savings & loan associations, mutual savings banks, building & loan associations, credit unions or similar organizations; bank deposits, accumulated dividends paid by life insurance companies, indebtedness (bonds, debentures, notes and certificates); in course of trade or business; delayed death benefits from insurance companies; accrued to a REMIC regular interest holder, or paid to a CDO holder.
			<b>034</b>	Savings Bonds - interest paid on U.S. Savings Bonds, Treasury Bills, Treasury Bonds and Treasury Notes.

	<b>1099-LTC</b>	<b>Distributions from Long Term Care Insurance Contract</b>		
			<b>030</b>	Gross Benefits
			<b>031</b>	Accelerated Death Benefits Paid
	<b>1099-MSA</b>	<b>Distributions from Medical Savings Accounts</b>		
			<b>042</b>	Earnings on Distributive Excess Contributions
			<b>043</b>	Gross Benefits
	<b>1099-MISC</b>	<b>Statement for Recipients of Miscellaneous Income</b>		
			<b>022</b>	Medical Payments - payments made in the course of trade or business to each physician or other supplier or provider of medical or health care services, including payments made by medical and health care insurers under health, accident, and sickness insurance programs.
			<b>024</b>	Rents – income received as rents; e.g., owner of housing project, real estate rentals for office space, machine rentals and pasture rentals.
			<b>025</b>	Royalties – income paid from oil, gas, mineral properties, copyrights and patents.
			<b>032</b>	Other Income - income not reportable in other boxes on form; e.g. prizes and awards, punitive damages, deceased employee’s wages paid to estate or beneficiary.
			<b>048</b>	Substitute Payments for Dividends - total payments received by a broker on behalf of a taxpayer in lieu of dividends or interest as a result of a transfer of a taxpayer's securities for use in a short sale.
	<b>1099-OID</b>	<b>Statement for Recipients of Original Issue Discount</b>		
			<b>002</b>	Interest – amount paid or credited. The difference between the stated redemption price at maturity and the issue price of a debt instrument.
			<b>083</b>	Original Issue Discount - the difference between the issue price of a debt instrument (e.g., stock, bond or promissory note) and the stated redemption price at maturity.
			<b>145</b>	Original Issue Discount on Treasury Obligations – amount of OID on U.S. Treasury obligation for the part of the year it was owned by the record holder.

	<b>1099-PAT R</b>	<b>Statement for Recipients of Taxable Distributions Received from Cooperatives</b>		
			<b>067</b>	Patronage Dividends - cash, written notice of allocation or other property distribution by a farmer's cooperative.
			<b>068</b>	Nonpatronage Dividends - cash, written notice of allocation or other property distribution by a farmer's cooperative.
			<b>069</b>	Retained Allocations - cash, per-unit retail certificates and other property distributed by a cooperative
			<b>070</b>	Redemption Amount - value of written notice of allocation issued as patronage dividends.
	<b>1099-R</b>	<b>Distributions from Pensions, Annuities, Retirement or Profit-sharing Plans, IRAs, Insurance Contracts, Etc.</b>		
			<b>056</b>	Unrealized Appreciation – Portion of distribution that represents net unrealized appreciation in securities of the employer corporation (or subsidiary or parent corporation) attributable to employee contributions.
			<b>057</b>	Other Income - actuarial value of annuity contract or retirement bond, retirement account exchange or death benefit payment that is part of a lump-sum distribution.
			<b>128</b>	Gross Distribution - total amount of distribution from pensions (including disability), profit-sharing plans, retirement plans, employee savings plans and/or annuities before income tax or other deductions are withheld. Includes premiums paid by a trustee or custodian for current life or other insurance protection, or IRA or SEP distributions. Savings Bonds distributed from a pension plan, death benefit payments and death payments made by employers that are not part of a plan. In the case of a distribution representing CDs, the net amount is reported.

MS 0723\*

BENDEX INCOME CODES

A. BENDEX Earned Income Types.

- AG - Agricultural wages have been reported
- PE - Annual report of pension income
- SE - Self-employment earnings have been reported
- 00 - Annual report of earnings
- 03 - First quarter report of earnings
- 06 - Second quarter report of earnings
- 09 - Third quarter report of earnings
- 12 - Fourth quarter report of earnings

B. BENDEX Unearned Income Types.

- |  |  |
|--|--|
| A - Social Security  | M - Civil Service pension                    |
| B - Black Lung   | N - Child Support                            |
| C - VA compensation  | O - Other unearned income                    |
| D - RR retirement  | P - Employment related pension               |
| E - VA pension   | Q - Workman's Compensation                   |
| F - Assistance based on need<br>and not excluded from<br>unearned income | R - Rents, interest, dividends,<br>royalties |
| H - Income in-kind   | S - Other                                    |
| K - Blind countable income   | T - Income under a demonstration<br>project  |
| L - Military pension   | V - Net deemed income                        |
|  | W - Additional income disregards             |

MS 0730 ELECTRONIC DISQUALIFIED (1)  
RECIPIENT SUBSYSTEM (eDRS)

The Electronic Disqualified Recipient Subsystem (eDRS) is a national database of all individuals disqualified due to an Intentional Program Violation (IPV) in the Supplemental Nutrition Assistance Program (SNAP).

IPV disqualifications must be entered on the Worker Portal in order to track occurrences and to allow the matches of out-of-state disqualification information. The eDRS system sends and retrieves data via real time web service interface to transmit SNAP IPV disqualification information.

[A. Effective 3/1/16, staff in the Division of Family Support who are working from the Program Integrity queue will receive eDRS tasks via the Worker Portal for disqualifications entered by other states.

An eDRS query will be sent for each adult household member requesting SNAP benefits on Worker Portal at application, recertification and at member add, if the new member is age 18 or older.

If the query results in a match:

1. An eDRS task is created and sent to the Program Integrity queue. The disqualification details will automatically populate the IPV screen. This will provide the details of the IPV disqualification including occurrence, decision date, start date and length of the disqualification. Contact information for the originating state is also provided.
2. The worker starting the task must contact the originating state to request documentation of the IPV. In order to enter the IPV in the Worker Portal, one of the four types of supporting documentation must be obtained; either:
  - a. A signed waiver of an Administrative Disqualification Hearing (ADH);
  - b. An ADH order;
  - c. A deferred adjudication agreement; or
  - d. A court order.

The document will verify the disqualification time period and how the IPV was determined.

3. The originating state has 20 days to provide the documentation. Non-expedited cases will not dispose until after the 20<sup>th</sup> day in order to allow time for the verification to be obtained.
  - a. For cases meeting expedited criteria, process the case without the IPV verification and document in comments that information relating to an out-of-state IPV has been requested but not provided by the originating state.
  - b. For cases not meeting expedited criteria, if the documentation is not received by the 20<sup>th</sup> day or by the 10<sup>th</sup> day for a member add,

process the case without the information and document in comments that information relating to an out-of-state IPV has been requested but not provided by the reporting state. The task will remain open with the Program Integrity worker.

4. Once the verification documents are received from the originating state, the appropriate disqualification is entered on the Worker Portal.
  5. Scan all the documentation received from the originating state to support the disqualification into the electronic case file and attach to the disqualified individual within the "Claims and Hearings" category and under "Out of State Verification" type.
  6. Eligibility must be ran when the individual's disqualification is verified for a current time frame and they are actively receiving benefits. Failure to verify eDRS matches timely could result in agency errors. A call to eDRS must be made for each adult household member at every application, recertification or member add.
- B. Kentucky's Locality Contact is the Claims Management Section (CMS). Other states contact CMS to obtain Kentucky's disqualification verification for their matches.

CMS will review the case file on Worker Portal for the disqualification verification. If CMS is not able to locate the verification, CMS will request it from the Regional Claims Worker (RCW). Field staff must provide the verification to support the disqualification, within 5 work days of receiving a request.]

MS 0740\*

STATE ON-LINE QUERY (SOLO)

SOLO is a match process with the Social Security Administration (SSA) to verify a social security number (SSN) in real time. The match occurs for numbers that have never been verified on KAMES. If an SSN has been verified by "SA", an SOLO match does not occur. The SOLO screen appears if there are no SSN/NAME matches or the matches are not the applicant's or other household member's. The SOLO screen will indicate if the SSN is verified by SSA, and if not verified, the reason for the discrepancy. Once a number is verified by SOLO, the social security number field is protected and the verification code "SQ" is system applied.

- A. At application or member add if SOLO indicates the SSN security number is not verified, review the name, date of birth, and SSN with the applicant to ensure no mistakes were made in the entry of information.
  - 1. If corrections are needed to the initial entries, a second SOLO transaction is submitted.
  - 2. If the number remains unverified, KAMES loads a "X" in the field "If you wish a pseudo number to be assigned, enter a "X". The "X" is protected and a pseudo number is assigned.

When a pseudo number is assigned, request the individual verify an SSN by a copy of the SSN card or written verification from the SSA.

- B. Names must match with SSA records. If the individual's name has changed since issuance of the SSN, the individual must report the change to SSA.
- C. For applications and member adds, the message "SSA Link Unavailable" will display if the SOLO system is not available. The worker is able to proceed with matches completed by the State Verification Exchange System (SVES) process. (SA is applied as the verification source)
- D. The SOLO screen appears once an SSN is entered on the SSN Change function on KAMES. If not verified, review the SSN card or written verification to see if it matches what was entered on KAMES. If the information entered is verified by a card or SSA written statement, the individual must contact the SSA to resolve the discrepancy. SSN change actions cannot be completed if SOLO is not available. F3 out of the SSN Change Function and attempt the change the next day.



MS 0800

HOW TO PREVENT A CLAIM

The following measures are used to avoid errors and detect fraud:

- A. All points of eligibility are explored, verified, and documented in the case record. Ensure the following actions occur:
  1. Thoroughly question the client on all aspects of eligibility;
  2. Verify statements by examining documents the applicant provides or by obtaining information from appropriate third party sources;
  3. Verify a report of new employment or termination of employment by employer contact. If contact is not possible, document the reason in case comments.

[\*Note: For Child Care all new employment must be verified three months from the hire date. All questionable forms of verification must be matched against the Wage File Data, Eligibility Advisor or tax records.]
- B. Clarify inconsistencies;
- C. Make sure applications are signed, accurately dated, and maintained in the electronic case file;
- D. Inform clients of the:
  1. Responsibility to provide correct and complete information;
  2. Responsibility to report changes correctly and timely;
  3. Consequences of incorrect statements or omissions including the potential of being prosecuted for fraud;
  4. Requirement to repay benefits received in excess of the eligible amount;
- E. [SNAP recipients are informed of:
  1. The proper use of SNAP benefits; and
  2. Simplified Reporting (SR) requirements.]
- F. Medicaid clients are informed of the proper use of the KY Health card.
- G. Supervisors or designated personnel review a sample of cases before final disposition;
- H. Workers should complete thorough interviews with open-ended questions.
- I. Use the Determining Eligibility Through Extensive Review (DETER) process where operational. See [MS 0900](#); and
- J. Enter disqualifications timely.

MS 0800

HOW TO PREVENT A CLAIM

- K. [Cash assistance and SNAP applicant and recipients are informed of the proper use of the EBT card.]

MS 0810

HOW TO IDENTIFY A CLAIM

(1)

- A. [Identification of claims is an automatic process if an overpayment is detected by the Worker Portal. For example, Field Staff makes appropriate case changes and the Worker Portal calculates an overpayment, the claim is automatically referred to the Regional Claims Worker (RCW) with the Supplemental Nutrition Assistance Program (SNAP) claim amount automatically calculated. All other SNAP claims and Individual Child Care Claims are manually initiated.
- B. An automated claim exists when:
1. Benefits issued exceed the eligible amount (overpayments)
- C. A Manual Claim is created when the following occurs:
1. SNAP benefits are trafficked;
  2. Benefits designated for a specific purpose are used to purchase unapproved items or services;
  3. Claims are identified as occurring prior to implementation of the Worker Portal and are not processed on Kentucky Claims Debt (KCD) Management System;
  4. Medicaid Fraud;
  5. Individual Child Care Fraud;
  6. Child Care Provider Fraud;
  7. Some supportive service payments are overpaid;
  8. Violations occurring prior to SNAP Worker Portal conversion (10/2015); and
  9. Excessive EBT card replacements. A 5<sup>th</sup> card request will generate a task to the RCW to investigate and determine if a claim will be pursued.]
- D. Claims may be identified by review of the following sources:
1. System matches such as Batch Matches, New Hire Matches, and Paris Matches
  2. Collateral contacts;
  3. "Hotline" referrals from the Office of Inspector General (OIG);

4. Quality Control (QC) reviews;
  5. Electronic Benefits Transfer (EBT) transaction history;
  6. Case reviews; or
  7. Management Evaluation (ME) reviews.
- E. Claims may also be identified by:
1. Changes – Client reports a change, but after the worker verifies the situation, it is discovered the change was not reported timely.
  2. Analysis of expenses vs. income – Client's expenses exceed their income, which may be an indicator of unreported income.
  3. Worker Interview – A thorough interview increases the likelihood of the applicant reporting other income, such as contributions from family members or friends, which may not be counted in the case.
  4. Income – Check stubs reflect an increase due to a change in pay rates or overtime worked.
  5. Deductions given in error- such as the Standard Utility Allowance (SUA), Basic Utility Allowance (BUA), 30 and 1/3 deduction, etc.
  6. SNAP Simplified Reporting (SR) Households – Determine:
    - a. If the household's monthly gross income exceeds the allowed limit for the household size; or
    - b. If any member of the household age 18 through 49, failed to report working fewer than 20 hours a week.

MS 0820

BENEFIT MANAGEMENT

(1)

[The Benefit Management tool provides automated support to manage claims and collection activity. Access is available on Worker Portal under Benefit Management located on the menu bar.]

Benefit Management is used by field staff to:

- A. Record and calculate claims;
- B. Document the circumstances of the claim and related activities;
- C. Correct and track a completed claim;
- D. Issue claim-related notices;
- E. Track claim payments; and
- F. Inquire the status of claims.

MS 0830

[RESPONSIBILITIES FOR CLAIMS]

(1)

[A. Field Staff are to take the following actions:

1. Enter a change to a case and rerun eligibility which prompts the Discrepancy Overpayment screen; this can also result in processing a disqualification.
2. Enter the Discrepancy Overpayment detail, which creates a task for the Regional Claims Worker (RCW) to begin the claims process.
3. Process disqualifications on the Worker Portal

B. Regional Claims Workers are responsible for the following:

1. Processing Automatic Claims
2. Process Supplemental Nutrition Assistance Program (SNAP) and Child Care Assistance Program (CCAP) individual-only disqualifications
3. Determine whether to validate and establish or No Claim the claim and update the status in the system
4. Determine the claim type and verify the claim amount
5. Establish a Manual Claim
6. Initiate Fraud Referrals to OIG
7. Submit requests for claim adjustments
8. Contacting the household to determine the reason for a claim and to explain the computation of the claim amount.
9. Set up of Claims electronic case files.
10. Screening claims for suspected fraud and taking the following action:
  - a. Referring the claim(s) meeting criteria to the Office of Inspector General (OIG) for further investigation and possible prosecution. See [MS 0910](#); or
  - b. Sending forms FS-80, Notice of Suspected Intentional Program Violation (SIPV), and FS-80 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, to a SNAP household with a claim that does not meet criteria for OIG referral or OIG does not pursue prosecution.
  - c. Regional claims workers are to update comments on the Worker Portal whenever any action is taken on a claim and to ensure that all appropriate dates and codes are entered on the Benefit Recovery

Screen, in order to document that appropriate action is taken during the claim process when:

1. Form FS-80 and FS-80 Supplement A, are mailed to the recipient;
2. Form FS-80 Supplement A is signed by the recipient and returned;
3. Form FS-111, Deferred Adjudication Disqualification Consent Agreement is signed; or
4. An Administrative Disqualification Hearing (ADH) is requested, scheduled, affirmed, or reversed.

This information is reviewed for correctness during the Case Review and the Management Evaluation (ME) review process.

11. Requesting and participating in SNAP Administrative Disqualification Hearings or court proceedings to give testimony to identify a recipient, and testify to the explanation given of the recipient's rights and responsibilities.
12. Verifying and imposing SNAP disqualifications identified by the electronic Disqualified Recipient Subsystem.
13. Providing an explanation of benefit reduction to affected households.
14. Responding to fraud hotline requests generated by OIG.
15. Accepting non cash payments (checks, money orders, or EBT) and issuing receipts for payments brought to the local office for established claims. Non-cash payments are to be mailed to the Claims Management Section (CMS) at 275 E. Main St. 3E-I Frankfort, KY 40621. Advise recipient to send any future payments to CMS.
16. Referring questions relating to the payment of claims, other than those relating to benefit reduction, to the CMS at 502-564-3440.
17. Referring all questions relating to tax intercepts, garnishment of wages, and other intercepts to CMS at 502-564-3440.
18. Reporting alleged SNAP retailer and Medicaid provider fraud to the OIG Fraud Hotline at 1-800-372-2970.
19. Forwarding bankruptcy information to the CMS.
20. Notifying the CMS when a case with an established claim is eligible for a restoration (SNAP) or supplemental benefits (KTAP or Kinship Care). CMS will offset the claim with the benefit amount.
21. Identifying and referring suspicious case situations prior to approval to the DETER program where it is operational. Refer to [MS 0900](#).
22. Documenting information regarding to alleged trafficking activity. The value of trafficked benefits is determined by the recipient's statement, adjudication, or the documentation that forms the basis for the trafficking allegation. A record of actual transactions on the EBT website account is provided to OIG by the CMS.]

MS 0840 CLAIMS MANAGEMENT SECTION INFORMATION (1)  
AND RESPONSIBILITIES

A. The Claims Management Section (CMS) is located in the Division of Family Support. The section can be reached by:

- [1. Phone 502-564-3440;
2. Fax 502-564-9810;
3. E-mail [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov) ;]
4. Mail sent to the Cabinet for Health and Family Services, Department for Community Based Services, Nutrition Assistance Branch, Claims Management Section, 275 East Main Street 3EI, Frankfort, Kentucky 40621.

B. CMS is responsible for:

1. Pursuing collection of all claims not repaid by benefit reduction.
2. Responding to client inquiries regarding the repayment of claims.
3. Reviewing all field referrals to the Office of Inspector General (OIG).
4. Monitoring the progress of claims referred to or identified by OIG.
5. Reviewing recommended and final orders related to claims.
6. Preparing and routing exceptions to recommended orders related to claims.
- [7. Monitoring time frames and notifying the field regarding timely completion of claims.
8. Providing information to other states regarding food benefit disqualifications appearing on the electronic Disqualified Recipient Subsystem.]
9. Negotiating repayment agreements with clients.
10. Accepting, posting, and providing receipts for payments on claims.
11. Suspending or terminating collection efforts on claims.
12. Identifying and referring claims for collection by various intercept programs.
13. Maintaining and monitoring bankruptcy information.



- [14. Completing actions on the Worker Portal to compromise a food benefits claim.
15. Adjusting balances on the Worker Portal when a claim is reduced by a restoration (SNAP) or supplemental (KTAP, Kinship Care).
16. Adjusting and entering claim balances when claims are corrected by the regional claims workers (RCW). Specifically, CMS is responsible for approving all corrections and applying corrections to the claim balance. This includes court compromised amounts which must be entered by CMS on the Worker Portal. After the claim corrections or court compromised amounts are determined by the RCW, CMS is contacted at [CHFS.DFSClaims@ky.gov](mailto:CHFS.DFSClaims@ky.gov) to request the adjustment be approved and entered on Worker Portal. The RCW enters comments on the Worker Portal and clearly explains the intended action pending for CMS approval.]

MS 0850 ELECTRONIC CLAIMS FILES (1)

All claims records contain sufficient documentation to support establishing a claim and are maintained as Electronic Case Files (ECF). Retain hardcopy case records for claims established prior to implementation of ECF. The case record may be scanned into ECF if it applies to a newly discovered claim after ECF was implemented in your region.

- A. Scan the ECF information only relating to the claim not retained on another system. Claims that require Bendex verification will be maintained in a hardcopy control folder.
  1. Information used to establish the claim, such as:
    - a. Form PAFS-431, Claim Referral (for claims prior to the Worker Portal;
    - b. Overpayment Discrepancies screen information on the Worker Portal;
    - c. Verification such as Income and Eligibility Verification System (IEVS) records (see Volume I [MS 0680](#), IRS SAFEGUARDING ISSUES, regarding Federal Tax Information (FTI)); employer statements and collateral contacts;
    - d. [Recipient's signed DCC-90, Subsidized Child Care Assistance Application Summary;
    - e. Signed DCC-94, Child Care Service Agreement and Certificate;
    - f. DCC-99B, Claims Calculation Sheet;
    - g. DCC-99C, Client Provider Sheet, if applicable;
    - h. Information from the Office of Inspector General (OIG), such as form IR-1, Investigative Report; ]
    - i. Quality Control (QC) reports;
    - j. Worker Portal comments about client's statement;
    - k. E-mails;
    - l. Hot line referrals; and
    - m. Deter Investigation Reports.
  2. Legal documents and hearing results:
    - a. Correspondence from OIG;
    - b. Court order/decision;
    - c. Final order from a fair hearing;
    - d. Administrative Disqualification Hearing final order; and
    - e. [FS-80, Notice of Suspected Intentional Program Violation, FS-80 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, FS-111, Deferred Adjudication Disqualification Consent Agreement, DCC-84, Notice of Suspected Intentional Program Violation, DCC-84 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or DCC-83, Deferred Adjudication Agreement.]
  3. The Worker Portal maintains the comments, calculations, and notices. Copies of the following must be maintained in the ECF:
    - a. Claim-related correspondence manually sent to the client;

- b. Notice of Repayment Schedule, if appropriate;
  - c. Correspondence to and from CMS;
  - d. Payments forwarded to CMS from the local office;
4. Copies of receipts for payments received in the local office.
  5. Refer to Volume I [MS 0040](#) for information on Purging Obsolete Material.

MS 0860

TIME FRAMES FOR ESTABLISHING A CLAIM

(1)

[Claims must be established within 90 calendar days from the date of discovery. Pending claims not established within 90 days appear on the Pending Claims and Discrepancies Past Due report accessed via the Worker Portal.

KTAP and related programs must be established by the end of the quarter following the quarter the claim is discovered.

The Claims Management Section monitors this report monthly and advises local office staff to take action on pending and past due claims.

The Pending Claims and Discrepancies Past Due report is available to local staff for use in monitoring the completion of claims within the required time frames.]

MS 0870                      GENERAL PROCEDURES FOR ALL CLAIMS                      (1)

[Claims are identified on active and inactive cases both automatically and manually. The county where the household or member lives is responsible for completion of the claim when the case remains active. Pending claims are transferred to the new county of residence if benefits are being received. For households who move out of state or inactive cases, the last county of residence where benefits were received is responsible for completion of the claim.

The basic process for task creation of claims includes the following:

1. Field Staff Reports a Change on a case, requiring them to complete the Discrepancy Overpayment information screen in the Worker Portal;
2. Claims Workers receive a task notifying them that the system generated a claim;
3. Field staff creates a Claim referral under the Benefit Management tab. A manual claim referral will be created for Medical Assistance, TANF related, and SNAP trafficking potential claims;
4. Claims Workers receive a task notifying them that the Field Staff Worker submitted a claim referral; and
5. Claims Workers must establish the claim in order for it to become a legitimate claim on a case.

Complete the following actions for any suspected over issuance occurring in the SNAP, KTAP, Kinship Care, and KTAP related programs administered by Family Support field staff:

- A. Review the circumstances to determine the reason for the error and correct any active cases.
- B. Determine if any companion cases exist which may be affected by the claim.
- C. After entering a change, rerunning eligibility, and disposing the case on the Worker Portal, you are directed to the Overpayment Discrepancies screen where you will proceed with the following steps.
  1. Scroll to the right of the screen to view all details that should be entered.
  2. Select the proper method under the Detection drop down.
  3. Select cause of the discrepancy under the Reason drop down.
  4. Select claim type under the Category Type drop down.
  5. Click Next to submit the discrepancy.

- D. Enter all available information for the potential claim on the Worker Portal within 10 days of the discovery date.
- E. Scan claim information into the Electronic Case File (ECF). See [MS 0850](#).
- F. Schedule an appointment with the household on the Worker Portal, if needed, to occur no later than 30 days from the discovery date the claim is entered on the Worker Portal. Appointments are not to be scheduled for Agency Error claims. See [MS 1020](#) for SNAP trafficking procedures. The appointment can be scheduled as a face-to-face or phone interview (except when a phone number is not available). The claims worker is responsible for contacting the client at the time the phone interview is scheduled. The face-to-face interview is scheduled in the local office of the county that the client is active or last received in. If the client is not currently receiving benefits and has moved out of the county that has the claim, the client may travel to the county for the interview, be given a phone interview or the new region may be asked to handle the claims interview. (Note: If the claim is split due to household members moving in or out, a 2<sup>nd</sup> appointment is not required. Only the initial interview is required.
- G. Households who refuse to provide information required to determine ongoing eligibility are discontinued for non-cooperation.
- H. Document on the Worker Portal under the Benefit Recovery tab and Claim Comments link on the left hand panel:
1. Every action taken and the date it happened.
  2. List in chronological order the circumstances that resulted in the claim.
  3. False, misleading, or untimely statements made by the member(s).
  4. List all verification used to determine the claim.
  5. An explanation of the category of the claim.
  6. An explanation of any corrective action taken to prevent future errors of the type that caused the claim.
  7. For claims caused by unreported income, indicate who had the income, the type of income, name of employer if it is earned income, and time period of receipt of the unreported income.
  8. List any additional income that was counted in the case, along with deductions given during the time period of the claim.
  9. The hearing decision and other actions pertaining to the disposition of the claim such as completion of a waiver to a hearing, termination of an OIG referral, or court disposition.
- I. Compute the claim amount based on available information, i.e. wage records, batch match, work number, driver license, etc. Claims workers are not to

investigate using Facebook, Google or by calling family, friends, employers or landlords to seek information about the client, that they did not verify. If a collateral contact is used to substantiate a claim, request and obtain written verification from the source for the claim record.

Example 1: The case record contains form PAFS-76 that was completed by the landlord. When the claims worker contacts the verification source to determine time period of household composition, it is found it was not completed by the landlord. The claims worker does not Google Search for the landlord's information to try to contact them to question them about the client's household situation. In the claim, it is notated that the client returned false verification, as the landlord did not complete the PAFS-76.

Example 2: The case record contains form PAFS-700 from client's employer. The employer can be contacted to verify information pertaining to client's employment, but is not to be questioned about the client's living situation.

- J. If verification of the claim cannot be substantiated by any available source, determine if the claim should be referred to OIG for further investigation. If the claim does not meet criteria for referral then no claim exists. If information later becomes available to establish the claim, it can be reentered as a potential claim on the Benefit Recovery Module.]
- K. Potential fraud claims in excess of \$3000 are referred to the Office of Inspector General (OIG) per [MS\\_0910](#) for further investigation. If a disability exists or LEP is present, prior to completing a referral to OIG, seek an assessment of the client's ability to understand program rules from the DCBS EEO Coordinator or CHFS EEO Compliance Branch, 275 East Main Street 5 C-D, Frankfort, Kentucky 40621 or call 502-564-7770.

MS 0880 GENERAL PROCEDURES FOR A SUSPECTED FRAUD CLAIM (1)

A preliminary determination of suspected fraud is made after review of the information available to the worker regarding the circumstances of the claim and the client's statements regarding the reason(s) for the claim. The supervisor must agree with the findings of the worker prior to proceeding with a fraud hearing for Supplemental Nutrition Assistance Program (SNAP) or referring the case(s) to the Office of Inspector General (OIG) for possible prosecution. Use criteria in [MS 0910](#) to refer a case to OIG.

A. Fraud is suspected when a client:

1. Makes a false or misleading statement in order to receive benefits;
2. Misrepresents, conceals, or withholds factual information in order to receive benefits;
3. Commits a violation of the Food and Nutrition Act relating to the use, presentation, transfer, acquisition, receipt or possession of SNAP benefits. Specifically prohibited is:
  - a. Purchasing a controlled substance using SNAP benefits;
  - b. Purchasing firearms, ammunition, or explosives using SNAP benefits;
  - c. Buying or selling SNAP benefits on or after 8/22/96; and
  - d. Making a false statement on or after 8/22/96 pertaining to identity or residence in order to receive duplicate benefits.
4. Permits an individual other than those listed on the KY Health Card to obtain health care benefits;
5. Misuses a Medicaid covered service, such as medical transportation, for a non-medical purpose.
6. Misuses supportive service payments.

[B. Suspected fraudulent SNAP claims are established on the Benefit Recovery Module as Inadvertent Household Error (IHE) claims with a Suspected Intentional Program Violation Indicator (SIPV).]

After the claim has been established as SIPV, a change in status must be completed within 90 days. If the claim is not referred to OIG, pursue the IPV by sending form FS-80, Notice of Suspected Intentional Program Violation and form FS-80 Supp A, Voluntary Waiver of Administrative Disqualification Hearing to the recipient for signature. If the waiver is not returned within 10 calendar days submit a request for an Administrative Disqualification Hearing (ADH) within the next 10 calendar days. See [MS 0500](#) concerning collateral contact verification.



- C. A SNAP claim is not considered fraud unless:
1. The client voluntarily signs form FS-80, Supp. A, Voluntary Waiver of Administrative Disqualification Hearing; or]
  2. It is determined fraud by a hearing officer in an Administrative Disqualification Hearing, confirmed by a final order, and all further appeals are completed; or
  3. The client signs form FS-111, Deferred Adjudication Disqualification Consent Agreement, to avoid criminal prosecution; or
  4. A court action establishes fraud.
- D. Claims that are referred to OIG remain established as IHE with a SIPV indicator until OIG:
1. Returns the referral declining to pursue court action; or
  2. Final action is completed in the fraud determination.
- [E. Fraud is established judicially for Medicaid and TANF related programs. (KTAP, Kinship Care, RAP, FAD, WIN, KWP Supportive Services). Claims that do not meet the criteria for referral to OIG are categorized as non-court on the Worker Portal.]
- F. All Medicaid claims occurring due to suspected fraud are referred to OIG. See [MS 1240](#).

MS 0890          HOW TO DETERMINE THE FIRST MONTH OF A CLAIM          (1)

To determine the first month of the claim, apply the following rules.

- A. For applications that are incorrectly processed based on information provided at the interview, the claim is established for the effective month of approval and continues for every subsequent month the incorrect information is used. Example: Client applies for benefits and fails to report a source of income. The claim begins the month of approval and continues until the income is considered in the determination of the benefit.
- B. The 10-10-10 formula is used to determine the first month of the claim.
  - 1. Determine when the change became known to the household;
  - 2. From that date, allow the household 10 days to report;
  - 3. Allow the worker 10 days to act on the report; and
  - 4. Allow 10 days for adverse action.
  - 5. The month in which the adverse action period ends determines the first month of the claim. The beginning month of the claim is the next month after adverse action ends.
- C. Simplified Reporting households have until the 10<sup>th</sup> of the month following the month a change occurs to report a required change. Example: A household's income increases above the permitted gross limit in August. The client has until September 10 to report the change. The worker has 10 days to act on the change (September 20), and 10 days (September 30) are allowed for adverse action. The first month of the claim is October.
- D. [A reportable KTAP or Kinship Care change is required to be reported within 10 days. When changes decrease benefits or result in discontinuance of a case, the change must be entered on the Worker Portal by either the negative action cut-off or IM cut-off date, whichever affects the next month's benefits.]

Example 1: An individual reports a member of the benefit group left the home on 9/5/10. IM cut-off is 9/21/10. Negative action cut-off is 9/20/10.

As this change will decrease benefits, the change must be entered by 9/20/10 to be effective for 10/1/10. If the change is entered after the negative action date an AE claim exists for 10/1/10.

Example 2: An individual reports a member of the benefit group has left the home on 11/5/10. Due to holidays, IM cut-off falls on 11/17/10. Negative action cut-off is on 11/19/10. The change must be entered by 11/17/10 in order to be effective 12/1/10 or a claim exists.

- E. For KTAP or Kinship Care claims resulting from the failure of the household to report a child's absence from the home within 5 days, without good cause, the claim will begin the month after the child left the home.

MS 0900 DETERMINING ELIGIBILITY THROUGH EXTENSIVE REVIEW (1)

[The Determining Eligibility Through Extensive Review (DETER) program is offered by the Office of Inspector General (OIG) to prevent individuals from receiving benefits fraudulently. A DETER referral is appropriate ONLY if a specific issue affecting eligibility is identified. Cases that appear suspect are referred to the DETER program for investigation.

- A. Refer only applications and reapplications that cannot be resolved through normal case processing. DETER is not used on expedited Supplemental Nutrition Assistance Program (SNAP) applications.
  - 1. Access the DETER function on the case summary screen on worker portal.
    - a. Enter detailed comments in the DETER referral window regarding the allegation and what case type is being referred to DETER.
    - b. Scan all related information into the Electronic Case File (ECF)
  - 2. DETER is operational in all counties.
  - 3. Caseworkers must explore all avenues available to resolve the issue before referring the case to DETER. An inappropriate DETER referral will be returned to the worker.
- B. After satisfying the verification requirements or when all avenues have been exhausted, use the following guidelines to determine if a referral to DETER is appropriate.
  - 1. During the initial application, the caseworker suspects the client may have withheld information during the course of the interview.
  - 2. The client provides any verification relative to the eligibility determination that appears to have been altered or not authentic.
  - 3. The applicant provides contradictory information relative to any eligibility factor.
  - 4. The client does not respond during application or reapplication to questions relating to eligibility.

Example: The client states rent and utilities are being paid, no income is reported, and client does not have valid explanation as to how the expenses are being paid.

- C. After the DETER referral is made pend the case for up to 15 days or until the case due date whichever occurs first to allow the investigator time to gather information and report findings. The investigator has up to 15 calendar days to complete the investigation and provide their findings unless the case due date is less than 15 calendar days from the date of the DETER referral. If there is not 15 days prior to the case due date you must specify, in the DETER

comments box, the case due date. Once the DETER investigation is complete, OIG returns the final report to the worker who initiated the DETER referral and the worker's supervisor.

1. Comment thoroughly the reason for the DETER investigation and pending the application.
2. Pend the case until forms DTR-2, Case Detail Summary Sheet; DTR-2A, DETER Response and Request for Action; and DTR-3, DETER Investigation Report, are received from the DETER investigator or until the case reaches its due date whichever comes first. Do not pend cases past their due date.

Example: A SNAP application is taken on January 1. After verification had been returned on January 23 the worker noticed an altered verification form and initiated a DETER referral. There is not 15 days prior to the case due date of January 30. The worker must specify, in the DETER comments box, when the referral is created that the investigation needs to be completed by January 29.

Example: A SNAP application is taken January 1. Client first stated that the father of the child was in the home but then she stated that the father of the child was out of the home. The worker through all avenues of questioning cannot determine if the father is in the home. The worker on January 1 submits a DETER referral. The worker would not need to specify a due date when the DETER referral is submitted.

- D. Caseworkers will receive forms DTR-2, DTR-2A, DTR-3, and a document titled Report Attachments containing any supporting documentation obtained during the investigation via e-mail. Caseworkers must review all information provided by the DETER Investigator and weigh the findings against any contrary evidence provided by the household.
1. Review form DTR-3 and take appropriate action according to the DETER findings within 10 days or sooner if the case due date is less than 10 days from receipt of the findings.
  2. If the DETER findings are inconclusive, process the case, and if the case is approved, utilize the unclear information function located on worker portal on the case summary screen.
  3. If the findings are conclusive, do not automatically allow written statements provided by the client that are contrary to the DETER findings to supersede the DETER report.
  4. If a potential claim is identified follow procedures used to refer the case for a claim.
  5. Workers have 30 calendar days from the date the investigation findings are received to return form DTR-2, annotated with the results the findings had on the case, to DETER. If a response is not provided to DETER within

30 days, DETER will send a follow-up request. A response to the follow-up request is due back to DETER within 15 days.

E. Document in Worker Portal comments:

1. The date and reason for the DETER referral.
2. Results of the investigation.

\*NOTE: Comments on Worker Portal become a permanent record, which may be used in an Administrative Hearing or Court proceeding. Use only portions of the findings, which specifically support the action taken by the caseworker.

F. File all DETER forms in ECF.]

MS 0910

REFERRAL OF CLAIMS TO  
THE OFFICE OF THE INSPECTOR GENERAL

(1)

The Department for Community Based Services (DCBS) contracts with the Office of the Inspector General (OIG) of the Cabinet for Health and Family Services (CHFS) to investigate and pursue prosecution of individuals suspected of fraudulently receiving or trafficking program benefits.

A. The following claims are referred to OIG for investigation:

1. [Medicaid (MA) claims, regardless of the amount, when a client has withheld or provided false information in order to receive assistance. MA claims are not entered on the Worker Portal unless adjudicated through the court system.
2. A KTAP, KTAP supportive services, KC, FAD, WIN, RAP, or SNAP case suspected of fraud, when the claim amount:
  - a. Is estimated to be \$7,500 or more due to unreported wages, only;
  - b. Is estimated to be \$3,000 or more for reasons other than unreported income;
  - c. There are companion case(s) and the combined amount is estimated to be \$3,000 or more; or
  - d. There is a companion MA case with at least one month of suspected ineligibility.
3. SNAP trafficking cases that are believed to be \$3,000 or more and have been identified as a result of a disqualified retailer.

\*Note- SNAP trafficking hotline referrals will no longer be referred to OIG regardless of dollar amount. SNAP trafficking hotline referrals will be handled administratively.]
4. SNAP trafficking involving controlled substances, firearms, ammunition, explosives, or controlled substances, regardless of the suspected amount.
5. Low-Income Home Energy Assistance Program (LIHEAP) cases, regardless of the amount.

B. Take the following actions when suspected fraud is discovered and the claim meets criteria in Item A:

1. [Field Staff will take action to generate a task to the regional claims worker by entering the information for the potential claim on the Worker Portal Overpayment Discrepancies screen. The regional claims worker is to take action within 10 days of the discovery date.
2. Take action to correct ongoing benefits.

3. Within 10 days of entering the claim on the Worker Portal, schedule an appointment with the household to discuss the claim and obtain verification.]
  4. Calculate the claim based on available verification.
  5. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, for claims that include Medicaid.
- C. [Navigate the Worker Portal to the Benefit Recovery tab from the top navigation and then select Create New Referral in the left hand navigation box under the Fraud Referral section, then proceed with the following steps:
1. Enter Claim #,
  2. Click Add to append the claim to the referral.
  3. The Claims Referral section will be populated with the associated claims details.
  4. Specify the claim which will serve as the primary claim by clicking the Radio button in the Primary Claim column.
  5. The Claim Details section populates with the relevant details of the Head of Household.
  6. Scroll to the right of the screen to select the check box Associate Claim; this must be done for each claim you want referred.
  7. Enter any comments associated with the referral.
  8. Click Submit to send the referral; this will send the request to your supervisor to approve so that it will be sent to CMS to review. After CMS reviews the referral, it will go to OIG to investigate.

When the claim is maintained on the Electronic Case Filing System (ECF), documentation located in the Worker Portal and ECF is not emailed to OIG. OIG has access to ECF and can view and print needed information. ]

Non-established SNAP claims must be received in Claims Management Section (CMS) no later than 30 days from the date of discovery. Established SNAP claims must be received in CMS no later than 10 days from the date of establishment.

[CMS reviews the referral and supporting documentation before submitting the referral to OIG on the Worker Portal.]

- D. OIG may request a claim to be re-calculated based on the findings of the investigation. Complete all re-calculations within 15 calendar days of the request by OIG. NOTE: These computation requests are sent directly to OIG. Contact the OIG investigator and CMS inbox at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov) if there will be a delay in completing computations.



- E. OIG has a 90-day time-frame to complete the investigation and determine if prosecution will be pursued.
1. If prosecution is not pursued, OIG closes their case and returns the claim to DCBS for administrative action, which must be taken within 10 calendar days.

For SNAP claims:

- a. If fraud is highly suspected, pursue administrative establishment of an Intentional Program Violation (IPV) claim. See [MS 1070](#).  
[b. If the claim was caused by the client but fraud cannot be determined, change the category on the Worker Portal form Suspected Intentional Program Violation (SIPV) and complete as an Inadvertent Household Error Claim (IHE).  
c. If OIG determines the claim resulted from an Agency Error (AE), review the claim circumstances. The DCBS claims worker determines the appropriate category of a claim. If an AE is found, change the indicator on the Worker Portal, and complete the claim.]
2. If a portion of the claim is not prosecuted but returned to DCBS for administrative action, a separate claim is established and procedures for the appropriate claim category are followed. Only one disqualification period is entered if both claims are of the same circumstances.
3. If prosecution is pursued, OIG serves as liaison between DCBS and the courts and prosecutors.
  - a. When possible, OIG will notify field staff at least five days in advance of a court or conference that requires their appearance.
  - [b. When the case is adjudicated, OIG will provide copies of the order or agreement and annotate the Worker Portal for DCBS to follow-up.]
  - c. The local office may contact the court directly to obtain court documents if adjudication has occurred. Copies of the court documents are forwarded to the regional claims worker and CMS as soon as they are obtained.
  - [d. If the case is prosecuted and the individual found guilty, CMS changes the claim to Intentional Program Violation - Court on the Benefit Management Module. A disqualification is entered on the Worker Portal within 3 days of notification of prosecution.
  - e. OIG can initiate an investigation without a referral from DCBS. If notified to do so by OIG, the pending claim is entered on the Benefit Management Module using the date the referral is created by OIG as the discovery date.
  - f. OIG may return a referral to DCBS when they are not able to complete the investigation within the required 90-day timeframe. If the claim is returned and the suspected fraud referral requires investigation by OIG, another referral is completed on the Worker Portal and the referral is submitted back to OIG through CMS.
  - g. After disqualification periods have ended, the disqualified member must be added back to the SNAP case as a household member. Complete a case change to add the member.]

MS 0920 FRAUD "HOTLINE" REFERRALS (1)

- A. The Office of Inspector General (OIG) maintains a toll free hotline, 1-800-372-2970, to report suspected fraud.
1. When a caller contacts the local office regarding fraud, provide this number.
  2. Use this number to report alleged Medicaid vendor fraud.
  3. Use this number to report alleged employee fraud.
  4. When a caller indicates he/she is unable to leave a message on the Hotline, take the information and email OIG at [OIG.Claims@ky.gov](mailto:OIG.Claims@ky.gov).
- B. OIG screens complaints and sends valid hotline referrals to the Service Region Administrator Associate (SRAA) via the Complaints, Investigations, and Collections System for OIG. The SRAAs and designated individuals can access the hotline information at <https://webapp.chfsinet.ky.gov/oigimsii/>. To obtain access, contact OIG at (502) 564-2815.

When a hotline referral is received:

1. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation.
2. [If a change becomes known to the agency through a hotline referral, enter the change on the Worker Portal. The Worker Portal will generate an RFI requesting verification of the change. When the requested verification is returned, enter the verification in the Worker Portal and allow the system to process the change. If the verification is not returned, the Worker Portal will act on the change according to policy in Vol. II, [MS 6750](#) and [MS 6760](#), as appropriate.

Example: It is reported that a noncustodial parent is in the home with income. Enter the information on the Worker Portal and allow the case to pend for verification of household composition and income.

3. If enough information is not provided to enter the change on the Worker Portal, enter "Y" to the question, "Is contact needed to verify unclear information?" and leave the verification field blank. Only use this function if the allegation applies to all EDG's on the case. Do not use if the hotline referral is program specific. An RFI is generated requesting the household contact DCBS to discuss unclear information and allows the household 10 days to comply. If contact is not made within 10 days and a verification code is not entered for the question, the case will automatically discontinue.
4. If it appears there is a possible claim, complete the Overpayment Discrepancies screen on the Worker Portal, within 15 work days from the date of the hotline referral.

5. If it is determined no claim exists based on the hotline referral information, indicate the reason for no action on the Worker Portal and return to the SRAA within 15 work days from the date of the hotline referral.
  6. If the hotline referral is determined to involve suspected trafficking allegations, refer to Vol. I, [MS 1020](#), Trafficking and Retailer Fraud.]
- C. The Food and Nutrition Service (FNS) maintains a hotline number for the general public to report fraudulent activity. Once they receive the hotline report, FNS emails the complaint to the Nutrition Assistance Branch (NAB) for the state to take action on the complaint. NAB will email the report to the designated regional contact for investigation.
1. Enter the complaint on the Complaint Module on Worker Portal. All whistleblower complaints will not necessarily be fraud. Some complaints may be issues regarding case processing and other general case resolution issues.
  2. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure supporting documentation. Only use collateral contacts as a verification source as a last resort in these complaints.
  3. [When a change becomes known to the agency, enter the change on the Worker Portal. Worker Portal will generate an RFI requesting verification of the change. When the requested verification is returned, enter the verification on Worker Portal and allow the system to process the change. If the verification is not returned, the Worker Portal will act on the change according to policy in Vol. II, [MS 6750](#) and [MS 6760](#), as appropriate.  
  
Example: NCP is in the home with income. Enter the information on the Worker Portal and allow the case to pend for verification of HH comp and income.
  4. If enough information is not provided to enter the change on the Worker Portal, Access the unclear information tab on the case action column of the case summary screen. Only use this function if the allegation applies to all EDG's on the case. Enter the date the unclear information was received and select what the unclear information is in regard to and leave the verification field blank. An RFI is generated requesting the household contact DCBS to discuss unclear information and allows the household 10 days to comply. If contact is not made within 10 days and a verification code is not entered for the question, the case will automatically discontinue. If it appears there is a possible claim, complete Overpayment Discrepancies screen, within 15 work days from the whistleblower complaint.
  5. In instances of household composition allegations, please review the complaint thoroughly and if the complaint appears to be valid complete the Overpayment Discrepancies Screen within the timeframe mentioned above so that the complaint can be reviewed and sent to OIG if necessary.

- Example: A Whistleblower complaint is received and states that the client's reported household composition is fraudulent; that the father of the youngest child is, and has always been in the home, and that the oldest child, which the client has included in the household, is not in the home. The complaint states that there is proof of the client's statements being false, that arrest records can be found and social services can be contacted to verify. In this instance the Overpayment Discrepancies screen would be completed and sent to the regional claims worker. The claims worker would send the complaint to OIG as other documentation provided by the client would be considered questionable and the complaint appears to be valid.
6. For unreported wage complaints use any verification source available. If wages are found, complete the Overpayment Discrepancies screen within the timeframe mentioned above.
  7. For self-employment income complaints, complete the Overpayment Discrepancies screen in the timeframe mentioned above.
  8. [If it is determined no claim exists based on the hotline referral information, indicate the reason for no action on the Worker Portal and respond to NAB within 15 work days from the date of the hotline referral.]
  9. If the hotline referral is determined to involve suspected trafficking allegations, refer to Vol. I, [MS 1020](#), Trafficking and Retailer Fraud.]
  10. You must notify NAB by email at [CHFS.FoodBenefitsPolicy@ky.gov](mailto:CHFS.FoodBenefitsPolicy@ky.gov), using the proper chain of command, within 25 days of receipt of the whistleblower complaint. Please include a brief summary of events taken on the complaint.

MS 0930

EMPLOYEE FRAUD

(1)

Employee fraud is defined as fraudulent activity by an employee responsible for administering an assistance program who knowingly obtains benefits or provides assistance to an individual in order to obtain benefits, or receive increased benefits, for which the individual is not eligible. The employee committing the fraud is subject to prosecution. If convicted, this felony is punishable by imprisonment of 5-10 years and/or a fine up to \$10,000 or double the gain.

A Department for Community Based Services (DCBS) or contract employee who knows or suspects that fraud has or may have occurred must report it within 24 hours to their supervisor, Service Region Administrator (SRA)/Division Director, or by calling the OIG Fraud hotline at 1-800-372-2970. An employee who fails to report suspected fraudulent activity may be subject to disciplinary action and dismissal, as well as relevant criminal penalties.

Employee fraud claims are completed by a designated individual as determined by the Division of Service Regions.

[Do not enter a fraud claim which involves any Department for Community Based Services (DCBS) employee on the Worker Portal. This applies even if the individual is not responsible for administering an assistance program. To complete a SNAP overpayment, use the automated form FS-103 on the "Historical Allotment Calculator" located in the DFS Forms Library. For a KTAP overpayment, use application PA-30.1 accessed on the KYNET Menu.]

MS 0940

WHO MUST PAY A CLAIM

(1)

The following persons are responsible for paying a claim:

- [A. Each person who was an adult member of the household when the claim or food benefit trafficking occurred;

Example: A household consists of 4 members: 2 adults and 2 children. One adult is the head of household (HOH) and the case is in his name and social security number. An overpayment is discovered and a claim established. Because the client has an active case, the claim will automatically be repaid by benefit reduction. If the case is discontinued, benefit reduction ceases and demand letters are issued from the Worker Portal to the head of household. If the other adult member of the household subsequently reapplies for benefits, responsibility for repayment transfers to the active case and benefit reduction will be imposed.]

- B. A sponsor of an alien household member if the sponsor is solely at fault;
- C. A person connected to the household, such as an authorized representative, who trafficked food benefits or caused a food benefit claim;
- D. For claims relating to recipients residing in a Drug and Alcohol Abuse (DAA) treatment center, the designated representative of the center or the center.
- E. An individual court ordered to repay the Cabinet.

Example: A person, not connected to a household, is arrested and convicted for EBT trafficking. The court orders repayment of the fraudulently obtained benefits.

- [F. Every month the Benefit Recovery Module matches the individual number from the claim with active Worker Portal cases. If a "hit" is detected, benefit reduction will begin on the active Worker Portal cases that contain adult members from the claims case.

Example: A Supplemental Nutrition Assistance Program (SNAP) claim contains 2 adult household members. The HOH has an active SNAP EDG and the other adult household member is active in a separate SNAP EDG therefore benefit reduction will occur on both SNAP EDG's simultaneously.]

- G. For claims involving emancipated minors, collection is pursued only if the household contained no adults at the time the claim occurred. Example: A teen couple living alone.
- H. The responsibility to repay a KTAP or Kinship Care claim is with the caretaker relative who was a member of the case or the payee. Repayment is never sought from the children.

- I. Collection may be pursued from a child member of the case at the time the AFDC claim occurred if all adult members are deceased.
- J. The client or responsible party is liable for repayment of the value of benefits when a determination is made that the benefits were obtained by committing a medical program violation. See [MS 1240](#).

MS 0950 CLAIM REPAYMENT METHODS (1)

Claims may be repaid using one of the following methods:

- A. LUMP SUM. For active or inactive households, if the household elects to pay the claim at one time, collect a lump sum payment. DO NOT ACCEPT CASH. A check or money order made out to the Kentucky State Treasurer, EBT benefits, or voluntary return of an issued check is accepted form of payment. For amounts over \$300.00 and the payment is in the form of a check, a cashier's or certified check is required.
1. Do not require the household to liquidate all of its resources to make a lump sum payment.
  2. It is permissible for the household to make a lump sum payment as partial re-payment of the claim.
  3. [If the household chooses to make a monthly or lump sum payment from Electronic Benefits Transfer (EBT) benefits, complete form EBT-6, Claims Repayment Request, for the Supplemental Nutrition Assistance Program (SNAP) claim. Form EBT-61, EBT Benefits Account Adjustment Request, for the Kentucky Transitional Assistance Program (KTAP) can be used if the client wishes to return the entire KTAP grant to prevent a claim. Submit to the Claims Management Section (CMS) by email to [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov) or by fax to (502) 564-9810.]
  4. If the household voluntarily returns an issued benefit check to use as payment on a claim, issue a PAFS 30.3, Multi-Program Claims Receipt, to the client. Forward the check along with form PAFS-61, Disposition of Returned Check, to:  
  
Department for Community Based Services  
Division of Family Support  
Nutrition Assistance Branch  
Claims Management Section  
275 East Main Street, 3 E-1  
Frankfort, Kentucky 40621
- B. INSTALLMENTS. If the client with an inactive benefits case chooses to pay by installment payments, CMS negotiates and accepts payments. A client who is paying a claim by benefit reduction in an active case can also choose to make additional payments by installment. Notify CMS of the client's request.
- [C. BENEFIT REDUCTION. If an adult household member is active in a case, the household's benefits are reduced to recover the remaining balance not paid by a lump sum payment. The Worker Portal reduces benefits automatically. The initial benefit, when a household is first certified, cannot be reduced. Benefit reduction cannot be used to pay FAD, WIN, Supportive Services Remedial Health Care, or AFDC program claims.



- D. The minimum amount of benefits recovered each month by benefit reduction calculated by the Worker Portal is: ]
1. SNAP Agency Error or Inadvertent Household Error Claims - the greater of 10% of the monthly benefit or \$10. The client can choose to increase the reduction amount.
  2. SNAP Intentional Program Violation Claims - the greater of 20% of the monthly benefit entitlement or \$20. The client can choose to increase the reduction amount.
  3. 10% of the KTAP or Kinship Care maximum payment for claims established due to overpayments of KTAP, Kinship Care, Relocation Assistance, Education Bonuses, or Kentucky Works supportive services. A minimum amount of \$1 is issued in cases with benefit reduction.
  4. The \$16 minimum SNAP benefit level for 1 and 2 member households applies only to the allotment prior to reduction. Actual benefits for any size household may be zero if benefit reduction occurs
- E. TAX INTERCEPT. CMS obtains payment through intercept of State and Federal tax refunds, lottery offsets, stimulus payments and other options.
- [F. EXPUNGED BENEFITS. Expunged benefits are applied to claims. This payment method is an automated function by the Worker Portal and no action is required by staff. If a client has multiple claims, the expunged benefits are applied to the oldest claim first.
- G. RESTORATIONS. SNAP claims can be offset using restorations as a payment. When a SNAP case is owed a restoration, the Worker Portal will match prior to issuing the restoration. When a SNAP claim exists, update the Worker Portal comments about payment being applied to the claim and contact CMS by email at [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov). CMS will apply the amount of restoration being used to offset the amount owed in the SNAP claim. Any remaining amount of the restoration owed to the client is issued by the local office.
- H. SUPPLEMENTALS and SPECIAL CIRCUMSTANCES. KTAP, TANF-related (TR) and Kinship Care claims can be offset using a supplemental or special circumstance as payment. When a KTAP/TR case is owed a supplemental /special circumstance, the Worker Portal will match prior to issuing the supplemental/special circumstance and alert the worker of the claim. When a KTAP/TR claim exists, update the Worker Portal comments about payment being applied to a claim and contact CMS by email at [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov). CMS will apply the amount of the supplemental /special circumstance being used to offset the amount owed in the claim. The special circumstance will be applied to the claim if appropriate. Any remaining amount of the supplemental/special circumstance owed to the client is issued by the local office.]

MS 0960

COLLECTING PAYMENTS ON CLAIMS

(1)

Collection of a claim is either by benefit reduction or by the Claims Management Section (CMS) located in the Division of Family Support in Frankfort.

- [A. The Worker Portal will automatically reduce benefits on active households with a claim, unless the claim was adjudicated in court.
- B. The Benefit Management Module sends notices and pursues collection from households with claims. All repayment notices issued to clients are maintained on the Worker Portal.
- C. Once the court adjudicated claim is outside court jurisdiction and benefits are active, the Worker Portal begins benefit reduction.
- D. The local office's responsibilities are to:
  - 1. Enter all newly established claims on the Benefit Management Module.]
  - 2. Never accept cash payments.
  - 3. Accept payments made by check (personal, cashier, certified) or money order to pay on an established claim.
  - 4. Tell the client to send payments, made out to the Kentucky State Treasurer, to CMS at:

Department for Community Based Services  
Nutrition Assistance Branch  
Claims Management Section  
275 East Main Street, 3E-1  
Frankfort, Kentucky 40621
  - 5. Notify CMS by e-mail at [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov) of changes that impact the repayment of a claim, e.g. address changes, adjustments, hearing requests, bankruptcy petitions, etc.]
  - 6. Cease collection activity if the client requests a hearing in response to a demand letter pending receipt of a final order.
  - 7. Advise clients to contact CMS at 502-564-3440 regarding any questions about repayments or intercepts.
  - 8. The transfer of claims to or from other states requires the approval of the CMS Supervisor. Notify CMS by e-mail at [CHFS.DFS.CLAIMS@ky.gov](mailto:CHFS.DFS.CLAIMS@ky.gov) of all requests received from other states or initiated in the local office. CMS staff will notify local office staff if any further action is required.]

MS 0970

WHEN A CLAIM IS OVERPAID

(1)

- A. If it becomes known that a household has overpaid a claim by benefit reduction, the client is refunded the overpaid amount. The household is refunded the money even if it is currently ineligible for benefits. Field staff:
1. Authorize the restoration of food benefits for overpayment of a food benefit claim.
  2. Refund an overpayment of a KTAP or related program by special circumstance.
  - [3. Advise the Claims Management Section (CMS) of the need for reconciliation of the overpayment of the claim on the Worker Portal.]
- B. When a claim is overpaid through cash payments, CMS will authorize a refund for the overpayment.

MS 1000 CATEGORIES OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) CLAIMS (1)

A claim occurs when a household receives benefits to which it is not eligible or trafficks SNAP benefits. Refer to Volume I, [MS 1020](#), for information on trafficking. There are three categories of SNAP benefits claims:

- A. Agency Error (AE) – occurs when the claim is caused by a worker’s action or failure to take action which includes:
  - 1. Failure to take prompt action on a client reported change;
  - 2. Incorrectly computing income and deductions;
  - 3. Failure to take prompt action on a change known to the agency.
  
- B. Intentional Program Violation (IPV) – occurs when it is established by admission, hearing, or prosecution that a client:
  - 1. Deliberately made a false or misleading statement;
  - 2. Deliberately misrepresented, concealed, or withheld facts;
  - 3. Purchased a controlled substance, guns, ammunition, or explosives with benefits;
  - 4. Bought or sold SNAP benefits on or after 8/22/96;
  - 5. Made false statements regarding identity or place of residence in order to receive duplicate benefits on or after 8/22/96.
  - 6. Commits any act that violates the Food and Nutrition Act of 2008, federal SNAP regulations or state law, for the purpose of using, presenting, transferring, acquiring, possessing or trafficking Electronic Benefit Transfer cards used as part of an automated benefit delivery system.
  
- C. Inadvertent Household Error (IHE) – occurs when the claim is caused by misunderstanding or an unintended error by the client or fraud is suspected, but the determination is not final.
  - 1. This includes claims caused by:
    - a. Failure to provide correct or complete information;
    - b. Failure to report a change in circumstances;
    - c. Receipt of benefits pending the outcome of a hearing that upholds the agency;
    - d. The agency’s inability to prove fraud in a hearing or court proceeding.
    - e. Suspected IPV claims in which the head of household is deceased and there are other adult members in the home.

2. If the agency has sufficient evidence to pursue IPV but the application(s) for the claim period cannot be located, remove claim months that exceed 12 months prior to discovery and pursue the claim as an IHE.
3. [Claims where fraud is suspected but are pending a final determination from an Administrative Disqualification Hearing or court proceeding are flagged with the SIPV (Suspected Intentional Program Violation) category on the Benefit Management Module. The category is changed to IHE, IPV, or AE when a hearing decision is final. An IPV as a result of a court's determination of guilt, due to fraud, is coded on the Benefit Recovery Module as intentional program violation – court adjudicated.]

MS 1005 NO CLAIM DETERMINATION (1)

Consider a Supplemental Nutrition Assistance Program (SNAP) overpayment a “No Claim” if:

- A. [An expedited SNAP case is processed with verification postponed, and benefits were calculated based on the best available information provided by the client. If there is no evidence that information was withheld, no claim exists. In instances of a system error or worker error that causes erroneous benefits to be issued, a claim is pursued.
- B. There is no signed application and it is not clear that the recipient completed an application and it is not clear an interview was conducted. This does not include applications initiated by the client on the Self-Service portal.

Example: A claim referral is completed on a recipient. The recipient was contacted by the regional claims worker and the recipient stated that she has not been contacted or been in the office for an interview. There was also no signed application on file. Since there is no clear evidence that the client applied, there would not be a claim. However, the SNAP case should be discontinued.

Example: A claim referral is completed on a recipient. The recipient had applied for SNAP using the SSP. The worker approved the application without conducting an interview. Since an application was initiated on the SSP, a claim is pursued.]

- C. When “No Claim” is determined, document the case record regarding the basis of the determination.
- D. [Reference MS 1010 Procedures for Specific Households for procedures on lost or unsigned applications and electronic signature applications.]

MS 1010 PROCEDURES FOR SPECIFIC HOUSEHOLDS (1)

A. Categorically Eligible

For households failing to report income that results in an overpayment, establish a Supplemental Nutrition Assistance Program (SNAP) benefits claim.

B. Authorized Representatives

1. The household is liable for a claim if it provides incorrect or incomplete information to the authorized representative acting in its behalf.
2. The authorized representative is responsible for a claim when he/she trafficks benefits or otherwise causes an overpayment.

C. Sponsored Aliens

1. The alien is responsible for claims that occur when the sponsor unknowingly provides incorrect information.
2. The alien and sponsor are responsible for repayment of the claim unless:
  - a. The sponsor cannot be located or the relationship with the household is otherwise broken;
  - b. The sponsor is a nonprofit organization.
3. If the sponsor provided incorrect information in a deliberate effort to obtain benefits for the alien, establish claims in the names of both and assign one-half of the overpayment amounts to each claim.

D. Drug/Alcohol Abuse (DAA) Treatment Center Residents

The DAA treatment center is responsible for any overpayment due to the misuse of benefits or misrepresentation of information.

E. Voluntary Quit

A claim is established for an individual who fails to report a voluntary quit and is not disqualified timely. The claim period is determined by the occurrence of the voluntary quit violation. Refer to Volume IIA, [MS 4550](#), Penalties for Noncompliance, to determine the claim period.

F. Ineligible Members

Review for a potential claim if a household containing an ineligible member fails to report a change that makes the member eligible to be included and his/her income and resources counted. This includes an ineligible student, a member having a work related disqualification, a drug or fleeing felon, a probation or parole violator, and ineligible aliens.

### G. Disqualified Members

Establish a claim if a household containing a disqualified member fails to report a change in income or resources. Disqualified members are those disqualified for an Intentional Program Violation, a work penalty, enumeration, a drug felony, or for failure to meet citizenship requirements.

### H. Fleeing Felons

If a member has an outstanding felony warrant and received benefits while the warrant was in effect, a claim is appropriate.

### I. Simplified Reporting (SR)

1. SR policy was effective 2-1-02 and includes all cases with earned income, including self-employment.
2. SR policy was expanded effective 3-1-03 to include all cases except households with members who are elderly or disabled with NO earned income.
3. SR policy was expanded 4-1-09 to all households.
4. When processing SNAP benefit claims, use policy that was in effect at the time the claim occurred.

### J. Dual Participation (SNAP)

An overpayment can occur when an individual gives false or misleading information about their identity and/or place of residency in order to receive simultaneous benefits in multiple states. Dual participation is verified by contacting the other state and verifying the benefits were issued for the same time period as in Kentucky and the benefits were accessed and used. It is not dual participation if benefits are only accessed in one state.

Example 1: Client applies in Kentucky and states that she is not receiving benefits in any other states. A report verifies the client was receiving benefits in another state for the same time period. The report verifies the client accessed and used the benefits from the other state at the same time they were receiving and using benefits in Kentucky. This would be explored as a Dual Participation Claim.

Example 2: Client applies in Kentucky and states that she is not receiving benefits in any other state. A report verifies client was active in another state and issued benefits on her EBT card at the time she was approved in Kentucky, however the benefits have not been used. Due to Simplified Reporting rules there is no claim in the other state as an address change is not a required report. This would not be considered dual participation, however a claim is pursued for benefits issued in Kentucky as the client is required at application to report receipt of benefits from other states in



order for verification of benefits and closure of the other state's case to be obtained.

#### K. Missing/Unsigned Applications (SNAP)

A missing/unsigned SNAP application does not prevent a SNAP claim from being established.

[Example 1: A claim referral is completed on a recipient. The referral is split into two claims due to the household situation; each claim will be assigned a different claim number. Both claims are referred to the Office of Inspector General (OIG) for prosecution. The first claim case is prosecuted but the second claim is returned to the local office for administrative action due to missing packets. Worker Portal indicates the client completed the recertification timely, information was updated on Worker Portal and OIG evidence supports an intentional program violation. Without the application, there is not sufficient evidence to prove fraud in a hearing or court proceeding. In this instance an Intentional Program Violation cannot be pursued, but an Inadvertent Household Error (IHE) can be established.]

Example 2: A recipient applies for and is approved for SNAP August 1, 2012. Household income exceeds limits in September 2012 and is not reported until the recertification interview in July 2013. The agency wants to pursue the claim as Suspected Intentional Program Violation (SIPV) but the signed application cannot be located. In this instance an Intentional Program Violation cannot be pursued. Without the application there is insufficient evidence to support fraud; pursue an Inadvertent Household Error (IHE) claim.

Example 3: Recipient completed a recertification June 1, 2012. Income in August 2012 exceeds limits and the recipient reports the change untimely to the agency. The household did not sign the SNAP application at the June recertification. In this instance the correct category would be an Inadvertent Household Error (IHE).

#### L. [Electronic Signature

Beginning August 1, 2012, recipients can choose to sign future applications electronically. When the electronic signature process is completed the application prints with "Electronically" in the signature line. The worker comments on Worker Portal as to who is interviewed in completing the application or recertification.]

Applications completed with an electronic signature are considered signed applications. Pursue any claim discovered for the period covered by an application signed electronically. This includes suspected intentional program violations.

MS 1015      DRUG/ALCOHOL ABUSE TREATMENT CENTER CLAIMS      (1)

Drug/Alcohol Abuse (DAA) treatment centers are responsible for the misuse of SNAP and/or the misrepresentation of information on behalf of a center resident. Pursue a claim in either of these instances. The DAA facility is responsible for repayment of a claim established due to misuse of benefits or misrepresentation of information. These types of claims are established for SNAP over-issuances that occurred on or after January 1, 2010.

[Establish a claim in the name of the resident if an agency error occurs. The resident is responsible for repayment of the claim. If the resident has an active case on Worker Portal, it will be subject to benefit reduction.]

- A. Establish separate claims for each resident whose benefits are overpaid if the treatment center is the cause of the overpayment or the misuse.
  1. Use claim type FD - Food Stamp (DAA) for claims involving a center.
  - [2. The claim is established as Inadvertent Household Error (IHE) on the Benefit Management Module.
  3. All FD claims are in the name of the treatment center. The benefit Management Module will assign a 10 digit claim number when the claim is submitted.
  4. If there are multiple claims against the treatment center, separate each claim by a sequence number.
  5. The resident of the drug treatment center is not responsible for the repayment of the IHE claim; therefore, if the client has an active SNAP case on Worker Portal he/she is not subject to benefit reduction.
  
- B. If an Intentional Program Violation (IPV) is suspected, the Food and Nutrition Service (FNS) is contacted by the Nutrition Assistance Branch. If FNS imposes a federal disqualification against the DAA facility, the Claims Management Section (CMS) will change the claim category from IHE to IPV on the Benefit Management Module. A disqualification is not entered on the Worker Portal when the IHE category is changed to IPV.]

MS 1020                      TRAFFICKING AND RETAILER FRAUD                      (1)

A. Trafficking is the act of:

1. Buying, selling, stealing, or exchanging Supplemental Nutrition Assistance Program (SNAP) benefits, SNAP Electronic Benefit Transfer (EBT) cards, card numbers, Personal Identification Numbers (PIN), or manual vouchers for cash or consideration other than eligible food either directly, indirectly, in complicity or collusion with others or acting alone;
2. Attempting to buy, sell, steal or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers, and Personal Identification Numbers (PINS), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;
3. Exchanging the EBT card or SNAP benefits for firearms, ammunition, explosives, or controlled substances. The Office of Inspector General (OIG) identifies and refers all cases involving firearms, ammunition, explosives, or controlled substances to the Kentucky State Police (KSP);
4. Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;
5. Intentionally reselling or exchanging eligible food purchased with SNAP benefits for the purpose of obtaining cash and/or other considerations; or
6. Retailers knowingly purchasing products originally purchased with SNAP benefits in exchange for cash or considerations other than eligible food.

- B. The Office of Inspector General (OIG) refers recipient trafficking hotline referrals to the Nutrition Assistance Branch (NAB). NAB will refer the recipient trafficking hotline referrals to the regional claim staff for investigation. For non-trafficking related hotline referrals refer to Vol I [MS 0920](#). If EBT account transactions indicate the possibility of trafficking or misuse of benefits, determine the total amount of suspicious transactions. The claim is only entered on the Benefit Recovery Module when the client signs form FS-80 Supp. A, Voluntary Waiver of Administrative Disqualification Hearing (ADH) Intentional Program Violation (IPV), an IPV is established by an ADH or the claim has been adjudicated in court.

[Example: A fraud hotline report is received from OIG that a recipient is selling his \$200 benefits each month in exchange for cash. A review of transactions on the Fidelity Information Service (FIS) website confirms the pattern for the past year. The transaction by both the recipient and the other individual is trafficking and the claim amount is \$7500. The claim is pursued as trafficking, the FS-80 and FS-80 Supp. A mailed, and if not returned, the claim is referred

for ADH. Even though the transactions were over \$3000.00, individual trafficking is not referred to OIG.]

- C. For allegations received and/or identified by local office staff, create a claim referral by accessing the benefit management screen on Worker Portal for the regional claims staff to investigate.
- D. When allegations that a recipient has trafficked SNAP benefits, are received by the regional claims staff, use the following procedures:
  - 1. [Access the recipient's account on the (FIS) website and review transaction information for the period described in the allegations.]

Review transaction history for the following:

- a. Whole dollar transactions. These could indicate payments of credit accounts, cash transactions or gas purchases.
- b. Back-to-back transactions within a time period too short for the scanning of eligible items. This can indicate ineligible sales or cash transactions.
- c. Large purchases at a retailer who carries a minimum of eligible food items. This could indicate payment of credit accounts or cash transactions.
- d. Vendor location. Determine if the recipient bypassed other EBT vendors to do business at the specific location indicated by EBT transactions. Utilize the SNAP Retailer Locator which provides locations of retailers who accept SNAP benefits. Access the Retailer Locator at [www.fns.usda.gov/snap/retailerlocator.htm](http://www.fns.usda.gov/snap/retailerlocator.htm). To bypass other retailers indicates the recipient may be using the specific retailer for a unique reason. Question the recipient as to the reason. Note: When retailer trafficking fraud is believed to also be occurring in assisting the client to commit the fraud, retailers are referred to OIG for further investigation by the USDA. See item 'E' in this MS.
- e. A large or questionable number of lost or stolen EBT cards and/or substantial requests for replacement EBT cards. This could indicate the individual is selling the card, reporting it lost or stolen, and requesting a new card and PIN to receive the next month's benefits.

Example 1: During a claim interview, a recipient acknowledges selling his EBT card with \$200 of SNAP benefits for \$100, and giving his PIN to an individual outside of a local discount store. A review of transactions on the EBT website confirms the date and amount of benefits on the card. The transaction by both the recipient and the other individual is trafficking and the claim amount is \$200. Pursue an IPV, including the other individual if identified. If the client signs form FS-80 Supp. A or an IPV is established by an ADH, use disqualification code, Trafficking, administrative finding.

Example 2: A fraud hotline report is received from OIG alleging that a recipient who has \$400 of benefits on the card, sold \$100 of SNAP benefits for \$50. It is the worker's responsibility to confirm that the actual transactions support the allegations in the fraud hotline report.

The worker should try to identify more than \$100. A review of transactions on the EBT website confirms the date and amount of the reported transaction and support the allegation that trafficking occurred. The amount of the claim is the amount of benefits sold (\$100) as verified per transactions on that date. During the interview to discuss the transaction, if the recipient admits to the violation that benefits were sold and signs form FS-80 Supp. A or an IPV is established by an ADH, use disqualification for Trafficking, administrative finding.

Example 3: If items purchased through a store credit account are non-eligible items, the use of the EBT card or benefits on the card for payment of the credit account is pursued as trafficking. During a claims interview, a recipient admits to paying on a store credit account with an EBT card. A review of the EBT website account confirms numerous whole dollar (\$15.00; \$12.00; \$18.00) transactions which could indicate gas purchases. Trafficking is pursued.

Example 4: A hotline referral was received stating that a retailer purchased 20 cases of soda from recipient who purchased the soda with SNAP benefits. Trafficking is pursued against the individual and OIG is notified by the person who received the referral using procedures outlined in Item E of this section, of the retailer's participation in the transaction.

2. If after reviewing the EBT transaction history, no suspicious activity is found, annotate Worker Portal comments that no trafficking exists.
3. If suspicious activity has been identified, take the following action:
  - a. Make copies of the EBT account showing the suspicious transactions.
  - b. Include all supporting documentation such as hotline reports or third party reports in the claim file.
  - c. Schedule an appointment with the recipient in the local office of the county where the recipient resides to discuss the suspicious transactions. An appointment can be scheduled using the Worker Portal appointment scheduling system. Form PAFS-2, Application Letter or Notice of Expiration, can also be used when scheduling these appointments. Do not discuss the allegations by phone. The face-to-face discussion is to display all documentation supporting the allegations in person with the recipient.
  - d. Thoroughly document the discussion with the recipient as the information obtained is the basis for action taken by DCBS.
  - e. If the household later contacts the agency to cooperate, a face-to-face interview is required. When a claims specialist is not available onsite, each local office will have a designated worker and backup to interview clients who come in to resolve a fraud or trafficking complaint.

4. If after a review of the documentation and/or discussion with the recipient (if interview was conducted), it is determined that no dollar amount can be established and no claim exists, indicate the reason for the action in Worker Portal comments and scan the documentation into the electronic case file.
  5. If after a review of the documentation and/or discussion with the recipient (if interview was conducted), trafficking or another program violation is pursued, provide the household with form FS-80, Notice of Suspected Intentional Program Violation, and form FS-80, Supp. A. If the recipient reviews the forms at the meeting and signs form FS-80, Supp. A, enter a trafficking, administrative finding, disqualification on the Worker Portal.
  6. If form FS-80, Supp. A is mailed and returned signed; enter a trafficking, administrative finding, on the Worker Portal.
  7. If form FS-80, Supp. A is not returned or is returned unsigned, schedule an administrative disqualification hearing. See Vol I [MS 1070](#).
  8. Claims pursued as trafficking are not established as Suspected Intentional Program Violation (SIPV) claims. The claim is only entered on Worker Portal when the client signs form FS-80, Supp. A, an IPV is established by an ADH, or the claim has been adjudicated in court. Administratively determined trafficking claim amounts (determined through review of the EBT account on the FIS website), are entered on the Benefit Management Module.
- E. The Food and Nutrition Service (FNS) investigates, prosecutes, and disqualifies a retailer when fraud is substantiated.
1. FNS notifies the Nutrition Assistance Branch (NAB) that a retailer is disqualified and provides a listing of SNAP benefit recipients that had transactions, meeting trafficking criteria at that store, during the investigated period.
  2. NAB forwards the information of the SNAP recipients involving high dollar amounts to OIG who makes a determination whether to pursue prosecution.
  3. A list of recipients not pursued by OIG for prosecution is forwarded to the regional office of the county in which the client resides. Staffs are to follow the steps outlined in Item D of this section.
- Note: Recipients identified by NAB must be sent for ADH if the FS-80A, Supp. A, is not signed or returned.
- F. For EBT cards and/or EBT card numbers that are received by the local office from law enforcement:
1. Ask law enforcement if they are investigating the household. If law enforcement is conducting the investigation, only document Worker Portal comments that law enforcement is investigating the recipient for SNAP trafficking;

2. If law enforcement is not conducting the investigation, follow procedures outlined in Item D of this section.
  3. Destroy any EBT cards that are received in the local using procedures outlined in Vol I [MS 0290](#).
- G. Report any type of alleged retailer fraud directly to the OIG Fraud Hotline 1-800-372-2970.
- H. Recipients can be convicted of trafficking as a result of an investigation by other law enforcement agencies. Department for Community Based Services (DCBS) staff is notified when a recipient is convicted of trafficking. If restitution is ordered, it is paid to Claims Management Section (CMS) in the Cabinet for Health and Family Services. The claim must be entered on the Benefit Management Module. CMS will notify field staff to:
1. Create a claim file; and
  2. Enter the disqualification on Worker Portal for the trafficking offense as indicated in the court order.

MS 1025                    SNAP ELECTRONIC BENEFIT TRANSFER (EBT) MISUSE

EBT misuse is defined as:

1. Using SNAP benefits, excluding trafficking, for any reason other than to purchase food for eligible household members.
2. [Maintaining a credit account with a retailer for the purchase of eligible items paid with SNAP benefits is not considered trafficking. However, the worker will need to pursue an intentional program violation (IPV).

Example 1: The payment with an EBT card on a credit account in which only eligible food items were purchased is not considered trafficking but is against program rules. SNAP benefits must be debited at the time the food is received.]



MS 1030                    HOW TO CALCULATE A SUPPLEMENTAL NUTRITION                    (1)  
   ASSISTANCE PROGRAM (SNAP) CLAIM

For each month that a household is suspected of receiving an overpayment, determine the correct amount of SNAP benefits, if any, the household was entitled to receive. Use policy in effect at the time the claim occurred. When calculating a SNAP claim, the worker is only required to verify and use new information that was not considered when the benefits were authorized. The worker is not required to re-verify all factors pertaining to the household.

EXCEPTION: All errors found during any SNAP case review, including Management Evaluation (ME) and Quality Control (QC) reviews, must be corrected to ensure that the basis of issuance is correct based on the review findings.

All claims are calculated on the Benefit Recovery Module.

A. Date of Discovery:

1. Agency Error (AE) or Inadvertent Household Error (IHE) claims cannot be calculated for more than 12 months prior to the date of discovery. If the claim also extended into the discovery month or subsequent months, these months are included in the claim period.

Example: It is discovered in February 2005 that a household received excess benefits for the period January 2004 through March 2005. A change was completed to correct benefits effective April 2005. The claims months are February 2004 through January 2005 (12 prior months), the discovery month of February. January 2004 is not a claim month since it is more than 12 months prior to the discovery date.

2. Inadvertent Household Errors with a Suspected Intentional Program Violation (SIPV) and Intentional Program Violation (IPV) cannot be calculated for more than 6 years prior to the discovery date. If an SIPV claim is not determined to be fraud by admission, hearing, or prosecution, it must be recalculated as an IHE or AE claim.

B. Household Composition

When establishing a claim containing household members that are not active during the entire time frame of the claim, establish separate claims containing the appropriate active household members.

Example: A claim contains three adult household members for the period of January through June. The head of household is an active member for the entire 6 months of the certification period. The second adult household member was only an active member of the case from March - April. The third adult household member was only an active member of the case from May -June. Three separate claims are established. The first claim would contain the head of household and would be established for the months of January and February. The second claim would contain the head of household and second household members for the months March and April.

The third claim would contain the head of household and the third household member for the months of May and June.

Example: A claim contains three adult household members and one child for the period of July – December. The head of household was active six months of the certification period. The child and second adult household member were active from September – October. The third household member was active from November – December. Three separate claims are established. The first claim would contain the head of household for the months of July-August. The second claim would contain the head of household, the second household member and the child for the months of September and October. The third claim would contain the head of household, the second household member, the child, and the third household member for the months of November and December.

C. Utility Allowance:

Households entitled to use the Standard Utility Allowance (SUA) or Basic Utility Allowance (BUA) were required to use the appropriate standard effective June 2003. Beginning June 2003 actual utility expenses are used only if the household was not entitled to the SUA or BUA. Prior to June 2003, the household had the option of choosing to use a standard deduction or actual expenses.

D. Earned Income:

When calculating an Intentional Program Violation (IPV) or Inadvertent Household Error (IHE) claim involving unreported earnings, do not apply the 20% earned income deduction to the part of the earnings the household did not report timely, when this is the reason for the claim.

E. Reported Information/Changes:

For REPORTED information/changes not considered in the original benefit, use the reported income received for the appropriate household member's reported expenses (except for utility), household size, and any other household circumstances not considered.

1. Reported income does not have to be re-verified. Use the converted income that was used in the original allotment.
2. When calculating the claim, use all other household circumstances that were correctly considered. Include the actual income that was omitted in error.
3. If wages were known and not acted on, allow the actual dependent care expenses as a deduction. Budget the reported wages that were not acted on by using the anticipated converted income that should have been used in the original allotment.
4. Reported, but unverified reported wages. If wages were reported but verification not provided, the worker may use wage match data to calculate the claim. Use the gross quarterly income, divided by three months, and

round to the nearest dollar to obtain the average monthly amount. If the employment was less than three months, average the gross amount over the period of time between the begin and end dates of employment. This date may be determined by contact with the employer or client.

5. Consider any countable income from ineligible and disqualified members. Refer to [MS 1010](#).
6. For prorated or annualized income, count the prorated or annualized amount for each month of the claim, even in months when the income was not received (Example: countable student income).
7. Consider any countable unearned income.
8. Consider any deductions that were reported but not acted upon.
9. Consider any deductions that were considered in the case during the claim period.

F. Unreported Changes/Information:

For UNREPORTED information/changes that were not considered in the original benefit, use the actual income for the appropriate household member(s) that was not reported, actual household size, and any other household circumstances that were required to be reported.

1. Consider ACTUAL income. DO NOT average and convert any income that was not reported.
2. Reported income does not have to be re-verified. Use the anticipated converted income that was used in the original budget.
3. When calculating the claim, use all other household circumstances that were correctly considered.
4. DO NOT allow the earned income deduction for that portion of the earned income not reported. If the household reports part but not all of the earned income, allow the deduction on the part that was reported.
5. Verify wages. If wages are discovered but verification has not been provided, the worker may use wage match data to calculate the claim. Use the gross quarterly income, divided by three months, and round to the nearest dollar to obtain the average amount per month. If the employment was less than three months, average the gross amount over the period of time between the begin and end dates of employment. This date may be determined by contact with the employer or client.
6. Consider any countable income from ineligible and disqualified members.
7. For prorated or annualized income, count the prorated or annualized amount for each month of the claim, even in months when the income was not actually received (Example: countable student income).

8. Consider any countable unearned income.
9. Consider changes in deductions IF required to be reported. Otherwise, consider deductions that were used in the case for the claim period.
10. [DO NOT consider expenses on unreported self-employment/farm income.]
11. DO NOT consider unreported deductions.
12. Consider any deductions that were considered in the case during the claim period.

G. A claim can be reduced by:

1. Applying any underpayment occurring because of a reported, but not acted upon, change in household circumstances. The limit for the restoration of benefits is one year prior to the under payment discovery date. If the underpayment happened more than one year before the underpayment discovery date, the underpayment may not be used to offset the overpayment when calculating a claim.
2. EBT benefits expunged from the household's EBT benefit account (up to the amount of the claim) that have not been applied to another claim.
  - a. If the benefits are expunged after the claim is established, the Regional Claims Worker enters the Claim Adjustment via the Benefit Management Module and CMS applies the expunged benefits.
  - b. If the benefits are expunged before the claim is established and the case is active, the worker can compromise the payment. Refer to Volume I, [MS 1140](#).
  - c. If the benefits are expunged before the claim is established and the case is inactive, the worker contacts the Claims Management Section.
3. The date and amount of expunged benefits is displayed on Worker Portal.

MS 1040 JOINT NON-FRAUD AND FRAUD CLAIMS (1)

[A joint claim occurs when there is more than one category of claim for the overpaid period. When a claim occurs due to an Intentional Program Violation (IPV) and an Agency Error (AE) or Inadvertent Household Error (IHE), calculate on Worker Portal, each type of claim as outlined below. Enter comments in Worker Portal explaining how the claims are computed.]

A. Compute the AE or IHE claim prior to completing the IPV claim.

1. Enter the actual amount of benefits the household received during each month in question. To determine the amount the household actually received, do the following:
  - [a. Access the benefits screen from the Worker Portal Benefit Recovery tab and select the Claim Details menu; and]
  - b. Go to the field which shows the amount issued each month in question. Any overpayment which occurred more than 12 months prior to the discovery of the overpayment is not included.
2. Enter the issuance case data, correcting the AE or IHE claim factor but excluding the IPV factor.
3. The amount of the AE or IHE claim is the difference between the two allotment totals.
4. Initiate collection action.

B. IPV claim.

1. Use the benefit data from item A. 2 and include the IPV change.
2. Subtract the corrected benefit amount, which includes all known changes, from the benefits in item A. 2. The difference is the IPV claim amount.
3. Take action as appropriate for IPV claims independently from the AE or IHE portion of the claim

Example: An IPV claim is identified due to a client's deliberate failure to report RSDI income. Upon further review it is discovered that the client was given a medical deduction in error during the same time period of the unreported RSDI. Compute the AE claim first based on the incorrect medical deduction. A separate claim is computed for the IPV due to unreported RSDI, using the benefit amount that was determined to be correct in the AE claim.



- (2) The worker enters the appropriate disqualification for the member on the Worker Portal for active and inactive cases using the following steps from the Worker Portal IPV Information screen:
  - i. Select Program SNAP
  - ii. Select YES under Sources; this is the only option
  - iii. Select the IPV occurrence
  - iv. Enter the decision date
  - v. Enter the start date
  - vi. Enter the end date

To enter the disqualification you must go to the individual summary screen and select "Manage IPV's". Once the recipient serves their disqualification time period, eligibility will have to be ran before the recipient is added back to the SNAP EDG.]

Note: Per federal regulation, no further administrative appeal procedure exists after an individual who waives his/her right to an ADH and a disqualification penalty is imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The recipient is entitled to seek relief in a court having appropriate jurisdiction.

- C. When OIG advises they will not pursue prosecution in a case but fraud is still suspected, follow procedures in B. If fraud is ruled out, change the category of the claim to IHE or AE and recalculate the claim amount.
- D. [If the final order from the Division of Administrative Hearings establishes an IPV, disqualify the member on Worker Portal. If the final order does not establish IPV, change the category of claim to IHE or AE per the findings of the hearing officer and recalculate the claim amount for an AE claim.]

MS 1060                      CRITERIA FOR PURSUING AN INTENTIONAL                      (1)  
PROGRAM VIOLATION CLAIM

The burden of proof to establish an Intentional Program Violation (IPV) is on the agency. Evidence used to demonstrate this must support the accusation of IPV and prove intent to commit food benefits fraud. The supervisor must review all evidence and concur with the worker's findings before pursuing an IPV claim. An IPV may also be pursued due to an out-of-state match via the electronic Disqualified Recipient System (eDRS).

A. Evidence may include, but is not limited to:

1. A signed SNAP benefits application used to determine eligibility for the claim period. A lost, unsigned, or otherwise unavailable application does not prevent establishing a claim;
2. Computer printouts;
3. Income and Eligibility Verification System (IEVS) records;
4. Form PAFS-700, Verification of Income;
5. Form PAFS-76, Information Request;
6. Form PAFS-702, Proof of No Income; and
- [7. Worker Portal notices to the recipient.

Example: An application signed by the client on 1/1/12 during a recertification interview in which the client reported no source of income. Verification received by the agency on 10/1/12 that verified the client went to work on 2/2/12 and was over the gross income limit for 2/12. Verification also received showing client had failed to report husband in home and he also had income at application. The evidence would include the application, Worker Portal Notice of Approval, income verification, collateral contacts, wage records, etc., and all other supporting documentation including Worker Portal comments relating to statements made during the interview.

Example: An application signed by the client 1/1/12 reporting no source of income at the initial interview. Verification received by the agency on 10/1/12 indicates client was working at time of initial application. The evidence would include the application, verification received concerning income showing date started work and all income received since employment, Worker Portal Notice of Approval and all other supporting documentation including Worker Portal comments relating to statements made during the interview.



B. The Worker Portal will interface with eDRS to:

1. Obtain the latest Intentional Program Violation (IPV) disqualification information for an individual from states other than Kentucky.
2. Post IPV disqualifications from Kentucky to the national eDRS database.
3. Maintain IPV disqualification records, including the abilities to:
  - a. Create, update, and delete IPV disqualifications from the state of Kentucky in Worker Portal as well as in the eDRS system, AND
  - b. Create, update, and delete IPV disqualifications from states *other than* Kentucky, only within Worker Portal.]

MS 1070 ADMINISTRATIVE DISQUALIFICATION HEARINGS (1)

An Administrative Disqualification Hearing is conducted by the Division of Administrative Hearings (DAH) to determine if an Intentional Program Violation (IPV) has occurred. The format of the hearing is similar to that of a fair hearing, except the burden of proof is on the Agency.

- A. Refer a case for a disqualification hearing via form FS-79, Request for an Administrative Disqualification Hearing, within 10 calendar days if there is sufficient evidence to substantiate a claim of IPV and one or more of the following situations apply:
  1. The claim does not meet criteria for referral to the Office of Inspector General (OIG);
  2. The facts of the case do not warrant civil or criminal prosecution and OIG closes their case;
  3. Form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, is not received signed within 10 days of being sent to the household.
- B. Review Worker Portal for previous disqualifications before completing the FS-80, Supplement A. Make DAH aware of the prior IPV that was established by signing an FS-80, Supplemental A., whether it is a 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> offense. If client commits an IPV after July 1, 2013, the waiver can be offered to establish an IPV for each program violation.
- C. [Complete form FS-79, Request for an Administrative Disqualification Hearing, and send it with all evidence that will be presented at the hearing along with a copy of the FS-80, Notice of Suspected Intentional Program Violation, sent to the household, via email to [SNAPHearings@ky.gov](mailto:SNAPHearings@ky.gov). Also, send copies to the Claims Management Section at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov). If delivery via electronic communication fails, please send documentation to:

Cabinet for Health and Family Services  
Division of Administrative Hearings  
105 Sea Hero Road, Suite 2  
Frankfort, Kentucky 40601.

Requests may also be faxed to 502-573-1014.]

- D. Only evidence listed on the FS-79 can be introduced at the hearing, if information is not listed on the FS-79 or evidence is missing, ask the hearings officer to withdraw from the hearing and then re-submit a new FS-79 with the corrected information and the necessary evidence to DAH and CMS. Complete the FS-79 using the following guidelines:
  1. Provide a detailed explanation of the charges, attaching additional sheets if necessary.
  2. List the chronology of events which led the worker and supervisor to suspect an IPV occurred, e.g., when and how the claim was discovered,

- the client's history of not reporting changes, and the client's statements regarding the situation, ONLY if it supports the IPV.
3. List each piece of evidence which should include all KIF-101, SNAP applications, including electronically signed or voice recorded signatures, FS-2, 6 Month Reviews, PAFS-700 Wage Verifications & Wage History/Pay Stubs, Wage File Data, Work Number Verification, Certified Court Orders, Retail Store Closure-Trafficking USDA Letter, Photos of Store Inventory, EBT Transaction History, Excessive EBT Card Replacement Notice and History of EBT Cards and Invalid Pin #, Comments Screens that support the IPV, Written Statement/Emails from the client or other parties that support the IPV, Notice of Eligibility (NOE), showing Simplified Reporting Policy (SR), etc. that supports a determination of an IPV. Include the FS-79 as part of the list of evidence. Redact any private information that should not be disclosed at the hearing.
  4. Electronic Signature application(s) and dates are verified by Worker Portal inquiry. However, in pursuing the IPV claim, provide the hardcopy application to show the electronic signature was used in order to process the SNAP application for the time period of the claim.
  5. Voice Recorded Signature applications and dates are verified through the Worker Portal. However, in pursuing the IPV claim, you must present the original Voice Signature Application and the completed Voice Signature Application Instruction Letter that was scanned into ECF for the SNAP case. The worker documents the case record thoroughly to explain all case actions taken. Review SNAP clarification, "Voice Signature with No Application in ECF", issued November, 2015, to ensure procedure is followed to protect the validity of the application for the hearing.
  6. Any prior disqualification verification, i.e. FS-80A, FS-111, Court documentation, prior hearing affirmation, or out of state disqualification verification, must be presented at the hearing.
  7. When a hearing is requested on Worker Portal, tasks are systematically created for the requested hearings based on SNAP/Medicaid/KTAP/Child Care eligibility and Claims. A task will be sent to DAH along with any documentation associated with the hearing request. The type of hearing requested will determine the task that is created by DAH and the type of notice sent back to each region. The regions have assigned designated hearings PAPS that will be a part of the queue to receive tasks concerning the notices for the different types of hearings. The hearing PAPS will log the hearing notices and assign a task to the appropriate supervisor/worker for that region. They will monitor the hearing process and track results.
  8. Once a hearing has been requested through Worker Portal on the Hearing Request Summary page and submitted to DAH, corrections cannot be made to the hearing request on Worker Portal; instead, an email will need to be sent to DAH for corrections to the hearings request.
  9. Individuals who are not on Worker Portal or have never had a case on KAMES, i.e. "caseless individuals", must first be assigned an individual number prior to requesting a hearing. The Individual number is created

by clicking on the Individual tab at the top of the navigation page through Worker Portal. Enter the required information on the individual. Once all information is entered, the system navigation will take you to the Individual Summary screen and the process is complete. The individual is now then known to Worker Portal and the worker can create a manual claim against the individual.

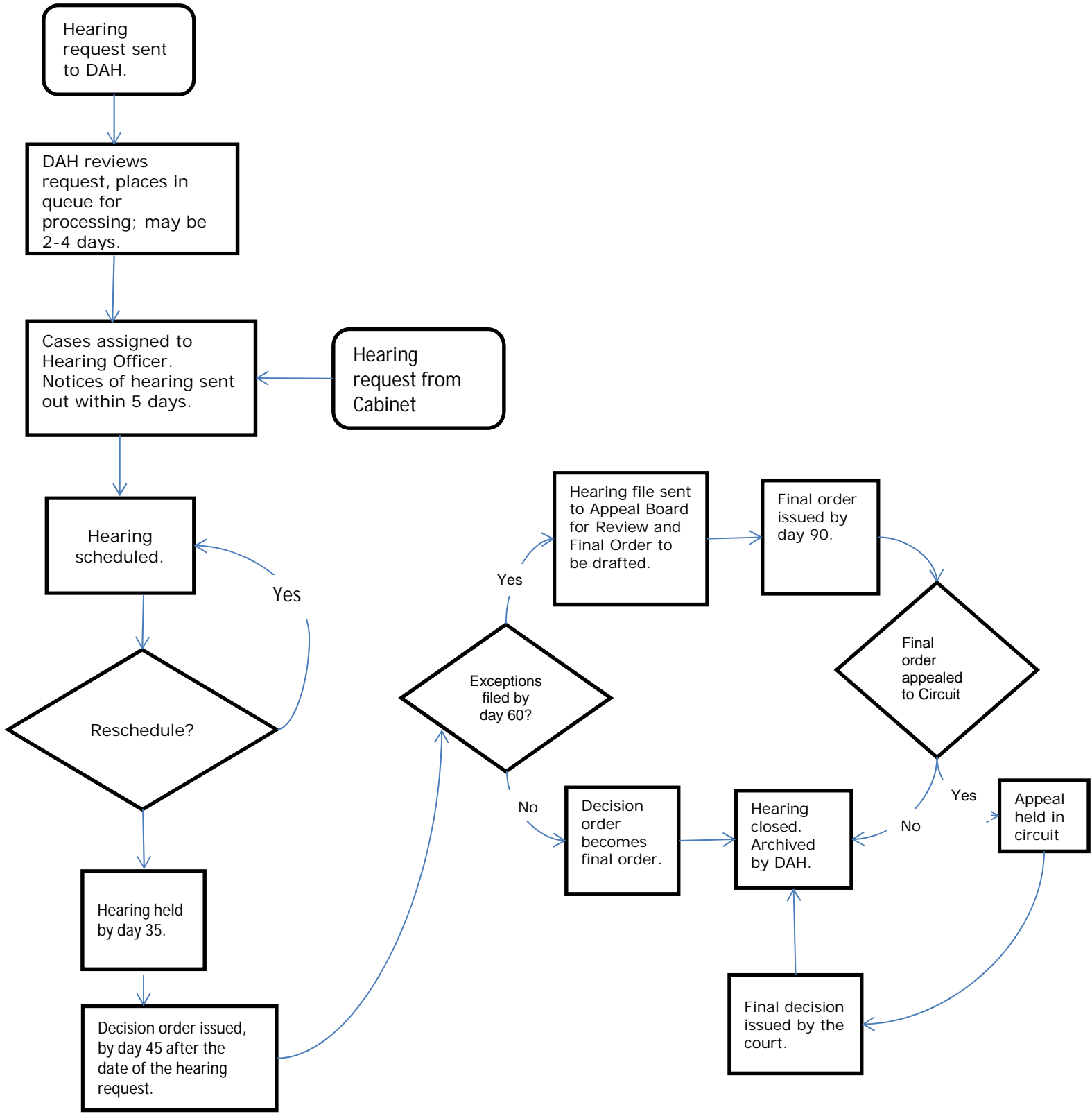
- E. [The DAH schedules the hearing and provides written notice to the household at least 30 days in advance of the hearing date. The notice advising of the date and time is sent to the household with a copy to the worker.

An agency representative must be present at each hearing. The agency cannot ask DAH to reschedule the hearing if the designated individual cannot attend. Another claims worker will have to be assigned to attend the hearing.

1. Hearings held telephonically – The agency's evidence must be sent by email to the DAH with the FS-79 and by mail to the client. ALL evidence must be labeled as: Exhibit 1, 2, and 3 or Exhibit A, B, C, etc. prior to sending to DAH and to the client.
  2. Hearings held face to face – The agency's evidence must be sent by email to DAH when submitting the FS-79 and must be labeled. The client will receive a copy of the evidence at the scheduled face to face hearing. Additionally, if another worker had input in the case or gathered collateral information during the time at issue, include that worker as a witness. Attendance by a DCBS worker is mandatory under these circumstances so that the evidence is not considered "hearsay".]
- F. A requested hearing may be withdrawn and the DAH contacted at 502-564-3140 to cancel the hearing when:
1. Information becomes available that indicates IPV did not occur. Contact the client when this occurs.
  2. The client signs form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing.
- G. The preparation for and conduct of an administrative disqualification hearing is the same as a fair hearing. Refer to [MS 0450 B](#).
- H. After the hearing is conducted, the DAH issues a recommended order which is sent for review to all participants at the hearing. Follow policy in [MS 0510 C](#) when filing an exception to a recommended order.
- I. The Cabinet for Health and Family Services Appeal Board for Public Assistance issues the final order and copies are sent to the client, client's representative, local office, and Service Region Administrator Associate.
1. If the final order determines an IPV occurred, enter the IPV disqualification on Worker Portal within 3 work days of receiving the order.
  2. If the case is active, change the category to IPV on Worker Portal. If inactive, contact CMS by e-mail at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov) to change the category.

3. If the final order determines an IPV did not occur and an SIPV claim has been established, recalculate the claim amount and make system entry changes on the Worker Portal to show the correct category, IHE or AE, of the claim. If the case is not active, contact CMS by e-mail at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov) to change the category or terminate the claim if the claim period is more than 12 months prior to the discovery date.
  4. The claims worker updates Worker Portal to reflect the dates that the form FS-80 and FS-80 Supplement A are sent and when the ADH hearing has been requested, scheduled, affirmed or reversed.
- J. If the client is dissatisfied with the final order, a petition can be filed in the Circuit Court of the county where the member lives within 30 days of receipt of the final order. Although a court appeal may be filed, the disqualification is imposed on Worker Portal; however, it may be subject to change by the decision of the Court.

ADMINISTRATIVE DISQUALIFICATION HEARING  
PROCESS FLOW CHART





MS 1100 LOCAL OFFICE PROCEDURES FOR ACTING ON ADMINISTRATIVE DISQUALIFICATION HEARING FINAL ORDER (1)

When a final order is received and:

- A. The final order states that the member did not commit an Intentional Program Violation (IPV), take action on the case as directed by the final order.
- B. After reviewing an IPV claim which was previously established by signing form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, prior to 10/1/92, and the hearing officer finds that there is insufficient evidence to support a determination of an IPV, take the following action:
  - [1. The Supervisor deletes the IPV disqualification;
  2. Restore any benefits lost as a result of the Disqualification on Worker Portal;]
  3. Notify the Claims Management Section (CMS) by memorandum if the claim has already been paid in full. Include the following information:
    - a. Claim name and number;
    - b. Original claim amount;
    - c. Date of final order; and
    - d. Current case status.
  - [4. Update Worker Portal.]
- C. The hearing was dismissed with the annotation, "Order To Remove From The Docket":
  1. Update the Comments screen on Worker Portal to show the Administrative Disqualification Hearing (ADH) was dismissed. Continue to pursue collection on the Inadvertent Household Error/Suspected Intentional Program Violation (IHE/SIPV) claim until another hearing can be requested and held;
  2. Scan the final order and the recommended order into the electronic case file under the Claims tab;
  3. For cases prior to Electronic Case Filing, annotate in red, "DO NOT PURGE" on the outside of the case record and claims control folder;
  4. For households previously dismissed as a result of a returned notice annotated as "Unclaimed" or Undeliverable", if a new and current address becomes known to the Agency, a new form FS 80, Notice of Suspected Intentional Program Violation, and form FS-80 Supp. A, Voluntary Waiver of Administrative Disqualification Hearing, are to be mailed to the recipient. Allow 10 days for the return of form FS-80 and form FS-80 Supp. A before requesting an ADH. Send a new form FS-79, Request for an Administrative Disqualification Hearing, with a copy of the previous



hearing decision/final order to the Division Administrative Hearings (DAH) if form FS-80 and form FS-80 Supp. A are not returned.

- D. The hearing was dismissed because a notice was not sent by certified mail, and/or someone other than a household member signed for it, immediately resubmit a new form FS-79 to the DAH so that a new notice may be sent.
- E. Be sure to include all pages of the FS-79 along with the evidence that will be presented at the hearing. Also, send copies to the Claims Management Section at [CHFS.DFS.Claims@ky.gov](mailto:CHFS.DFS.Claims@ky.gov) . The agency must submit the evidence to DAH by email and to the client by mail at least 8 days prior to the scheduled telephonic hearing. Prior to sending the evidence to DAH and the client, ALL evidence must be labeled as: Exhibit 1,2,3 or A,B,C, etc. Provide a summary of the evidence on form FS-79.
- E. The member is found guilty of an IPV; refer to [MS 1110](#), if a claim has been established. The disqualification is entered within 3 work days of the notification.

MS 1110 INTENTIONAL PROGRAM VIOLATION (1)  
DISQUALIFICATION PENALTIES

[A disqualification is entered on the Worker Portal within 3 work days of notification that an individual has committed an Intentional Program Violation (IPV). Notification is a signed FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing or FS-111, Disqualification Consent Agreement, a final order from a hearing decision, or notices of a court decision or agreement that finds the member guilty. When it has been determined that an individual is determined to have committed an IPV, he/she is disqualified on the Worker Portal even if not currently participating in, or has never received, SNAP benefits.

- A. An individual committing an IPV indicated below is disqualified for the period shown. Multiple disqualifications may be imposed concurrently and not consecutively. Disqualification periods can overlap one another depending on the decision date entered. The disqualification is entered on the Worker Portal.]

1. Trafficking SNAP benefits of \$500 or more on or after 8/22/96. Disqualification can only be imposed based on a Federal, State or local court order.

Disqualification: Permanent for the first offense.

[Trafficking \$500 or more on the Worker Portal.]

2. Makes a fraudulent statement, or misrepresentation of identity or residence, in order to receive duplicate food benefits on or after 8/22/96. This applies to a client who creates an alias to get SNAP benefits at separate addresses and/or receiving in more than one state simultaneously.

- a. 10 years for the 1<sup>st</sup> offense;
- b. 10 years for the 2<sup>nd</sup> offense;
- c. Permanent for the 3<sup>rd</sup> offense.

[Fraud/duplicate benefits on the Worker Portal.]

3. Uses or receives SNAP benefits in a transaction involving the sale of a controlled substance.

- a. 24 months for the 1<sup>st</sup> offense;
- b. Permanently for the 2<sup>nd</sup> offense.

[Drug trafficking less than \$500 on the Worker Portal.]

4. Uses or receives SNAP benefits in a transaction involving the sale of fire arms, ammunition or explosives. Disqualification can only be imposed based on a Federal, State, or local court order.

Disqualification: Permanently for the first offense  
[Firearms trafficking on the Worker Portal.]

5. Trafficking as determined by an administrative finding of fraud in a disqualification hearing or signed FS 80, Supplement A "Voluntary Waiver of Administrative Disqualification Hearing".
  - a. 12 months for the 1<sup>st</sup> offense;
  - b. 24 months for the 2<sup>nd</sup> offense; or
  - c. Permanently for the 3<sup>rd</sup> offense.

[Trafficking, administrative finding on the Worker Portal.]

6. Application fraud and/or non-report of changes
  - a. 12 months for the 1<sup>st</sup> offense;
  - b. 24 months for the 2<sup>nd</sup> offense; or
  - c. Permanently for the 3<sup>rd</sup> offense.

[Application fraud/non-report of changes on the Worker Portal.]

Example: A recipient applies (or recertifies) for SNAP benefits and reports no income. It is later discovered the client was employed and was receiving wages at the time of the application interview.

7. Commits an Intentional Program Violation (IPV), and another IPV listed above does not apply to the offense committed.

Disqualification:

- a. 12 months for 1<sup>st</sup> offense;
- b. 24 months for the 2<sup>nd</sup> offense;
- c. Permanently for the 3<sup>rd</sup> offense; or
- d. The length of penalty assigned by the court.

[Intentional Program Violation on the Worker Portal.]

- B. The amount of time served while disqualified is determined by the offense and whether it is the 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> occurrence. Disqualification occurrences are counted cumulatively for all the offenses.

[Example: A person commits an Intentional Program Violation, then a Trafficking offense. The Trafficking disqualification is added to the Worker Portal as a 2<sup>nd</sup> occurrence, not a first.]

- C. [For permanent disqualifications check the box titled "Permanent Disqualification" located under "Occurrence" on the IPV details screen. This will automatically upload "99" in the number of month's field. "99" in this instance is not the number of months disqualified, "99" is what is accepted on the Electronic Disqualified Recipient Subsystem (eDRS) for the permanent disqualification.
- D. When an IPV disqualification is entered on the Worker Portal, the add 3 calendar days to the "Disqual Decision Date" to set the "Disqual From Date". The 3 calendar days allow for mailing the disqualification notice. For disqualifications that are the result of a court order use the

circuit/district court entered stamp date as the disqualification decision date. For disqualifications that result from Form FS-80 Supplement A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, the disqualification decision date is the date the agency received the form FS-80A.]

1. If the "Decision Date" plus 3 calendar days ends on or before SNAP cut-off, the "Start Date" is the first day of the following month.
  2. If the "Decision Date" plus 3 calendar days ends after SNAP cut-off, the "Start Date" is the first day of the month after the month following the disqualification decision month.
- E. The "End Date" is entered based on the number of months the recipient is disqualified.
1. Individuals who are permanently disqualified have the "From Date" set as described in Item C above. The "Through Date" left blank.
  2. The disqualification period is automatically uploaded after all the required disqualification information is entered.
- F. If a notice of IPV determination is received while the case is pending, enter the IPV disqualification on the system.
1. [Worker Portal sets the disqualification period based on the information entered.
  2. After Worker Portal uploads the disqualification dates, return to the pending application and rerun eligibility.
  3. If the disqualification time frame includes the pending eligibility period the disqualification is applied when the application is disposed.]
- G. An IPV disqualification does not pend for adverse action.
- H. Once a disqualification period begins, it continues uninterrupted for the entire number of months regardless of whether the disqualified member's household is eligible for benefits. The disqualification period does not start and stop depending on the household's eligibility.
- I. After disqualification periods have ended, the disqualified member must be added back to SNAP case as a household member. Complete a case change to add member.
- J. If a disqualification is not imposed timely and the disqualification period has not elapsed, impose the penalty showing the proper disqualification period. Establish an Agency Error (AE) claim for any months benefits were received when the individual should have been disqualified. For claims adjudicated in court, establish an agency error claim for benefits received as a result of a disqualification not being entered within 45 days of the court decision.

[Example: An individual should have been disqualified for the months of January through December the same year. In June, it is discovered that the disqualification penalty was not imposed. At the time of discovery, enter the disqualification on the Worker Portal showing the disqualification period January through December. Establish an AE claim for January through June if the individual received benefits.]

- K. When a determination of an Intentional Program Violation (IPV) is reversed by a court of appropriate jurisdiction, reinstate the member if the household is currently eligible. Restore any benefits lost as a result of the disqualification, not to exceed 12 months prior to the date of notification of the court's reversal of the imposed disqualification. A member is not entitled to restoration of lost benefits for the period of disqualification based solely on the fact that a criminal conviction could not be obtained, unless the member successfully challenges the disqualification in a separate court action.

MS 1120                      DEFERRED ADJUDICATION OF INTENTIONAL                      (1)  
PROGRAM VIOLATION CLAIMS

After the food benefits claim has been processed by the Office of Inspector General (OIG), an agreement not to prosecute may be reached between the court and the member suspected of the Intentional Program Violation (IPV). This agreement is called deferred adjudication.

- A. If adjudication is deferred, the member accused of the IPV is provided an opportunity by the court to sign form FS-111, Deferred Adjudication Disqualification Consent Agreement.
- B. By signing form FS-111, the accused member does not admit guilt. The member only consents to imposition of the appropriate disqualification period and repayment of the claim.
  - 1. The form must be signed by the accused member and the head-of-household, if different persons, and the prosecuting attorney.
  - 2. The member is under no obligation to sign such an agreement.
- C. OIG is responsible for providing a supply of forms FS-111 to the County/Commonwealth Attorney's office.
- D. If a case is sent back to the local office indicating the member has agreed to deferred adjudication but the County/Commonwealth Attorney's office does not send form FS-111, OIG contacts the member and has the form signed.
- [E. If the household consents to disqualification, impose a disqualification on the Worker Portal upon receipt of form FS-111.]

MS 1140 [COMPROMISING SNAP CLAIMS

- A. The Claims Management Section (CMS) determines if a Supplemental Nutrition Assistance Program (SNAP) claim will be compromised. Staff is not to discuss or offer a compromise. If an individual contacts the local office about the inability to pay a claim, refer the individual to CMS at (502) 564-3440.
- B. Advise the household of the right to request a fair hearing if the household disagrees with the agency's decision on compromising their claim. ]

MS 1150

TREASURY OFFSET PROGRAM

(1)

The Treasury Offset Program (TOP) is authorized by federal law to collect delinquent Supplemental Nutrition Assistance Program (SNAP) debts owed to the federal government. SNAP claims are considered federal debts and are subject to TOP collection efforts. Note: Claims in other programs administered by the Department for Community Based Services are not subject to TOP collection efforts.

Worker Portal monitors collections of SNAP claims and systematically determines if the claim has reached delinquency status for submission to TOP. Recipients who contact the local office with questions about collection of their claim through TOP should be directed to the Claims Management Section (CMS) at 502-564-3440.

Claims in which an intercept has occurred will display on the TOP Claims report on Worker Portal. This report is monitored by CMS.

A. Criteria for sending a delinquent claim to TOP:

1. A SNAP claim;
2. A current claim balance of greater than \$25;
3. Not currently in benefit reduction status;
4. Not being repaid under a repayment plan or a repayment plan was set but the agreed date of payment and/or the amount to be paid monthly is not being met by the recipient;
5. Not included under an automatic stay due to bankruptcy; and
6. Not currently under a court's restitution order or a restitution order was issued but the ordered amount to be paid is not being met by the recipient.

B. A participant must do one of the following to avoid his/her debt being submitted to TOP:

1. Repay the debt by sending a check or money order payable to Kentucky State Treasury for the full amount owed to:

Cabinet for Health and Family Services  
Division of Family Support  
Claims Management Section  
275 East Main Street 3E-1  
Frankfort, KY 40621

2. Agree to a repayment plan, if unable to pay debt in full, by contacting CMS at (502) 564-3440. The client must agree to a repayment plan



acceptable to CMS and make regular payments by the agreed date as required in the repayment plan.

3. Request in writing a review if the client believes the debt is not owed. The client must send evidence to support his/her position to:

Cabinet for Health and Family Services  
Division of Family Support  
Claims Management Section  
275 E. Main Street 3E-1  
Frankfort, KY 40621

CMS will notify the client of the decision regarding the debt.

4. Verify bankruptcy: If the client filed for bankruptcy and the automatic bankruptcy stay is in effect, the client is not subject to offset or other collection actions. SNAP claims established by court order, waiver or administrative disqualification hearing as IPV are not affected by the bankruptcy petition. CMS receives notification of bankruptcy from the federal court but will accept official documentation provided by the client or their legal representative.

C. [Collection process before going to TOP .

1. A claim is considered delinquent when payment has not been received within 30 days of the initial demand letter or is 1 day late on a previously arranged payment plan.
2. At 90 days after the debt becomes delinquent, the KCD-1.60 day notice is sent to the client. This notice includes information on how he/she can avoid having his/her debt submitted to TOP and the type of Federal payments that may be offset to collect on the claim.
3. If after 60 days from the date of the KCD-1.60 Notice the client has not responded, the debt is submitted to TOP.

NOTE: A total of 120 days must elapse from the delinquent date before a claim can be submitted to TOP.]

D. Eligible Federal Payments:

TOP will reduce or withhold payments due to the client by the amount of the debt from the following federal sources:

1. Income tax refunds, including Earned Income Tax Credit;
2. Up to 15% of a federal salary payment, including military;
3. Up to 25% of a Federal Retirement payment;

4. Military Retirement;
5. Contractor/Vendor payments;
6. Other federal payments, including loans to the client that are not exempt from offset;
7. Up to 15% of federal monthly payments such as Social Security Retirement, Survivors and Disability Benefits, Railroad Retirement (other than Tier 2) and Black Lung Part B Benefits. The client is entitled to keep at least \$750.00 per month of his/her federal payment; and
8. Stimulus payments.

Note: Supplemental Security Income payments (SSI) are not subject to TOP intercept. Stimulus payments received by SSI recipients can be intercepted by TOP.

- E. Once a debt is submitted to TOP, the client's payments may be federally offset until the debt is paid in full.
- F. TOP is authorized to add penalties, fees or other cost for each tax offset processed. The current fee amount is \$17.
- G. If an offset is taken from both spouses who filed a joint return and the debt belongs to only one, an amended tax return can be filed with an Injured Spouse form through the tax preparer. These forms may be obtained through their tax preparer or online at [www.irs.gov](http://www.irs.gov).
- H. A client in TOP filing a rapid refund (which is a short term loan) with their tax preparer may have their refunds delayed if they are being offset. Any questions regarding how long their tax refund may be delayed will need to be directed to their tax preparer.
- I. TOP will offset only the amount owed. Any remaining tax refund will be sent to the client directly from the IRS unless other debts for which the client is responsible and eligible for intercept further prevent the remaining tax refund from being received.

MS 1200 CASH ASSISTANCE AND OTHER RELATED PROGRAM CLAIMS (1)

A. Claims occur in the cash assistance programs when the benefit issued exceeds the eligible amount and there is a loss to the Agency. This includes receipt of benefits pending resolution of a hearing when the Agency is upheld. Cash assistance programs are:

[1. Aid for Families with Dependent Children (AFDC) - the last month benefits were issued in this program was September 1996. A claim must be established and collection pursued for all overpayments discovered on or after 4/1/82. Use claim type codes 'AF' on Worker Portal.

2. Kentucky Transitional Assistance Program (KTAP) - the first month benefits were issued in this program was October 1996. Use claim type codes 'PA' on Worker Portal.

a. Claims are established and collection pursued for all overpayments occurring due to client error, fraud, or non fraud, regardless of the discovery date.

b. Claims are established and collection pursued for all overpayments occurring on or after 2/1/05 due to agency error.

3. Kinship Care Program (KC) – the first month benefits were issued in this program was October 1999. Use claim type codes 'KC' on Worker Portal.

a. Claims are established and collection pursued for all overpayments occurring due to client error, fraud or non fraud, regardless of the discovery date.

b. Claims are established and collection pursued for all overpayments occurring on or after 2/1/05 due to agency error.

B. Related program claims occur when an individual erroneously receives or uses a payment intended for Kentucky Works supportive services or short term assistance. Use claim type codes 'TR' on Worker Portal. Related programs are: ]

1. Kentucky Works Supportive Services. Claims are established and collection pursued for all overpayments occurring on or after 1/1/06. An overpayment occurs when the recipient is not eligible for KTAP but is authorized a supportive service or is KTAP eligible but fraudulently receives the payment.

Forgery of form PA-33, Verification of Kentucky Works Participation, does not automatically establish a claim. For example, the participant received transportation assistance for August prospectively. In September, he/she returns form PA-33 to verify participation for August and to request transportation assistance for October. The

worker discovers the participant has forged the information on form PA-33. Before authorizing transportation, the worker denies the request for transportation and begins conciliation. If the worker discovers the forgery after transportation has been issued, a claim is established on transportation issued for October.

Failure to meet KWP participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there is no claim.

Supportive services are:

- a. Transportation funds;
  - b. Items or services needed to participate in KWP activities or employment;
  - c. Tuition and short term training;
  - d. Fees;
  - e. Remedial health care;
  - f. Car repair funds.
2. Relocation Assistance Program (RAP). Claims are established and collection pursued for all overpayments occurring on or after 3/1/07. A claim occurs when:
    - a. A recipient is not eligible for KTAP but receives RAP; or
    - b. A recipient does not meet the eligibility criteria to receive RAP; or
    - c. A recipient misuses a payment.
  3. Family Assistance Diversion (FAD). Claims are established and collection pursued for all overpayments occurring on or after June 1, 1999. A claim occurs when:
    - a. A recipient is technically or financially ineligible for FAD; or
    - b. A recipient misuses a payment.
  4. Work Incentive (WIN) reimbursements. Claims are established and collection pursued for all overpayments occurring on or after April 1, 2003. A claim occurs when:
    - a. A recipient is erroneously identified for a reimbursement; or
    - b. A recipient fails to report a change that impacts WIN eligibility.
  5. Educational Bonus. Claims are established and collection pursued for all overpayments occurring on or after 1/1/06. A claim occurs:
    - a. When a recipient is not eligible for KTAP or Kinship Care; or
    - b. A payment is issued due to agency error; or
    - c. Verification of educational attainment is falsified.



the client during the ineligible month. If it is later determined the client was ineligible for KTAP at the time payment was authorized, establish a claim.

- b. The client purchases items or services that are not approved by the agency. The claim amount is the amount of supportive services payments not spent on approved items.
- c. The agency erroneously authorizes payments. The claim amount is the difference between the correct payment and authorized amount.
- d. If it is determined that the client fraudulently received supportive services, establish a claim. The claim amount is the amount of supportive services that was authorized.

NOTE: Failure to meet KWP participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there would be no claim.

2. FAD overpayments occur when:
  - a. The client is not technically eligible for FAD. The claim amount is the total of all FAD payments issued.
  - b. The client purchases items not approved by the agency. The claim amount is the amount of FAD not spent on approved items.
3. Relocation overpayments occur when:
  - a. The client does not meet eligibility criteria for a payment. The claim amount is the amount issued for relocation expenses.
  - b. The client purchases items or services that are not approved by the agency. The claim amount is the amount not spent on approved items.
4. Education bonus overpayments occur when:
  - a. The member receiving the bonus is not eligible for KTAP or Kinship Care in the month of graduation.
  - b. The payment is erroneously issued.
  - c. Proof of graduation is falsified.
  - d. In all instances, the claim amount is the amount of the bonus.
5. WIN overpayments occur when:
  - a. The member receiving WIN reimbursements is not employed.
  - b. The household does not contain a dependent child.
  - c. The income of the household exceeds 200% of the federal poverty limit.
  - d. The earned income that caused discontinuance of the KTAP benefit is not reported timely.
  - e. In all instances, the claim amount is the amount of the reimbursement.

MS 1220

CLAIMS FOR SSI RECIPIENTS

When a Supplemental Security Income (SSI) individual is determined not eligible to receive an SSI payment regardless of the reason:

- A. Determine K-TAP eligibility for each month the member was excluded from K-TAP.
- B. Use actual resources and income received in the specific month, including the resources and income of the member who was receiving the SSI payment. DO NOT include the SSI payment as income.
- C. If the case was ELIGIBLE for K-TAP, determine the correct payment and compare to the amount issued. If the correct amount is less than what was issued establish a claim for the difference.
- D. If the case was INELIGIBLE for K-TAP for a given month, the K-TAP issued is the claim amount.

EXAMPLE: In January 2008, it is discovered a parent receiving SSI was not eligible for SSI beginning January 2007. The resources and income of the SSI recipient had been excluded in determining K-TAP eligibility. Re-determine financial eligibility using all resources and income (DO NOT count the SSI) for all months the family received K-TAP and SSI. If the family is K-TAP ineligible, the claim amount is the K-TAP benefit issued.

- E. No claim exists if the SSI individual is removed from the K-TAP case effective the date given to SSA. The initial SSI payment is reduced dollar for dollar by the individual's proportionate share of the K-TAP benefit amount up to the month of the effective removal from the case.

MS 1230

RETAINED CHILD SUPPORT

(1)

[Consider child support retained by the Agency when calculating any Kentucky Transitional Assistance Program (KTAP) or Kinship Care claim.]

- A. Retained support is the amount of collected support reported by Child Support Enforcement (CSE) minus collections forwarded (e.g., escrow) to the recipient as verified on KASES.
- B. If retained child support is equal to or more than the benefits issued for a month (before benefit reduction), there is no claim.
- C. If the absent parent is known, access KASES to determine CSE retained support.
  1. Use the KASES Accounting Function, "05" to determine if child /spousal support is paid.
  2. Select option "21", Benefit Summary to display the Benefit Selection Inquiry screen.
  3. Select the appropriate IVD# to display the Benefit Summary Inquiry screen.
  4. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.
  5. Use \$CSUP STATE to determine the amount of State retained support for the month.
  6. If more than one payment is received during the month, the screen will display the total dollars distributed to the participant and/or retained by the State.
- D. Calculate the amount of child support kept by the State and compare that monthly amount to the amount of benefits issued for each month of the potential claim.
  - [1. If the retained child support for an individual month equals or is greater than the KTAP benefits received for that month, no claim exists for that month. Update Worker Portal to show the claim was not established.]

EXAMPLE: The client received \$235 KTAP benefits. The client was only entitled to \$150. Child support was retained in the amount of \$235.

2. If the retained child support for the month is less than the KTAP issued, subtract the corrected benefit amount for that month from retained child support. Deduct the remaining child support from the overpayment for that month.



EXAMPLE: \$210 of KTAP benefits is issued. The correct amount is \$100. Child support of \$140 was retained by CSE.

Calculate using the following steps.

Step I - Determine if a claim exists

Benefits Issued \$ 210  
Retained Child Support 140  
Child Support Retained is Less than Benefits - Claim Exists

Step II - Calculate the overpayment

Benefits Issued \$ 210  
Corrected Benefits - 100  
Amount of Overpayment = \$ 110

Step III - Determine if claim can be reduced by the retained child support.

Retained Child Support \$ 140  
Corrected Benefits - 100  
Excess Child Support = \$ 40

Step IV - Deduct the excess child support from the claim amount.

Amount of Overpayment \$ 110  
Excess Child Support - 40  
Balance of Claim = \$ 70

3. If the retained child support for the month is less than the corrected benefit for the month, there is no excess child support. Do not deduct child support from the overpayment.

EXAMPLE: \$230 is issued. The correct amount is \$180. Child support of \$80 is retained.

Corrected Benefit - 180  
Remainder = \$ 0

There is no excess child support.

MS 1240 MEDICAL ASSISTANCE CLAIMS (1)

- A. Medical Assistance claims occur when a recipient or responsible party, age 18 or older, causes a financial loss to Medicaid by:
1. Deliberately making false or misleading statements in order to obtain MA benefits;
  2. Allowing an individual other than those listed on the KYHealth card to obtain health care benefits by use of the household's KYHealth card; or
  3. Inappropriately using a covered service (e.g., using Non-Emergency Medical Transportation (NEMT) to go to work, etc.).
- B. When an overpayment of MA occurs due to suspected fraudulent actions:
1. [Refer the suspected MA claim to OIG by completing the Overpayment Discrepancies screen on the Worker Portal. When there are suspected food benefits Intentional Program Violation (IPV), Kentucky Transitional Assistance Program (KTAP), or Kinship Care (KC) fraud cases which involve at least one month of MA ineligibility, refer all cases to OIG regardless of the dollar amount.
  2. Enter comments on Worker Portal regarding the referral to OIG.
  3. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, indicating the eligibility status for each household member. OIG will obtain the dollar amount of Medicaid usage for each ineligible month. This will be added to the overpaid benefits from the other programs to determine if prosecution will be pursued.
- C. A Medical Assistance claim is entered on Worker Portal only when the claim is adjudicated through the court. If OIG determines the medical card was not used during the ineligible period or fraud cannot be established, there is no claim on Worker Portal.]
- D. Payments on Medical Assistance claims are handled by CMS or OIG. OIG may recommend collection of erroneously issued Medicaid benefits where prosecution is not pursued. In those instances, collection efforts are the responsibility of OIG.