COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

OPERATION MANUAL
Volume I

OMTL- 324

General Administration

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MS 0001 PURPOSE OF INSTRUCTIONAL MATERIAL

Instructional material contains policies and procedures of the Department for Community Based Services (DCBS) in respect to the assistance programs of Kentucky Transitional Assistance Program (K-TAP), State Supplementation for the Aged, blind, or Disabled, Medicaid Program (MA), and the Food Stamp Program (FS).

MS 0003 ORGANIZATION OF INSTRUCTIONAL MATERIAL

A. Procedures which apply to all programs are grouped together (where possible) in the front of the manual. Eligibility criteria, specific to each program, is contained in separate volumes. In order to make the material readily available, it is divided as follows:

1. VOLUMES represent the major divisions of the manual, and are identified by the volume number beneath the title of the manual.
2. CHAPTERS represent major divisions of a volume, and are identified by the subject which appears on the top line in the page heading.
3. SUBCHAPTERS are vision of chapters. A subchapter includes closely related material and is identified by the title which appears between the lines in the page heading.
4. SECTIONS are basic units and are identified by a 4 or 5-digit number.

B. The Operation Manual (OM) is provided in tow formats: hardcopy and Internet.

1. For the hardcopy manual, each page carries the transmittal letter number and the issuance date. When the content of a page is revised, the “Effective” date of the page is revised. The revised page carries a “Revision” date (e.g., R. 6/1/88) which corresponds with the brackets ([ ]) containing the revision(s). superseded pages are removed and destroyed in accordance with the “Instructions for Operation Manual Maintenance” shown on the Transmittal Letter.
2. [The manual is on Internet at http://manuals.chfs.ky.gov/dcbs_manuals/DFS/index_dfs.asp] Each section has an effective date. The effective date relates to the brackets found in the section. New section numbers are denoted by an asterisk (*) just to the right of the number. For revisions within an existing section, brackets are placed at the beginning and end of the revised material, which correspond with the effective date of the section.

MS 0005 [INSTRUCTIONAL MATERIAL

All instructional material is issued by the Division of Family Support (DFS) electronically to Training staff, Office of Ombudsman staff, Central Office staff, Regional Office staff and Field Services Supervisors (FSS).

It is the responsibility of the FSS to ensure a hardcopy of the Forms Manual and Computer Manual is updated and available for staff under his/her supervision. If the supervisor is responsible for more than one county, he/she is provided a hardcopy for each county. The Operation Manual is accessed on-line at http://manuals.chfs.ky.gov/dcbs_manuals/DFS. No hardcopy of the Operation Manual is provided.]

It is the responsibility of each supervisor or designated individual to maintain current instructional material for use in the performance of his/her job function. This material is updated according to instructions on the transmittal letters issued.

Each local office also makes instructional material available for review in the office by any client or other individual requesting such review. The local office interprets any policy or procedure contained therein.

[Any organization with an interest in welfare programs can access the Operation Manual on the Internet at:
http://manuals.chfs.ky.gov/dcbs_manuals/DFS.

A. The OPERATION MANUAL includes the policy and procedures for programs administered by DFS. This manual is accessed on-line.

B. The COMPUTER MANUAL includes computer forms, screens, and procedural instructions for:

   1. PA-62 System;
   2. System Tracking Employability Program (STEP);
   3. Family Alternatives Diversion (FAD) System;
   4. State Data Exchange (SDX);
   5. Kentucky Claims Debt (KCD) Management System;
   6. EZ System; and
   7. Report Distribution System (RDS).

   The Computer Manual is available on-line as the sections are revised. Access the on-line sections at:
   http://chfsnet.ky.gov/cfs/dcbs/dfs/ComputerManualSections.htm.

C. The FORMS MANUAL includes facsimiles of forms and their procedural instructions. As forms or procedural instructions are revised they are made available on-line. Access the on-line forms at:
   http://chfsnet.ky.gov/cfs/dcbs/dcbsforms.htm.

D. The OPERATION, FORMS and COMPUTER MANUAL UPDATES are issued when there is insufficient lead time to implement a policy or clarification by a transmittal letter. Information contained in Updates is incorporated by transmittal letter into the appropriate manual at a later date.

1. Operation Manual Updates are filed in Volume X. Each Update is retained in this volume until obsoleted or incorporated. An Update may cover several different issues. Each update contains cross-reference links to the affected manual sections.

2. Forms Manual Updates dealing with forms or procedural instructions, are given a page number and filed immediately behind the existing procedural instructions.

3. Computer Manual Updates dealing with computer forms or procedural instructions are given a page number and filed behind the existing procedural instructions.

4. Forms and Computer Manual Updates instruct staff to remove and destroy previous updates, and/or insert new updates and pen and ink changes for incorporation.]

MS 0007 OTHER INSTRUCTIONAL MATERIAL

[Other formalized instructional material issued by the Program Assistance and Resource Branch include:

A. BULLETINS which issue material of a continuing nature, not appropriate for incorporation into the Operation Manual; for example, Directories, special projects, etc. all bulletins are maintained on the Report Management and Distribution System (RMDS) which may be accessed by DCBS staff.]

B. The COMPUTER MANUAL which includes computer forms and procedural instructions.

C. The FORMS MANUAL which includes facsimiles of forms and their procedural instructions.

D. POLICY AND PROCEDURAL UPDATES which are issued when there is insufficient lead time to implement a policy or clarification by a transmittal letter. Information contained in Updates is incorporated, by transmittal letter, into the appropriate manual at a later date.

1. Policy Updates are filed in a specific Volume as instructed by the Update. Each Update is retained in this volume until obsoleted or incorporated, at which time retention instructions are issued. A Policy Update may cover several different issues. Each issue has a specific manual section number and pen and ink references relate each Policy Update section to the appropriate manual cite.

2. Procedural Updates dealing with forms or their procedural instructions, are given a page number and filed immediately behind the existing procedural instructions.

3. Procedural Updates dealing with computer forms or their procedural instructions are given a page number and filed behind the existing procedural instructions.

4. Updates instruct staff to remove and destroy previous updates, and/or insert new updates and pen and ink changes for incorporation.

MS 0020 CABINET FOR HEALTH AND FAMILY SERVICES RESPONSIBILITIES

The Cabinet for Health and Family Services (CHFS) recognizes that children are our greatest natural resource; individuals and their families are the most critical component of a strong society; and that each must be afforded safe, secure and nurturing environments. CHFS provides statewide leadership in protecting and promoting the well-being of Kentuckians by delivering quality human services.

Support functions are also provided to the Department for Community Based Services (DCBS) by the Cabinet through various offices:

A. Office of the Secretary;
B. Office of Human Resource Management;
C. Office of Administrative and Technology Services;
D. Office of Legal Services;
E. Office of the Ombudsman;
F. Office of Communications and Administrative Review;
G. Office of Policy and Budget; and
H. Office of Inspector General

MS 0022 DEPARTMENT FOR COMMUNITY BASED SERVICES

The Department for Community Based Services administers an array of services including services to enhance family self-sufficiency and child and adult protection and permanency. The Department consists of seven Divisions:

A. Division of Service Regions;
B. Division of Child Care;
C. Division of Violence Prevention Resources;
D. Division of Protection and Permanency;
E. Division of Administration & Financial Management;
F. Division of Program Performance; and
G. Division of Family Support

MS 0026 DIVISION OF FAMILY SUPPORT

[The Division of Family Support provides technical support to the Division of Service Region staff for all benefit programs administered by the Cabinet. The benefits include:

A. Kentucky Transitional Assistance Program (K-TAP);
B. Food Stamp Program (FS);
C. Medicaid Program (MA);
D. State Supplementation; and
E. Individual and Family Grant Program (IFGP) following a presidentially declared disaster.

The Operations Support Branch (OSB) provides technical support to the Department for Community Based Services field staff. The Branch maintains caseloads for specific program cases and has responsibility for the timely and accurate issuance of food stamp benefits. Claims activity is also a function of this Branch. Within OSB are four Sections, the Case Processing Section, EBT Administrative Section, Claims Section, and Technical Support Section.

The Program Assistance and Resource Branch (PARB) is responsible for the development of detailed instructions and clarification of all K-TAP, Medicaid and Food Stamp policy. Staff is responsible for developing and distributing all instructional and written material to Family Support field staff. This includes Manual Transmittal Letters, Policy Updates, Each Local Office Memorandum, Daily Case Status Report (DCSR) General Information Messages, as well as the forms used by Family Support staff. PARB also facilitates the resolution of automated systems problems encountered by Family Support field staff.]

MS 0028 LOCAL OFFICE RESPONSIBILITIES

See Policy Clarification

Each county has a local office responsible for:

A. Determining eligibility;

B. Providing facts and information to interested parties;

C. Providing services during the entire workday, except lunch hours in offices with less than three employees. [The Department is responsible for setting office hours that take into account the special needs of all food stamp applicants, especially households containing working members. The Cabinet encourages the use of flextime to accommodate the needs of working recipients, which allows them to be seen before 8:00 a.m. and after 4:30 p.m. Any offices using protected hours for workers must ensure that those hours are staggered in order that customers can be assisted from 8:00 .m. to 4:30 p.m. and during the lunch hour.] These services include:

1. Accepting and distributing applications;
2. [Interviewing; and]
3. Accepting case related information.

D. [Advise households that are applying for or receiving both Food Stamp and K-TAP benefits that the K-TAP time limits and eligibility requirements do NOT apply to the receipt of Food Stamp benefits. In addition, advise the households that they may still be eligible or continue to receive Food Stamp benefits even though they stop receiving K-TAP benefits.]

[E.] Displaying informational posters and memoranda;

[F.] Maintaining and distributing informational pamphlets including facts about various benefit programs, civil rights, and hearing rights; and

[G.] Maintaining case record information according to current retention and disposal schedule.

MS 0031 The Online 117 Case Review Process

All case reviews are completed on the web-based online 117 Case Review System located at https://webapp.chfsnet.ky.gov/dcbscasereviews/. 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 and statewide basis.

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

1. A case is worked correctly;

2. A case decision is made according to Agency policy;

3. All information is obtained, reviewed and evaluated to substantiate a decision;

4. Impending changes are identified and spot checks are set up and handled 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 are to follow the guidelines issued by the Service Region Administrator's (SRA) office which establish the required number of cases to be reviewed. Special reviews may be included in the case review quota.

2. Reviewers are to use the different levels of review available. Each level of case review 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. Follow program specific procedural instructions available on the web-based online 117 Case Review System. These instructions can be viewed by opening the link on the case review below the "Review Section" on the 117.

2. Reviewers read cases thoroughly.

3. When a reviewer completes a case review, the reviewer is to print a copy of the review for the worker and place a copy of the review in the case record if the review does not contain any errors. However, if there are errors, the reviewer is to:

   a. Cite specific policy where an error is identified.

   b. Print and provide a copy of the review along with the case record to the worker once the case review is concluded. The worker makes the necessary corrections and returns the case to the reviewer within the allotted timeframe. If the worker disagrees with the review a conference with the reviewer may be requested.

   c. When the reviewed case is returned to the reviewer, the reviewer is to ensure that the necessary corrections are made.

   d. When all necessary corrections are made, the reviewer accesses the incomplete online 117 review and enters a "NO" on the "Action Needed" tab to show that the case review is complete.

      Note: Reviewers may use the "Detailed Activity by Reviewer" report to track the status of case reviews.

   Although the worker is given a copy of the review, the copy is to be retained for professional use only. Under no circumstances are completed reviews considered an employee's personal property. The completed review is a part of the Agency's records and is confidential information.

   The review outcomes shall be used in the performance evaluation of an employee. The review identifies the caseworker's policy strengths and needs. Reviewers also use the Online 117 System to identify the need for special reviews, if necessary. A special review is identified by selecting a sample of case actions completed by a worker and identifying areas in which the worker has shown difficulties in applying correct policy. A special review can also be used to identify areas of policy that are frequently applied incorrectly.

D. Central Office Functions.

Central Office staff will review cases that have not been reviewed and also cases that have been reviewed at the 1st or 2nd level. Cases from every region will be reviewed on a quarterly basis.

If errors are noted, local staff have a maximum of 10 work days to make corrections. In some instances case records or material may be needed by Central Office staff in order to complete the review. In the event that records or material needs to be reviewed for a particular case, the Program Specialist is contacted for specific information to be faxed or scanned and provided to Central Office within 5 working days from the date the information was requested.

E. 117 Reports

The information gathered by the 117 Reports is used to reduce 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.

MS 0032 Online 117 Case Review Reports

The Online 117 Case Review System captures the results of case reviews and compiles these results into different reports. The reports summarize the reviews completed by each worker, unit, county and region.

A. The Online 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 available on the 117 Case Review System and a short descriptive summary of information provided by each report. 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 of reviews in error is divided by the total number of reviews and the result is the percentage of error. Each category has a subtotal that reflects the following error types:

a. Verification Error: Occurs when a case lacks required verification.

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 and 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 by Region: 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 number, case name, case decision, review date, review level, review type and error categories.

4. Cases in Error by Unit: This report is used to track the complete/incomplete status of reviews. It identifies reviews in error by unit. The unit data is broken down to identify the reviewer's name, the worker's name, the case number and name. This report identifies whether the worker that completed the action is a case decision or non-case decision worker. Additionally this report provides the date a review is entered, the action due date for any needed corrections, the level of review, the type of program and the error categories.

5. Detailed Activity by Region, Detailed Activity by Reviewer, and Detailed Activity by Unit: These reports are used to obtain an overall total of reviews completed by region, reviewer or unit. These reports give the current status of all reviews for the region, for a reviewer or a unit and the level of these reviews, the program type 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. Error Detail by Elements: This report tracks errors by unit and caseworker. The report is used to identify trends by the case action and the specific elements cited.

8. Error Summary by Element: This report tracks errors by case decision and non-case decision actions. This report is used to identify errors that are broken down by the specific elements cited.

9. Issuance Only Error Detail by Element: This report tracks elements in error by issuance only.

10. Review Summary by Region, Review Summary by Unit and Review Summary by Worker Code: These reports give an account of the totals for reviews in error for each region, unit and worker code. The totals for case decision/non-case decision reviews are identified and a total for the error categories is also provided.

11. 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 worker name is provided.

12. Statewide Review Summary: Provides a statewide summary of the number of reviews completed and the totals for reviews in error for all regions.

MS 0090 PURPOSE OF BENEFIT PROGRAMS

The purpose of the Food Stamp (FS) and Income Maintenance (IM) programs (K-TAP, Medicaid, State Supplementation, etc.) is to assist low income families with food, money, medical services, etc.

The programs operate based on federal law and regulations issued by the Administration for Children and Families which governs K-TAP, State Supplementation which is governed by state statutes and administrative regulations, the Health Care Financing Administration which governs Medicaid, and the Department of Agriculture, Food and Nutrition Services which governs food stamps. Other program guidelines result from Supreme Court decisions, Kentucky Revised Statutes (KRS), Kentucky Administrative Regulations (KAR), Court of Appeal decisions, etc.

MS 0091 PROGRAM FUNDING

As a condition for federal financial participation (FFP), program policy and procedure must comply with the Social Security Act/Food Stamp Act and federal regulations.

Food Stamp Program benefits are funded entirely by federal money. Both state and federal money are used for the administration of the program. K-TAP and Medicaid use state and federal monies for both administrative and assistance payments costs. The State Supplementation program for the aged, blind, and disabled is funded entirely by the state.

MS 0092 APPLYING FOR ASSISTANCE

Individuals have the right to apply in any county for any program administered by the Department. [Applications filed in a county other than the county of residence must be accepted in the county of application and forwarded, per Volume VI, MS 1240 and MS 1245, to the applicant's county of residence by the end of the following day.] An application is considered to have been made when the application is entered on-line and/or the appropriate application form is signed.

If an individual or their representative signs an application by making a mark (X), the mark must be witnessed by one person, either related or unrelated to the individual, who can write.

[In addition to allowing Food Stamp households to file food stamp applications by submitting the form in person, through an authorized representative, or by mail, staff can accept applications by fax. See Volume II, MS 6100 for application processing and MS 6320 and MS 6330 for interviewing procedures.]

A person whose application has been previously denied or one whose assistance has been discontinued may reapply at any time.

Residence in a spouse abuse center does not affect the individual's right to apply.

MS 0093* RIGHT TO APPLY

Generally, application is made in the county of residence. However, individuals can make application for any program offered by the Agency in any county office, regardless of the county of residence. Additionally, application can be made by the individual, their parent, representative, statutory benefit payee, committee, guardian, power of attorney or authorized representative, as applicable in each program. Cases which are the responsibility of another county office are then appropriately forwarded to the office responsible for ongoing approval or action. For procedures regarding the determination of caseload responsibility and transfer responsibility, see MS 0155.

MS 0094 WHERE TO APPLY

A. Both KAMES and the PA-62 system have the capability to send the MAID to the county where the recipient resides and to also maintain those functions required of the caseworker responsible for the case, even if the recipient is in a county different from that of the responsible caseworker.

B. If the individual is applying in a county other than the county of residence, including applications made for a hospitalized individual, the application is taken by the county contacted as follows:

1. For FS, enter the application online.

2. For IM:

a. If the application is taken on KAMES, enter the application online and process if possible.
b. If the application will be entered on PA-62, complete the appropriate application forms.
c. If the applicant is hospitalized, follow the procedures outlined in Vol. III, MS 2015, Vol. IV, MS 1210, and Vol. IVA, MS 1370, as appropriate.

3. The pending application is processed in the county of residence, using the original application date. [For FS, applications filed in a county other than the county of residence must be accepted in the county of application and forwarded, per Volume VI, MS 1240 and MS 1245, to the applicant's county of residence by the end of the following day.]

4. Transfer a pending application if the county of residence is different from the county where the application is made, as follows:

a. To transfer cases taken on KAMES, see Volume VI, MS 1240 and MS 1245.
b. To transfer cases taken on the PA-62 system, use form PAFS-25, complete caseload reassignment and immediately mail the forms and information to the appropriate county of the same day the application is taken.

[C. Applications or information brought into the DCBS office are to be accepted from the individual bringing them in and action taken on that information or, if the information is for a case in another county, immediately mail the information on the same day received to the county office where the case is carried.

D. A separate MA application is not required for persons applying for or receiving K-TAP. In situations where the individual received a money

payment or Medicaid card from another state and the Kentucky K-TAP application is denied due to excess income, KAMES will make a determination of eligibility for MA using the MA scales.]

MS 0095 TAKING THE APPLICATION

Every individual has the right to apply for any program administered by the Agency at any county office, regardless of county of residence. No individual is refused the opportunity to apply. Eligibility requirements or Agency procedures do not preclude the opportunity for an individual to apply and obtain a determination of technical and financial eligibility or ineligibility.

[A.] The application is usually completed in the applicant's county of residence.

[B.] Accept any information or verification from individuals coming into the local office regarding their case or on behalf of a LTC individual residing in another county.

1. Any information for individuals residing in another county should be mailed to the county where the case is carried on the day received.

2. For individuals residing in another county making initial contact with the Agency, the application can be taken on KAMES and forwarded pending or disposed to the county where the case is to be carried.

3. For LTC cases currently active on KAMES, the KIM-101 must be signed and mailed to the county where the case is carried. Access to KAMES requires obtaining a caseload reassignment for those cases already active on KAMES.

[C.] For an inquiry not resulting in an application, complete an Inquiry/Update PAFS-97, on KAMES.

[D.] IF THE INDIVIDUAL IS PHYSICALLY OR MENTALLY DISABLED OR IS ELDERLY, provide reasonable accommodation to any special needs the individual may have no matter where the interview is conducted. Special needs may include, but are not limited to:

1. Interpreter services for hearing impaired individuals. Refer to MS 0108;

2. Additional space for the interview to accommodate an individual in a wheelchair;

3. Scheduling appointments when special transportation services are available; or

4. Making a home visit.

[E.] IF THE INDIVIDUAL IS NON-ENGLISH SPEAKING, obtain interpreter services. Refer to MS 0108.

[F.] If the applicant is physically unable to come to the office to apply, make a home visit to complete the application process. If the physically impaired

individual, including the disabled, blind, or hearing impaired individual, has no friend or relative to help with the application process and interview, refer that individual to county and community resources.

[G.] If the individual is applying in a county other than the county of residence, including applications made for a hospitalized individual:

1. The local office in the county contacted:

   a. Takes the application;
   b. Transfers the application by form PAFS-25 to the county of residence on the same day the application is taken and follows procedures on KAMES to complete the transfer; and
   c. Explains to the applicant that the application will be maintained in the county of residence.

2. The local office in the county of residence:

   a. Sends form PAFS-2, or the RFI from KAMES, the same day the application is received, if needed, to request additional information or to schedule a face-to-face interview, if not done in the county of application; and
   b. Processes the application using the original application date. If the application is processing due to no pending data, approve the case in the county contacted prior to transfer.

[H. If an MA application with a statutory benefit payee, committee, guardian, power of attorney, representative or authorized representative (AR) is completed in a county other than the recipient's county of residence, follow procedures outlined in A-H with the following exceptions:

1. Transfer pending cases whose statutory benefit payee, committee, guardian or power of attorney live out-of-state to the county in which the applicant/recipient resides; and

2. Transfer pending cases to the power of attorney's Kentucky county of residence only if that person is also the designated statutory benefit payee for other forms of assistance such as SSI, RSDI, RR or VA.

3. The individual seeking to apply on behalf of an LTC case must never be required to travel outside his home county to conduct Agency business for the individual/recipient who may reside in another county and for whom he/she is responsible.

   a. Anyone applying for or conducting business on behalf of an LTC applicant can conduct the application, recertification or follow-up visit in the representative's home county. Information or verification received is to be forwarded to the county where the LTC recipient resides.
   b. This county may be different from the recipient's county of residence.

   For more on an AR see MS 1330.]

[I.] The county where the DJJ worker who is applying has case responsibility for a child Medicaid eligible and in the custody of the DJJ.

1. This county may be different from the managed care or non-managed care county where the DJJ child is physically located.

2. The DJJ child's case county code must be the DJJ child's county of residence. Both the case mailing address and case residence address must be the DJJ child's physical location.

3. When the DJJ child's county of residence and the DJJ worker's location are the same, managed care or non-managed care county, the case mailing address is the DJJ worker's address and the DJJ child's case residence address is the physical location of the DJJ child.

[J.] The county where the CBW who is applying has case responsibility for a child Medicaid eligible and in the custody of the Cabinet, including patient liability.

MS 0096 WHO SIGNS THE APPLICATION

[The individual(s) allowed to sign the application may vary depending specific program requirements. Below are the policy specifications regarding who can sign the application:]

A. Applications for K-TAP are signed by the specified relative. See Volume III, MS 2025.

B. Applications for food stamps must be signed by an adult individual or their adult authorized representative.

C. Applications for MA are signed by:

1. The individual or the parent of the child;

2. [The aged, blind or disabled individual, the statutory benefit payee, committee, guardian or the authorized representative (AR). See MS 1330];

3. The representative of the responsible agency, Department of Juvenile Justice (DJJ) or Children's Benefits Worker (CBW), for a child in foster care or state subsidized adoption;

4. [The parent or the AR for a mentally ill or mentally retarded child];

5. [The parent or other specified relative (SR), of a needy child or AR for the parent];

6. For N cases, either parent may sign the application to protect the filing date. The qualifying parent MUST sign form MA-7, Supplement A, before the case can be approved. DO NOT refuse to take an application signed by a non-qualifying parent; or

7. For "I" or "Y" cases:

a. [The parent, other SR or the AR, when the child does not live with a parent or other SR; or
b. The pregnant woman, her spouse, or an AR]
(1) If the pregnant woman under age 18 is receiving services from an authorized child welfare agency, an agency representative may sign the application.
(2) If the pregnant woman under age 18 is receiving basic maintenance needs from her own parents, either she or her parents sign the application.

D. For all programs:

1. The SAVE requirement of the declaration of citizenship/alien status must be signed by either the SR or if included, the second parent (SP). One

adult member may sign for all the members, both adults and children. A declaration is not required for a deemed eligible newborn.

2. If an individual or their representative signs an application by making a mark (X), the mark must be witnessed by one person, related or unrelated to the individual, who can write.

3. For food stamp purposes, aliens who do not wish the Department to contact the INS to verify immigration status, the agency must give the household the option of withdrawing its application or participating without that member. See Vol. II, MS 5220 for how to consider income of ineligible aliens.

MS 0100 CIVIL RIGHTS – GENERAL REQUIREMENTS

Comply with Civil Rights laws by meeting the following requirements:

A. 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 benefit determination, hearings, or any other aspect of program operation.

B. [Advise all applicants of their civil rights including their right for a hearing on alleged discrimination at application by giving them the pamphlet, Civil Rights .

C. Explain the pamphlet Civil Rights to applicants who question their rights or do not understand their rights.]

D. All vendors used by the Department are required to certify compliance with the Civil Rights Act.

MS 0102 CIVIL RIGHTS – WRITTEN COMPLAINT

If an individual complains of discrimination and is able and willing to put it in writing, do the following:

A. [Explore the circumstances and determine if the individual wishes to request a hearing or complete a CHFS Client Civil Rights Complaint form.

B. Use the Fair Hearing process if the individual alleges denial of eligibility because of agency policy or a discriminatory application of agency policy.

C. Use a CHFS Client Civil Rights Complaint form if the individual alleges discrimination in the method services are provided or refusal of access to services.

D. If the Civil Rights Complaint form is returned to the local office. Forward the form to the local Equal Employment Opportunities (EEO) counselor. The local EEO counselor completes the form and forwards to DCBS, EEO Counselor Coordinator (EEOCC) and the SRA.]

E. In addition, for food stamp cases, advise the applicant of his right to file a Report of Discrimination with the Office of the United States Department of Agriculture, Food and Nutrition Service (FNS).

1. This report can be submitted concurrent with or in place of the filing of the Client Civil Rights Complaint form for any of the above reasons.

2. The individual files this complaint with FNS by personal letter mailed to:

USDA Director
Office of Civil Rights
Whitten Building, Room 326W
14th and Independence Avenue, SW
Washington, D.C. 20250-9410

3. Advise the applicant that all such complaints filed directly by the applicant with FNS must contain the following information to facilitate investigations:

a. The name, address and telephone number or other means of contacting the person alleging discrimination.
b. The location and name of the organization or office which is accused of discriminatory practices.
c. The nature of the incident or action or the aspect of program administration that led the person to allege discrimination.
d. The reasons for the alleged discrimination, i.e., age, race, sex, disability, religious creed, national origin or political belief.
e. The names, titles, if appropriate, and addresses or persons who may have knowledge of the alleged discriminatory acts.

f. The date or dates on which the alleged discriminatory actions occurred.

[4. Notify the EEO/Civil Rights Compliance Branch Manager in writing of any discrimination complaint you become aware of. Send written complaints to the following address:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St., 5C-D
Frankfort, KY 40621
Fax: (502) 564-3129]

MS 0106 CIVIL RIGHTS – VERBAL COMPLAINT FOR FS PROGRAM

If an individual is unwilling or unable to put a verbal allegation in writing, the FNS employee who receives the allegation documents the complaint in writing.

A. Every effort is made by the individual accepting the complaint to have the complainant provide the information specified in MS 0102. Complaints are accepted by the Secretary or the Administrator of FNS, even if the information specified is not complete. However, investigations are conducted only if the information required is provided.

B. A complaint must be filed no later than 180 days from the date of the alleged discrimination. However, the time for filing may be extended by the Secretary of Agriculture.

C. [Anyone who becomes aware of any discrimination complaint must notify the EEO/Civil Rights Compliance Branch Manager in writing (fax, e-mail, etc.) at the following address:

EEO/Civil Rights Compliance Branch Manager
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St., 5 C-D
Frankfort, KY 40621
Fax : (502) 564-3129]

MS 0108 [CIVIL RIGHTS - DISABLED INDIVIDUALS]

A. [The Department for Community Based Services is required to make reasonable accommodations to ensure all services are accessible to the disabled.] Any hearing impaired person applying for program benefits, must have interpreter services made available 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 required for the deaf or hard of hearing, do the following:

1. At application, reapplication and recertification, provide the individual with forms OPB-001-A, Your Right to Effective Communication, and OPB-001-B, Waiver of Interpreter Services. Document in the case record that forms OPB-001-A and OPB-001-B were given to the recipient. Additionally, if completed, file a copy of form OPB-001-B in the case record and provide the client with the original.
2. 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);
3. Request interpreter assistance from a local school or social service agency; or
4. Contact the Kentucky Commission on the Deaf and Hard of Hearing (KCDHH) Access Center at 800-372-2907. The Access Center is a language interpreter referral service for state agencies.
5. At application, reapplication and recertification, or at anytime an interpreter service is used, provide the individual, including a household member, performing the interpreter service with form OPB-002, Interpreter Confidentiality Assurance Form. File a copy in the case record.

B. Whenever possible, interpreter services involving no additional cost to the agency must be used. In situations when a service is performed by a qualified interpreter and a fee is charged, do the following:

1. Obtain a signed statement from the qualified interpreter which includes:

   a. Name of interpreter;
   b. Social Security Number;
   c. Address; and
   d. Amount of fee. (See chart below.) This hourly rate includes time spent in travel, time spent interpreting and mealtime, with the exception of mileage. Mileage is paid at the state rate. Additionally, 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; and

Suggested fee schedule for individuals with the following certificates:

(1) CSC, CT and CI, RSC, CDI-P, SC:PA, OIC:C, NAD Level V -- $25 an hour.
(2) [CI or CT, IC/TC, NAD Level IV --- $25 an hour.]
(3) IC or TC --- $20 an hour.
(4) [OIC:S/V, OIC:V/S, NAD Level III --- $20 an hour.]
(5) Non-certified interpreters (including NAD Level II and I) $10 an hour.

2. Complete form OPB-003, Certification of Interpreter Services Provided, after service is rendered, including the above information and mail to:

General Accounting
Attention: Tim Beason
[275 East Main Street, 4E-A]
Frankfort, KY 40621

MS 0112 LIMITED ENGLISH PROFICIENCY (LEP) REQUIREMENTS

The Civil Rights Act of 1964 and subsequent Executive Order 13166 of August 2000 mandated that individuals with Limited English Proficiency (LEP) be provided language access to all federally funded programs and services. This includes the programs administered by our Cabinet - K-TAP, Medical Assistance, Food Stamps and any other program funded by the Temporary Assistance for Needy Families (TANF) block grant. These requirements not only apply to all Cabinet staff but also to any contracted vendors used by the Cabinet to provide services.

A. LEP means that an individual is limited in his/her understanding of the English language either verbally or written. This lack of understanding can be a barrier to accessing programs or services.

B. The Cabinet must ensure all LEP individuals have meaningful language access to all programs. Providing meaningful access includes:

1. Identifying LEP individuals and their language needs. This can be done by using the Interpretation Service Available poster, commonly known as an "I Speak" poster. The "I Speak" poster displays a message in various languages such as "Point to your language. An interpreter will be called". [The "I Speak" posters are available at http://chfsnet.ky.gov/afa/ohrm/dem/lep. Select "LEP Office Signage and Telephone Resources" to access the poster and other helpful materials.]
2. Informing LEP individuals that interpreter services are available at no cost to the individual by:
   a. Posting notices in appropriate languages in the local offices;
   b. Using "I Speak" posters; and
   c. Providing information in appropriate languages in Agency outreach materials.
3. Providing interpreter services, without unreasonable delay and at no cost to the individual. The individual cannot be asked to find and/or pay for an interpreter. There are four options for accessing interpreter services:
   a. CHFS Language Access Section (LAS) Interpreters;
   b. CHFS Deemed Qualified Interpreter Service;
   c. CHFS Approved Community Based Partner Interpreters; and
   d. Language Line Interpreter Service.

   [Information concerning these four options may be accessed at: http://chfsnet.ky.gov/afa/ohrm/dem/lep. Select "Interpretation Resources".]

4. Providing translated copies of essential forms and informational materials at no cost to the individual. [These forms may be accessed at http://chfsnet.ky.gov/cfs/dcbs/dcbsforms.htm If a translated version of a form is not listed on the Cabinet website, request translation of the form by sending the Translation Request Form (access form through the LEP website) to the Division of Family Support through your Regional Office.

C. Interpreter services approved by the Cabinet (using one of the four options in item B.3.) must be provided to LEP individuals, if available, even if the individual wants to use an unapproved interpreter.] The Cabinet approved interpreter would sit in on the interview to ensure all questions and responses are interpreted correctly. [If the LEP individual chooses to use his/her own interpreter, the individual signs the form, Waiver of Interpreter Services – Limited English Proficiency (LEP). This form can be accessed from http://chfsnet.ky.gov/afa/ohrm/dem/lep. Select "Interpretation Resources".]

D. An LEP individual may select an English-speaking representative to act on his/her behalf. It is important that a qualified interpreter be used to explain the option and the significance of selecting a representative. In addition, any forms used in the selection process must be interpreted into the appropriate language of the LEP individual.

1. If the English-speaking representative is not accompanied by the LEP individual, no interpreter is needed.
2. If the English-speaking representative is accompanied by the LEP individual, a qualified interpreter, if available, must be present to monitor the interaction between the LEP individual and the representative to ensure the accuracy of the interpretation.

E. The Cabinet monitors the usage of LEP services. Monitoring is completed through a web-based tool that is accessed at https://webapp.chfsnet.ky.gov/lep. Each Region develops a monitoring plan and designates staff in each county to be responsible for entering the LEP services data on the monitoring tool.

There is an online training concerning the monitoring tool at http://www.training.eku.edu/lep. Select Forms and then, LEP Interaction Tracking Implementation Instructions. [It is imperative that all usage of LEP services be entered on the on-line monitoring tool.]

MS 0115 PROVIDING LEP SERVICES

The Cabinet must ensure all individuals with Limited English Proficiency (LEP) have access to all programs and services administered by the Cabinet. Use the following policy and procedures to identify LEP individuals and to provide LEP services to these individuals.

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

1. Determine the primary language of the individual. If other than 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. In addition, 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.

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 client needs to be recertified, the worker should schedule a LAS interpreter for the recertification appointment.

2. CHFS Deemed Qualified Interpreter Service. If LAS staff is not available, choose an interpreter from the CHFS approved list of Cabinet employees who are deemed qualified to provide interpreter services.

   Access the list at http://chfsnet.ky.gov/os/ohrm/dem/lep and select "Interpretation Services".

3. CHFS Approved Community Based Partner Interpreters. If neither a LAS interpreter nor a CHFS deemed qualified interpreter is available, contact an approved non-CHFS interpreter. This resource can provide interpreter services for a variety of languages, including Spanish.

   Access the list of approved non-CHFS interpreters at http://chfsnet.ky.gov/os/ohrm/dem/lep and select "Interpretation Services".

   These services usually involve a cost. To pay for these services, submit form OPB-003, Certification of Interpreter Services, to:

   Accounts Payable
   Attention: Sandra Skalley

275 East Main Street, 4E-A
Frankfort, KY 40621

4. Language Services Associates, Inc. (LSA). If none of the resources in items 1, 2 or 3 can provide interpreter services for a particular LEP individual, use the LSA. Contact the individual in the local office who is designated to access LSA to arrange for the service. The instructions for the LSA may be accessed at http://chfsnet.ky.gov/os/ohrm/dem/lep.

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. Have the individual complete the form, Waiver of Interpreter Services – Limited English Proficiency (LEP). This form can be accessed at http://chfsnet.ky.gov/os/ohrm/dem/lep.

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. The Language Access Section Translation Request Form is accessed through the Language Access Section website.

E. Document in the case record and on KAMES or STEP when interpreter services are used. Documentation should include:

1. Date when services were requested and provided;
2. What option was used; and
3. 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 monitoring tool according to the Region's monitoring plan. This tool can be accessed at http://chfsnet.ky.gov/os/ohrm/dem/lep select "Online LEP Interactions Form". It is imperative that the usage of LEP services is entered on the monitoring tool as the information is used to identify what LEP services are needed for the region.

MS 0120 [CONFIDENTIALITY REQUIREMENTS]

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 nor used in any manner so as to become a part of public record.

[B.] Forms and/or information utilized in the voter registration process are to remain confidential and be used only for voter registration purposes.

[C. Any person who violates requirements regarding confidentially 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 requirements regarding safeguarding IRS information, refer to MS 1915.]

MS 0122

PENALTY FOR FAILURE TO SAFEGUARD INFORMATION

Any person who violates requirements regarding confidentially is subject to fine of not less than $50 and not more than $200, or imprisonment for not more than 6 months, or both.

MS 0124 DISCLOSURE OF INFORMATION – FOOD STAMPS

All FS case records are confidential and information contained in them cannot be disclosed or opened for public inspection. The use or disclosure of information obtained from the applicant household is available only to employees of the Cabinet for Families and Children and USDA officials in the performance of duties as directly connected with the administration and enforcement of the Food Stamp Program. Disclose information to others only as follows:

A. Cooperate in providing information directly connected with the administration of Federal or Federally aided, means-tested assistance programs such as K-TAP or the School Lunch Program.

   1. If there is a written request by a responsible member of the household, its current representative, or a person acting on the household's behalf, the material and information contained in the case file is made available for inspection during normal business hours.

   2. The local office may withhold confidential information, such as the names of individuals who have disclosed information about the household without the household's knowledge or the nature or status of pending criminal prosecutions.

B. Employees of the United States Comptroller General's office for authorized audit examination purposes.

C. Local, State or Federal law enforcement officials who:

   1. Furnish the recipient's name and indicate that the individual:
      a. Is fleeing to avoid prosecution, custody, or confinement for a felony;
      b. Is violating a condition of parole or probation; or
      c. Has information necessary for the officer to conduct an official duty, related to a felony or parole violation.

   2. Are investigating an alleged violation of the Food Stamp Program and who provide a written request. The written request must include, at minimum, the following information:
      a. The identity of individuals requesting information and their authority to do so;
      b. The violation being investigated; and
      c. The identify of the person on whom the information is requested.

   3. Provide the law enforcement officials in item 1 with the recipient's address, Social Security Number, and photograph, if available.

4. If the requesting officer in item 2 indicates he wishes to take case record material with him, offer to provide photo copies. If he indicates only originals will suffice, make photo copies for the case record. Annotate the case record.

5. If the entire case record is requested, discuss with the officer what specific pertinent information may be acceptable rather than the entire case record. If the entire case record is still requested and photo copies will not suffice, make photo copies of the last two packets for the case record.

6. If the recipient is identified as a fleeing felon, enter an IPV disqualification per MS 1701.

7. The Kentucky State Police (KSP) may identify a potential FS fraud during the course of other investigations.

   a. [KSP use form KSP-58, Request for Confidential Information, to request information concerning fraud or potential fraud investigations, whether identified by DCBS or another source.]

   b. Upon presentation of form KSP-58 for the release of information, ensure it is completed in its entirety. If the form is not completed in its entirety, DO NOT release the information and DO NOT sign the form. Refer to the procedural instructions for form KSP-58.

D. A responsible member of the household or its representative.

1. Make material and information contained in the case file available during normal business hours.

2. Withhold confidential information, such as the names of individuals who have disclosed information without the household's knowledge or the nature or status of cases pending criminal prosecution.

E. [Anyone whom the household has authorized, via a signed form CFS-1, Informed Consent and Release of Information and Records, to receive the information.]

F. Persons directly connected with the administration or enforcement of the programs which are required to participate in the Income and Eligibility Verification System (IEVS), to the extent food stamp information is useful in establishing or verifying eligibility or benefit amounts under those programs.

G. Persons directly connected with the administration of the Child Support Program under Part D, Title IV of the Social Security Act in order to assist in the administration of that program and employees of the Secretary of Health and Human Services as necessary to assist in

establishing or verifying eligibility or benefits under Titles II and XVI of the Social Security Act.

H. Cooperate in providing information necessary to verify a suspected or known senior or child abuse situation, which has been reported to the proper authorities.

I. Follow court orders, unless otherwise notified by Regional Office staff or the court.

1. Court orders must be signed by a judge and have an assigned docket number, but may or may not require a court appearance.

   a. If the officer of the court, such as an attorney provides the local office with a court order, signed by a judge, the specified information must be released to the officer of the court.
   b. If a court appearance is required, the agency must comply or be held in contempt.

2. For procedures regarding subpoena requests, refer to MS 0130.

J. Only Board of Elections officials may view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

MS 0126

DISCLOSURE OF INFORMATION
K-TAP, MEDICAID AND OTHER BENEFIT PROGRAMS

[Information concerning benefit programs other than Food Stamps may be released to the following, provided they comply with HIPAA. Refer to Volume I, MS 0127:]

A. Public employees including any identified representative of the Department of Health and Human Services in the performance of his/her duties in connection with the administration of the public assistance or child support enforcement programs pursuant to part D of Title IV of the Social Security Act.

B. Law enforcement agencies and their representatives including county and commonwealth attorneys, district and circuit court judges, and grand juries in discovering and prosecuting cases involving fraud.

A potential fraud situation in the K-TAP, Medicaid and other benefit programs may be identified by the Kentucky State Police during the course of other investigations. Form KSP-58, Request for Confidential Information, is utilized by the Kentucky State Police when requesting information concerning fraud or potential fraud investigations, whether identified by DCBS or another source.

Upon presentation of form KSP-58 for the release of information, ensure it is completed in its entirety.

If the form KSP-58 is not completed in its entirety, DO NOT release the information and DO NOT sign the form. Refer to the procedural instructions for form KSP-58.

If the requesting officer indicates he/she wishes to take case record material with him/her, offer to provide photo copies. If he/she indicates only originals will suffice, make photo copies for the case record. Annotate the case record.

If the entire case record is requested, discuss with the officer what specific pertinent information may be acceptable rather than the entire case record. If the entire case record is still requested and photo copies will not suffice, make photo copies of the last two packets for the case record.

C. Federal, state and local law enforcement officials who, in the proper exercise of their duties, provide the name of a K-TAP recipient, and satisfactorily demonstrate that the recipient is:

1. A fugitive felon. A fugitive felon is a person who is charged or convicted of committing a felony and has escaped from custody within the jurisdiction wherein the felony occurred. A fugitive felon for the purpose of this definition may either reside in or outside of Kentucky in an attempt to avoid prosecution;

2. An individual violating a condition of probation or parole;

3. An individual who has information that is necessary for the officer to conduct his/her official duties; or

4. An individual involved in a criminal investigation.

   The location or apprehension of the recipient must be within the official duties of the law enforcement officer.

   Release of information in such cases is limited to information that is specific to the investigation.

D. Members of Congress and the General Assembly, limited to cases of individual constituents who have requested information regarding their application or payment status.

E. Any representative that has requested a hearing before an agency hearing officer, to the extent necessary for the proper presentation of the case. The release of information under this provision is limited to only that information applicable to the hearing request. In addition, any information or names obtained shall not be used for commercial or political purposes.

F. Officials administering any federal or federally assisted program which provides assistance in cash or in kind, or services directly to individuals on the basis of need. Disclosure is limited to K-TAP and benefit programs other than Medicaid.

G. Any audit or similar activity; e.g., review of expenditure reports or financial review, conducted in connection with the administration of any federal or federally assisted program. For Medicaid, the audit/activity must be conducted in connection with the administration of the Medicaid program. This is limited to governmental entities authorized by law to conduct such an audit or activity.

H. Any employer to certify receipt of K-TAP for purposes of claiming a tax credit under Public Law 94-12 of the Tax Reduction Act of 1975.

I. Any individual or agency agreeing to Departmental standards of confidentiality for the purpose of the provision of social services, employment or training to recipients of K-TAP and benefit programs other than Medicaid.

J. Any service providers attempting to provide assistance to Kentucky Works participants. The release of information under this provision is limited to purposes directly connected with providing services or issuing supportive services payments.

K. Officials administering any title IV-E foster care and adoption assistance programs.

L. Local law enforcement agency, the Kentucky State Police, Commonwealth or county attorney to report known or suspected instances of child abuse or neglect of a child receiving assistance. The local office cooperates in providing information necessary to verify a suspected or known, senior or child abuse situation which has been reported to the proper authorities.

M. Attorneys, absent parents, etc., who appear in the local office with a COURT ORDER carrying a signature of a judge or an individual with the authority of a judge such as a Domestic Relations Commissioner. If the court ordered information is due within 10 calendar days, the information can be released. If the local office has any questions on whether the court order meets the specified criteria or the local office has in excess of 10 calendar days to provide the information, contact the Eligibility Services Branch through the Regional office. Unless otherwise notified by regional office staff or the court, court orders must be followed. For procedures regarding subpoena requests, refer to MS 0130.

N. Only Board of Elections officials may view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

[Note: Any material released via fax to the above mentioned entities is monitored per HIPAA requirements. The receipt of faxes must be arranged so that the person receiving the fax is available to immediately retrieve the faxed information.]

MS 0127

HIPAA Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, changes the criteria for agencies entering into confidentiality agreements with the Department for Community Based Services (DCBS). All DCBS staff, as well as staff of all agencies with whom we do business or exchange information are now subject to the confidentiality requirements of HIPAA. HIPAA information is available on the Internet at the following website: http://aspe.os.dhhs.gov/index.cfm.

A. The HIPAA component which most directly impacts DCBS staff, concerns safeguarding the privacy 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. Speak softly so that others do not overhear health information.

D. Most agencies affected by HIPAA are designated as either covered entities or business associates. A covered entity is defined as a health care provider, a health care clearing house or a health plan. The Division of Protection and Permanency (DPP) is a DCBS covered entity. The Department for Medicaid Services (DMS) is also a covered entity.
A business associate is an agency which performs a function for a covered entity. Family Support staff has been classified as a business associate due to our contractual relationship with DMS.

MS 0128 AGREEMENT TO SAFEGUARD INFORMATION

An agency, organization, or school may obtain recipient information once a confidentiality agreement is approved by the Division of Family Support (DFS). [The approved agency MUST be made aware that they are subject to the confidentiality requirements of HIPAA. For more information see Volume I, MS 0127.]

A. DFS has the responsibility for receiving and approving the agency's or organization's request to enter into an agreement with this Department for receiving and safeguarding information.

B. Agencies permitted to enter into agreements with this Department must meet the following criteria:

1. The agency must be federally funded;

2. Provide needs-based service, where eligibility is based on a means test; and Staff of the agency must be subject to the same confidentiality requirements as CHFS employees.

C. Organizations which do not meet the above criteria include churches, church sponsored organizations or associations, civic clubs, United Way funded local agencies, the Red Cross, individuals such as temporary help in local offices, custodians, guards, repairmen, summer workers, landlords, or college students working on research papers, etc. Subsidized housing projects would be eligible, but not individual landlords for profit apartment complexes. Case information can only be released to the above groups if the recipient completes form DCBS-1, Informed Consent and Release of Information and Records, and, if necessary, DCBS-1A, Informed Consent and Release of Information and Records Supplement.

D. A listing of all currently active confidentiality agreements with this Department is maintained with DFS.

E. If the agency/organization/school meets the requirement in item B, and requests the information, provide form PAFS-20, Request for Initiation of Confidentiality Agreement. Instruct the agency/ organization/school to complete and send the form to the following address:

Department of Family Support
275 East Main Street, 3E-I
Frankfort, KY. 40621

If a local school system is requesting a list of all school aged children within the county which receive food stamps and/or K-TAP, instruct the school system to attach a copy of their request to form PAFS-20 when it is submitted.

F. Refer to MS 0124 through MS 0126 for procedures on releasing information to other employees of DCBS, or other Departments outside DCBS.

MS 0130 SUBPOENAED INFORMATION

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 Agency is the initiator of court action, including but not limited to fraud or unsuitable home actions.

B. If a subpoena requests a court appearance by an employee for an action unrelated to the administration of the agency's programs, the employee must obey the subpoena by appearing in court with the case record as directed.

There are several types of request for information used by our judicial system. Clarifications regarding disclosure may be routed on a case-by-case basis to the Office of Counsel Regional Attorney at the discretion of the Regional Office. Regional Office contacts the Regional Attorney once a subpoena is received.

The following is a list of requests encountered most often by our agency and the response required:

1. REGULAR SUBPOENA. These are often signed by clerks and are simply a request to appear in court. Failure to appear in court at the designated date and time will cause the agency to be held in contempt.

   a. Obey the subpoena and appear in court, with the requested information.
   b. Prior to disclosing the records or giving testimony relating to the case, advise the court that case material is confidential pursuant to KRS 194.060 and KRS 205.175. [Such information is subject to the confidentiality requirements of HIPAA and can only be released with a court order. For more about HIPAA see Volume I, MS 0127.]
   c. The court, at that time, may order disclosure of the records or information, and the factual contents of the case record must be shared.

2. GRAND JURY SUBPOENA. Although these are not court orders and a judge is not present at the proceeding, our Office of Counsel has clarified that information may be released to the grand jury.

a. The requested information can be provided to the prosecuting attorney or given during the grand jury appearance.
b. Failure to follow these instructions will cause the agency to be held in contempt.
c. [ALL information, requested by and provided to the grand jury, is confidential and subject to the confidentiality requirements of HIPAA, see Volume I, MS 0127. NO aspect of any case is to be discussed with anyone.]

C. Do not release information to attorneys, absent parents, etc., who appear in the local office with a subpoena. This does NOT apply to attorneys acting on behalf of the Agency, such as a county attorney involved in child support activities.

D. If the SUBPOENA is presented in the local office for release of information in a setting other than a courtroom or in the presence of a judge, contact Regional Office immediately. The supervisor is to advise the Regional Office of all such requests.

1. Clarifications regarding disclosure are routed on a case-by-case basis to the Office of Counsel Regional Attorney by the Regional Office.

2. [This allows for timely notice for the potential action.]

a. If time permits, the Regional Attorney may intervene on behalf of the local office staff. The Regional Attorney might contact the attorney who requested the information to advise him/her that a representative of the Agency would appear but could not give testimony without a court order. This could not be accomplished without the presence of a judge.
b. Another option is the Regional Attorney might file a motion to set aside the subpoena. The time available would determine the method.
c. If the employee is not required to appear, the Regional Attorney will notify the local office through the Regional Office.

E. Unless notified otherwise by Regional Office or the Court, the employee must appear as directed by the subpoena. [If the subpoena requests an employee to provide case information by appearing somewhere other than a courtroom setting, such as a lawyer's office, the employee must appear and explain that case material is confidential pursuant to KRS 194.060 and KRS 205.175, and subject to the confidentiality requirements of HIPAA, see Volume I, MS 0127. The employee must further explain that the information cannot be disclosed without a court order.] If there is not enough time for intervention, do not forward to the Regional Attorney. The employee must appear as directed.

MS 0132 REVIEW OF CASE RECORD OF LIVING OR DECEASED RECIPIENTS

Pertinent parts of the case record may be reviewed upon request by the recipient, committee, or representative authorized by forms DCBS-1, Informed Consent and Release of Information and Records, and DCBS-1A, Informed Consent and Release of Information and Records Supplement.

An individual, other than the recipient, with the written consent of the recipient may review any portion of a case record a recipient is allowed to view. Pertinent parts include forms completed by the recipient, worksheets, correspondence to or from the recipient, MRT decisions and non-confidential medical records related to the hearing issue.

[Non-confidential medical records may also be shared if requested in connection with an application for federally sponsored or assisted programs providing support on the basis of need (e.g., SSI disability claims, etc.). The recipient is NOT permitted to view medical records marked as "confidential – not to be viewed by (shared with) the patient", confidential material, names of individuals providing information, the nature or status of criminal proceedings, or any records subject to HIPAA procedures. For more information regarding HIPAA see Volume I, MS 0127. If the recipient requests to view confidential material, inform the recipient that he/she must obtain a court order before the material can be released.]

Child support payment screens are often printed and maintained in the case record. If the child support printout contains tax refund information, that information is removed or blocked out. The tax refund amounts are absent parent/IRS material and must safeguarded following procedures listed in Vol. I., MS 1915 C1.

To assist a recipient or his representative in a decision as to whether to request a hearing or to prepare for a hearing after a request has been filed. The recipient or representative may review pertinent parts of the case record, including non-confidential medical records RELATED to the hearing issue. Case record inspection is conducted in the local office with care taken that no part of the record is lost. If requested, copies of the record pertinent to the issue are prepared for the recipient or his/her representative.

RECORDS OF DECEASED RECIPIENTS

[Information needed for settlement of a former recipient'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 0127.]

MS 0136 RECIPIENT PRIVACY

[Respect the recipient's right to privacy. Safeguard the privacy of the recipient's information per HIPAA policy found in Volume I, MS 0127.]

A. Do not conduct interviews in the presence of a third party without the recipient's consent.

B. Do not discuss confidential information with collateral contacts.

C. Do not discuss case situations informally.

MS 0140* DOCUMENTATION

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 are 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 were understood by 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 is in to apply 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 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; or
   m. The joint custody of children within the household.

B. Additional documentation for the Food Stamp Program:

Comment on any unusual circumstances such as atypical consideration of deductible expenses.

C. Additional documentation for MA programs:

1. Comment on any unusual circumstances pertaining to any type of MA Program, such as:

   a. Retroactive coverage; or
   b. Third party liability (TPL).

   Comment on any unusual circumstances pertaining to Family MA or AFDC-Related MA, such as:

   a. Medical Support Enforcement (MSE) referrals and good cause;
   b. Deprivation factors for children; or
   c. The reason for a field determination of incapacity.

2. Comment on any unusual circumstances pertaining to Adult MA, such as:

   a. A change in the level of care;
   b. Vehicles, properties, property records check, life insurance policies, burial reserves, prepaid burial funds, pre-arranged funeral trusts or contracts regarding irrevocability or ownership that impact resource eligibility; or
   c. Resources requiring review or approval from Central Office (Central Office MUST review all annuities, all trusts, burial reserves over $10,000, QIT's, homestead extension requests, undue hardship request and forms relating to these types of resources).

      Note: Prior to sending an item for DMS review make sure that the LTC case and/or Waiver case has an initialed and signed MA-34, Declaration of Annuities. This is a requirement for all LTC and Waiver cases.

D. Additional documentation for K-TAP programs:

Comment on any unusual circumstances pertaining to K-TAP and Kinship Care, such as:

1. The reason for a field determination of incapacity; or
2. Why separate cases are set up to accommodate standard filing requirements.

NOTE: 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 Hearing Branch, Department of Medicaid staff, clients and their legal counsel.

If a recipient, related to or a close acquaintance of a worker, comes in to the local office to make an application, that worker does not take the application nor does the supervisor assign that case to the worker. This includes family members related by birth or marriage, through first cousins. The worker is responsible for advising the supervisor if the applicant is a relative or close acquaintance.

Supervisors or designated persons accept and process applications filed by DCBS employees.

A. All applications or reapplications must be acted on promptly. Except in unusual case situations, no longer than 30 days is to elapse between application date and authorization for action date. If the time frames required by the specific program are not met, document the reason for delay in the case record.

To assure authorizations for action are transmitted promptly, each office must:

1. Review cases of workers without case decision immediately;

2. Expedite pre-audit procedures; and

3. Submit all authorizations on the same day as prepared.

B. [For benefit programs other than Food Stamps, contacts with the Department by or on behalf of potential applicants not resulting in an application, complete an “Inquiry/Update PAFS-97”, by selecting option “I” off the KAMES menu.

C. For food stamp cases, the “Inquiry/Update PAFS-97” is only to be completed when the KAMES application must be deleted because the applicant refuses to complete the shortened version of the on-line application.]

If a representative has not been designated in writing by the household, complete form KIM-77 to protect the household’s application date. Provide the individual making application with form FS-120, form KIM-100, Supplement A to be completed by the household and a manually completed form PAFS-2 requesting a written statement from the household authorizing the individual to make application. Schedule an interview within 10 days for the application to be completed. If the application appointment is kept and all verification, including written authorization designating the

representative, is received, process the on-line application. If the appointment is not kept, at the end of 30 days process a paper denial and send the household from FS-105.

D. Ongoing eligibility is reviewed periodically as required by specific program guidelines.

E. Deny an application for assistance or discontinue benefits if:

1. An individual withdraws the application or requests discontinuance;

2. It is established a technical factor or criteria of need is not met;

3. An individual fails to clarify questionable eligibility factors.

F. Use established computer systems to process case actions and authorize benefits.

MS 0151* GOOD CAUSE CODES FOR UNTIMELY CASE PROCESSING

As there are times that IM cases go past due through no fault of the worker, a "good cause" code is being added to pending applications, re-applications and program transfers for K-TAP, Adult MA, Family MA and Kinship Care cases. This code will allow cases that are pending for certain types of verification or reviews additional time past the 30-day time period to be considered as untimely with "good cause".

The following are the "good cause" reasons and the appropriate code for each type:

1 = Proof of Citizenship
2 = Client request for additional time for applicants to provide mandatory verification such as trusts, life insurance policies, income verification, etc.
3 = Medical Review Team (MRT) decision
4 = Department for Medicaid Services (DMS) response on reviews of Trusts, Annuities, Funerals over $10,000.00, etc.
5 = Spend down
6 = Kinship Care (KC)/ Permanency & Protection (P&P) issue when benefits are backdated.

The entry for "good cause" can only be entered on a pending application, re-application or program transfer case. Cases with a "good cause" entry will pend for supervisor approval before the case will dispose. The "good cause" reason field is not a required entry and entries can be deleted by either the worker or the supervisor if the entry was inappropriate. The case will no longer pend for supervisor approval if the good cause entry is deleted.

When taking a joint (IM/FS) application, both cases will pend if a "good cause" code is entered on the IM case. However, the Food Stamp (FS) case will process without supervisor approval for good cause once the worker goes back into the case.

The following are messages that will display on both the worker's and supervisor's DCSR:

A. "Good cause" entry and the case is not pending for any other reason is "PDG SVSR APR GOOD CAUSE".

B. "Good cause" entry and case is pending for mandatory verification is "PDG SVSR APR GOOD CAUSE – MMV".

C. "Good cause" entry and the case is pending for optional verification is "PDG SVSR APR GOOD CAUSE – MOV".

Once the case is processed, the code will remain in the case history. Workers are to document case notes thoroughly with the reason that the code was entered.

The following reports used in tracking case processing will reflect the cases that are untimely with "good cause" separately from those without "good cause":

HRFSSR1 – Combined Caseload Activity report;
HRKRMR1A – Application Activity by Unit report;
HRKRMR1B – Application Activity by Caseload report;
HRKRMR14 – Application Activity by County report;
HRKRMR17 – Application Activity Statewide report; and
HRKRMR1U – Applications Processed Untimely report.

HRFSSR1 Report:

For the county, region and state totals a field is added under the K-TAP, MA and KC fields for APPS. PROCESSED of "# UNTIMELY W/GC" to show the number/count of applications processed untimely/past due with good cause.

The addition of the field "# UNTIMELY W/GC" does not affect the percentage of cases shown as processed timely. The addition of this field is for informational purposes only to show how many of the "untimely/past due" applications processed were due to situations beyond the worker's control.

HRKRMR1A, HRKRMR1B, HRKRMR14, HRKRMR17 Reports:

The column heading for "PROCESSED PAST DUE REG" is changed to read "PROCESSED/PAST/TOTAL/GC". The total count of all processed past due is listed on the top line with the count GC (Good Cause) listed directly below. The total count of cases processed past due is not changed with the addition of the good cause past due counts but to show how many of the past due count had a "good cause" reason.

HRKRMR1U Report:

A column is added to this report titled "Good Cause Untimely". If an IM application is processed untimely and the case has a "good cause" indicator of 1 through 6, the reason code is displayed in this column. The totals for "Good Cause Untimely" is displayed by county, region and for the state.

MS 0153 CASE NUMBER ASSIGNMENT

A. [Assign PA-62 case numbers as follows:

1. Family MA: Case numbers consist of either 6 or 9 digits.] Assign numbers in sequence from the block of numbers allocated to the local office where the responsible worker is located. Once the number is assigned, that number is the permanent number of that case record. If a 9 digit case number is used, the fourth and fifth digits MUST ALWAYS be zero, (i.e., 123004567).

   For 6-digit case numbers, add three zeros before the 6-digit number (i.e., 000123456).

2. Adult MA and State Supplementation: Use the SSN of the applicant as the case number.

   a. Do not delay processing MA cases pending receipt of a SSN, as a pseudo number may be assigned. Develop a 9-digit pseudo number as follows:

      (1) First 3 digits are the county number preceded by zero for counties 1-99.
      (2) The first pseudo number issued in the county uses 6 nines as follows: 99-9999.] Subsequent numbers are assigned in descending order, 99-9998, 99-9997, etc. Maintain logs to assure duplicate numbers are not assigned.
      (3) Sample number: 034-J-034-99-9999.

   [Change the case pseudo number as soon as you receive the real SSN, if the case remains active.

B. The case number for a KAMES case is the SSN, whether verified or unverified, of the head-of-household.

   1.] If the head-of-household does not know his/her SSN or has never applied for SSN, assign a pseudo number by entering an “X” on the “Application/Recertification” Menu in the field, “For Option 1, if you wish an SSN assigned, please enter “X”.

   [2.] DO NOT manually assign the case a pseudo number unless this is a reapplication which was originally assigned a pseudo number. [In this particular instance, enter the same pseudo number.]

MS 0155* CASELOAD RESPONSIBILITY

Caseload responsibility is based on the following:

A. The county of residence of the applicant/recipient;

B. For IM cases, the county of residence of their statutory benefit payee, committee or guardian; or

C. The county where the Family Service Worker, Child Benefit Worker or the Department for Juvenile Justice caseworker applies.

1. If the county of residence of the recipient's parent/statutory benefit payee/committee/representative/power of attorney is the same as his/her county of residence or the county in which the LTC facility is located, the case is carried in that county.
2. If the county of residence of the recipient's parent/statutory benefit payee/committee is different than the county in which the LTC facility is located or the LTC facility is out-of-state, the case is carried in the county where the parent/statutory benefit payee/committee resides.

   If there is a representative or power of attorney, the case is carried in the county where the recipient resides unless the power of attorney is also the statutory benefit payee for other forms of assistance, such as SSI, RSDI, RR or VA.

3. If the recipient is a member of a K-TAP or Family MA case, the case continues to be carried in the county where the family resides.
4. If the recipient's parent/statutory benefit payee/committee/representative/power of attorney resides out-of-state, the case is carried in the county where the LTC facility is located.
5. Case responsibility for K-TAP or Family MA is as follows:
   a. The LTC individual is in a facility and the family group is in a different county.
      (1) The case remains in the county in which the family lives; and
      (2) DCBS field staff in the county in which the facility is located maintains contact with the LTC individual.
   b. LTC individual in an out-of-county facility applies for assistance based on disability.
      (1) Accept and process the application; and
      (2) Coordinate activity with the caseworker having responsibility for the family case.

MS 0156 CASE RECORD

The case record is the official document of the Department establishing accountability for the expenditure of state and federal funds. [The supervisor is responsible for insuring case records are properly maintained, purged of obsolete material, and accessible to staff.]

A. Each case record contains pertinent facts about each applicant and recipient. Information includes date of application, date and basis of disposition, facts essential to determination of initial and continuing eligibility, need for, and provision of assistance, and basis for discontinuing assistance. Discontinued case records are retained to provide accountability for expenditure of funds and for informational purposes.

B. Case records are readily accessible to staff at all times and are recognized as the official documents of the Department, establishing accountability for the expenditure of state and federal funds. Case records are:

1. Opened one at a time except for comparative study;
2. Purged of obsolete material;
3. Arranged in proper order;
4. Never stored in desks;
5. Returned to case record file on a timely basis;
6. Never removed from local office except to transfer to another county, the Hearing Branch, Quality Central or Regional Office.

MS 0159 CASE RECORD CONTENT

All case records represent a continuing documentation of eligibility for assistance. The case record contains sufficient material to substantiate validity of all authorized assistance.

A. The PA case record contains the following material as appropriate.

1. Applications;
2. Appropriate worksheets;
3. Computer entry forms;
4. Other forms used to document and verify eligibility for assistance, or vendor payments;
5. Notices;
6. Hearing information;
7. Information regarding overpayments and underpayments, as appropriate; and
8. Additional information/verification.

B. The FS case record contains the following material, as appropriate:

1. Applications;
2. Documentation;
3. Verification;
4. Forms;
5. Notices;
6. Hearing information;
7. Claims information;
8. Restoration information;
9. Any other relevant information.

C. All forms required to establish eligibility in a PA or FS case, but not completed at each case action, are moved forward and retained in the current packet. Subjects include, but are not limited to, the following:

1. Work registration;
2. Child Support;
3. EPSDT;
4. Incapacity/disability determination; and
5. Third Party Liability.

D. KWP related forms and material retained within the K-TAP case record. The K-TAP case record is divided into two sections with the KWP related material filed in the back section.

MS 0162 PURGING OBSOLETE MATERIAL

See Policy Clarification

Material not directly related to eligibility or benefit authorization is not retained. To assure records contain only relevant material, case records are purged of all outdated material during the recertification process.

DO NOT PURGE cases involving fraud or claims unless the claim is paid-in-full for 3 years. (See MS 0162 B regarding FS fraud claims.) If the claim has been paid-in-full for 3 years and has been kept for 5 years and is not involved in an audit, the case record can be purged. If the paid-in-full claim is involved in an audit, do not purge the case record until the audit is completed.

A. For benefit programs other than FS, material retained permanently in an active case is:

1. Case history sheet(s), PAFS-116;
2. All computer entry documents;
3. Application and need determination forms;
4. All forms used to establish technical eligibility;
5. All forms relating to Long Term Care;
6. Hearing decisions on which eligibility is based;
7. Any narrative recordings which established eligibility; and
8. All forms and material related to fraud or overpayment claims.

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 cases after 5 years. Purged material is shredded or burned.

B. For FS cases, maintain all local office records related to certification and issuance such as but not limited to, monthly reports, application registers and issuance listings, for a period of three years from the month of origin.

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

1. Material which is older than three 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, but not limited to, signed disqualification consent agreements, court determinations, signed waivers 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 1659.

2. Irrelevant material.

C. Local offices utilizing off-site storage facilities must provide case record material within 48 hours of the request by the FNS QC reviewers. All case records which are divided between on-site and off-site storage must be combined prior to pickup by the FNS QC reviewer.

MS 0166* TRANSFER OF CASE RECORDS ON THE PA-62 SYSTEM

Transfer active or pending case records on the PA-62 system when a change of address is reported by the individual or the county of residence has changed. EXCEPTION: For cases handled by a Department of Juvenile Justice (DJJ) worker, the case is carried in the county of the DJJ worker.

Cases with a statutory benefit payee, committee or guardian are carried active in the county in which the statutory benefit payee, committee or guardian resides and are transferred only if the statutory benefit payee, committee or guardian moves or changes. Cases are carried in the county of the power of attorney ONLY if that person is also the designated statutory benefit payee for other forms of assistance such as SSI, RSDI, RR or VA.

Cases whose statutory benefit payee, committee, guardian or power-of-attorney live out-of-state are carried in the county in which the applicant/recipient resides.

A. To transfer a case from county to county or from unit to unit within a county, transfer a case on or before the 26th day of the month. After the 26th day of the month, hold and transfer the case on the first workday of the following month.

B. Advise the applicant/recipient to notify the post office in the old county of residence of the new address.

C. If an applicant/recipient moves to another county, upon receipt of notification from either the applicant/recipient or the new county of residence, the Field Services Supervisor (FSS) or designated individual in the old county of residence, reassigns a PA-62 case by submitting form PA-62, PAS/LTC Authorization, showing the new county number, assigns a caseload code consisting of the responsible worker's county number and 099 and enters the new verified address of the applicant/recipient if known. Transfer the case record by form PAFS-25, Transfer of Case Record or Material, after form PA-62 clears V-print.

D. In the new county, the FSS or designated individual reassigns PA-62 case responsibility within 3 work days of receipt of the case record by:

   1. Submitting form PA-62 authorizing any changes, including the new address, if not previously entered by the county transferring the case; and

   2. Entering the caseload code of the worker with current case responsibility if the case is on the PA-62 System.

MS 0168 [TRANSFER OF CASE RECORDS ON KAMES]

For all programs, transfer active or pending case records, as needed, when a change of address is reported by the individual or the county of residence has changed. EXCEPTION: For cases handled by a Department of Juvenile Justice (DJJ) worker, the case is carried in the county of the DJJ worker.

Cases with a statutory benefit payee, committee or guardian are carried active in the county in which the statutory benefit payee, committee or guardian resides and are transferred only if the statutory benefit payee, committee or guardian moves or changes. Cases are carried in the county of the power of attorney ONLY if that person is also the designated statutory benefit payee for other forms of assistance such as SSI, RSDI, RR or VA.

Cases whose statutory benefit payee, committee, guardian or power of attorney live out-of-state are carried in the county in which the applicant/recipient resides.

[The following procedures are used to transfer an active or pending case on KAMES between counties.

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

1. Access Case Change and enter the new home and/or mailing address, including the new county code. Enter the previous verification source, unless new verification has been provided. Do not pend the change for verification of residency as this could have an adverse effect on companion cases. Residence must be reverified at the next recertification;
2. Access Case Change - Case General Information and delete or enter new verification of household size as necessary;
3. Document Comments;
4. The sending Field Services Supervisor (FSS) must immediately transfer the case to the supervisory caseload code for the new county. Enter "N" to "Send Notice?". If a notice is generated, it carries the name of the FSS in the new county as the caseworker.
   a. To obtain the caseload code enter "?" in the new caseload field on the case reassignment screen. On-line help displays the designated caseloads for county transfers.
   b. To update a designated caseload code, the FSS reports the change to KAMES security at (502) 564-0105.
5. Mail the hardcopy case record to the new county, accompanied by form PAFS-25 addressed to the FSS identified by on-line help. If a claim exists for the household, follow procedures found in Vol. I, MS 1512 for transferring that material.

6. The following procedures are unique for transferring FS and KWP cases.

a. Change the address. For food stamps, follow procedures in OM Volume II, MS 6765.
b. If the case being transferred contains a KWP participant, follow the procedures specific for transferring a KWP case located in Vol. I, MS 0170.
c. If a transferred FS case contains an ABAWD, make any necessary changes to the member's Tracking Report or disqualification file, if appropriate, prior to transfer. Notify the receiving county concerning the member's eligibility or ineligibility.
d. If a transferred FS case contains a member who has served, but not yet cured, a work related disqualification and the county of receipt is a waiver county, change the Cure Ind field to "Y" before the case is transferred.

7. Refer to MS 0419 for KenPAC transfer procedures.

B. The receiving county must follow these procedures:

1. The FSS receives a spot check "Case Transferred In-Do Reassign" the first workday after the sending county makes the caseload code change. The FSS reassigns the case to the appropriate worker and answers "Y" to "Send Notice?"; and
2. The DCSR of the new worker will display all spot checks and other DCSR messages related to the case. Access the case and take any required action.
3. If the case is received in an inactive ETP/ABAWD county, process a member add for any ineligible ABAWD or work registrant whose work related disqualification has been served and Cure Ind field has been changed to "Y".

C. Distribute verification received after case transfer as follows:

1. Verification received in the new county - hold and give to the appropriate caseworker when the case is assigned; and
2. Verification received in the old county - forward to the new county on the same day received.

D. When an active case with vendor payment requires transfer to another county, transfer the case in active vendor payment status. The receiving county completes the discharge transaction from the previous facility and the admission transaction to the new facility or address change to a private residence, as appropriate.

E. If the recipient reports the change of address to the new county, or applies for benefits and the worker discovers that an active case already exists in another county, do the following:

1. Obtain the recipient's current address and verify household size and shelter expenses;
2. Advise the applicant/recipient to notify the post office in the old county of residence of the new address.

3. Contact the worker responsible for the active case and request that it be transferred, giving all necessary information verbally; and
4. Conduct or reschedule a recertification interview, if it is the final month of the certification period and no recertification interview has been done in the other county.

F. When an FS case is transferred from an active ETP/ABAWD county to an inactive ETP/ABAWD county, the FSS takes the following action:

1. The active county acts on all outstanding work related spot checks before transferring the case;
2. The inactive county checks the DCSR for outstanding work related spot checks;
3. Within 24 hours of receiving a case with an outstanding work related disqualification, the inactive county verbally contacts the active county and returns the case for resolution; and
4. After the work related disqualification is entered and comments document these actions, the active county transfers the case to the inactive county.

G. If an individual comes into the office to apply, provide change information or request a recertification interview for a recipient in another county for whom they are responsible, take the following action:

1. The FSS or designated individual responsible for transfers is to call the county of residence for the applicant/recipient and request the case to be transferred to their county for case processing;
2. The caseworker enters the application, recertification or change information and accepts verification provided;
3. The RFI is given to the representative for return of the information to the county of residence for the recipient. Ensure they have the correct office address for mailing;
4. The FSS or designated individual responsible for transfers calls the recipient's county of residence to advise the case is being transferred back to the originating county; and
5. If information is returned to your office at a later date, ensure it is forwarded to the appropriate county for case completion.

H. The FSS or principal caseworker reassigns a case from one caseworker to another in the same county, by selecting Function “R” on the Main Menu. Complete the screen across, from left to right.

The new worker’s DCSR will display all spot checks and messages for a case that is reassigned.

I.] 099 Listing. Each month the computer generates a listing of all caseload codes with 099 in the 4-6 positions of the caseload code. This listing also shows the number of months this caseload code has been assigned and assists in tracking the disposition of case records transferred between counties. The listing is sent to the regional office.

[J. Applications filed in a county other than the county of residence must be accepted in the county of application and forwarded to the applicant's county of residence by the end of the following day.]

MS 0170

TRANSFER OF KENTUCKY WORKS CASES

This procedure for case transfer, applies only to K-TAP (C and W) cases assigned to case managers.

A. If the participant is not active in a component, the sending worker/case manager notifies the coordinator of the need to transfer the case out of county and relays the case name and new address.

The sending coordinator contacts by telephone or E-mail the receiving coordinator to determine the worker/case manager's caseload code, if applicable, in the new county.

The coordinator then sends form PAFS-628, Exchange of Information, to notify the existing case manager of the new caseload code.

1. The sending worker/case manager:
   a. Authorizes transportation and/or other supportive services payments due on STEP based on a completed form PA-33, Verification of Participation in Education or Training Activity, received in the old county prior to transfer. This is necessary when the caseload code change is accepted since the prior worker can no longer update STEP unless temporary access is obtained;
   b. Reassigns the case to the designated caseworker/case manager in the new county;
   c. Documents the STEP case record regarding the receipt of all forms due in the current month, whether the forms were complete and if all payments were issued. This information is also briefly summarized on form PAFS-25, Transfer of Case Record or Material; and
   d. Forwards any forms PA-33/KW-133, Verification of Post-Secondary Community Service, received after the case transfer to the new caseworker/case manager.

2. The receiving caseworker/case manager:
   a. Issues any forms PA-105/PA-33N necessary to obtain a complete form PA-33 or PA-33N by the end of current month;
   b. Enters payments upon receipt of complete forms;
   c. Manually issues forms PA-33 or KW-133, if appropriate. Update "Issue PA-33" field on the General Information screen, if appropriate, prior to activating the participant in a new component; and
   d. Schedules an appointment with the participant to explain component choices available in the new county and plans activities necessary to begin placement.

B. If the participant is active in a component, the sending caseworker/case manager notifies the case management coordinator of the need to transfer the case out of county and relays the case name and new address. [The sending case management coordinator contacts by telephone or e-mail the receiving case management coordinator to determine the caseworker's/case manager's caseload code, if applicable, in the new county.] The coordinator then sends form PAFS-628 to notify the existing case manager of the new caseload code.

1. The sending caseworker/case manager:

   a. Authorizes any supportive services payments due based on receipt of complete forms PA-33/PA-33N or KW-133. (This is necessary because after the caseload change is completed, the prior caseworker/case manager can no longer update STEP unless temporary access is obtained.);
   b. Reassigns the case to the new caseworker/case manager;
   c. Documents STEP regarding the status of forms returned and corresponding payments made;
   d. Briefly annotates form PAFS-25 regarding the status of forms and payments; and
   e. Verifies by phone, attendance and/or progress and last date attended with the provider if the client reports termination of a KWP component due to the move from the county and documents case record. This eliminates a problem for the participant whose new residence prohibits his/her return to the prior location for completion of form PA-33 or form KW-133 during the month following the move.

2. The receiving caseworker/case manager:

   a. Issues any forms PA-105/PA-33N necessary to obtain a complete form PA-33 or PA-33N by the end of the current month;
   b. Authorize payments upon receipt of completed forms PA-33 or KW-133;
   c. Schedules an appointment with the participant to introduce themselves and explain component choices available; and
   d. Refers the participant for placement in a new component, if appropriate.

MS 0172* TRANSFER OF DJJ CASES

Medicaid cases for children committed to the Department of Juvenile Justice (DJJ) are carried in the county where the DJJ worker is located. The county of residence matches the child's physical location. When transferring a KAMES case from one county to another, the residence county code and receiving caseload code must match or the transfer cannot be completed.

To transfer a DJJ case from one DCBS worker to another, do the following:

A. The sending county must:
   1. Contact the receiving county and advise them the case is coming;
   2. Change the county number on the case address screen to the county where the receiving DCBS worker is located; and
   3. Complete the case transfer.

B. The receiving county must:
   1. Reassign the case to the appropriate caseworker; and
   2. Change the county code to match the child's county of residence. This must be done on the same day the case is received.

MS 0174 GENERAL PROVISIONS FOR ASSIGNMENT OF CASELOAD CODES

Each worker and supervisor is assigned a unique caseload code.

If a new caseload is established, a previously unassigned caseload code in sequential order is given.

If a vacant caseload is filled, the new worker assumes the existing assigned caseload code.

The assignment of the caseload code or a change in the assignment of the code is reported by memorandum to the following address: Office of Technology Services, 275 E. Main St., 2E-B, Frankfort, KY 40621.

A. For KAMES cases, the caseload code is the combination of the county code and the worker code.

B. For cases on the PA-62 system, if case responsibility is permanently changed by reassigning the case to another worker or transferring the case out-of-county, the receiving worker submits form PA-62 changing the caseload code within 3 working days of being assigned the case. For changes in caseload code due to mass reassignment or balancing of caseloads, the receiving worker submits form PA-62 changing the caseload prior to the next computer deadline date.

If a worker processes case actions for an absent worker or a vacant caseload, enter the caseload codes of both workers.

MS 0175

DETERMINING CASELOAD CODE AND COUNTY OF RESIDENCE

Cases on both the PA-62 system and KAMES have reports generated by case-load codes. The caseload code is that of the worker responsible for the case. The case is carried in the county of residence for the applicant/recipient or in county of residence for the statutory benefit payee, committee or guardian. Recipients who have a power of attorney (POA) have their case carried in the county where the recipient resides unless the POA is also a statutory benefit payee for benefits such as RSDI, SSI, RR or VA.

Caseload code, address and county code are all separate functions on both systems. The caseload code must always be in the county where the responsible caseworker is stationed, since cases are reported by caseload code. The county code and address of the recipient is the county in which they reside which can be different from the county code of the caseworker responsible for case maintenance. This will ensure the recipient is sent the correct KY Health Card for managed care or non-managed care participation and Human Services Transportation Delivery (HSTD) system while the appropriate caseworker maintains case actions.

MS 0177

CASELOAD CODES

Each worker, or other staff responsible for completing casework is assigned one caseload code regardless of the number of programs for which the worker is responsible. A caseload code indicates the county and code of the worker responsible for that case. Codes are assigned by Quality Central personnel.

MS 0179 CASELOAD WEIGHTS

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

NA Food Stamps. 2.0
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
FAD. 3.0
Family MA/KCHIP. 1.6
TMA. 1.0
Non-Supplementation ABD/FGH. 5
PA1 Food Stamps. 1.4
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 0180 TIME DISTRIBUTION

See: OM Pol. Upd. 01-05, MS 99553, 5/1/01.
See OM Upd. No. 06-23, MS 99742, 9/16/06

Submit a completed form P-40, Employee Time Reporting, at the end of each payroll period indicating time spent on the various programs of the Department by entering the appropriate program/function code. The reports are the documentation used to allocate costs of administrations to the specific programs administered by the Department. It may be necessary to use pages 2 and/or 3 of form P-40, due to the addition of numerous program/function codes. In order to gather accurate information for Federal reports and funding, it is imperative that time be coded daily and accurately reflect activity. Additionally, enter the appropriate program/function code on all forms used for billing purposes.

MS 0183 TANF PROGRAM/FUNCTION CODES

See OM Pol. Upd. 01-05, MS 99553, 5/1/01.

These codes apply to all staff except as indicated below.

A. ZAGG – TANF Case Management Activities: Individuals use this code for time spent directly related to the assessment, the transitional assistance agreement providing supportive services including car repair and relocation, referral for services, etc., and entering and updating data on STEP.

B. ZAGQ – TANF Eligibility Determination and Administration: Individuals use this code when performing K-TAP eligibility determinations. This does not include time spent on Family Alternatives Diversion (FAD) program. Also, supervisors, Service Region Administrators, Regional Office staff, clerical support staff and Quality Central staff use this code for administrative activities not directly related to TANF work activities or TANF eligibility determinations. These activities include staff meetings, personnel actions, time keeping, case reviews, etc.

C. [ZAG4 – TANF Work Incentive (WIN) Reimbursements: Individuals use this code for time spent on providing WIN reimbursements.]

D. ZAGS – Kinship Care Eligibility Determination: Individuals use this code for time spent on performing Kinship Care eligibility determinations.

[E.] ZAGR – TANF Training: Individuals use this code for time spent in K-TAP and Kentucky Works training.

[F.] ZBAT – Child Support Training: Individuals use this code for time spent in child support training.

MS 0186 FS PROGRAM/FUNCTION CODES

See OM Pol. Upd. 01-05, MS 99553, 5/1/01.

These codes apply to all staff. If clerical staff cannot identify a specific code, use ZABE.

A. [ZABA.] Use this code for food stamp eligibility determinations for PA households; including activities such as interviews with the applicant, processing the food stamp application, and subsequent certification of eligibility.

B. [ZABB.] Use this code for food stamp eligibility determinations for NA households, including activities such as interviews with the applicant, processing the food stamp application, and subsequent certification of eligibility.

C. [ZABC. This code is used only by Quality Central staff who issue food stamps.

D. ZABE.] Use this code for central and local office administration and direction of the Food Stamp Program including clerical staff whose time cannot be assigned to specific program functions.

E. [ZABH. Use this code for all Management Evaluation charges by Management and Evaluation staff.

F. ZABM.] Use this code for all food stamp IPV related claims activity.

G. [ZABP.] Use this code for all food stamp IHE and AE related claims activity.

H. [ZABR. This code is used only by Quality Central and Regional Office staff who conduct food stamp outreach activities.

I. ZABS.] Use this code for Electronic Benefit Transfer (EBT) activities. This code is used only by Department personnel who are engaged in EBT activity.

J. [ZABV.] Use this code for Food Stamp Employment and Training activities. This code is used only by the county designated FSETP worker.

K. [ZAB1. Food Stamp Training: Individuals use this code for time spent in Food Stamp training.]

MS 0189 MEDICAID PROGRAM/FUNCTION CODES

See OM Pol. Upd. 01-05, MS 99553, 5/1/01.

A. ZACA. Use this code for the administration of the Medicaid program, eligibility determinations for Medicaid, auditing and clerical responsibilities. This code includes involvement with aged, blind, and disabled SSI recipients. Also code activities pertaining to Medicaid Quality Control and Hearings to this code.

B. ZACB. Use this code for Transitional Medical Assistance (TMA) activities.

C. ZACC. Use this code for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) activities.

D. ZACE. Use this code for activities related to applications in the "I" category accepted at off-site location.

E. ZACH. Use this code for activities related to processing claims, hearings, and collections related to Medicaid IPV process.

F. ZACM. Use this code for time incurred by trainers providing Medicaid basic training and by new employees attending basic training. Also use for travel and per diem expenses by trainers providing Medicaid basic training and new employees attending basic training.

G. ZACN. Use this code for estate recovery activities.

H. ZACR. [Use this code for the administration of the KCHIP program, eligibility determinations for the KCHIP program, auditing and clerical responsibilities.]

MS 0192 STATE SUPPLEMENTATION PROGRAM/FUNCTION CODES

A. ZADA. Use this code for the administrations of the State Supplementation Program including processing an application or reviewing or adjusting a State Supplementation payment. Normal eligibility determination activities are included. Also use this code for training and travel and per diem expenses associated with State Supplementation training.

B. ZADJ. State Supplementation training. Use this code for time spent in State Supplementation training.

MS 0195 OTHER ADMINISTRATION

A. ZACG. Use this code for Kentucky Physicians Care (KPC) Program activities.

B. ZAAR. Workers, case managers and other individuals use this code for time spent determining eligibility for FAD, both approvals and denials, and issuing FAD payments.

C. ZTRN. Use this code for training when other training codes for specific programs do not apply.

D. ZXAA. Use this code for all administration within the Department for Community Based Services which cannot be assigned to specific programs.

MS 0300 GENERAL REQUIREMENTS

See OM Upd. No. 07-21, MS 99770, 10/1/07

A. [Payments to eligible recipients or supportive services providers are made by check mailed from Quality Central. Exception: K-TAP recipients may request the direct deposit of their benefits.] Refer to MS 0302.

Lost, stolen, or mutilated checks are subject to replacement upon request. The process is NOT limited to situations reported during the month the check was intended to be received. This does not apply to checks cancelled by the worker because the recipient moved and could not be located. Checks cancelled because the worker was unable to locate the recipient are not replaced if the request is made after the expiration of the month covered by the cancelled check.

B. Those to whom payments are directly made include:
1. The specified relative with whom a child lives, or the relative's committee;
2. A protective payee;
3. The individual, payee or committee of the aged, blind, or disabled individual;
4. Providers of supportive services for participants; or
5. Kentucky Works participants for transportation expenses.

Employees of DCBS may not act on behalf of the payee by receiving, cashing, or co-signing checks.

C. The amount of K-TAP payment is based on computation of basic needs. There is no restriction on its use, it cannot be attached, and creditors cannot place a claim on it for debts.

D. When a recipient receives benefit of the check but does not pay outstanding bills, it is NOT the responsibility of the Agency to issue payment to the vendor. The settlement of the debt is between the recipient and vendor.

MS 0302 K-TAP/SSP DIRECT DEPOSIT

[K-TAP and State Supplementation (SSP) recipients, who have an open checking account, can choose to have K-TAP or SSP checks deposited directly into a checking account.

For K-TAP benefits, the Electronic Benefit Transfer (EBT) is another method available to K-TAP recipients who do not choose to have his/her check deposited directly into a checking account. This does NOT include KWP supportive services checks, relocation assistance payments or any other non-monthly K-TAP checks. These benefits are mailed in the form of a check to the recipient's mailing address.

K-TAP supplemental benefits resulting from case change actions on KAMES are deposited in the EBT account, including direct deposit cases, unless benefits are authorized by special circumstance. If benefits are authorized by special circumstance, the benefits are issued by a check.

SSP supplemental benefits and special circumstance payments will be mailed in the form of a check to the recipient's mailing address.

Direct deposit of the K-TAP or SSP check is optional. Recipients are not required to open a checking account. However, direct deposit is not possible without an existing checking account. Direct deposit can NOT be made to savings accounts.

The total amount of the K-TAP or SSP check must be deposited into one checking account. The amount of the K-TAP or SSP check cannot be divided among accounts.

A. Questions regarding direct deposit are on the case general information screens.

1. Ask all applicants/recipients, at application and at recertification, if they want the K-TAP or SSP check to be direct deposited.

2. If the applicant/recipient does not want direct deposit, answer "N" to the question "Do you want direct deposit?" on KAMES. No additional action is needed.

3. If the applicant/recipient wants the K-TAP or SSP check to be direct deposited, answer "Y" to the direct deposit question on KAMES.

B. Follow the process outlined below if the applicant/recipient wants to direct-deposit the K-TAP or SSP check.

1. Provide the applicant/recipient with form PA-63, Direct Deposit Authorization, for completion. Advise the applicant/recipient that form PA-63 is the only form that can be used to request direct

deposit of a K-TAP check. The applicant/recipient must sign and date this form.

2. If the applicant/recipient provides a blank check write "VOID" across the front of the check and attach it to form PA-63.

3. Refer to the bottom left of the check and enter the first 8-digits of the bank routing number and the applicant's/recipient's account number (up to 17 digits, both alpha and numeric) from the check onto KAMES.

   a. When using a check, the check number, which is found in the upper right hand corner, is also repeated at the end of the bottom row of numbers. Be sure you do not record the check number as part of the account number or bank number.
   b. The bank number is a 9 digit number; however, KAMES calculates the 9th digit internally.
   c. If the bank routing number does not match against a file provided by Treasury to KAMES, the message "Bank no. entered not valid" displays. The worker cannot leave this screen until the bank routing number is matched against the file or the checking account number and bank number are deleted. Once deleted, the case pends for 10 calendar days.

4. If the applicant/recipient does not have a blank check, give the applicant/recipient form PA-63 to take to the bank for completion.

5. The case will pend for the bank routing number and account number to be entered on KAMES for 10 calendar days. At the end of the 10-day period, if the applicant/recipient has not returned form PA-63, the direct deposit indicator is changed to "N" and the case is processed. K-TAP benefits will be deposited to the EBT account unless direct deposit is in place. A normal check issuance will occur for State Supp.

6. If the applicant/recipient provides a completed form PA-63 after the 10-day period, change the direct deposit entry on KAMES to a “Y” and enter the bank routing number and checking account number.

C. To add direct deposit, at recipient's request, at times other than application or recertification, send a form PA-63 to the recipient. When the completed form PA-63 is returned, complete a case change on KAMES following the steps item B. It takes a minimum of two months to affect a change for direct deposit.

   Example: A change is made before cut-off in September. The October check will be a regular EBT issuance. The November check will be direct-deposited. If the change is made after cut-off in September, October and November benefits will be a regular EBT issuance. The December check is direct-deposited.

D. If a recipient on direct deposit changes banks or changes the checking account at the same bank, complete a form PA-63 to stop the direct deposit on the prior checking account number and/or at the previous

bank and to add the new checking account number and/or new bank routing number following the steps in item B.

E. To stop the K-TAP direct deposit and revert back to monthly EBT issuance, complete form PA-63 indicating the stop order and enter the change on KAMES. To stop the State Supp direct deposit and revert back to monthly check issuance, complete form PA-63 indicating the stop order and enter the change on KAMES.

F. Advise the applicant/recipient to report a change in direct deposit information as soon as the change occurs. Explain to the applicant/recipient that the change will be effective the second monthly issuance following the change – if the change is completed prior to cut-off.

G. If the recipient wants to return the monthly K-TAP or State Supp direct deposit payment for any reason, the recipient provides the local office a certified check or money order for the benefit amount. The certified check or money order is made payable to the Kentucky State Treasurer. Forward the certified check or money order along with a completed Form PAFS-61, Notice of Returned Check and Authorization for Disposition, to:

Division of Administration and Financial Management
Cabinet for Health and Family Service
275 E. Main Street, 3W-C
Frankfort, KY 40621

Annotate in item 6, on form PAFS-61 that the certified check or money order is for the return of a K-TAP or State Supp direct deposit.

H. If a recipient has requested direct deposit and the change on KAMES has been completed, direct deposit will begin with the second monthly issuance following the change on KAMES – if the change is completed prior to cut-off. If the direct deposit has not begun by this time, check the bank routing number and checking account number on KAMES. If this information is correct, there may be a problem with the bank's receipt of the information, rejection by the bank, etc.

For K-TAP direct deposit issues contact the Family Self-Sufficiency Branch and for SSP direct deposit issues contact the Medical Support and Benefits Branch. Contact information for both branches is CHFS, 275 E. Main St., 3 E-I, Frankfort, KY 40621, (502) 564-7050.]

MS 0303 ENDORSEMENT OF CHECKS

Checks are endorsed by the person in whose favor they are drawn using the name as it appears on the face of the check. If the check is endorsed by a parent, committee, guardian, executor, or administrator, the endorsement must read “Parent of”, etc. Endorsements by mark are witnessed by at least one person, not related to the recipient, with full signature and address.

MS 0304 CHECKS RECEIVED BY THE LOCAL OFFICE

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, if 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. A monthly printout of all checks with a local office address is received by the Department. Each of these checks must have been cancelled or delivered. [Additionally, a report is generated which must be annotated and returned to Central Office.]

D. 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 Fiscal Services:

[Cabinet for Health and Family Services
DCBS – Division of Administration of Financial Management
275 E. Main Street, 3W-C
Frankfort, KY 40621
DO NOT FORWARD]

Indicate on the envelope what type of check it is.

MS 0306 RETURNED CHECKS

A. Checks including K-TAP, Food Stamp Employment and Training Program (FSETP), supportive services, FAD and State Supplementation, which cannot be delivered are returned to Quality Central. The worker is notified of the returned check by form PAFS-61 and the worker responds immediately according to procedural instructions for that form.

B. Authorize cancellation of a check if:
   1. The recipient of supplementation died prior to the first day of the month for which the check was issued; or
   2. 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 unless some attempt has been made to locate the recipient. If, subsequent to the cancellation of the check but prior to the expiration of the month covered by the cancelled check, the location of the recipient becomes known, the check must be made available to the recipient. This applies only to cancelled checks.
   3. The recipient voluntarily returned a K-TAP check to avoid an overpayment. See Volume I, MS 1851.
   4. A supportive services provider returns a duplicate payment.
   5. A supportive services payment is returned due to an incorrect amount or provider on the check. In this instance, the correct payment is reissued on STEP by the caseworker/case manager. See Forms Manual, Section III, procedural instructions for form PAFS-61.

   [Note: Once the check has been redeposited on the system, “CA” will appear in the benefit status field on inquiry. Workers will need to manually adjust tracking on the number of months of receipt.]

C. Remail a K-TAP or State Supplementation check if return was due to an incorrect address and the current mailing address is established. FAD and supportive service checks (except transportation) cannot be remailed. Take action to correct the address to assure delivery of subsequent checks.

D. Reissue a K-TAP 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 and reissue.)

   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, the check can be reissued to:
   1. The widow, parent, or guardian; or
   2. 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.

MS 0307 [SUPPORTIVE SERVICES REFUNDS AND ADJUSTMENTS

Use the following procedures for supportive services refunds and adjustments.

A. When a supportive services provider is paid by the Department for Community Based Services (DCBS) in error and has cashed the check and subsequently refunds either a partial amount or the total amount of the payment, the refund should be made via check made payable to the Kentucky State Treasurer. Forward the check with form PAFS-61, Notice of Returned Check and Authorization for Disposition, to:

Cabinet for Health and Family Services
DCBS – Division of Administration and Financial Management
275 E. Main St., 3W-C
Frankfort, KY 40621
DO NOT FORWARD]

Refer to procedural instructions for form PAFS-61.

[B. When form PAFS-61 is submitted to cancel a STEP payment or to refund a partial or complete repayment, DCBS – Division of Administration and Financial Management (DAFM), Fiscal Services Section, redeposits the funds. The Fiscal Services Section forwards a copy of form PAFS-61 to the Family Self-Sufficiency Branch, who ensures that STEP is adjusted accordingly. When the adjustment is made, the original county code of the staff who authorized the payment is changed to 121.]

MS 0309 MUTILATED CHECKS

[When a payee brings a mutilated or defaced check to the local office, return the check by form PAFS-61, Notice of Returned Check and Authorization for Disposition, to:

Cabinet for Health and Family Services
DCBS – Division of Administration and Financial Management
275 E. Main St., 3W-C
Frankfort, KY 40621
DO NOT FORWARD]

Annotate the envelope as to the type of check being returned, (e.g., Attention: K-TAP, Kinship Care, WIN, Supportive Services, FSETP or State Supplementation).]

Request reissuance of the original check be mailed immediately to the payee.

MS 0310 FAD PAYMENT ADJUSTMENTS

[All FAD checks which are cancelled or partially reimbursed are submitted with form PAFS-61, Notice of Returned Check and Authorization for Disposition, to:

Cabinet for Health and Family Services
DCBS – Division of Administration and Financial Management
275 East Main Street, 3W-C
Frankfort, KY 40621
DO NOT FORWARD]

DCBS – Division of Administration and Financial Management (DAFM), Fiscal Services Section, redeposits the funds and the Family Self-Sufficiency Branch (FSSB) staff adjust the FAD payment records and FAD available balance.] If a partial refund is submitted, the amount paid is altered and the balance adjusted.

[Lost or stolen FAD checks are processed the same as K-TAP checks.]

If a FAD check is stolen and cashed, the replacement check is NOT issued until the funds are collected from the entity which cashed the check. [K-TAP and Kinship Care checks are the only checks which are replaced before collection is completed.

If it is believed that a FAD check has been stolen, staff may call DAFM at (502) 564-7718 or (502) 564-7010 to determine whether the check is outstanding or has been cashed. If the check has not been cashed, a request for stop payment is made. If the stop payment holds, the check can be reissued.]

MS 0312 LOST AND STOLEN CHECKS

See OM Upd. No. 07-21, MS 99770, 10/1/07

A payee may request a replacement of a lost or stolen check. (K-TAP, Food Stamp Employment and Training Program, supportive services, FAD and State Supplementation.)

A. If the payee reports nonreceipt, loss, or theft of a check, verbally request the payee come into the office within 4 work days to sign form PAFS-60, Affidavit. It is assumed the check is lost or stolen if at least 1 day has elapsed since the normal delivery date, the person has not moved and the worker is aware that other persons received their checks. A K-TAP payee must report the loss or theft of a K-TAP check within 6 months of the intended receipt in order to receive a replacement. (Refer to MS 0315.)

B. Form PAFS-60 is REQUIRED before a replacement check may be issued. Following the report by the payee:

1. Send form PAFS-2 documenting the verbal appointment.
2. Inform the payee to return the original check, which is issued in a self-sealed envelope known as thermo-bond, to the DCBS office if the original check is received after form PAFS-60 is signed since a replacement check is forthcoming. The replacement check is yellow and not thermo-bond.

C. If the payee is a supportive services provider, send form PA-64, Provider Appointment Letter, to document the appointment. Form PA-64 also provides instruction for the provider to return form PAFS-60 signed and notarized if the provider chooses not to come in to the office.

D. If the payee fails to keep the first scheduled appointment to sign form PAFS-60:

1. Schedule a second appointment within 3 work days;
2. File copies of the appointment letters in the case record; and
3. If second appointment is missed, document the case record accordingly. No further action is required.

E. If the payee comes into the office, conduct the interview to determine if:

1. The check had been signed before the loss or theft;
2. Other persons in the neighborhood received their checks;
3. The payee recently moved and failed to provide a forwarding address to the Post Office; or
4. A change of address was submitted too late to redirect mailing of this check.

MS 0315 [REQUEST FOR DUPLICATE CHECK]

See OM Upd. No. 07-21, MS 99770, 10/1/07

A. [If the payee reports nonreceipt, loss, mutilation or theft, a duplicate check may be requested if the check has not been cashed. If a duplicate request is made by a representative due to the payee's physical or mental inability to do so, contact the Family Self-Sufficiency Branch (FSSB) through your Regional Office.

For K-TAP, Kinship Care or WIN checks, the payee must report the nonreceipt, loss, mutilation or theft of a check within 6 months of the intended receipt in order to receive a duplicate. Duplicates are not issued for requests made after the 6-month time limit.

EXAMPLE: The issuance date of the K-TAP check on KAMES is 6/6/97. The individual may request a duplicate of the K-TAP check through the end of 12/97. If the individual reports the nonreceipt, loss or theft of the K-TAP check in 1/98 or after, the duplicate request is denied.

If a request for a duplicate check is made after 6 months from the date of intended receipt of the check, verbally inform the individual of the duplicate request time limit. Complete form PA-105, Notice of Eligibility or Ineligibility, to inform the individual in writing of the denial of the duplicate request and to provide the individual his/her hearing rights concerning actions taken by the Agency.

B. Prior to having the client sign a form PAFS-60, Affidavit, requesting a duplicate check, explain the following:

1. Monthly K-TAP checks are mailed on the last work day of the month.
2. General rule-of-thumb is to wait 7 to 10 days from the daily check issuance date before completing form PAFS-60 requesting the duplicate.
3. Explain to individuals that it may be beneficial to wait a few days because the checks may overlap, and the original check cannot be cashed once a stop-payment is called in and a signed form PAFS-60 is sent to DCBS – Division of Administration and Financial Management (DAFM), Fiscal Services Section.

4.] A stop payment is placed on the missing check as soon as form PAFS-60 is signed. [A duplicate check can then be issued. Supportive services payments are not reissued as quickly as K-TAP checks due to different processing procedures.

5.] If, after the stop payment is authorized, the original check is found:
   a. The worker MUST be notified at once prior to the recipient or payee cashing the check. NOTE: The original K-TAP check is issued in a self-sealed envelope known as thermo-bond.
   b. [Inform the payee the duplicate check is NOT thermo-bond or system-generated.

c. Reiterate to the recipient (payee), after form PAFS-60 is signed, the payee MUST return the original thermo-bond check to the worker if found, and cash only the yellow duplicate check. If the original check is returned, cancel the original check utilizing form PAFS-61, Notice of Returned Check and Authorization for Disposition, and indicate form PAFS-60 was signed.

6. The duplicate procedure requires cooperation of the payee by timely signing of form PAFS-60 attesting to the loss; and

7. If it is found that the payee actually received the benefit of the reportedly lost check and a duplicate check, a claim will be established which the client must repay.

C. If, after a careful explanation of the duplicate process and the penalties for misrepresentation, the client (payee) requests a duplicate even if only one day has elapsed from the normal delivery date:

1. Make sure the check was not direct deposited. If a check was direct deposited, it cannot be replaced.
2. If the missing check was mailed to a P.O. Box, question the client thoroughly as to how the check could have been stolen from a locked P.O. Box.
3. If the client's mail is being delivered to a home address, advise the client to take measures necessary to prevent a repeat occurrence.

   Encourage clients to use Direct Deposit to eliminate theft of checks. If Direct Deposit is not an option for the client, workers might explore other options and as a last resort, suggest P.O. Box rental as an alternative means of protection against theft.

4. Complete form PAFS-60 when a duplicate check is requested. Workers must complete all portions of the “Agency Use Only” section of form PAFS-60 which pertain to the type of duplicate check being requested. Always provide the case name and number, as well as the worker name and code. It is impossible to process form PAFS-60 without the client's Social Security Number. Omitting information will delay processing of the duplicate check request because incomplete forms are returned to the field.

   The worker completes Parts I, III and IV for duplicate check requests. The client and Notary Public or Field Services Supervisor (FSS) must sign Part IV for duplicate check requests.

5. After the recipient (payee) signs form PAFS-60, the FSS or notary signs the form.
6. The FSS IMMEDIATELY calls DCBS – Division of Administration and Financial Management (DAFM), Fiscal Services Section, at (502) 564-7718 or (502) 564-7010 to determine if the missing check has been returned by the Post Office.]

   a. If the check has been returned, it is remailed to the correct address.
   b. [If the check is not found, the FSS or designated individual requests a stop payment on the check. The FSS or designated

individual provides a case name, case number, caseload code and caseworker phone number. DAFM, Fiscal Services Section, provides the control (log) number to be entered on form PAFS-60.

7. The FSS or designated individual immediately forwards the original form PAFS-60 to DAFM, Fiscal Services Section. A completed form PAFS-60 must follow a stop payment request to DAFM, Fiscal Services Section.
8. When form PAFS-60 is received by DAFM, Fiscal Services Section, and the stop payment holds (put in place before the check clears the bank), the duplicate check is issued. If the check is cashed before the stop payment is in place, refer to MS 0318 for further replacement procedures.

Under administrative regulation promulgated under KRS 205.170(1), all supervisors and Service Region Administrators (SRA) are empowered to administer the oaths required to complete form PAFS-60 for requests of duplicate checks only.]

D. After form PAFS-60 is completed or the payee/copayee refuses to sign, mail the original form PAFS-60 in a white number 10 envelope to:

[Cabinet for Health and Family Services
DCBS – Division of Administration and Financial Management
275 E. Main St., 3W-C
Frankfort, Ky. 40621
DO NOT FORWARD

Annotate the envelope as to the type of check, (e.g., Attention: K-TAP, Kinship Care, WIN, Supportive Services, FSETP (Food Stamp Employment and Training Program) or State Supplementation).]

For FAD payments, see FAD procedures in MS 0310.

E. Following completion of form PAFS-60, if the recipient/payee reports the original check has been received or found, instruct the recipient to return the original check to the local office. [Forward the returned check to DAFM, Fiscal Services Section, with form PAFS-61 according to form PAFS-61 procedural instructions.]

MS 0316 STEP CHECK ADJUSTMENTS

[When form PAFS-61 is submitted to cancel a STEP payment or to refund a partial or complete repayment, the General Accounting Branch redeposits the funds. The General Accounting Branch forwards a copy of the PAFS-61 to the Program Assistance and Resource Branch, who ensures that STEP is adjusted accordingly.] When the adjustment is made, the original county code of the staff who authorized the payment is changed to 121.

MS 0318 [REPLACEMENT CHECKS]

See OM Upd. No. 07-21, MS 99770, 10/1/07

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

A. [DCBS – Division of Administration and Financial Management (DAFM), Fiscal Services Section, obtains a copy of the cancelled check and mails a copy and the replacement check to the Field Services Supervisor (FSS) or the designated individual.]

B. The supervisor or designated individual immediately schedules a face-to-face interview with the individual to view the endorsement of the cashed check and to complete form PAFS-60, Affidavit, Parts II, III, and IV. Part IV MUST be signed by a Notary Public. The form cannot be signed by a supervisor who is not a Notary Public. If a Notary Public does not sign the form, the form is returned by Treasury requiring the signature. A new form PAFS-60 must be completed with all signatures. This will cause a delay in the replacement check.

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

1. [If the individual states the signature is his/hers, return the replacement check with form PAFS-61, Notice of Returned Check and Authorization for Disposition, explaining why the replacement check is being returned to:

   Cabinet for Health and Family Services
   DCBS – Administration and Financial Management
   275 East Main Street, 3W-C
   Frankfort, Ky. 40621
   DO NOT FORWARD]

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, give the replacement check to the individual. [Send the signed PAFS-60 to DAFM, Fiscal Services Section.] File the copy of the signed PAFS-60 and the copy of the cancelled check in the case record.
3. [If the individual fails to view the endorsement or does not sign form PAFS-60, return the replacement check with form PAFS-61 to DAFM, Fiscal Services Section, explaining why the check is being returned.] Do NOT give or mail the replacement check to the individual. File the copy of the cancelled check in the case record.

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

[The FSS or designated individual must respond to DAFM, Fiscal Services Section, within 10 calendar days from receipt of the request to view the endorsement.]

C. The replacement checks must be kept in a secure location. Do NOT allow the checks to be kept by the individual workers.

[D. If within six months of the first duplicate check, a second duplicate check is requested by the client, follow the procedures for duplicate check requests. In addition, change the mailing address for the checks to the local office address and require the client to pick up checks at the local office for the next six months.]

MS 0324 COMMITTEE APPOINTMENTS

See OM Upd. No. 07-21, MS 99770, 10/1/07

Committees eligible to receive K-TAP payments on behalf of a specified relative must have been appointed under either KRS 387.210 or KRS 387.320. [County courts have jurisdiction under KRS 387.210 for appointing committees for recipients adjudged incompetent by the circuit court or county court, if circuit court is not in session.] County courts have jurisdiction under KRS 387.320 for the appointment of a committee or curator for a person who deems himself/herself unfit due to age or disability to manage his/her own affairs.

MS 0327 PROTECTIVE PAYEE APPOINTMENT

See OM Upd. No. 07-21, MS 99770, 10/1/07

A. K-TAP payments are made to a third party payee without court action whenever:

1. A determination is made that a nonexempt Kentucky Works Program (KWP) participant payee has refused, without good cause, to participate in the KWP program;
2. A determination is made that the specified relative has failed to cooperate in Child Support activities;
3. An unmarried teen parent, under the age of 18, is not living in an approved adult supervised setting or is not attending school; or
4. Money mismanagement exists.

B. [Nonpayment of bills is used as an indication that mismanagement MAY exist.] A determination of mismanagement IS NOT BASED SOLELY on the fact bills are not paid timely. All relevant considerations are taken into account. These include whether;

1. The family experienced some emergency or extraordinary event for which it was necessary for available funds to be spent;
2. Expenses for necessary bills exceed the individual's K-TAP grant and other income; and
3. The family withheld payment as a reasonable exercise of consumer rights when there is a legitimate dispute as to whether terms of an agreement were met.

MS 0330 SELECTION OF PROTECTIVE PAYEE

A. Protective payees are designated by form PA-148, Protective Payment Agreement, and serve without pay. The payee must be concerned with the welfare of the K-TAP children. Give the recipient the opportunity to participate in the selection of a payee from any of the following individuals who are adults, 18 years of age or older and willing to accept responsibility:

1. A relative, including a family member if otherwise suitable;
2. A friend;
3. A neighbor;
4. A member or the clergy; or
5. A member of community service groups.

B. In the event an individual fails to keep an appointment to name a protective payee or is unable to name a protective payee, a protective payee is assigned for the individual from a protective payee resource file. The protective payee resource file is established by staff in each local office. Staff are to contact local clergy or members of community service groups to obtain names of individuals who are willing to be named as a third party payee.

These individuals must agree to:

1. Act as a payee for and accept and administer the monthly K-TAP benefit payment on behalf of the K-TAP recipient;
2. Use the payment only for the benefit of those individuals included in the benefit group;
3. Treat all information regarding this family in a confidential manner;
4. Furnish an accounting, upon request, to the Department for Community Based Services (DCBS) of the use of the K-TAP funds; and
5. Serve without pay or any compensation.

If individuals are not found to be placed on a resource file or the K-TAP recipient is unable or refuses to name a payee, the K-TAP recipient may remain the payee. However, efforts should be made to assist the individual with naming a protective payee or in obtaining a resource file from which a payee is named for the recipient.

C. In accepting the appointment as protective payee, the third party agrees to see the payment is used for the benefit of the members of the assistance group and, when spending is questioned, is accountable to the caseworker for the expenditure of funds. In addition, through efforts of the payee, the recipient in protective payment status as a result of money mismanagement is assisted in learning to handle money wisely. Refer this recipient to the County Extension Agent for

assistance with money management. A money management class may be offered.

D. Neither DCBS employees, nor landlords, grocers and other vendors of services used by the individual may serve as protective payees for K-TAP checks.

MS 0333 AUTHORIZING PROTECTIVE PAYEE PAYMENTS

A. [When a protective payee is required, due to noncooperation with the Division of Child Support (DCS), add or remove the protective payee according to policy in Vol. III, MS 3080.]

B. [If a protective payee is required due to noncooperation with the Kentucky Works Program (KWP), add or remove the protective payee according to policy in Vol. IIIA.] Refer to MS 4750 or MS 4770.

1. A protective payee is added if a nonexempt K-TAP recipient refuses, without good cause, to participate in the KWP program.
2. The protective payee is removed if a KWP penalty is cured or removed.

C. If an unmarried teen parent, under the age of 18, is determined not to be living in an approved adult supervised setting or the teen parent is without a high school diploma or equivalent and is not attending school, add or remove the protective payee according to teen parent policy.

D. When a protective payee is named due to inability of a recipient to handle funds, a notice is system generated and sent to formally advise the recipient of the effective date of payee change. Authorization of change will be withheld during the timely notice period, and if the recipient requests a hearing, no change will be made until the month after the decision by the hearing officer.

Protective payments under such circumstances are limited to 2 years. There is a periodic review at least every 6 months on the need to make the protective payment, and the way in which the protective payee's responsibilities are carried out. This type of protective payment is terminated when:

1. Relatives are considered able to manage funds; or
2. A legal guardian or representative is obtained through a judicial appointment because all efforts have failed to improve the use of the assistance payment on behalf of the child and the protective payment is likely to continue beyond 2 years.

MS 0350* ENROLLMENT

In managed care counties, the partnership accomplishes enrollment by mail, telephone or face-to-face interview. During the enrollment process, recipients select a primary care provider (PCP) and receive a member handbook along with informational materials from the partnership. Recipients who fail to select a PCP are assigned one. The local office distributes handouts, including the toll-free telephone number of the appropriate partnership and the toll-free telephone number for the Department of Medicaid Services (DMS), 1-800-635-2570, 1-800-775-0296 TTY.

All non-excluded Medicaid recipients in Carroll, Trimble, Henry, Oldham, Shelby, Jefferson, Spencer, Bullitt, Nelson, Washington, Meade, Hardin, Larue, Marion, Breckinridge and Grayson counties receive medical services other than behavioral health services through the Passport Health Plan.

Passport Health Plan is a Health Care Partnership, established by a Federal Medicaid wavier, and is unique to Kentucky. Behavioral health services are not included in the Passport Plan.

Passport Medicaid recipients are entitled to and receive the same medical coverage and services as other Medicaid recipients.

Passport Medicaid recipients are required to select a primary care physician (PCP) and access services through network providers. Medicaid services outside of the network or out-of-state must be arranged through the Passport Health Plan. The Passport Health Plan toll-free telephone number is 1-800-578-0603 and the TDD is 1-800-691-5566.

MS 0351* DEFINITIONS

A. Fee for Service – The traditional payment method used by DMS. Under this method, a specific amount is paid when a medical service is rendered.

B. Kentucky Health Care Partnership Plan – The name of the Kentucky program approved by the Health Care Financing Administration (HCFA), which established managed care for Medicaid (MA) recipients through regional groupings of medical providers known as partnerships.

C. Managed Care – The practice of making informed judgements of what an individual needs and then managing their treatment to ensure necessary and appropriate care is provided.

D. Partnership – A regional group of health care providers, such as doctors, hospitals, drug stores, therapists, laboratories, etc. Kentucky is divided into eight partnership regions. Each region will have a unique name.

E. Partnership Region – A grouping of counties designated by DMS as a geographical coverage area of a partnership health plan in Kentucky. There are 8 regions.

F. Primary Care Provider (PCP) – The recipient-selected provider or specialist who will authorize the recipient's health care. Workers are not involved in the PCP selection process.

G. [Behavior Health Services – Medical services related to the treatment of mental disorders and substance abuse.]

MS 0352 [KYHEALTH CARD AND MANAGED CARE CARD

Managed care partnership participants use the KYHealth Card that is issued to all other Medicaid recipients. They also receive a one-time Managed Care partnership card after enrollment and selection of a PCP.] The recipient's selected PCP, partnership and toll-free telephone number are listed on the back of the partnership card.

Recipients requiring services when outside their partnership region or out of state must contact their partnership to arrange care.

MS 0353 WORKER RESPONSIBILITIES

Field staff determine eligibility and provide a basic explanation of the Passport health care plan, along with information handouts.

A. The following are listings of included and excluded beneficiary groups.

1. Included Beneficiary Groups
   Medicaid through [Kentucky Transitional Assistance Program] (K-TAP)
   Family MA
   Children under 21 years [of age], in a Psychiatric Residential Treatment Facility (PRTF)
   Aged, Blind or Disabled MA (Noninstitutionalized)
   Hospice (Noninstitutionalized)
   Pass Through
   State Supplementation
   Supplemental Security Income (SSI) (Noninstitutionalized)
   Guardianship Foster Care Children and Special Needs Adoption Program (SNAP)

2. Excluded Beneficiary Groups
   Spend Down
   Nursing Facilities
   Psychiatric Facilities
   Supports for Community Living (SCL)
   Home and Community Based Services (HCBS)
   Qualified Medicare Beneficiaries (QMB, QDWI, SLMB, and QI1)
   Intermediate Care Facilities for Mentally Retarded (ICF/MR)
   Time-Limited Coverage of Aliens
   Acquired Brain Injury (ABI)
   Personal Care Assistance (PCA)
   Home Care Waiver (HW)
   [Institutionalized Hospice
   Michelle P. Waiver]

Note: If a Medicaid recipient is already managed care eligible and is admitted to a nursing facility (NF) for less than 31 consecutive days, the Medicaid recipient remains in managed care.

If a Medicaid recipient is already managed care eligible and is admitted to a NF for a period which exceeds 31 consecutive days, the recipient is to be disenrolled from managed care effective with the 32nd day.

If the disenrollment is prior to the system cut-off, the effective date is the first day of the following month. If the disenrollment is after the system cut-off, the effective date is the first day of the second month.

B. A member handbook issued by [Passport provides a comprehensive list of covered services. Copies of this handbook are available to staff for informational purposes and for distribution to recipients, by requesting a copy from KYHealth Choices at 1-800-635-2570. Covered services include all services previously covered through regular MA. Questions regarding specific coverage should be referred to Passport.

C. Workers are to provide a brief explanation of the Kentucky Health Care Partnership Plan and to distribute informational materials.

Advise the applicants/recipients that, upon approval for Medicaid, they will be contacted by Passport for enrollment. Provide the toll-free telephone numbers of Passport and KYHealth for additional information.]

D. KenPAC is not available in a managed care county.

E. Adding Members:

1. If a current recipient in a managed care county is added to managed care or is disenrolled from managed care BEFORE system cut-off, the managed care effective date is the first day of the following month.

2. If a current recipient in a managed care county is added to managed care or is disenrolled from managed care AFTER system cut-off, the managed care effective date or disenrollment from managed care effective date is the first day of the second calendar month.

3. If an individual is added to an active case in a managed care county, the managed care effective date is the first day of the month of the requested change.

4. If a deemed eligible newborn is added to an active case in a managed care county, the managed care effective date is retroactive to the date of birth.

F. Special Considerations for Pregnant Women: A pregnant woman in her third trimester may be exempted from managed care through the end of her postpartum period. If her current physician is not a member of Passport, she may request an exemption by calling the KYHealth Choices toll-free telephone number, 1-800-635-2570. A pregnant woman in managed care will not receive retroactive Medicaid coverage. Apply policy in Vol. IV, MS 2780 for ongoing deemed eligibility.

G. Spend Down: Spend down applicants in managed care counties may establish regular Medicaid eligibility for any month in the retroactive quarter in which their income is above the Medicaid income scale. Eligible spend down months are not counted in the six-month guaranteed eligibility period.

H. Deprivation of Unemployment: For applications with a deprivation of unemployment in a managed care county, the managed care effective

date is the 31st day of unemployment or underemployment. If the family is eligible for the guaranteed six-month eligibility period, the six-month period will not include the partial month.

I. [Non-institutionalized Hospice: Non-institutionalized Hospice recipients are not eligible for retroactive Medicaid coverage under managed care.

J. Aliens (qualified and unqualified): Aliens who are eligible only for time-limited emergency Medicaid may receive up to two months of retroactive Medicaid coverage and are exempt from managed care. The current processing to determine the period of Medicaid coverage will not change. See Vol. I, MS 2000 for determining whether an alien is qualified or unqualified.

K. Recipients may request a fair hearing as a result of enrollment into managed care and DMS conducts the fair hearing. If a recipient is not already enrolled in managed care and chooses not to participate in managed care during the hearing process, a regular Medicaid card is issued until the final order is completed. Passport also has a grievance procedure, explained in the member handbook. Their procedures handle issues such as recipient dissatisfaction with provider assignment.]

MS 0355* GUARANTEED COVERAGE

There is NO retroactive MA coverage with the plan, but under managed care, all approvals are guaranteed six months of Medicaid eligibility regardless of their technical or financial eligibility.

A. The following criteria must be met to receive this once in a lifetime benefit:

1. The individual has never before received Kentucky Medicaid;
2. The individual applies for Medicaid in a managed care county on or after the managed care implementation date;
3. The individual remains in a managed care county within the original partnership or moves to another county covered by another partnership.

Individuals excluded from managed care or not residing in a managed care county are not guaranteed the six months of eligibility.

B. Additional recipients ineligible for the guaranteed six-month period are:

1. Incarcerated recipients;
2. Aliens (legal and illegal) who are emergency Medicaid only; and
3. Recipients requesting discontinuance of Medicaid.

C. Individuals becoming MA ineligible prior to the end of the 6 months of guaranteed coverage are discontinued on KAMES and entered on the PA-62 system. These cases cannot be maintained on KAMES.

D. The guaranteed six-month eligibility period does not apply to QMB or SLMB. In order to receive QMB or SLMB benefits during the six-month eligibility period, regular QMB or SLMB technical and financial eligibility requirements must be met.

MS 0400 INTRODUCTION

[The Kentucky Patient Access and Care System (KenPAC) links Medicaid recipients with a participating physician or "KenPAC provider" who is responsible for coordinating and providing primary medical care to the KenPAC recipient, authorizing referrals for specialty care, and for maintaining the continuity of patient care 24 hours per day, 7 days a week.

A. The purpose of the KenPAC program is to:

1. Assure needed access to care;
2. Provide for continuity of services;
3. Strengthen the patient/physician relationship;
4. Promote the educational and preventive aspects of health care;
5. Prevent unnecessary utilization and cost; and
6. Improve the quality of care received.

B. All non-exempt recipients are required to select a KenPAC provider. Recipients are given the opportunity to select a participating KenPAC provider within the KenPAC medical service area. The medical service area is the recipient's county of residence, an adjacent county or bordering state. If the recipient fails to select a provider, the system assigns each member in the case a KenPAC provider in the recipient's county of residence.

C. The Department for Medicaid Services maintains a KenPAC toll-free telephone number to assist providers and recipients who have specific questions pertaining to KenPAC. The toll-free number, 1-800-635-2570, is available between 8:00 a.m. and 4:30 p.m. (EST), Monday through Friday. Refer providers and recipients to this number only if local staff are unable to assist these individuals. Staff should use all available resources such as KAMES and Policy Manuals, before referring providers and recipients to this number.]

MS 0403 [KenPAC EXEMPT RECIPIENTS

See OM Pol. Upd. 03-10, MS 99613, 3/1/03.
See OM Pol. Upd. 03-23, MS 99631, 6/1/03.

A. Recipients are exempt from participating in KenPAC if in:

1. Foster care or subsidized adoption status;
2. Mental hospitals or PRTF, skilled nursing facilities, intermediate care facilities for the mentally retarded, HCBS Waiver programs, SCL, ABI, Personal Care waiver, and Home Care waiver;
3. Spend down cases;
4. Aged, blind or disabled cases;
5. A county with no KenPAC provider. The non-KenPAC counties are Gallatin and Hancock;
6. KenPAC hearing status as a result of appealing the necessity to select a KenPAC provider;
7. Alien time-limited cases;
8. Individuals who are covered by the KHIPP program;
9. Individuals who receive both Medicare and Medicaid benefits ;
10. Individuals residing in Managed Care Counties;
11. An American Indian who is a registered member of a Federally recognized tribe;
12. In the custody of the Department of Juvenile Justice and is placed outside the home;
14. A recipient who has a Medicaid eligibility period that is retroactive;
15. A recipient who is receiving Hospice services;
16. Children receiving services from the Commission for Children with Special Health Care Needs; and
17. A recipient who is deceased on the date of eligibility approval.]

MS 0406 [KenPAC PROVIDER SERVICES

When medical services are needed, other than emergency services, the recipient should contact their KenPAC provider.

A. The following services are provided by the KenPAC provider:

1. Primary care services and referrals for other physician specialty services;]
2. Pharmacy services, when the prescription is issued by the KenPAC provider;
3. Hospital Inpatient/Outpatient Services;
4. Home Health Agency Services;
5. [Laboratory Services and radiological services;]
6. Ambulatory Surgical Center Services;
7. Primary Care Center Services;
8. Rural Health Center Services;
9. Durable medical equipment and supplies;
10. Advanced registered nurse practitioner services; and
[11. Physical therapy, occupational therapy, and speech therapy.

B. Other services available to recipients without a required referral or authorization by the KenPAC provider include but are not limited to:

1. Obstetrical and family planning services;
2. EPSDT screening services by EPSDT Clinics;
3. Hospital based psychiatric services;
4. Mental Health services;
5. Chiropractic care;
6. Podiatry;
7. Screening/treatment for sexually transmitted or communicable diseases;
8. Certain dental, vision and hearing services; and
9. Medical Transportation.]

MS 0408 [KenPAC PROVIDERS

A listing of participating KenPAC providers in each county is available on the Kentucky Automated Management and Eligibility System (KAMES). The listing includes:

A. Provider name, address and telephone number;
B. Provider number. When a provider has met their quota the provider number is blank.
C. Site Code. The site code is a four digit number indicating a KenPAC provider's county and office location;
D. Specialty. KenPAC provider specialties are generally limited to:

1. General Practitioners;
2. Family Practitioners;
3. Pediatricians;
4. Obstetricians;
5. Gynecologists;
6. Internists;
7. A certified physician's assistant;
8. Osteopathy; and
9. Registered Nurse Practitioner.

E. Quota. This is the maximum number of KenPAC patients that can be assigned to the provider.
F. Assigned. This is the actual number of patients currently assigned to the provider.
G. Exceed. A "Y" or "N" in this field indicates if a physician with a full quota is willing to accept additional patients. For KenPAC assignments to a physician with a full quota see MS 0416.
H. KenPAC provider selections are made using the following guidelines:

1. A general or family practitioner accepts family members of all ages;
2. A pediatrician accepts any child age 13 and below;
3. An internist accepts any family member age 14 and above;
4. An obstetrician or gynecologist accepts female family members age 14 and above (or younger if the female is pregnant or otherwise appears in need of the types of services provided by such practitioners).

A pregnant woman is not required to select an OB/GYN as her KenPAC provider but may if she chooses to do so. If a pregnant woman selects a provider other than an OB/GYN, she may receive pregnancy-related services from any Medicaid participating OB/GYN without a referral from her KenPAC provider.]

MS 0410 KenPAC PROVIDER ASSIGNMENT

See OM Pol. Upd. 03-23, MS 99631, 6/1/03.

The Medicaid applicant is given the opportunity to select a KenPAC provider. Every effort should be made to complete the KenPAC provider selection for all family members during the application interview.

A. During the application interview, thoroughly explain the KenPAC program and hearing rights.

B. Access the current list of KenPAC providers on KAMES. DO NOT USE A HARD COPY LIST FOR ASSIGNMENTS. Explain the guidelines relating to KenPAC provider specialty and assist the recipient in making their provider selection.

C. [If the applicant selects a KenPAC provider with a closed quota and there is a "Y" indicator in the exceeds field, refer to MS 0416.]

D. If an applicant fails to select a KenPAC provider prior to approval, a system-generated notice is sent after the application is approved. This notice is dated the 3rd workday of the month following the approval month. This notice advises the recipient to contact their worker to select a provider within 10 days. If a provider is not selected within 10 days, the system will assign a KenPAC provider.

E. For cases that are reapproved within 90 days of the effective date of discontinuance, case members are to be reassigned to the same provider unless a new provider is requested. If the provider has a full quota, refer to special assignment in MS 0416.

F. For cases that are reinstated within 90 days of the effective date of discontinuance, case members are to be reassigned to the same provider each member had at the time of case discontinuance. If the applicant chooses a new provider, the new provider can be entered, only as a change action following the case reinstatement. [If the provider has a full quota, refer to special assignment in MS 0416.]

G. For member add, follow application processing procedures in items A, B, and C.

MS 0412 [KenPAC PROVIDER CHANGES

See OM Pol. Upd. 03-23, MS 99631, 6/1/03.

KenPAC provider changes are made at the request of the recipient, DMS or the KenPAC provider.

A. The recipient may request a KenPAC provider change at any time. A recipient request for changing a KenPAC provider DOES NOT require face-to-face contact. Prompt action is required on provider changes. The recipient cannot see their new provider until the effective month of change.

B. If a provider is no longer participating in KenPAC, DMS:

1. Deletes the KenPAC provider;

2. A system-generated notice is sent to the recipient with instructions to contact the local DCBS office within 10 days to select a new KenPAC provider; and

3. If a new KenPAC provider is not selected, the system assigns a provider and a notice is mailed to the recipient.

C. If a KenPAC provider requests a recipient be disenrolled from the KenPAC provider's patient load and reassigned to a new KenPAC provider:

1. DMS deletes the KenPAC provider information prior to the monthly cutoff date;

2. A system generated notice is sent to the recipient with instructions to contact the local DCBS office within 10 days to select a new KenPAC provider; and

3. If a new KenPAC provider is not selected, the system assigns a provider and a notice is mailed to the recipient.]

MS 0414* KenPAC SPECIAL AUTHORIZATION

A KenPAC special authorization may be made by DMS for a case member to see a different KenPAC provider other than the currently assigned KenPAC provider.

A. Special authorization may be approved in the following situations:

1. When a recipient alleges the currently assigned KenPAC provider refuses to see them and the recipient needs medical assistance.

   a. The worker takes immediate action to process a KenPAC provider change. The worker should explain when the change will be effective.
   b. If the recipient wishes to see the new provider prior to the effective date of change, advise the recipient to contact the KenPAC toll free telephone number.

2. In the case of an administrative error and the recipient requests to see his or her new provider prior to the effective date of the provider change transaction, the worker must contact DMS at (502) 564-5476 and request a special authorization.

B. If the special authorization request to see a different KenPAC provider is approved by DMS, the recipient is given a referral by DMS to the new KenPAC provider for the current or a subsequent month.

When a change in a KenPAC provider is accepted PRIOR to the monthly cut-off date, the change is effective for the next month. When a change in a KenPAC provider is accepted AFTER the monthly cut-off date, the change is effective the 2nd month after acceptance.

MS 0416* KenPAC PROVIDER SPECIAL ASSIGNMENTS

See OM Pol. Upd. 03-23, MS 99631, 6/1/03.

KenPAC provider special assignments procedures are required when a recipient requests a physician with a closed quota, when the provider is outside of the service area and has been approved by DMS, and when physician approval is required prior to assignment.

A. If a provider has a closed quota and there is a "Y" indicator, the provider is willing to accept additional assignments. Assignments can be made without the KenPAC provider's approval only in the following situations:
   1. Request for reassignment by a former KenPAC patient who is reapproved for Medicaid within 90 days of the effective date of discontinuance.
   2. Reinstatement of a case within 90 days of the effective date of discontinuance.
   3. Request to add a newborn child of a current patient.
   4. Request to add a spouse, child or sibling of a current patient included in the same case.

   If a provider has a closed quota and there is an "N" indicator that the provider is not willing to accept additional assignments, the only assignment that can be made is the reassignment of a former patient who is reapproved for Medicaid within 90 days of the effective date of discontinuance.

   To complete these special assignments, contact the Program Assistance and Resource Branch at (502) 564-7050 while the worker is in the case completing the transaction. This will result in immediate assignment to the provider.

B. If a recipient indicates medical treatment is provided by a KenPAC provider outside of the recipient's KenPAC medical service area, and the recipient requests the medical treatment continue with this KenPAC provider, prior approval must be obtained from the Department of Medicaid Services. The supervisor prepares and sends a written request to:

   KenPAC Program
   Department for Medicaid Services
   275 East Main Street, Sixth Floor
   Frankfort, Ky. 40621

   1. Forward a copy of the request for tracking purposes to the Branch Manager, Program Assistance and Resource Branch, 275 E. Main Street, 3W-D, Frankfort, Ky. 40621.
   2. The request must include the following information:
      a. Case name and number;
      b. Case member requesting provider change;
      c. Requested KenPAC provider's name, physician number, and site code; and

d. The specific reason for the recipient's request.

3. If the recipient's request is approved DMS notifies PARB. PARB enters the requested KenPAC provider on the system and notifies the local office.
4. If the recipient's request is denied PARB will contact the local office.

C. Approval by the KenPAC provider with a closed quota with a "Y" indicator is required for following situations.

1. Request for reassignment by a former KenPAC patient of the KenPAC provider who is reapproved for Medicaid after 90 days has elapsed from the effective date of discontinuance; or
2. The recipient was a private pay patient of the provider prior to becoming Medicaid eligible.

Only those individuals meeting the above two criteria are to be referred to the physician to request assignment. The physician will submit the appropriate documentation to Operation Support Branch (OSB) for special assignment.

MS 0419 TRANSFER OF KenPAC CASE RECORDS BETWEEN COUNTIES

Transfer of a case from one county to another requires various actions based on the type of the move.

A. Within medical service area. When a recipient moves out of the county but stays within the same medical service area, the worker in the new county of residence changes the KenPAC provider ONLY if requested by the recipient.

B. Out of medical service area.

1. When a recipient moves out of the medical service area, the system generates a timely notice to the recipient with instructions to contact the DCBS office in the new county to select a new KenPAC provider.

[2.] The worker in the new county of residence changes the KenPAC provider information. To avoid system assignment of a KenPAC provider, the change must be accepted by the system on or before the cutoff date in the month following the removal of the previous provider.

[3. When medical services are required prior to the effective date of the new assignment, the treating KenPAC provider, if appropriate, obtains a referral from the previously assigned KenPAC provider.

4.] If referral can not be obtained, special assignment procedures should be followed. See MS 0416.

C. Between KenPAC and Non-KenPAC Counties

1. When a recipient enrolled in KenPAC moves from a KenPAC county to a non-KenPAC county, the system notifies the recipient of the change.

2. When a recipient moves from a non-KenPAC county to a KenPAC county:

a. During the initial enrollment period, enrollment is not required until the scheduled KenPAC interview; or

b. After the initial enrollment period, the system generates a timely notice to the recipient with instructions to contact the DCBS office in the new county to select a KenPAC provider.

To avoid system assignment of a KenPAC provider, the change must be accepted by the system on or before the cutoff date in the month following the county code change.

MS 0421 [KenPAC GRIEVANCE PROCEDURE

See OM Pol. Upd. 03-23, MS 99631, 6/1/03.

A grievance may be filed by the recipient, a household member, legal counsel or an individual acting on behalf of the household or recipient, if dissatisfied with a KenPAC service.

A. A grievance relates to any service covered under the KenPAC program such as:

1. Dissatisfaction with quality of medical care received or not received under the KenPAC program;
2. KenPAC medical billing questions or problems; and/or
3. Dissatisfaction with the denial of a request for a provider outside of KenPAC medical service area.

B. A grievance may be filed by:

1. Calling the KenPAC toll-free telephone number at 1-800-635-2570; or
2. Writing a letter to the KenPAC Customer Service Branch, 275 East Main Street, 6E-A, Frankfort, Kentucky 40621.

C. After the grievance is reviewed by skilled professional medical staff of the Physician and Practitioner Branch, a written decision will be sent to the recipient.

D. The recipient may appeal the grievance decision within 10 working days of receipt by calling (502) 564-4321 or writing the Commissioner, Department for Medicaid Services, 275 East Main Street, 6W-A, Frankfort, Kentucky 40621.

MS 0422* KenPAC HEARINGS

An applicant or recipient has the right to request a hearing, if dissatisfied with the KenPAC program participation requirements.

A. For applicants who request a fair hearing, enter the hearing code on the KenPAC screen to prevent system-assignment of a KenPAC provider.

B. For recipients who request a fair hearing during the timely notice period, enter the hearing code on the KenPAC provider screen to avoid system-assignment.

Upon receipt of the hearing decision take the appropriate action.

If a hearing is requested, refer to Volume I, MS 0565 and 0568.

MS 0450 [KYHEALTH CARD

The KYHealth card is issued at approval to all recipients eligible for Medicaid on a continuing basis, and on initial approval for periods of eligibility for excess income spend down cases. A new card is not issued for subsequent Spend Down quarters unless the recipient no longer has the original card.

Recipients use the KYHealth card to obtain medical services from participating providers. The recipient should present the KYHealth card to the provider at the time of service.

If the recipient maintains no fixed or permanent address, and can provide no mailing address, the KYHealth card can be issued in care of the local DCBS office. This procedure is used at the recipient's request when no other means of delivering the KYHealth card are available.]

MS 0453 SECURING MEDICAL SERVICES

Recipients may secure medical services from participating vendors by showing proof of Medicaid eligibility.

The MAID card is presented to the medical vendor at the time of service.

MS 0456 [NONRECEIPT OF KYHEALTH CARDS

If an undelivered KYHealth card is received in the local office, take the following action:

A. Send the KYHealth card to the new address, if available, and assure appropriate action is taken to correct the address; or

B.] If ineligible, assure appropriate action is taken to discontinue eligibility.

[C. Before local office input of recipient requests for a duplicate KYHealth card, determine if the card has been returned by Central Office to the local office.]

1. [Requests for duplicate cards for SSI recipients can be processed by local office staff on KAMES MAID-ISS file.]
2. [Except for emergency medical need situations, do not process requests for duplicate KYHealth cards on new approvals less than ten days from the case disposition.]

MS 0457 OUT OF STATE REQUEST FOR TERMINATION OF MEDICAID

[For situations in which a former Kentucky resident is unable to obtain Medicaid coverage in another state because Kentucky has issued Medicaid coverage for a specific month, the recipient may request immediate termination of Kentucky Medicaid. Refer out-of-state recipients requesting immediate termination of Medicaid directly to the Department for Medicaid Services (DMS), Customer Services Branch, at (800) 635-2570 or (502) 564-5183.]

DMS will require the individual to provide a signed statement requesting that Medicaid coverage be terminated. If no medical claims have been paid on the recipient's behalf for the requested month of termination, DMS will provide a written statement verifying Medicaid termination effective with the requested month.

MS 0458* SSI RECIPIENTS MOVING INTO KENTUCKY

See OM Update No. 05-13, MS 99697, 3/7/05
See: OM. Upd. 04-09, MS 99661, 2/1/04.

SSI recipients who move from another state into Kentucky and who require medical services can receive a Kentucky MAID for use based on the following:

1. SSI eligibility is on the system; or
2. SSA verifies to OSB that eligibility exists.

To assist an individual in this situation, call OSB with the recipient's name, SSN and the need for a Kentucky MAID. OSB enters case information on KAMES under the Special Circumstances segment.

MS 0459 PROVIDING VENDOR BILLING/SERVICE INFORMATION

The local office provides eligibility information to medical vendors requesting assistance with MAID numbers, eligibility dates, and issue dates of MAID cards, if available on any active, inactive or pending case.

Department for Medicaid Services (DMS) provides information regarding Medicaid coverage and reimbursement policies and referrals to the fiscal agent regarding billing questions or problems.

A. Refer all vendor questions regarding BILLING to UNISYS, at 1-800-807-1273.

B. Refer vendor complaints regarding eligibility problems to 502-564-5020.

C. For inquiries received from a physician, hospital or other medical vendors requesting KenPAC or managed care information, ONLY the KenPAC or managed care provider's name, address and telephone number are provided.

D. Refer all Medicaid providers with inquires about Medicaid covered services to DMS at 502-564-2687.

E. Requests for authorization of MA payment when the provider is billing for a service which took place more than 12 months ago are to be referred to DMS at 502-564-2687. Medical providers must request payment for services within 12 months from the date of the service or within 12 months from the date of issuance of the MAID authorizing MA coverage for the date of service. Advise the provider who is inquiring about payment for services after the 12-month period has ended to call DMS.

[F. Refer attorneys requesting medical billing information to DMS Financial Management, at 502-564-6205.]

MS 0462 OUT-OF-STATE MEDICAID INQUIRIES

Refer persons from other states who need information regarding Medicaid to Department for Medicaid Services staff at telephone number 1-800-635-2570.

MS 0500 THE QC SYSTEM

A. To qualify for federal funding, the state is required to provide a system of quality control (QC) meeting federal requirements to assure the programs administered by the State meet eligibility requirements. 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 provides a nationwide, systematic, and continuous accountability for the quality and accuracy of Food Stamp and Public Assistance case actions.

B. In addition to assuring validity of caseloads, the QC System is designed to:

1. Support and contribute to program development;
2. Point out weakness in the instructional system and variances in interpretation of policies and procedure;
3. Develop more efficient central office level supervision of local office performance; and
4. Contribute to the development of training plans.

C. Sample cases are chosen by means of systematic random sampling on a monthly basis and are reviewed in depth to substantiate field determination of eligibility and computation of the grant amount. [If errors are found, the field is notified by form PAFS-343 or by memorandum.]

D. In addition to preparing analysis and periodic reports required by the United States Department for Health and Human Services and the United States Department of Agriculture, the Office of Performance and Enhancement is responsible for analysis of QC findings. On the basis of these reports and analysis, the Division of Family Support determines the corrective action required and the manner in which it is implemented.

E. For FS, an annual report is filed with FNS based on the compilation of monthly reviews completed. These reports are used to determine the nature and extent of problems in the areas covered, to keep informed about changes in levels of error, and to evaluate the effects of policies and other changes in administration.

MS 0503 FUNCTIONS OF QC REVIEWERS

QC reviewers, stationed throughout the state, are assigned selected sample cases for review. The review includes:

A. Analysis of the case record including adequacy of each of the steps taken by the local office in the process of determining eligibility and the amount of payment;

B. Face-to-face interviews;

C. Other investigation, including collateral contact necessary to assure documentation of all eligibility factors and correctness of payment; and

D. [Preparation of form PAFS-343 listing defects, if any.]

QC reviewers approach cases objectively, limiting the review to the case record, interview, and collateral contacts. Reviewers are not permitted to discuss cases and/or give policy interpretations to local office staff.

[Findings on individual cases are reported on form PAFS-343 by the QC Branch Manager directly to Field Services Supervisors 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 local office supervisor by memorandum.

MS 0506 LOCAL ACTION ON QC FINDINGS

[To ensure that the Division of Program Performance and local office staff meet time standards for responding to Quality Control (QC) reviews, form PAFS-343 will be sent electronically to:

- Division of Program Performance;]
- Service Region Administrator (SRA);
- Service Region Administrator Associate (SRAA); and
- Service Region Program Specialist

NOTE: It will be the responsibility of the Program Specialist to forward to the appropriate Field Services Supervisor.

The advanced electronic copy will allow appropriate time for Regions to determine if they disagree with the QC decision and take exception. The hardcopy PAFS-343 with all supporting documentation will continue to be received.

These procedures apply to all Food Stamp, K-TAP/KWP and MA reviews.

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

A. If the case was cited in error:

1. If necessary, schedule an interview with the recipient.

2. If the recipient disputes the information as reported on the PAFS-343, additional collateral contacts may be necessary to substantiate or refute the QC findings.

3. If the findings reported are correct, take action to correct the case within 10 calendar days from the date of the electronic form PAFS-343.

4. Initiate a claim determination or restoration of lost benefits, as appropriate.

5. File form PAFS-343 in the case record in the packet relevant to the review month.

6. Within 20 calendar days from the date of the electronic form PAFS-343, the Field Services Supervisor (FSS) completes the electronic

form PAFS-343.1, Response To Quality Control Errors. The electronic form PAFS-343.1 can be found at: http://chfsnet.ky.gov/cfs/dcbs/dcbsforms.htm.

7. This form identifies the error, what caused the error and what corrective action has been taken.

   a. Forward one copy to the SRA.
   b. Forward one copy to the SRAA.
   c. Forward one copy to the Program Specialist.
   d. [Forward one copy to the applicable program branch in the Division of Family Support:

      1) Food Benefits, Nutrition Program Assistance Section at CHFSFoodBenefitsPolicy@ky.gov;
      2) Medicaid, Medical Support and Benefits Branch at CHFS DFS Medicaid Policy@ky.gov;
      3) K-TAP KWP, Family Self-Sufficiency Branch.

   e. Forward one copy to the Division of Program Performance, Quality Control Branch.
   f. Maintain one copy in the case record in the packet relevant to the review month.

B. If the case was cited as correct, review form PAFS-343A for "Related Observations" and take the appropriate action on the case.

C. If the PAFS-343 indicates the recipient "refused" to cooperate with QC, take action to impose the disqualification. Please reference OM, Vol. I, MS 0508 for K-TAP, MS 0509 for MA and MS 0512 for food stamps.

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

1. Within 15 calendar days from the date of the electronic form PAFS-343, the Field Services Supervisor provides the Service Region Program Specialist with the following information on why they are taking 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 request, within 20 calendar days from the date of the electronic form PAFS-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 0508* REFUSING TO COOPERATE WITH QC - K-TAP

Quality Control (QC) staff contacts field staff for the name of the worker who is responsible for the case. Provide the QC reviewer with the name and telephone number of the worker.

The QC reviewer sends the appointment letter and includes the worker's name as a contact person. The QC reviewer keeps the appointment with the recipient. If the recipient does not respond or refuses to cooperate with the QC review, the K-TAP case is NOT affected. No follow-up by the caseworker is required. If the recipient does not keep the appointment with the QC reviewer, NO further action is necessary. DO NOT discontinue the K-TAP case.

MS 0509 REFUSAL TO COOPERATE WITH QC – MA PROGRAMS

In the MA 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 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 PA-105 to propose discontinuance for failure to keep the interview appointment in the local office.

MS 0512 [REFUSAL TO COOPERATE WITH QUALITY CONTROL (QC) – FOOD STAMP PROGRAM]

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.

If the QC analyst did not have any contact with the household, (household failed to respond to the appointment letters, did not contact the QC analyst personally or verbally, or contact their food stamp worker concerning the appointment) then it is considered as failure to cooperate and no disqualification is applied.

A. [Upon receipt of notification from QC that a household has refused to cooperate, enter disqualification for refusal to comply with QC. The disqualification is entered by the supervisor. KAMES discontinues the case and issues form KIM-105 to the household, indicating the household's refusal to cooperate as the reason for termination or denial of benefits and outlining the action the household must take if it wishes to reapply and cooperate.

B. If the household disbands and members reapply, delete the disqualification from KAMES.] Document in comments. The disqualification only applies while the household remains intact.

C. If the household remains intact and reapplies within the QC review period or within 95 days of the close of the review period, the household must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services.

1. If the household states that it is still unwilling to cooperate with the QC analyst, the disqualification remains on the system and the system will deny the reapplication 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 QC by memorandum within 3 working days of the date of reapplication, of the household's intention to cooperate with the QC analyst. The memorandum contains any current identifying case information, the QC review number and review date. Send the memorandum to:

[Office of the Ombudsman
Quality Control Branch
Attn: Branch Manager
275 E. Main Street, 1E-B
Frankfort, Kentucky 40621]

b. Upon notification that the household intends to cooperate, the QC analyst schedules a home visit with the household. After the home visit 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 subsequently determines that the household is no longer cooperating with the review process, follow item A.

D. If the household reapplies more than 95 days after the end of the annual QC review period (October 1 through September 30 of any given year), the household does not have to cooperate with the QC analyst for the prior review period. However, the household must verify all eligibility requirements prior to being determined eligible.

E. If the household is terminated for refusal to cooperate with a Federal QC analyst and reapplies after 7 months from the end of the annual QC review period, the household does not have to cooperate with the Federal QC analyst for the prior review period. However, the household must verify all eligibility requirements prior to being determined eligible.

MS 0520 AUDITS - PURPOSE

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.

MS 0523 AUDIT PROCESS

The audit process includes the following procedures:

A. The Division of Family Support (DFS) notifies the Office of Performance Enhancement (OPE), 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 and OPE 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 OPE, 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 DFS Director and the SRA.

F. If the established timeframe cannot be met, an interim report on the progress is submitted to the DFS Director and the SRA.

G. DFS notifies the SRA and local office Supervisor when the audit is officially closed.

MS 0530 MANAGEMENT EVALUATION REVIEWS - PURPOSE

Management Evaluation (ME) reviews are conducted to identify deficiencies in case processing. Counties are reviewed either yearly or on a two or three year schedule depending on their size, past review history and potential impact on the error rate. [Copies of review findings are forwarded to the supervisor.]

MS 0533 COUNTY QUALITY INITIATIVES PLAN

Exit conferences are a routine part of the ME process. QI plans are developed during the exit conferences as areas of deficiency are discussed. [All parties, including the MRO, QI Specialist, supervisor, SRA or designee and county staff contribute to the plan development.]

The plan is required to be submitted within 10 workdays of the ME exit. If the QI plan is not received within this timeframe a reminder note is sent to the FSS, from the QI Branch.

Reminder notes also are sent if the evaluation due dates are not met. These notes are intended to be used as an organizational and management tool.

QI plans are completed as follows:

A. Program: A program must be selected according to the content of the evaluation. FS and PA quality initiatives can be addressed separately or jointly.

B. County/Unit: Indicate the county/unit for which the plan is being done.

C. Date: This is the date the QI Plan is being submitted. The plan should indicate if it is initial or follow-up.

D. 1. Deficiency: Indicate the deficiency area addressed.

2. Staff Meeting: Enter the date ME review findings were/will be covered in staff meetings.

3. Action Taken: Explain specific actions taken to correct each erred case if possible.

4. Quality Initiatives: Explain the quality initiatives that will be implemented as a result of the review, such as; training and workshops (formal and in-house), tip sheets, team reviews, project recall, pre-audit, internal monitoring and control procedures, special element reviews, etc.

5. Proposed Evaluation Date: The evaluation date should be 90 days from the date submitted.

6. Follow-Up Evaluations: When giving the follow-up evaluation, specific statistics must be included. If the QI plan is a joint

plan, statistics must be given for each program separately. This indicates if the QI plan was successful or if a new plan needs to be developed for one or both programs (FS/PA).

After statistics are given, indicate if you are requesting deletion or extension of current QI plan, or if a new plan is proposed.

7. Next Evaluation Date: Indicate when the next evaluation will be submitted. This date is three months from the date the follow-up is submitted.

8. Supervision: The plan is signed by the supervisor(s) who is (are) responsible for its implementation.

MS 0550 [ADMINISTRATIVE HEARING OVERVIEW]

Any applicant for or recipient of any type of assistance from the Department for Community Based Services 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-PA-326, Hearing Procedure for Kentucky Family Support Programs.

[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 FS:

[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. 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 withdrawal. The worker, supervisor and the household member and/or representative attend the agency conference.

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 farmworkers, 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 activity which 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 requests any 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 Administrative Hearings Branch 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 4140, 4750 and 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 one of 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 facts in the individual case.

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

[The recipient is notified by the Hearings Branch 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 Hearings Branch or the local office in writing, prior to the scheduled hearing date.

[The recipient may either bring evidence to be submitted for consideration at the hearing to the local office, where the evidence will be copied and sent to the Hearings Branch or mail copies directly to the hearing officer.] The recipient may also bring evidence to the hearing and request that the hearing officer consider this information in the determination. Telephonic hearing may be utilized in all counties.

MS 0553 TIMELY NOTICE OF DECREASE, DISCONTINUANCE

If information in an IM or FS case indicates reduction or discontinuance of benefits for any or all members in a case, notify the client of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement applies. This 10-day period is the Timely Notice Period.

A. For cases on the PA-62 system:

1. Prepare and mail form MA-105 giving the reason for the proposed action. [If the recipient's failure to provide complete information relates to the proposed action, detail the exact information needed on the form.]

2. If the timely notice period does NOT expire in the month form MA-105 is sent, take action the day following the expiration of the timely notice period.

   [Day 1 of the 10-day timely notice period is the day after the date of the RFI or form MA-105.] The time period expires at the end of the 10th day following the date on the form. If the 10th day is on a weekend or holiday, the timely notice period expires on the next work day (e.g., if form MA-105 is dated 12/1, the timely notice period expires 12/11). Case action is taken on 12/12.

3. Submit form PA-62 on the day after the date the timely notice period expires if the notice:

   a. Is sent after the monthly cutoff date;
   a. Expires before the monthly cutoff date; or
   b. Expires in the following month.

   If the timely notice expires after the monthly cutoff date, but prior to the last work day of the month, submit form PA-62 within 3 days prior to the monthly cutoff date.

B. For cases on KAMES:

1. The system sends form KIM-105 when the change is entered on the system.

2. Case changes entered on the system with a timely notice period expiring on or before the last calendar day of the month, are effective with the following month's issuance.

3. If the timely notice period does not expire in the month form KIM-105 is sent, action is taken by KAMES, the day following the expiration of the timely notice period.

MS 0559 EXCEPTIONS TO TIMELY NOTICE REQUIREMENT – PA PROGRAMS

A notice of action taken is required, but a timely notice of a reduction or discontinuance of benefits is not required in the following circumstances:

A. The Department receives a clear written statement, signed by the recipient, that he/she no longer wishes to receive assistance.
B. A "P" case is discontinued.
C. Death of aged, blind, or disabled recipient is verified.
D. The whereabouts of the recipient is unknown and mail sent to the recipient by the local office or Quality Central is returned. [The recipient's check and/or MAID card are made available if the recipient's whereabouts become known during the payment period of the check or MAID card.]
E. Assistance has been ACCEPTED in another state.
F. A K-TAP child is removed from the home as a result of court action.
G. State Supplementation recipient has entered a long term care facility resulting in vendor payment status.
H. The recipient enters a penal or correctional institution.
I. A recipient under age 65 enters a tuberculosis hospital.
J. A recipient between age 21 and 65 enters a mental hospital.
K. Time limited Medicaid is terminated and the recipient has been informed in writing at the time the assistance was granted, of automatic termination at the end of a specified period or under specified conditions.

MS 0562 EXCEPTIONS TO TIMELY NOTICE PERIOD – FOOD STAMPS

A notice of action taken is required but an individual notice of timely action is not required for the following actions:

A. MASS CHANGE. Certain changes are initiated by the State or Federal Government, which may affect the entire caseload or significant portions of the caseload. [These changes include adjustments to the income eligibility standards and the maximum shelter and dependent care deductions; adjustment to the Thrifty Food Plan and standard deduction; annual adjustments to the State's heating and cooling costs/SUA; periodic cost-of-living adjustments to Social Security, SSI and other federal benefits; periodic adjustments to K-TAP and other changes in the eligibility criteria based on legislative or regulatory actions.

B. NOTICE OF DEATH. The worker determines based on reliable information that the recipient in a one person household has died.]

C. MOVE FROM PROJECT AREA. The worker determines, based on reliable information, that the household has moved from the state.

D. COMPLETION OF RESTORATION OF LOST BENEFITS. The household has been receiving an increased allotment to restore benefits, the restoration is complete, and the household was previously notified by form KIM-105 when the increased allotment would terminate.

E. ANTICIPATED CHANGES IN THE MONTHLY ALLOTMENTS. The household's allotment varies from month to month within the certification period to take into account changes which were anticipated at the time of certification, and the household was so notified by form KIM-105 at the time of certification.

F. REDUCTION DUE TO APPROVAL OF K-TAP GRANT. The household jointly applied for K-TAP and food stamp benefits, the K-TAP application is still pending and the household was notified that food stamp benefits would be reduced upon approval of the K-TAP grant.

G. EXCLUDED FOR INTENTIONAL PROGRAM VIOLATION. A household member is excluded for intentional program violation and the benefits of the remaining household members are reduced or terminated to reflect the disqualification of that household member.

H. EXPEDITED SERVICES. Reduction or discontinuance of benefits due to receipt-nonreceipt of postponed verification which differs from applicant statement.

I. RESIDENTS OF DRUG OR ALCOHOLIC TREATMENT CENTERS OR GROUP LIVING ARRANGEMENT. The eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement is

terminated due to the facility's loss of either its certification from the appropriate State agency or agencies, or its status as a representative is suspended due to FNS disqualifying it as a retailer.

J. COUPON REDUCTION TO REPAY A CLAIM. Converting a household from cash repayment to coupon reduction as a result of failure to make an agreed upon repayment.

K. INCORRECT NOTICE OF APPROVAL/DENIAL (KIM-105). If a worker error results in the mailing of an incorrect form KIM-105, General Notice of Action, a corrected form KIM-105 is sent by the system when the correct information is entered through a case change action. Establish an AE claim for overissued benefits or provide a supplemental payment if an underissuance resulted from the error.

L. HOUSEHOLD REQUEST. The household voluntarily requests, in writing, that its benefits be terminated.

M. RETURNED MAIL. Agency mail sent to the household is returned with no known forwarding address.

MS 0565 THE HEARING PROCESS

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 0570.

A. Upon receipt of a request for a hearing:

1. Complete form PAFS-78, Request for Hearing, Appeal or Withdrawal.

2. If the hearing issue involves a negative action, attach a copy of the negative action notice (i.e., KIM-105 series, FS-105, MA-105, PA-105, or KWP-205) to form PAFS-78 and forward to the Hearings Branch. The system-generated notices are maintained on RDS and may also be accessed through DocumentDirect. These notices include KAMES, FAD, and Food Stamps. If the notice is not available at the time of the request, forward form PAFS-78 within 24 hours and forward the copy of the notice as it becomes available.

   Do NOT send a copy of the case record or current packet to the Hearings Branch. Instead, follow the instructions in item B.

3. If the request is from an individual with limited English proficiency and requires interpreter services, annotate the hearing request with this information.

4. All requests must be forwarded via form PAFS-78 within 24 hours of receipt of the request to:

   Cabinet for Health and Family Services
   Office of Legislative and Public Affairs
   Division of Administrative Hearings Branch (Families and Children)
   275 East Main St., HS 1E-D
   Frankfort, KY 40621

B. After forwarding the hearing request via form PAFS-78, prepare for the hearing by reviewing the case record and writing a summary of the issue/action that prompted the request. Form PAFS-78.1, Administrative Hearing Summary, is an optional form that may be used to record a summary. If the hearing involves a claim issue, it may be necessary to contact the claims worker for additional information. Attach the summary and form PAFS-78 to 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 case 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.

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 form PAFS-78 or written hearing request, the Hearings Branch schedules the hearing and may need to contact the client for clarification of the reason for the hearing. The Hearings Branch notifies the client, field staff, and appropriate Service Region Administrator Associate (SRAA) of the issue to be heard, along with the date, time and place of the hearing. The SRAA 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 are to mark their calendars and 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. The supervisor is responsible for ensuring the Agency representative is fully prepared. Failure to prepare for and/or attend a hearing is not acceptable.

D. At the hearing, the 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. For details on preparation refer to MS 0589.

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 Service Region Administrator Associate;
3. The local office; and
4. The Department for Medicaid Services, if the issue involved patient status in a skilled nursing home.

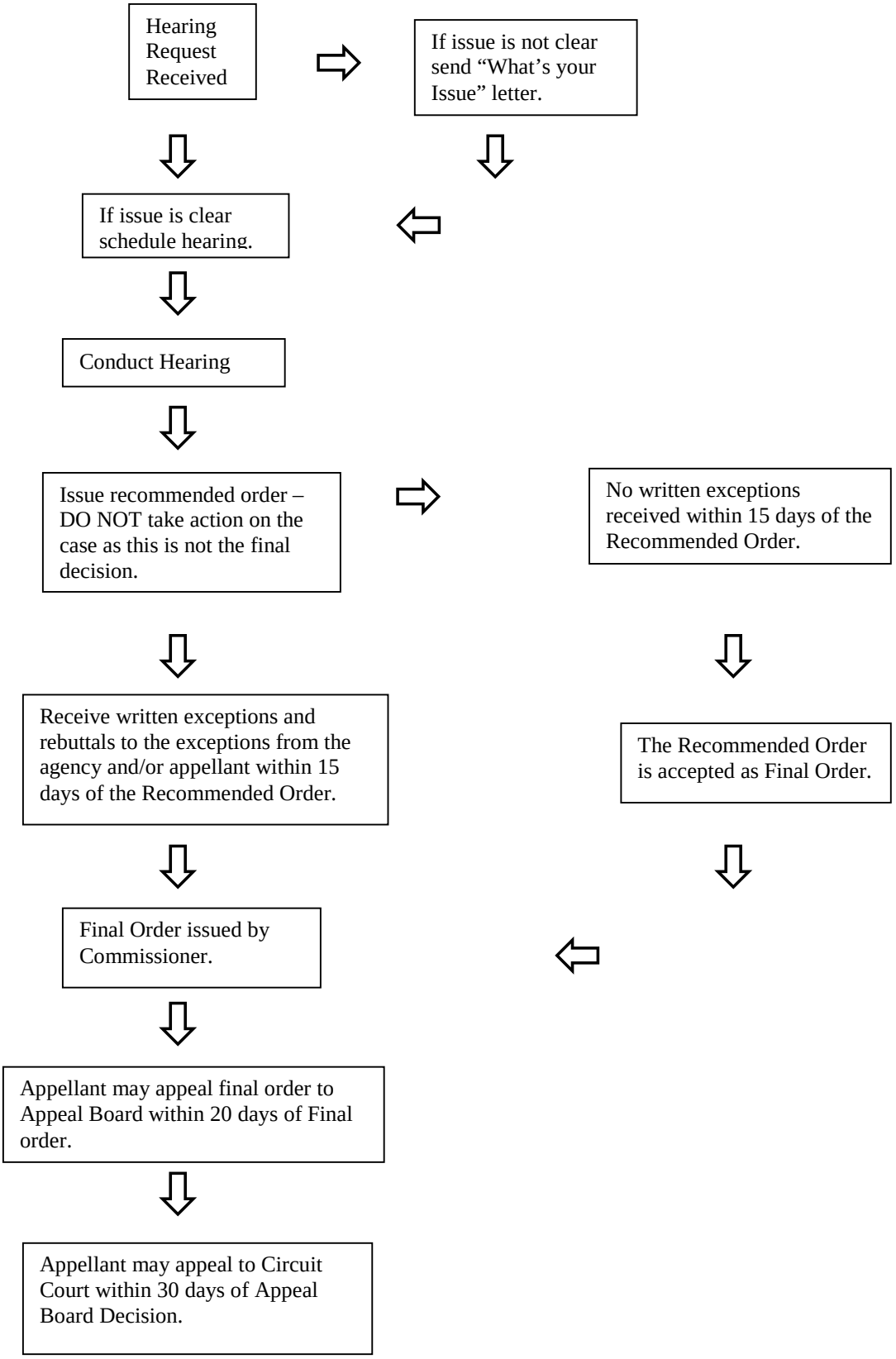
If any of the parties disagree with the recommended order, an exception can be filed with the Quality Assurance Branch within 15 calendar days of the date of the recommended order. For detailed procedures, refer to MS 0594.

F. Quality Assurance staff reviews all timely exceptions to the recommended order and drafts a final decision for submission to the Commissioner.

G. The Commissioner signs the final order and sends copies to the client, representative, if any, the local office, and to the appropriate Service Region Administrator Associate. Refer to MS 0598.

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 0601.]

Hearing Process Flow Chart



MS 0568 THE HEARING REQUEST

A hearing request is a clear expression, either oral or written, to review an action/decision of the Agency.

A. The request must be filed 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, either written or oral, are forwarded by form PAFS-78, Request for Hearing Appeal or Withdrawal, which is completed by or for the client according to procedural instructions for the form.

1. When completing form PAFS-78 for an ETP/KWP related issue, indicate that the hearing request involves an ETP/KWP issue.

2. If received by phone or through the mail, indicate this on form PAFS-78 on the client's signature line. It is not necessary for the client to sign form PAFS-78 if request is received by phone or mail.

3. When a client has moved out-of-state and subsequently requests a hearing, the client is advised that the agency does not schedule hearings out-of-state, but an in-state hearing may be scheduled if the client wishes to return to Kentucky.

C. When completing form PAFS-78, be specific as to the client's reason for the hearing request. Use statements like: "The client does not agree with the amount of earnings counted in her K-TAP case". Do NOT write "client request", "client disagrees with denial", etc. In addition, if the hearing involves an emergency situation, clearly annotate on form PAFS-78 that it is an emergency.

D. [A request for a DCBS hearing may be submitted by the client or their representative directly to the:

Cabinet for Health and Family Services
Office of Legislative and Public Affairs
Administrative Hearings Branch
275 E. Main St., HS1 E-D
Frankfort, KY. 40621]

1. [The Hearings Branch requests that the local office complete form PAFS-78 and forward within 24 hours to the Administrative Hearings Branch address provided above along with copies of adverse action notices related to the hearing issue. If the notice is unavailable, proceed in forwarding form PAFS-78 and then forward the notice when it becomes available. To expedite the process, form PAFS-78 can be faxed to (502) 564-4043.]

2. The burden of proof for the case action is the responsibility of the Agency.

E. The client may voluntarily withdraw the hearing request any time prior to the hearing. If the client wishes to withdraw the request, complete form PAFS-78 and forward to the Hearings Branch.

F. A request for a hearing related to Medicaid covered service issues is heard by the Department for Medicaid Services (DMS).

1. Hearings may include, but are not limited to:

a. Patient level of care status determinations in any type of vendor payment case;

b. Electronic Data Systems (EDS) denial of payment for services;

c. Services provided through EPSDT; and

d. Issues related to managed care services or participation.

2. Accept DMS hearing requests per MS 0550.

a. Annotate in red across the top of form PAFS-78, "Medicaid Hearing Request".

b. Forward the hearing request within 24 hours to:

Department for Medicaid Services
Division of Administration & Financial Management
Administrative Service Branch
HR Building, 6W-C
275 East Main Street
Frankfort, Kentucky 40621-0001

c. DO NOT send the case record to DMS.

d. The DCBS worker does not attend the DMS hearing.

3. Clients can also request DMS hearings by calling the Administrative Services Branch directly, at (502) 564-8196, ext. 3175.

4. If the hearing issue is participation in managed care and:

a. The client has not been issued a managed care KYHealth card or one has been issued but is not yet effective on the day the hearing is requested, take action to exempt the recipient from managed care until the hearing process is completed. Use exemption code H, hearing request; or

b. The client has already received managed care services, participation continues in effect until the hearing process is completed.

1) Consider managed care services received if a managed care KYHealth card has been issued and is effective on the day the hearing is requested.
2) Do not enter an exemption code.

c. If the hearing determines that the recipient should be managed care exempt, the recipient is identified as exempt due to hearing decision using exemption code E, hearing approved.

5. The only appeal process which applies to DMS hearings is Judicial review. The Appeal Board does not review these cases.

6. DCBS staff remain responsible for hearings on Medicaid eligibility and follow the regular procedures for requesting an administrative hearing.

MS 0570 HEARING REQUESTS INVOLVING MEDICAL REVIEW TEAM DETERMINATIONS

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 worsened condition, 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 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);

   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, or PA-601R, Referral for Redetermination of Incapacity/Disability;
         (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 to MRT, complete form PAFS-78, Request for Hearing, Appeal or Withdrawal. 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 to support his/her claim of incapacity/disability.

1. New evidence is new hospital records, new tests results, new specialist's report or appointment, etc.

2. New evidence is NOT a statement from the family doctor, follow-up appointment with a family doctor, routine appointment with family doctor, etc.

D. When a hearing involves an MRT determination, take a copy of the last packet of medical information, including form PA-601T or PA-601R 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.

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 still do not act on a case until a final order is received.]

MS 0572* HEARING REQUEST FOR MEDICAID DISCONTINUED DUE TO THE LOSS OF SUPPLEMENTAL SECURITY INCOME (SSI)

Individuals that are discontinued from Medicaid due to the loss of SSI are eligible for a fair hearing and continuation of benefits if the request is timely. These hearings are held in the county in which the individual or payee resides. The local Department of Community Based Services (DCBS) staff is required to represent the agency at these hearings.

Upon receipt of a hearing request, the worker should be familiar with the situation and be able to give the reason why the Medicaid benefits ended. Review and take the following to the hearing:

- PA-10-SSI notices which are located on RDS;
- SDX screens (pages 1 and 2 of the discontinuance action) showing the pay status code and MA discontinuance date; and
- An explanation of the discontinuance reason which is located in the SDX manual under pay status codes.

Copies of the SDX screens are to be 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 the 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 0574 HEARING TIME FRAMES

A. For IM programs, 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 FS, 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 Hearings Branch acknowledges all hearing requests, conducts a hearing, and issues a recommended order within 60 days of receipt of a timely request for a Food Stamp hearing or within 90 days for IM programs. The commissioner has 45 days from the receipt of the recommended order in which to issue the final decision.

D. If the hearing request is untimely, forward the request and any information concerning why the request was untimely to the Hearings Branch. The hearing officer determines from the information provided whether the household had good cause for submitting an untimely request.

E. Individuals discontinued from SSI may request a fair hearing due to discontinuance of MA.

1. If a hearing is requested within 10 days of the date of form PA-10-SSI, enter a PA-62 document to continue MA eligibility as a J, K or M case until a hearing decision is rendered. On form PA-62, enter code "99" in field 73, "Deprivation" field, to indicate the case is in hearing status. If the final order determines the case remains eligible, enter "00" to remove the "99" code. It is not necessary to enter the income amount on form PA-62.

2. If a hearing is requested after 10 days but within 30 days of the date on form PA-10-SSI, MA eligibility is NOT continued, but the hearing is conducted according to normal procedures.

3. If applying for eligibility under another program code, determine eligibility according to current procedures.

4. If the hearing affirms the Agency's action, take action to discontinue the case within 24 hours.

MS 0576* SCHEDULING THE HEARING

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 advises the client of:

1. The right to bring an attorney and/or witnesses if desired.

2. The form includes 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 Food Stamps 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. For IM programs, a client or his/her representative may request a delay of the hearing for an essential reason beyond the control of the client. The decision to grant the delay is made by the hearing officer.

MS 0578* PROGRAM PARTICIPATION
PENDING THE HEARING - IM PROGRAMS

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 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 the 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 the reason met the good cause criteria and the client requests that the benefits continue, reinstate the case within 5 work days to the level prior to the timely notice if it was discontinued as a result of the timely notice.

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 form PAFS-78;

2. Record on a separate application register marked "Reinstatements."

3. If reason for discontinuance is "failure to keep recertification interview," complete a recertification.

4. For all other reasons for discontinuance, complete form PA-1.1C Supplement B, Interim Notations, or annotate comments on KAMES, as appropriate.

5. 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.

6. For cases on the PA-62 system, if benefits were received in the current month, enter the local office address on form PA-62, and submit another form PA-62 to change the address to that of the client.

   a. When the check directed to the local office arrives, prepare form PAFS-61 to cancel check and forward with the check to the Resource Management Section (formerly General Accounting).

   b. If a second check is received in the local office, notify the recipient to pick up the check. Verify that the address has been changed for future checks.

D. For checks received in the local office, follow procedures found in Vol. I, MS 0304.

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 0580

PROGRAM PARTICIPATION PENDING THE HEARING - FS PROGRAM

[Depending upon the circumstance 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 food stamps received pending the hearing officer's decision, a claim is established against the household for the value of extra stamps 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. [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 when benefits are reduced or terminated pending the hearing officer's decision.
5. The household fails to appear for the hearing, and the Hearing Branch 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 0583 DENIAL/DISMISSAL OF HEARING REQUEST

A. [The Hearings Branch 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 voluntary completion of form PAFS-78, Request for Hearing, Appeal or Withdrawal, with notation of the reason for withdrawal.] In all instances in which the client has a representative or attorney, the client is advised to consult with the representative before signing the withdrawal form. If the original request was made by a representative, the worker personally assures that the representative concurs in the withdrawal. If the representative does not concur with the withdrawal request, indicate this on form PAFS-78 which requests the withdrawal.

[Send form PAFS-78 to the Hearings Branch.]

C. [If the client or representative fails to appear for a hearing and the reason is unknown, a notice is mailed by the Hearings Branch.] The notice advises the client to contact the hearing officer, in writing or by telephone within 10 days, if he 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 0586 [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 at 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 0589 CONDUCT OF THE HEARING

A. Hearings are conducted by an impartial hearing officer who is skilled in the art of interviewing, who has the ability to reason effectively, and who is knowledgeable of the Department's law, policy and procedures. [The Hearings Branch operates independently and recommended orders are based only on facts as 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, 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 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 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, system screen prints (including 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 DFS Central Office. Do not submit training materials, forms or items not issued or sanctioned by the DFS Central Office, cartoons, etc., 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. Taking the case record to the hearing to assist in responding to questions asked during the hearing.

8. Dressing professionally.

9. Using professional language when presenting the summary and evidence. When called upon to present the Agency's position, speak clearly and confidently. Explain the policy and procedure used in terms that everyone attending the hearing can understand. Do not use phrases such as: "I don't know"; "I haven't a clue"; "I don't agree with the policy"; "It's just done that way", etc. If you are unsure of a response, state, "I do not have that information, but if you allow time, I will get it".

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 Food Stamps 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 an essential reason beyond the control of the client.] The decision to grant the delay and continue the hearing is made by the hearing officer.

MS 0594 RECOMMENDED ORDER

After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is not the final order; therefore, DO NOT take action 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. Specifies 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 that it 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 Service Region Administrator Associate (SRAA);
   d. The local office; and
   e. The Department for Medicaid Services 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 can remand the case to the Medical Review Team (MRT) for a re-determination. However, DO NOT take action to remand the case back to MRT until the final order is received.

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), follow procedures in MS 0601.

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

1. If o exceptions or rebuttals to the recommended order are received within the 15-day period, the recommended order is reviewed to ensure that it is in accordance with regulations. A final order is drafted and then forwarded to the Commissioner of DCBS. The Commissioner reviews and signs the final order.

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 5 work days to review and request an exception. An exception can only be based on the facts and evidence presented at the hearing. No new information or evidence may be used to take exception.
      2) Send requests for an exception to the Program Specialist for the Region. The Program Specialist reviews the request for validity and forwards valid requests via e-mail within 2 work days to the appropriate program Branch in DFS Central Office as listed:

         - Food Stamp Hearings

         [Nutrition Assistance and Accountability Branch at CHFSFoodBenefitsPolicy@ky.gov; ;

         - Medical Assistance Hearings

         Medical Support and Benefits Branch at CHFS DFS Medicaid Policy@ky.gov; or

         K-TAP, Kinship Care, FAD, KWP, Relocation Assistance, WIN Hearings

         - Family Self-Sufficiency Branch.

      3) After reviewing for validity, Branch staff submits the exception to the Office of the Commissioner. A copy of the exception is also sent to the client and representative, as appropriate.

   b. 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.

c. Commissioner's office] staff reviews all timely exceptions to the recommended order and drafts a final decision for submission to the Commissioner.

MS 0598 [THE FINAL ORDER

The Commissioner of the Department for Community Based Services issues the final order for the hearing.

A. The final order either 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 Commissioner has 45 days to issue a final order from the date the Commissioner:

1. Receives the official record of the hearing in which a recommended order is not submitted; or
2. Receives the recommended order.

C. The Commissioner signs the final order and mails a copy of the final order to the following:]

1. The recipient;
2. The representative;
3. [The Service Region Administrator Associate (SRAA);]
4. The local office; and
5. 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 0601 LOCAL OFFICE FOLLOW-UP

[When the final order signed by the Commissioner is received in the field, the final order along with the recommended order is carefully reviewed by both the supervisor and worker for any reference to future action in the case. The order is posted on form PAFS-116, Case History Folder.

A. For reversals of denials or discontinuances of IM cases, take case action in the local office to approve or reapprove the case and return the case record to the active file.

For reversals involving reduction of IM benefits, take case action in the local office 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 Food Stamp benefits must be reflected in the benefit allotment within 10 days of the receipt of the final order.

Final orders which result in the issuance of a supplemental or restoration of Food Stamp benefits must be reflected in the household's 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 yes, offset, 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 two days of receipt of the final order, send an appointment letter to the client to come into the office to complete a new form PA-601T, Referral for Medical Determination. 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 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 on the case, 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, in addition, the final order includes recommendations for referrals, for example, to Rehabilitation Services, immediately follow-up such recommendations.

E. In cases in which the Agency is affirmed, 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. For continuity, a brief statement of action, including date of the final order is noted in the case. If pertinent records or facts of substantive value becomes 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.

[G. For continuity, enter a brief statement of action, including date of final order on the KAMES "Comments" screen, and on form PAFS-116.

H.] The Long Term Care material contains specific procedures relative to hearings in which the issue relates to patient status in a Long Term Care facility.

MS 0607 APPEAL TO THE APPEAL BOARD

[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 (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 0574.]

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. 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 to the Hearing Branch. Do not send the case record unless it is requested. The Hearing Branch will forward necessary material and the tape of the hearing to the Appeal Board.

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 0610 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 0613 THE DECISION

[The Appeal Board decision is mailed to the recipient and the recipient's legal counsel by the Appeal Unit. 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 20 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. 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 0616 JUDICIAL REVIEW

[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 20 days from the date of the Appeal Board's decision.

[B. The Hearing Branch requests the entire case record from the local office and forwards the case to the Office of General Counsel for referral to court.

C. The court reviews the record as certified by the Secretary, Cabinet for Families and Children, and no other evidence can be admitted.

D.] The court disposes of the case in a summary manner, limiting its decision to a determination of whether:

[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 such a manner as to constitute 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 0601 for local office procedures after the appeal decision is received.]

MS 0625 CITIZENSHIP AND IDENTITY REQUIREMENTS FOR K-TAP AND MA PROGRAMS

To be eligible for K-TAP and MA (including State Supplementation), an individual must be a citizen of the United States or a qualified alien as specified in Vol. I, MS 2000. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for a time-limited medical card if an emergency medical condition exists. See Vol. I, MS 2075.

Families of foreign birth are to present evidence of alien status or citizenship prior to approval.

Effective July 1, 2006, all individuals applying for Medicaid and K-TAP must present proof of citizenship and proof of identity as a technical eligibility requirement. These citizenship and identification procedures have no effect on Medicaid eligibility determinations for qualified aliens as procedures for qualified aliens per Vol. I, MS 2000-2035 are unchanged.

A. Citizenship requirements for K-TAP and all MA programs are as follows:

1. The following individuals are exempt from these requirements and are not required to verify citizenship or identity:

   a. Deemed eligible newborns under age 1;
   b. Two-Month Emergency Time Limited Medicaid applicants;
   c. SSI individuals;
   d. Medicare recipients;
   e. Foster care children;
   f. Subsidized adoption Title IV-E children; and
   g. RSDI recipients receiving benefits based on disability.

2. If the individual is NOT exempt the applicant must present verification of citizenship. The document must show a U.S. place of birth or that the person is a U.S. citizen and must be the original document. First look for verification of citizenship from the primary tier, Tier 1. If verification cannot be obtained from Tier 1, look into subsequent tiers for possible acceptable forms of verification. However if verification of citizenship is obtained from tiers 2, 3, 4, or if notarized statements are used, then verification of identity <u>must also</u> be provided. If verification of identity is required, the verification must be an original document.

   The following are the tiers of acceptable verification.

   a. TIER 1 (highest reliability)

      Acceptable <u>primary</u> documentation for identification and citizenship may be one of the following:

      1. A U.S. Passport;

2. A Certificate of Naturalization (DHS Forms N-550 or N-570); or
3. A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

b. TIER 2 (satisfactory reliability)

Acceptable secondary documentation to verify proof of citizenship:

1. A U.S. birth certificate (workers may print a copy of a birth certificate from KVETS, the birth index file search program). Workers may access the website for vital statistics to obtain information for the applicant/recipient on how they can request birth certificates from other states at http://www.vitalchek.com/listphone.asp;
2. A Certification of Birth issued by the Department of State (Form DS-1350, FS-240 or FS-545);
3. A U.S. Citizen I.D. card (DHS Form I-197 or I-179);
4. The SAVE database is approved for the purposes of verifying citizenship for naturalized citizens;
5. An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code "KIC";
6. Final adoption decree;
7. Evidence of Civil Service employment by the U.S. government before June 1976;
8. An official military record of service showing a U.S. place of birth; or
9. A Northern Mariana Identification Card, Form I-873.

c. TIER 3 (satisfactory reliability – use only when neither primary nor secondary evidence is available)

Acceptable third-level documentation to verify proof of citizenship:

1. U.S. hospital birth record on hospital letterhead that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth. (DO NOT accept a souvenir birth certificate.);
2. Life, Health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date;
3. Religious records recorded in the U.S. within three months of the birth; or
4. Early school records.

d. TIER 4 (lowest reliability)

Acceptable fourth-level documentation to verify proof of citizenship:

1. Birth records of citizenship that was filed with Vital Statistics within five years of the birth; or

2. Federal or State census record showing U.S. citizenship or a U.S. place of birth for persons born 1900 through 1950. (To obtain this information, the applicant or worker can complete Form DC-600, Application for Search of Census Records and Proof of Age. In remarks, state U.S. citizenship data requested for Medicaid eligibility.) This form can be found on the U.S. Census website at http://www.census.gov; or

3. Institutional admission papers from a nursing home, skilled nursing care facility or other institution that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth; or

4. Medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth unless the application is for a child under 5; or

5. Indian tribal records. If presented for citizenship verification, forward the documents to the Medical Support and Benefits Branch for approval by the Department for Medicaid Services.

e. LAST RESORT

Notarized statements may be accepted for citizenship verification as a last resort only if no other documentation is available. Naturalized citizens are permitted to utilize this process as well.

Procedures are as follows:

1. Written notarized statements MUST be signed under penalty of perjury, from two individuals of which only one can be related;
2. These two individuals MUST have personal knowledge of the events establishing the applicant's claim of citizenship. At least one statement must contain information regarding why other documentation is not available;
3. The person signing the notarized statement must provide proof of his/her own citizenship and identity.

B. Identification requirements for K-TAP and MA programs are as follows:

1. Individuals who provide acceptable primary documentation from Tier 1 have met the identification technical requirements for K-TAP and MA.

2. Individuals who verify citizenship by documentation items listed in Tiers 2, 3 or 4, as well as those signing notarized statements for applicants, must also provide proof of identification. Acceptable original documentation to verify identity consists of the following:

a. A current state driver's license bearing the individual's picture or state identity document with the individual's picture; or

b. Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document; or

c. Other official documentation issued by the state in which the individual resides; or

d. The use of three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, and employer ID cards; or

e. Data matches or documentation from other agencies can be used to meet the identification requirement. These include:

1. Food Stamps;
2. Child Support;
3. Law enforcement;
4. Correction agencies, including juvenile detention;
5. Division of Motor Vehicle records;
6. Expired driver's license – unless questionable;
7. Protection and Permanency documentation, including child protective materials; or
8. Other official documentation issued by local, state or federal governments from the individual's place of birth or residence.

f. The facility director or administration may attest to the identity for disabled individuals in a residential care facility.

3. Identification for children age 16 or younger (age 18 in limited circumstances) may be documented by one of the following if none of the items listed above is available:

a. School identification card with a photograph;
b. Military dependent's identification card if it contains a photograph;
c. School record that shows date and place of birth and parent(s) name;
d. Daycare or nursery school record showing date and place of birth;
e. An affidavit or notarized statement; or
f. A statement signed under penalty of perjury by a parent or guardian attesting to the child's identity.

Note: The statement signed by a parent/guardian DOES NOT have to be notarized as the Medicaid or K-TAP application he/she is signing states that he/she is attesting, under penalty of perjury, to the information provided for the eligibility determination for all members.

As always, assist individuals who encounter any difficulty in obtaining documentation for verification of identification and citizenship. Please be especially mindful of potential challenges facing the elderly, the disabled, the blind and those coping with other types of limitations.

MS 0626

K-TAP AND MA CASE PROCESSING FOR CITIZENSHIP VERIFICATION

To be eligible for K-TAP or MA, an individual must be a citizen of the United States or an alien as specified in Volume I, MS 2000.

A. Process K-TAP and MA cases as follows:

1. Document the original citizenship and identity verification source in case comments and copy verification for the case record.

2. Allow applicants, who do not have adequate verification at the interview, 30 days to provide citizenship verification.

3. The case will approve the members that have met the citizenship and identity requirements (provided all other technical and financial requirements have been met).

4. If the applicant cannot obtain the necessary documents and requests assistance, the worker is to assist the applicant in obtaining documentation.

Note: For joint applications, DO NOT hold the Food Stamp case pending if all other program requirements have been satisfied. Also, for companion Food Stamp and Medicaid or K-TAP cases, the client's failure to present documentary evidence of citizenship for Medicaid or K-TAP does not make the client's citizenship questionable for the Food Stamp case. However, if verification is received in the companion Medicaid or K-TAP case that indicates the client is not an American citizen or makes the client's statement in the Food Stamp case questionable, consider the information as a change known to the agency and take appropriate action to obtain verification. Reference Vol. II, MS 2900.

B. KAMES captures citizenship verification information for K-TAP and MA cases therefore workers are no longer required to print and require members to sign form KIP-106, Save.

C. ACCEPTABLE verification codes for citizenship are;

1. WS (written statement); or
2. OR (original record).

Any other codes entered will trigger an error message.

D. The following are timeframes on actions involving citizenship verification:

1. Applications, recertifications and member adds requiring verification of citizenship only, will pend for 30 days.
2. Applications, recertifications and member adds requiring mandatory and citizenship verification will pend for 10 days.

3. Applications, recertifications and members adds requiring optional and citizenship verification will pend for 30 days.
4. An application or recertification may be pended over 10 days or 30 days when deemed necessary. Case change pending procedures remain unchanged.

E. Cases will not pend for verification of citizenship for those individuals who are receiving Medicare Part A, Medicare Part B or who are conditionally enrolled in or are entitled to enroll in Medicare Part A.

F. A member who is deemed eligible or is in the first 6 months of Transitional Medical Assistance (TMA) will remain active even if verification of citizenship is not provided.

MS 0650 ENUMERATION REQUIREMENTS FOR K-TAP AND MA PROGRAMS

Require each member of the benefit group, other than a deemed eligible newborn, to furnish a Social Security Number (SSN) or apply for an SSN as a technical eligibility requirement. [Do NOT require the applicant to provide an SSN or apply for an SSN for an individual who will not be a member of the K-TAP or MA benefit group.] EXAMPLE: If a grandmother is applying for a grandchild and is not going to be included in the case, she does not have to provide an SSN for herself.

A. Obtain the SSN for each member in a K-TAP or MA case.

1. Accept the individual's statement as verification of the SSN for KAMES cases. No additional verification is required, unless questionable. If the individual provides verification, copy it and file in the case record.
2. If the specified relative (SR) refuses to cooperate with enumeration requirements for a child, exclude that child only from the case. If the unenumerated child is the only eligible child in the home, deny/discontinue the case.

   For MA purposes, the SR remains eligible as technical eligibility related to enumeration does not have to be established for their continued eligibility. Additionally, the child does not have to be in the same case with the SR for the SR to be eligible.

3. If a member of the benefit group receives food stamps, and a Numident match was completed as indicated by "SA" on KAMES, accept this as verification of the individual's SSN and document in the case record.

B. Review the case during initial, ongoing, or interim contact to determine if enumeration is complete on all members. Enumeration is NOT required for deemed eligible newborns who are receiving MA only. Enter the SSN for each enumerated member on the system. If an individual, who must be enumerated, is not currently enumerated, complete form SS-5. Specific information regarding application for an SSN is in MS 0656.

C. Include the individual in the case when the individual, who must be enumerated, does not yet have an SSN and is cooperating with the enumeration process. The individual is cooperating when he:

1. Allows DCBS to mail original documentation to SSA with completed form SS-5; or
2. Returns:
   a. Form SS-10;
   b. Form SSA-2853;
   c. A signed system-generated receipt issued by SSA; or

d. Form SSA-5028 following a face-to-face interview with SSA.

D. For PA-62 cases, the system automatically assigns a pseudo number, unless the individual is in a J, K, M, F, G, or H case. If the person who does not have an SSN is an individual in a J, K, M, F, G, or H case, assign a pseudo number to the individual according to MS 0153. Use this number as the case number.

E. To maintain the integrity of case history, the system or worker assigned pseudo number is used until the SSN is entered on the system through an SSN change action or the SSN is system applied from the SSA tape. The system applied SSN is indicated by "SA" verification source code. If the unenumerated head-of-household or member is discontinued, the previously system-assigned pseudo number is obtained through Inquiry or review of the previous case record. Enter the pseudo number at reapplication if the individual has not yet obtained an SSN. Do not answer "Y" to the "Assign Number?" question. Receipt of the system applied SSN or documentation from SSA serves as verification of the SSN.

F. When an individual, who must be enumerated, does not have an SSN and a face-to-face interview is required with SSA according to MS 0656, do not consider the individual enumerated until one of the following is returned:

1. Form SS-10;
2. Form SSA-2853
3. A signed system-generated receipt issued by SSA; or
4. Form SSA-5028.

G. Form SSA-2853 is acceptable verification of an SSN application ONLY when signed by an authorized hospital official. Remind the individual to provide the Agency a copy of the SSN upon receipt of the card as SSN applications made under the Enumeration at Birth Project will not be on enumeration tapes.

1. For cases on the PA-62 system, spot check the case for 90 days from the date of the SSA-2853 for receipt of the SSN.

2. For cases on KAMES, the system sets up the spot check for 90 days from the date of the SSN application for receipt of the SSN.

The system-generated SSA receipt is acceptable verification of an SSN application ONLY when signed by an SSA official.

H. Applications may be approved, or eligibility continued, during the period pending issuance of a number by the SSA.

MS 0651

ENUMERATION REQUIREMENTS FOR THE FOOD STAMP PROGRAM

A. [As a requirement for applying and participating in the FSP, each household member must provide their Social Security Number (SSN). Providing this requested information is voluntary, however, failure to provide a SSN will result in the denial of food stamp benefits to the individual failing to provide a SSN. Staff should advise applicants of this provision at initial certification and member add. Household members denied for this reason are considered excluded members.]

If the household can provide a social security card or other official documentation provided by an organization or source which verifies the SSN, make a copy of the card or documentation and file this information in the case record. Enter verification code "OR" on KAMES.

B. All SSN's entered on the system at application or member add are sent to the Social Security Administration (SSA) and matched against the Numident file. If no discrepancy occurs between the number provided by the agency and Numident, verification code "SA" is system applied for that SSN and no further agency action is necessary. Once verification code "SA" is applied, this code uploads at reapplication unless case data has been moved to off-line history.

If a discrepancy occurs between the agency provided SSN and Numident, a spot check appears on the DCSR. Within 10 calendar days of receiving an SSN exception, notify the household in writing to resolve the discrepancy. Advise the household that the discrepancy must be resolved within 10 calendar days from the date the notice is sent. If the household fails to cooperate, disqualify the FS member whose SSN could not be verified.

C. Assign a pseudo number for food stamp household members who do not know their SSN or who have never applied for a SSN. Assign a pseudo number for the head-of-household by entering an "X" as directed on the "Application/Recertification Menu" screen. [Assign a pseudo number for case members who are not the head-of-household by entering “9s" in the SSN field.

To maintain the integrity of case history, use the system-assigned pseudo number until the SSN is entered on the system through a SSN change action. If the unenumerated head-of-household or member is discontinued, the previously system-assigned pseudo number is obtained through Inquiry or review of the previous case record. Enter the pseudo numbers at reapplication if the individual has not yet obtained a SSN.]

D. When a pseudo number is assigned to a case member, that case member must apply for an SSN as outlined in this subchapter, section SSN Applications.

If the household is eligible for expedited services, request, but do not require, the household to apply for SSN's prior to initial certification. However, allow those household members unable to provide the required SSN or who do not have one prior to the first full month of participation to continue to participate only if the household applies for an SSN or satisfies the good cause requirements outlined in this subchapter, section Good Cause Criteria. [Newborns may be certified up to six months without an SSN, prior to having to show good cause. See Vol. I MS 0656 C3 for procedures on entering.]

If the household is not eligible for expedited services, require the household to apply for SSN's for each member.

E. Only complete the "Date of SS-5" field when form SS-5 is complete or if form SS-10, form SSA-5028 or form SSA-2853, Message from Social Security, is provided. Do not complete "Date of SS-5" field if household has filled out form SS-5 but must provide additional verification so that the agency can send the form to the SSA. In this case, complete the "Good Cause Date."

Only complete the "Good Cause Date" field when the household cooperates in completing form SS-5 but necessary verification is missing, or when the household must provide form SS-10, form SSA-2853 or SSA-5028 as verification of completing SSA requirements.

Form SSA-2853 is acceptable verification of an SSN application ONLY when signed by an authorized hospital official. [Workers must remind the individual to supply the SSN to the agency upon receipt of the card.]

MS 0653 FAILURE TO COMPLY

A. Failure to comply with enumeration requirements means:

1. A statement of intent not to provide/apply for a SSN;
2. Failure to apply for a SSN; or
3. The member fails to supply documentation required for completion of form SS-5 without good cause. As long as a good faith effort is being made to provide the SSN, good cause exists for failing to provide the number.

B. For K-TAP, sanction the member not enumerated.

C. For MA, technically exclude the members, other than a deemed eligible newborn, who are not enumerated. A member technically excluded for enumeration may be included in the MA family size if advantageous to the assistance group.

D. [As a requirement for applying and participating in the FSP, each household member must provide their Social Security Number (SSN). Providing this requested information is voluntary, however, failure to provide a SSN will result in the denial of food stamp benefits to the individual failing to provide a SSN. Staff should advise applicants of this provision at initial certification and member add. Household members denied for this reason are considered excluded members.]

The disqualification applies to the individual for whom the SSN is not provided and not to the entire household. If a household member is excluded for refusing to obtain or provide a SSN, form KIM-105 is issued to the household notifying them of the exclusion, the reason for the exclusion, the eligibility and benefit level of the remaining members and the actions the household must take to end the member's exclusion. Consider all the resources of the disqualified individual available to the household. All income of the disqualified individual is considered minus the individual's prorated share. The member is disqualified in an on-line process by the system until information is entered by the worker showing that the member is complying with enumeration requirements.

The disqualified household member becomes eligible upon providing the Agency with a SSN or applying for a SSN at the local office, if otherwise eligible.

MS 0656 SSN APPLICATIONS

IF APPLICATION FOR A SSN WITH the Social Security Administration (SSA) IS VERIFIED, do not complete form SS-5. Obtain a copy of form SS-10, form SSA-2853, a signed system-generated receipt issued by SSA, or form SSA-5028 for the case record.

[In completing form SS-5 for a member, verify the date of birth, identity, and citizenship of the individual using evidence required by SSA and procedures for form SS-5.]

ENSURE each individual who completes form SS-5 understands the use of the number and has read and understands "The Privacy Act and Your Request for a Social Security Number" which is printed on page 4 of form SS-5.

To preserve the anonymity of the natural parents and to assure the contents of the original case record remain confidential for children placed for adoption or subsidized adoption, follow enumeration procedures outlined in the Welfare Enumeration Manual, section 00305.145.

A. VERIFICATION. Acceptable proofs of age include:

1. Birth certificate from any hospital NOT shown in the appendix to the procedural instructions for form SS-5;
2. Verification of birth registration (Notification of Birth Registration issued by Vital Statistics);
3. If the member was born in Kentucky in 1976 or later, IMS Program HR E7, Birth Index File;
4. Hospital record;
5. Baptismal record;
6. School record; and
7. INS records.

If a birth certificate, birth registration, baptismal record, etc., is used for proof of date of birth, additional verification is required to establish that the document is actually that of the applicant. Procedural instructions to form SS-5 give a complete listing of acceptable evidence of age and identity. Any document showing a birth place in the United States establishes citizenship.

DO NOT use one document to verify both age and identity (e.g., driver's license); a driver's license verifies identity only. An additional document to verify age is required.

Applicants born outside the United States, Puerto Rico, Guam, U.S. Virgin Islands or American Samoa must prove legal entry into the United States or present proof of citizenship

B. INTERVIEWING. The SSA conducts the required face-to-face interviews for:

1. All individuals age 18 or over applying for the first SSN card;

2. All aliens applying for their first SSN card;
3. Aliens using their INS card for identification for a replacement card; and
4. [Individuals who will not allow their original verification to be forwarded to SSA.]

C. PROCESSING. When completing form SS-5 enter the Welfare Identification Number in the NPN block. This entry will cause the SSN to be automatically loaded to the appropriate systems. If the NPN is not completed or not completed correctly, the SSN cannot be automatically loaded and the worker must enter the SSN manually.

Send completed forms SS-5 along with original verification of birth and identity each week to the Regional or District SSA office serving the specific county. SSA is responsible for returning original verification to the applicant.

1. Enumeration is completed in the following manner:

   a. For all SSN applications for which form SS-5 includes an NPN, once the SSN is assigned, SSA will forward the SSN information to our agency. Then the SSN is loaded to the appropriate systems.
   b. Complete the enumeration process by submitting a Social Security Account Number Change Only transaction on form PA-62 or an SSN change on KAMES as appropriate immediately upon receipt of the verified SSN if the data base was not system updated.

2. Spot check the case at 90 days to ensure the SSN is loaded to the system. If it is not loaded, contact the member to determine if the member has received the SSN. For cases on KAMES, spot checks are posted to the DCSR Report Menu, Pending Case Actions, Expiring Enumeration.

   a. If the member has received the SSN, manually load the SSN to the appropriate system.
   b. If the member has applied for the SSN but has not received the SSN, reinitiate the SS-5 process.

      For cases not on KAMES, a monthly listing of all members NOT enumerated is produced. This listing is generated at the same time the coming due listing is produced.

3. At recertification, review the case to ensure enumeration is complete for all members and that the SSN is loaded to the appropriate system. If the FS household cannot provide an SSN or proof of application at its next recertification after the birth of a new household member, allow the FS household up to six months following the birth month to provide the information. Use the good cause fields on KAMES to allow the household up to six months to comply, while ensuring that the newborn member is not automatically removed from the case.

MS 0659 GOOD CAUSE CRITERIA

If the household member, based on religious grounds refuses to provide an SSN, the member has good cause for failing to comply. If the household member is unable to provide evidence such as out-of-state birth records which are necessary for completing form SS-5, the member has good cause for failing to comply as long as he is making a good faith effort to obtain the evidence.

A. For FS, good cause must be shown monthly in order for such a household member to continue to participate. [However, newborns may be certified up to six months without an SSN, prior to having to show good cause.]

B. For programs other than FS, if you question whether the member is making a good faith effort to obtain the out-of-state birth records, require the household to provide verification such as copies of letters sent to request the information.

MS 0662 USE OF THE SSN

The Department for Community Based Services is authorized to use SSN's in the administration of benefit programs. The SSN is used in the following ways:

A. Access BENDEX information regarding individuals who currently receive K-TAP, MA, or State Supplementation benefits and receive benefits under Title II of the Social Security Act (RSDI);

B. Access the State Data Exchange (SDX), to determine if any household member is currently receiving SSI income and the amount;

C. Access other computer files available to the Department, e.g., IEVS, UI, etc.; and

D. Prevent duplicate participation and determine the accuracy and/or reliability of other income information given by households, e.g., wage records.

MS 0700 INTRODUCTION TO FEDERAL BENEFIT CHANGES

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

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

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

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

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

D. Individuals in Long Term Care who only receive SSI are not affected by the conversion.

MS 0703 INCREASE IN BENEFITS

The annual increases in SSA benefits occurs effective January 1.

A. [The amount of the RSDI increase is 5.8%. The standard SMI premium is $96.40 per month.]

B. The Federal Benefit Rate (FBR) for SSI is:

1. [$674 for a single individual;

2. $1011 for a couple; and]

3. Total income of SSI claimants receiving SSI and any other income is $20 more than the above amounts.

C. [The 2008 Federal Benefit Rate (FBR) for Black Lung is:

1. Claimant - $599.00;

2. Claimant and 1 dependent - $898.40;

3. Claimant and 2 dependents - $1048.10; and

4. Claimant and 3 or more dependents - $1197.90.]

MS 0706 VERIFYING NEW RSDI/SSI AMOUNTS

A. SSI OR COMBINATION OF SSI AND RSDI BENEFITS. No action is required for these cases, as the system completes the conversion using tapes from the SSA.

B. RSDI ONLY BENEFITS. For PA-62 conversion, compute the new RSDI amount.

1. Multiply the current amount by the percentage. [Use 1.026, the percentage plus one, and the result is the new amount.]

2. SSA rounds down the converted RSDI amount.

   a. Multiply the December RSDI amount (dollars and cents) by the January percentage increase, to determine the federal benefit conversion amount.
   b. Round the federal benefit conversion amount down to the nearest 10 cents.
   c. Subtract the SMI amount as of January from the rounded federal benefit amount.
   d. Round this new amount down to the nearest dollar, to determine the net amount of RSDI income.
   e. Add the SMI amount, as of January, to the net amount to determine the gross amount of RSDI income.
   f. If there is no SMI, rounding occurs at the 1st computation, with the amount rounded down to the next whole dollar.

3. 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. Contact the district SSA office if unable to verify benefit amount from these sources.

MS 0707 VERIFYING OTHER NEW AMOUNTS

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

A. RAILROAD RETIREMENT. Benefits for these individuals may increase or decrease.

1. Use form PAFS-54 or the "KAMES-IM Active Cases with RR Benefits", listing to send ONE ALPHABETICAL LIST of claimants per local office to:

a. U.S. Railroad Retirement Board, PO Box 3705 Louisville, Ky. 40201. Telephone: (502) 582-5208
b. List claimant's name and wage earner's name.
c. List claim number as it appears on the Medicare card.
d. The Louisville District Office serves most Kentucky counties, except the following:

	Counties:	Send to:
(1)	Boone, Bracken, Campbell, Gallatin, Grant, Kenton, Mason, Pendleton and Robertson	Cincinnati District Office CBLD Center, RM. 201 36 East 7th Street Cincinnati, Ohio 45202 Telephone: (513) 684-3188
(2)	Ballard, Livingston, Marshall and McCracken	St. Louis District Office Young Federal Bldg. 1222 Spruce St., RM. 1213 St. Louis, Mo 63103 Telephone: (314) 539-6220
(3)	Boyd, Carter, Elliott, Floyd, Greenup, Johnson, Lawrence, Lewis, Martin and Pike	Huntington District Office New Federal Bldg., RM. 112 640 4TH Ave. Huntington, WV 25721 Telephone: (304) 529-5561
(4)	Henderson and Union	Indianapolis District Office The Meridian Centre 50 South Meridian, Suite 303 Indianapolis, IN 46204 Telephone: (317) 226-6111
(5)	Calloway, Carlisle, Fulton, Graves and Hickman	Nashville District Office 233 Cumberland Bend Dr., STE 206 Nashville, TN 37228 Telephone: (615) 736-5131

2. 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.

B. VA BENEFITS. Use form PAFS-53 or "KAMES-IM Active Cases with VA Benefits" to send ONE ALPHABETICAL LIST of claimants per local office to:

   1. [Department of Veterans Affairs, Regional Office, 321 West Main Street, Suite #390, Louisville, KY 40202.] Telephone: (800) 827-1000
   2. 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 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.

C. 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. Take appropriate case action the first possible month.

MS 0709 PA-62 LISTINGS

[The following listings are produced by the PA-62 system. Each listing must be reconciled by the worker and returned to the supervisor.]

A. Before the conversion, several listings are produced that identify cases that have data problems with regard to the SMI premium, Social Security and SSI income. Use these listings to correct cases prior to conversion. The preconversion listings are:

1. J, K, M Cases with SSI income;
2. F, G, H State Supplementation cases with SSI income;
3. A, B, D cases with "No SSI Income";
4. J, K, M cases with SMI not equal to the standard SMI premium;
5. Medicaid Waiver cases with an invalid case status; and
6. LTC cases with invalid institution status.

B. Manual conversion listings are:

1. [Family MA cases with income from statutory benefits and/or responsible relative;]
2. J, K, M cases with income from RR, VA, Black Lung and/or income from responsible relative;
3. State Supplementation cases with income from other statutory benefits and/or responsible relative;
4. Active Pass Through cases;
5. Cases with community spouse/family income allowance; and
6. A B or D cases with case status 09.

C. Listings produced after the system conversion has run:

1. A, B, or D State Supplementation cases with "No SSI Income";
2. State Supplementation, Waiver and Hospice cases converted by the system;
3. Non-institutionalized J, K, or M cases converted by the system;
4. LTC (program code A, B, D, J, K, M) cases converted by the PA system;
5. SSI recipients discontinued from SSI due to increase in Social Security benefits (potential Pass Through cases);
6. A, B, and D cases included in the RSDI conversion with potentially incorrect SSI income; and
7. A, B, and D, or F, G, and H State Supplementation cases potentially ineligible due to the RSDI conversion.

MS 0710 KAMES LISTINGS

All conversion listings must be reconciled by the worker and a desk review completed on each case. [Return the annotated listing to the supervisor, who ensures that actions are completed timely and correctly.]

A. These listings are generated prior to the conversion.

1. A listing titled "IM and FS cases with SSI income and an SMI premium counted" is produced prior to conversion, for active cases on KAMES. Review each case listed and correct errors no later than cut-off in November. All cases must be corrected prior to the automated conversion.

2. Listings are generated the first of November as follows:

a. The master list includes all cases which have unearned income of Veterans Administration (VA) Benefits, Railroad Retirement (RR), or Black Lung. The manual conversion must be completed prior to cut-off in February.

b. Separate listings for RR, VA and Black Lung benefit recipients are produced. The RR and VA listings are sent to local county offices and then forwarded to the appropriate agencies for verification of income. The listings take the place of forms PAFS-53 and PAFS-54.

B. The following exception listings are generated on hardcopy after the automated conversion is run in December for cases which the system could not convert:

1. Cases with SSI and could not be converted using the SDX tape; and
2. Cases with RSDI that could not be converted using the BENDEX tape.

C. An exception listing for all cases containing income from VA, RR or Black Lung benefits which have no action taken by the end of February, is generated March 1.

D. The following listings are posted to RMDS after conversion.

1. HR KIMJ16 Mass change discontinuance report.
2. HR KIMJ17 Cases affected by Mass Change.

MS 0712 PA-62 AUTOMATED CONVERSION

The RSDI and SSI amount shown on the PA-62 data base is automatically adjusted in the following situations:

A. F, G, or H State Supplementation cases with institutional status code of P1, P4, or P5 with RSDI income;

B. A, B, or D State Supplementation cases with institutional status code of P1, P4, or P5 with SSI Income or SSI and RSDI income;

C. [J, K, or M category, HCBS, SCL, non-institutionalized Hospice cases with institutional status code M6, M8, M9, W1, and W2, with RSDI income and total income is equal to or less than the appropriate standard;]

D. A, B, D, J, K, or M Institutionalized Hospice cases with institutional status M7, with RSDI income;

E. J, K, or M cases with case status 03;

F. A, B, or D and J, K, or M LTC cases with institutional status of M2, M3, M5, or R1, with RSDI income; and

G. [The personal needs allowance will be converted and the patient liability adjusted accordingly for HCBS, SCL and noninstitutionalized Hospice cases with no RSDI or SSI income.]

H. The State Supplementation standard will be converted in all A, B, D, F, G, or H cases with institutional status P1, P4, or P5.

For those cases automatically converted by the PA-62 system, the PA-62 turnaround documents are sent to local offices to be filed in the case record. System-generated form PA-105A is sent for cases automatically converted. [Copies of form PA-105A are maintained on microfiche in Quality Central.]

MS 0715 PA-62 MANUAL CONVERSION

Use the following procedures to manually convert cases on the PA-62 system.

A. All statutory income must be manually converted in the following situations:

1. [Family MA cases, including P and U cases on the PA-62 system;]
2. Active Pass Through cases;
3. State Supplementation cases on the PA-62 system with institutional status codes of P2, P6 or P7; and
4. A, B, D cases with status of 09.

[Appropriate local DCBS offices are notified of active cases not system converted due to conflicting data on the PA-62 system.]

B. Statutory income other than RSDI and SSI must be manually converted in the following situations:

1. J, K, or M cases with Surplus from a responsible relative;
2. A, B, or D SSI Alert cases with statutory benefits other than RSDI; and
3. State Supplementation cases with Institutional Status codes of P1, P4 and P5, and statutory benefits other than RSDI and SSI.

C. Projected RSDI amounts for the month of the federal change are given for J, K, M, and F, G, or H cases on the PA-62 system. [For Family MA cases on the PA-62 system, the listings contain the amounts of RSDI benefits in the month before the federal change.] Use lists to:

1. Assure all appropriate cases are converted;
2. Identify potential Pass Through cases, if application is made;
3. Assure State Supplementation P1, P4 and P5 discontinued cases are program transferred to F, G, H Pass Through if appropriate;
4. Assure verification of RR, VA, and Black Lung amounts;
5. [Assure vendor payment section on form PA-62 is changed if appropriate, for ALL LTC, Hospice, HCBS and SCL cases, including cases automatically converted;] and
6. Assure money payment cases to be discontinued due to conversion are program transferred to the appropriate MA program, if eligible.

MS 0718 WORKER ACTIVITY - PA-62 CONVERSION

The following actions are completed for cases on the PA-62 system.

A. Record all calculations/verification as appropriate.

B. Submit PA-62 documents daily.

C. Post forms PAFS-116 and PA-31 with mo/yr "C" to show automated/ manual conversion is completed. Annotate appropriate listing and return to the FSS when the conversion action is completed.

D. Send form PAFS-628, if appropriate.

E. For State Supplementation cases, review discontinued money payment cases for possible Pass Through or other MA eligibility, and;

1. [If eligible, program transfer.
2. If ineligible for ongoing Pass Through or other MA, complete MA-105 form and enter, "When your medical expenses are more than the amount of this increase, you may wish to reapply for Medicaid."]

MS 0719 [SUPERVISORY ACTIVITY

Supervisory activity regarding conversion includes:]

A. Check State Supplementation application registers and make sure that all State Supplementation December approvals are converted using January income and standards.

B. [Assure that form PA-62 is completed and input for all manually converted cases. Additionally, form PA-62, including vendor payment section, must be completed for all LTC, U, Hospice, HCBS and SCL cases.]

C. Collect annotated conversion listings and ensure that all cases have been converted as required.

MS 0721 PA-62 TIMEFRAMES AND PROCEDURES

Process cases, which are on the PA-62 system, in the following manner:

A. [Family MA Cases, except U;]

1. Applications processed in December.

a. Use December RSDI income to determine eligibility for December and the retroactive period. Determine ongoing eligibility using the January amount of RSDI.
b. If the increase in RSDI results in MA ineligibility, complete a special circumstance transaction to authorize MA eligibility for December and the appropriate retroactive months. Advise the individual of potential spend down eligibility.
c. If ongoing eligibility is established, after the approval document showing December income clears, submit a change document to reflect January income.

2. Conversion of active cases.

a. [RSDI income must be manually converted for all Family MA categories.]
b. Complete the manual conversion prior to the December cutoff date.

B. State Supplementation Cases;

1. Applications processed in December;

a. On approval documents submitted and accepted any time during December, use December income and standards.
b. On approval documents for applications accepted in December but processed in January, use the new income and standard to determine eligibility and payment amounts for January and ongoing. For December, use the prior income and standard amounts to determine eligibility and payment amount. Issue the payment amount for December by special payment on the approval transaction document.

2. Conversion of State Supplementation Cases;

a. For changes on an active State Supplementation case during the month of December, use new income and standards.
b. For active State Supplementation cases, requiring manual conversion, provide timely notice for decreases and complete the manual conversion prior to cutoff in December so that the change will be effective in January.

C. Spend Down Cases;

1. Calculate income on the actual income received each month in the quarter.
2. Consider the conversion income only in the months actually received.
3. Combine income for the quarter and convert to an average monthly income.
4. Determine quarterly excess, if appropriate.
5. Determine the monthly cost of SMI using the old SMI amount for months prior to January and the new SMI amount for January, and after, as appropriate.

D. [HOSPICE, HCBS and SCL Cases;

1. Hospice, HCBS and SCL case approvals in December.]

   a. Use December income and special income standard on approval documents submitted and accepted in December.
   b. When the approval document is accepted and returned, submit a 2nd document on or before the last work day in December, using January converted statutory benefit and the new special income standard.

2. Once the conversion has been run in December, the conversion transaction will be uploaded on PA-62, effective January. Therefore, any changes to the case record for December must be completed as a Special Circumstance Transaction.
3. Conversion of active cases;

   a. [For conversions that result in INCREASES in patient liability for Hospice, HCBS and SCL cases, submit form PA-62, including vendor payment section, AFTER December 1 but BEFORE January 1.
   b. For conversions that result in DECREASES in patient liability for Hospice, HCBS and SCL cases, submit form PA-62, including vendor payment section, AFTER January 1 but BEFORE February 1.]

E. LTC and U Cases.

1. Application approvals in December.

   a. For all approvals submitted prior to December cutoff, process these cases using December income and the computer will convert the income at December cutoff, if applicable, for ongoing eligibility.
   b. For all approvals submitted after December cutoff, two forms PA-62, including vendor payment section, are required:

      (1) The first to cover month of admission; and
      (2) The second to cover January conversion information.

2. Once the conversion has been run in December, the conversion transaction will be uploaded on PA-62 effective January. Therefore, any changes to the case record for December must be completed as a Special Circumstance Transaction.

3. Conversion of active cases;

   a. If patient liability increases, submit form PA-62, including vendor payment section, AFTER December cutoff but BEFORE January cutoff.
   b. If patient liability decreases, submit form PA-62, including vendor payment section, AFTER January 1 but BEFORE February 1.

4. Restrictions

   a. [DO NOT complete conversion forms PA-62 on deceased or discharged recipients.]
   b. Conversion forms PA-62 including vendor payment section, cannot report any other change information unless the change is to be effective the January conversion month, for example, increase in other income or any verified deduction.

F. RESTRICTIONS ON ALL CASES FOR THE DAY OF CUTOFF AND THE LAST WORK DAY OF DECEMBER.

1. Do not submit approval documents containing conversion income.
2. Do not resubmit approval documents previously submitted but not accepted by the computer.

MS 0722 KAMES AUTOMATED CONVERSION

KAMES will automatically adjust RSDI and SSI income for all members unless otherwise noted as an exception in MS 0723.

A. For applications taken prior to conversion and approved after mass change runs, a case change must be processed after approval in order for the system to issue the proper benefits for the month prior to conversion and the month of conversion. The case change can be processed on the same day as the approval.

B. Special consideration of RSDI income for QMB Cases on KAMES is needed, as the cost of living increase cannot be applied to QMB eligible individuals until March. In order to accommodate this federal requirement, special procedures are used. The newly increased amount of RSDI income is entered on the screen. The KAMES system internally subtracts the percentage increase for that year from the amount of income entered. This calculation WILL NOT display on the screens. However, the reduced amount of income is correctly used in the case. This process ensures the increased amount of income is not considered in a QMB case until required. The system automatically considers the increased income at the appropriate time.

MS 0723 KAMES MANUAL CONVERSION

A. The federal benefit amount must be manually converted for cases that include:

1. Veterans Administration Benefits;
2. Railroad Retirement;
3. Black Lung;
4. SSI or RSDI/SSI cases with SMI premiums;
5. Cases with SSI and member not on SDX Tape, payment status inactive or an SSI overpayment or underpayment exists;
6. Cases with RSDI that could not be converted using the BENDEX tape; and
7. State Supplementation Cases potentially ineligible due to the RSDI conversion.

B. Use the following timeframes:

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 no later than the March issuance.

3. For any case not converted to the new Federal benefit level by the due date, complete a claim.

MS 0725 QUALIFIED MEDICARE BENEFICIARIES STANDARD CONVERSION (QDWI, QMB, SLMB, AND QI-1)

Qualified Medicare Beneficiaries income standards increase each January, which are based on poverty level guidelines published by the federal government, and loaded on KAMES effective April of each year. As these income standards do not increase at the same time as the RSDI cost of living (COLA) increase each January, the RSDI COLA increase cannot be considered available income in the QDWI, QMB, SLMB, and QI-1 eligibility determination until the QDWI, QMB, SLMB, and QI-1 income standards increase on KAMES. However, increases in any other type of income must be considered in the eligibility determination when they are available.

A. As a result, the following special considerations apply when determining QDWI, QMB, and SLMB eligibility of an RSDI recipient.

For case actions on Z only cases or dual eligible applications/recertifications with Railroad Retirement and/or RSDI income, processed between January 1st and the effective date of the Qualified Medicare Beneficiaries income standard increase each year, determine QMB/SLMB/QI-1 eligibility. Enter Railroad Retirement and/or RSDI amounts correctly for the same for months. KAMES applies a special deduction (called the "You Can't See Me" deduction) to the QMB/SLMB/QI-1 calculation for the new year's income if the case is approved prior to the new standards being in effect. This prevents the Railroad Retirement and/or RSDI increase from being used until the standard increases.

B. For increases in the QMB standard, KAMES converts active MA recipients to MA/QMB/SLMB dual eligibility if technical and financial eligibility requirements are met.

1. The automated conversion is completed to convert cases with countable income equal to or less than the Qualified Medicare Beneficiaries standard plus the $20 general exclusion and Medicare Part A to dual MA/QMB/SLMB eligibility.

2. The system changes the case status to the dual eligibility case status code and removes the SMI premium disregard.

C. For cases with vendor payment status, KAMES also completes a vendor payment conversion.

1. For this conversion, the system recomputes the patient liability due to removal of the SMI premium disregard.
2. That liability amount is compared to the current patient liability amount on the Long Term Care 552 Master.
3. If the amounts match, the vendor payment section is converted but reflects the same patient liability.

4. If the amounts do not match, the vendor payment section is converted to reflect the new patient liability amount and a new MAP-552 is generated.
5. A listing of cases converted in the vendor payment conversion is available on RDS for informational purposes.

MS 0900 TIME FRAMES FOR INCREASES IN PUBLIC ASSISTANCE

When the state agency makes an overall adjustment to PA payments, corresponding adjustments in the household's food stamp benefits are handled as a mass change.

When there are at least 30 days advance knowledge of the amount of the PA adjustment, food stamp benefits are adjusted to be effective in the same month as the PA change.

MS 0906 AUTOMATED NOTICES

A notice of action taken is required, but a timely notice of a reduction or discontinuance of benefits is not required. For households whose benefits increase or do not change, a computer generated notice will be sent to the household. KAMES generates all required notices for any case action taken as a result of the conversion.

MS 1000 PA-62 GENERAL INFORMATION

[Family MA, and Aged, Blind or Disabled MA cases which are carried on the PA-62 system, spot checks are automated.] Spot check types can be input on form PA-62, fields 83a and 84a. [Use these fields to input the specific type to generate a spot check listing in the month input in fields 83b or 84b respectively. Refer to the Computer Manual, the PA-62 system for spot check codes.]

A listing is found on RMDS in the month the spot check is due, to notify the worker that a change or other action is necessary. A control listing is generated to the supervisor through RMDS. [Enter the spot check type and corresponding date on form PA-62 whenever a need for a spot check is identified. The spot check type and date are automatically deleted (except code 03) from the system when the spot check listing is generated.]

The spot check listings are generated at cut-off. A second listing will be generated at the end of the month. Both listings are found on RMDS. This listing will capture spot checks added after cut-off and before the end of the month and are due the following month. The cases identified with spot check type "03" will appear on both listings in the month the spot check is due.

MS 1010 PREGNANT WOMEN PA-62 SPECIAL PROCEDURES

At the time the spot check for birth of child is due (the month following the month of the anticipated birth), a notice is sent to the client notifying her of the need to report the birth. During her pregnancy she may also receive special mailings to notify her of potential benefits to which she may be entitled (e.g., EPSDT, WIC, etc.)

If no action has been taken within 30 days, the spot check for the pregnant woman is placed on a supplemental listing titled "Past Due Spot Checks" and sent to the Director's Office for follow-up. The caseworker must manually delete spot check type "03."

The pregnant woman spot check type is given priority over other spot check types when space is limited.

MS 1013 MANDATORY COORDINATION OF MEDICAID WITH WIC

As a result of the Omnibus Budget Reconciliation Act (OBRA) of 1989, States are required to advise Medicaid recipients of potential eligibility for services provided by the Women, Infants and Children (WIC) program. In order to meet the requirement for notification and referral without adding additional workload for the caseworker, a unique PA-62 spot check code is utilized to identify those individuals for whom a WIC referral is appropriate.

A. [For cases on the PA-62 system enter a spot check code "17" (potential eligibility for WIC) on the PA-62 document for an individual in a Family MA case who is pregnant, postpartum or under age 5. Enter the spot check type on form PA-62 at the time of case approval, recertification or interim to add an affected individual to the case, and when the agency becomes aware that the client is pregnant.] The spot check generates a written notice to the household advising that members may be eligible for WIC services.

B. For cases on KAMES a similar notice is system-generated when the information on the Standard Filing Unit screen indicates that potential eligibility for WIC exists.

C. [An annual notice is sent to all K-TAP only households concerning the services provided by the WIC program.]

MS 1100 OVERVIEW OF THE CHILD CARE ASSISTANCE PROGRAM

Eligibility for the Child Care Assistance Program (CCAP), is determined by service agents, contracted by the Cabinet, for all individuals except for those who are:

- [Participants in the Kentucky Works Program (KWP) including sanctioned individuals participating in KWP to cure the penalty;]
- Employed K-TAP recipients; or
- Receiving child protective services from the Division of Protection and Permanency.

Eligibility for Child Care Assistance for KWP participants or employed K-TAP recipients is determined by the KWP case manager or K-TAP worker.

The list of the service agents and counties each serve are located at http://chfs.ky.gov/dcbs/dcc/apply.html.

A. The CCAP serves:

1. K-TAP recipients, including teen parents, who need child care while they are employed or participating in KWP;
2. K-TAP recipients who need child care in order to work and whose K-TAP case is discontinued and whose income remains at or below 165% of the federal poverty level. These individuals may be eligible for CCAP for 12 months from the effective month of discontinuance;
3. Families with children receiving protective services;
4. Non-K-TAP teen parents who need child care in order to attend school; and
5. Low-income families who need child care while they are working. This includes Kinship Care caregivers.

B. 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 assistance for caring for that child.

C. Family Support staff may address the child care needs of applicants and recipients by:

[1. Approving child care benefits for K-TAP recipients using form DCC-85A, K-TAP Approval for Child Care Assistance.

2. Referring recipients of Food benefits, Medicaid, child only K-TAP cases with no 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.

D. A summary of the CCAP for workers is contained in form DCC-113, Child Care Assistance Program (CCAP) Information for Workers, which can be accessed at http://chfsnet.ky.gov/dcbs/dcc/forms/]

MS 1115 CCAP ELIGIBILITY REQUIREMENTS

To be eligible for the Child Care Assistance Program (CCAP), one of the following criteria must be met.

A. The parent or responsible adult must be:

1. Working;

2. Attending an education/training program and:

   a. Employed for a minimum of 20 hours per week; or
   b. Participating a minimum of 20 hours per week:
      (1) As a student teacher;
      (2) In an internship; or
      (3) In a practicum; or
   c. Participating in a combination of item a. and item b. equaling 20 hours per week.

3. Receiving K-TAP and working or participating in the Kentucky Works Program; or

4. A teen parent (through age 19) attending high school.

5. 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.

B. The household includes a dependent child needing care who is:

1. Under age 13;
2. Under the 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 less than 150% of the federal poverty level. The income of responsible adults in the household is considered in the eligibility determination completed by the service agent. Income of a child is excluded.

D. The income limit for a family discontinued from K-TAP is 165% of the federal poverty level for the twelve months following the effective month of closure of K-TAP benefits. If the income exceeds 165% of the federal poverty level before the end of the 12 months, eligibility for CCAP ends.

E. Families receiving child care assistance are responsible for a co-payment paid to the child care provider or the recipient. 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 free programs.

MS 1125 CCAP REFERRAL PROCESS

The family is referred to the appropriate Child Care Assistance Program (CCAP), service agent for the county in which the family resides. The procedure for referral and the exchange of information between the Department for Community Based Services and the service agents is developed on a local level.

A. For Kinship Care, Food Benefit, Medicaid or payee only K-TAP cases, the DCC-85A approval process is inappropriate. Use form DCC-86, Referral for Low-Income Child Care Assistance, to refer the family to the service agent to determine eligibility for child care assistance.]

B. Refer to Volume IIIA, MS 5270 for specific instructions for approval for CCAP for KWP participants.

MS 1200 OVERVIEW

The National Voter Registration Act (NVRA) of 1993 was signed into law on May 20, 1993 and is effective January 1, 1995. The purpose of NVRA, also known as the Motor Voter Act, is to ensure that more opportunities are available for all people to register to vote or update voter registration.

[The Motor Voter Act requires applications to register to vote be provided at agencies that provide benefits under the Kentucky Transitional Assistance Program (K-TAP), Special Supplemental Food Program for Women, Infants, and Children (WIC), Medicaid, and Food Stamp programs, Armed Forces recruitment offices, Driver Licensing, agencies providing services to persons with disabilities and other designated agencies.] These agencies must distribute voter registration forms, provide assistance in completing forms and ensure the completed voter registration forms reach the proper state election office for processing. These services are provided by the agencies at application for benefits for the programs administered by those offices, at recertification for benefits and if reporting a change of address.

MS 1210 RESTRICTIONS

The Motor Voter Act prohibits any person providing voter registration services from:

A. Seeking to influence an applicant/recipient's political preference or party registration;

B. Displaying any such political preference or party allegiance; and

C. Making any statement to an applicant/recipient or take any action that may leave the individual with the impression that a decision to register or not to register to vote will have any bearing on the availability of program services or benefits.

Failure to follow these restrictions could result in a fine, imprisonment (not to exceed 5 years) or both.

MS 1220 INDIVIDUALS TO BE REGISTERED

Applicants/recipients meeting all of the following criteria are provided the opportunity to complete an application to register to vote or update his/her current voter registration. [This opportunity is to be made available at application (including program transfer), recertification or if reporting a change of address for K-TAP, Medicaid or Food Stamps.] The individual must:

A. Be age 18 or over; AND

B. Be present in the office at the time of the interview or when a change of address is reported; AND

C. Not be registered to vote or not registered to vote at his/her current address.

Individuals not included in the assistance application are not registered to vote through this process. This includes individuals who are payee only, a representative or are acting as a responsible party.

Caseworkers must provide the same level of assistance to individuals applying to register to vote as are provided for other applications for assistance. This includes, but is not limited to, assistance in completing the application to register to vote, unless the applicant/recipient refuses any such assistance.

NOTE: Completion of the Voter Registration Form is only an application to register to vote. The State Board of Elections must approve the application to register to vote and sends a confirmation or denial notice to the applicant.

MS 1230 VOTER REGISTRATION PROCEDURES

A. [For applicants/recipients age 18 or over, the following procedures are utilized at application (including program transfer or member add) and recertifications.]

1. Indicate on KIM screen HRKIMA0H-Member Information, on page 6 of the hard copy KIM-100 form or on form PA-20, MA Voter Registration Supplement, (the PA-20 is only used for MA cases not on KIM) if the applicant/recipient is present at the interview with a "Y" or "N" in the Present at Interview field.

   a. If "N," skip the next 2 questions. No further action is required if the individual is not present at the interview; or
   b. If "Y," proceed to the next question.

2. In the Is He/She Registered to Vote at Current Address? field, record the individual's response with a "Y" or "N."

   a. If "N," proceed to Step 3; or
   b. If "Y," the individual states he/she is registered to vote at his/her current address, no further action is needed.

3. If the individual indicates he/she is not presently registered to vote or not registered to vote at his/her current address, provide the individual with form PAFS-706, Voter Registration Rights and Declination. PART I, Rights, is read by or to the individual and he/she indicates understanding by signing and dating PART I of the form.

4. After the individual reviews his/her rights and signs PART I of form PAFS-706, record the individual's response to the question "Would you like to apply to register to vote here today?" in the appropriate field on KIM, form KIM-100 or form PA-20.

   a. If "N," have the individual complete PART II, Declination, of the form PAFS-706. The worker then signs and dates PART III of the form and files the original in the fold of the most current form PAFS-116. The copy is given to the individual. No further action is necessary.

      NOTE: If the individual is applying for or receiving benefits in multiple assistance programs, file the original form PAFS-706 in the Food Stamp case record and make copies to file in any related cases.

   b. If "Y":

      (1) On KIM, a system-generated facsimile of the Commonwealth of Kentucky Voter Registration Card is produced

with the assistance application. The individual's name, SSN, date of birth, sex, county of residence and address will be uploaded on the system-generated facsimile of the Voter Registration Card. The individual must check his/her party affiliation, read or have read to him/her the Voter Declaration and sign and date the form. Provide each individual an envelope in which he/she can seal his/her system-generated Voter Registration Form.

(2) For any application/recertification not completed on KIM (including hardcopy KIM-100 applications taken when the system is down, etc.), provide the individual with form SBE 01, Commonwealth of Kentucky Voter Registration Card. The individual must complete form SBE 01, read or have read to him/her the Voter Declaration, and sign and date the form.

If requested, assist the individual in completing form SBE 01 or the system-generated facsimile.

The individual must be provided the opportunity to complete the form in private.

Instruct the individual to deposit his/her sealed system-generated application or form SBE 01 in the locked Voter Registration box in the local office.

After the initial form PAFS-706 is signed by the individual, the worker is only required to ask him/her once a year if he/she would like to register to vote if not registered to vote at his/her current address.

B. When a recipient reports a change of address, while in the local office, the worker must take the following steps.

1. Complete PART I of form PAFS-706.
2. If the recipient declines to complete the Voter Registration Card, complete PART II of form PAFS-706.
3. If the recipient chooses to make an application to register to vote, provide him/her with form SBE 01. The recipient can deposit form SBE 01 in a sealed envelope in the locked Voter Registration box at the local office.
4. Annotate on form PAFS-126, Change Report Form, that the recipient completed a hardcopy Voter Registration Card.

If a recipient reports a change of address by another method, the local office sends the recipient form SBE 01 (Mail-In), Commonwealth of Kentucky Mail-In Voter Registration Form, upon request and annotates form PAFS-126 appropriately. Form SBE 01 (Mail-In) is self-addressed, but requires postage.

MS 1485* EMPLOYEE FRAUD

Fraudulent activity by an employee occurs when a person responsible for administering an assistance program knowingly obtains benefits or aids an individual to obtain benefits, or receive increased benefits, for which the individual is not eligible. The employee committing the fraud is guilty of a felony. Conviction of this type felony is punishable by imprisonment of 5-10 years and/or a fine up to $10,000 or double the gain.

MS 1495* HOW TO PREVENT A CLAIM

The following is a list of verification measures used statewide to avoid agency errors and to detect fraudulent applications in all programs prior to determining eligibility.

A. Explore and verify all points of eligibility and document the case record. This may include the following actions:

   1. Thorough questioning;

   2. Verify applicant's statements by examining documents in his/her possession or by obtaining information from appropriate third party sources; or

   3. Verify any new employment or termination of employment reported by contacting the employer. If contacting the employer is not possible, case comments must state why contact was not made.

B. Clarify all inconsistencies;

C. Complete all spot checks as indicated by the case situation;

D. Ensure that all applications are signed and correctly dated;

E. Ensure that all clients are made aware of:

   1. The legal responsibility to provide correct and complete information;

   2. The legal responsibility to report changes correctly and timely;

   3. The consequences of incorrect statements or omissions including repayment or possible criminal penalties;

   4. The responsibility to report receipt of benefits in an amount greater than that to which the client was entitled;

   5. The requirement of repayment in all situations where benefits received exceed the entitled amount;

   6. The proper use of food stamp benefits; and

   7. Simplified reporting requirements.

F. Supervisors or their designated personnel MUST review a select number of cases for technical and financial eligibility prior to approval;

G. Workers should attend communication/interviewing workshops periodically; and

H. Refer to the Determining Eligibility Through Extensive Review (DETER) policy and procedures in MS 1508.

I. Enter all disqualifications timely.

MS 1497* HOW TO IDENTIFY A CLAIM

A claim exists when an amount is owed because of benefits that are overpaid or benefits that are trafficked.

A. Claims may be identified through information from the following sources:

1. The Income and Eligibility Verification System (IEVS) includes computer matches with various benefits programs, such as wage records, unemployment insurance, etc.;

2. Collateral contacts;

3. "Hotline" referrals from the Office of Inspector General (OIG);

4. Quality Control (QC) reviews;

5. Spot checks;

6. EBT transaction history;

7. Supervisory review; or

8. Management Evaluation (ME) review.

B. Claims may also be identified through:

1. Batch Match – Some wages do not appear on programs at the time of the interview. Wages may be posted on batch match six months or more later.

2. Changes – Client may report a change, but after worker verifies the situation, it is noticed the reported change was not made timely.

3. Expense vs. Income – Client's expenses are more than their income. Possible income not being counted in case.

4. Worker Interview – A thorough interview most likely will cause the applicant to report other income, such as contributions from other family members or friends, which is not being counted in the case.

5. Income – Check stubs reflect income increase due to raise in pay or overtime worked. Increase not reported.

6. Deductions given in error such as Standard Utility Allowance (SUA) and Basic Utility Allowance (BUA), etc.

7. Simplified Reporting Household – Determine:

   a. If the household's monthly gross income is more than the amount listed on form FS-8, Food Stamp Simplified Reporting Requirements Handout, for the household size; or

b. If any member of the household who is age 18 through 49, failed to report working less than 20 hours a week.

MS 1504* CLAIMS COMPUTER SYSTEM

The Kentucky Claims Debt (KCD) Management System is dedicated exclusively to claims and claim activity. Access is available on the KYNET Application Menu.

Use KCD to:

A. Record pending claims;

B. Calculate or compute claims;

C. Complete a correction of a claim;

D. Track claim completion;

E. Issue refunds of payments;

F. Make adjustments to claims;

G. Issue claim-related notices and repayment agreements;

H. Track claim repayment for claims; and

I. Inquire the status of claims.

MS 1507 MAINTAINING CLAIMS CONTROL FILES

The local office maintains a claims control file containing individual claims control folders.

A. Set up a claims control folder for each claim. If the client has 3 separate claims, 3 separate folders must be set up. The information on the 3 claims cannot be combined into one folder.

B. Keep the following information in the claims control folder as needed to document each claim. All items may not apply to every claim.

1. Information used to establish the claim, such as:

a. Form PAFS-431, Claim Referral;

b. Verification such as (IEVS) records or other listings, statements from employers, statements from collaterals, etc.;

c. Information from Office of Inspector General (OIG); and

d. Claim Computations.

2. Verification of Food Stamp (FS) participation. Use KAMES Inquiry Segment "J" (Benefits) for each claim month identified.

3. 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 Food Stamp Program Violation, FS-80 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or FS-111, Deferred Adjudication Disqualification Consent Agreement.

4. Repayment material on or after 10/1/05. KCD maintains the claim history for "Comments" screens, calculation screens, and letter history. The following copies must be maintained in the claims control folder:

a. Copies of claim related correspondence manually sent to the client;

b. Copy of the Notice of Repayment Schedule, if appropriate;

c. Copy of form PAFS-444, Collection Information Update;

d. Copy of payments forwarded to CMS from the local office.

C. Separate the claims in the control file alphabetically into the following categories:

1. Pending claims;

2. Active claims;

3. Inactive claims;

4. Claims referred for legal action/disqualification hearings;

5. For FS, terminated claims; and

6. Closed claims.

D. Color code the claims control folders as follows:

1. Blue tab - Fraud/Intentional Program Violation (IPV); and

2. White tab - Nonfraud/Inadvertent Household Error (IHE) and Agency Error (AE).

E. Retain the claims control folder (except for an IPV claim) for 3 years after the claim is paid-in-full or terminated, unless the claim is part of an audit. If part of an audit, retain the claims control folder until the audit is completed.

F. DO NOT PURGE IPV claim records or any case records which are used to support either pending disqualifications or disqualifications which are being or have been served. IPV claim records are used to respond to requests from states, which are participating in the Disqualified Recipient Subsystem.

MS 1508* DETERMINING ELIGIBILITY THROUGH EXTENSIVE REVIEW

The Determining Eligibility Through Extensive Review (DETER) program is a service offered by the Office of Inspector General (OIG). The purpose of DETER is to prevent individuals from obtaining benefits fraudulently from Food Stamps (FS), K-TAP, Medicaid (MA) or other programs administered by the Department for Community Based Services (DCBS). Cases that appear suspect with respect to eligibility requirements, should be referred to the DETER program for investigation. [Only cases that cannot be resolved through normal case processing procedures are referred to DETER.]

A. Although the primary focus of DETER is applicant eligibility, referrals may be made at recertification or other times as warranted.

   1. All applications, reapplications, recertifications and interims with questionable documentation or verification are referred to DETER, using form DTR-1, DETER Referral.

   2. [For a current list of counties in which DETER operates, refer to http://chfsnet.ky.gov/os/oig/deter.htm]

   3. Case workers must explore all avenues available to resolve the issue(s) in question before referring to DETER. Inappropriate DETER referrals will be returned to the worker.

B. [A DETER referral is appropriate ONLY if a specific issue affecting eligibility is identified. Referrals are made to DETER only after staff have all possible verification and documentation on all eligibility factors required by policy. Case disposition is pended for a maximum of 30 days to allow the DETER investigator to complete the investigation and report his/her findings to the caseworker. The DETER investigator has 15 work days to complete the investigation and return the form/conclusion for applications only. All other DETER referrals are prioritized. The DETER referral form, DTR-1, is sent via e-mail as an attachment to aid in ensuring the 30-day standard of promptness is met. Do not hold cases past 30 days if a response is not received within the 30 day time frame.]

   1. For K-TAP cases, allow KAMES to compute the grant amount prior to the referral. However, prior to the disposition, remove verification of residency, which will pend the application. Pend the case up to 30 days until forms DTR-2, Case Detail Summary Sheet; DTR-2A, DETER Response and Request for Action; and DTR-3, DETER Investigation Report, are sent by the DETER investigator.

2. For FS cases, allow KAMES to compute the FS allotment. However, prior to the disposition, remove verification of residency, which will pend the application. The case will remain in pending status up to 30 days until forms DTR-2, DTR-2A and DTR-3 are sent by the DETER investigator. If the case is expedited do not pend.

3. For referrals which involve multiple programs; i.e., K-TAP, FS or MA, include ALL case information on a single DTR-1. DO NOT send any part of the actual case record(s).

The grant determination and computation of the FS allotment is needed to complete form DTR-1 prior to the referral.

C. After satisfying the verification requirements, use the following criteria as a reference to refer K-TAP/MA cases (either pending or active) to DETER.

1. Identification. Applicant presents an identification document which appears to have been altered and/or does not appear to be authentic.

2. Residency. Applicant presents verification of residency; e.g., rent receipts, mortgage payments, etc., that appears to have been altered and/or written by the applicant.

3. Relationship. Applicant presents documentation to establish a relationship to the child for whom assistance is requested, which appears to have been altered and/or does not appear to be authentic (e.g., birth certificates, marriage licenses, divorce records, adoption papers, notarized statements from people who know about the relationship).

4. Deprivation. Applicant reports residency with a member of the opposite sex, claims no marriage and reports no blood/legal relationship between household member and him/herself and children in grant. However, client gives conflicting information throughout the interview.

   The applicant provides contradictory information relative to the whereabouts of the absent parent.

   Example: Applicant advises that the whereabouts of the non-custodial parent (NCP) is unknown. However, applicant reports that the NCP has contact with the child, displays knowledge relative to activities of the NCP, or recently had a child, or is pregnant and the NCP is reportedly the father.

5. Resources. Applicant reports savings account for children, but no savings/checking accounts for him/herself. Worker notices client

writing checks while in office. When questioned about writing checks, client states she is paying bills for someone else with their checkbook.

6. Earned Income. The principal wage earner has a long history of employment and reports the receipt of Unemployment Insurance Benefits (UIB), and then reports termination of UIB, but is still unemployed.

   Applicant presents an employment verification document that is not signed or appears to have been altered, and/or does not appear to be authentic.

7. Unearned Income. Worker receives an anonymous call stating client is receiving child support directly from NCP. When worker questions the client, the client states he/she is not receiving child support but gives other conflicting information.

8. Catch-all. Any information workers question client about and the client can/does not provide an adequate response.

   Example: Client states her rent is $200.00 and her utilities are $175.00; however, she reports no income and can not explain how her bills are paid.

D. After satisfying the verification requirements, the following criteria are used as a reference to refer FS cases (either pending or active) to DETER:

1. Identification. Applicant presents an identification document which appears to have been altered and/or does not appear to be authentic.

2. Residency. Applicant presents verification of residency; e.g., rent receipts, mortgage payments, utility bill, etc., that appears to have been altered and/or written by the applicant.

3. Household Composition. The household reports a drastic increase in household size or provides inconsistent information (e.g., Social Security Number, date of birth, relationship) relative to claimed number of household members.

4. Resources. The household reports savings account for children, but no savings/checking accounts for adults. Worker notices client writing checks while in office. When questioned about writing checks, client states she is paying bills for someone else with their checkbook.

5. Earned Income. The household in which the principal wage earner has a long history of employment, reports the receipt of UIB, and then reports termination of UIB, but is still unemployed.

Applicant presents an employment verification document that is not signed or appears to have been altered and/or does not appear to be authentic.

6. Unearned Income. Worker receives an anonymous call stating client is receiving child support directly from NCP. When the worker questions the client, the client states he/she is not receiving child support but gives other conflicting information.

   The household reports enrollment in institutions of higher learning, but does not report scholarships or loans.

7. Catch-all. Any information workers question client about and the client can/does not provide an adequate response.

   Example: Client states her rent is $200.00 and her utilities are $175.00; however, she reports no income and can not explain how her bills are paid.

E. DETER referral and reporting procedures are as follows:

Complete form DTR-1 and forward it to DETER in one of the following manners:

1. [Send the form via e-mail as an attachment to CHFS.DETER@KY.GOV which can also be accessed by typing "CHFS DETER Program" on the Outlook Global address listing.

   When sending a DETER referral via e-mail, do not include the client's name or social security number in the subject line or e-mail text. This identifying information can only be in the attachment.

2. Fax the form to (502) 564-7876, Attn: DETER; or

3. Mail the form to: Office of Inspector General
   DETER Program
   275 East Main St., 5E-D
   Frankfort, KY 40621]

   E-mail is the preferred method of sending form DTR-1 to DETER. Fax and postal service is used for backup purposes only.

   Give a detailed summary of the eligibility factors in question and explain what has been done to resolve these factors.

F. Caseworkers will receive forms DTR-2, DTR-2A and DTR-3 via e-mail from DETER. Hardcopies of each form will follow in the mail. When workers receive the forms via e-mail:

1. Review the information contained on form DTR-3 and take appropriate action according to the DETER findings. These actions may be to deny, discontinue, correct the case or take no action.

2. If the DETER findings are inconclusive as stated on the forms, send form PAFS-2, Application Letter or Notice of Expiration, with an appointment date and time to discuss the findings.

3. If a potential claim is identified because of DETER findings refer to Vol. I, MS 1497 for procedures used to establish a claim. Workers must discuss DETER findings with the client to obtain all required information needed to establish the claim period.

   Example: Client has a "C" K-TAP case in which the deprivation is divorce. The household consists of the client and her 2 children. It is discovered through a DETER investigation that the NCP is living in the same household and has been since the day of application for K-TAP benefits. DO NOT state no claim for this case as could have been potential "W" case. Client falsified information at application and a claim does exist. Workers can approve the case ongoing with the NCP included if all technical and financial eligibility requirements are met.

Workers have 30 calendar days from the date the forms are received via e-mail to: schedule an appointment, take action on the case, complete form DTR-2, and return the DTR-2 to DETER. Annotate form DTR-2 with the results of the effect DETER findings had on the case.

Once the worker receives the DETER findings, all cases must be acted upon. Simplified Reporting is not considered as the information is known to the agency.

If DETER does not receive form DTR-2 by the end of the 30 days, workers will receive form DTR-2.1A, DETER Response and 2nd Request for Action, via e-mail with forms DTR-2, DTR-2A and DTR-3 attached. Workers have 15 calendar days from the day form DTR-2.1A is received to complete form DTR-2 and send to DETER. Forms DTR-2A, DTR-2.1A and DTR-3 contain facts and findings uncovered by the DETER investigator. Forms DTR-2A, DTR-2.1A and DTR-3 are filed in the case.

G. If the case is pending verification at the end of the 30 day timeframe, staff may request a 15 calendar day extension to respond and avoid receipt of the 2nd request by:

   1. Responding to all individuals on the original e-mail letting them know what action has been taken; and

2. Providing a date (within the 15 calendar days) as to when action will be completed.

MS 1509* TIMELY/PAST DUE

To be considered timely, Food Stamp claims must be established within 90 calendar days from the date of discovery unless the pending claim is being investigated by OIG.

All claims not established by the end of the quarter following the quarter the claim was discovered are considered past due.

MS 1512* MOVES OUT-OF-COUNTY OR IN/OUT-OF-STATE

A. If the client, who has a pending or established claim, moves from the county to another location within the state and has requested assistance in the new county, transfer the active Income Maintenance (IM) or Food Stamp (FS) case on KAMES and the claim on Kentucky Claims Debt (KCD) Management System to the new county. It is the responsibility of the new county to notify the Claims Management Section (CMS) of any changes.

If the client does not request benefits in the new county, the old county retains responsibility for the claim. A claims case can be transferred one time during a month.

B. If it becomes known that a client with a pending claim due to Agency Error (AE) or Inadvertent Household Error (IHE) moves out-of-state, we must still establish the claim.

C. If the client has moved out-of-state and the Office of Inspector General (OIG) returns the completed investigation of IPV claim, establish the claim on KCD.

Use procedures outlined in MS 1590, for the processing of (IPV) claims returned to the local office when the client has moved out-of-state.

D. In cases where a household moves out-of-state, CMS initiates or continues collection action against the household for any erroneous benefits which occurred while in Kentucky. The state which issued the erroneous benefits to the household has the first opportunity to collect.

E. If the household applies for FS benefits in another state and the other state contacts Kentucky regarding the claim, send all relevant claim information, including any current or past disqualifications to that state to establish the claim there and remove the claim in Kentucky, if the KAMES case is active. If the FS case is inactive, staff must contact CMS to complete the required KCD entries. CMS will enter the appropriate code to terminate the debt and transfer the claim out-of-state.

F. For FS, if the worker becomes aware that a household has a claim in another state, contact that state to determine if the state is currently taking action to collect the claim and if any household member has a disqualification period which is currently being imposed or which has never been imposed.

1. If the state is not pursuing collection action on the claim and it does not intend to pursue collection action, obtain copies of the relevant claims information from that state and initiate collection action against the household.

2. If the state indicates that the household is currently disqualified for IPV or that the household has a disqualification period which has never been imposed, the disqualification of the individual in that state is valid in Kentucky. Contact that state to get the effective dates of the disqualification and upload this on KAMES.

3. Obtain copies of the relevant material related to the disqualification including, but not limited to, the hearing decision, the household's waiver of the Administrative Disqualification Hearing (ADH) deferred adjudication agreement, or the court decision, which led to the disqualification.

G. For Kentucky Transitional Assistance Program (K-TAP) cases, if a client moves to Kentucky and has a claim in another state, do not attempt collection on the out-of-state claim.

MS 1514 WHAT IS A CLAIM IN FOOD STAMPS (FS)

A. A claim occurs when a household has received benefits to which it is not entitled or traffics benefits. Refer to Vol. I MS1520

Establish a claim against a household that received more food stamps than it was entitled to receive.

All adult household members age 18 years or older are jointly and separately liable for the value of any overpaid benefits.

There are three categories of FS claims:

1. Agency Error (AE) – occurs when the claim is caused by an agency action or failure to take action;

2. Inadvertent Household Error (IHE) – occurs when the claim is caused by a misunderstanding or unintended error on the part of the household. Additionally, an IHE can have a Suspected Intentional Program Violation (SIPV) indicator when fraud is suspected and has not yet been established; and

3. Intentional Program Violation (IPV) – occurs when the claim or benefits misuse is determined to be an act of FS trafficking or intentional misrepresentation.

When processing claims, use policy that was in effect at the time the claim occurred.

B. Consider the overpayment a “No Claim” if:

1. The FS overpayment occurred because the agency failed to ensure that a household fulfilled procedural requirements, [Ex: The FS-8 was not given for signature.

The simple failure to have a signed application does not rule out a claim.]

2. The FS case is inactive and the FS claim amount is $125 or less, except for those discovered through QC review.

a. If the FS case becomes active during the month, the system will automatically upload “Option A”, Pending or Established Claims, and change the “no claim” to a pending claim that is ready to be established; or

b. If an expedited Food Stamp case is processed with postponed verification, pursue a claim only when benefits are issued based on erroneous information supplied by the household. Do not establish a FS claim if the household and the agency anticipated circumstances based on the best available information and it is later discovered that the household was not actually entitled to the benefits that were issued. Expedited benefits are issued based on the client's statement, as long as information is not intentionally withheld.

MS 1515* CLAIMS PROCEDURES FOR SPECIFIC FOOD STAMP (FS) HOUSEHOLDS

There are special procedures to follow for FS cases containing specific types of members. Use the following procedures for FS cases with members meeting the following criteria:

A. Categorically Eligible Households

1. If a categorically eligible FS client who is not subject to simplified reporting requirements fails to report resources to the Kentucky Transitional Assistance Program (K-TAP) or Supplemental Security Income (SSI) worker, which make him/her ineligible for K-TAP and/or SSI, the individual also becomes ineligible for FS if these resources exceed FS resource limits. Discontinue the FS case effective the same month as the K-TAP or SSI case. Receipt of K-TAP/SSI rendered the member categorically eligible for FS, therefore, no FS claim is established.

2. If a K-TAP/SSI client fails to report income that results in an overpayment, establish a FS claim in addition to the K-TAP claim. Make a fraud determination, if appropriate.

B. Authorized Representatives

1. The household is liable for any claim as a result of incorrect or incomplete information provided by the authorized representative without the household's knowledge even if the authorized representative is not a household member.

2. The authorized representative even if he/she is not a member of the household is ONLY responsible for a claim occurring when he/she is the representative for an alcoholic/drug treatment center, or when he/she is guilty of trafficking Electronic Benefit Transfer (EBT) benefits.

C. Sponsored Aliens

1. There are special procedures to follow for claims involving cases whose members are sponsored aliens.

   a. Both the alien and the sponsor are responsible for repayment of claim, unless the sponsor is without fault or the sponsor can show good cause for withholding information or for providing incorrect information. A nonprofit organization acting as a sponsor is not responsible for repaying claim.

b. The sponsor is considered to have good cause when the relationship has broken down.

c. Verify good cause through the sponsor's statement or through inability to locate the sponsor.

d. If good cause is determined not to exist, the sponsor is entitled to a fair hearing to contest a determination that the sponsor was at fault or to contest the amount of the claim.

2. If the sponsor provides incorrect information and the alien indicates, or the sponsor states, that the sponsor was unaware of the actual situation, the sponsor is without fault. However, the alien is still responsible for the claim. Place the claim in the alien's name only. The claims are established on KCD for both the sponsor and the alien, with one-half of the overpayment amount assigned to each claim.

3. If the sponsor provided incorrect information in a deliberate effort to obtain benefits for the alien, without good cause, place the claim in the name of the sponsor and the alien. Both are responsible for repayment. The claims are established on KCD for both the sponsor and the alien with one-half of the overpayment amount assigned to each claim.

D. Voluntary Quit

It may be necessary to establish a claim for an individual who fails to report a voluntary quit timely which would have made the individual disqualified for a specified time period, unless the penalty can still be imposed timely. If a claim is required, the claim period would be determined by the occurrence of the voluntary quit violation.

E. Households with Ineligible Members

Establish a claim if a household containing an ineligible member fails to report a change in a situation that makes the member eligible to be included and his/her income and resources counted. Ineligible members include an ineligible student, ineligible Able-Bodied Adults without Dependents (ABAWD), drug felon, fleeing felon, probation/parole violator, and aliens.

F. Households with Disqualified Members

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

G. Households with Fleeing Felons

If a member had an outstanding felony warrant, had knowledge of this warrant, and the household did not report that the household member was a fleeing felon, establish a claim. Once the member has knowledge of the felony warrant, either by receiving the warrant or being notified of its existence, the member will be considered fleeing.

H. Simplified Reporting Households (SR)

1. SR policy was effective 2-1-02 and included all FS cases with earned income including self-employed households.

2. SR policy was expanded effective 3-1-03 to include all FS cases including zero income households with the exception of FS households where all the members were defined as elderly or disabled with NO earned income.

3. When processing FS claims, use policy that was in effect at the time the claim occurred.

MS 1520* TRAFFICKING BENEFITS/SELLING FOOD/RETAILER FRAUD

Trafficking for food stamp purposes means the buying or selling of benefits for cash or other consideration other than eligible food, or the exchange of firearms, ammunition, explosives, or controlled substances for food stamp benefits. The Claims Management Section (CMS) will contact local office staff as appropriate for claims establishment.

A. The Department of Community Based Services (DCBS) is required to identify, investigate and prosecute recipient Electronic Benefits Transfer (EBT) trafficking. DCBS has contracted with the Office of Inspector General (OIG) to assist in this responsibility. DCBS also cooperates with the U.S. Department of Agriculture, Food and Nutrition Service (FNS) in their identification of retailer trafficking.

1. Local staff is responsible for:

a. Reporting any trafficking allegations to CMS. Include as much information as possible regarding the alleged trafficking activity.

b. Reporting any type of alleged retailer fraud directly to FNS, Lexington office at the following telephone number: (859) 233-2411.

c. Appearing in court or attending an administrative disqualification hearing as required to identify the recipient and testify as to rights and responsibilities.

d. Documenting as much information as possible regarding the alleged trafficking activity. The value of trafficked benefits is determined by the individual's admission, adjudication, or the documentation that forms the basis for the trafficking determination.

e. Entering Intentional Program Violation (IPV) disqualification for instances of trafficking as appropriate.

f. Entering pending trafficking claim on Kentucky Claims Debt (KCD) Management System if instructed by OIG.

g. Establishing the claim on KCD once the waiver has been signed or the claim has been adjudicated.

2. OIG is responsible for the following activities:

a. Reviewing EBT transaction activities and patterns to assist in identifying suspected trafficking.

b. Referring any suspected trafficking activity for investigation.

c. Referring a trafficking claim to court or to an administrative disqualification hearing, as appropriate.

d. Appearing in court or at the hearing to provide expert witness testimony related to the investigation and its findings.

Trafficking also includes selling the EBT card or the benefits in the account to a retailer or to another individual. The EBT system produces monthly reports, which show unusual amounts as well as high dollar amounts debited from the EBT account. These reports are monitored for signs of possible trafficking.

B. The selling of food purchased with food stamp benefits on an EBT card is considered an Intentional Program Violation (IPV) rather than a trafficking offense in the food stamp program. However, if no claim is to be established, disqualification is imposed if the recipient signs the appropriate waiver or is determined guilty by an Administrative Disqualification Hearing (ADH) or court of appropriate jurisdiction.

Take the following actions upon the discovery of a suspected IPV involving the selling of food purchased with an EBT card:

1. Contact OIG by phone, 1-800-372-2970;

2. OIG will review to determine if other program violations exist;

3. OIG has the option to have form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or FS-111, Deferred Adjudication Disqualification Consent Agreement, signed by the client during the interview process. Enter the disqualification on KAMES if a signed form FS-80, Supplement A, or FS-111 is received from OIG. Do NOT establish a claim;

4. If no indication of possible illegal EBT use is found, the allegation will be returned to the local office for final action;

5. The worker must then schedule the head of household to come in to the local office to be questioned about the allegation;

6. If no evidence or admittance of an IPV is found after an investigation and questioning the individual, file the report in the client's file; or

7. If an IPV is admitted to:

a. Complete form FS-80, Notice of Suspected Intentional Food Stamp Program Violation;

b. Mail to the individual forms FS-80 and FS-80, Supplement A;

c. If form FS-80, Supplement A is signed and returned, enter the appropriate disqualification on KAMES; and

d. Place the disqualification in the client's file. Do not establish a claim; or

e. If form FS-80, Supplement A, is not returned, schedule an administrative disqualification hearing.

MS 1525 PROCEDURES FOR SUSPECTED CLAIMS

If there is reason to suspect that a claim has occurred in an active or inactive case, enter the claim, except for Medicaid (MA) claims, on the Kentucky Claims Debt (KCD) Management system. MA claims ARE NOT put on the KCD system until it is determined they have been adjudicated through the court.

Effective February 4, 2008, all Child Care claims are entered on the Kentucky Claims Debt (KCD) Management system by the Child Care Assistance Program staff in Central Office.

Follow these procedures when a potential claim is suspected. All potential Intentional Program Violation (IPV) FS claims are established under the Inadvertent Household Error (IHE) claim category using the Suspected Intentional Program Violation (SIPV) indicator field.

A. Review circumstances surrounding the claim to determine the reason for the error and correct the ongoing case to prevent any further claims.

B. Determine if any companion cases exist which may be affected by the reason for the claim.

C. Complete form PAFS-431, Claim Referral, according to procedural instructions.

D. Enter all available information and discovery date for the potential claim on the Kentucky Claims Debt (KCD) Management System, Option A. Schedule an appointment with the household. (Procedures are located in the Computer Handbook, Section XII.)

E. Once verification is obtained, complete the calculation of the claim.

F. If additional information or verification is needed, contact any collateral necessary to calculate the amount of the overpayment. Work the claim based on the best available information, i.e., wage records, batch match, etc. These contacts can be made without obtaining the individual's consent. If a collateral contact cannot be used for verification (e.g., bank accounts) and the individual fails or refuses to provide required verification on a claim, consider that no claim exists. However, if it is highly suspected that an IPV occurred and the claim amount is over $1,000, refer to the Office of Inspector General.

G. If it is suspected that an overpayment may exist on an active or inactive case, but the amount of the overpayment cannot be verified:

1. Annotate the case record in red across the cover "POTENTIAL CLAIM - DO NOT PURGE"; and

2. Process on KCD as no claim.

H. If, at a later date, the individual reapplies or information to compute the claim becomes available, reenter on KCD and establish the claim.

I. If a claim is established and the case is active, KCD automatically initiates benefit reduction.

J. If a claim is established and the case is inactive, the Claims Management Section initiates collection.

MS 1530 HOW TO CALCULATE A FOOD STAMP (FS) CLAIM

[For each month that a household is suspected of receiving an overpayment, determine the correct amount of Food Stamp (FS) benefits, if any, the household was entitled to receive. Use policy in effect at the time the claim occurred.]

When calculating a FS claim, the worker is only required to verify and use new information the agency becomes aware of that was not considered when the benefits were authorized. The worker is not required to re-verify all factors pertaining to the household. A claim cannot be calculated using information that was not required to be reported.

A. Simplified Reporting:

1. Simplified Reporting (SR) for FS households with countable earnings, which include households with self-employment income, became subject to SR requirements effective February 2002.

2. SR was expanded effective March 2003, to include all FS households except households whose only members are elderly or disabled and have no earned income.

B. 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. Actual utility expenses can only be used if the household was not entitled to the SUA or BUA beginning June 2003.

C. Earned Income:

When calculating an Intentional Program Violation (IPV) or Inadvertent Household Error (IHE) claim involving unreported earned income, do not apply the earned income deduction to that part of any earned income which the household failed to report in a timely manner when this is the reason for the claim.

D. AE/IHE:

1. Agency Error (AE) or IHE claims cannot be calculated for more than 12 months prior to the date of discovery. If a claim also occurred in the discovery month and any future month, these months are also included in the claim period but are not considered as a part of the prior 12-month 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 on the case to correct benefits ongoing, effective

April 2005. The only months the household is liable for a claim in this situation are February 2004 through January 2005 (12 prior months), plus the discovery month of February and the month, March 2005. The month of January 2004 cannot be used in the claim calculations since it is more than 12 months prior to the discovery date.

2. An AE or IHE claim shall only be established for categorically eligible households when it can be computed on the basis of a change in net income and/or household size.

3. The Kentucky Claims Debt (KCD) Management System allows Inadvertent Household Error (IHE) claims with the Suspected Intentional Program Violation (SIPV) indicator code to be calculated for more than a 12-month period.

E. Intentional Program Violation (IPV):

1. For an IPV claim, the overpayment must be calculated beginning with the month the act of IPV occurred. However, this does not include any amount of the claim that occurred in a month more than 6 years prior to the discovery date.

2. [The KCD system allows IHE claims with the SIPV indicator code to be calculated for up to 6 years from the discovery date.]

3. Trafficking-related claims are the value of the trafficked benefits as determined by the individual's admission, adjudication, or the documentation which forms the basis for the trafficking determination.

F. Reported Information/Changes:

For REPORTED information/changes not acted on in the original benefit allotment, 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. Continue to budget the anticipated 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, include 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. Verify reported wages. If wages were reported but verification was not provided, the worker may use wage match data to calculate the claim. Use the gross quarterly income, divided by three months, 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 start and stop dates of employment. This date may be determined by contact with the employer or client.

5. Consider any countable income from ineligible and all disqualified members. Refer to MS 1515.

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 actually received (Example: countable student income).

7. Consider any countable unearned income.

8. DO NOT consider unreported deductions.

9. Consider any deductions that were reported but not acted upon.

10. Consider any deductions that were considered in the case during the claim period.

G. Unreported Changes/Information:

1. For UNREPORTED information/changes that were not considered in the original benefit allotment, 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.

   a. Consider ACTUAL income. DO NOT average and convert, for any income that was not reported.
   b. Reported income does not have to be re-verified. Continue to budget the anticipated converted income that was used in the original budget.
   c. When calculating the claim, use all other household circumstances that were correctly entered.
   d. DO NOT allow the earned income deduction for that portion of the earned income which was not reported. If the household reports part but not all of the earned income, allow the deduction on the part that was reported.
   e. 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, 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 start and stop dates of employment. This date may be determined by contact with the employer or client.
   f. Consider any countable income from ineligible and all disqualified members.
   g. 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).
   h. Consider any countable unearned income.

i. Consider changes in deductions IF required to be reported. Otherwise, consider deductions that were used in the case for the claim period.
j. DO NOT consider unreported deductions.
k. Consider any deductions that were reported but not acted upon.
l. Consider any deductions that were considered in the case during the claim period.

2. For trafficking claims, the amount of the claim is the amount of the benefits trafficked. Trafficking claims may be determined by the individual's admission, adjudication, or documentation that forms the basis for the trafficking determination, such as the Electronic Benefit Transfer (EBT) transaction history. Trafficking claims are independent of the issuance and certification process. Therefore, if a person is found to have an overpayment and trafficks those overpaid benefits, two claims may be established. This would result in the individual owing more benefits than were actually issued.

H. Apply the following to the claim:

1. A claim can be reduced by 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 underpayment 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. A claim can be reduced by any EBT benefits expunged from the household's EBT benefit account (up to the amount of the claim) that have not previously been applied to any other claim.

   a. If the benefits are expunged after the claim is established, KAMES 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 Vol. I MS1700.
   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 amount of benefits expunged for a particular benefit month can be seen on the benefit inquiry screen on KAMES by:

   a. Select Option J off KAMES inquiry.
   b. Scrolling down to the bottom of the screen where the EBT amount expunged and the date of expungment are displayed.

MS 1535 HOW TO DETERMINE THE FIRST MONTH OF A FOOD STAMP CLAIM

To determine the first month of the claim, apply the following rules for applications, recertifications and changes. The first month of the claim cannot be later than two months from the month in which the change in household circumstances occurred.

NOTE: Simplified Reporting (SR) households have different reporting requirements that must be taken into consideration when determining if a claim exists.

A. Changes – Unreported and Reported

1. The 10-10-10 formula is used to determine the first month of the claim, when a change is not reported to the agency by the client. The failure to report may be a result of Intentional Program Violation (IPV) or Inadvertent Household Error (IHE). When the overpayment is discovered, do the following:

   a. Determine when the change became known to the household;

   b. From that date, allow the household 10 days to report;

   c. Allow the agency 10 days to act on the report; and

   d. Allow 10 days for adverse action.

   The month in which the adverse action period ends determines the beginning month of the claim. The beginning month of the claim is always the next month after adverse action ends.

   Example 1: A non-SR household failed to report a change in unearned income. The change was known to the client on 10/2/05. Allow 10 days for the client to report (10/12/05), 10 days for the agency to act on the change (10/22/05), and 10 days adverse action (11/1/05). Since the adverse action period ends in 11/05, the first month of the claim is 12/05.

   Example 2: SR households have until the 10th day of the month following the change to report that their income exceeds the 130% gross income limit. The household's income exceeded the limit 9/05. Allow 10 days for the client to report (10/10/05), 10 days for the agency to act on the change (10/20/05), and 10 days adverse action (10/30/05). The first month of the claim is 11/05.

2. The 10-10-10 formula DOES NOT apply to a change that the household reports and verifies and the agency fails to take action on. The 10-10 formula applies to these situations.

   Example: A household reports an increase in income and provides a written statement to verify this on 10/2/05. The worker failed to take action on this reported change until 12/05 effective with benefits 1/06. Allow 10 days from the household reported and verified change date (10/12/05), and 10 days

adverse action (10/22/05). The first month of the claim is 11/05 for this AE claim.

3. The 10-10-10 formula does apply to changes that the household reports but has not verified and the worker failed to take action to request verification.

   Example: A household makes a phone contact to the worker on 10/2/05 and reports an increase in income that happened 10/1/05. The worker fails to issue a RFI requesting verification. The client comes in for his/her recertification interview 12/05 and brings in the verification of his/her income then. The worker discovers a change report form in the case record and knows the client has reported the change. An AE claim is established based on allowing the client 10 days to provide verification from the date the change became known (10/11/05), 10 days for agency action (10/21/05), and 10 days adverse action (10/31/05). The first claim month is 11/05.

B. Applicant Households

1. The first month of the claim for applicant households is the first month of the certification period that the household reported incorrect information.

2. An applicant household has 10 calendar days from the date of the Notice of Eligibility to report changes which occur after the date of the interview. This does not apply to SR cases. To determine the first month of the claim, apply the 10-10-10 rule from the date after the date on the Notice of Eligibility.

C. Timely Recertification

1. If the household is recertified prior to the end of the certification period, the household must report changes within 10 calendar days of the date the change becomes known. If a change is not reported and the 10 calendar day period ends before the case is recertified, the first month of the claim is the first month of the new certification period. This does not apply to SR cases.

   Example: The certification period expires 4/30/05. A recertification interview was held 3/30/05. The client received notice of approval of Social Security on 4/11/05. The client did not report the change. The recertification was processed on 4/25/05. The 10 calendar days for the client to report expired 4/21/05, prior to processing the case. May is the first month of the claim.

2. If the 10 calendar day period for the client to report ends after the case is recertified, apply the 10-10-10 rule to determine the first month of the–claim. The client has 10 calendar days from the date of the Notice of Eligibility to report changes.

   Example: In the same situation as in C1, the case was processed 4/18/05, the notice was mailed 4/21/05. The 10 calendar days for the client to report expired 5/1/05. The agency must allow 10 calendar days to act (5/11/05). Allow the 10 days for adverse action to expire 5/25/05. June is the first claim month.

D. Untimely Recertification

1. A household filing an untimely recertification in the last month of its certification period has 10 calendar days to report changes which occur after the interview and before the certification period ends. If the 10 days to report expires prior to the case being certified, the first month of the claim is the first month of the new certification period. This does not apply to SR cases.

   Example: The certification period ends on 4/30/05. The household has an untimely recertification interview on 4/25/05. A change occurs on 4/28/05. The household has 10 calendar days to report (5/8/05). The case is processed 5/12/05. May is the first month of the claim.

2. If a change occurs after the certification period ends but before the case is certified, or the 10 calendar days to report expires after the case has been certified, the household has 10 calendar days from the date of the Notice of Eligibility to report. Apply the 10-10-10 rules from the date after the date of the Notice of Eligibility. This does not apply to SR cases.

   Example: The certification period ends on 4/30/05. The household has an untimely recertification interview on 4/24/05. A change occurs on 5/2/05. The household has 10 calendar days to report (5/12/05). If the case is processed prior to 5/12/05, apply the 10-10-10 rule from the date after the date of the Notice of Eligibility.

3. If a change occurs after the certification period ends and the 10 calendar days to report expires before the case has been certified, the first claim month is the first month of the new certification period. This does not apply to SR cases.

   Example: Same as previous example, but the case is processed 5/12/05 or later. May is the first claim month.

MS 1540* WHAT IS AN AGENCY ERROR (AE) CLAIM

A. Instances of AE which may result in a Food Stamp (FS) claim include, but are not limited to, the following:

1. Agency failed to take prompt action on a change reported by the household;

2. Agency incorrectly computed the household's income or deductions or otherwise assigned an incorrect benefit;

3. Agency failed to provide a household a reduced level of food stamp benefits because its public assistance grant changed; and/or

4. Agency failed to take prompt action on a change that became known to the agency.

Use policy in effect at the time the claim occurred.

B. Consider the claim a "No Claim" if:

1. The Food Stamp (FS) claim occurred because the agency failed to ensure that a household fulfilled the following procedural requirements, such as signing the application form;

2. The FS case is inactive and the FS claim amount is $125 or less, except for those discovered through QC review;

a. Kentucky Claims Debt (KCD) Management System "Option A", Pending or Established Claim, will automatically upload as a "no claim" when the claim information is entered on KCD. Press enter to continue the "no claim" processing.

b. If the FS case becomes active during the month, the system will automatically upload "Option A", Pending or Established Claims, and change the "no claim" to a pending claim that is ready to be established; or

3. The FS AE claim occurred more than 12 months before the month that the agency became aware of a potential claim.

C. If an expedited food stamp case is processed with postponed verification, pursue a claim only when benefits are issued based on erroneous information supplied by the household. Do not establish a FS claim if the household and the agency anticipate circumstances based on the best available information, and it is later discovered that the household was not actually entitled to the benefits that were issued. Expedited benefits are issued based on the client's statement, as long as information is not intentionally withheld.

MS 1545 HOW TO PROCESS AGENCY ERROR (AE) CLAIMS

If a possible overpayment of benefits occurs in an active or inactive Food Stamp (FS) case, enter the claim on the Kentucky Claims Debt (KCD) Management system. Regardless of the detection source, all food stamp claims must be processed timely. If it is determined that an overpayment occurred, the claim must be established within 90 days from the date of discovery.

When a possible overpayment of benefits is discovered, the worker:

A. Completes form PAFS-431, Claims Referral.

B. [Enters the case on KCD within 10 days of the discovery date.] The discovery date on KCD is the date the agency is aware of sufficient facts or evidence to suspect that a claim took place.

C. Within 10 days of receiving information of a possible claim, a KCD system generated appointment letter is sent to the household.

1. If the household keeps the appointment, the worker:

a. Discusses the circumstances regarding a possible claim and reviews any returned documentation or forms;
b. Determines the appropriate type of claim. If not AE, reviews as a Inadvertent Household Error (IHE) claim or possible fraud Intentional Program Violation (IPV) claim and;
c. Requests additional verification if needed, and give the household 10 days to return;
d. Establishes the claim on KCD with information returned by the household or whatever information is available.

MS 1550* WHAT IS A INADVERTENT HOUSEHOLD ERROR (IHE) CLAIM

A. Instances of IHE which may result in a Food Stamp (FS) claim include, but are not limited to, the following:

   1. The household unintentionally failed to provide correct or complete information;

   2. The household unintentionally failed to report changes that it was required to report in its household circumstances;

   3. The household unintentionally received benefits it was not entitled to receive pending a fair hearing decision because the household requested a continuation of benefits based on the mistaken belief that it was entitled to such benefits;

   4. The household is suspected of fraud or Intentional Program Violation (IPV), but that determination is dismissed or overturned by the deciding agency such as court or a hearing officer; or

   5. Evidence <u>does not</u> provide sufficient proof of intent to commit fraud. For example, a signed FS application showed no income reported at recertification. The client provided a PAFS-700, Verification of Income, indicating employment was obtained later in the recertification month; and a subsequent FS application showed the income was reported at the next recertification. This could be interpreted as Inadvertent Household Error (IHE).

   Use agency policy in effect at the time the claim occurred.

B. Consider the claim a “No Claim” if:

   1. The FS claim occurred because the agency failed to ensure that a household fulfilled procedural requirements, such as signing the application form;

   2. The FS case is inactive and the FS claim amount is $125 or less, except for those discovered through QC review.

      a. Kentucky Claims Debt (KCD) Management System “Option A”, Pending or Established Claim, will automatically upload as a “no claim” when the claim information is entered on KCD. Press enter to continue the “no claim” processing.

b. If the FS case becomes active during the month, the system will automatically upload “Option A”, Pending or Established Claims, and change the “no claim” to a pending claim that is ready to be established; or

3. The FS IHE claim occurred more than 12 months before the month of discovery.

C. If an expedited food stamp case is processed with postponed verification, pursue a claim only when benefits are issued based on erroneous information supplied by the household. Do not establish a FS claim if the household and the agency anticipate circumstances based on the best available information, and it is later discovered that the household was not actually entitled to the benefits that were issued. Expedited benefits are issued based on the client’s statement, as long as information is not intentionally withheld.

MS 1555 HOW TO PROCESS AN INADVERTENT HOUSEHOLD ERROR (IHE) CLAIM

If a possible overpayment of benefits occurs in an active or inactive Food Stamp (FS) case, enter the claim on the Kentucky Claims Debt (KCD) Management system. Regardless of the detection source, all food stamp claims must be processed timely. If it is determined that an overpayment occurred, the claim must be established within 90 days from the date of discovery.

When a possible overpayment of benefits is discovered, the worker:

A. Completes form PAFS-431, Claims Referral.

B. [Enters the case on KCD within 10 days of the discovery date.] The discovery date on KCD is the date the agency is aware of sufficient facts or evidence to suspect that a claim took place.

C. Within 10 days of receiving information of a possible claim, a KCD system generated appointment letter is sent to the household.

1. If the household keeps the appointment, the worker:

a. Discusses the circumstances regarding a possible claim and reviews any returned documentation or forms;

b. Determines the appropriate type of claim. Inadvertent Household Error (IHE) claim, reviews as a possible fraud Intentional Program Violation (IPV) claim and;

c. Requests additional verification if needed, and give the household 10 days to return;

d. Establishes the claim on KCD with information returned by the household or whatever information is available.

MS 1560* JOINT AGENCY ERROR/INADVERTENT HOUSEHOLD ERROR (AE/IHE) FOOD STAMP (FS) CLAIMS

A joint claim occurs when there is more than one claim category involved.

If the household received a larger allotment than it was entitled to receive, establish a claim against the household equal to the difference between the allotment the household received and the allotment the household should have received.

A. A Food Stamp (FS), AE and IHE claim may include any months within the 12-month period prior to the month that the agency became aware that a claim might exist. For IHE with a Suspected Intentional Program Violation (SIPV) indicator, refer to MS 1570. If a claim also occurred in the discovery month and any future month, these months are also included in the claim period but are not considered as part of the 12-month period. The 12-month period does not include the month in which the potential claim is discovered.

EXAMPLE: It is discovered in April 1997, that the household received an overpayment during the period January 1996 through May 1996. The only months the household is liable for a claim in this situation are April and May 1996.

B. In cases involving changes, determine the month the claim initially occurred as follows:

1. If, due to an inadvertent error, the household failed to report a change in its circumstances within the required time frames, the first month affected by the household's failure to report is the first month in which the change would have been effective had it been reported timely. This must be no later than 2 months from the month in which the change in household circumstances occurred.

EXAMPLE: On 5/25/05, the client reported employment which began 4/20/05. The case was adjusted effective 7/05. To establish the beginning month of the claim, assume the change was reported within 10 days. The worker has up to 10 days to act on the change and send the notice of timely action. The client has 10 days in which to respond to the notice. The beginning month of the claim is 6/05.

2. If the household reported the change timely but the agency did not act timely on the change, the first month affected by the failure to act is the first month the agency would have made the change had it acted timely. This cannot be more than 2 months from the month in which the change in household circumstances occurred. If a notice of timely action was required but not provided, assume that the required time frames would have expired without the household requesting a fair hearing.

EXAMPLE: On 2/12/05, a household member reported the receipt of $8,000 from a lottery on 2/4/05. The worker failed to act on the information. The worker has up to 10 days to act on the reported change and send the notice of timely action. The client has 10 days in which to respond to the notice. Since the client reported the change timely, assume that the worker took action on 2/22/05. The notice would expire in 3/05 making the effective month 4/05. The claim begins in 4/05.

C. Do not allow the 20% earned income deduction to unreported or untimely reported earned income when calculating an IHE claim.

D. Once the amount of the AE or IHE claim is established, offset the amount of the claim against any amounts which have not yet been restored to the household or against any expunged benefits.

The amount of benefits expunged for a particular benefit month can be seen on the benefit inquiry screen on KAMES by doing the following:

1. Select Option J from the inquiry menu; and

2. Scroll down to the bottom of the screen to find the Electronic Benefits Transfer (EBT) amount expunged and the date the benefits were expunged.

MS 1565* JOINT AGENCY ERROR/INADVERTENT HOUSEHOLD ERROR (AE/IHE) AND INTENTIONAL PROGRAM VIOLATION (IPV) CLAIMS

A joint claim occurs when there is more than one category of claim.

When a claim occurs because of both IPV and either an AE or IHE, calculate on Kentucky Claims Debt (KCD) Management System each type of claim as outlined below, using actual amounts during each overpayment month to compute the claim. Enter on the KCD comments screen a brief statement of the corresponding claim and the amount of the other claim.

A. AE or IHE claim.

1. Enter the total amount the household actually received during each month in question. To determine the amount the household actually received, do the following:

   a. Access the benefits screen from the KAMES inquiry 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.

MS 1570* WHAT IS AN INADVERTENT HOUSEHOLD ERROR (IHE)/SUSPECTED INTENTIONAL PROGRAM VIOLATION (SIPV) CLAIM

Instances of suspected fraud which may result in a claim include, but are not limited to, the following:

A. The client is suspected of obtaining Food Stamp (FS) benefits by:

1. Making a false or misleading statement;

2. Misrepresenting, concealing, or withholding facts; or

3. Committing a violation of the Food Stamp Act, food stamp regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt or possession of FS benefits. Specifically prohibited actions include:

   a. Purchasing a controlled substance using FS benefits;

   b. Purchasing firearms, ammunition, or explosives using FS benefits;

   c. Buying or selling FS 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.

B. Suspected fraud claims are established on the Kentucky Claims Debt (KCD) Management System as Inadvertent Household Error (IHE) claims and enter a “Y” in the SIPV indicator field.

Use policy in effect at the time the claim occurred.

MS 1575 HOW TO PROCESS A SUSPECTED INTENTIONAL PROGRAM VIOLATION/INTENTIONAL PROGRAM VIOLATION (SIPV/IPV) CLAIM

If a potential claim of Food Stamp (FS) benefits occurs in an active or inactive case, enter the claim on the Kentucky Claims Debt (KCD) Management system.

Regardless of the detection source, all potential Food Stamp claims must be processed timely. If it is determined that an overpayment has occurred, the claim must be established within 90 days from the date of discovery.

A. When a potential claim is discovered in an active or inactive case, the worker must do the following:

1. Complete PAFS-431, Claims Referral. The supervisor reviews the circumstances indicated on the referral and signs the form if in agreement.

2. The discovery date is the date the agency is aware of sufficient facts or evidence to suspect that an overpayment took place.

3. Take appropriate action to correct the case and ongoing benefits.

4. Within 10 days of the discovery date, enter the case on the KCD system, send an appointment letter and any needed verification forms to the household.

   a. If the household shows for the appointment:

      (1) Discuss the circumstances regarding a possible claim and review any returned documentation or forms.

      (2) Determine the category of the claim.

      (3) If additional verification is needed, request the information and give the household 10 days to return.

      (4) If at the end of 10 days the requested information is not returned, establish the claim with available information.

      (5) If information is returned, enter on the KCD system and establish the claim.

b. If the household does not keep the appointment, work the claim based on the best available information.

B. A suspected fraud claim is established as an Inadvertent Household Error (IHE) claim, with a “Y” entered in the SIPV field. The KCD system allows IHE claims with the SIPV indicator code to be calculated for up to 6 years from the discovery date.

C. [For IHE/SIPV claims which are less than $3,000 and do not involve at least one month of Medicaid ineligibility, within 10 days of establishing the claim complete form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing. To ensure the waiver is appropriate, the supervisor reviews the evidence before the form is mailed to the household.]

1. If the household does not return form FS-80, Supplement A, follow procedures to schedule an Administrative Disqualification Hearing (ADH).

2. If the household returns form FS-80, Supplement A or the Hearing Officer determines the member is guilty of an IPV violation, within 10 days of the IPV determination, make adjustments on the KCD system as outlined in items a-d. Enter the appropriate disqualification period on KAMES, no later than 3 work days from receipt of the FS-80, Supplement A or final order.

   a. If the FS case is active, remove the (Y) from the SIPV indicator field and change the category of the claim from IHE to IPV.

   b. If the FS case is inactive, designated local office staff will need to contact the Claims Management Section in Central Office at (502) 564-3440 to have the (Y) removed from the SIPV indicator field and to change the category from IHE to IPV. Local Office staff is responsible for entering the disqualification of the member on KAMES.

   c. If the FS claim is determined by the Hearing Officer to be a regular IHE, the worker will need to go back into the KCD system and change the SIPV indicator field from (Y) to (N). The worker may be required to refigure the claim and remove any inappropriate months listed for an IHE claim.

   d. If the FS claim is determined by the Hearing Officer to be an AE claim, the worker will change the claim category from IHE to AE and remove the (Y) from the SIPV indicator field. The worker may be required to refigure the claim and remove any inappropriate months listed for an AE claim.

A repayment notice notifies households of the collection procedures for IHE Food Stamp claims processed with an SIPV claim indicator code. Collections will use IHE collection procedures unless an IPV determination is made and changed on KCD.

D. The following IHE/SIPV established claims are referred to OIG:

1. [IHE/SIPV of $3,000 or greater;

2. If unable to obtain verification and it is strongly suspected the claim may be $3,000 or greater, the worker MUST include verification of an attempt to obtain any information needed to process the claim such as copies of appointment and/or employer letters, etc. Comments in the case record must reflect all attempts to obtain verification and list the names and phone numbers of any collateral contacts used.]

3. Any IHE/SIPV amount if it involves at least one month of Medicaid ineligibility.

If an IHE/SIPV claim is referred to OIG, DO NOT mail the client form FS-80, Supplement A.

Refer to MS 1672 for information regarding fraud referrals.

MS 1580 WHAT IS AN INTENTIONAL PROGRAM VIOLATION (IPV)

IPV occurs when it is determined that a Food Stamp (FS) client.

[A. Deliberately makes a false or misleading statement;

B. Deliberately misrepresents, conceals, or withholds facts; or

C. Commits a violation of federal or state laws or regulations relating to the use, presentation, transfer, acquisition, receipt or possession of FS benefits. Specifically prohibited actions include;

1. Purchasing a controlled substance with FS benefits;

2. Purchasing firearms, ammunition, or explosives with FS benefits;

3. Buying or selling FS benefits on or after 8/22/96; and

4. Making a false statement on or after 8/22/96, pertaining to identity or residence, in order to receive duplicate benefits.

5. Selling] food purchased with FS benefits on an Electronic Benefits Transfer (EBT) card.

D. An IPV is established when:

1. The member is found to have committed IPV through an Administrative Disqualification Hearing (ADH) or by a court of appropriate jurisdiction;

2. The member agrees to imposition of the disqualification by voluntarily signing form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing or form FS-111, Deferred Adjudication Disqualification Consent Agreement as part of a deferred adjudication agreement between the individual and his legal counsel and the court; or

3. The appropriate law enforcement officials notify the agency that the member meets the above criteria.

E. Selling food purchased with an EBT card is an IPV, however, no claim amount is established. Disqualification is imposed if the client signs the appropriate waiver or is determined guilty by an Administrative Disqualification (ADH) or court of appropriate jurisdiction.

MS 1585* HOW TO PROVE AN INTENTIONAL PROGRAM VIOLATION (IPV)

The burden of proof of IPV is on the agency evidence used to demonstrate this must support the accusation of IPV and prove intent to commit food stamp (FS) fraud.

A. Evidence includes, but is not limited to:

1. Signed FS application, used to determine eligibility at the time of the claim;

2. Computer printouts;

3. Income and Eligibility Verification System (IEVS) records;

4. Form PAFS-14, Client Responsibility for Reporting Changes;

5. Form PAFS-700, Verification of Income;

6. Form PAFS-76, Information Request; and

7. Form FS-8, Simplified Reporting Requirements Handout.

B. An example of evidence that clearly proves intent to commit fraud is a signed FS application showing that no income was reported at the recertification interview, together with form PAFS-700 that indicates the client was employed at that time and had received at least one pay check prior to the interview.

C. This evidence does not provide sufficient proof of intent to commit fraud; a signed FS application showing no income reported at recertification, a PAFS-700 indicating the client gained employment later the same month, and a subsequent FS application showing the income was reported at the next recertification. This could be interpreted as Inadvertent Household Error.

D. All evidence to be presented at an Administrative Disqualification Hearing (ADH) must be listed on form FS-79, Request for an Administrative Disqualification Hearing. If evidence is not listed, it cannot be introduced at the hearing.

E. All evidence must be shared with the client at the hearing. If the names of collateral contacts who provide information regarding the IPV cannot be released to the client, that evidence cannot be used.

F. Each document to be used must be listed separately. Stating "the entire case record" is not acceptable.

G. If no evidence is listed on form FS-79, the hearing is automatically dismissed.

MS 1590* HOW TO PROCESS AN INTENTIONAL PROGRAM VIOLATION (IPV) CLAIM

If a potential claim of Food Stamp (FS) benefits occurs in an active or inactive case, enter the claim on the Kentucky Claims Debt (KCD) Management system. Regardless of the detection source, all potential food stamp claims must be processed timely. If it is determined that an overpayment has occurred, the claim must be established within 90 days from the date of discovery.

Take the following steps to determine that an overpayment resulted from fraudulent activity.

A. Enter the pending claim information on the Kentucky Claims Debt (KCD) Management System. Schedule an appointment to review the evidence with the client and to discuss the circumstances of the claim. KCD sends the appointment letter.

B. Based on the available evidence and on the household's declaration of the circumstances which caused the claim, determine whether the claim is a result of a possible IPV. If the household fails to respond to the appointment letter, base the determination upon the evidence available to the Agency and establish the claim as an Inadvertent Household Error (IHE) with a Suspected Intentional Program Violation (SIPV) indicator code if evidence warrants an IPV.

C. Review the evidence with the Field Services Supervisor (FSS), or designated principal caseworker where there is no resident FSS, for concurrence on the decision of possible IPV.

1. At no time may this supervisory review precede or coincide with the fact-finding interview described in item A. above.

2. Handle the claim as an Agency Error (AE) or IHE and remove any calculation months which occurred more than 12 months before the discovery date, if:

   a. The FSS does not concur with a decision of possible IPV; and/or

   b. There is a lack of evidence to support a decision of IPV.

3. If the FSS, or where the FSS is responsible for more than one county, the designated principal caseworker concurs with the decision of possible IPV and the evidence warrants scheduling an Administrative Disqualification Hearing (ADH), the FSS signs form FS-80, Notice of Suspected Intentional Food Stamp Program Violation.

4. Forms FS-80 and FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, are then mailed to the household.

5. This offers the household member who signed the application and the head-of-household, if different, the opportunity to voluntarily waive their right to an ADH by signing form FS-80, Supplement A.

6. Allow the household 10 calendar days to sign form FS-80, Supplement A.

7. By signing the waiver, the member and head-of-household, if different, consent to the imposition of a disqualification penalty whether or not they admit committing a violation.

8. Form FS-80, Supplement A must be signed by both the member and head-of-household, if these are different persons.

9. Neither the member nor the head-of-household, if different, are under any obligation to sign form FS-80, Supplement A. Use NO COERCION in obtaining the appropriate signatures.

10. If the member requests additional information concerning hearing procedures, provide the member with the pamphlet PAM-PA-326, Hearing Procedure for Kentucky Family Support Programs, which provides information on hearing procedures for Family Support programs.

D. If the member and the head of the household, if appropriate, sign the voluntary waiver, impose IPV disqualification penalties within 3 work days.

E. If form FS-80, Supplement A is not signed, initiate action to schedule an administrative disqualification hearing by completing form FS-79, Request for an Administrative Disqualification Hearing.

F. When the Agency is aware that a client, who is suspected of committing an IPV, has moved out-of-state, refer the claim to the Hearing Branch and provide the out-of-state address. The Hearing Branch will schedule the hearing as usual. If the notice is not returned or is returned unclaimed, the hearing will not be held. If the signed certified mail notice is returned, the hearing will be held even though the client might not be present.

G. Forward form PAFS-25, Transfer of Case Record or Material, form FS-79, Request for an Administrative Disqualification Hearing, and copies of all evidence listed on form FS-79 to the Hearing Branch. If a prior IPV claim exists which was established by waiver, an appropriate form FS-79, all evidence and other relevant information regarding that claim must accompany the current claim material. In this instance only, complete and mail to the member form FS-80. A separate form FS-79 must accompany each claim sent.

H. If the member requests a postponement of the hearing, advise the member to contact the Hearing Branch to reschedule the hearing. DO NOT reschedule the hearing.

I. If the member contacts the worker about signing form FS-80, Supplement A, offer the member and the head-of-household, if different, the opportunity to sign the waiver.

1. Notify the Hearing Branch by telephone that form FS-80, Supplement A has been signed so that the Hearing Branch can cancel the hearing.

2. Follow-up the call with a memorandum and a copy of the signed form FS-80, Supplement A.

3. The household is under no obligation to sign form FS-80, Supplement A.

J. If a case has already been referred to the Hearing Branch and it is learned that the client has moved out-of-state, advise the Hearing Branch of the client's move. The Hearing Branch will mail the hearing notice to the client's new address.

K. Attend the hearing representing the Agency and present the evidence supporting the IPV. Please refer to MS 1585 regarding supporting evidence. In addition, please reference MS 1605 regarding the local office procedures for representing the Agency in an Administrative Disqualification Hearing (ADH).

MS 1600* WHAT IS AN ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

The Administrative Disqualification Hearing (ADH) is conducted TO DETERMINE IF AN Intentional Program Violation (IPV) has occurred. An ADH is conducted by the Hearing Branch in all counties. The format of the ADH is similar to that of a fair hearing, except the burden of proof is on the Agency. Hearings are conducted by an impartial hearing officer who does not have any personal stake or involvement in the case.

A. Refer a case for an ADH if there is sufficient documentary evidence to substantiate a claim of Intentional Program Violation (IPV) and one of the following situations apply:

   1. The facts of the case do not warrant civil or criminal prosecution;

   2. The case was referred for prosecution by the Office of Inspector General (OIG) and declined by the prosecutor;

   3. The case was referred for prosecution and the referral has been formally withdrawn; or

   4. The household does not voluntarily sign form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing.

B. Inform the household of its right to a fair hearing on the issues of the amount of the claim and the reason for the claim.

C. If the household requests a fair hearing in conjunction with the ADH, refer both requests using the appropriate hearing request forms to the Hearing Branch. It is at the discretion of the hearing officer whether to consolidate the two hearings.

D. The hearing officer provides the client with a final order notice, indicating the hearing decision.

MS 1605* WHAT ARE THE LOCAL OFFICE RESPONSIBILITIES FOR AN ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

Follow these procedures when an ADH is required:

A. Complete form FS-79, Request for an Administrative Disqualification Hearing. Prepare form in quadruplicate. Mail the original and two copies to the Hearing Branch with form PAFS-25, Transfer of Case Record or Material, to:

Cabinet for Health and Family Services
Office of Legislative and Public Affairs
Division of Administrative Hearings
Families and Children Administrative Hearings Branch
275 East Main St., HS 1E-D
Frankfort, KY 40621

Include copies of form FS-80, Notice of Suspected Intentional Food Stamp Program Violation, and all evidence listed on the request. One copy is filed in the claims control folder.

B. Give a detailed explanation of the statement of charges, presenting the reasons the agency believes the individual committed an Intentional Program Violation (IPV). Due to limited space on the form, additional comments may need to be placed on a separate piece of paper. Provide explanation that additional comments are attached for the Statement of Charges.

C. Give a description of the events which led the agency to determine a program violation has occurred (e.g., when and how the claim was discovered, the client's history of not reporting changes, etc.) Due to limited space on the form, additional comments may need to be placed on a separate page. Provide explanation that additional comments are attached for the Summary of Events.

D. Give a detailed list of all evidence which supports the agency's claims of IPV (e.g., PAFS-700 dated 12/15/01; PAFS-76 dated 10/1/01; etc.) DO NOT list or forward information that is not pertinent to the establishment of the IPV. A statement of "entire case record" and/or copies of the entire case record is not acceptable. Due to limited space on the form, additional comments may need to be placed on a separate page. Provide explanation that additional comments are attached for the List of Evidence.

E. Include a copy of all evidence listed and submit the copies to the Hearing Branch along with the completed form FS-79. The copies of the evidence are sent by the Hearing Branch to the client for review prior to the scheduled hearing. EVIDENCE NOT LISTED OR SENT TO THE HEARING BRANCH CANNOT BE INTRODUCED AT THE HEARING.

F. After forwarding the hearing request via form FS-79, prepare for the hearing by reviewing the case record and writing a summary of the issue/action that prompted the Hearing. Give a copy of the summary to the supervisor for review.

1. Include in the summary all information, documentation, notices, forms, comments, etc., that support the IPV determination. Be clear and concise with the explanation in case you are unable to attend the hearing and the supervisor or another worker must represent the agency's position.

2. Make copies of any manual or system-generated notices that are related to the IPV issue to present at the hearing.

3. Make copies of all manual sections that relate to the IPV determination. Include any pertinent policy clarifications that support the agency.

4. DO NOT include unprofessional language or comments in the summary.

G. Upon receipt of form FS-79, the Hearings Branch schedules the hearing. The worker and supervisor are to mark their calendars when notice is received as to the date and time of the hearing. The worker, supervisor or designated individual MUST prepare, attend and actively participate in the hearing.

H. At the hearing, the worker or individual attending the hearing must be prepared to present the facts surrounding the IPV determination. 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. Making at least two copies of any forms, notices, documentation, and system screen prints (including comments) that are to be presented as evidence to support the IPV. One copy is for the hearing officer and the other is for the client. (Remember, if the evidence is not listed on the FS-79, it CANNOT be presented at the hearing).

4. Making at least two copies of all pertinent manual sections that support the IPV determination. One is for the hearing officer and the other is for the client.

5. Contacting individuals that may be witnesses for the agency to notify them of the time and place for the hearing. Witnesses may include another worker, claims worker, OIG investigator, etc. Witnesses should be briefed on the issue in order for them to testify effectively.

6. Taking the case record to the hearing to assist in responding to questions asked during the hearing.

7. Dressing professionally.

8. Using professional language when presenting the summary and evidence. When called upon to present the agency's position, speak clearly and confidently. Explain the policy and procedure used in terms that everyone attending the hearing can understand. Do not use phrases such as: "I don't know"; "I haven't a clue"; "I don't agree with the policy"; "It's just done that way", etc. If you are unsure of a response, state, "I do not have that information, but if you allow time, I will get it."

I. After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is sent for review to all parties who attended the hearing. If any of the parties disagree with the recommended order, an exception can be filed with the Quality Assurance Branch. No action is taken on the claim based on the recommended order; must receive final order.

1. The client has 15 calendar days from the date shown on the recommended order to file an exception.

2. The Division of Family Support (DFS) has 15 calendar days from the date shown on the recommended order to file an exception. Exceptions filed later than 15 calendar days are disallowed.

3. The exception by the agency is to be filed by Quality Central DFS staff. Use the following procedures to have an exception filed:

   a. Upon receipt of a recommended order, the worker and his/her supervisor have 5 work days to review and request an exception be filed. Remember, the exception can only be based on the facts and evidence PRESENTED at the hearing. No new information or evidence may be used to take exception.

   b. Send requests for an exception to the Program Specialist for the Region. The Program Specialist reviews the request for validity and forwards valid requests via e-mail within 2 work days to:

      Nutrition Assistance and Accountability Branch
      Attention: Branch Manager
      275 East Main St. 3 E-I
      Frankfort, KY 40621

   c. After reviewing for validity, Branch staff submits the exception to the Quality Assurance Section, Office of the Ombudsman. A copy of the exception is also sent to the client and representative, as appropriate.

4. Quality Assurance staff reviews all timely exceptions to the recommended order and drafts a Final Order for submission to the Commissioner.

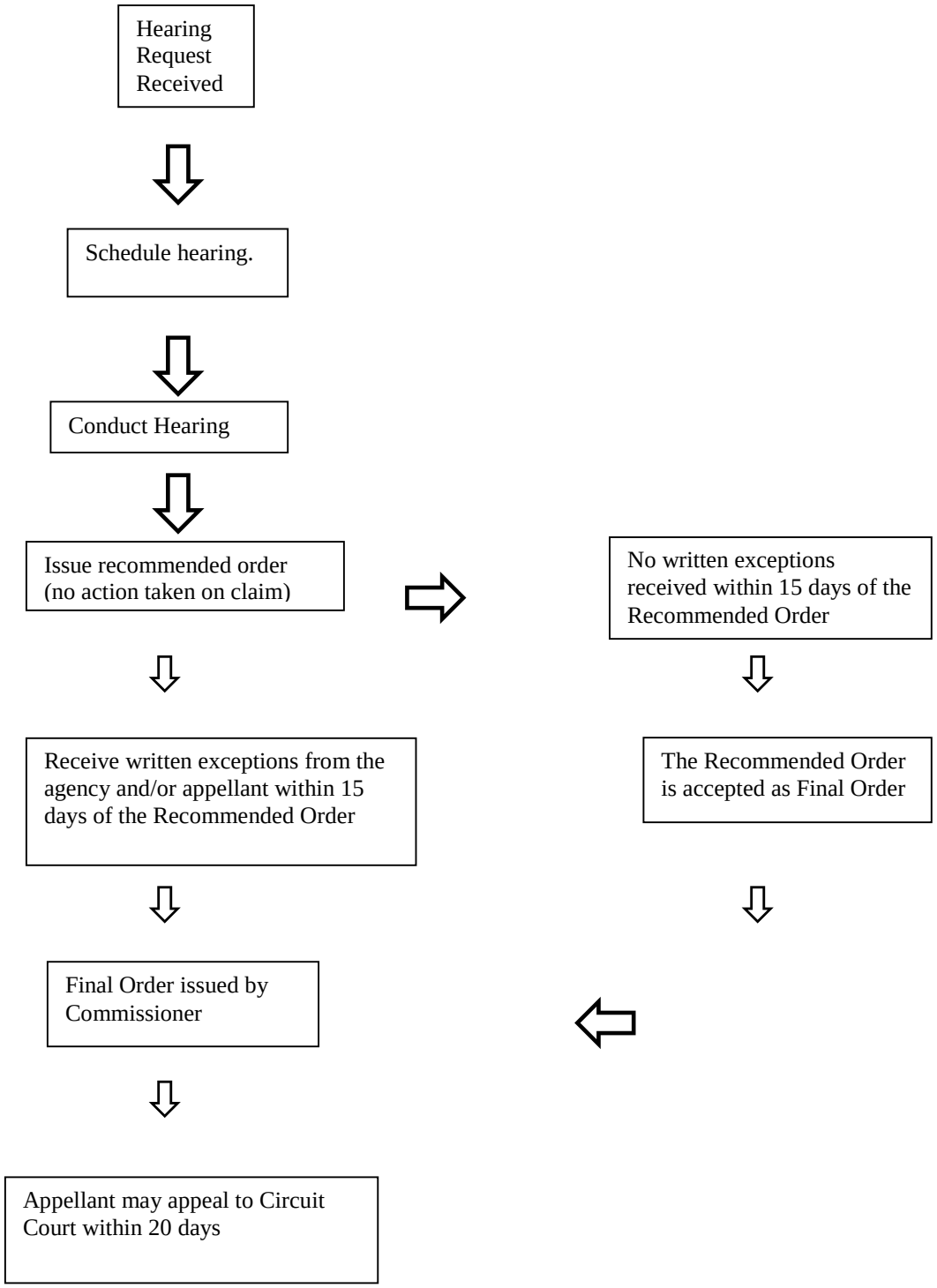
5. The Commissioner signs the Final Order and sends copies to the client, representative (if any) the local office, and to the appropriate SRAA.

J. If the Final Order upholds the agency's determination that an IPV disqualification has occurred, the worker must enter the IPV disqualification on KAMES within 3 workdays of the receipt of the Final Order.

K. If the Final Order disagrees with the agency's determination that an IPV has occurred and an SIPV/IHE claim has been established, refer to MS 1575 for KCD system entry changes that are needed.

MS 1610*

ADMINISTRATIVE DISQUALIFICATION HEARING PROCESS FLOW CHART



MS 1615* WHAT ARE THE HEARING BRANCH RESONSIBILITIES FOR AN ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

Upon receipt of form FS-79, Request for an Administrative Disqualification Hearing, the hearing officer:

A. Schedules a disqualification hearing and provides written notice to the household member suspected of an IPV at least 30 days in advance of the scheduled disqualification hearing. The notice advising of the date and location of the hearing is mailed by the Hearing Branch, Certified Mail Return Receipt Requested, to the member with a copy forwarded to the worker.

The 30-day advance notice is provided in order to permit the household adequate time to prepare for the hearing. However, the household may request less advance notice to expedite the scheduling of the hearing.

B. The time and place of the hearing is arranged so that the hearing is accessible to the household member suspected of Intentional Program Violation (IPV).

1. If the household member or its representative is not present at the hearing, a review of the returned notice will be completed, and if the return notice was signed/accepted by the addressee or if the notice was annotated "Refused", the hearing is conducted.

2. Even though the household member is not present, the hearing officer is required to carefully consider the evidence presented by the Agency and determine if an IPV was committed.

3. If the household member is found to have committed an IPV, but the hearing officer later determines that the household member or representative had "good cause" for failure to appear:

a. The previous decision shall not remain valid;

b. A new hearing shall be conducted; and

c. The “good cause” decision shall be entered into the record.

4. If the review of the notice determined that it was returned annotated "Unclaimed" or "Undeliverable", the hearing will not be held and the case should be annotated, "Order To Remove From The Docket".

C. Conducts the hearings and:

1. Administers oaths or affirmations as required by the State;

2. Requests, receives, and makes part of the record all evidence determined necessary to decide the issue;

3. Ensures that an orderly hearing process is followed; and

4. Provides a hearing record and renders a hearing decision.

D. Issues a Recommended Order.

1. The hearing officer bases the determination on clear and convincing evidence which demonstrates that the household member committed and intended to commit an IPV.

2. The hearing officer's decision specifies the reasons for the decision, identifies the supporting evidence, identifies the pertinent manual section and response to reasonable arguments made by the household member or representative.

3. Decisions of the hearing officer must comply with federal policy and are based on the hearing record.

4. Retain the hearing decision containing the substance of what transpired at the hearing, including all papers and requests filed in the hearing proceeding, in the case record and make the record available to the household or its representative at any reasonable time for copying and inspection.

5. The Recommended Order is sent for review to all parties who attended the hearing.

6. Submits a draft of the Final Order to the Commissioner.

MS 1620 WHAT ARE THE CLIENT'S RIGHTS DURING AN ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

The member suspected of an Intentional Program Violation (IPV) and the household have the following rights:

A. The member or representative is entitled to only one postponement of up to 30 days provided the request for postponement is made at least 10 days in advance of the date of the scheduled hearing. If the hearing is postponed, the 90 day limit is extended for as many days as the hearing is postponed.

B. The member's rights during an ADH are the same as outlined in MS 0586. In addition, the hearing officer advises the household member or representative that he/she may refuse to answer questions during the hearing.

C. A pending disqualification hearing does not affect the member's or the household's right to be certified and participate in the program, if technical and financial eligibility factors are met.

1. Do not disqualify a household member until the Final Order is received and the hearing officer has determined that the member has committed IPV. Determine the eligibility and benefit level of the household in the same manner as any other household.

2. If the misstatement or action for which the household member is suspected of IPV does not affect the household's current circumstances, continue to base the household's allotment on the latest certification action or recertify the household based on the new application and the household's current circumstances. However, terminate the household's benefits if the certification period has expired and the household fails to reapply.

3. Reduce or terminate the household's benefits if the Agency has documentation which substantiates that the household is ineligible or eligible for fewer benefits (even if these facts led to the suspicion of IPV and the resulting hearing) and the household does not request a fair hearing and continuation of benefits pending the hearing. The Agency may have facts which substantiate that a household failed to report a change in its circumstances even though the Agency has not yet demonstrated that the failure to report involved a violation.

4. For Food Stamp cases pending an ADH, DO NOT cease collection activity.

MS 1625* CLIENT REQUEST FOR REDERTERMINATION BASED ON PRIOR WAIVER/FS-80

Any Intentional Program Violation (IPV) claim which was established prior to 10/1/92 by a signed form FS-80, Notice of Suspected Intentional Food Stamp Program Violation, must be reopened for a redetermination at the household's request. This is necessary because the waiver used prior to 10/1/92 failed to contain all of the information required by Federal regulations.

A. If any individual requests a reconsideration of such an IPV claim, complete form FS-79, Request for an Administrative Disqualification Hearing, and forward it, together with all evidence and other relevant information to the Hearing Branch.

B. An ADH will be scheduled and the claim designation of IPV will be redetermined by the hearing officer.

C. If sufficient evidence is unavailable to support the IPV determination, the claim is reduced by the hearing officer to Inadvertent Household Error (IHE).

D. This redetermination is done even if the claim has been paid in full.

MS 1630* PROCEDURES FOR AGENCY WITHDRAWAL OF ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

Once an ADH is requested, it is not withdrawn unless subsequent information comes to the worker's attention which indicates that an Intentional Program Violation (IPV) was not the cause of the claim or when the client contacts the worker about signing form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing.

A. Take the following steps when IPV is no longer suspected.

1. In discussion with the supervisor, review all the evidence on which the original determination was based as well as the new information on which the redetermination is based.

2. If the supervisor agrees with the worker's determination that the claim was not the result of an IPV, the supervisor prepares a memorandum to the hearing officer outlining the basis on which the original determination was made and the factors involved that support the redetermination and requests the hearing be cancelled.

3. Contact the member by letter informing him/her that the request for the ADH was withdrawn and the reasons for this determination. If there is a chance that the member will not receive the letter prior to the time of the scheduled hearing, contact the member or representative by phone and follow up in writing.

4. Retain copies of all related correspondence in the case record.

B. If the member contacts the worker about signing form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, offer the member and the head-of-household, if different, the opportunity to sign the waiver. The household is under no obligation to sign form FS-80, Supplement A.

1. Notify the Hearing Branch by telephone that form FS-80, Supplement A, has been signed so that the Hearing Branch can cancel the hearing.

2. Follow-up the call with a memorandum and a copy of the signed form FS-80, Supplement A.

MS 1635 LOCAL OFFICE PROCEDURES FOR ACTING ON ADMINISTRATIVE DISQUALIFICATION HEARING (ADH) FINAL ORDER

When a final order is received and:

A. The final order states that the member did not commit an Intentional Program Violation (IPV), take appropriate action on the case as indicated by the final order.

B. After reviewing an IPV claim which was previously established by signing form FS-80, Notice of Suspected Intentional Program Violation (SIPV), prior to 10/1/92, the hearing officer finds that there is insufficient evidence to support a determination of IPV, take the following action on the case:

1. The Supervisor must delete this IPV occurrence from the disqualification file;

2. Restore any benefits lost as a result of the disqualification;

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 the Kentucky Claims Debt (KCD) Management system, as appropriate.

C. If the hearing was dismissed with the annotation, "Order To Remove From The Docket":

1. Update the Comments screen on KCD system to show the ADH was dismissed. Continue to pursue collection on the Inadvertent Household Error (IHE)/SIPV claim until another hearing can be requested and held;

2. File a copy of the final order and the recommended order in the case record and claims control folder;

3. Annotate in red "DO NOT PURGE" on the outside of the case record and claims control folder;

4. Any time a current address becomes known to the Agency for households previously removed from KCD as a result of the hearing decision/final order "Order To Remove From The Docket", submit a 2nd form FS-79 with a copy of the previous hearing decision/final order to the Hearing Branch.

D. If a 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 Hearing Branch so that the new notice may be sent.

E. The member is guilty of IPV, refer to MS 1575, SIPV/IPV Claims process, if a claim has been established.

MS 1640* APPEAL RIGHTS FOR ADMINISTRATIVE DISQUALIFICATION HEARING (ADH)

After an adverse disqualification final order, no further administrative appeal procedure exists for the member. A determination of an Intentional Program Violation (IPV) made by a hearing officer cannot be reversed by a subsequent fair hearing final order. However, any party who is dissatisfied with the ADH final order may secure judicial review of the decision by filing a petition for review against the Commissioner within 20 days after the final order. The petition is filed in the Circuit Court of the county in which the member resides. In such cases, the period of disqualification is imposed, but may be subject to change by the court.

MS 1645 IMPOSING INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATIONS

If an IPV disqualification is being served when a work related offense is determined, impose the work related disqualification concurrently with the IPV disqualification. Impose disqualifications when notified that an individual has committed one of the following offenses.

A. Determined by a Federal, State, or local court to be guilty of having used or received Food Stamp (FS) benefits in a transaction involving the sale of a controlled substance.

Disqualification:

1. 2 years for 1st offense; or

2. Permanently for 2nd offense.

B. Found guilty by a Federal or State court or an Administrative Disqualification Hearing (ADH) on or after 8/22/96, of making a fraudulent statement, or misrepresentation of identity or residence, in order to receive duplicate FS benefits. This applies to a client who creates an alias to get FS benefits at two separate addresses.

Disqualification: 10 years.

C. Convicted on or after 8/22/96 by a Federal, State or local court of trafficking in FS benefits of $500 or more.

Disqualification: Permanent upon the first offense.

D. Found to have committed IPV through an ADH or by a court of appropriate jurisdiction.

Disqualification:

1. 12 months for the 1st offense;

2. 24 months for the 2nd offense;

3. Permanently for the 3rd offense; or

4. Penalty assigned by the court.

E. Signed form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing.

Disqualification:

1. 12 months for the 1st offense;

2. 24 months for the 2nd offense; or

3. Permanently for the 3rd offense.

F. Signed form FS-111, Disqualification Consent Agreement, in cases referred for prosecution.

Disqualification:

1. 12 months for the 1st offense;

2. 24 months for the 2nd offense; or

3. Permanently for the 3rd offense.

G. Determined by a Federal, State or local court to have used or received food stamp benefits in a transaction involving the sale of firearms, ammunition or explosives.

Disqualification: Permanent upon the first offense.

H. Enter the appropriate disqualification on KAMES as listed below:

1. 397 – Intentional Program Violation;

2. 433 – Trafficking $500 or more; or

3. 434 – Fraud/duplicate benefits.

MS 1647 COURT IMPOSED DISQUALIFICATIONS

Notification of the court decision includes, but is not limited to, a copy of the court order or receipt of form PAFS-88, OIG Referral. Take the following actions when notified that an individual is found guilty of an intentional Program Violation (IPV) in a court of law.

A. Enter the guilty member on the KAMES disqualification file, no later than 3 work days following receipt of the court order or other notification.

B. Disqualify a member for the length of time specified by the court. If the court fails to impose a disqualification period, impose the disqualification period per Vol 1. MS 1645, unless contrary to the court order.

[The disqualification penalty must begin as soon as administratively feasible.] The court-imposed disqualification begins within 45 calendar days of the date the court found the member guilty of civil or criminal misrepresentation or fraud.

C. If the court fails to address restitution, initiate collection action.

MS 1649* DEFERRED ADJUDICATION

After the Food Stamp (FS) 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 the opportunity by the court to sign form FS-111, Deferred Adjudication Disqualification Consent Agreement. Cases of deferred adjudication are cases in which a determination of guilt is not obtained from a court due to the accused member having met the terms of a court order, or the accused member is not prosecuted due to having met the terms of an agreement with the prosecutor.

B. By signing form FS-111, the accused member makes no admission of 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 by the County/Commonwealth Attorney.

2. The member is under no obligation to sign such an agreement.

3. If the member refuses to sign, the County/Commonwealth Attorney takes appropriate action.

C. OIG represents the Agency in the prosecution of an IPV.

1. OIG informs the prosecuting attorney that the terms of the court order may include the disqualification of the accused member and the restitution of the claim.

2. The prosecuting attorney and the accused member may agree upon deferred adjudication.

3. OIG requests that any deferred adjudication agreement includes the disqualification of the accused member and the restitution of the claim.

D. The Field Services Supervisor (FSS) in each county is responsible for providing a supply of forms FS-111 to the County/Commonwealth Attorney's office. In counties with more than one supervisor, the Service Region Administrator designates the supervisor responsible for contacting the County/Commonwealth Attorney’s office.

E. In presenting the form to the County/Commonwealth Attorney's office, the supervisor or designee explains that:

1. The Food and Nutrition Service (FNS) regulations require the form be signed in order to disqualify the individual from participation in the Food Stamp Program.

2. If form FS-111 is signed, treat the claim as an IPV for collection purposes.

3. The County/Commonwealth Attorney orders the form through the local office.

F. 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, the FSS or designee contacts the member and has the form signed.

1. After the form is signed, it is returned to the County/Commonwealth Attorney's office for signature.

2. If the member cannot be reached, the supervisor or designee contacts the County/Commonwealth Attorney's office and requests the form be completed.

G. If the household consents to disqualification, impose disqualification penalties upon receipt of form FS-111.

MS 1651* INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATION EFFECTIVE DATE

Disqualify the member using the following time standards:

A. If a member is determined to have committed an IPV, enter the disqualification on the disqualification file no later than 3 work days following receipt of the hearing decision, court order, form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or FS-111, Deferred Adjudication Disqualification Consent Agreement.

B. When an IPV disqualification is entered on the Disqualification File, KAMES adds 3 calendar days to the "Disqual Decision Date" to set the "Disqual From Date". The 3 calendar days allow for mailing the disqualification notice.

1. If the "Disqual Decision Date" plus 3 days ends on or before food stamp cut-off, the "Disqual From Date" is the first day of the following month.

2. If the "Disqual Decision Date" plus 3 calendar days ends after cut-off, the "Disqual From Date" is the first day of the month after the month following the disqualification decision month.

3. The "Date Worker Added the Disqual" field does not affect the "Disqual From Date".

C. An IPV disqualification does not pend for adverse action.

D. Once a disqualification period begins, continue the disqualification uninterrupted for the entire number of months of disqualification 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.

MS 1653* FAILURE TO IMPOSE DISQUALIFICATION

If a disqualification is not imposed, do the following:

A. If the disqualification period has not elapsed, impose the penalty showing the proper disqualification period. Establish an Agency Error (AE) claim for the months benefits were received when the individual should have been disqualified.

   Example: An individual should have been disqualified for the months of January through December. In June, it is discovered that the disqualification penalty was never imposed. At the time of discovery, enter the individual on the disqualification file on KAMES showing the disqualification period as January through December. Establish an AE claim for the months of January through June as the individual received benefits to which he/she was not entitled. If the allotment for July was not corrected, include July in the claim.

B. If the disqualification period has elapsed, establish an AE claim for the months benefits were received when the disqualification penalty should have been imposed. Enter the disqualification period on the disqualification file on KAMES. The disqualification period and the AE claim months are the same.

   Example: An individual should have been disqualified for the months of January 2005 through December 2005. In January 2006 the worker discovered that the penalty was never imposed. Establish an AE claim for the period of January 2005 through December 2005. Enter the disqualification period of January 2005 through December 2005 on the disqualification file.

Establishment of the AE claim in both instances serves as one offense when determining the number of months to be imposed for future disqualifications.

MS 1655* COURT REVERSAL OF DISQUALIFICATIONS

In cases where the determination of an Intentional Program Violation (IPV) is reversed by a court of appropriate jurisdiction, reinstate the member in the program if the household is currently eligible. Restore any benefits that were lost as a result of the disqualification, not to exceed 12 months prior to the date of State agency notification of the court's reversal of the imposed disqualification. A member would not be entitled to restoration of lost benefits for the period it was disqualified based solely on the fact that a criminal conviction could not be obtained, unless the member successfully challenged the disqualification in a separate court action.

MS 1657* INTENTIONAL PROGRAM VIOLATION (IPV) DISQUALIFICATION FILE

A disqualification file is maintained on KAMES for all members who have been disqualified due to Intentional Program Violations (IPV).

A. When a member is determined to have committed an IPV, enter the social security number of the disqualified member on the disqualification file even if that member is not currently participating in an active food stamp household.

B. If a disqualification is reversed by a court of appropriate jurisdiction, the Supervisor must delete the information on the file.

C. If a disqualification is changed to an Inadvertent Household Error (IHE) as a result of the household's failure to receive the hearing notice, or the hearing officer overturning an IPV determination per final order, the Field Services Supervisor deletes the information from the disqualification file. This is the ONLY time an IPV disqualification is deleted.

D. The following information is contained on the disqualification file for each disqualified member:

1. Member Social Security Number;

2. Member Status;

3. Member Name;

4. Date of Birth;

5. Member Sex;

6. Date on which the disqualification is added to the file;

7. Member Status Reason Code;

8. Disqualification from/through date;

9. Number of months disqualified;

10. Disqualification decision date;

11. Member Status Source Code;

12. Frequency of Offense (1st, 2nd or 3rd);

13. Intentional Program Violation (IPV) Occurrence; and

14. Case Number where the IPV occurred.

MS 1659 DISQUALIFIED RECIPIENT SUBSYSTEM (DRS)

See OM Upd. No. 07-24, MS 99773, 11/12/07

The Disqualified Recipient Subsystem (DRS) is a national file of all clients found guilty of an Intentional Program Violation (IPV) and currently disqualified or have been disqualified in the past. DRS is maintained by the Food and Nutrition Service (FNS) and is used to match monthly against KAMES to determine if a household member, regardless of status, has a previous violation in another state.

A. Matches appear on the Report Distribution System (RDS) Report KIFJ14, which is run on the day after food stamp (FS) cut-off, each month.

Report KIFJ22 captures individuals listed on KRFJ14 that no action has been taken in the last 90 days. Failure to resolve DRS matches results in agency errors. Do the following, regardless of case status:

1. Initiate contact within 5 workdays with the Locality Contact in the other state listed on the report to obtain verification of the disqualification.

2. After receiving documentation from the originating state, determine if the disqualification file on KAMES needs to be updated, and if a claim is appropriate because the disqualified individual received benefits during the period of disqualification.

3. The supporting documentation from the Locality Contact is filed in the claims control folder and the exception listing is annotated and returned to the supervisor for tracking purposes.

B. Kentucky's Locality Contact is the Claims Management Section (CMS) Supervisor in the Nutrition Assistance and Accountability Branch. Other States contact CMS to obtain Kentucky's disqualification verification for their matches.

1. The DRS matches appear in the county that initially entered the disqualification on KAMES.

2. CMS contacts that county to request the supporting documentation. Submit copies of material from the claims control folder to support the disqualification within 5 workdays of receiving the memorandum.

3. If the claim was transferred to another county after the disqualification was entered on KAMES, advise CMS of the new location in order to avoid delays in responding to the out-of-state Agency. Contact the new county and advise them of the match date.

C. As a result of the requirement to provide IPV claims information to States participating in DRS, IPV claims records are retained indefinitely, as long as the records can be used by another State, i.e., the records are accurate, relevant, up to date and complete.

MS 1662* SUPERVISOR RESPONSIBILITIES FOR REFERRALS TO THE OFFICE OF INSPECTOR GENERAL (OIG)

The supervisor or designee must:

A. Review form PAFS-88, OIG Referral Summary/Disposition, Part A to determine if further documentation is necessary.

B. Complete form PAFS-88, Part A, item V to indicate the action taken on the referral.

C. Return inappropriate referrals to the worker with reason entered on form PAFS-88, Part A.

D. Annotate the case record across the cover in red "ERRONEOUS BENEFIT - DO NOT PURGE."

E. Referrals are forwarded to OIG or are returned to the worker for administrative action. Please refer to MS 1672.

MS 1664* OFFICE OF INSPECTOR GENERAL (OIG) RESPONSIBILITIES

OIG is responsible for the following activities:

A. [Completes an investigation within 90 calendar days of receipt for all non-established food stamp referrals of suspected fraud in which the loss is estimated to be $3,000 or greater or a month or more of Medicaid ineligibility is involved, regardless of the amount;]

B. Completes an investigation on all other referrals as soon as possible;

C. OIG will review trafficking cases and make a determination if further action is needed;

D. Requests computations from the Department for Community Based Services (DCBS) by memorandum, and provides a monthly listing of outstanding requests;

E. Secures Medicaid expenditures for all referrals of suspected fraud, in which there is a period of ineligibility for Medicaid for a case or recipient;

F. Upon completion of the investigation, returns referrals/cases with form PAFS-88, OIG Referral Summary/Disposition, to the appropriate DCBS office for administrative action;

G. When notified, appears as an expert witness for administrative disqualification hearings or court cases; and

H. Provides monthly OIG status reports, tracking activity on all referrals.

MS 1667* PROCEDURES FOR ACTING ON OFFICE OF INSPECTOR GENERAL (OIG) FRAUD "HOTLINE" REFERRALS

OIG maintains a toll free hotline, 1-800-372-2970, which is used by the public to report suspected fraud. When local offices receive calls reporting potential fraud, the caller should be given this 800 number.

A. For allegations of program misuse, OIG sends form PAFS-84, Fraud Hotline Information Referral, to the local office. Upon receipt of form PAFS-84, review the case. If the case DOES NOT reflect the information contained in the referral, take the following action EVEN IF THE CASE IS CURRENTLY INACTIVE:

1. Investigate the allegation to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation. Enter the potential claim on the Kentucky Claims Debt (KCD) Management System.

2. If it cannot be determined that an overpayment occurred, enter the pending claim on KCD. From KCD, the worker generates an appointment notice to discuss the information contained on form PAFS-84.

3. If the client does not keep the appointment or the allegation cannot be verified, refer the claim to OIG for further investigation.

4. If the case is active, make any required changes in the case to reflect the verified information. Decrease the benefits or discontinue the case, if appropriate.

5. If it is determined that an overpayment has occurred, enter that information on KCD and establish a claim.

6. If it is determined that an overpayment does not exist based on the information contained on form PAFS-84, establish the pending claim on KCD as a no claim. Comment thoroughly giving the reason an overpayment was not found.

7. Complete Part II of form PAFS-84 and return to OIG.

B. When a PAFS-84 is received on a simplified reporting (SR) case addressing information that is not required to be reported during the certification period, investigate the allegation and follow the steps outlined in item A. If the allegation affects current receipt, enter the verified information and let KAMES process the change accordingly.

MS 1668 WHAT CASES ARE REFERRED TO OFFICE OF INSPECTOR GENERAL (OIG)

The following claims are referred to OIG:

A. MA cases, regardless of the amount, when a client has withheld or provided false information in order to receive assistance. Do not enter MA claims on KCD until the claim has been adjudicated through the court system. Do not refer MA claims which are not the result of suspected client fraud. Correct the case and take no further action regarding the nonfraud claim.

B. [K-TAP cases suspected of fraud, when the claim amount is $3,000 or greater or if there is a companion case(s) and the combined amount is $3,000 or greater. Send the Kentucky Works case if appropriate.

C. Kinship Care cases suspected of fraud, when the claim amount is $3,000 or greater or if there is a companion case(s) and the combined amount is $3,000 or greater.

D. TANF Related cases suspected of fraud, when the claim amount is $3,000 or greater or if there is a companion case(s) and the combined amount is $3,000 or greater.

E. Food Stamp cases suspected of fraud, when the claim amount is $3,000 or greater or if there is a companion case(s) and the combined amount is $3,000 or greater.]

F. Food Stamp client trafficking cases, regardless of the suspected amount.

MS 1670 PROCEDURES FOR REFERRALS TO OFFICE OF INSPECTOR GENERAL (OIG)

Referrals of overpayment of benefits are made to OIG on Kentucky Transitional Assistance Program (K-TAP), Kinship Care (KC), Family Alternative Diversion (FAD), Supportive Services (SS), Medical Assistance (MA) and Food Stamp (FS) cases. Only fraud/suspected Intentional Program Violation (IPV) cases are referred.

Effective February 4, 2008, all Child Care claims are entered on the Kentucky Claims Debt (KCD) Management System by the Child Care Assistance Program staff in Central Office.

Use the following procedures in referring cases to OIG.

A. Take the following actions upon discovery of a suspected Intentional Program Violation (IPV) or fraud claim. These procedures apply to the overpayment of benefits and the misuse of an Electronic Benefits Transfer (EBT) card.

1. Identify the potential claim and enter it on the automated claims system, Kentucky Claims Debt (KCD) Management system;

2. Take appropriate action to correct the case and ongoing benefits;

3. Schedule an appointment to discuss the claim with the household and attempt to secure verification necessary to substantiate the suspected claim;

4. During the appointment, explore whether the client has a disability or language barrier that limits his or her ability to understand and/or follow program rules. If such evidence exists, the worker must provide additional information and assistance where needed to reduce the change of an overpayment from client error.

5. If there are fraud claims in multiple programs, add the estimated claim amounts together to obtain the total loss.

6. [Refer cases in which the total loss is estimated to be $3,000 or more to the OIG.]

   With form PAFS-88, OIG Referral Summary/Disposition, include all signed applications for the established or suspected overpayment period. In addition, submit the following items which support the suspicion of fraud or verify how the claim(s) are established for the period indicated on form PAFS-88:

   a. All signed forms PAFS-700 and PAFS-76.
   b. Any written statements that verify household composition, wages, or child support.

c. Any additional information that verifies income from wages, child support, or other sources of income and including bank statements, etc.
d. All forms PAFS-14.
e. All forms FS-8.

7. [If the suspected fraud claim is estimated to be less than $3,000 and Medicaid was received by the household during an apparent period of Medicaid ineligibility:

   a. Submit completed form OIG-1, Medical Assistance Eligibility Summary, with form PAFS-88, to OIG;

   b. OIG will obtain Medicaid expenditures for the appropriate members and months in question;

   c. Upon receipt of form PAFS-88 and total Medicaid expenditures from OIG, add that amount to the estimated claim amount for all cases;

   d. Refer to OIG if the combined total is $3,000 or more;

   e. Take appropriate administrative action if the suspected fraudulent amount is less than $3,000; and

   f. An MA claim is not entered on KCD until the claim is adjudicated by the court.]

8. If an MA case has no other related cases, refer the MA case to OIG regardless of the amount.

9. Upon receipt of returned forms PAFS-88 and investigative reports from OIG, update KCD as necessary;

10. Complete calculation requests from OIG within 15 calendar days of receipt;

11. In response to a subpoena, appear in court as an expert witness, to testify and present evidence of fraudulent activity;

12. Take appropriate administrative action, establish claims and refer them to CMS as directed by OIG; and

13. Update KCD as necessary.

    Note: Medical Assistance claims are put on the KCD system once the claim has been adjudicated through the court.

B. Take the following actions upon the discovery of a suspected IPV involving the selling of food purchased with an EBT card.

1. Contact OIG by phone, 1-800-372-2970;

2. OIG will review to determine if other program violations exist;

3. OIG has the option to have form FS-80 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or FS-111, Deferred Adjudication Disqualification Consent Agreement, signed by the client during the interview process. Enter the disqualification on KAMES if a signed form FS-80, Supplement A, or FS-111 is received from OIG. Do NOT establish a claim.

4. If no indication of possible illegal EBT use is found, the allegation will be returned to the local office for final action;

5. The worker must then schedule the head of household to come in to the local office to be questioned about the allegation;

6. If no evidence or admittance of an IPV is found after an investigation and questioning the individual, file the report in the client's file; and

7. If a client admits an IPV the supervisor reviews the evidence to ensure the waiver is appropriate and then the forms FS-80, Notice of Suspected Intentional Food Stamp Program Violation, and FS-80, Supplement A are mailed to the individual. If a signed FS-80, Supplement A is received, enter the appropriate disqualification on KAMES within three days and place the disqualification in the client's file. Do not establish a claim.

8. If the disability or LEP is questioned, but the agency decides to go forward with the OIG referral, the worker must seek review of the decision from the DCBS ADS/504 Coordinator, or other authorized personnel.

MS 1672 OFFICE OF INSPECTOR GENERAL (OIG) FRAUD REFERRALS

A. Any FS claim discovered on or after June 1, 2005, which will be referred to OIG, must first be referred to the Nutrition Assistance and Accountability Branch, (NAAB) Claims Management Section (CMS) within 10 calendar days from the established date. CMS will then forward the claim to OIG. The only types of claims that must be referred to CMS are:

1. [Established Suspected Intentional Program Violation (SIPV) claims (Inadvertent Household Error (IHE) claims with a (Y) in the SIPV indicator field) of $3,000 or greater; and]

2. Established SIPV claims (IHE claims with a (Y) in the SIPV indicator field) which involve at least one month of Medicaid ineligibility, regardless of the dollar amount.

3. [If the worker is unable to obtain verification and strongly suspects the overpayment may be $3,000 or greater, the worker completes a referral to OIG within 30 days of discovery. The worker MUST include verification of the attempt to obtain any information needed to process the claim, such as a copy of the interview appointment letter, copy of letter to any employers necessary, etc. Comments in the case record must reflect all attempts to obtain verification and list the names and phone numbers of any collateral contacts used.]

4. Do not mail form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, until OIG has completed their investigations.

B. [All other types of claims, Kentucky Transitional Assistance Program (K-TAP), Kinship Care (KC), etc., anticipated to be $3,000 or greater alone or with a companion case, which will be referred to OIG, must first be referred to CMS within 30 days of discovery.]

C. Once it has been determined that a claim must be referred to OIG, complete form PAFS-88, OIG Referral Summary/Disposition, for any companion cases in which benefits were received during the established or suspected overpayment period. A separate form PAFS-88 is completed.

D. The supervisor or designee must:

1. Review form PAFS-88, Part A, to determine if further documentation is necessary.

2. Complete form PAFS-88, Part A, item V to indicate the action taken on the referral.

3. Return inappropriate referrals to the worker with reason entered on form PAFS-88, Part A.

4. Annotate the case record across the cover in red "ERRONEOUS BENEFIT - DO NOT PURGE."

5. Return to the worker for the following action:

   a. With form PAFS-88, OIG Referral Summary/Disposition, include all signed applications for the established or suspected overpayment period. In addition, submit the following items which support the suspicion of fraud or verify how the claim(s) are established for the period indicated on form PAFS-88:
      (1) All signed forms PAFS-700 and PAFS-76.
      (2) Any written statements that verify household composition, wages, or child support.
      (3) Any additional information that verifies income from wages, child support, or other sources of income and including bank statements, etc.
      (4) All forms PAFS-14.
      (5) All forms FS-8.

      These items should also be forwarded from any companion cases for which benefits were received during the established or suspected overpayment period.

   b. Complete form PAFS-25, Transfer of Case Record or Material; and

   c. Mail form PAFS-25, form PAFS-88 and the copies from the case record(s) to:

      Department for Community Based Services
      Division of Family Support
      Nutrition Assistance and Accountability Branch
      Claims Management Section
      275 East Main Street, 3E-I
      Frankfort, KY 40621

E. OIG will complete the investigation within 90 calendar days of receipt of the case referral on all non-established food stamp claims.

F. During the investigation OIG may request computations from the Department for Community Based Services (DCBS) by memorandum. DCBS must complete computations within 15 calendar days of receipt. When computations have been completed:

   1. Forward the original and one copy of the Kentucky Claims Debt (KCD) Management system calculation screens to OIG.

   2. Send the PAFS-88 and copies of all pertinent documents and information related to the alleged fraud.

   3. Provide copies of any other case record material when and if requested.

G. OIG serves as liaison between DCBS and appropriate courts or prosecutors, including attending pretrial conferences and advising DCBS of any changes pertaining to the case.

H. OIG notifies DCBS staff at least 5 workdays, if possible, in advance of court or conference sessions that may require their appearance. In some instances, the timeframe is set by a subpoena which may be less than 5 workdays.

I. OIG will return closed cases with form PAFS-88 to the Claims Management Section who will forward to the local office for action.

1. For OIG investigations closed due to “Facts Insufficient to Support Fraud”, “No Dollar Amount” and “Agency Error”, the worker will need to:

   a. Go back into KCD system and change the SIPV from (Y) to (N) for IHE claims OR will need to change the claim category from Inadvertent Household Error (IHE) to Agency Error (AE) and remove the SIPV indicator field for an AE claim.

   b. Refigure the claim and remove any inappropriate months listed for an AE or IHE claim.

2. For OIG investigations that are closed and an Intentional Program Violation (IPV) is still suspected:

   a. Change the KCD system to show the claim as an IHE with an SIPV indicator of (Y).

   b. Complete form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing. To ensure the waiver is appropriate, the supervisor reviews the evidence before the form is mailed to the household.

   c. Allow the household 10 calendar days to sign form FS-80, Supplement A.

   d. By signing the waiver, the member and head of household, if different, consent to the imposition of a disqualification penalty whether or not they admit committing a violation.

   e. Form FS-80, Supplement A, must be signed by both the member and head of household, if these are different persons.

   f. Neither the member nor the head of household, if different, are under any obligation to sign form FS-80, Supplement A. Use NO COERCION in obtaining the appropriate signatures.

   g. If the household does not return form FS-80, Supplement A, follow procedures in Administrative Disqualification Hearing (ADH) to schedule a hearing.

h. If the household returns form FS-80, Supplement A, the worker will go back into the KCD system within 10 days of receipt to make adjustments as outlined in the following. The worker must also enter the appropriate disqualification period on KAMES within 3 working days of receipt.

(1) If the FS case is active, remove the (Y) from the SIPV indicator field and change the category of the claim from IHE to IPV.

(2) If the FS case is inactive, designated local office staff will need to contact the Claims Management Section in Central Office at (502) 564-3440 to have the (Y) removed from the SIPV indicator field and to change the category from IHE to IPV. Local Office staff are responsible for entering the disqualification of the member on KAMES within 3 working days of receipt.

MS 1674* OFFICE OF INSPECTOR GENERAL (OIG)
REQUEST FOR COMPUTATIONS

Complete the following procedures within 15 calendar days of the request for computation from OIG. Kentucky Claims Debt (KCD) Management System computations are done for Kentucky Transitional Assistance Program (K-TAP), Kinship Care (KC), Supportive Services and Food Stamp (FS) cases only.

A. Indicate Medical Assistance (MA) eligibility for each month of the claim using form OIG-1, Medical Assistance Eligibility Summary.

B. For FS the worker can print the screen that shows the reconciliation number. For K-TAP, the worker can print the screen that shows the check number.

C. When computations for the K-TAP and/or the FS case have been completed:

1. Forward the original and one copy of the KCD Management system calculation screens to OIG. Send the PAFS-88 and copies of all pertinent documents and information related to the alleged fraud. Provide copies of any other case record material when and if requested.

2. [If the combined total amount of the K-TAP, FS Intentional Program Violation (IPV) claim, and companion claims is less than $3,000 AND there is a prior conviction for fraudulent receipt of benefits for K-TAP:

   a. Forward the original and one copy of the KCD calculation screens for the K-TAP and companion claims to OIG.

   b. Also forward the original and one copy of the KCD calculation screens for the FS claim. Although the FS IPV case is not being referred for prosecution, these forms are required to determine the time period and total amount of the claim for the case name. Send a memorandum to OIG explaining the referral is being handled administratively because the total amount of the claim is under $3,000.

3. If the combined total amount of the K-TAP, FS IPV claim, and companion claim belonging to the client or client's spouse, is less than $3,000 and there is no prior fraud conviction and no MA ineligible months, referral to OIG is no longer appropriate. Send a memorandum to OIG explaining the referral is being terminated because the total amount of the claim is under $3,000 and attach a copy of the KCD calculations that were used to compute the claim.

D. In situations of referral for erroneous benefits in multiple programs that exceed $3,000 at the time of referral, if one or more claims are dropped resulting in a total claim of less than $3,000, the case will be returned to the local office for claims processing. Court action will not be pursued when the combined amount does not exceed $3,000.]

MS 1676* INTRODUCTION TO COLLECTIONS

Collection of a claim is either done automatically through benefit reduction or through various methods by the Claims Management Section (CMS).

A. If the household has a claim and is currently receiving benefits, Kentucky Claims Debt (KCD) Management System automatically begins benefit reduction. If the claim was adjudicated in court, the claim will not be benefit reduced.

B. If the claim was adjudicated in court, or if the household is not receiving benefits, KCD will send notices to the household requesting payment on the claim and CMS pursues collection.

C. Once the court adjudicated claim is outside court jurisdiction and if the household is receiving benefits, KCD will automatically begin benefit reduction.

MS 1678* LOCAL OFFICE RESPONSIBILITIES FOR COLLECTION ACTIVITY

The local office has responsibility for collection activity as follows:

A. Accepts any payment if made by personal check, cashier's check, certified check, or money order and forwards the payment to:

Nutrition Assistance and Accountability Branch (NAAB)
Claims Management Section (CMS)
275 East Main St., 3E-I
Frankfort, KY 40621

DO NOT ACCEPT CASH AS PAYMENT.

B. Notifies NAAB, Claims Management Section (CMS), by form PAFS-444, Collection Information Update, of any change which becomes known to the Agency which affects the collections process, e.g., address changes, total claim amount change, etc.

C. Establishes a separate section within the claims control file for all inactive claims.

D. Takes no action on any claim referred to CMS which might jeopardize their collection activities. CMS has statutory authority to collect any type of claim.

E. Refers to CMS all questions, other than those regarding benefit reduction, from clients about their obligation to repay. The local office has the responsibility to explain why the claim was established and how computations were completed.

F. Follows guidelines in MS 0568 if the local office is contacted by a client who wishes to appeal Tax Intercept. CMS notifies the client if an amount is withheld from his/her State/Federal income tax refund to repay the balance of his/her claim.

G. Refers the individual to CMS, at (502) 564-3440 for further information when contacted by the client concerning the withholding of salary garnishment or administrative offset. CMS personnel is responsible for all actions required to be taken by the Department concerning these repayment methods.

H. Refers questions regarding KCD claims reports to NAAB, Claims Management Section at (502) 564-3440.

I. Refers questions regarding claims policy to NAAB, Food Stamp Section, at (502) 564-3440.

J. Refers KCD system issues to KAMES Help Desk at (502) 564-0105.

MS 1679 PAYMENTS RECEIVED IN THE LOCAL OFFICE

Accept payments in the local office if made by a cashier's check, certified check, personal check or money order. DO NOT ACCEPT CASH. If payment is accepted do the following:

A. Review the claim on the Kentucky Claims Debt (KCD) Management System. If an established claim does not exist on KCD, do not accept a payment. Have the client contact the Claims Management Section (CMS);

1. Tell the client to make future payments to the Claims Management Section (CMS);

2. [Complete form PAFS-30.3;

   a. Make a photocopy of the payment and photocopy of the completed form PAFS-30.3
   b. Give the original form PAFS-30.3 to the client or person making the payment;

3. File a photocopy of the payment and photocopy of the form PAFS-30.3 in the claims control folder; and

4. Forward the original payment with form CHR-115.2, Interoffice Memorandum and a copy of form PAFS-30.3 to CMS at:

   Nutrition Assistance and Accountability Branch
   Claims Management Section, 3E-I
   275 East Main Street
   Frankfort, KY 40621

B. If the claim is being collected by benefit reduction and the client makes an additional payment;

1. Complete form PAFS-30.3;

   a. Make a photocopy of the payment and photocopy of the completed form PAFS-30.3;
   b. Give the original form PAFS-30.3 to the client or person making the payment;

2. File a photocopy of the payment and photocopy of form PAFS-30.3 in the claims control folder; and

3. Forward the original payment with form CHR-115.2, Interoffice Memorandum and a copy of form PAFS-30.3 to CMS at

   Nutrition Assistance and Accountability Branch
   Claims Management Section, 3E-I
   275 East Main Street
   Frankfort, KY 40621]

Note: Payments are posted to KCD by CMS upon receipt of the Interoffice Memorandum.

C. Additionally, the clients may use their Electronic Benefits Transfer (EBT) benefits to repay an established claim.

1. If the client contacts the local office and requests that benefits be debited from their EBT account, do the following:

   a. Inquire the EBT account through the EBT Browser on the Internet, to determine if the client has a sufficient balance to cover the request;
   b. If the client does not have a sufficient amount to cover the request, allow them to request an amount up to their EBT account balance.

2. If the client has sufficient benefits in the account to cover the repayment, complete form FSEBT-6, Claims Repayment Request, and fax to CMS at (502) 564-9810 by close of business that day. CMS staff takes the following action:

   a. Debits the EBT account for the appropriate amount;
   b. Applies the payment to the Food Stamp claim; and
   c. The KCD system sends the client a receipt advising of the action taken and balance remaining on their food stamp claim.

MS 1680* CLAIMS MANAGEMENT SECTION (CMS) RESPONSIBILITIES FOR COLLECTION

CMS is responsible for the following regarding collections of claims:

A. Accepts payments for claims;

B. Posts all payments made by clients;

C. Sends a notice acknowledging receipt of the payment;

D. Make claim adjustments and process referral when necessary;

E. Negotiates repayment agreements with the client and sends demand letters, which ensures repayment of the FS claim in 3 years unless other wise specified by court order;

F. Suspends and/or terminates collection of a claim when appropriate;

G. If the claim is established, and the client is not currently repaying the claim, CMS will pursue collection activity;

H. Maintains Tax Offset information;

I. Liaison between OIG and local office;

J. Maintains bankruptcy information;

K. Reviews all Hearing orders that involve claims;

L. Contacts Commonwealth/Circuit Clerk attorneys regarding non-payments;

M. Answers all questions from clients about their obligation to repay CMS; and

N. Compromising Food Stamp claims for inactivity.

MS 1682* WHO MUST REPAY THE FOOD STAMP (FS) CLAIM

The following persons are responsible for paying a claim:

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

B. A sponsor of an alien household member if the sponsor is at fault; or

C. A person connected to the household, such as an authorized representative, who actually trafficks or otherwise causes a claim or trafficking.

If repayment cannot be obtained through the claimant, the responsibility to repay rests with all adult household members, included in the FS case at the time of the claim. All adults who were in the household at the time of the claim period are jointly and equally liable for the claim for the amount of any claim during the months they received FS benefits.

Example: A FS household consists of 4 members: male and female adults and 2 children. The male is designated as the head of household and the FS case is in his name and social security number. An overpayment is discovered in the FS case and a claim established. Because the client has an active FS case, the claim will automatically be pursued for benefit reduction.

If the FS case is discontinued because the male adult moves out of the household, benefit reduction ceases and payment demand letters are issued from the Kentucky Claims Debt (KCD) Management System because the FS case has become inactive.

If the female member of the household reapplies for Food Stamps, the FS case is now in her name and social security number; therefore, she becomes responsible for the claim. Every month the KCD system matches social security numbers associated with claims against social security numbers associated with active FS cases. If a “hit’” is detected, the claim will begin benefit reduction against the “hit” social security number.

NOTE: The client has to have been an adult at the time of the claim for a “hit” to occur.

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.

MS 1684* FOOD STAMP (FS) REPAYMENT METHODS

FS claims may be repaid using one of the following methods:

A. LUMP SUM. For active or inactive households, if the household is financially able to pay the claim at one time, collect a lump sum repayment. DO NOT ACCEPT CASH AS PAYMENT.

1. Do not require the household to liquidate all of its resources to make this one lump sum repayment.

2. If the household is financially unable to pay the entire amount of the claim at one time and prefers to make a lump sum payment as partial repayment of the claim, accept this method of repayment.

3. If the household chooses and has given written permission to make a lump sum payment from benefits in the Electronic Benefits Transfer (EBT) account as full or partial repayment of the claim, accept this method of repayment. The household must complete a form FSEBT-6, Claims Repayment Request, to do this. The worker submits the form to the Claims Management Section (CMS).

B. INSTALLMENTS. If the client with an inactive food stamp case chooses to repay the claim by installment payments, CMS does the following:

1. Negotiates a repayment schedule with the household which will allow for repayment of the claim within 3 years if not repaid through a lump sum.

2. Accepts payments in regular installments.

3. All repayments are due no later than the 10th of the month. The household may use EBT benefits as full or partial payment of any installment. If the full claim is not repaid after 36 installments, the remaining amount of the claim MAY be compromised unless pursued through the Treasury Offset Program (TOP).

4. Suspends and/or terminates collection of the FS claim, when appropriate.

C. BENEFIT REDUCTION. If the household is currently participating, reduce the household's allotment to recover any amount not repaid through a lump sum payment in cash and/or EBT benefits. The Kentucky Claims Debt (KCD) Management System will do this automatically. The initial allotment, when a household is first certified, can not be reduced.

Determine the minimum amount of EBT benefits to be recovered each month through allotment reduction as follows:

1. AGENCY ERROR/INADVERTENT HOUSEHOLD ERROR (AE/IHE) CLAIMS. The amount to be recovered is the greater of 10 percent of the

household's monthly ALLOTMENT or $10 per month. The client is given the option of paying a higher amount than this if they voluntarily choose to do so.

2. INTENTIONAL PROGRAM VIOLATION (IPV) CLAIMS. The amount to be recovered is the greater of 20 percent of the household's monthly ENTITLEMENT or $20 per month. The entitlement is the amount of benefits the household would receive if an IPV disqualified member was included in benefit calculation. The client is given the option of paying a higher amount than this if the client voluntarily chooses to do so.

3. Follow normal rounding procedures when calculating the amount of the benefit reduction.

4. The $10 minimum benefit level for 1 and 2 member households applies only to the allotment prior to reduction. The actual benefits received may be less than $10 if benefit reduction is made.

D. COURT ORDERED COMMUNITY SERVICE. A court may order public work/community service for penalty and/or payment for claims. If a court order is received which orders community service as restitution for claims, take the following actions:

1. Send a demand letter to the household. Explain that the household must notify the agency when the work is completed and, if work is not completed (or only partially completed), the household will be required to pay back the balance of the claim.

   When the community service work is completed, enter the total value of the work completed to compromise the claim on the KCD system.

2. If the client does not fulfill the total work obligation in the court specified time frame, request payment for the difference between the claim and the amount of work performed. Compromise the claim for the total value of the community service completed by the procedures below:

   a. Divide the number of hours worked by the number of hours required by the court;

   b. Multiply the result by the total claim amount;

   c. Subtract the result from the total claim amount; and

   d. Send a demand letter for the claim balance.

Contact the Nutrition Assistance and Accountability Branch, Claims Management Section (CMS) for procedures for handling these types of claims. Never send community service claims to CMS for collection.

E. TAX INTERCEPT. CMS also recovers claims through State/Federal tax refund intercept, lottery offsets, other options as mandated by courts, or offset done by Revenue or CMS.

F. EXPUNGED BENEFITS. Offset claims using expunged benefits. This payment method is an automated function handled by KAMES and no action is required by staff. If a client has multiple claims, the expunged benefits are applied to the oldest claim first.

MS 1686* PROCEDURES FOR APPROVALS/REAPPROVALS FOR CASES WITH CLAIMS

During the application interview with the client, do the following:

A. If the client has received benefits before, request the case record from the previous county.

B. Determine if the client has an outstanding claim. If yes and case is approved:

1. Request the claim control folder and case record from the previous worker.

2. For Food Stamps, Kentucky Transitional Assistance Program (K-TAP) and Kinship Care cases, once the case is approved, the system will automatically send a new repayment agreement to the household and benefit reduction will be automatically imposed after 30 days. If the client chooses to repay an amount higher than the minimum, enter this amount on the Kentucky Claims Debt (KCD) Management System in the “Additional Monthly Repayment Amount” field.

MS 1688 COLLECTION PROCEDURES FOR ACTIVE CASES - NEW CLAIMS

A. For Kentucky Transitional Assistance Program (K-TAP), Kinship Care (KC), Food Stamp (FS)-Inadvertent Household Error/Agency Error (FS-IHE/AE) claims and non-court Intentional Program Violation (IPV), the Kentucky Claims Debt (KCD) Management System sends the appropriate Repayment Request Letter and Repayment Agreement, based on KCD entries:

1. Benefit reduction on K-TAP and Kinship Care nonfraud, FS IHE/AE and non-court IPV claims with active benefits are automatically reduced by KAMES.

2. If the client responds by paying all or part of the claim, accept the payment and forward to: Claims Management Section (CMS).

3. If the client responds by requesting a fair hearing, cease collection activity until the hearable issue is resolved. Do not consider the claim delinquent during the period of time the hearing decision is pending. Take the following action once notified by the client that a fair hearing is requested:

   a. Follow procedures in MS 0568 for submittal of hearing requests.

   b. If there is an active claim with benefit reduction, cease collection. See KCD Computer Manual, Option G.

   c. If the claim is inactive on the KCD system, advise CMS by form PAFS-444, Collection Information Update, of the fair hearing request. Upon receipt of form PAFS-444, CMS logs it in and ceases collection activity.

4. Once the final order is received in the local office, access KCD, Option G, and complete the appropriate entries. If the claim is inactive, send form PAFS-444 back to CMS to notify them of the hearing decision. KCD automatically generates the appropriate notification to the client as follows:

   a. If the Agency is not affirmed, the client is notified that no payments are required and that any refunds due to the client will be issued.

   b. If the Agency is affirmed, the client is sent a new demand letter and repayment agreement. The client is advised that the debt will be considered delinquent if payment is not received within 30 days from the receipt of the new demand letter.

B. For K-TAP and Medicaid fraud and court adjudicated FS IPV claims:

1. KCD sends the initial demand letter based on entries. Claims adjudicated by the appropriate court of jurisdiction are issued demand letters and collection is pursued. Additionally, the Food Stamp member is to be disqualified.

2. Accept payment if the household responds by repaying all or part of the claim. Send the payment to CMS.

C. Medical Assistance claims are put on the KCD system once it is determined the claim has been adjudicated through the court.

MS 1690 COLLECTION PROCEDURES FOR INACTIVE CASES - NEW CLAIMS

All newly established claims, even if the case is inactive, are entered on the Kentucky Claims Debt (KCD) Management System, by the claims worker.

Medical Assistance claims are put on the KCD system once it is determined the claim has been adjudicated through the court.

KCD sends the appropriate repayment demand letter, which also notifies the client of his/her hearing rights. The Claims Management Section (CMS) pursues collection activity.

MS 1694* COLLECTION PROCEDURES FOR MULTIPLE FOOD STAMP (FS) CLAIMS

When an FS case contains multiple Agency Error (AE), Inadvertent Household Error (IHE) or Intentional Program Violation (IPV) claims, the Claims Management Section (CMS) initiates claims collection according to the following guidelines.

A. If multiple claims exist on an active FS household, the Kentucky Claims Debt (KCD) Management System will begin coupon reduction on the claim which has the oldest established date, until that claim is paid in full. The KCD system will then begin coupon reduction on the next oldest claim until it is paid off, etc.

B. If the household requests to repay an additional amount on a claim along with the coupon reduction amount, the worker will go into the KCD system, Option G, and enter the extra amount the household wishes to pay in the field titled “Additional Monthly Repayment Amount”.

C. If a household forwards one payment to be applied to multiple claims in more than one program, CMS will divide the payment equally among the claims and apply the payment accordingly.

MS 1696* COLLECTION OF LAST FOOD STAMP (FS) PAYMENT

Use the following procedures to collect the last Food Stamp (FS) claim payment.

A. If the last payment of a claim involves dollars and cents and the client wishes to repay by check or money order, collect the exact amount and forward to the Claims Management Section (CMS).

B. If the last payment of a claim involves dollars and cents AND benefit reduction is the repayment method, the Kentucky Claims Debt (KCD) Management System will reduce the dollar amount and CMS will compromise the cents.

C. In no instance is more than the actual amount of the established claim collected, but if there is an excess collection, CMS will follow refund procedures in MS 1698.

MS 1698* FOOD STAMP REFUNDS

If it becomes known that a household has overpaid a Food Stamp (FS) claim, which was collected through coupon reduction, authorize a supplemental issuance for the total amount of the overpayment and annotate comments.

A. Authorize the supplemental issuance EVEN IF THE HOUSEHOLD IS CURRENTLY INELIGIBLE for the Food Stamp Program.

B. Do not request refunds for less than $1.00.

C. Do not refund if overpaid through expungement.

D. Advise the Claims Management Section (CMS) of the need for reconciliation of the overpayment of the claim on the Kentucky Claims Debt (KCD) Management System.

When a claim is overpaid that was collected through cash payments, CMS will authorize a refund for the total amount of the overpayment:

1. Within 30 days of overpayment, CMS requests through General Accounting a refund to the client.

2. Refund checks are mailed to the client's last known address.

3. Refund checks that are undeliverable are returned to General Accounting to be redeposited.

4. CMS will not request refunds for less than $1.00.

5. Do not refund if the claim is overpaid through expungement.

MS 1700* COMPROMISING FOOD STAMP (FS) CLAIMS

A. If the household states that it would cause undue economic hardship to repay the claim, the claims worker must evaluate the household's situation to determine if compromising is appropriate and the amount to be compromised. The criteria to determine undue economic hardship may include but is not limited to:

1. Excessive shelter expenses;

2. Catastrophic Illness;

3. Recent loss of job;

4. The household has become homeless; or

5. Funeral expenses.

B. The Field Services Supervisor or Regional Specialist shall make the final determination of whether to compromise or not to compromise the claim and contact CMS. However, CMS has to complete the action on the Kentucky Claims Debt (KCD) Management System. Contact CMS staff at (502) 564-3440 if this situation occurs and assistance is needed with KCD entries.

C. For inactive FS cases, if the household states that it would cause undue economic hardship to repay the claim, CMS must evaluate the household’s situation to determine if compromising is appropriate and the amount to be compromised and complete any action needed on KCD.

D. Advise the household of the right to request a fair hearing if the household disagrees with the agency's decision concerning the amount compromised or any later adjustments.

MS 1702* WHEN TO TERMINATE A FOOD STAMP (FS) CLAIM

Food Stamp claims may be terminated under the following conditions by Claims Management Section (CMS) staff only:

A. Claim is invalid;

B. All Adult household members die;

C. Claim balance is $25 or less and the claim has been delinquent for 90 days or more unless other claims exist against the household resulting in an aggregate claim total of greater than $25;

D. The claim is delinquent for 10 years or more; or

E. Cannot locate the household.

After a claim has been terminated/written off, it may be reinstated if a new collection method or a specific event, such as; winning the lottery, inheritance, etc., increases the likelihood of collection.

Use the monthly lists of terminated claims to update claims folders as appropriate. The terminated claims display on DocumentDirect or the Report Distribution System (RDS) as “HRKCDR34 – KCD Terminated Claims List”.

NOTE: However, local office staff may terminate a claim on benefit reduction if approved by the Field Services Supervisor or Regional Program Specialist.

MS 1704 CLAIMS AND BANKRUPTCY

[When the local office receives official notification that a household with any type of established claim has filed a bankruptcy petition, forward the notice by mail to:

Cabinet for Health and Family Services
Department for Community Based Services
Nutrition Assistance and Accountability Branch
Claims Management Section, 3E-I
Frankfort, KY 40621

Maintain hardcopy bankruptcy information locally in the claims control folder and forward any original documents to CMS.

CMS will:

A. Update the Kentucky Claims Debt (KCD) Management System to show that bankruptcy is pending.

B. Determine if the department will pursue payment.

C. Track the claim until the bankruptcy court makes a final determination.

D. Take the appropriate action and annotate the case comments screen on KCD when notification of bankruptcy discharge is received.]

MS 1706

KY TAX OFFSET

The Claims Management Section (CMS) intercepts income tax refunds through the KY Revenue Cabinet to repay a client's delinquent claim.

A. Delinquent claims which may be sent to the KY Revenue Cabinet are:

1. Food Stamp (FS) claims with categories of Agency Error (AE), Inadvertent Household Error (IHE), Intentional Program Violation (IPV) and Intentional Program Violation Court (IPC);

2. K-TAP (PA) claims with categories PAE, PNC and PAC;

3. [AFDC (AF) claims with categories AAE, AAC, and ANC;

4. Kinship Care (KC) claims with categories KAE, KNC and KCC;

5. Medical Assistance (MA) claims;

6. Child Care (CC) claims with categories CAE, CCC, and CNC;

7. Employment Training Program (ETP) with categories (OT) claims;

8. Current claims with an outstanding balance of $25 or more;

9. FS, PA, AF and KC claims not currently in benefit reduction status;]

10. All claims not being repaid under a repayment plan;

11. FS claim under 10 years old (unless it is covered by a court judgment);

12. All claims not included under an automatic stay due to bankruptcy; and

13. All claims not currently under litigation.

B. Client Action to Avoid Referral to KY Revenue Cabinet

The client must do one of the following to avoid his/her debt being submitted to the KY Revenue Cabinet:

1. Repay the debt by sending a check or money order payable to Kentucky State Treasury, for the full amount owed to:

CHFS
Division of Family Support
Nutrition Assistance and Accountability Branch
Claims Management Section
275 E. Main St., 3E-I
Frankfort, KY 40621

2. Agree to a Repayment Plan, if unable to pay the debt in full, by contacting CMS at (502) 564-3440. The client must agree to a repayment plan acceptable to CMS and make payments required in the repayment plan.

3. Request a review if the client believes the debt is not owed. The client must send evidence to support his/her position to:

   CHFS
   Division of Family Support
   Nutrition Assistance and Accountability Branch
   Claims Management Section
   275 E. Main St., 3E-I
   Frankfort, KY 40621

CMS will notify the client of the decision regarding the debt.

4. Bankruptcy: If the client files for bankruptcy and the automatic bankruptcy stay is in effect, the client is not subject to offset or other collection actions while the stay is in effect. The client will need to notify CMS of the stay by sending evidence concerning the bankruptcy.

C. Collection Process before going to KY Revenue Cabinet:

1. A claim is considered delinquent when payment has not been received for 30 days.

2. When the debt becomes delinquent, a notice is sent to the client.

3. When the notice period is complete and the client has not responded, the debt is submitted to the KY Revenue Cabinet.

   Note: A total of 60 days must have elapsed.

D. Debts are submitted to KY Revenue Cabinet annually. [The client's tax refunds may be intercepted each year until the claim is paid in full.

E. If an offset is taken from both spouses who filed a joint return and the debt belongs to only one, the other spouse may file an amended separate return. If both spouses filed the original return both must file an amended return too. They would need to include an IRS Injured Spouse form with the amended return.]

F. KY Revenue Cabinet will offset only the amount owed. Any remaining refund will be sent back to the client directly from KY Revenue Cabinet.

MS 1708* TREASURY OFFSET PROGRAM (TOP)

The Treasury Offset Program (TOP) is authorized by the Debt Collection Act of 1982 and the Debt Collection Improvement Act of 1996 (DCIA). The overall purpose is to maximize collections of delinquent Food Stamp debts owed to the federal government by ensuring quick action to enforce recovery and the use of all appropriate collection tools. Food stamp claims are considered federal debts and are, therefore, covered under the DCIA.

A. Delinquent claims submitted to TOP must be:

1. Food Stamp Claims with categories of AE, IHE, IPV and IPC;

2. A current claim balance of $25 or more;

3. Not currently in benefit reduction status;

4. Not being repaid under a repayment plan;

5. Under 10 years old (unless it is covered by a court judgement);

6. Not included under an automatic stay due to bankruptcy; and

7. Not currently under litigation.

B. Client Action to Avoid Referral to TOP

Client must do one of the following to avoid his/her debt being submitted to TOP:

1. Repay debt by sending check or money order payable to Kentucky State Treasury for the full amount owed to:

   CHFS
   Division of Family Support
   Nutrition Assistance and Accountability Branch
   Claims Management Section
   275 E. Main St., 3E-I
   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 payments required in the repayment plan.

3. Request a review if the client believes the debt is not owed. The client must send evidence to support his/her position to:

   CHFS
   Division of Family Support
   Nutrition Assistance and Accountability Branch
   Claims Management Section
   275 E. Main St., 3E-I
   Frankfort, KY 40621

   CMS will notify the client of the decision regarding the debt.

4. File for 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 while the stay is in effect. The client will need to notify CMS of the stay by sending evidence concerning the bankruptcy.

C. Collection Process before Going to TOP:

1. Claim is considered delinquent when payment has not been received within 30 days of initial demand letter or is 30 days late on a previously arranged pay plan.

2. Within approximately 90 days after debt becomes delinquent, form KCD1.60 Notice is sent to the client. This notice includes information on how he/she can avoid having his/her debt submitted to TOP and what Federal payments can be offset.

3. When the KCD1.60 Notice period is complete (60 days from the date of the KCD1.60 Notice) and the client has not responded, the debt is submitted to TOP.

NOTE: A total of 180 days must elapse from the delinquent date before a claim can be submitted to TOP.

D. Eligible Federal Payments:

TOP will reduce or withhold any eligible Federal payments due to the client by the amount of the debt such as:

1. Income tax refunds, including earned income tax credit;

2. Up to 15% of Federal salary pay, including military pay;

3. Up to 25% of Federal retirement;

4. Military retirement pay;

5. Contractor/vendor payments;

6. Other Federal payment, including certain loans to the client, that are not exempt from offset; and

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 per month of his/her Federal payment.

E. Once a debt is submitted to TOP, the client may be Federally offset until the debt is paid in full.

F. TOP is authorized to add penalties, fees or other costs for each tax offset processed.

G. If an offset is taken from both spouses who filed a joint return and the debt belongs to only one, the other may file an Injured Spouse Form with the IRS. These forms may be obtained through their tax preparer.

H. The clients filing Rapid Refund 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. Clients may want to check to see if the tax preparer will allow them to do an electronic filing instead of a Rapid Refund, which may speed up their refunds.

I. TOP will offset only the amount owed. Any remaining tax refund will be sent back to the client directly from the IRS.

MS 1710* INTRODUCTION TO FOOD STAMP (FS) RESTORATIONS

When a household receives fewer benefits than it is entitled to receive and the loss was not caused by the household, restore those benefits which were lost.

A. Process FS restorations within 30 days from the date of discovery even if the household is not currently eligible. Complete calculations on form FS-103, Food Stamp Worksheet, and enter amount owed on KAMES.

B. Use restorations to offset already established claims.

C. If the 10th day of any timeframe falls on a weekend or holiday both the client and/or the Agency have until the next work day to complete the action.

D. For each month affected by a FS loss, determine if the FS household was actually eligible. If there is no information in the household's case file to document that the household was actually eligible, send form PAFS-2 to the household to request information to determine eligibility for the month in question. For each month the household cannot provide the necessary information to demonstrate its eligibility, consider the household ineligible.

MS 1712* FOOD STAMP RESTORATION REASONS

Food Stamp (FS) benefits may require restoration for the following reasons:

A. Wrongfully denied, delayed, or terminated benefits due to agency error;

B. Reversal of an administrative disqualification for Intentional Program Violation (IPV);

C. The loss is caused by an error by the Department for Community Based Services (DCBS) or by the Social Security Administration (SSA) through joint processing. Such an error includes, but is not limited to, the loss of an applicant's food stamp application after it has been filed with SSA or DCBS;

D. The state becomes aware that an alien applicant was granted retroactive eligibility by the Balanced Budget Act of 1997.

MS 1714* NOTIFICATION OF FOOD STAMP RESTORATION

Restorations issued on Kentucky Automated Management and Eligibility System (KAMES) include notification of the following:

A. The amount of benefits to be restored;

B. Any offsetting that was done; and

C. The right to appeal the Agency's decision through the fair hearing process.

MS 1716* DISPUTED FOOD STAMP BENEFITS

If it is determined that a household is entitled to restoration of lost Food Stamp benefits, but the household does not agree with the amount to be restored or any other action taken to restore lost benefits, the household may request a fair hearing within 90 days of the date the household is notified of its entitlement to restoration of lost benefits.

A. If a fair hearing is requested prior to issuance of the benefits, the household receives the amount of lost benefits determined pending the results of the fair hearing.

B. If the fair hearing decision is favorable to the household, restore the lost benefits in accordance with that decision.

If a household believes it is entitled to restoration of lost benefits but a review of the case file does not support that claim, the household has 90 days from the date of the determination to request a fair hearing. Restore lost benefits to the household only if the fair hearing decision is favorable to the household.

MS 1718* CALCULATING FOOD STAMP RESTORATIONS

After correcting the case to prevent a loss in future months, determine the months for which benefits are to be restored as follows:

A. If the household was eligible but received insufficient benefits, determine which months the household was issued benefits by reviewing the Kentucky Automated Management and Eligibility System (KAMES) Benefits segment for the affected months.

B. Do not restore food stamp (FS) benefits for any period of time more than 12 months prior to whichever of the following occurred first:

1. The date the Agency received a request for restoration of benefits from the household;

2. The date the Agency is notified or discovers that the household lost benefits; or

3. The date the request for a fair hearing was received.

4. While there are situations in which the amount restored may cover a period of time greater than one year, the determination of the amount of benefits to be restored can go back no further than 12 months prior to the date indicated above.

EXAMPLE: A currently participating household requests a restoration of benefits for a 1 year period. It takes 2 months to establish the household's entitlement. The household would receive restoration for more than 12 months.

MS 1720* FOOD STAMP (FS) RESTORATION METHODS

Regardless of whether a FS household is currently eligible or ineligible, restore lost FS benefits by issuing an allotment equal to the amount of benefits that were lost.

A. If the amount of the restoration does not exceed the maximum benefit allotment for the household size, enter the restoration on KAMES to be issued as a lump sum.

B. If the amount to be restored exceeds the maximum benefit allotment for the household size, advise the household of its right to choose the method of issuance.

1. If the household requests monthly installments, honor reasonable requests and restore the benefits accordingly.

2. In restoring lost benefits in monthly installments, the minimum amount to be restored is not less than the maximum food stamp allotment for the size of the household involved.

C. Explain the options by contact with the household in person, by telephone, or by sending form FS-105, Notice of Eligibility or Ineligibility.

D. Document case comments with the date, how the explanation was given, and the option chosen by the household.

E. Calculate the restoration manually using form FS-103, Food Stamp Worksheet.

F. Enter the restoration on KAMES with the appropriate method of issuance selected by the household.

G. If the household does not make a selection within 10 days, issue the restoration as a lump sum.

H. If the household or any of its members cannot be located, file a copy of form FS-103 in the case record and annotate the case that a restoration is due. Mark the front cover of the case folder “DO NOT PURGE, RESTORATION DUE”. If a current in-state address becomes known, contact the household about the restoration.

I. When a FS household is due lost benefits and the household composition has changed, restore the lost benefits to the household containing the majority of the individuals who were household members at the time the loss occurred. If unable to locate the household members, issue the restoration to the household containing the individual who was head of household when the benefits were lost.

J. If the entire household lives out-of-state or moves out-of-state before the restored benefits are issued, do the following:

1. If the current out-of-state address is known, issue the restoration on KAMES and contact the household regarding the restoration.

2. If the current out-of-state address is not known, mark the front cover of the case folder "DO NOT PURGE, RESTORATION DUE." If a current out-of-state address becomes known, follow the instructions in #1 above. If the household moves back in state, contact the household about the restoration.

MS 1721* FOOD STAMP RESTORATION PROCESSING

See OM Upd. No. 08-02, MS 99778, 2/4/08

Any restorations completed will display on the worker's and supervisor's Daily Case Status Report (DCSR) as a pending action. Supervisors have the capability to initiate and sign off on restorations.

When a probationary worker or any worker hits "enter" for a manually issued Food Stamp restoration, the prompt "ACTION PENDED - GIVE FILE TO SUPV/PRIN" will be seen. To successfully sign off on a case, the supervisor, principal, or designated individual must be logged on to KAMES in his/her own "HRII" code. The terms, supervisor and principal, in this context, apply to individuals coded with KAMES security clearance type 02 (supervisors) and type 24 (principals). In order for a designated individual to sign off, the designated individual must have a security clearance of type 02 or type 24. These are the individuals with clearance to sign off on an action. It does not refer to an individual's personnel classification.

Additionally, two reports are stored on the Report Distribution System (RDS) to capture manually issued restorations. The reports are: HRKRPR6B, RPT Replacement, Supplement, Restoration Report; and HRKRPR6C, RPT Replacement, Supplemental, Restoration Report by Supervisor. Each report will have the region, county, unit, caseload code, program code, case name, case number, mailing address (except for food stamp transactions), issue type, issue date and amount. The reports will be sorted by region name, county, unit and caseload code and will display a total for each worker and county. The first report will capture actions initiated by workers and principals and the second report will capture actions initiated by supervisors. Reports are run the third workday of each month reporting for the previous month.

Regional office staff are to review these reports on a monthly basis.

MS 1722 OFFSETTING FOOD STAMP (FS) CLAIMS

Prior to issuing a FS restoration of lost benefits, determine if the household has an outstanding claim by reviewing the Kentucky Claims Debt Management System (KCD).

A. [If the household has a claim and a restoration is owed, notify Claims Management (CMS) Section of the amount.

B. CMS will compromise or terminate the claim as required.

C. CMS will notify the local office of a claim adjustment, if any and if further local office action is required.]

MS 1750 [MEDICAID PROGRAM VIOLATION (MPV) DEFINITIONS

Terms used in Medicaid Program Violation (MPV) are as follows:]

JUDICIAL REVIEW. [A review of final Agency orders by the appropriate Circuit or District Court, plus any further appeal to the Kentucky Court of Appeals and/or Kentucky Supreme Court.

[MEDICAID PROGRAM VIOLATION (MPV). MPV is an action in which a recipient or responsible party made a false or misleading statement, misrepresented, concealed or withheld facts or committed a violation of any state or Federal law or regulation relating to Medicaid.

PENALTY. An administrative action taken by the Office of Inspector General (OIG) or any other entity representing the Department for Medicaid Services (DMS) which may require the repayment of the value of the covered services received.]

RESPONSIBLE PARTY. An individual who is the statutory benefit payee, legal guardian or committee for an individual applying for or receiving Medicaid.

MS 1751* HOW TO PREVENT A MEDICAL ASSISTANCE (MA) CLAIM

The following is a list of verification measures used statewide to detect fraudulent applications in all programs prior to determining eligibility.

A. All points of eligibility are thoroughly explored, verified, and documented in the case record when required, and should include the following actions:

   1. Thorough questioning;

   2. Verify applicant's statements by examining documents in his/her possession or by obtaining information from appropriate third party sources; or

   3. Verify any new employment or termination of employment reported by contacting the employer. If contacting the employer is not possible, case comments must state why contact was not made.

B. All inconsistencies are clarified;

C. All spot checks are completed as indicated by the case situation;

D. All applications are signed and correctly dated; and

E. All clients are made aware of:

   1. The legal responsibility to provide correct and complete information;

   2. The legal responsibility to report changes correctly and timely;

   3. The consequences of incorrect statements or omissions including repayment;

   4. The responsibility to report receipt of benefits in an amount greater than that to which the client was entitled;

   5. The requirement of repayment in all situations where benefits received exceed the entitled amount; and

   6. The proper use of the KYHealth card.

F. Supervisors or their designated personnel review a select number of cases for technical and financial eligibility prior to approval.

G. Workers attend communication/interviewing workshops periodically; and

H. Determining Eligibility Through Extensive Review (DETER). See MS 1508.

MS 1752 [WHAT IS A MEDICAID PROGRAM VIOLATION (MPV)

A. Medicaid Program Violation (MPV) occurs when the Medical Assistance (MA) recipient or responsible party, age 18 or older, caused a financial loss to Medicaid by:]

1. Making false or misleading statements to obtain MA benefits;
2. Misrepresenting, concealing, or withholding a fact or facts to obtain MA benefits;
3. Committing a violation of any state or Federal law or regulation relating to the Medicaid program;
4. Defrauding the Department during the Medicaid eligibility process;
[5. Abusing the Medicaid program by 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
6. Inappropriately using a covered service (e.g., using Non-Emergency Medical Transportation (NEMT) to go to work, etc.)

B. [The MPV determination is based on suspected fraud referrals from DCBS, information obtained by OIG or other sources.

C. The individual can repay the value of covered benefits in full.

D. The individual is allowed to pay the amount of the MPV through installments.]

MS 1753* WHAT IS MEDICAID FRAUD AND ABUSE

A. Medicaid vendor fraud and abuse is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;
2. Furnishing or ordering Medicaid services that are substantially in excess of the client's needs or that fail to meet professionally recognized health care standards;
3. Misrepresenting factors concerning a facility's qualifications as a provider;
4. Failure to comply with the terms and conditions for vendor participation in Medicaid and to effectively render service to recipients; or
5. Submitting false or questionable charges to the Department for Medicaid Services.

B. Forward reports of suspected Medicaid vendor fraud and abuse by form MAP-356, Suspected Vendor Fraud/Abuse Medicaid Referral, to:

Office of Inspector General (OIG)
Division of Special Investigations
275 East Main Street, 5E-D
Frankfort, KY 40621-0001

MS 1755 [HOW TO IDENTIFY A MEDICAID PROGRAM VIOLATION (MPV)

A possible MPV is identified through:]

A. Computer matches;

B. Collateral contacts;

C. [Hotline referrals (PAFS-84, Medicaid and Welfare Fraud Hotline Information Referral)];

D. Quality Control reviews; and

E. Other valid reports or information previously unknown to the Agency.

MS 1760 PROCEDURES FOR MEDICAID PROGRAM VIOLATION (MPV) REFERRALS TO THE OFFICE OF INSPECTOR GENERAL (OIG)

A. Medical Assistance (MA) claims are put on the Kentucky Claims Debt (KCD) Management system once it is determined the claim has been adjudicated through the court.

B. Refer suspected MPV by using form PAFS-88, OIG Referral Summary/Disposition.

1. If there are suspected FS Intentional Program Violation (IPV) or K-TAP fraud cases which involve at least one month of MA ineligibility, refer all cases to the Office of Inspector General (OIG) through the Claims Management Section regardless of the dollar amount.

2. If the MA case has no other related cases, refer the MA case directly to OIG.

Annotate form PAFS-116, Case History Folder, that an MPV referral has been made to OIG.

Enter comments on KAMES regarding the MPV referral to OIG.

MS 1795 PROCEDURES FOR REPAYMENT OF MEDICAID PROGRAM VIOLATION (MPV) CLAIMS

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 an MPV.

If MPV is a stand alone claim, repayment of the value of benefits is made to the Office of Inspector General (OIG)/Fraud Waste and Abuse Identification and Prevention (FWAIP) by:

A. Lump sum payments. If the client or responsible party states he/she is financially able to pay the entire amount of the claim at one time, collect a lump sum payment by cashier's check, money order or personal check. However, the client or responsible party is not required to liquidate all resources to make this lump sum payment;

B. Installments. FWAIP will negotiate a payment schedule with the client or responsible party for repayment of any amounts of the claim not repaid through lump sum payment;

C. Civil action for garnishment or liens by a court; or

D. A lien on any property owned by the client or the responsible party.

E. If the MPV overpayment has been adjudicated through the courts, the Claims Management Section (CMS) has the responsibility to collect.

Upon receipt of a payment agreement signed by the client or responsible party to repay, FWAIP initiates collection action against the client or responsible party unless the client or responsible party cannot be located or has repaid the value of benefits owed.

MS 1800 WHAT IS A KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIM

[Claims occur when cash benefits issued exceed the eligible amount and there is a loss to the Agency for a specific month. This includes, but is not limited to, additional benefits received pending resolution of a hearing when the Agency is upheld and when the timely notice period allows benefits in excess of the entitled amount.

A. Repayment must be pursued on all Aid for Families with Dependent Children (AFDC) claims discovered on or after 4/1/82, regardless of the amount or when the claim occurred. The last month AFDC benefits were issued in Kentucky was September 1996. Use claim type 'AF'. The categories of AFDC claims are AFDC Agency Error (AAE), AFDC Court (AAC), and AFDC Non-Court (ANC).

B. Repayment must be pursued on all K-TAP claims discovered after 10/1/96 except for a claim due to an agency error. The claim type for K-TAP is 'PA'.

1. For overpayments due to agency error that occurred between 10/1/96 and 2/1/05, no claim is established.

2. Overpayments due to agency error that occurred on/or after 2/1/05 must have a claim established and repayment pursued.

K-TAP claims are determined using 10-10-10 policy.]

MS 1803 [WHO MUST REPAY THE KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIM]

The responsibility to repay primarily rests with the caretaker relative who was a member or the payee of the overpaid K-TAP case. Repayment is never sought from the children.

A. [To collect a claim of a K-TAP case of which the caretaker relative was a member, seek repayment from the caretaker relative or the caretaker relative's current K-TAP case.] Repayment is sought from the caretaker relative REGARDLESS of the current case status.

1. [If the caretaker relative is currently receiving K-TAP, KAMES automatically initiates benefit reduction for active cases; or

2. If the caretaker relative is NOT currently receiving K-TAP, the Claims Management Section pursues collection.

3. If the caretaker relative dies, collection of the claim stops and the claim is closed unless both parents were members of the overpaid case. Repayment is sought from the surviving parent.

B. Both the alien and the sponsor are responsible for repayment of the claim, unless the sponsor is without fault or the sponsor can show good cause for withholding information or for providing incorrect information. A nonprofit organization acting as a sponsor is not responsible for repaying claims.

1. Good cause procedures are:

a. The sponsor is considered to have good cause when the relationship has broken down.

b. Good cause also exists if the sponsor withheld information to protect the identity and physical or mental well being of the alien.

c. Verify good cause through the sponsor's statement or through inability to locate the sponsor.

d. If good cause is determined not to exist, the sponsor is entitled to a fair hearing to contest a determination that the sponsor was at fault or to contest the amount of the claim.

2. If the sponsor provides incorrect information and the alien indicates, or the sponsor states, that the sponsor was unaware of the actual situation, the sponsor is without fault. However, the alien is still responsible for the claim.

3. If the sponsor provided incorrect information in a deliberate effort to obtain benefits for the alien and if the alien is unable to repay, seek repayment from the sponsor through cash repayment. However, the alien is still responsible for the claim.

C. Collect from only one case at a time. When more than one active case contains an adult member of the overpaid assistance group, collect from the first appropriate case. Collect the claim in the following order:]

1. The K-TAP case in which the caretaker relative is currently a member; or

2. Any K-TAP case in which the second parent or payee of the overpaid assistance group is currently a member.

MS 1806 [HOW TO ESTABLISH KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIMS

A claim is a financial assistance payment that exceeds the eligible amount and there is a loss to the Agency for the specified month.]

A. A loss to the Agency occurs when the amount of child support retained by the Agency does not equal or is less than the amount of the K-TAP benefits issued (before benefit reduction). Refer to MS 1827.

B. In cases where child support activity is not appropriate, there is a loss to the Agency since no child support is retained. However, it is not necessary to establish a claim.

C. [When income received is more than the amount considered in computing the benefit amount, an overpayment may exist and the claim process is initiated.] Refer to MS 1818.

D. A claim may be appropriate when a K-TAP child is away from the home in excess of 30 days without good cause and the SR does not report this absence within 5 days.

MS 1809 REQUESTING INFORMATION FOR KENTUCKY TRANSTIONAL ASSISTANCE PROGRAM (K-TAP) CLAIMS

If a possible overpayment of cash benefits occurs in an active or inactive K-TAP case, enter the claim on the Kentucky Claims Debt (KCD) Management system.

When a possible overpayment of benefits is discovered, the worker:

A. Complete form PAFS-431, Claim Referral;

B. [Enter the pending K-TAP claim on the Kentucky Claims Debt (KCD) Management System within 10 days of the discovery date];

C. Uses screen A on KCD to schedule an appointment and/or gather information needed to establish and/or compute the amount of the claim.

D. Computes the claim amount with the information available if the client does not respond to the KCD notice.

E. Takes no further action to establish a claim if the client responds to the KCD notice, denies the questioned case situation occurred, and provides verification which establishes that no overpayment occurred.

F. Completes the claim on the KCD system using verification provided by the client or information available to the Agency.

G. Discontinues the case if the client fails to provide requested information that is needed to determine ongoing eligibility. Use the discontinuance reason non-cooperation.

MS 1818 [HOW TO DETERMINE KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIM PERIOD]

Use the following procedures to determine the begin and end dates of a K-TAP claim.

A. [A client is allowed 10 days to report a change, 10 days for the worker to act on the change, and 10 days for advance notice of the negative action.

B. If the client fails to report or reports a change untimely, use the 10-10-10 formula.

1. Determine when the change became known to the client and could have been verified. For example: If the client knows the rate of pay when she is told she got the job, the change can be verified through phone contact with the employer.] Use the date she starts to work rather than the date of the first paycheck;

2. [From the date the change became known to the client and could be verified, allow 10 days to report;]

3. Allow 10 days for the worker to act on the change;

4. Allow 10 days for the adverse action period; and

5. The beginning month of the claim is always the month after the adverse action period ends.

EXAMPLE 1: [The client fails to report she began work on 1/10.] Allow 10 days for the report (1/20), 10 days for the worker to act (1/30), and 10 days for the adverse action (2/9). Since the adverse action period ends in February, the first month of the claim would be March.

EXAMPLE 2: [The client fails to report she began to work 12/1.] Allow 10 days for the report (12/11), 10 days for the worker to act (12/21), and 10 days for the adverse action (12/31). Since the adverse action period ends in December the first month of the claim would be January.

[C. If a client receives a nonrecurring lump sum payment, determine an ineligibility period.] Once the ineligibility period is established, determine the beginning month of the claim based on when or if the change was reported.

EXAMPLE 1: [A client reports in April that she received $15,000 inheritance on 12/16.] The worker calculated the

ineligibility period to be 28 months. The first month of the ineligibility period is December. To determine the beginning month of the claim, allow 10 days to report (12/26), 10 days to act on the change (1/5) and 10 days for the adverse action period (1/15). The beginning month of the claim is February.

EXAMPLE 2: [The worker is notified on 1/15 that in January the client received a child support escrow payment of $470.] The ineligibility period was one month, January. There would be no claim.

[D.] 10-10-10 does not apply to a claim resulting from a child's absence from the K-TAP home without good cause, which is not reported within 5 days by the SR.

[E. The period of the claim ENDS with the month the benefit amount was reduced or discontinued or the circumstances causing the claim no longer exist.]

MS 1821 HOW TO CALCULATE KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIMS

When computing a K-TAP claim, use the actual income received and allow actual deductions to determine the benefit amount for each month. For cases which involve self-employment income, the self-employment income is annualized or averaged using 3 months actual income, whichever is appropriate.

A. A claim does not result solely from normal fluctuations which do not last over 30 days. Normal fluctuations include 5th or periodic paychecks or sporadic overtime.

B. It is not necessary to verify receipt of a K-TAP check before initiating the claim process. However, if the client states a check was NOT RECEIVED for 1 or more of the months during which the overpayment occurred:

1. Review the case record for the client's report of nonreceipt during the period in question; and

2. [Request photocopies of checks for the client's denial or affirmation of signature by email to Rebecca Hoover or sending a memo to:

Cabinet for Health and Family Services
DCBS – Division of Administration and Financial Management
275 E. Main Street, 3W-C
Frankfort, KY 40621
DO NOT FORWARD]

If the client denies the signature, the month in question IS NOT a claim month.

C. Use the KCD system to compute the total amount of a claim.

D. Refer to MS 1827 and 1828 if child support is collected by the Division of Child Support (DCS) for this client. [The amount of a claim may be offset by the child support collected and retained by the Cabinet.]

E. When computing a claim for a prior period, use policy in effect at the time of the claim.

F. If the claim process is in place to collect a claim and a subsequent claim for a different time period or different circumstance is discovered, follow the establishment and collection procedures for an individual claim AND DO NOT add the claims together. Complete the claim process at this time, but do not reduce the benefits nor seek cash repayment until the first claim has been repaid in full.

EXAMPLE: A claim has been established for a client due to improperly reporting wages for January, February, and March. Subsequently, the client fails to report receiving unemployment benefits causing a claim for April and May. Separate calculations are completed for each circumstance. A separate claims control folder is established for each of the two claims.

G. If the eligible amount for a claim month is less than $10, show the entitlement amount as $0. Recoup the entire benefit for that month.

MS 1824 [KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIMS FOR SSI RECIPIENTS

When the local DCBS office is notified by the Social Security Administration (SSA) or discovers an Supplemental Security Income (SSI) individual was not eligible to receive an SSI payment during a specific month or months regardless of reason:]

A. Redetermine K-TAP eligibility for the specific month;

B. Use actual resources and income received in the specific month, including the resources and income of the responsible relative who was receiving an SSI payment. DO NOT include the SSI payment received as income.

C. If the case was ELIGIBLE for K-TAP in the identified month, determine correct payment and compare the amount received to the correct payment. [The difference is the amount of the claim to be collected.]

D. If the case was INELIGIBLE for K-TAP for a given month, collect the entire K-TAP payment for the specific ineligible month.

EXAMPLE: In 1/98, it is discovered a parent who was receiving SSI was ineligible for SSI beginning 1/97. The resources and income of the SSI recipient were excluded in determining K-TAP eligibility since 8/97. Redetermine financial eligibility using all resources and income (include resources of the SSI parent but DO NOT count the SSI payment received) for all months the family was receiving both K-TAP and the ineligible SSI payment. [If the family was K-TAP ineligible, the overpayment is the full K-TAP benefit amount received in the ineligible month. If the family was eligible in any or all months, recompute benefit amount using actual income received excluding the SSI payment in the specific month.]

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 1827 RETAINED CHILD SUPPORT

Consider child support retained or kept by the Agency when calculating any K-TAP claim.

A. [Retained support is the amount of collected support reported by DCS minus collections forwarded (e.g., escrow) to the recipient as verified on form PA-401 or on KASES.]

B. If the child support kept for the overpaid month is equal to or more than the amount of K-TAP benefits issued (before benefit reduction) for that month, there is no net loss to the Agency and no claim for that month.

1. This applies to all claims, regardless of the reason for the claim, for cases in which child support activities were being pursued.

2. If the absent parent is "unknown", this process is not required.

C. [Obtain the required information for computing the DCS retained support by;

1. Sending form PA-401, Letter to Verify Child Support Collections to: Accounting Branch, Division of Child Support, PO Box 2150, Frankfort, Kentucky 40602-2150; or]

2. Accessing KASES.

MS 1828 CHILD SUPPORT CALCULATIONS

[Calculate the amount of child support kept by the Division of Child Support (DCS) and compare that monthly amount to the amount of benefits received for each month of the potential claim.]

A. If the retained child support for an individual month equals or is greater than the K-TAP benefits received for that month, no claim exists for that month. [Update KCD to show the claim was not established.

EXAMPLE: The client received $235 K-TAP benefits. The client was only entitled to $150.] Child support was retained in the amount of $235.

Actual Benefits Received	$ 235
Retained Child Support	235

Since the retained child support equaled the K-TAP benefits received, there was no loss to the Agency and no claim.

B. If the retained child support for the month is less than the K-TAP received, subtract the corrected benefit amount for that month from retained child support. Deduct the remaining child support from the overpayment for that month.

EXAMPLE: [The client received $210 of K-TAP benefits.] Her correct benefits were $100. Child support of $140 was retained by DCS. Calculate using the following steps.

Step I - Determine if a claim exists

Actual Benefits Received	$ 210
Retained Child Support	140

Child Support is Less than Benefits - Claim Exists

Step II - Calculate the overpayment

Actual Benefits Received	$ 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

C. 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: [The client received K-TAP in the amount of $230; however, she was only entitled to $180.] Child support was retained in the amount of $80.

Retained Child Support	$ 80
Corrected Benefit	- 180
Remainder	= $ 0

There is no excess child support.

MS 1830 [HOW TO COLLECT KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) NONFRAUD CLAIMS]

A claim is considered nonfraud unless a court has determined that fraud exists. [Once the nonfraud claim is established:]

A. If the claim is connected to an active case:

1. [KCD sends a letter to notify the client that a claim has occurred, the amount of the claim and that benefit reduction will be initiated for repayment.

2. The KCD letter provides the client 30 days to request a hearing regarding the fact that a claim did occur and/or the amount of the claim.

B. If the claim is connected to an inactive case:

1. KCD sends a letter to notify the client that a claim has occurred and the amount of the claim.

2. The KCD letter provides the client 30 days to request a hearing regarding the fact that a claim did occur and/or the amount of the claim. It also demands repayment of the claim.

C. If the client requests a hearing on the fact a claim exists and/or the amount of the claim, pend collections on KCD. Enter the fair hearing date and code on KCD for active cases. For inactive cases on KCD, contact the Claims Management Section.

D. If an appeal is requested, DO NOT take collection action until a decision is received from the Appeal Board.]

MS 1833 [HOW TO COLLECT KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) FRAUD CLAIMS

A claim is considered fraud when a court determines the client received benefits fraudulently.] After receipt of the court decision, take one of the following actions:

A. [Enter that information on KCD. KCD sends a letter requesting repayment of the claim.

B. If the claim involves court ordered repayment and there are circumstances where fraud existed in some but not all of the months in which the claim occurred, treat as follows:

1. If the court orders a specific monthly amount of repayment and there are also nonfraud months in the claim, benefit reduction is initiated on the nonfraud months, if appropriate, and cash repayment on the fraud months.

2. If the court does not address repayment and the claim was:]

a. Identified prior to 4/1/82, take no further action; or

b. [Identified on or after 4/1/82, initiate collection of the claim either through benefit reduction for active cases or through the Claims Management Section for inactive cases.]

MS 1839 [KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) REPAYMENT OPTIONS

See OM Upd. No. 07-21, MS 99770, 10/1/07

The repayment options to collect Aid for Families with Dependent Children (AFDC)/K-TAP claims are as follow:

A. Lump sum payment. The client can elect to repay the claim in full with a lump sum payment. However, benefit reduction is automatically initiated for active cases if the lump sum payment is not received prior to the end of the month in which the claim was established on KCD.

B. Installment payments. The client can elect to repay the claim by installments negotiated with the Claims Management Section on inactive cases.

C. Benefit Reduction. Benefit reduction is a method of repaying a K-TAP claim for a currently active case. KAMES automatically initiates benefit reduction upon notification by KCD.

1. Benefit reduction cannot exceed 10% of the K-TAP maximum payment for the appropriate benefit group size. KAMES computes the benefit reduction amount.

BENEFIT REDUCTION SCALE		
Benefit Group Size	Maximum Payment	Monthly Benefit Reduction
1	186	18
2	225	22
3	262	26
4	328	32
5	383	38
6	432	43
7 or more	482	48

2. If the K-TAP PAYMENT IS LESS THAN THE REDUCTION AMOUNT indicated on the Benefit Reduction Scale, then:

a. KAMES reduces the K-TAP payment to $1 for the appropriate number of months necessary to collect the claim; and

b. The case remains an active K-TAP case with all rights and responsibilities.

c. There is no benefit reduction when the benefit amount is under $10. For collection purposes, process as an active cash installment case.

d. If due to benefit reduction the payment amount falls below $10, a check is issued.

3. For cases that were in benefit reduction status with excess collections, follow procedures in MS 1860.

4. If a change occurs in the case which requires collection from a new case such as when the adult member responsible for the claim is removed and subsequently joins another case, the KCD system will match to the new case on KAMES and benefit reduction will occur from the new case.]

MS 1851 [VOLUNTARY RETURN OF KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CHECK - TO AVOID CLAIM

The client may VOLUNTARILY return a K-TAP check to avoid a claim.

A. If a check is returned by form PA-61, Notice of Returned Check and Authorization for Disposition, from Central Office , DO NOT reduce the claim by the amount of the check.] Follow procedures in MS 0306 for returned checks.

B. [DO NOT request a client to return a K-TAP check.

C. If a client is totally ineligible for a month AND VOLUNTARILY returns a K-TAP check to avoid a claim which would have occurred if the check had been cashed:

1. Complete form PA-30.2, Payment Receipt, (client completes the "Completed by Client" section of the form);

2. Annotate the case record that client voluntarily returned the check;]

3. Complete form PA-61 to cancel the check;

4. [Send a copy of form PA-61 to the appropriate Division of Child Support area office;] and

5. Determine excess support collection.

6. [Because no claim for that month occurred, DO NOT enter on KCD unless additional months are involved in the claim.

D. The client cannot avoid a new claim for a given month by returning the K-TAP check, received in that month, if the case is in benefit reduction for a previous claim.

EXAMPLE: The client's K-TAP check is $203 because the client's benefit amount of $225 per month is being reduced by $22 to repay a prior claim. The client is ineligible for April and voluntarily returns the $203 check received that month. The new claim is established for April for $225 and would be reduced by the amount of the returned $203 check leaving a balance owed for April of $22. The amount to be collected by benefit reduction in April on the previous claim would be $22.

E. DETERMINE THE EXCESS COLLECTION when a client is ineligible and voluntarily returns a K-TAP check for a month to avoid a claim.]

1. Determine if countable support was collected during the month the K-TAP check was intended to cover (e.g., a K-TAP check received 6/1/97 covers the month of 6/97), according to procedure in MS 1827.

2. If countable support was not collected during that month, no further action is required.

3. [If countable support was collected during that month, the amount of countable support is considered an excess collection and is refunded to the client.] Request refund of the excess collection according to procedure in MS 1860.

MS 1854 [VOLUNTARY RETURN OF KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CHECK - TO REPAY CLAIM

The client may VOLUNTARILY return a K-TAP check to use as repayment of a prior claim.

A. If a check is returned by form PA-61 from Central Office, DO NOT reduce the claim by the amount of the check.] Follow procedure for returned checks in MS 0306.

B. [DO NOT request a client to return a K-TAP check.

C. If a client VOLUNTARILY returns a K-TAP check to use as a payment on a prior claim:

1. Complete form PAFS-30.3, Multi-Program Claims Receipt;

2. Annotate the case record that the client VOLUNTARILY returned the check; and

3. Forward the check to the Claims Management Section who will post the check as a payment on KCD.]

MS 1857 [HOW TO OFFSET THE KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) CLAIM

When there is a claim, regardless of any offsetting underpayment, first follow full collection procedures for the claim.

A. K-TAP hearing and appeal rights MUST FIRST BE EXHAUSTED (this means either a fair hearing was requested and the hearable issue has been resolved or the 30 days have expired and no hearing was requested) regarding the existence and/or the amount of the claim. DO NOT offset the amount of the claim with the underpayment or issue any special payments for the underpayment, until the client is satisfied the claim occurred and has exhausted all hearing and appeal rights.

B. When a case has BOTH A CLAIM AND AN UNDERPAYMENT, reduce the claim, or the outstanding claim being collected, by the amount of the underpayment.

C. When the underpayment involves a claim being collected by Claims Management Section (CMS), contact CMS to obtain the current balance of the claim, inform them of the underpayment amount, and determine the new balance due on the claim.

D. When the UNDERPAYMENT IS USED TO OFFSET A CLAIM, or the outstanding claim is being collected, compute the underpayment using form PA-30.1, Automated Budget Program.

1. If the outstanding balance on the claim is greater than the underpayment, collect the difference.

2. If the underpayment is greater than the balance of the claim, authorize a special payment for the difference, unless the claim is being collected by the Claims Management Section, then the Claims Management Section issues a refund.]

MS 1860 [PROCEDURES FOR REFUNDS IN KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) AND OTHER PROGRAMS

When the local office discovers a claim has been overpaid, even if the excess collection is from money received by Division of Child Support (DCS), refund the excess collection to the client if case is active. If inactive, contact the Claims Management Section (CMS) to complete the action.

A. Make a refund when the client is ineligible and voluntarily returns a K-TAP check for a month to avoid a claim, and countable support was collected for the request month.

1. This also applies when the client requests a refund of child support collected when the client's K-TAP check is returned for other reasons (e.g., the client's K-TAP check was returned by mail); or

2. If the amount of the excess payment is in the form of a check or money order, or the client's K-TAP check has been returned due to insufficient address, etc., and the client or DCS requests a refund of collected child support, send a memorandum to CMS, outlining appropriate information, including case name, case number, address, the total amount of payments made by the client, the total amount of the excess payment made by the client and the total amount of reimbursement requested.] Do not request refunds for less than $1. File a copy of the memorandum in the Claims Control folder.

3. [Determine the amount of reimbursement when a client requests a refund of collected child support using the following procedures:]

a. Verify return of the K-TAP check for the month in question;

b. Contact the local DCS office to verify for the month in question, the total amount of child support collected for current obligation only (this does not include the amount collected for arrearages), and the amount of escrow, if any, forwarded to the client;

c. Subtract escrow, if appropriate, from the verified amount of current child support obligation collected. [Use the difference as the amount of reimbursement requested on the memorandum to CMS.] NOTE: The result of this calculation should be less than or equal to the K-TAP benefits for the month in question. The amount of the reimbursement should NOT exceed the K-TAP benefits for the month in question.

EXAMPLE 1: [In April, the client makes a request for a refund of child support collected in March. She returned her March K-TAP check of $228.] Her K-TAP case was discontinued effective April 1. DCS verifies $400 child support collected for current obligation in March and that out of that amount collected, they distributed a $122 Escrow payment. The reimbursement is calculated as follows:

$400 (Child Support) - $122 (escrow) = $288 (refund)

B. [Refund excess claims collections as a special circumstance.] The household does not have to be currently eligible.

MS 1863 [PROCEDURES FOR KENTUCKY TRANSITIONAL ASSISTANCE PROGRAM (K-TAP) UNDERPAYMENTS

An underpayment exists when a client is issued an amount less than the eligible benefit amount, through no fault of the client.]

A. The following are potential causes of a K-TAP underpayment.

[1.] Misapplication of policy;

[2.] Computation errors in determining supplemental benefits;

[3.] Failure to act on timely reported changes in the household's living situation;

[4.] Failure to confirm or clarify information pertaining to eligibility; or

[5.] Income considered in a payment month is more than actually received, due to a change in circumstances. A change in circumstances is defined in Volume III, MS 2872.

[B. For active K-TAP cases, when an underpayment is discovered, correct the current case as appropriate.

C. If an underpayment is identified, determine if there is an established claim for which the hearing and appeal rights have been exhausted and collection is being pursued.

1. If there is an established claim, use the underpayment to offset the claim. Refer to MS 1857 for details.

2. Do not delay issuing the supplement in order to offset a pending claim.

D. Use PA-30.1 to compute the underpayment. The supervisor or designated individual reviews the underpayment calculations for correctness. Issue the supplemental after the supervisor or designated individual reviews and concurs or use the underpayment to offset an existing claim. MS 1857.]

MS 1867*

SUPPORTIVE SERVICES AND EDUCATIONAL BONUS OVERPAYMENT

Repayment must be pursued on all supportive services and educational bonus overpayments discovered on or after January 1, 2006, regardless of the amount. A claim is established for supportive services and educational bonus overpayments due to client or agency error. This includes a supportive service or educational bonus paid pending a hearing decision.

A. Overpayment for a supportive services or educational bonus payment can occur for the following reasons:

   1. After initial determination of eligibility for the Kentucky Transitional Assistance Program (K-TAP), the individual is determined ineligible;

   2. The payment exceeds the eligible amount;

   3. Agency error;

   4. The individual refuses to apply the supportive services payment to the provider of the service needed;

   5. The individual failed to use the supportive services benefit for services or goods deemed necessary for Kentucky Works Program (KWP) participation;

   6. The individual provides falsified verification or documentation of KWP participation to obtain supportive services benefits; or

   7. The individual is not eligible for the educational bonus.

B. The responsibility to repay a supportive services or educational bonus overpayment rests with the specified relative or second parent. To recover an overpayment of supportive services or an educational bonus payment, seek repayment from the specified relative, second parent or the specified relative's or second parent's current K-TAP case. Repayment is sought from the specified relative or second parent regardless of the current K-TAP case status.

C. Collection of supportive services overpayments includes:

   1. Transportation payments;

   2. Purchase of an item or service needed by the K-TAP recipient for participation in a KWP activity including items not listed on form PA-32, Authorization for Supportive Services Payments;

   3. Car repair expenditures;

   4. Short-term training;

   5. Required fees for participation in a KWP activity; and

6. Remedial health care funds if the individual is determined ineligible for K-TAP benefits when the payment was made.

Collection of an educational bonus overpayment is made even if the bonus is paid to a member who is not a required participant in KWP.

D. When an overpayment of supportive services or an educational bonus occurs, take the following action:

1. Enter the identifying information for the overpayment on the Kentucky Claims Debt Management (KCD) System.

2. Determine the amount of the supportive services or educational bonus overpayment.

a. For a case that is totally ineligible, the claim is the total amount of all supportive services or educational bonus payments issued during the period of ineligibility.

b. For a case in which the individual fails or refuses to use the supportive services benefits for services or goods deemed necessary for KWP participation, the amount of misused benefits is the overpayment amount.

c. For a case that is issued a supportive services or educational bonus payment that exceeds the eligible amount or benefits are obtained falsely, the claim is the amount that exceeds the eligible amount or the amount obtained with falsified verification or documentation.

d. For a case that involves agency error, the overpayment is the total amount the agency issued incorrectly.

KCD can calculate the amount of a supportive services or educational bonus overpayment.

E. A supportive services or educational bonus overpayment may be repaid by:

1. Lump sum for an active or inactive case;
2. Installment payments negotiated by the Nutrition Assistance and Accountability Branch (NAAB), Claims Management Section (CMS). This option is only to collect overpayments for inactive cases; and
3. Benefit reduction of the K-TAP case with the exception of Remedial Health Care funds.

F. CMS pursues collection of the overpayment. If the household has a supportive services or educational bonus overpayment and is currently receiving K-TAP benefits, the K-TAP benefits are automatically reduced by the KCD system with the exception of collection for Remedial Health Care funds. Remedial Health Care goods and services are state funds and, therefore, cannot be collected through benefit reduction. For reduction amount guidelines, see Volume I, MS 1848.

G. A supportive services and educational bonus overpayment may be combined with other benefit group overpayments for referral to OIG for investigation.

H. Advise the individual of his/her right to request a fair hearing if he/she disagrees with the agency's decision concerning a supportive services or educational bonus overpayment. If an individual requests a fair hearing, cease collection activity until the hearable issue is resolved. The hearing process does not prohibit issuance of supportive services or educational bonus payments for which the individual may be eligible.

MS 1869* PROCEDURES FOR RELOCATION ASSISTANCE PROGRAM (RAP) PAYMENT CLAIMS

Use the following policy and procedures for establishing and collecting a RAP claim. Repayment must be pursued on all erroneous RAP payments discovered on or after March 1, 2007, regardless of the amount.

A. A RAP claim exists when:

1. After initial determination of eligibility for RAP, the household is determined ineligible due to agency error or client error;

2. The household or individual does not apply the RAP payment to the moving expense;

3. The household or individual does not move; or

4. The job does not materialize.

B. The K-TAP household can repay the RAP claim by using one of the methods below:

1. A lump sum for an active or inactive K-TAP case;
2. Installment payments negotiated by the Nutrition Assistance and Accountability Branch, Claims Management Section (CMS). This option is only to collect claims for inactive K-TAP cases; or
3. Benefit reduction of the K-TAP grant.

C. Enter the potential claim on the Kentucky Claims Debt (KCD) Management System as claim type “TR” category “RAP”.

D. Establish a separate claims folder for the RAP claim.

E. After the claim is established, follow the collection procedures found in MS 1830 and MS 1833 to collect RAP claims.

F. A RAP claim may be combined with other claims of the benefit group for referral to the Office of the Inspector General (OIG) for investigation.

G. Advise the individual of his/her right to request a fair hearing if he/she disagrees with the agency’s decision concerning a RAP claim. If an individual requests a fair hearing cease collection activity until the hearable issue is resolved.

MS 1870 KINSHIP CARE PROGRAM CLAIMS

See Policy Clarification

See OM Upd. No. 07-21, MS 99770, 10/1/07

A claim is established for overpayments due to a client (Kinship Care caretaker relative) or agency error. This includes assistance paid pending a hearing decision.

A. Claims are to be repaid by the Kinship Care caretaker relative only. The claim does not follow the child.

B. There are two types of Kinship Care claims: nonfraud and fraud, which is determined by the court.

C. [Refer suspected fraud Kinship Care claims only with amounts of $3,000 or more to the Office of Inspector General through CMS. Refer to MS 1668.]

D. The methods of repayment are:

1. If the Kinship Care case is active, KAMES automatically collects by applying a 10% maximum monthly reduction of future Kinship Care Program benefits based on the number of children in the Kinship Care case until the claim is repaid; or

2. If the Kinship Care case is inactive, the Claims Management Section pursues collection of the claim.

E. Enter the Kinship Care claim on the KCD system.

MS 1880 [WHAT IS A FAMILY ALTERNATIVES DIVERSION (FAD) CLAIM

Claims in the FAD Program can occur for two reasons:]

A. After the initial determination of eligibility, the individual is determined ineligible; or

B. The individual is determined eligible for the program and then refuses to apply the benefits to the provider of the service needed to resolve a short-term emergency that was identified by the individual at the time of application.

MS 1885 HOW TO ESTABLISH THE FAMILY ALTERNATIVES DIVERSION (FAD) CLAIM

When you become aware that FAD benefits have been erroneously provided, take the following action:

A. Enter the claim on the KCD system as claim type “TR” category for FAD.

B. Determine the amount of the FAD payment made erroneously, as KCD cannot calculate the amount of the FAD claim.

1. For a case that is totally ineligible, the claim is the total amount of FAD payments issued.

2. For a case in which the individual fails/refuses to use the FAD benefit for the specific short-term need, the amount of the benefit which the individual has misused is the overpayment amount.

C. [Refer suspected fraud FAD only with payments of a $3,000 or more to the Office of Inspector General. Refer to MS 1668.]

D. Establish a separate claims control folder for the FAD claim.

E. After the claim is established, collection is pursued by the Claims Management Section.

MS 1890 [COLLECTION PROCEDURES FOR FAMILY ALTERNATIVES DIVERSION (FAD) CLAIMS

Collection of the claim is sought from the adult member of the FAD case.

The adult member can repay by a lump sum or by installments. FAD claims cannot be repaid by benefit reduction.

The Claims Management Section pursues collection of the claim.]

MS 1891 [WHAT IS A WORK INCENTIVE (WIN) REIMBURSEMENT CLAIM

A claim of Work Incentive (WIN) reimbursements can occur for the following reasons:]

A. The K-TAP case is erroneously identified as WIN eligible; or

B. The client fails to report a change that affects WIN eligibility.

MS 1895 PROCEDURES FOR WORK INCENTIVE (WIN) REIMBURSEMENT REPAYMENT

Use the following policy and procedures for repayment of the WIN claim.

A. Seek repayment from the adult who received the erroneous WIN reimbursement.

B. The adult can repay either by a lump sum or installment payments. A WIN claim cannot be repaid by benefit reduction of a K-TAP case.

C. Enter the claim on the Kentucky Claims Debt (KCD) Management System as claim type "TR" category for WIN.

D. [Refer suspected fraud WIN claims of $3,000 or more to the Office of Inspector General through CMS. Refer to MS 1668.]

E. Establish a separate claims folder for the WIN claim.

F. After the claim is established, the Claims Management Section pursues collection of the claim.

MS 1910 INTRODUCTION TO IEVS

[Income and Eligibility Verification System (IEVS) is a federally mandated system designed to identify case discrepancies by means of various computer matches.] IEVS compares the SSN's of K-TAP, MA, and FS 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. Verification will be needed at the next recertification.

[Information obtained through IEVS matches is subject to the confidentiality provisions as detailed in MS 0120-0149 in addition to the safeguarding procedures detailed in MS 1915.]

A. 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.

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 is reviewed and resolved prior to processing.

The Batch Match process matches computer file data against case/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 "0" (out-of-household). Resolve Batch Match hits through the Batch Match function.

B. [Member information is entered on form PA-62, PAS/LTC Authorization, when the case is approved or a member is added to the case.] For applications and member additions, IEVS requirements are met by manually accessing appropriate KYIMS programs and resolving discrepancies prior to approval or addition.

For recipients, IEVS matches are performed by comparing SSN's on the PA-62 data base to information on various computer files.

Data produced from computer matches run against Wage Records, UIB, state BENDEX, SDX, and Food Stamp files is available the month prior to recertification on RMDS and is accessed through the IEVS-A.1 report.

MS 1915 [IRS SAFEGUARDING ISSUES]

See OM Upd. No. 07-26, MS 99775, 12/1/07

The Internal Revenue Service (IRS) requires that certain 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.

A. What IRS information must be safeguarded?

1. [All information which could be obtained from a Federal Tax return, (this includes but is not limited to Batch Match, IEVS or BENDEX) even if it was actually obtained from another source;] and
2. Any material containing an individual's Social Security Number.

B. Securing Case Record and Other Recipient Related Information

1. [Place all case records and recipient information in locked file cabinets or other secure locations when not directly working on the contents.] Do not leave case records on chairs, floors, the top of file cabinets, etc., when not specifically processing case information. At a minimum, ensure that all case records are not accessible before leaving the office.
2. When absent from your work station and before leaving the office, secure case records.
3. Check mail trays for recipient information regularly and do not leave this material in the mail trays overnight.
4. Unauthorized individuals should not be in work areas unsupervised.
5. During recipient interviews, only case record information which pertains to that recipient is visible on the desk or surrounding areas.
6. Lock your terminals when not in use, and ensure that terminals display only information relating to the recipient during interviews.
7. Sign off terminals when leaving for the day.

[8. The office building must be secured by doors with hinges on the inside or, if the hinges are on the outside, the hinges must have non-removable pins.]

C. Recipient Information Forwarded in the Mail

1. Double-seal envelopes relating to IRS information. Double-seal means one sealed envelope inside a separately sealed envelope. [Double-seal form PAFS-7, Notice of Appointment/Request for Verification.]
2. Double-seal IEVS-A.1 data before mailing to the Nutrition Assistance and Accountability Branch.

D. IRS Hits

If a batch match hit is the result of data received from IRS, the worker will see an "X" under the column "CM" on the DCSR. Once the worker goes into the batch match, a code type will be listed on the IRS hit. [The individual KAMES codes are listed in the codes manual accessed on RDS and DocumentDirect, report HR KIMR51 (T1) TABLE CODES REPORT.]

E. Procedures for Safeguarding IRS Information – Batch Match

1. When the IRS hit is received on the computer, complete form PAFS-7, Notification of Appointment/Request for Verification, 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 the screen or mention IRS in this letter or in any comments in the case.
2. The original form PAFS-7 is mailed to the recipient. A copy of form PAFS-7 must be kept in a locked file cabinet or locked box designated for the office/unit's forms PAFS-7. DO NOT FILE FORMS PAFS-7 IN CASE RECORDS.
3. The locked file cabinet or box for forms PAFS-7 must be stored in a locked room. If a locked file cabinet in a locked room is not possible for a unit/office, then a locked box in a locked file cabinet or locked desk is another possible solution to meeting the IRS's requirement of two barrier security. There should be limited access to the files. Designate one person as the responsible party for the locked file and a back-up. A log should be kept that includes the date, case name and number of each form PAFS-7 and who accessed the file. The log should be kept in the locked file.
4. If verification is returned concerning the request made on form PAFS-7 and if there is not a claim established, then the information is filed in the PAFS-7 file cabinet along with the PAFS-7. Allowable comments in the case concerning the resolution of the hit would be "Batch match hit dated 'mo/day/year' resolved, information filed in PAFS-7 files."
5. If verification returned concerning the request results in a claim, then normal claims procedures are followed in setting up a claim. [Staff are not to use form PAFS-18, Liquid Asset Verification and Invoice for Payment, to obtain verification of IRS information. Only use form PAFS-7 to request this information.]

F. Procedures for Safeguarding BENDEX Information

1. No BENDEX screens are to be printed or placed in the case records. This is because BENDEX information is considered "Federal Tax Information" as it comes from the IRS data tapes. If there is a need to print out and keep the information for a specific case, the printout must be kept in a "double barrier" locked file drawer or lock box. (Double barrier meaning a locked box – <u>in</u> a locked file cabinet, or a

locked file drawer – in a locked room etc.) The case itself should only have a reference indicating that there is further information in the locked file – wherever it is kept.

Document in the case comments the income amount was verified by inquiry on mo/day/year.

2. Purge all BENDEX files, IEVS and other information obtained from the IRS at the next case action from all prior packets. Purge the case even if the case action was a discontinuance or denial.

   Purge any KASES screens that contain IRS data that was printed before 8/26/04.

G. Disposing of Recipient Information and Case Record Material

To dispose of case records, listings, or other recipient information regarding IRS data, complete the following actions:

1. Shred the material into 5/16 inch or smaller strips and place in a designated box.
2. The designated boxes are sealed and placed in the most secure area available, preferably a space that can be locked.
3. [Complete the Certificate of Disposal form so that the material is collected and burned.

H. Penalties for Failure to Safeguard IRS Information

1. Unauthorized disclosure of Federal income tax returns or tax 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);
2. A taxpayer may bring suit for civil damages in a US District Court for unauthorized disclosure of tax returns and tax return information, per Internal Revenue Code Section 7431. This Section allows for punitive damages in case of willful disclosure or gross negligence, as well as the cost of the action; and
3. These civil and criminal penalties apply to the individual worker even if unauthorized disclosures were made after employment with the Agency.

I.] Internal Safeguarding Reviews

A self assessment survey form will be sent to each county/unit on a yearly basis to be completed by the supervisor.

1. These survey forms contain questions dealing with local office safeguarding procedures and instruct supervisors to hold a staff meeting in each county/unit to remind staff of local office safeguarding procedures.
2. Use this staff meeting as an annual reminder of Federal penalties associated with unauthorized disclosure of IRS data.

3. Advise the employees that these civil and criminal penalties apply even if the unauthorized disclosures were made after their employment with the Agency terminates.

4. In addition to explaining the penalties, a copy of the law must be given to each employee.

[5. To ensure all Family Support staff, including newly hired staff, are aware of the correct procedures for safeguarding IRS data, each Field Services Supervisor (FSS) must review the IRS Safeguarding Issues with staff and complete a Certification of Receipt of Awareness training document. The Certification Document is to be maintained in each local office and may be reviewed during Management and Evaluation (ME) reviews and during the IRS audit.

J. If an improper disclosure is discovered or witnessed, report the violation to the Service Region Administrator Associate (SRAA) for your Region. The SRAA forwards the report to the Division of Family Support. The SRAA takes action to ensure the violation does not occur again.]

MS 1920 PA-62 MATCHES

The following information describes the frequency in which PA-62 case data is matched against various computer files.

A. Wage record and UIB matches are run as follows:
   1. Wage Records - Members in cases coming due the following month are matched.
   2. UIB - Members in cases coming due the following month are matched. Any recipient who is found to be receiving UIB will be matched each month as long as he/she receives UIB.

B. State BENDEX and SDX - Matches are run against state BENDEX (both unearned income data, and wage and pension data) and SDX (SSI data) files for members coming due for recertification the following month.

C. Other Computer Matches for Unearned Income (Computer Matching Data Information).
   1. Approvals are matched in the month following approval.
   2. Members are matched annually at staggered intervals.

D. Enumeration matches are accomplished by matching SSN data on the PA-62 file with SSN data on SVES. When information is returned from SSA indicating that an SSN could not be verified, these "No Matches" are generated on the Listing of Non-Verified PA Social Security Numbers as follows:

   1. Approvals are matched in the month following approval.
   2. Members with no verification indicator are matched annually at staggered intervals.

MS 1925 KAMES MATCHES

The following information describes the frequency in which KAMES case data is matched against various computer files.

[For households subject to SR requirements, do not resolve the KAMES MATCHES hit during the certification period for any hit that is not "verified upon receipt." (See Vol. II, MS 6707.) Resolve the hit at the next recertification.]

A. Wage Records

1. Applications, recertifications and member adds are matched on-line prior to disposition.

2. The SSN's of all active case members are matched monthly, except the month after application or recertification. Resolve exceptions through Batch Match. If a wage match exception is resolved one month, an exception is not generated again until the wage quarter and/or the case members' wages change. Additionally, no exception is generated unless there is more than a $75.00 variance, up or down, between the quarterly wage amount and the case member's monthly earnings, multiplied by 3.

B. UIB

1. Applications, recertifications and member adds are matched on-line prior to disposition.
2. The SSN's of all active case members are matched monthly. Resolve exceptions through Batch Match.

C. Social Security Administration

1. BENDEX (Unearned Income Data and Earnings and Pension Data)

a. Bendex data does not appear on-line at application or member add unless the case member has previously received benefits and this information has not yet been purged from the state maintained Bendex file.
b. Bendex data appears on-line at recertification.
c. Bendex files are matched against all SSN's of active case members on the KAMES data base the month after the case is approved, reinstated or recertified. Resolve discrepancies through Batch Match.

2. SDX

a. Applications, recertifications and member adds are matched on-line.

b. SSN's of active case members on the KAMES data base are matched the month after the case is approved, reinstated or recertified.

3. Enumeration. Case member SSN's entered on the system at application and member add, which do not generate the system imposed "SA" verification code are matched against the SVES file maintained by the Social Security Administration (SSA). Discrepancies appear as spot checks on the worker's DCSR.

D. Other Computer Matches for Unearned Income (Computer Matching Data Information)

1. Applications and member adds are matched in the month following application or addition. Discrepancies appear on the Batch Match function and RMDS program HR FSS Case Data Fact Sheet.
2. Members are matched annually at staggered intervals. Discrepancies appear on the Batch Match function and RMDS program HR FSS Case Data Fact Sheet.

E. Computer Matching Program for the Disqualified Recipient Subsystem (DRS) maintained by the Food and Nutrition Service (FNS).

1. FNS-supplied data runs monthly against the active FS database, which includes all active, disqualified and ineligible members.
2. Members matching with the disqualified file from another state appear on RMDS report HR KIFJ14, DRS Match Report. Refer to MS 1739 for additional information.

MS 1930 RESOLVING IEVS DISCREPANCIES

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

[For households subject to SR requirements, do not resolve the IEVS hit during the certification period for any hit that is not “verified upon receipt”. (See Vol. II, MS 6707.) Resolve the hit at the next recertification.]

A. Match Data Requiring NO Independent Verification

1. Matching data from FS, UI, 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 the data sheet for PA-62 and in "Comments" for KAMES cases. Resolve the discrepancy and take appropriate case action within 30 days, based on the resolution.
3. If the matching data is not questionable, take appropriate case action within 30 days after the control date/match date.
4. For data received from these sources which is not considered in the case record, adjust benefits timely.

B. Match Data Requiring Independent Verification

1. Matching data from Wage Records, Computer Matching Data and BENDEX (Wage and Pension) files require independent verification since the data obtained in the match is at least several months old and may not reflect current household circumstances.

   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 form 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. Form PAFS-7 is used in place of form PAFS-2 or RFI for IEVS related interview appointments and requests for verification. For cases coming due for recertification, use form PAFS-2 or RFI as appropriate to request needed verification at the time of the regular interview.

b. For cases not due for recertification, send form PAFS-7 within 5 work days after receipt of the match and allow the household 10 calendar days from the date of the notice to provide the requested verification.

Ensure that the forms PAFS-7, PAFS-2 or RFI advises the household of all verification that is needed to resolve the discrepancy.

c. 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 form PAFS-7, PAFS-2 or RFI, as appropriate and allow 10 calendar days for the recipient to return the additional verification.

d. Upon receipt of verification, send the appropriate notice of eligibility/ineligibility, if required, and adjust benefits timely.

e. If verification is not provided, deny or discontinue the case.

f. Document all actions thoroughly and completely.

g. For KAMES cases, annotate "Comment" and clear the exception through the Batch Match function.

h. [For PA-62 cases, annotate the appropriate eligibility determination worksheet or interim notation sheet, and control listing, and mail the control listing to the Nutrition Assistance and Accountability Branch.]

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 preceding the last available Wage Records quarter.

EXAMPLE: If the last available Wage Records quarter is the third quarter of 1997, shown as 3/97, the quarter preceding the last available Wage Records quarter would be the second quarter of 1997, shown as 2/97.

(1) If there are no matches for either of these quarters, no independent verification is required to resolve the Wage Records match. Submit the appropriate listing to clear the match from the computer or clear 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 submit appropriate listing to clear the match or clear through Batch Match.
(b) If independent verification is required, refer to item B., 2., of this section.

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 submit the appropriate control listing to clear the match or clear the discrepancy through Batch Match, as appropriate.
b. Independent verification is required, if the case record does not contain adequate verification. Refer to item B., 2., of this section. Additionally:

(1) Indicate on form PAFS-7, the type, source/location, and account number, if appropriate, of the income listed for the identified household member.
(2) If an 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.

MS 1940 RESOLVING PA-62 MATCHES

Access MA match data on RMDS through either the HR IEVS-A.1 Fact Sheets or HR IEVS-C.1 Fact Sheets Report.

A. Workers may only access IEVS data coded to their caseload code through these reports and supervisors may access IEVS data for the entire county or counties which they supervise.

B. Information on RMDS HR IEVS-A.1 Fact Sheets or HR IEVS-C.1 Fact Sheets is not screen printed except in unusual circumstances. Destroy screen printed material immediately when it is no longer needed and under no circumstances file the material in the case record.

C. A control listing is produced of all hits for each data type. The worker's RMDS displays a control listing which contains all cases for each type match with his/her caseload code.

1. Access the control listing for IEVS-A.1 material through the HR IEVS-A.1 Fact Sheet Listing Report.
2. Access the control listing for IEVS-C.1 material through the HR IEVS-C.1 Fact Sheet Listing.

D. The supervisor's RMDS displays a control listing which contains all cases in the unit/county under his/her supervision.

1. Access the supervisor control listing for IEVS-A.1 data through the HR FSS-A.1 Control List Report.
2. Access IEVS-C.1 data through the HR FSS-C.1 Control Listing Report.
3. The supervisor control listing is screen printed and used in tracking the resolution of worker's match data.
4. The worker's control listing is printed and annotated as match data is resolved.
5. The resolve date is the date all exceptions for that case are resolved.

E. Upon receipt of IEVS data, review the case record and compare the matching data with the case record information. If the data is correctly considered, annotate the appropriate case record and annotate the corresponding IEVS Fact Sheet listing.

F. IEVS-A.1 Match Data.

1. Each month the SSN's for case members in cases coming due for recertification the following month are matched against wage match (SWICA), UIB, BENDEX, SDX and FS files.

2. The results of these matches are loaded on RMDS the month prior to recertification.

3. For each case member, the IEVS-A.1 Fact Sheet shows the computer file matched and either the match data or the words "No Match".
4. This information remains on RMDS for two months.

    a. The first version of the IEVS-A.1 Fact Sheet displays data for cases the month before a case is coming due.
    b. The second version displays match data for cases with recertifications due that same month.

G. IEVS-C.1 Match Data.

1. Case member SSN's are matched to the federal computer matching data tape the month after approval, member addition and annually on a staggered basis.
2. If a match occurs, the member and accompanying income and/or resource match data is displayed on the IEVS-C.1 Fact Sheet.
3. This information is displayed on RMDS in three versions.

    a. When the next match is run, the first version is deleted.
    b. At all times, the three most recent versions display on RMDS.

H. After the worker's control listing is completed, mail the listing to:

Cabinet for Families and Children
Division of Family Support
[Nutrition Assistance and Accountability Branch (NAAB)
275 E. Main Street, 3W-D]
Frankfort, KY 40621

1. [Forward HR IEVS-A.1 Fact Sheet Listings to NAAB by the last day of the recertification month.

2. Forward HR IEVS-C.1 Fact Sheet Listings to NAAB when all discrepancies are resolved or 90 days after the match date, whichever is sooner.]

MS 1941 RESOLVING KAMES MATCHES

See Addendum To: OM Upd. No. 07-15, MS 99764, 6/4/07
See OM Upd. No. 07-15, MS 99764, 6/4/07

The following processes performed by the system are designed to meet IEVS requirements.

[For households subject to SR requirements, do not resolve the Batch Match hit during the certification period for any hit that is not “verified upon receipt’. (See Vol. II, MS 6707.) Resolve the hit at the next recertification.]

A. On-Line Matches. On-line matches are uploaded by the system at application and recertification. This information appears prior to disposition and is resolved before the case action is processed.

When a discrepancy between on-line data and applicant reported information occurs:

1. Resolve the discrepancy by following procedures outlined in MS 1930.
2. Thoroughly document "Comments" concerning the resolution.

B. Batch Match. Batch Match is a function of the case change segment and provides information regarding discrepancies between case record data and data on various computer files for all household members, including ineligible and disqualified household members having a status code NOT prefaced by an "N" or "O".

Computer files are compared to case member information on the second weekend of every month, as described in MS 1925. If an exception is identified, a spot check is posted to the caseworker's DCSR the following Tuesday.

C. Death Match. Effective 9/25/00, KAMES began the match of all food stamp recipients, regardless of age, against the Social Security Administration’s (SSA) file of deceased individuals. This occurs at application and recertification as follows:

1. The system will match the member SSN against a SSA file of member name, member SSN, and date of death of the member.

2. For applications, the match is completed nightly for all household members on food stamp applications approved that day.

3. For recertifications coming due the following month, the match is completed the Friday prior to the last workday of the month for all active household members.

4. [If a match is received from SSA, a spot check, "SSN verified DOD as MMDDCCYY" will post to the worker's DCSR. Take action on the spot check in a timely manner as follows:

   a. Review the case record to determine if the death of the member was reported.
   b. Ensure the social security numbers have been verified by the SSA coding or a copy of the card and entered correctly.
   c. If the death was not reported, send a Request for Information (RFI) to the household informing them of the information that was received from SSA and request verification from the household of current household composition.
   d. If the household reports the death of the identified household member, remove the deceased member from the food stamp case effective the first possible month.
   e. If the household states that the member is not deceased, and verifies the household composition, take no action to remove the member from the food stamp case. Inform the household member that there is a discrepancy with the information reported by the SSA. Advise the household that they must resolve this discrepancy with the SSA.
   f. If the household fails to respond to the RFI by verifying household composition, discontinue the food stamp case.
   g. If necessary, establish a claim.

D. Prisoner Match. Effective November 1, 1998, in accordance with a Presidential directive, SSA must make available prisoner status information to States, the Food and Nutrition Service (FNS), the Department of Education and other Federal benefit paying entities.

As a result, effective 5/1/99, we began matching food stamp member SSNs to SSAs prisoner information as follows:

1. For applications, on the night of approval, this match is completed for all members who are at least 15 years old.
2. For recertification, this is done the first Friday prior to month-end for all active members age 15 or older who are due for recertification in the following month.
3. Prisoner match criteria consists of the following:
   a. Member name;
   b. Member SSN; and
   c. Member date of birth.]

[4. A new report has been added to RMDS. The report is titled "Prisoner Information Report". The report number is HRKIPR89. It is sorted by county, unit within the county and caseload code within the unit. The report displays the following:

   a. County;
   b. Unit;
   c. Caseload code;
   d. FS case number and case name;
   e. Prisoner SSN;

f. Prisoner name;
g. Prisoner ID number;
h. Date of confinement;
i. Release date;
j. Report date;
k. Prison name;
l. Prison address; and
m. Facility contact.

5. If a match is received, a spot check posts to the worker's DCSR notifying them to check the RMDS "Prisoner Information" report.

   Workers should act on their spot checks the day they display or at least print their matches each day.

6. If a prison match is received, take the following steps in determining whether the household member should be removed from the food stamp case:

   a. Call the facility contact person listed on the match report and verify whether the member is currently incarcerated. Document findings in comments.

   b. If it is confirmed through the facility contact person that the member is in prison, do a case change to remove the member.

      1) If the household states the member is no longer in prison, request verification that they have been released;
      2) Document results in comments; and
      3) Evaluate the case for any possible overissuance.]

   [c. For cases coming due for recertification, the worker receives a spot check the month before the recertification is due. This allows the worker to resolve any discrepancies when the household comes in for recertification.

E.] To clear the exception from the DCSR exception list:

1. Access Case Change segment "A" from the Case Change menu.
2. Select segment "HH," Batch Match, from the Case Change segment menu.
3. On the Batch Match screen overlay the "Y" with an "R."
4. Prior to ending session on a Batch Match exception, the following statement appears on the calculation screen: "If IEVS related action, enter code. If non-IEVS, enter NA." Enter the IEVS code for the type of discrepancy resolved.

   a. SW - SWICA (Wage Records)
   b. UI - Unemployment
   c. BU - Bendex Unearned Income
   d. BE - Bendex Earned Income

e. SD - SDX
f. CM - Computer Match

[F.] During the nightly batch cycle all exceptions for that member that have been resolved are deleted from the DCSR Exception List.

1. The member's name and SSN remain on DCSR until all discrepancies for that member have been resolved.
2. Although a CM exception is cleared through the Batch Match function and subsequently removed from the DCSR Exception List, the corresponding information regarding the hit remains on RMDS for the remainder of the 90 days.

MS 1943 BATCH MATCH FOR INACTIVE CASES

When a case is discontinued for any reason before an outstanding batch match exception can be resolved, the exception remains on the worker's DCSR until either the hit is resolved or the inactive case is written to offline history. If the case is reapproved in less than 90 days by another caseworker, the unresolved exception appears on the new caseworker's DCSR for resolution.

To clear an exception on inactive cases, go through Case Change only.

A. Select "A" ("Change Segment") from the Case Change Menu.

B. [Select "HH" ("Batch Match") from the Case Segment Change Menu.]

C. Resolve the exception as you would on any case that is active.

MS 1944 BATCH MATCH AT RECERTIFICATION/REAPPLICATION

Batch Match resolution is a function of the case change process. Therefore, exceptions cannot be individually deleted from the Batch Match Exception Listing beginning with the first day of the month in which a case is due for recertification until such time as the recertification is processed.

[SR households must have Batch Match hits which are not “verified upon receipt” resolved during the next recertification process. (See Vol. II, MS 6707.)]

A. If the worker determines as part of the recertification or reapplication process that all outstanding exceptions for all household members may be resolved, answer "Y" to the question "Have all outstanding Batch Matches been resolved?" on the disposition screen. This results in all "Y's" being overlaid with "R's" on all outstanding Batch Match segments for the household and deletes these exceptions from the worker's monthly Batch Match Exception Listing.

B. Enter an "N" in response to this question, if all outstanding Batch Match segments remain unresolved or if there are no outstanding matches. This results in any outstanding exceptions remaining on the worker's Batch Match Exception Listing.

C. The question and "Y/N" answer remains available for inquiry on the pending data base but does not move to case master for inquiry after the case is disposed.

MS 1946 SSN NO MATCH

[An SSN no match appears as a KAMES spot check when a discrepancy occurs between the Agency provided SSN and the SSN information maintained on the Social Security Administration's (SSA) SVES file.] Refer to Volume VI, MS 1505 for information about SVES spot checks. To clear these discrepancies do the following:

A. Review the case record for accuracy. Compare the case member's name, date of birth and SSN as it appears on the system to any available documentary evidence in the case to ensure these items are entered accurately. If an error is found, correct the information and clear the exception.

B. If no recording error is found, contact the household by form PAFS-7 within 10 calendar days, scheduling an interview to discuss the discrepancy and do the following:
   1. Advise the household that there is conflicting information concerning a specific SSN that the Agency received from SSA.
   2. Advise the household that the discrepancy must either be resolved within 10 calendar days of sending the notice or they must contact SSA to resolve the problem.
   3. If the SSA is contacted, verification must be provided by the FS recipient.
   4. The Agency may request an SSN card or other acceptable document to verify the accuracy of the number.
   5. If an error is found between the system entered information and the documentary evidence, correct the case information and clear the exception.

C. If the household provides verification that indicates the SSA information is inaccurate, clear the exception and document in "Comments" the reason the discrepancy was not resolved.

D. If the household refuses to cooperate in resolving the discrepancy, disqualify the individual whose SSN could not be verified and document in comments the reason for the disqualification. The disqualified individual remains ineligible for FS benefits until the discrepancy is resolved or the household has contacted the SSA and cooperated in resolving the discrepancy. Once verification is provided that the household has cooperated with SSA, the disqualified individual is eligible for FS benefits while SSA completes its review.

MS 1947 COMPUTER MATCH (CM) EXCEPTIONS AND RMDS

A CM exception appears on Batch Match when a case member's SSN matches an SSN on the Computer Matching Data (CMD) tape. The Batch Match screen is unable to accommodate specific income and resource information contained on the CMD tape. For this reason, this income and resource information is loaded on RMDS Program HR FSS Case Data Fact Sheet.

[For households subject to SR requirements, do not resolve the Computer Match (CM) Exceptions and RMDS hit during the certification period for any hit that is not "verified upon receipt". (See Vol. II, MS 6707.) Resolve the hit at the next recertification.]

A. The same tape is used to generate CM exceptions on KAMES, and the HR FSS Case Data Fact Sheet. The tape is then compared to the active KAMES data base at the next monthly Batch Match run. Because of this, CM exceptions and RMDS data may post to different caseload codes.

B. Use the following procedures when resolving CM exceptions and locating accompanying data on HR FSS Case Data Fact Sheet:

1. A CM exception type is identified on the Batch Match screen.
2. Access RMDS program HR FSS. If additional CM information for the discrepancy appears on the RMDS/HR FSS Case Data Fact Sheet, resolve the discrepancy per instructions in MS 1941.
3. If additional information for the CM exception is NOT on RMDS/HR FSS, determine if the case record was transferred prior to the Batch Match run, but subsequent to the RMDS upload. If the case has been transferred, the supervisor accesses HR FSS Case Data Fact Sheet for the prior caseload code to obtain the additional data for the exception.

   [If the case record has not been transferred, contact the Nutrition Assistance and Accountability Branch, Technical Support Section for instructions.]

4. If HR FSS Case Data Fact Sheet contains information but there is no corresponding CM exception in the caseload code, no agency action is necessary.

[C.] Confidentiality Requirements for RMDS/HR FSS Case Data Fact Sheet. All data received on the Computer Matching Data tape is subject to strict confidentiality and safeguarding requirements. For this reason:

1. RMDS/HR FSS Case Data Fact Sheet information remains available for only 90 days after the information first appears on the system;

2. Workers can access only that portion of RMDS/HR FSS Case Data Fact Sheet that is posted to their caseload code and supervisors can only access this program for caseload codes in their county;

3. INFORMATION ON RMDS/HR FSS CASE DATA FACT SHEET IS NOT SCREEN PRINTED except in unusual circumstances. Screen printed material is immediately destroyed when it is no longer needed and under no circumstances is this material ever filed in the case record; and

4. Information on RMDS/HR FSS Case Data Fact Sheet is not copied from the screen and filed in the case record for any reason.

MS 1948 UNEMPLOYMENT INSURANCE BENEFITS

When entering State UIB amounts on the unearned income screens, enter a minimum of two biweekly amounts. Batch Match compares the last two payments on the UIB data base to the first two verified payments on the unearned income screen. Therefore, if only one biweekly UIB amount is entered, a monthly exception is generated even though the UIB income is being considered correctly in the case.

MS 1955 COMPUTER MATCH CODES

The type of earnings matched displays in the COMPUTER MATCH field on the third line from the bottom of the screen. The following are definitions of computer match income.

01 - DIVIDENDS: A distribution of property (usually cash) made by a corporation to its shareholders. Generally the payment is made out of its earnings and profits.

02 - INTEREST: This is any interest on evidences of indebtedness (including bonds, debentures, notes, and certificates) issued by a corporation in registered form, or interest on other evidences of indebtedness issued by a corporation of a type offered by corporations to the public. Includes interest on deposits with a bank and amounts paid by a mutual savings bank, savings and loan association, building and loan association, cooperative bank, homestead association, credit union, or similar organization, in respect of deposits, investment certificates, or withdrawable or repurchasable shares. Also interest on amounts held by an insurance company under agreement to pay interest and interest on deposits, with stockbrokers and dealers in securities. Interest payments of $10 or more are reported.

03 - GROSS WINNINGS: A payer of gambling winnings must report any winnings over $600 on Form W-2G, Certain Gambling Winnings. Any person receiving a payment for a wager in a sweepstakes, wagering pool, lottery, or other wager (including a pari-mutual pool with respect to horse races, dog races, or jai alai) will provide statement of winnings to the player upon the player's demand. A racetrack is required to furnish the IRS only the names of recipients of payments of $600 or more. Payment of gambling winnings of $1,200 or more from bingo or slot machine play or $1,500 or more from keno games must be reported. Nevada gambling casinos must file information returns for bingo and keno payoffs of $600 or more.

14 - UNEMPLOYMENT COMPENSATION: Generally includes any amount received under an unemployment compensation law of the United States or of a state. It includes benefits paid by a state or the District of Columbia from the Federal Unemployment Trust Fund and railroad unemployment compensation benefits of $10 or more.

18 - RENTS: Compensation made in any form, by a tenant to a landlord or owner for the use of land, buildings, or any property, movable or fixed, especially when paid in money at regular or specified intervals. A real estate agent reports on Form 1099-MISC the gross amount of rents collected on behalf of a property owner (without deduction of commissions, fees or expenses retained), if such amount totals $600 or more during the taxable year.

19 - ROYALTIES: A share of proceeds paid to a proprietor, author, or inventor, by those doing business under some right belonging to him. Royalty payments, totaling $600 or more in a calendar year, made by a publisher directly to an author or his literary agent (individual or partnership, not a corporation) must be reported on Form 1099-MISC. The agent must file information on returns showing the gross amount he received from the publisher (prior to any deduction of commissions, fees, and expenses) and paid over to the author.

20 - PRIZES AND AWARDS: Gross income includes all amounts received as prizes and awards, unless it is a scholarship or fellowship grant excluded from gross income. These prizes and awards include (but are not limited to) prizes and awards in contests of all types, as well as any prizes and awards from an employer to an employee in recognition of some achievement in connection with his employment. If the prize or award is not made in money but is made in goods or services, the fair market value of the goods or services is the amount included in income.

21 - ADDITIONAL WINNINGS FROM IDENTICAL WAGER: An identical wager is more than one wager on the same exact thing (for example, two $2 bets on a particular horse to win the same race). All identical wagers are compiled to determine if the total amount is more than $1,000.

22 - SAVINGS BONDS: Amounts of interest on U.S. Savings Bonds, Treasury bills, Treasury notes, and Treasury bonds.

27 - CASH LIQUIDATION DISTRIBUTION: Payments received when an interest in a corporation is disposed of by sale or exchange of the capital stock, by redemption of the stock by the corporation, or by complete or partial liquidation of the corporation.

28 - NON-CASH LIQUIDATION DISTRIBUTION: A corporation making any distribution in liquidation must file a Form 1099-DIV in each calendar year of the liquidation for each stockholder to whom it makes a distribution of $600 or more during the year. The basis of property received in a distribution in complete or partial liquidation in which gain or loss is recognized by the stockholder is the fair market value of the property at the time of distribution. If no gain or loss is recognized on the distribution, the basis of the property distributed is the adjusted basis of the stock surrendered.

30 - SUBSTITUTE PAYMENTS: A payment in lieu of: (1) tax-exempt interest to the extent that interest has accrued while a short sale was open, and (2) a dividend, if the ex-dividend date is after the transfer of stock for use in a short sale and before the closing of the short sale.

32 - BUSINESS INCOME: Income reported on IRS Schedule K1, Form 1041, Beneficiary's Share of Income, Deductions, Credits, Etc. This income represents the sum of the beneficiary's allocable share of business income and other non-passive income, rental income, rental real estate and other passive income.

33 - INVESTMENT EXPENSE: Expenses reported on IRS Form 1099-DIV, Statement for Recipients of Dividends and Distributions.

38 - UNREALIZED APPRECIATION: A value determined by the net unrealized appreciation in an employer's securities. Unrealized appreciation may occur when a trust is created or organized in the United States and forming part of a stock bonus, pension, or profit-sharing plan of an employer for the exclusive benefit of his employees or their beneficiaries, and a distribution includes securities of the employer corporation (or a subsidiary of the parent corporation) and the net unrealized appreciation in the employer's securities can be computed, the amount is reported on the Form 1099-R.

39 - OTHER INCOME: Payers whose distribution includes items not covered by any other entries on Form 1099-R and information to employees or beneficiaries is desired would report it as other income. (For example the current actuarial value of an annuity contract that is a part of a lump-sum distribution or the value of US retirement bonds that may be distributed to employees or beneficiaries.)

40 - INTEREST FORFEITURE: Amounts of interest or principal forfeited as a penalty for early withdrawal of savings from a time savings account.

43 - PATRONAGE DIVIDENDS: An amount paid to a patron by an organization on the basis of quantity or value of business done with or for the patron, under an obligation of the organization to pay the amount. The obligation existed before the organization received the amount paid. This is determined by reference to the net earnings of the organization from business done with or for its patrons. The amount reported is for payments of $10 or more during the calendar year.

44 - NON-PATRONAGE DISTRIBUTIONS: Includes amounts paid as dividends on the cooperative's capital stock during the taxable year. Also amounts paid in money, qualified written notices of allocation, or other property and paid on a patronage basis to a farmers cooperative's patrons from earnings which result from business done for the United States or any of its agencies, or from earnings from sources other than patronage.

45 - PER-UNIT RETAIN ALLOCATIONS: Form 1099-PATR shows total per-unit retain allocations paid in cash, qualified per-unit retain certificates (face amount), and other property. Per-unit Retain Allocation means any allocation by an organization to a patron with respect to products marketed for him.

46 - REDEMPTION OF NON-QUALIFIED AND RETAIN ALLOCATIONS: All redemptions of nonqualified written notices of allocation issued as patronage dividends, nonqualified written notices of allocation issued as nonpatronage allocation (applicable only to certain qualified farmers cooperatives), and nonqualified per-unit retain certificates, issued with respect to marketing.

50 - REAL ESTATE SALES: Income reported on Form 1099-S, Proceeds From Real-Estate Transactions. Gross proceeds from sale or exchange of real estate.

53 - ORIGINAL ISSUE DISCOUNT: The difference between the issue price and the stated redemption price at maturity. In the case of bonds or other evidences of indebtedness registered with the Securities and Exchange Commission, "issue price" means the initial offering price to the public at which price a substantial amount such as bonds, etc. were sold.

54 - AGRICULTURAL SUBSIDIES: USDA agricultural subsidy payments made to recipients during the year. Form 4347 has been issued for optional use by persons who, as payees of record, receive from the USDA cash program payments belonging to other persons. Form 1099-G reports the actual owner of the payments.

55 - PRIOR YEAR REFUND: Refunds, credits, or offsets of state or local income tax for which the recipient previously had been allowed a deduction on his/her Federal income tax return. Payments of $10 or more are reported.

56 - DISCHARGE OF INDEBTEDNESS: Any amount in excess of $600 that was owed to the Federal Government and that has been declared uncollectible as a result of a defaulted obligation, not in dispute, and either a Federal statute expiration for collection of the debt has occurred or a formal compromise agreement has been entered into.

If an amount less than the amount owed is accepted as payment in full, the difference between the amount of the debt and the settlement amount is entered on form 1099-G. The discharge or forgiveness of indebtedness is taxable income to the person originally liable for that amount of indebtedness.

61 - STOCKS AND BONDS: The gross proceeds from any disposition of securities (including short sales), commodities, or forward contracts.

63 - AGGREGATE PROFIT AND LOSS: In a bartering transaction, the total profit (or loss) for the year from regulated futures or foreign currency contracts is reported.

64 - REALIZED PROFIT AND LOSS: In a bartering transaction, the profit (or loss) realized by the customer on closed regulated futures or foreign currency contracts in prior years.

69 - DEBT OUTSTANDING: Reported on Form 1099-A, Information Return for Acquisition or Abandonment of Secured Property, for each borrower if money is lent in connection with the trade or business and, in full or partial satisfaction of the debt, an interest in property that is security for debt is acquired, or the lender has reason to know that the property has been abandoned.

70 - DEBT SATISFIED: For acquisition by the lender only of property, the amount of debt satisfied by the acquisition.

73 - ORDINARY INCOME K-1: Income reported on IRS Schedule K-1, Form 1120S, Shareholder's Share of Income, Credits, Deductions, etc. and Form 1065, Partner's Share of Income, Credits, Deductions, etc. In a trust/partnership/subchapter "S" corporation each beneficiary/partner/shareholder must report his or her distributive share of income or loss whether or not it is actually distributed. Generally, the distributive share is determined by the trust instrument, partnership agreement, or shareholding.

74 - REAL ESTATE: Income/Losses reported on IRS Schedule K-1, Form 1120S, Shareholder's Share of Income, Credits, Deductions, Etc. and Form 1065, Partner's Share of Income, Credits, Deductions, Etc. These forms are used to report net income/loss from rental real estate activities and other rental and business activities.

75 - OTHER RENTAL: Income/Losses reported on IRS Schedule K-1, Form 1120S and Form 1065.

76 - GUARANTEED PAYMENTS: Income reported on Schedule K-1, Form 1065, Partner's Share of Income, Credits, Deductions, Etc. The guaranteed payment is the sum of a partner's distributive share of payments guaranteed to partners.

80 - GROSS DISTRIBUTIONS: Income reported on IRS Form 1099-R, Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, Etc. Gross amount distributed from an IRA or SEP distributions or net amount distributed from trust representing CDs redeemed early, etc. Also included are the value of U.S. Savings Bonds distributed from a pension plan, death benefit payments, and death payments made by employers that are not part of a plan.

88 - APPRAISAL VALUE: Appraised value of property abandoned or voluntarily conveyed to the lender in lieu of foreclosure.

90 - PASSIVE INCOME: Income reported on Schedule K-1, Form 1041, Beneficiary's Share of Income, Deductions, Credits, Etc. The form is used to report the sum of the beneficiary's allocable share of business income, other non-passive income, rental income, rental real estate and other passive income.

97 - SHORT TERM CAPITAL GAIN: Capital gain net income is the excess of the gains from sales or exchanges of capital assets over the losses from such sales or exchanges or an asset given this effect under the Internal Revenue Code. The capital asset is stock held by the taxpayer.

98 - LONG TERM CAPITAL GAIN: The same as above.

MS 1956* BENDEX CODES

A. BENDEX Earned Income Types. The system displays the type of earnings matched starting on line 7.

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. The system displays the types of State Data Exchange income matched starting on line 17:

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

MS 2000 CRITERIA FOR QUALIFIED ALIENS

See Policy Clarification

Individuals must be U.S. citizens or qualified legal aliens to receive K-TAP and Medicaid benefits. Nationals of Puerto Rico, U.S. Virgin Islands, American Samoa or Swain's Island are equivalent to U.S. citizens.

A. Qualified aliens are:
   1. Aliens lawfully admitted for permanent residence;
   2. Permanent resident aliens who are veterans honorably discharged for reasons other than alienage, their spouses or unmarried dependent children;
   3. Permanent resident aliens who are active duty, other than training, in the U.S. military, their spouses or unmarried dependent children;
   4. Refugees who were admitted under Section 207 of the Immigration and Nationality Act (INA);
   5. Asylees who were granted asylum under Section 208 of the INA;
   6. Aliens whose deportation is being withheld (political asylees) under Section 243(h) of the INA or after April 1, 1997, the renumbered Section 241(b) of the INA;
   7. Aliens admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988;
   8. Aliens paroled in the U.S. under Section 212(d)(5) of the INA for a period of at least one year: If INS document I-94 indicates the individual will be in U.S. for at least 1 year, eligibility may potentially start after parolee status is granted;
   9. Aliens who are granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to 4/1/80;
   10. Aliens granted status as a Cuban and Haitian entrant (as defined by Section 501(e) of the Refugee Assistance Act of 1980).

       Section 501(e) defines Cuban and Haitian entrants as any individual:

       a. Granted parole status as a Cuban/Haitian entrant (status pending);
       b. Granted any other special status established under INA laws for these nationals;
       c. Being a national of Cuba or Haiti, paroled into the U.S. and has not acquired another status under INA;
       d. Subject to exclusion or deportation proceedings under INA; or
       e. Having an application for asylum pending with Immigration and Naturalization Service (INS).

       If any of the individuals listed in item 10 have a final, nonappealable, legally enforceable order of deportation or

exclusion entered against them, they are NOT eligible under this provision; or

11. Aliens who are battered or subjected to extreme cruelty in the U.S. either as:

    a. An adult by:

        (1) A spouse or parent; or
        (2) A member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to the battery or cruelty; or

    b. A child by:

        (1) A spouse or a parent of the alien without the active participation of the alien in the battery or cruelty; or
        (2) A member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to the battery or cruelty; and

    c. The alien no longer resides in the household with the individual responsible for the battery or cruelty;
    d. There is a substantial connection between the battery or cruelty and the need for the benefit; and
    e. The alien has been approved or has a petition pending for:

        (1) Status as a spouse or child of the U.S. citizen;
        (2) Status as a permanent resident alien;
        (3) Suspension of deportation status pursuant to Section 244(a)(3) of the INA.

        "Battered or subjected to extreme cruelty" means an individual who has been subjected to:

        - Physical acts that resulted in, or threatened to result in, physical injury to the individual;
        - Sexual abuse;
        - Sexual activity involving a dependent child;
        - Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;
        - Threat of, or attempts at, physical or sexual abuse;
        - Mental abuse; or
        - Neglect or deprivation of medical care;

12. Aliens who are victims of human trafficking, and eligible relatives. Refer to MS 2005 for detailed policy and procedures.

13. Afghan and Iraqi aliens who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006. These Iraqi and Afghan aliens served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children.

B. The following qualified aliens cannot receive K-TAP or Medicaid (except for the time-limited MA, See MS 2075) for 5 years from their date of entry:

1. Aliens lawfully admitted for permanent residence ON or AFTER August 22, 1996;
2. Aliens paroled in the U.S. under Section 212(d)(5) of the INA for a period of one year. EXCEPTION: Cuban/Haitians entering under Section 212 are considered in the same manner as those entering under Section 501.
3. Aliens who (or whose child or parent) have been battered or subjected to extreme cruelty in the U.S.

C. Afghan and Iraqi aliens granted special immigration status are exempt under Section 1059 of the NDAA of 2006 or Section 1244 of the NDAA of 2008 from the 5-year ban for a limited time.

1. The time limits are:
   a. For Afghan aliens, the exemption lasts 6 months; and
   b. For Iraqi aliens, the exemption lasts 8 months.

   The exemption period begins on the date the Afghan or Iraqi entered the U.S. with a special immigration status or the date the special immigration status was granted, if granted after the date of entry.

2. During the exemption period, the Afghan and Iraqi aliens are considered like refugees.
3. To exempt the Afghan or Iraqi alien from the 5-year ban, enter "A2" for the alien entry status code on KAMES. Also, enter a spot check for the month the alien is no longer exempt.
4. Once the 6 or 8-month exemption period ends, these immigrants are subject to the 5-year ban. Change the alien entry status code to "A3" on KAMES. This imposes the 5-year ban.

D. Aliens designated as PRUCOL, permanently residing under color of law, are NOT eligible for K-TAP and Medicaid (except for time-limited MA, see MS 2075).

E. The unqualified aliens may receive for their children if the children are citizens or qualified aliens.

MS 2005 TRAFFICKING VICTIMS PROTECTION ACT

The Trafficking Victims Protection Act of 2000 (Public Law 106-386) was enacted in October 2000 to combat trafficking through increased law enforcement, to ensure effective punishment of traffickers, to protect victims, and to provide certain Federal and State assistance to victims. Traffickers force young women and children into prostitution, slavery and forced labor through coercion, threats of physical violence, psychological abuse, torture and imprisonment.

Section 107 of the Act provides that "victims of a severe form of trafficking: are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal official or agency, including the Department of Health and Human Services (HHS). [Individuals identified as victims and their eligible relatives are treated to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the Immigration and Nationality Act (INA). 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. With respect to the K-TAP, Medicaid and Food Stamp programs, victims and eligible relatives of trafficking, like refugees admitted to the United States under Section 207, are not barred from receiving benefits during their first five years in the United States.]

HHS is responsible for certifying that the 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. The Office of Refugee Resettlement (ORR) is designated by HHS to provide the certification-related functions. 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. It is not necessary for the worker to determine whether someone is a victim of a severe form of trafficking or to contact the Immigration and Naturalization Service or any other division of the Department of Justice to consult on these issues.

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 Stamp 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, provide benefits and services to the victim in the same manner as refugees admitted under Section 207.

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 Stamp case and/or "87" for the IM case, for the eighth month starting with the month of HHS/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 HHS/ORR, take no further action until the next Food Stamp or IM recertification.
2. If it is verified that a victim of a severe form of trafficking is not recertified with HHS/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 HHS/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”, as stated in the Trafficking Victims Protection Act, provide the individual the phone number of the Department of Justice, Division of Civil Rights, (888) 428-7581, or the Refugee State Coordinator, Becky Jordan, Catholic Charities of Louisville, (502) 636-9263.

If it is believed that a child has been subjected to a severe from of trafficking, the agency involved should call Loren Bussert at (202) 401-4732. The worker should complete form PAFS-628, Exchange of Information, to make a referral to Protection and Permanency (P&P) staff. P & P staff make the decision if the alleged maltreatment meets the adult or child eligibility criteria for intake.

MS 2010 INS DOCUMENTS

The following are the most common INS documents used by aliens entering the U.S.

A. I-94, Arrival Departure Record, is provided to aliens entering the country for either temporary stay or for permanent residence. 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 – Fiance or fiancee 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.]

B. I-151, commonly known as the "green card" was provided to aliens entering the U.S. prior to March 1996. In March 1996, the I-151 was replaced by the I-551. Some aliens admitted for permanent residence before August 22, 1996 will have this document.

C. I-551, Resident Alien, is provided to aliens entering the U.S. for permanent residence on or after August 22, 1996. The I-551 is valid for 10 years from the date of the issuance.

D. A passport for a lawful permanent resident alien can be issued with the stamp stating "Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence".

E. Form I-185, Canadian Border Crossing Card.

F. Form I-186, Mexican Border Crossing Card.

G. Form SW-434, Mexican Border Visitor's Permit.

H. Form I-95A, Crewman's Landing Permit.

I. Other INS documents can also be used to verify status such as an INS letter from an immigration judge, a stay of deportation, or court order.

MS 2020 VERIFICATION OF ALIEN STATUS

Verify the status of an alien through the Immigration and Naturalization Service (INS) documentation.

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

Status of Alien	INS Document
Permanent resident alien before August 22, 1996	I-151 or I-551
Permanent resident alien on or after August 22, 1996 If veteran of US Military If active duty US Military	I-551 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 INS 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.

MS 2030 GENERAL VERIFICATION REQUIREMENTS

Since many aliens left their homelands under emergency situations, they may not have all the required documentation for eligibility. Many aliens do not have verification or documentation of birth, marriage, divorce or relationship. Therefore, 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.

[Unless questionable, the alien's statement may be accepted for verification of marriage, divorce, relationship and prior labor market attachment. INS 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 INS documents.

In addition, many aliens have limited English language skills and may need interpreter services. Work with refugee resettlement agencies if the alien is involved with them. When sending requests for information, make every effort to ensure that the alien understands the request. If the refugee is in the office with an interpreter or has a relationship with a refugee resettlement agency, discuss the possibility of signing form CFS-13, Informed Consent and Release of Information and Records, to allow the sharing of the request for information with the appropriate entity or individuals.]

If the alien is sponsored, use any records or information, which is provided by the sponsor or refugee resettlement agency.

MS 2035 SAVE

Federal law requires that the immigration status of aliens applying for benefits be verified. The Systematic Alien Verification for Entitlement (SAVE) is the INS-operated 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 Admission (I-94) Number. This number is 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 and eligible relatives.

Use the following procedure when an alien applies for benefits.

A. Initiate a request for verification by SAVE, by forwarding the following information to the individual designated to access SAVE.

   1. Case name and number;

   2. Names of any alien members and their corresponding alien numbers, birth dates and social security numbers, if available; and

   3. Worker name, code and phone number.

      DO NOT delay processing the case for the receipt of SAVE information.

B. Within 3 work days from receipt of the request, the designated individual accesses the Alien Status Verification Index (ASVI) data base to obtain SAVE information.

   1. The ASVI assigns a verification number which is used as a reference number if further verification from INS is needed.

   2. ASVI provides the name, alien number, birthdate and social security number, if available, which is retained by the ASVI data base.

   3. The designated individual compares the information and decides whether further verification by form G-845, Document Verification Request, is necessary.

   4. The designated individual forwards the result of the ASVI check to the local office.

C. When the SAVE response is received:

1. If SAVE verifies alien status, annotate the case record and file the response in the case.

2. If SAVE does not verify alien status:

   a. [Complete form G-845, Document Verification Request. Attach copies of the INS documentation and form DCBS-1, if appropriate, with a single staple in the upper left-hand corner of form G-845. Send to the File Control Office:

      Status Verification Unit
      US Citizenship and Immigration Services
      US Department of Homeland Security
      1240 East 9th Street, Room 501
      Cleveland, OH 44199]

      DO NOT deny or discontinue the case based on alien status until a response is received.

   b. If the INS response on form G-845 indicates the alien status document is valid, annotate the case record and file the form in the case.

   c. If the INS response on form G-845 indicates the alien status document is not valid, deny or discontinue benefits for the unverified alien.

MS 2040* ALIENS SPONSORED BEFORE 12/19/97

The income and resources of an individual sponsoring an alien before 12/19/97 are considered when determining alien eligibility for K-TAP if:

A. The alien individual or family is applying for benefits for the first time before 12/1/97; and

B. The sponsor has signed a guarantee of support concerning the sponsored alien; and

C. The aliens are NOT:

1. Refugees;
2. Asylees;
3. Conditional entrants admitted as refugees;
4. Parolees; or
5. Dependent children of sponsor and/or sponsor's spouse.

If the alien meets the above criteria, the income and resources of the sponsor are considered available to the alien when determining eligibility. This applies only to sponsoring individuals, who are considered private sponsors, and NOT to organizations or churches, which are considered public sponsors, sponsoring alien families or individuals.

The income and resources of a sponsor are considered available to the alien for only a 3-year period starting with the alien's date of entry into the United States.

The above criteria also applies when considering income of the individual sponsor in determining eligibility for Adult MA.

Sponsor income is not considered available when determining income eligibility for Family MA.

Resources of the individual sponsor are NOT considered in determining eligibility for Family MA or Adult MA.

MS 2043* PUBLIC/PRIVATE AGENCY AS SPONSOR

An individual alien whose sponsor is a public or private agency is ineligible for assistance during the 3 years following entry into the United States unless the Department determines the agency:

A. No longer exists; or
B. Has become unable to meet the individual's needs.

The 3-year ineligibility period does not apply to refugees, asylees, parolees, conditional entrants, Cuban/Haitian entrants or dependent children of the sponsor.

MS 2046* ALIEN-SPONSOR RELATIONSHIP

A. The alien applicant for K-TAP, Family MA, or Adult MA is responsible for obtaining the cooperation of the sponsor and for providing the requested information and documentation necessary to determine eligibility. Aliens failing to obtain the cooperation of the sponsor or provide information, are not eligible for assistance.

B. The sponsor is considered to have good cause or be without fault for providing incorrect information when:

1. The alien-sponsor relationship has broken down due to the relocation of either party to the extent that the parties no longer reside in the same state; or
2. Information about himself, the spouse, or alien was withheld to protect the identity, and physical and/or emotional well-being of the alien.

C. The following is evidence of good cause:

1. A break down in alien-sponsor relationship due to the relocation of either party is documented and verified by obtaining evidence of the current addresses of both sponsor and alien;
2. If the sponsor claims good cause due to the necessity to protect the well-being of the alien, the statements of the alien and sponsor are accepted as documentation; or
3. If the sponsor provides incorrect information and the alien indicates that the sponsor was unaware of the actual situation, the sponsor is without fault since no deliberate effort was made to obtain benefits by presenting incorrect information.

D. In many situations, INS indicates that the sponsors are withdrawing their sponsorship of aliens soon after the alien arrives in this country. If this situation occurs and the alien has not obtained another sponsor, the income and resources of the original sponsor are still considered as available to the alien when determining eligibility.

MS 2049 SPONSOR RESOURCES

[To determine K-TAP eligibility for the alien, compute the liquid resources of the sponsor and his/her spouse, if living together, and consider in the case as follows:

A. The total liquid resources of the sponsor, the spouse if appropriate, are computed as if the sponsor was applying for K-TAP.

B. The total liquid resources are subject to a $1500 disregard with the remainder considered as a liquid resource available to the alien. If the sponsor is not sponsoring all members of an alien assistance group, the liquid resources are considered available only to the members sponsored.]

In some situations, an individual serves as sponsor for 2 or more alien assistance groups. In such cases the resources are divided equally between or among the sponsored aliens who receive or are applying for assistance.

DO NOT consider resources of the sponsor and his/her spouse, if living together, in the alien's Family MA or Adult MA case.

MS 2052 SPONSOR INCOME

Income from K-TAP or SSI is exempt from consideration when determining sponsor's monthly income available to the alien. Additionally, the sponsor's income is not subject to the K-TAP gross income limit.

The sponsor's total monthly gross earned and unearned income is subject to the following disregards:

A. Less 20%, up to a maximum of $175, from all gross income received as wages or salary, or as net earnings from self-employment, deduct the full amount of costs incurred in producing self-employment income; and
B. Deduct an amount equal to the K-TAP maximum payment scale based on the number of members in the sponsor's family. This includes all persons within the home who are claimed by the sponsor and/or spouse as dependents in determining federal personal income tax liability; and
C. Actual child support or alimony paid by the sponsor and/or spouse to or for individuals residing outside the household; and
D. Any amounts actually paid by the sponsor to people not living in the household who are claimed by the sponsor as dependents to determine his or her federal personal income tax liability.

Count the surplus of the sponsor's and/or spouse's income in the alien's K-TAP or Family MA assistance budget as unearned income.

MS 2055* SPONSORSHIP OF 2 OR MORE GROUPS

In some situations an individual serves as a sponsor for 2 or more alien assistance groups. In such cases the income is divided equally between or among the sponsored aliens who receive or are applying for assistance.

If the sponsor has signed an agreement guaranteeing support for some, but not all members of an alien assistance group, the sponsor's income and resources are considered available only to the sponsored members. Resources of the sponsor are NOT considered in the alien's Family MA or Adult MA case.

Income and resources are not considered available to unsponsored aliens in determining need unless the sponsored aliens actually make the income available to the unsponsored members of the assistance group. Only the amount made available is considered for computation and is shown as unearned income.

MS 2060* ALIENS SPONSORED ON OR AFTER 12/19/97

With the passage of the Balanced Budget Act of 1997, privately sponsored aliens must meet additional income and resource requirements. A private sponsor is an individual not an organization or group.

A. Certain 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 Under Section 213A of the Act.

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. 3;
3. Departs the U.S. permanently; or
4. 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 passage of the Balanced Budget Act of 1997.

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, to verify 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 the cooperation necessary to process the application from the sponsor's household;
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 2065* EXCEPTIONS TO DEEMING SPONSOR INCOME AND RESOURCES

There are certain exceptions for deeming income:

A. The alien is determined indigent if:

1. The amount of the sponsor's income and resources given to the alien does not exceed the amount agreed to in the affidavit; AND
2. 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 Eligibility Services Branch.

B. If the alien or alien's child has been subjected to extreme cruelty or has been battered in the U.S. by:

1. A spouse or parent; or
2. A spouse or parent's family living with the alien or alien's child and the spouse or parent allows the cruelty or battery; or

C. 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:

1. A spouse; or
2. 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 2070* DEEMING SPONSORS INCOME AND RESOURCES

Deeming applies to all aliens sponsored by individuals. Deeming continues until the alien gains citizenship.

Sponsored aliens who complete the affidavit of support on or after 12/19/97, must have both their sponsor's and sponsor's spouse's income and resources deemed as available to the alien.

A. The total income and resources of the sponsor and his spouse are considered available to the alien's household. Consider the deemed income as unearned income.

B. Recalculate the deemed income and resources, once verified, if a change in sponsorship occurs during the recertification period.

MS 2075 TIME-LIMITED MA ELIGIBILITY

See Policy Clarification

Effective October 1, 1999, any alien, legal, illegal or legalized who, does not meet the qualified alien requirements for ongoing MA, may be eligible for time-limited MA due to an emergency medical condition. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for time-limited emergency Medicaid coverage, if eligibility requirements are met. [Aliens with a visa designation of "T1" victims of human trafficking, qualify for time-limited emergency medical coverage.]

A. The alien must still meet the technical and financial requirements for Adult or Family MA, with the exception of enumeration to be eligible for time-limited emergency coverage. KCHIP3 (150% - 200% of the Federal Poverty Level) does not provide alien time-limited MA coverage.

B. Aliens applying for time-limited MA due to an emergency medical condition, are exempt from enumeration requirements.
   1. Enter the SSN if provided, but do not require the alien to apply for an SSN if there is none.
   2. If there is no SSN, KAMES will assign a pseudo number.

C. Time-limited MA coverage includes the first day of the month in which the emergency medical condition begins and continues through the following month. It is important to note that no service related to any transplant may be provided on an emergency basis.

D. An emergency medical condition is defined as a medical condition in which the absence of immediate medical treatment could result in:
   1. Placing the patient's health in serious jeopardy;
   2. Serious impairment to bodily functions; or
   3. Serious dysfunction of any bodily organ or part.

   The normal delivery of a baby is considered an emergency and a covered service. The MA eligibility only covers the month of delivery and the following month. The individual is not eligible for postpartum coverage.

   Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain information about the medical condition, the date of the emergency treatment, and indicate the medical provider considers the condition an emergency medical condition.

   If the statement is lacking information or the information is unclear, contact the medical provider for additional information or clarification. This contact may be done by telephone or letter.

The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.

E. Use procedures outlined in Volume IV or Volume IVA to determine program category, technical and financial eligibility.

MS 2085 EXTENSION OF TIME-LIMITED MA

[An extension of time-limited MA may be requested by a recipient if the emergency medical condition continues. The individual must file a new application and submit a new physician's statement verifying the emergency event is an on-going/continuing condition.

A. An extension of time-limited emergency medical coverage for a non-qualified alien is based on an approval by the Department for Medicaid Services (DMS). The extension request must be received by the Medical Support and Benefits Branch (MSBB) within 30 days of the end of the emergency Medicaid eligibility period. MSBB forwards the request to DMS.

   For aliens who request additional coverage 30 days beyond the expiration of the eligibility period, send form MA-105, Notice of Eligibility or Ineligibility, for denials of the extensions.

B. Obtain a new written statement from the medical provider verifying the emergency medical condition will exist for a period beyond the time-limited coverage. The new statement must contain detailed information of the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue.

C. Mail or fax a memorandum to Medical Support and Benefits Branch (MSBB):

   Division of Family Support
   Attn: Medical Support and Benefits Branch
   275 East Main Street, 3E I
   Frankfort, Kentucky 40621

   (502) 564-4021]

   The memorandum must contain the following information:

   1. Case name and number;
   2. Case member for whom the extension is requested;
   3. A statement of how long the emergency medical condition will continue; and
   4. Attach the medical provider's statement.

D. Retain a copy of the memorandum and the medical provider's statement in the case record.

E. [MSBB forwards the request to the Department for Medicaid Services (DMS) who approves or denies the extension. For approvals, DMS provides the effective dates of the extension.

F. After the DMS determination is made, MSBB notifies field staff of the decision.]

G. Upon receipt of an extension approval, update the case accordingly.

1. Enter the extension information on disposition screen PC14.
2. KAMES discontinues MA for the alien once the approved coverage expires.

End of Volume I