

# EDUCATION & TRAINING *Services Section*

GEORGIA DEPARTMENT OF HUMAN RESOURCES  
DIVISION OF FAMILY & CHILDREN SERVICES



## Food Stamp Phase III

For New Family Independence  
Workers

### Participant Guide

March 3, 2008



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## Objectives for Introduction



### **Participants will:**

- ❑ Meet other participants/trainers
- ❑ Discuss standards, expectations, and attendance policy for the training course
- ❑ Examine topics of discussion for Phase III
- ❑ Implement a strategy for decision making

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# Topics For Discussion Phase 3 New Worker Training

## Day 1

- Introduction
- Using Other Resources

## Day 2

- Using Other Resources
- Basic Interviewing Skills
- Identifying Red Flags

## Day 3

- Management
- OIS Referrals
- ABAWD Identification

## Day 4

- Periods of Eligibility
- Changes
- Shelter
- Skill Building

## Day 5

- Skill Building (continued)
- Childcare Communication
- Knowledge Assessment
- Closing Discussion/Activity



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## **EDUCATION AND TRAINING SERVICES SECTION**

### **OFFICE OF FAMILY INDEPENDENCE SOCIAL SERVICES**

#### **TRAINING PROGRAMS**

### **CLASSROOM STANDARDS, EXPECTATIONS AND ATTENDANCE POLICY**

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As professional employees with the Department of Human Resources (DHR), Division of Family and Children Services (DFCS), all participants in the Office of Family Independence (OFI) and Social Services training programs must abide by the DHR Standards of Conduct, which set forth acceptable and unacceptable conduct toward peers, supervisors, managers, and clients. Trainees are encouraged to review the DHR Standards of Conduct found at:

<http://www2.state.ga.us/departments/dhr/ohrmd/Policies/1201.pdf>

The standards and expectations for the professional behavior of trainees in the classroom are as follows:

When Division employees are in training, their conduct must reflect their commitment and service to DHR and DFCS. Time spent in the classroom and in field practice is a normal workday.

Trainers serve in a supervisory role in the classroom. Responding to the trainer in accordance with the DHR Standards of Conduct is standard operating procedure.

Trainees are expected to complete written tests that cover material presented in class.

Trainees are expected to behave in a respectful manner. Examples of behaviors that are unacceptable and will not be tolerated include the following:

- inattentiveness during classroom time as exhibited by holding side conversations, conducting personal business, reading outside material or sleeping;
- personal attacks, use of offensive language, argumentativeness, or excessive talking;
- use of the Internet for reasons other than classroom activity;
- eating or drinking while in the computer lab;
- use of cell phones, radios or beepers during class. All such devices must be turned off during class and replies to calls must be made during official breaks.

Engaging in these behaviors or in any behavior deemed disruptive or inappropriate by the trainer may result in an immediate conference with the trainer, notification to the trainee's immediate supervisor, administrator or director, or expulsion from class. The trainer will confer with the appropriate authority prior to expelling a trainee from class.

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In addition to adhering to the Classroom Standards and Expectations, the following attendance policies apply to all staff while engaged in any training:

Trainees are expected to arrive on time and adhere to the time allotted for breaks and lunch. If an emergency arises that warrants arriving late or leaving early, the trainee must address the emergency with the trainer in concert with approval from the supervisor.

Annual leave should not be requested and cannot be approved during training. Any exceptions must be discussed with the appropriate authority prior to training.

The only acceptable excuses for being absent from classroom training are the following:

Sick leave (e.g. emergency illness or medical appointments for acute illnesses). In the case of sick leave, trainees must notify their immediate supervisor in the county office as soon as possible to report their absence from classroom training.

OR

Court leave (e.g. subpoena to court, unexcused jury duty). In the case of court leave, trainees must obtain prior approval from their immediate supervisor in the county office as soon as possible in order to be absent from classroom training.

The county supervisor or administrator is the only employee who can approve a trainee's leave request. For Centralized Hire trainees, the administrative supervisor is the only employee authorized to approve a trainee's leave request. The trainer/facilitator **will NOT** approve any leave.

The county supervisor must notify the appropriate authority as soon as possible that a trainee will be absent from class due to sick or court leave.

The appropriate authority will notify the trainer of the absence.

Trainees absent from class due to approved sick or court leave may be required to make up all or part of the course depending on the length of the absence and the length of the course. This may affect time frames for their completion of training. The appropriate authority will determine with the trainer whether a trainee will continue a course, after consultation with the trainee's supervisor.

For the purposes of determining expulsion from a class, notification regarding leave, or continuation in a class, the appropriate contact via an e-mail is:

- For attendance at any Office of Financial Independence training e-mail: [OFItraining@dhr.state.ga.us](mailto:OFItraining@dhr.state.ga.us)
- For attendance at any Social Services training e-mail: [SStraining@dhr.state.ga.us](mailto:SStraining@dhr.state.ga.us)

I \_\_\_\_\_ have read and understand the Classroom Standards, Expectations and Attendance Policy for OFI and Social Services training programs.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Objectives for Other Resources



### **Participants will:**

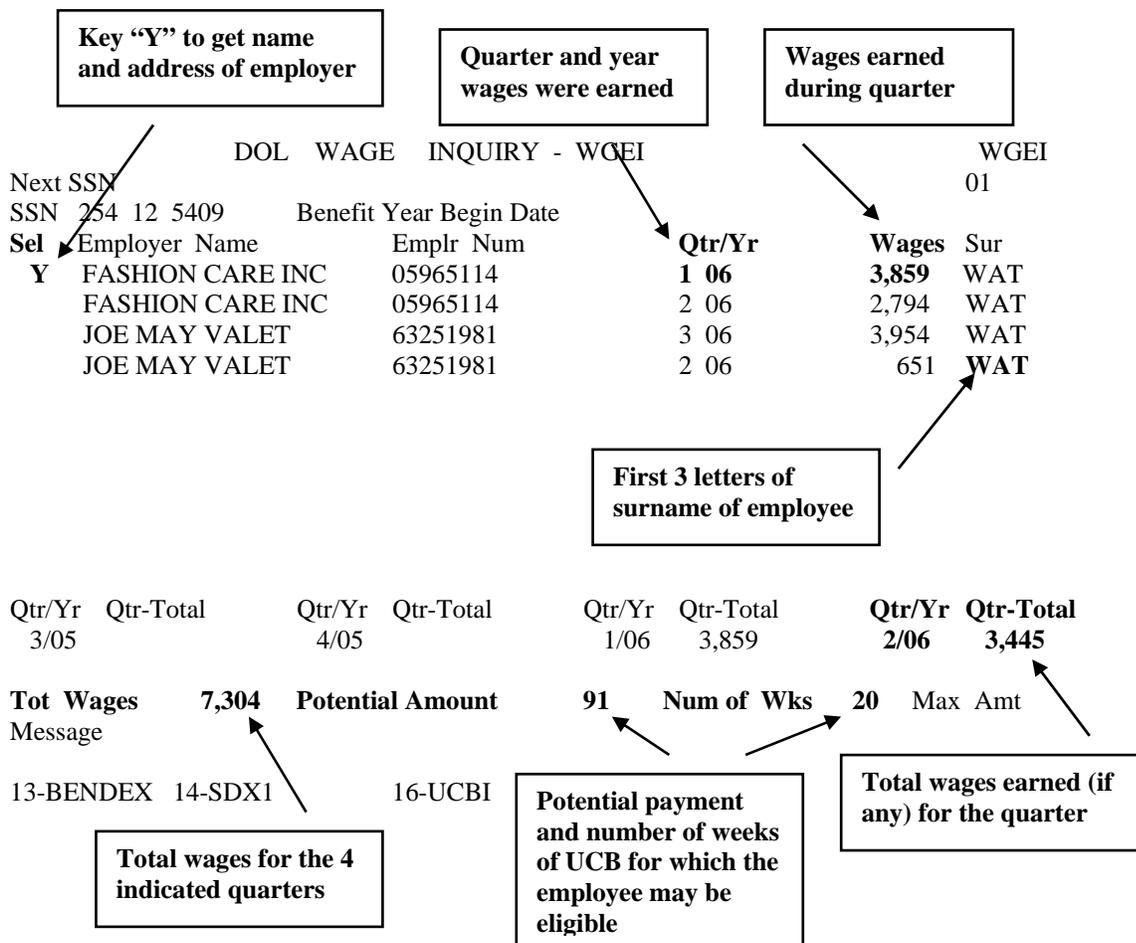
- Examine DOL, BENDEX and SDX screens
- Review the policy regarding excess medical deductions
- Demonstrate the ability to correctly enter medical deduction information into SUCCESS computer system
- Discuss Workers' Compensation payments
- Explore Section 8 and subsidized housing situations



## ***Using Other Resources***

*There are a variety of other resources that provide valuable information to the case manager. Some of these resources, such as the interfaces available through Clearinghouse, are readily available, but require some explanation. Others are benefits such as Workers' Compensation and Section 8/HUD Housing that can provide valuable information to the case manager if you know what to look for. In the rest of this section you will learn how to retrieve this information.*

## CLEARINGHOUSE - DOL WAGES



**DOL shows wages for quarters. The most current wages will be from the previous quarter.** For example, in December, the most recent quarter available on Clearinghouse would be the 3<sup>rd</sup> quarter (July, August, September).

When you have an A/R who has lost their job, look for potential eligibility for UCB.

**Compare the surname on DOL with the A/R's surname for discrepancies.** The discrepancy can be for several different reasons. An incorrect SSN could have been entered by DOL or the employer. Or the A/R is using another name. This could be because of a recent marriage or divorce or because the A/R is working under another name. These discrepancies need to be resolved!

## DOL WAGES – EXAMPLE

DOL WAGE INQUIRY - WGEI				WGEI	
Next SSN					01
SSN	255 22 4500	Benefit Year Begin Date			
Sel	Employer Name	Emplr Num	Qtr/Yr	Wages	Sur
	<b>BEVERLY HEALTH INC</b>	<b>05965114</b>	<b>1 06</b>	<b>3,859</b>	<b>SMI</b>
	<b>BEVERLY HEALTH INC</b>	<b>05965114</b>	<b>2 06</b>	<b>2,794</b>	<b>SMI</b>
	KAISER INC	63251981	3 06	3,954	SMI
	<b>KAISER INC</b>	<b>63251981</b>	<b>2 06</b>	<b>651</b>	<b>SMI</b>
	<b>CALDWELL TEMP</b>	<b>71298451</b>	<b>2 06</b>	<b>427</b>	<b>SMI</b>

Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
3/05		4/05		1/06	3,859	2/06	3,872

Tot Wages	7,731	Potential Amount	91	Num of Wks	20	Max Amt
Message						

13-BENDEX 14-SDX1 16-UCBI

This A/R has wages from three different employers and wages from all of them in the second quarter of 2006. What are some of the possible reasons for this A/R's work history in the second quarter of 2006?

## DOL WAGES – Exercise

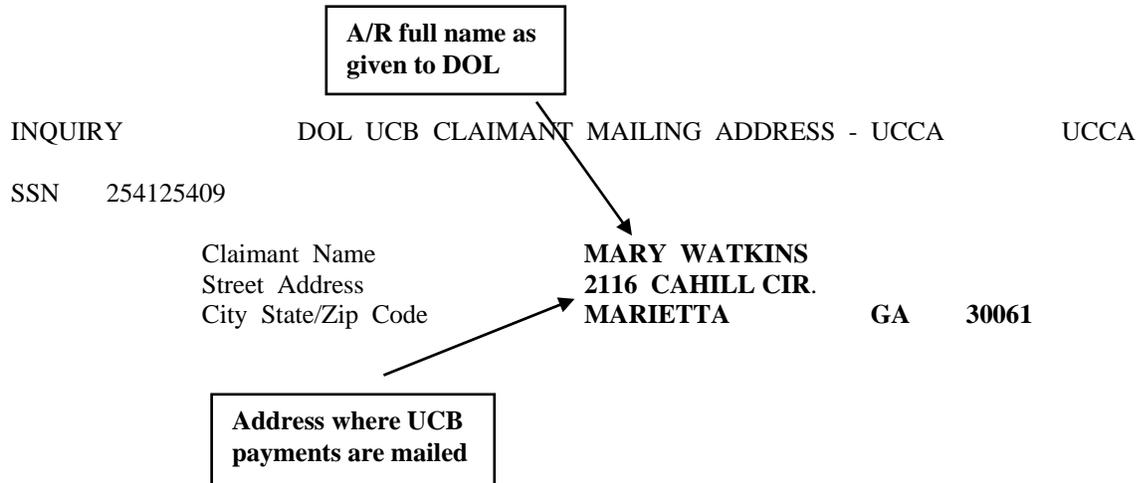
DOL WAGE INQUIRY - WGEI				WGEI	
Next SSN				01	
SSN	255 01 4112	Benefit Year Begin Date			
Sel	Employer Name	Emplr Num	Qtr/Yr	Wages	Sur
	HOPKINS CORP	05748116	4 05	1,987	JON
	PRUDENTIAL	05561111	3 05	2,501	JON
	PRUDENTIAL	05561111	2 05	4,901	JON
	FAST TEMP	71298451	1 06	984	KIN
Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
2/05	4,901	3/05	2,501	4/05	1,987
Tot Wages		10,373	Potential Amount	116	Num of Wks
Message				24	Max Amt
13-BENDEX		14-SDX1	16-UCBI		

**You are looking at this DOL screen on 5/2/06 for your A/R, Pamela Jones. Answer the following questions:**

1. On 5/2/06, what is the latest qtr. that would be available on DOL?
2. Approximately when did Ms. Jones work for Prudential?
3. Is Ms. Jones still employed by Prudential?
4. What are her total earnings from Fast Temp?
5. Is Ms. Jones potentially eligible for Unemployment? How much? How many weeks?
6. Are there any discrepancies in the DOL information?



## CLEARINGHOUSE – UCB ADDRESS



*Always resolve discrepancies between the address and name reported to you and the address and name reported to UCB.*

***The UCB address is where the UCB check is sent.*** Along with this check is a stub that must be completed by the recipient verifying their job search to DOL. If the recipient does not return this completed stub, he will not continue to receive UCB. So it is extremely rare for a recipient not to give their actual address to UCB.

***The mailing address does not come up automatically.*** You have to select it on the previous UCB screen. Always look at the mailing address if the A/R is receiving or recently received or applied for UCB.

*If you have a discrepancy between the address reported to you and the UCB address, then you have a **questionable situation!***

## UCB – Exercise

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INQUIRY      DOL      UNEMPLOMENT INSURANCE PAYMENT HISTORY - UCBI
                                01  04  06                                01
Next SSN                                           Mailing Address (UCCA) Y
SSN 258 12 4498  Month/Yr      01/06 and 13 Months Prior
SUR ROL  Ben Yr Begin 02/01/05 WBA 160 MBA 3040 Weeks Dur 19 Clm VALID
      Monthly Totals           Totals for last 10 weeks           EUC Eff Date
Month/Year  Paid  # of Checks  Check Date           Amount Paid
12/05      725   5           12/27/05             145
11/05      580   4           12/20/05             145
10/05
09/05
08/05      580   4           12/13/05             145
07/05      290   2           12/07/05             145
06/05      290   2           12/01/05             145
05/05
04/05
03/05      580   4           11/24/05             145
02/05      290   2           11/18/05             145
01/05
12/04
  
```

Message

13 – BNDX      14 – SDXI      15 – WGEI

**You are looking at this UCB screen on 1/4/06 for your A/R, Stephanie Rollins.  
Answer the following questions:**

1.      When did the benefit year for this UCB claim begin?
  
2.      When will the benefit year for this claim end?
  
3.      How much is the WBA?
  
4.      How much is the MBA?
  
5.      How much is the actual UCB payment?

6. Why isn't the A/R receiving the WBA?
7. When did the A/R receive her first check?
8. When did the A/R receive her last check?
9. What happened April through October?









## SOCIAL SECURITY (RSDI) AND SSI

**Social Security (RSDI) and SSI (Supplemental Security Income)** are two very distinct programs, both of which are administered by the Social Security Administration (SSA). It is very important to understand the differences between the two programs.

### RSDI

RSDI stands for **R**etirement, **S**urvivors, **D**isability Insurance. Each of these words explains what Social Security (RSDI) is.

- ✓ **Retirement** – an individual can receive retirement payments from Social Security starting at age 62. In addition, the spouse and dependent children of this person can also receive benefits through the retired person's account.
- ✓ **Survivors** – the spouse and dependent children of a deceased individual may receive SS benefits through the deceased person's account.
- ✓ **Disability** – an individual can receive disability payments at any age. In addition, the spouse and dependent children of the disabled person can also receive SS benefits through the disabled person's account.

The amount of the RSDI payment is determined by the contributions that were made to their account while employed. If the contributions do not produce a specified minimum amount (which changes annually), then the person can receive either a combination of RSDI and SSI payments, or SSI alone.

### SSI

SSI stands for Supplemental Security Income. A disabled individual of any age (and a person who is 65 or older is defined as disabled) may be eligible for SSI if they are not eligible for RSDI because they have not paid enough contributions into their RSDI account. SSI benefits are paid only to an individual.

### Important Facts

When a person applies for RSDI disability, he also applies for SSI. When a person is approved for RSDI disability, he is almost always approved for SSI first because processing for SSI is faster and after two or three months of SSI eligibility he then starts receiving RSDI. This means that almost everyone approved for Disability receives SSI for at least a few months.

**A person approved for benefits by the SSA may receive them in one of three ways:**

- ✓ **receive RSDI only**
- ✓ **receive SSI only**
- ✓ **receive a combination of RSDI/SSI**

## ***SOCIAL SECURITY CLAIM SUFFIXES\**** ***(Or BICs - Benefit Identifying Codes)***

(Person's own #)	DI	=	Supplemental Security Income (SSI)
(Person's own #)	A	=	Wage earner (person paid in - is retirement)
(Spouse's #)	B	=	Spouse benefit - living wage earner
(Parent's #)	C	=	Child benefit (parent is dead or disabled - stops at age 18)
(Deceased person's #)	D	=	Widow/widower
(Deceased person's #)	E	=	Benefit for young widow with minor child (stops when youngest child turns 16)
(Child's #)	F	=	Parent's benefit - drawing on child's account
(Person's own #)	HA	=	Disability
(Person's own #)	J or K	=	Special age benefit (very few living)
(Person's own #)	T	=	Entitlement to hospital benefit (not enough quarters to draw a check - Medicare B only)
(Deceased person's #)	W	=	Widow under 60 who is disabled

\*When a number follows the letter, more than one person is drawing on this claim number. Youngest is lowest number.



## SOCIAL SECURITY – BENDEX INQUIRY

<p>INQUIRY NEXT SSN Claimant Name JOHN County 050 <b>SSA Claim Number 256 21 4987 A</b> Agency Code 110 State Control Data <b>Mo. Benefit Payable 150.00</b> <b>Gross Amount Payable 150.30</b> Net Monthly Amount 150.00 Black Lung Acct. No. 00000000 BL Entit/Term Date 00 00 BL Status BL Payment Amount 0.00 RR Claim No RR Status <b>SMI Option Code Y</b> <b>SMI Premium Amt 93.50</b> <b>SMI Premium Payer 110</b> SMI 3<sup>rd</sup> Party DT Entit/Term 00 00 Dual Entit SSN 000 00 000</p> <p>Message 0020 INQUIRY COMPLETED SUCCESSFULLY 14 – sdx 15 – wgei 16 – ucbi</p>	<p style="text-align: center;">BENDEX INQUIRY – BNDX</p> <p style="text-align: right;">BNDX 01 SEX M DOB 06 21 35</p> <p><b>Beneficiary's own SSN 256 21 4987</b> <b>Claimant SSN 256 21 4987</b> Category of Assistance A Old BIC Payment Status CP Date of Initial Entitlement 07 93 Date of Current Entitlement 07 93 Communication Code MAT Prev Gross Amt 150.30 Date 11 97 <b>SSI Entit/Term Dt 06 93 Status E</b> <b>Monthly Overpymt Deducted 0.00</b> End Date Overpayment 00.00 H.I. Option Code E Amt 0.00 H.I. Date Entit/Term 06 96</p> <p>Disab Onset 00 00 Trip Entit SSN 000 00 0000</p> <p style="text-align: right;"><b>Direct Dep C</b></p>
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This is an example of a typical BENDEX screen. It contains some information that is self-explanatory, some information that is not useful and some information that is relevant. Following is an explanation of what the codes for the most useful information mean.

**1 SSA Claim Number** – This is the claim number that was entered in SUCCESS, but if the number doesn't match the info in the SSA files, then the number from SSA is entered.

**2 Beneficiary's own SSN** - This is the SSN for the A/R. What we call Social Security is officially named RSDI which stands for **R**etirement, **S**urvivors, **D**isability Insurance. An individual can receive SS because he is retired or disabled. In addition, his spouse and children can also receive benefits through his account if he is retired, disabled or deceased.

**3 Claimant SSN** – If a child or spouse is receiving SS benefits through a parent's or spouse's account; this is the SSN of that person.

**4 Mo. Benefit Payable** – This is the net amount of the SS payment. If the A/R ever received SS, there will be an amount here.

**5 Gross Amount Payable** – This is the gross monthly SS payment due before any deductions for Medicare. This is the SS payment (including the cents) that you budget in your case unless an overpayment is being deducted from the SS. However, if the overpayment was due to fraud, then you would count the gross payment. Note that the gross amount usually includes cents. This payment, including the cents should be budgeted in the case.

**6 SSI Entit/Term Dt and Status** – The SSI entitlement/termination date indicates either the first month of SSI or the month after the last month of an SSI payment if SSI has been terminated. The status indicates whether the SSI is active or terminated. The codes A, E, and M indicate an SSI payment. D indicates denial. Codes T through Z indicate termination of SSI.

**7 Monthly Overpymt Deducted** – This indicates an overpayment withheld from the SS check. Remember that if the overpayment is the result of fraud, then you would count the gross amount payable.

**8 SMI Option Code** - This code indicates Medicare eligibility status. Codes G and Y show eligibility. Any other letters show ineligibility for Medicare.

**9 SMI Premium Amount** – This indicates the amount of the Medicare premium deducted from the SS check. In your budgeting, this is not deducted from the SS check. But remember that if the A/R is responsible for the Medicare payment, then this premium is budgeted as a medical deduction in FS.

**10 SMI Premium Payer** - This indicates who is responsible for paying the Medicare premium. If the A/R receives SSI or a low SS check, then the state may pay this premium for the A/R. This is indicated by the code 110. If the A/R does not pay this premium, then a medical deduction is not allowed for it. If the A/R is responsible for the premium, then the code should be “self”.

**11 Direct Dep** – This indicates whether there is direct deposit of the SS payment and the type of bank account that the check is deposited into. The code is C for checking and S for savings.

## ***BENDEX INQUIRY – Exercise***

INQUIRY	BENDEX INQUIRY – BNDX		BNDX
NEXT SSN			01
Claimant Name	SAMUEL	JOHNSON	DOB 07 21 32    SEX M
County	050		Beneficiary's own SSN    254 31 7952
SSA Claim Number	254 31 7952 A		Claimant SSN    254 31 7952
Agency Code	110		Category of Assistance    A
State Control Data			Old BIC    Payment Status CP
Mo. Benefit Payable	746.00		Date of Initial Entitlement    07 93
Gross Amount Payable	839.50		Date of Current Entitlement    07 93
Net Monthly Amount	839.00		Communication Code    MAT
Black Lung Acct. No.	00000000		Prev Gross Amt 839.50    Date    11 00
BL Entit/Term Date	00 00	BL Status	SSI Entit/Term Dt 06 96    Status E
BL Payment Amount	0.00		Monthly Overpymt Deducted    0.00
RR Claim No		RR Status	End Date Overpayment    00.00
SMI Option Code	Y	Date Entitled 06 96	H.I. Option Code E    Amt    0.00
SMI Premium Amt	93.50	Date Term 00 00	H.I. Date Entit/Term    06 96
SMI Premium Payer	SELF		
SMI 3 <sup>rd</sup> Party DT Entit/Term		00 00	Disab Onset 00 00    Direct Dep S
Dual Entit SSN	000 00 000		Trip Entit SSN    000 00 0000

Message

0020 INQUIRY COMPLETED SUCCESSFULLY  
14 – sdx    15 – wgei    16 - ucbi

**You are looking at the BENDEX screen for Samuel Johnson. Answer the following questions:**

1. Are Mr. Johnson's Social Security number and claim number different?
2. How much is his "monthly benefit payable"?
3. How much is his "gross amount payable"?
4. Is the A/R eligible for Medicare?
5. How much is the Medicare premium?
6. Who pays the Medicare premium?
7. What is the amount of Social Security that you would budget in the FS case?

## SSI – SDX1 INQUIRY

INQUIRY STATE DATA EXCHANGE - SDX1										SDX1 01
NEXT SSN										
Client Name	JOHN NGUYEN				Client ID					
DOB	05 19 1950	Race	W	Individual SSN		152 21 0698				
Date of Death		Mrtl	3	Alien Code	N	Es. Ind	0	--SDX Transaction--		Multiple SSN
Appl Date	02 09 88	Denial Date		Denial Code		Appeal Date		Appeal Code	08	Onset Disab/ Blindness
									11 23 04	SSI Elig Date
									02 09 88	Medic Test
Chg Dt	02 88	Pay Stat	C01	Fed Liv	A	State/Cnty	11530	FS Appl	N	FS Stat
								FS Input Date	03 88	TPL Cd
										Medic Eff Dt
										02 09 88
Adv Pay	2	Bdgt Mo.		SSI/GPA	328.00	Mthly Asst	262.00	----- STATE SUPPLEMENT -----		
								Amt Pd	Elig Pd	Grant
----- OVERPAYMENT -----						----- RESOURCES -----				
Ind	Balance	Waiver Amt		Waiver Date		House	MV	Lfe	Ins	Prop
						Z	B	Z		Z
Message										

The State Data Exchange Screens (SDX) contain information about the Supplemental Security Income (SSI) benefit amounts. There are three SDX screens for SSI. This is a typical example of the first screen (SDX1) of SDX. The screen contains some information that is self-explanatory, some information that is not useful and some information that is relevant. Below is an explanation of what the codes for the most useful information mean.

- 1 **Mrtl Sts** – This indicates the marital status of the SSI recipient. The codes are: 1 (married and living together), 3 (single, widowed or divorced) and 4 (married, but separated).
- 2 **Appl Date** – This indicates the application date for SSI.
- 3 **Denial Date and Appeal Date** - The denial date indicates when an SSI application has been denied. The appeal date indicates when the denial was appealed.
- 4 **SSI Elig Date** – This indicates the begin date of SSI eligibility.
- 5 **Chg Dt** – The change date indicates the latest change or update to the SSI.

**6 Pay Stat** - The payment status indicates whether the recipient is currently receiving SSI. This is coded in a letter and two number format (for example, T22). But since there are dozens of these codes, you can use just the letter prefix to determine the payment status. The letter codes are:

**C** – the A/R is currently receiving SSI; usually this is coded as C01

**H** – the case is in “hold” status while an action is pending

**N** – this means “non-pay” and indicates that the A/R is not receiving SSI

**S** – this means “suspense” and indicates that the A/R may be eligible for SSI, but the check is currently being withheld

**T** – this means that the SSI check has been terminated

**7 Fed Liv** – The “federal living arrangement” for the A/R in the budget month. The codes are A (own household), B (another’s household), C (parent’s household) and D (an institution).

**8 SSI/GPA** – This indicates the SSI gross payable amount. This is the gross amount that the A/R is entitled to receive before any overpayments are withheld. Budget the gross payment.

**9 Mthly Asst** – The monthly assistance is the actual amount of the SSI payment. If this payment is less than the SSI/GPA, then an overpayment is being withheld. The monthly assistance payment is budgeted unless the overpayment was the result of fraud. **Effective October 1, 2002 the monthly assistance payment amount should always be used in the budget.**

**10 Overpayment** – This concerns SSI overpayments. The codes for the Ind (indicator) are O (overpayment), U (underpayment) and B (both over and underpayment). The balance shows the current amount of the overpayment. The waiver indicates the amount of the overpayment that has been waived from repayment.

**11 Resources** – This concerns the resources of the A/R. The codes for house are A (owns residence) and Z (does not own home). The codes for MV, motor vehicles, are B (owns vehicle) and Z (no vehicle).

## SSI – SDX2 INQUIRY

INQUIRY	[1]	STATE DATA EXCHANGE – SDX2	SDX2
Client Name	JOHN	NGUYEN	Client ID 01
DOB	05 19 1950		Individual SSN 152 21 0698
EI Net Amt	<b>UI Net Amt</b>	Deemed Inc Amt	<b>SSI/GPA</b> <b>Mthly Asst</b>
	<b>250.00</b>		<b>328.00</b> <b>262.00</b>
----- EARNED INCOME INFORMATION -----			
Period	Wage Est	Self-em. Est	Blind      PASS
----- UNEARNED INCOME INFORMATION -----			
Type	Recip Amt	Start Dt	Stop Dt      Claim Num      Freq Cd
A	270.00	01 06	152409860 8      C
A	264.00	01 05	152409860 8      T
S	40.00	01 05	CASH FR SON      N
[3]	[4]	[5]	[6]      [7]      [8]

Message

[1] **UI Net Amt** – This indicates the unearned income budgeted for SSI after deductions. This income is used by SS to determine the SSI payment. This field and the **EI Net Amt** and **Deemed Inc Amt** fields are important because they show you income that the A/R has reported to SS.

[2] **SSI/GPA** and **Mthly Asst** – These fields are a duplication of the same fields on SDX1.

**Unearned Income Information** – The SDX2 screen contains useful information about other income that the A/R may have. This information should be compared to what has been reported to you. Note that the screen also indicates information about earned income, but in the vast majority of cases, the other income is unearned, which is why we will concentrate on that.

**3** **Type** - This indicates the type of unearned income. The codes for the most common types of unearned income are:

**A** – Social Security (RSDI)

**C, E** – Both of these codes are for VA (Veteran’s Administration) income

**H** – In-kind Income. This refers to the support provided by someone that the A/R lives with. This is a monetary valuation that SS assigns to the assistance (usually the providing of housing) that the A/R receives. It is not actually income and would not be budgeted in FS. However, it usually indicates that there is another HH member.

**N** – Child Support

**Q** – Workers’ Compensation

**S** - Other. This indicates income for which a code doesn’t exist. It is usually explained under **Claim Number**. Note that in our example, this other income is documented as **Cash Fr(om) Son**.

**4** **Recip. Amt** – The monthly amount of unearned income received. SS applies a \$20 exclusion to this income to produce the **UI Net Income**.

**5** **Start Date** – This indicates the date the income started.

**6** **Stop Date** – This indicates the last month that the income was received. Note that in our example, there are two Social Security payments (code **A**). The first one has no stop date, which indicates that it is ongoing. The second one has both a start and stop date, which indicates the period of time that this amount of Social Security was received. Since Social Security is increased every year, this will be seen very frequently. Note also that the start and stop date for the cash is the same month. This indicates that it was one-time only income.

**7** **Claim Num** – This indicates either the claim number through which the income is received or documentation of what the income is. Note that in our example, the SS claim number is different from the A/R’s. Note also the documentation of the contribution.

**8** **Freq Cd** – The frequency code indicates how often the income is received. The codes for frequency are:

**C** – This indicates a continuous monthly payment. This is income that is currently being received.

**N** – This indicates that the income was one-time only.

**T** – This indicates terminated income. This, along with the stop date, shows you the last month that the income was received.



## SDX INQUIRY – Exercise

```

INQUIRY                STATE DATA EXCHANGE - SDX1                SDX1
NEXT SSN                01
Client Name EDITH      AYERS                Client ID
      DOB 10 19 1998      Race B                Individual SSN 289 21 5627
Date of      Mrtl Alien Es. Pers. --SDX Transaction--      Multiple
Death      Sex Sts Code Ind      Code      Date      SSN
      F 3 N 0      08      11 23 04      0
      Appl Denial Denial Appeal Appeal Onset Disab/ SSI Elig Mediced
      Date Date Code Date Code Blindness Date Date Test
02 09 99                02 09 99      02 09 99
Chg Dt Pay Stat Fed Liv State/Cnty      FS FS FS Input TPL Mediced
02 99 C01 C 11530      Appl Stat Date Cd Eff Dt
      N N 02 99      N 02 09 99

      ---- STATE SUPPLEMENT ----
      Amt Pd Elig Pd Grant
Adv Pay Bdgt Mo. SSI/GPA Mthly Asst
      2 512.00 512.00
----- OVERPAYMENT -----
Ind Balance Waiver Amt Waiver Date
House MV Lfe Ins Prop
      Z Z Z Z
  
```

Message

**This is the SDX1 screen for Edith Ayers. Answer the following questions:**

1. What is the A/R's birth date?
2. When did the A/R apply for SSI?
3. What is the begin date of SSI eligibility for the A/R?
4. What is the payment status for the A/R?
5. What is the "federal living arrangement" for the A/R?
6. What amount would you budget in the FS case?

## **SDX2 INQUIRY – Exercise**

```

INQUIRY                STATE DATA EXCHANGE – SDX2                SDX2
                        01
Client Name DENNIS      BERGKAMPF                Client ID
      DOB 05 21 1949                Individual SSN 255 21 9598

EI Net Amt  UI Net Amt  Deemed Inc Amt  SSI/GPA  Mthly Asst
      440.00                52.00                52.00
----- EARNED INCOME INFORMATION -----
Period      Wage Est      Self-em. Est      Blind      PASS

----- UNEARNED INCOME INFORMATION -----
      Type      Recip Amt      Start Dt      Stop Dt      Claim Num      Freq Cd
      A          460.00          01 06          255219598 8      C
      A          449.00          01 05          12 05          255219598 8      T
      H           50.00          01 05          01 05          255219598 8      N
    
```

**You are looking at the SDX2 screen for Dennis Bergkampf. Answer the following questions:**

1. Is there any earned income currently budgeted in the SSI case?
2. Is there any unearned income currently budgeted in the SSI case?
3. What type of unearned income is currently budgeted in the SSI case?
4. What is the amount of the unearned income that the A/R currently receives?
5. What other type of unearned income has the recipient received?
6. When was the other type of income received?

## ***SDX3 INQUIRY – Exercise***

INQUIRY	STATE DATA EXCHANGE - SDX3	SDX3
		01
Client Name JANE	F CAMPION	Client ID
DOB 04 02 1996		Individual SSN 256 68 1794
Payee Name and Address		Residence Address
MARY CAMPION FOR		1562 CAMPBELLTON ROAD
JANE CAMPION		ATLANTA GA
1562 CAMPBELLTON ROAD		30331-6958
ATLANTA GA		
30331-6958		

### Message

PF13 BNDX      PF15 WGE1      PF16 UCBI

**This is an SDX screen for Jane Campion. Answer the following questions:**

1. What is the birth date for the A/R?
2. Is there a payee for the A/R?
3. Are the payee and residential addresses the same?

# MEDICAID AND MEDICARE

## Medicaid

A recipient of SSI, no matter how small the SSI payment may be, is almost always eligible for Medicaid. There is no premium payment for Medicaid coverage. Medicaid usually pays all medical expenses.

Some RSDI recipients are also eligible for Medicaid. There are various Medicaid programs for which RSDI recipients with low RSDI payments or high medical bills may be eligible.



## Medicare



All RSDI recipients who receive RSDI retirement are covered by Medicare. But if the recipient receives RSDI disability, he must usually wait two years for Medicare coverage. Dependents (children and spouses) who receive RSDI are not eligible for Medicare except for a spouse 65 or older.

Medicare usually does not pay all medical expenses. Normally the A/R has a Medicare premium, deductibles, a portion of bills and prescriptions that he is responsible for paying. **Currently (2007) the Medicare Part B premium is \$93.50 per month. The A/R may also have Medicare Part D for prescription drugs.**

## FS MEDICAL DEDUCTIONS

AUs that have members who are age 60 or older or who meets the FS definition of disabled, are eligible for an excess medical deduction if the non-reimbursable portion of their medical bills exceeds \$35 per month. Recall that “disabled” is defined as the recipient of certain specified benefits that include RSDI and SSI. When you have an A/R who receives RSDI and/or SSI, then you should be careful to explore eligibility for an excess medical deduction.

### Why This Is Important

Medical deductions are important for the obvious reason that this is part of policy.

Beyond that, however, we should remember that the people who are eligible for an excess medical deduction are the elderly and disabled. When they are eligible for FS, it is because they have fixed income, low income and sometimes, no income. These are some of the most vulnerable people in our society. Food Stamps are often a vital supplement to their low income.

This is especially true when they have medical expenses. If a person is eligible for an excess medical expense, then we need to allow them all of the deductions they are eligible to receive. It can make a major difference in the amount of Food Stamps that they can receive. We do not want to be responsible for someone making a decision between food and medicine because we have not done our job.

### SSI Recipients

SSI recipients are always eligible for Medicaid. Medicaid usually pays all medical expenses, but the SSI recipient may have some medical expenses that Medicaid doesn't pay. Because an SSI recipient is potentially eligible for an excess medical deduction, always ask if the SSI recipient has any medical expenses for which they are responsible for paying.

### Social Security Recipients

For FS budgeting, it is absolutely essential to determine if the RSDI recipient:

- ✓ is eligible for Medicare
- ✓ is responsible for paying the Medicare premium

**If an RSDI recipient is eligible for Medicare and pays the Medicare premium, then the A/R is eligible for an excess medical deduction.** The Medicare premium is currently \$93.50 (effective 1/07), which means that the A/R already has a \$58.50 excess medical deduction that must be budgeted in the FS case.

The information about the Medicare deduction is available to you via the BENDEX screens. The following examples of BENDEX screens will show you what to look for.

## MEDICARE – BENDEX INQUIRY A/R Pays Medicare Premium

The Gross Amount Payable is the SS payment before the Medicaid premium is deducted. *If there are no overpayments, this is budgeted in the FS case.* The Mo. Benefit Payable is the SS payment after the Medicare deduction.

<p>INQUIRY NEXT SSN Claimant Name SALLY P County 113 SSA Claim Number 256 21 4092 A Agency Code 110 State Control Data <b>Mo. Benefit Payable 541.00</b> <b>Gross Amount Payable 634.50</b> Net Monthly Amount 634.50 Black Lung Acct. No. 00000000 BL Entit/Term Date 00 00 BL Status BL Payment Amount 0.00 RR Claim No RR Status <b>SMI Option Code Y</b> <b>SMI Premium Amt 93.50</b> <b>SMI Premium Payer SELF</b> SMI 3<sup>rd</sup> Party DT Entit/Term Dual Entit SSN 000 00 000</p>	<p style="text-align: right;">BNDX 01</p> <p>DOB 06 21 52 SEX F Beneficiary's own SSN 256 21 4092 Claimant SSN 256 21 4092 Category of Assistance A Old BIC Payment Status C Date of Initial Entitlement 07 93 Date of Current Entitlement 07 93 Communication Code MAT Prev Gross Amt 621.50 Date 11 05 SSI Entit/Term Dt 06 93 Status E Monthly Overpymt Deducted 0.00 End Date Overpayment 00.00 H.I. Option Code E Amt 0.00 H.I. Date Entit/Term 06 93  Disab Onset 44 63 Direct Dep C Trip Entit SSN 000 00 0000</p>
--	---

Message

002

The SMI option code indicates whether the A/R is covered by Medicare; "Y" and "G" mean yes. The SMI premium amount indicates the amount of the Medicare premium. The SMI premium payer indicates who is responsible for paying the premium. "Self" means that the A/R pays and so is eligible for a medical deduction in FS.

## MEDICARE – BENDEX INQUIRY A/R Is Not Covered By Medicare

<p>INQUIRY NEXT SSN Claimant Name JOSEPH P AYERS County 050 SSA Claim Number 254 22 9487 A Agency Code 110 State Control Data <b>Mo. Benefit Payable 718.00</b> <b>Gross Amount Payable 718.30</b> Net Monthly Amount 718.00 Black Lung Acct. No. 00000000 BL Entit/Term Date 00 00 BL Status BL Payment Amount 0.00 RR Claim No RR <b>SMI Option Code N</b> SMI Premium Amt 00 00 SMI Premium Payer SMI 3<sup>rd</sup> Party DT Entit/Term 00 00 Dual Entit SSN 000 00</p>	<p style="text-align: right;">BNDX 01 SEX M Beneficiary's own SSN 254 22 9487 Claimant SSN 254 22 9487 Category of Assistance A Old BIC Payment Status CP Date of Initial Entitlement 07 98 Date of Current Entitlement 07 98 Communication Code MAT Prev Gross Amt 706.30 Date 11 05 SSI Entit/Term Dt Status E Monthly Overpymt Deducted 0.00 End Date Overpayment 00.00 H.I. Option Code E Amt 0.00 H.I. Date Entit/Term Disab Onset 00 00 Direct Dep Trip Entit SSN 000 00 0000</p>
---	---

**Note that the only difference in the two amounts is the result of rounding. Medicare is not being deducted.**

**The SMI option code is "N" which indicates that the A/R is not covered by Medicare. Note that premium amount and payer are blank. The A/R is not entitled to a deduction for a Medicare premium.**

Message  
20 INQUIRY COMPL  
14 – sdx 15 – wgei

## **MEDICARE – BENDEX INQUIRY**

### **A/R Does Not Pay Medicare Premium**

<p>INQUIRY NEXT SSN Claimant Name JOAN N C ROLL County 050 SSA Claim Number 256 21 4561 A Agency Code 110 State Control Data <b>Mo. Benefit Payable 397.00</b> <b>Gross Amount Payable 397.00</b> Net Monthly Amount 397.00 Black Lung Acct. No. 00000000 BL Entit/Term Date 00 00 BL Status BL Payment Amount 0.00 RR Claim No RR Stat <b>SMI Option Code Y</b> <b>SMI Premium Amt 93.50</b> <b>SMI Premium Payer 110</b> SMI 3<sup>rd</sup> Party DT Entit/Term Dual Entit SSN 000 00 000</p> <p>Message 0020 INQUIRY COMPL 14 – sdx 15 – wgei</p>	<p style="text-align: right;">BNDX 01 DOB 10 21 29 SEX F Beneficiary's own SSN 256 21 4561 Claimant SSN 256 21 4561 Category of Assistance A Old BIC Payment Status CP Date of Initial Entitlement 07 90 Date of Current Entitlement 07 90 Communication Code MAT Prev Gross Amt 397.00 Date 11 05 SSI Entit/Term Dt 06 93 Status E Monthly Overpymt Deducted 0.00 End Date Overpayment 00.00 H.I. Option Code E Amt 0.00 H.I. Date Entit/Term 06 93 Disab Onset 00 00 Direct Dep Trip Entit SSN 000 00 0000</p>
--	--

**Note that there is no difference between the two amounts. Medicare is not being deducted.**

**The A/R has Medicare coverage. The code for the Premium Payer is "110". 110 is the code that indicates the state is paying the premium. The A/R is not eligible for a medical deduction for the Medicare premium because the premium is being paid for the A/R.**

## BENDEX INQUIRY – Exercise

INQUIRY	BENDEX INQUIRY - BNDX	BNDX
NEXT SSN		01
Claimant Name PENELOPE	M BENTON	DOB 10 10 35 SEX F
County 114		Beneficiary's own SSN 252 43 9434
SSA Claim Number 252 43 9434 A		Claimant SSN 252 43 9434
Agency Code 110		Category of Assistance C
State Control Data		Old BIC Payment Status CP
Mo. Benefit Payable 521.00		Date of Initial Entitlement 05 95
Gross Amount Payable 614.50		Date of Current Entitlement 05 95
Net Monthly Amount 614.50		Communication Code MAT
Black Lung Acct. No. 00000000		Prev Gross Amt 603.50 Date 11 05
BL Entit/Term Date 00 00 BL Status		SSI Entit/Term Dt 00 00 Status
BL Payment Amount 0.00		Monthly Overpymt Deducted 0.00
RR Claim No RR Status		End Date Overpayment 00 00
SMI Option Code Y Date Entitled 05 95		H.I. Option Code E Amt 0.00
SMI Premium Amt 93.50 Date Term 00 00		H.I. Date Entit/Term 00 00
SMI Premium Payer SELF		
SMI 3rd Party DT Entit/Term 00 00		Disab Onset 05 95 Direct Dep C
Dual Entit SSN 000 00 0000		Triple Entit SSN 000 00 0000

Message

14-sdx 15-wgei 16-ucbi

**This is a BENDEX screen for Penelope Benton. Answer the following questions:**

1. What is the amount of RSDI you would budget in the FS case?
2. Is the A/R eligible for Medicare?
3. How much is the Medicare premium?
4. Who is responsible for paying the Medicare premium?
5. Should the A/R have a medical deduction in the FS case?

## BENDEX INQUIRY – Exercise

INQUIRY	BENDEX INQUIRY - BNDX	BNDX
NEXT SSN		01
Claimant Name BETTY M RICKS	DOB 01 26 29	SEX F
County 115	Beneficiary's own SSN 411 46 1942	
SSA Claim Number 254 48 7647 B6	Claimant SSN 254 48 7647	
Agency Code 110	Category of Assistance A	
State Control Data	Old BIC Payment Status CP	
Mo. Benefit Payable 397.00	Date of Initial Entitlement 02 82	
Gross Amount Payable 397.00	Date of Current Entitlement 02 91	
Net Monthly Amount 397.00	Communication Code MAT	
Black Lung Acct. No. 00000000	Prev Gross Amt 397.00 Date 11 05	
BL Entit/Term Date 00 00 BL Status	SSI Entit/Term Dt 09 98 Status E	
BL Payment Amount 0.00	Monthly Overpymt Deducted 0.00	
RR Claim No RR Status	End Date Overpayment 00 00	
SMI Option Code Y	Date Entitled 01 94	H.I. Option Code E Amt 0.00
SMI Premium Amt 93.50	Date Term 00 00	H.I. Date Entit/Term 00 00
SMI Premium Payer 110		
SMI 3rd Party DT Entit/Term	00 00	Disab Onset 02 82 Direct Dep C
Dual Entit SSN 000 00 0000		Triple Entit SSN 000 00 0000

Message

14-sdx 15-wgei 16-ucbi

**This is a BENDEX screen for Betty Ricks. Answer the following questions:**

1. What is the beneficiary's Social Security number?
2. What is the SSA claim number?
3. What is the amount of RSDI that you would budget in the FS case?
4. What other income would you anticipate that the A/R would have?
5. Is the A/R eligible for Medicare?
6. Who pays the Medicare premium?
7. Does the BENDEX screen indicate that the A/R could have a medical deduction in the FS case?

## FSME SCREEN

CHANGE Month 04 06 1      FOOD STAMP MEDICAL EXPENSES - FSME      FSME 01  
 \*\*30 12 02 05      01  
 Client Name PATRICK      S PEARSE 3      Client ID 733009654  
 Remarks

Del	Freq	Pro. Num Of Mths	Type	Amt	V	Date Incurred	TPL Amt	Prorated Amount
	R		IP	93.50	LE	12 01 05		
Provider Name MEDICARE			<span style="border: 1px solid black; padding: 2px;">4</span>	<span style="border: 1px solid black; padding: 2px;">5</span>	<span style="border: 1px solid black; padding: 2px;">6</span>	<span style="border: 1px solid black; padding: 2px;">7</span>	<span style="border: 1px solid black; padding: 2px;">8</span>	
Provider Name								
Provider Name								
Provider Name								
Provider Name			<span style="border: 1px solid black; padding: 2px;">9</span>					
Provider			<span style="border: 1px solid black; padding: 2px;">10</span>					
Message								

More Med Exp

15-lett      24-del

This is an example of a typical FSME screen with a Medicare deduction. Below are the valid values for each field and explanations of the codes.

### 1 Freq(ueency)

```

+-----+
| O-ONE TIME          |
| P-PRORATED         |
| R-RECURRING       |
| Command ===> _____|
+-----+
    
```

This indicates how the expense will be budgeted in SUCCESS.

**One time** – the expense is a one-time expense AND will be budgeted in SUCCESS one time only.

**Note:** SUCCESS will not delete the one-time only expense correctly. The case manager must create an alert or make a note to delete the expense the next month.

**Prorated** – the expense is a one-time expense, BUT it will be prorated over the length of the POE.

Note: The AU makes the decision whether the expense is counted one time only or prorated. You should assist them by determining which method is most advantageous to them.

**Recurring** – this is a regularly occurring expense that is budgeted on a monthly basis. The most typical examples are regular monthly prescriptions, Medicare premiums and insurance premiums.

**2 Pro(rate) Num(ber) Of M(on)ths**

PRO.NUM OF MTHS = OVER HOW MANY MONTHS DO YOU WANT THIS EXPENSE TO BE PRORATED? (USE POLICY GUIDELINES.) IF THIS EXPENSE AND THE NUMBER OF MOS. FOR PRORATION IS ENTERED FOR THE ONGOING BENEFIT MONTH, THE PRORATED AMT. WILL BE DEDUCTED IN THE FOOD STAMP BUDGET UNTIL THE EXPENSE IS DELETED.

Command ==> \_\_\_\_\_

{More + }-+

If you prorate the expense, indicate the number of months of proration. This should equal the number of months remaining in the POE. For example, at review or application, the number of months would simply be the POE. But if the A/R reported a change in their medical expenses in the middle of their POE, then the expense would be prorated over the remainder of the POE.

**3 Type**

AC-ATTENDANT CARE  
DN-DENTAL  
DR-DOCTOR  
EQ-EQUIPMENT  
HO-HOSPITAL  
IP-INSURANCE PREMIUM  
OT-OTHER  
RX-PRESCRIPTION  
TR-TRANSPORTATION FOR MEDICAL

Command ==> \_\_\_\_\_

{More + }-+

This indicates the type of medical expense. “Other” is a major category that includes such common expenses as eyeglasses and hearing aids and such uncommon expenses as Seeing Eye dogs and artificial limbs.

**4 Am(oun)t**

AMT = WHAT IS THE FULL AMOUNT OF THE MEDICAL EXPENSE?

Command ==> \_\_\_\_\_

{More -+ }-+

This indicates the full amount of the expense before any reimbursements have been deducted.

**5 Verification**

```
+-----+
| AV-AVERAGE ACTUAL AMOUNT
| BI-VERD BILL
| CH-VERD CHECK
| CO-NOT VERD CONVERSION
| CS-CLIENT STATEMENT
| LE-VERD LETTER
| NV-NOT VERD FAILED
| RC-RECEIPT
| TC-VERD PHONE
|
| Command ===> _____
+-----+
```

This indicates how the expense was verified. A bill must be current which means that the bill is not more than 30 days old. This is a method of ensuring that the expense is a current one.

**6 Date Incurred**

```
+-----+
| DATE INCURRED = WHEN WAS THE MEDICAL EXPENSE INCURRED? (MMDDYY)
|
| Command ===> _____
+-----+ {More -+ }-+
```

***This is the date that the expense was incurred. This is different from the date of the bill. For example, an A/R may incur a dental expense on March 3, but provide verification of that expense as a bill dated June 10. The expense may be incurred at any time, but the bill must not be older than thirty days.***

Note: an expense can only be allowed as a deduction once. Once it has been allowed as a deduction, even if the A/R still has the expense, it cannot be allowed again.

**7 T(hird) P(arty) L(iability) Am(oun)t**

```
+-----+
| TPL AMT = HOW MUCH OF THIS EXPENSE WILL BE COVERED BY MEDICARE OR OTHER
| HEALTH INSURANCE COVERAGE?
|
| Command ===> _____
+-----+ {More -+ }-+
```

The TPL refers to the portion of the bill that will be paid for by someone other than the A/R. An excess medical deduction can only be allowed for that portion of a bill that the A/R is responsible for paying and intends to pay. Usually the TPL is Medicare or other health insurance, but it can also be relatives or even a hospital writing an expense off. **An expense cannot be allowed until TPL payments have been verified.**

**8 Prorated Amount**

```
+-----+
| PRORATED AMOUNT = THIS IS THE PRORATED MEDICAL EXPENSE DEDUCTION FOR THIS
| MEDICAL EXPENSE THAT WAS CALCULATED BY THE SYSTEM. THIS PRORATED AMOUNT
| WAS DETERMINED BY THE FOLLOWING CALCULATION:
| (FULL AMOUNT OF THE EXPENSE - AMOUNT OF EXPENSE PAID BY TPL)/NUMBER OF
|                                     MOS. PRORATED
| Command ==> _____
+-----+{More -->}-+
```

SUCCESSS will prorate the expense if you code the expense as “prorated” at the Frequency field and indicate the number of months of proration.

**9 Provider Name**

```
+-----+
| PROVIDER NAME = WHO PROVIDED THE MEDICAL SERVICE (HOSPITAL, DOCTOR,
| PHARMACY) THAT GENERATED THIS MEDICAL EXPENSE?
| Command ==> _____
+-----+{More -->}-+
```

Indicate the source of the medical expense. This is a partial list of the most common allowable medical expenses:

- ◆ medical and dental services (including chiropractic and psychotherapy)
- ◆ hospitalization (including outpatient treatment and nursing care)
- ◆ prescription drugs (including over the counter drugs prescribed by a Dr.)
- ◆ eye care expenses (including eyeglasses, contacts and exams)
- ◆ health insurance premiums (including Medicare premiums)

**10 Del(ete)**

```
+-----+
| DEL = DO YOU WANT TO DELETE THIS EXPENSE FROM THE DATABASE TO BE EFFECTIVE
| FOR THE BENEFIT MONTH LISTED ON THE SCREEN? IF SO, ENTER "Y", PRESS ENTER.
| Command ==> _____
+-----+{More +}-+
```

Delete the expense that you are no longer allowing as an excess medical deduction. Note: it is vital to document medical expenses so that you do not allow an expense to be counted twice.



## WORKERS' COMPENSATION

Workers' Compensation is a state program that provides payments to employees injured on the job. These payments currently have an estimated maximum benefit of \$450/week (2006). **These payments can be received for up to 400 weeks.**

If you have an A/R who is injured on the job, it is important to explore the possibility of their eligibility for Workers' Compensation. If you have an A/R who is receiving Workers' Compensation, it is important to be aware of the various ways that it can end because of the effect on the A/R's eligibility.

**Usually if an employee receives Workers' Compensation there are four different possibilities when it ends:**

- ✓ the employee returns to work and the Workers' Compensation is stopped
- ✓ the employee stops receiving weekly Workers' Compensation and is paid a lump sum settlement; this settlement can be a very large sum of money
- ✓ Workers' Compensation is terminated because the employer establishes that the employee is able to return to work; if the employee disagrees, this usually results in the employee being fired or quitting
- ✓ the employee returns to work on a reduced job or on a part-time basis; this employee may be able to receive reduced Workers' Compensation payments in addition to reduced earnings from the job

## **SECTION 8 / SUBSIDIZED HOUSING**



Section 8 and subsidized housing are programs to assist people with low income obtain affordable housing. Both of these programs base the rental payment upon the income of the family minus specified deductions. **Rent is set at 30% of this adjusted income.**

### **INCOME**

The household's income is "annualized" from an estimate of anticipated income. For example, if it is determined that the household's income is \$1000/month, then the annualized income would be \$12,000 (12 x \$1000).

### **DEDUCTIONS**

For non-elderly households, the allowable deductions are:

- ✓ \$480 dependent allowance for each minor and handicapped family member
- ✓ childcare expenses
- ✓ handicap expenses

For elderly households, the allowable deductions are:

- ✓ \$400 elderly allowance per household
- ✓ medical expenses

### **BUDGETING EXAMPLE**

Ms. Emily Watson earns \$1000/month (annualized to \$12,000). She has two minor children (each is allowed a dependent allowance of \$480; 2 x \$480 = \$960). She pays \$200/month for childcare (annualized to \$2400).

$$\begin{array}{r} 12,000 \text{ (income)} \\ - 2400 \text{ (childcare allowance)} \\ \hline 9600 \\ - 960 \text{ (dependent allowance)} \\ \hline \$8640 = \text{annualized income minus deductions} \end{array}$$

$$\$8640 \text{ divided by } 12 = \$720 \text{ (monthly income)}$$

$$\$720 \times .3 = \$216$$

**\$216 is the monthly rent payment for Ms. Watson.**

## Objectives for Basic Interviewing Skills



### **Participants will:**

- ❑ Discuss appropriate greetings to begin an interview
- ❑ Develop open questions to get an overview of the situation
- ❑ Establish an agenda for different types of interviews
- ❑ Establish patterns of discussion for each interview topic
- ❑ Examine the need to summarize the interview
- ❑ Discuss appropriate ways to close the interview

## ***Basic Interviewing Skills***



- I Greet the Client Appropriately**
- II Ask Open Questions to get the "Big Picture" and Develop Rapport**
- III Set an Agenda for the Interview and Get Agreement with the Client**
- IV Follow the Open, Closed, Summarize, and Document Pattern for Every Topic**
- V Summarize Frequently to Clarify Information**
- VI Close Interview with Explanation of "Next Steps"**

## *Basic Interviewing Skills*



### 3 Basic Fundamentals:

1. Build Trust
2. Focus on Solutions
3. Remain Positive

---

How can we build trust with our clients?

How can we focus on solutions?

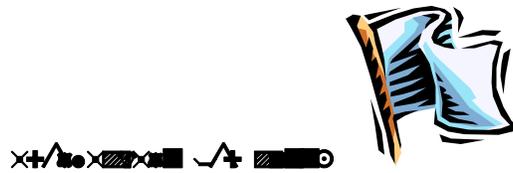
Why is remaining positive so important?

## Objectives for Red Flags



### **Participants will:**

- ❑ Discuss the definition of “red flags”
- ❑ Discuss five techniques to assist the case manager in identifying and resolving discrepancies
- ❑ Identify red flags in examples of verification



What is a Red Flag?

What may be behind a Red Flag?

*Five techniques to identify and resolve  
Red Flags*

- ◆ Review \_\_\_\_\_ and the case record \_\_\_\_\_ to the interview
- ◆ Use good \_\_\_\_\_ skills during the interview
- ◆ Observe changes in \_\_\_\_\_ language
- ◆ Clarify \_\_\_\_\_ information
- ◆ Examine \_\_\_\_\_ closely

( ) I DO (do or do not) intend to continue giving this money to the above person(s).

If you **do**, please show amount you intend to give in the future: \$ 600 every MONTH  
(Week/Month)

If you **do not**, please show last date you gave any money: \_\_\_\_\_

COMMENTS: I WILL HELP HER AS LONG AS SHE NEEDS IT.

TO: \_\_\_\_\_  
FROM: \_\_\_\_\_  
Case Number: \_\_\_\_\_

Dear \_\_\_\_\_

\*\*\*\*\*  
The information provided on this form reflects my total contribution. If any of this information is found to be intentionally inaccurate I may be subject to criminal prosecution for knowingly providing false information. (See Georgia Code Section 49-4-15 for the full reference.) I understand the meaning of this paragraph.

PLEASE READ CAREFULLY BEFORE SIGNING:

Please complete this form with the requested information and return it to this office in the enclosed envelope. If you have any questions, please call me. I am not in, please leave your name and phone number.

The information provided on this form reflects my total contribution. If any of this information is found to be intentionally inaccurate I may be subject to criminal prosecution for knowingly providing false information. (See Georgia Code Section 49-4-15 for the full reference.) I understand the meaning of this paragraph.

Melissa Laynes \_\_\_\_\_ 4-4-00  
Signature of Person Completing this Form (Week/Month) Date

I give this money directly to the above person(s) in the amount of \$ 600 per Month (Weekly/Monthly)  
Address \_\_\_\_\_

In the months listed below I gave the following amounts:

City	State	Zip Code	Amount	in	Month/Year
			\$ 600		MARCH
			\$ 600		APR
			\$ 600		MAY

I pay the following bills directly to the provider/company for the above person(s): Mortgage company; Rent; Landlord or Apartment office; Utilities (electric, gas, water, sewer, garbage collection, telephone companies); Finance companies; Bank or personal loans; Auto or truck payments; etc.

\$ 600 to \_\_\_\_\_  
\$ 600 to \_\_\_\_\_

NOTE: If you need more room please use the reverse of this form and continue to tell us the amount you pay and to which provider/company.

CO. FILE DEPT. CLOCK NUMBER  
CPB 004494 000758 FT 0000303462 1

ATLANTA BLOOD SERVICES REGION  
AMERICAN RED CROSS  
1925 MONROE DRIVE  
ATLANTA, GEORGIA 30324

Social Security Number: 417-08-83  
Taxable Marital Status: Married  
Exemptions/Allowances:  
Federal: 4  
State: 1 Plus 8 Dependents

Earnings Statement



Period Ending: 03/28/1999  
Pay Date: 04/09/1999

SONYA Y. RAY  
121 CHASE LANE  
NORCROSS, GA 30093

Earnings	rate	hours	this period	year to date
Regular	9.5000	40.00	380.00	3,975.75
Vac / P T O	9.5000	8.92	84.74	600.40
Overtime				49.88
Holiday				275.50
Shift			Gross Pay 464.74	15.75
Weekend				292.13
<b>Gross Pay</b>			<b>464.74</b>	<b>5,209.41</b>

Other Benefits and Information	this period	total to date
Tda		210.00

Reductions	Statutory	Other
Social Security Tax	-22.92	281.75
Medicare Tax	-5.36	65.89
Federal Income Tax		53.62
Aetna Den Pre	-10.01*	70.07
Aetna Uni Life	-1.10	5.50
American Fam L	-20.43	143.01
Garnishment 1	-115.00	805.00
Kai		573.02
Net Pay	174.92	210.00
S 1 D Pre	-21.17	21.98
<b>Net Pay</b>	<b>174.92</b>	<b>210.00</b>

\* Excluded from federal taxable wages  
Your federal taxable wages this period are \$339.73

# STANDARD APARTMENT LEASE - GEORGIA

Date of Lease: 10-07-99  
 Lease Term: 9 MONTHS  
 Commencement Date of Lease Term: 10-07-99  
 Termination Date of Lease Term: 06-18-2000  
 Monthly Rent: \$579.00  
 Monthly Charges: \$24.00 WATER & \$4.00 TRASH  
 Early Termination Fee: \$579.00 + \$150.00  
 Non-Refundable Fee: \$287.00  
 Month-to-Month Fee: \$MARKET RENT + \$150.00

Type of Lease: NEW  
 Apartment Type: DIPLOMAT  
 Service Charge for Dishonored Check: 55.00  
 Late Charges: 10% OF RENT  
 Security Deposit: \$N/A  
 Security Deposit Acct. #: N/A  
 Remote Deposit: \$N/A  
 Non-Refundable Remote Fee: \$N/A

Resident(s): LETICIA PADIL Apartment #: 240  
 Address: 240 CLUB PLACE, DULUTH, GA, 30098  
 Swipecard/Remote #: 634/00100

Lessor: Equity Residential Properties Management  
 Limited Partnership, an Illinois limited partnership, as agent for the owner of GWINNETT CROSSING Apartments

We are pleased to rent to you the above-described apartment. The Lease Term (both dates inclusive), Monthly Rent, Monthly Charges, security deposit and other deposits and fees are set forth above. As used in this Lease, the term "Community" means the apartment complex in which the apartment described above is located; the term "apartment" means apartment number 2403; the term "you" means the Resident(s) whose name(s) appear in this Lease, who are jointly and severally liable; the term "we," "our," and "us," means the person(s) or entity(ies) that holds legal title to the Community ("owner") and the Lessor (and all their employees and agents). The terms "we", "our", "us", "owner" and "Lessor" have the same meaning for purposes of this Lease and may be used interchangeably.

GENERAL PROVISIONS: This Lease, together with any written agreements and addenda executed simultaneously herewith, contains the entire agreement between the parties and shall not be changed, modified, or discharged in whole or in part except by an agreement in writing signed by Lessor and by Resident. THERE ARE NO ORAL UNDERSTANDINGS, terms or conditions and neither party has relied upon any representations, express or implied, not contained in this Lease or in written agreement(s), if any, executed simultaneously herewith.

**Additional Agreements and Addenda**

Your initials at the end of this sentence acknowledge that (i) you have received the Resident Handbook provided by us and except as modified by this Lease or an addendum to this Lease, you agree to abide by the policies as outlined in the Resident Handbook and (ii) any violation of the policies contained in the Resident Handbook shall constitute a default under this Lease and Lessor shall have the rights and remedies provided in Section 13 below of this Lease in addition to all other remedies available under this Lease or provided at law or in equity.

*E. Padil* (Initials)

Lessor shall pay for the following utilities (if checked) (subject to change as set forth below):  electricity,  gas,  water,  sewer,  garbage removal,  cable TV,  master TV antenna,  alarm systems. Resident shall pay for all other unchecked utilities and related deposits prior to move in and for all charges on Resident's utility bills. Resident shall not allow electricity to be disconnected by any means (including nonpayment of bill) until the end of the Lease Term or renewal period. Changes or installation of utility lines, meters, sub metering or load management systems, and similar electrical equipment serving the apartment shall be the exclusive right of the Lessor, provided such work does not substantially increase Resident's electric bills. Lessor shall have the right to install individual meters for measuring any or all utilities inside each apartment or to use any other method of measuring utility usage that Lessor reasonably deems to be appropriate. Lessor has the right to have the Resident billed all costs normally associated with such utility usage on a monthly basis. Should Lessor exercise this right, Lessor will notify Resident at least 30 days prior to commencement of such billing.

Move-In Checklist MIC  
 Guaranty  
 Pet Addendum

Storage Addendum  
 Concession Addendum  
 Utility Billing Service Addendum

C:\My Documents\STANDARD APARTMENT LEAS3.doc  
 January 27, 1998

SPARROWS' WALK APTS.  
Norcross, GA

DATE 2-5 1996 No 26405

BLDG # 10 APT # 80 PD CASH  PD CK  PD M.O.

RECEIVED FROM E. Henry DOLLARS

FOR MONTH OF Feb RENT \$ 635 CR FEE \$ \_\_\_\_\_ LTE CHG \$ \_\_\_\_\_  
SECURITY \$ \_\_\_\_\_ F-ADJ \$ \_\_\_\_\_ LEGAL \$ \_\_\_\_\_ APT REP \$ \_\_\_\_\_  
NSF/BK CHG \$ \_\_\_\_\_ REPL OF BOUNCED CHECK \$ \_\_\_\_\_

MISC. \_\_\_\_\_

DATE MOVED-IN \_\_\_\_\_

\$ 635 THANK YOU, By [Signature] **RECEIVED**  
Total Amount Paid FEB 7 1996



## Objectives for Management

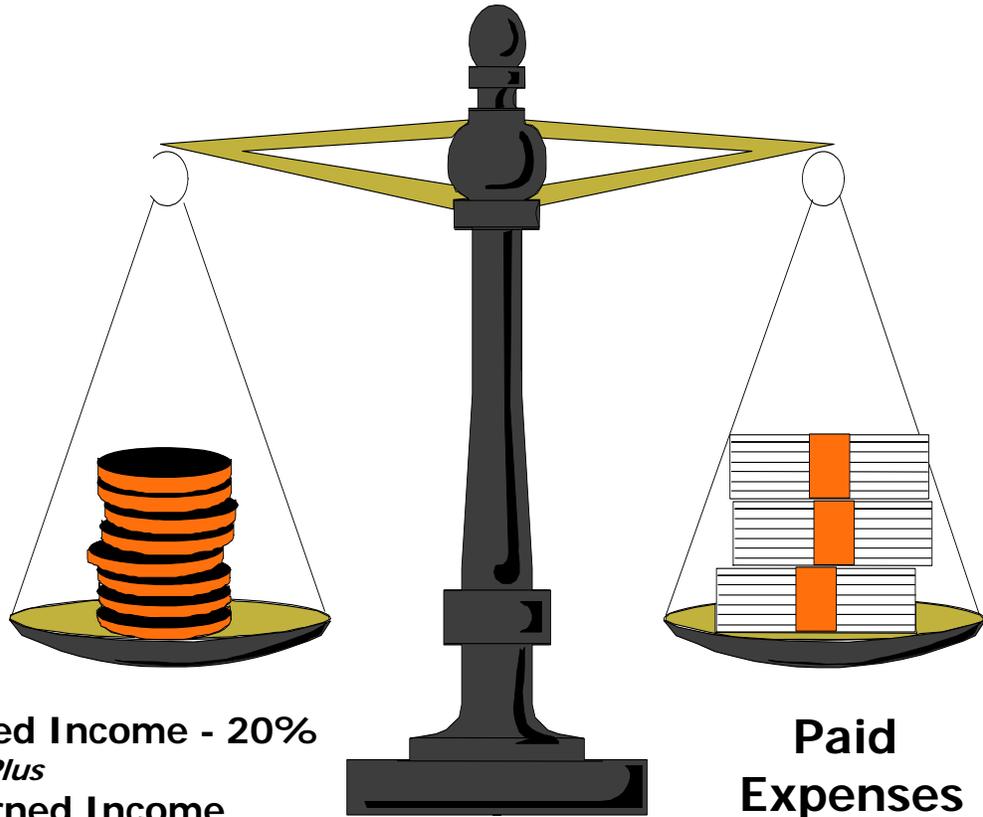


### **Participants will:**

- ❑ Calculate amounts used to determine an Assistance Unit's management of income and expenses
- ❑ Review basic interview skills
- ❑ Discuss additional techniques to resolve discrepancies in AU management
- ❑ Demonstrate the use of interview techniques to resolve management issues
- ❑ Explore procedures to request verification
- ❑ Analyze difficult management situations

# Management

*Compare:*



**Gross Earned Income - 20%**  
*Plus*  
**All Unearned Income**  
*Plus*  
**Available Liquid Resources**

**Paid  
Expenses**

*Use Expense Statement Form 354*

## GEORGIA DEPARTMENT OF HUMAN RESOURCES EXPENSE STATEMENT

Application     
  Review     
  Change

Does your household pay the following bills?

EXPENSE	AMOUNT DUE	HOW OFTEN PAID	LAST TIME PAID	PAID BY WHOM
Rent / Mortgage				
Property Taxes				
Property Insurance				
Utilities				
a. Electricity				
b. Gas				
c. Fuel Oil, Wood, Kerosene				
d. Well / Septic Tank / Water / Sewage				
e. Garbage				
f. Telephone				
<b>SUBTOTAL</b>				
Medical Expense				
Child Care Expenses				
Child Support Paid Out				
Health Insurance				
Auto Expense (payments, insurance, maintenance)				
Other				
<b>TOTAL</b>				

EXPEDITED?     Yes     No

Does anyone pay any of these bills or any other household bills for you?     Yes     No

If yes, who pays the bills? \_\_\_\_\_

What bills are paid? \_\_\_\_\_

Do you share the costs of monthly bills with anyone?     Yes     No

If yes, who? \_\_\_\_\_

What costs? \_\_\_\_\_

Comments / Documentation \_\_\_\_\_

I certify that I have reviewed the information on this form with the applicant / recipient.

Signature (Case Manager) \_\_\_\_\_

Date \_\_\_\_\_

UNTY:

CASE NUMBER:

**Georgia Department of Human Resources  
VERIFICATION CHECKLIST**

\_\_\_\_\_ County Department of Family and Children Services

\_\_\_\_\_  
Case Number  
\_\_\_\_\_  
Case Manager / Caseload  
\_\_\_\_\_  
Telephone Number  
\_\_\_\_\_  
Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The items checked below must be received by \_\_\_\_\_ (Due Date). If you cannot get the requested information and / or need more time, contact your case manager by phone or mail by \_\_\_\_\_ (Due Date). Your case manager may give you more time and may be able to help you get the information you need. Bring in or mail the items checked below or we will be unable to determine eligibility for an individual or the entire assistance unit.

TANF	Medicaid	FS		TANF	Medicaid	FS	
			Check stubs or statement from employer for:				Name and address of any person(s) giving you any child support, alimony, or any other contribution.
			Birth certificate / proof of citizenship/ proof of age for:				Address, social security number, phone number, and other information about the absent parent(s).
			Social Security card / application for:			NA	Proof you have applied for:
			Bank account statement – no more than 30 days old.				Statement from physician or health department to verify pregnancy and due date.
	NA	NA	Immunization Form 3231 for:				Letter of Award for Social Security, SSI, Veterans benefits, unemployment benefits, worker's compensation for:
			Other:				Other:

Bring in or mail proof of items checked below or we will not use the expense as a deduction in Food Stamps, and we may not be able to determine your eligibility for TANF, Food Stamps, or Medicaid.

TANF	Medicaid	FS		TANF	Medicaid	FS	
	NA		Proof of rent /mortgage payment.		NA		Proof of the amount of your gas, electric, telephone and other utility bills.
	NA		Proof of homeowner's insurance / property taxes.				Written statement of child care expenses for:
			Medical bills on which you still owe – physician, prescription drugs, health insurance premium, hospitalization.		NA		Proof of the legal obligation and the amount of child support paid to someone not in your home.
			Proof of the amount your insurance paid on your medical bills.				Other:

# MANAGEMENT



VS.



What is the purpose of discussing "management"?

In discussing management, we're comparing \_\_\_\_\_ income to \_\_\_\_\_ expenses.

Two specific interview skills (in addition to good basic skills) that must be used to point out a discrepancy are:

Stick to the \_\_\_\_\_

Use \_\_\_\_\_ statements

Another important interview skill to use is remaining \_\_\_\_\_ so that I don't explain the situation *for* the person.

When asking for verification, I need to:

\_\_\_\_\_ clearly

\_\_\_\_\_ obstacles

Get \_\_\_\_\_

Set \_\_\_\_\_

If the management explanation is vague or difficult to understand, two additional skills I can use are:

Sometimes, even if I do everything right, I still can't resolve the discrepancy. Some indications that it's time to end the interview include:

Some steps I can take to resolve the discrepancy if I've been unable to do so in the interview include:

If I've requested verification, it's important that I \_\_\_\_\_ it closely when I receive the information.

## Objectives for OIS Referrals



### **Participants will:**

- ❑ Discuss the importance of Intentional Program Violation (IPV) referrals
- ❑ Discuss the role of the Office of Investigative Services (OIS)
- ❑ Discuss the role of the Quality Control (QC)
- ❑ Examine the importance of distinguishing between an Overpayment (OP) Claim and Fraud
- ❑ Examine the OIS referral Form 5667
- ❑ Complete an OIS referral using Form 5667



## OIS REFERRALS

**An Intentional Program Violation (IPV)** is an intentional action by an A/R to establish or maintain an AU's eligibility, or to increase or prevent a decrease in the AU's benefits by providing false or misleading information or withholding facts.

**The Office of Investigative Services (OIS)** is the state agency that is responsible for investigating suspected fraud. The case manager makes referrals to OIS via the Form 5667, Request for Investigation.

A case manager should refer cases to OIS if the case manager **suspects** that the A/R has **intentionally** committed fraud. The case manager does not have to establish that fraud was committed, but only have reasonable grounds to suspect it. Committing fraud is defined as:

- ✓ **making false or misleading statements**
- ✓ **providing false information or concealing information**
- ✓ **failing to report a change**
- ✓ **failing to provide verification necessary to establish eligibility for historical months**

A case manager must complete Form 5667 within 30 days of becoming aware that suspected fraud exists. The case manager must submit the completed Form 5667 to OIS immediately upon completion.

**OIS will make a determination of the validity of the referral.** OIS will dismiss the referral, establish a non-fraud OP, or determine that fraud was committed. If fraud was committed, then OIS will seek repayment and/or prosecution.

## Overpayments

**It is important for the case manager to distinguish between overpayments (OP) and fraud referrals.**

If the case manager makes an error on the case that results in the A/R receiving more benefits than he is entitled to, then this is an **OP** (claim).

If the overpayment is the result of an error or misunderstanding on the part of the A/R, then this is an **OP** (claim).

If the overpayment is the result of an intentional action by the A/R to increase their benefits, then this is **suspected fraud** and a 5667 should be completed.

## Quality Control (QC)

**Quality Control is the federal agency that monitors Food Stamps accuracy.** This is primarily done by a random reviewing of a statistically significant sample of FS cases across the state. Their review determines our Error Rate that, in turn, determines our funding by the federal government.

Fraud referrals can have a major impact on our Error Rate. This is because QC will not review a case for which a Fraud Referral in the case was completed for the month under consideration.

**Example:** If the case manager completed a Form 5667 for June, July, and August and QC had chosen the case to be reviewed for the month of June, QC would not review the case because of the Form 5667 in the record.

.....



Georgia Department of Human Resources <b>OFFICE OF INVESTIGATIVE SERVICES</b> <b>REQUEST FOR INVESTIGATION</b> Two Peachtree Street, NW. Room 23-293 Atlanta, GA 30303-3142		1. COUNTY NAME/NUMBER: _____ 2. HOTLINE REFERRAL NUMBER: _____ 3. DFCS LOG NUMBER: _____					
<b>HEAD OF HOUSEHOLD INFORMATION</b>							
4. SOCIAL SECURITY # _____	5. DOB: _____	6. SEX: <input type="checkbox"/> M <input type="checkbox"/> F					
7. SUCCESS CLIENT ID# _____	8. RACE: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> O <input type="checkbox"/> W						
9. FIRST NAME: _____	10. INITIAL _____	11. LAST NAME: _____					
12. ADDRESS 1: _____	13. ADDRESS 2: _____						
14. CITY: _____	15. STATE: _____	16. ZIP: _____					
<b>SECONDARY HOUSEHOLD INFORMATION</b>							
18. SOCIAL SECURITY NO.	NAME	DOB	RELATIONSHIP	SUCCESS CLIENT ID NO.	REPEAT OFF.		
					<input type="checkbox"/> Y <input type="checkbox"/> N		
					<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>SUSPECTED PROGRAM VIOLATION</b>							
19. CATEGORY	20. STATUS		21. ESTIMATED OVERPAYMENT		22. SUCCESS AU ID NO.		
PROGRAM	ACTIVE	CLOSED	FALSE STMT	START DATE	END DATE	AMOUNT	CHILD CARE CASE NO.
<input type="checkbox"/> EBT	<input checked="" type="checkbox"/> EBT Trafficking ONLY						
<input type="checkbox"/> FS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> TANF	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> CAPS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<b>NON EBT</b>							
<input type="checkbox"/> FS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> TANF	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> CAPS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
23. METHOD OF DISCOVERY: <input type="checkbox"/> CLEARINGHOUSE <input type="checkbox"/> CLIENT REPORT <input type="checkbox"/> CSE <input type="checkbox"/> HOTLINE							
<input type="checkbox"/> QC <input type="checkbox"/> E4 LIST <input type="checkbox"/> PRISONER ALERT <input type="checkbox"/> UCB MATCH <input type="checkbox"/> OTHER							
24. SOURCE OF REFERRAL: _____							
<b>25. OP RESULTED FROM:</b>							
<input type="checkbox"/> A. UNREPORTED EARNED (Wages, Self Employment, ETC.)				Employer: _____ Employer Address: _____ (Address Continued)			
<input type="checkbox"/> B. UNREPORTED UNEARNED (SS, SSI, WC, UCB, VA, CS, ETC.)				Source: _____ Date Income Began: _____			
<input type="checkbox"/> C. RESOURCES (Insurance, Property, Bank Accounts, Etc.)				List Resources, Value, Property Location, Insurance Co.; Name of Bank, Etc.			
<input type="checkbox"/> D. HOUSEHOLD COMPOSITION/RESIDENCY (Child out of Home, Spouse in Home, Out of State, ETC.)				Name: _____			
<input type="checkbox"/> E. EBT TRAFFICKING (Card #, Store Name & Address, FCS #)				Name: _____			
<input type="checkbox"/> F. OTHER (Explain Dual Assistance)				Name: _____			
26. REPEAT OFFENDER: <input type="checkbox"/> Y <input type="checkbox"/> N							
27. Explain: (Describe Violation checked in #25. Include Names, Addresses, and Telephone Numbers, if known. Include Names of Respondent(s) if other than #18 above. Attach additional sheet if needed)							
28. WORKER/ORIGINATOR SIGNATURE				29. DATE		30. TELEPHONE NO.	

Form 5667 (Rev. 08/05)

**INSTRUCTIONS FOR THE REQUEST FOR INVESTIGATION\*\*\***

The OIS Form 5667 is to be completed per the following instructions. Numbers refer to the numbered boxes on the form. Fields designated with an asterisk (\*) are mandatory fields.

1. \* COUNTY DFCS: Enter the name of the current county in which the client's benefits are determined.
2. HOTLINE REFERRAL LOG #
3. DFCS LOG #

**HEAD OF HOUSEHOLD INFORMATION:**

4. HEAD OF HOUSEHOLD SOCIAL SECURITY NUMBER
5. \*DATE OF BIRTH (Month/Date/Year)
6. SEX (Male or Female)
7. \*SUCCESS CLIENT ID#
8. RACE (Asian, Black, Hispanic, Other, and White)
9. \*FIRST NAME
10. MIDDLE INITIAL
11. \*LAST NAME
12. \*ADDRESS 1 (enter the most current address)
13. ADDRESS 2
14. \*CITY
15. \*STATE
16. ZIP CODE
17. AREA CODE AND TELEPHONE NUMBER

**SECONDARY HOUSEHOLD INFORMATION:**

18. SOCIAL SECURITY NUMBER
  - \*NAME OF SECONDARY HOUSEHOLD MEMBER (First, Middle, Last name). This is the respondent/person that actually contributed to the suspected violation, i.e., adult child working, spouse/boyfriend in the home.
  - DATE OF BIRTH ( Month/Date/Year)
  - \*RELATIONSHIP ( Example: Son, Daughter, Husband, etc)
  - SUCCESS CLIENT ID #

\*REPEAT OFFENDER ( Check yes if central fraud files, SUCCESS, DRS or case records contain evidence of previous adjudication(s) for this recipient from a court proceeding, Administrative Fraud Hearing or WDH.

**SUSPECTED PROGRAM VIOLATION**

19. \*CATEGORY/PROGRAM: Check the Category (At least one, EBT or NON EBT, is mandatory):
  - EBT TRAFFICKING – Refers to allegations of EBT trafficking of benefits. i.e., selling the EBT card or a portion of the benefits on the card to another individual or vendor.
  - NON EBT – Refers to allegations involving any other eligibility requirement other than trafficking of benefits.
  - Check the Program Type. At least one Program Type (Food Stamp, TANF, CAPS) is mandatory. If multiple programs are involved, check the appropriate boxes.
20. \*STATUS: Check the box to indicate whether the program is Active or Closed. Check the box labeled False if a false statement was made.
21. \*ESTIMATED OVERPAYMENT: For all referred programs, an estimated overpayment period must be entered. This is an estimation of the first month and last month of overpayment. The estimated amount is usually the amount of benefits received during that period of time
22. \*SUCCESS AU ID/Child Care #: Enter the case number and SUCCESS AU ID for the corresponding program, ( i.e. Food Stamps, TANF and/or Child Care number).

**INSTRUCTIONS FOR THE REQUEST FOR INVESTIGATION\*\*\***

The OIS Form 5667 is to be completed per the following instructions. Numbers refer to the numbered boxes on form. Fields designated with an asterisk (\*) are mandatory fields.

23. **\*METHOD OF DISCOVERY:** Select the appropriate choice: Clearinghouse, Client Report, CSE, E4 List, Prisoner Alert, Hotline, QC, UCB Match or Other. IF "Other" is selected, please include a brief description.
24. **\*SOURCE OF REFERRAL:** State where the referral originated. Example: DFCS, CSE, QC.
25. **\*OP RESULTS FROM:** These six information fields are very important. The Request for Investigation can be processed in a timely and efficient manner only if necessary background information is provided by complainant. Check those that apply and be as specific as possible with your information. Attach additional sheets as necessary. Indicate if verification is available in the county office. Do NOT attach original verification. Maintain all original verification in the county; attach copies if appropriate.
26. **\*REPEAT OFFENDER:** Circle "yes" if central fraud files, DRS, SUCCESS or case records contain evidence of previous adjudication(s) for this recipient from a court proceeding, Administrative Fraud Hearing or WDH.
27. **EXPLAIN:** Describe the violation and provide any additional details.
28. **\*WORKER/ORIGINATOR:** The person who is completing 5667 should sign here.
29. **\*DATE OF REFERRAL:** Enter the date that the 5667 is completed. This is the date from which the FNS 12-month disposition timeframe is tracked. Submit completed 5667's to OIS immediately upon completion to avoid loss for investigative purposes based on the FNS 12-month rule.
30. **TELEPHONE NUMBER OF WORKER/ORIGINATOR.**

**NOTE:** Any supplemental information concerning the same allegations but uncovered subsequent to submission of the Form 5667 should be submitted on Form 713 or via GroupWise to the OIS investigator. A new Form 5667 should be completed for any new/different allegations of suspected fraud in the household.

**\*\*\*\*\* SPECIAL NOTE:**

This form was created using the Excel program. Due to the limitations of the program, if the person completing the referral enters more data than a field can accommodate, the information will not print when the form is printed. Therefore, be careful to limit data to the size of the cell. If it is necessary to submit further information, please attach extra sheets.

The form has been configured to print correctly on most printers. Due to the infinite variety of printers used by staff, you may need to adjust your page set up to accommodate your printer. For most printers the optimum setting for the page scale is 85% of normal size.

## ESTIMATED OVERPAYMENT

**Start Date** – Determine the first month that you suspect the fraud occurred. If you have corrected the case ongoing or closed the case due to suspected fraud, then determine the first month that you believe that the suspected fraud occurred. Remember that this is your best estimate. OIS will make the actual determination.

**End Date** – Determine the last month that you suspect the fraud occurred. If you have corrected the case ongoing or closed the case due to suspected fraud, then determine the last month that you believe that the suspected fraud occurred. Remember that this is your best estimate. OIS will make the actual determination.

**Amount** – Estimate the amount of the overpayment amount for each month of the suspected fraud. If you are in doubt, then simply use the entire monthly benefit amount as the overpayment amount. If you have corrected the case ongoing, then you may be able to use the difference between the previous amount and the corrected (current) benefit amount as the overpayment.



## Objectives for ABAWDs



### **Participants will:**

- Identify work registration criteria
- Determine ABAWD status
- Demonstrate the ability to code the SUCCESS “WORK” screen

# FOOD STAMP WORK PROGRAM EXEMPTIONS (ESS 3350)

All Food Stamp applicants/recipients must comply with the work program requirements unless they meet one of the exemptions listed below.

FOOD STAMP EXEMPTIONS	SUCCESS EXEMPT REASON CODE	SUCCESS WORK STATUS CODE
Under age 16	AG	NI
Age <b>16--17</b> and not Head of AU. Verification of school attendance and wages are required if the student is employed	AG	NI
Age 60 or older	AG	NI
Student enrolled at least half time in a recognized school/training program or institution of higher learning. A student in an institution of higher learning must meet student criteria to be included in the AU; see ESS policy manual section 3245. Verification, Form 875, is required to verify attendance and educational assistance.	ST	NI
Refugee participating in a recognized refugee education/training program at least half time. Verification of participation is required.	RF	NI
Caretaker of a child under 6. Child does not have to be a part of AU or live in the same home. Only one adult may use this exemption.	CA	NI
Caretaker of an incapacitated individual. Need for continuous care must be verified by a medical source. Does not need to be AU member or in the home.	CA	NI
Temporarily ill/unfit for employment with medical verification	TI	NI
Receiving disability benefits (SSI, RSDI, 100% VA, Railroad Retirement, Worker's Compensation, etc.) SDX, BENDEX, and /or Award letter required.	FE	NI
SSI/FS initial application filed at SSA. Verification of SSI application status not required if information is forwarded from SSA.	SS	NI
High Risk Pregnancy. Verification required from a medical source.	PR	NI
Working at least 30 hours a week on a job expected to last at least 30 days (includes self-employment). Verification of hours worked and wages is required.	EM	NI
Receiving weekly earnings at least equal to 30 hours multiplied by the federal minimum wage. This includes temporary breaks in employment not expected to exceed 10 work days and self-employment. Verification is required.	EM	NI

<b>FOOD STAMP EXEMPTIONS</b>	<b>SUCCESS EXEMPT REASON CODE</b>	<b>SUCCESS WORK STATUS CODE</b>
Seasonal migrant or non-migrant farm worker who is under contract to begin work within 30 days (verification is required).	MI	NI
VISTA (Volunteer in Service to America) volunteer (verification of status is required)	VV	NI
Regular participant in a drug/alcohol treatment or rehabilitation program Verification of participation is required.	DR	NI
Receiving, applied for or approved for Unemployment Compensation Benefits (UCB). Verification of application for benefits required if questionable.	UC	NI
Registered and complying with TANF Employment Services.	PC	NI
IPV disqualified, SSN Disqualified, and Ineligible AU members	AD	NI

An **ABAWD** is any individual who is:  
(Effective December 2004)

(1<sup>st</sup>) A \_\_\_\_\_ E&T registrant

Age \_\_\_\_\_ -- \_\_\_\_\_ (until month of 50<sup>th</sup>  
birthday)

NOT in an \_\_\_\_\_ with a child under \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ pregnant

NOT \_\_\_\_\_ or \_\_\_\_\_ unfit for  
employment

Must meet  
all 5 criteria

**NOTE:** If obviously unfit, and medical verification is not available to support the unfitness determination, register the A/R as a MANDATORY registrant (MR). Documentation of the unfitness is sufficient to determine the ABAWD status but does not exempt the A/R from work registration. Document the observed behaviors or physical conditions that deem the A/R unfit for employment at the current time.

# ABAWD

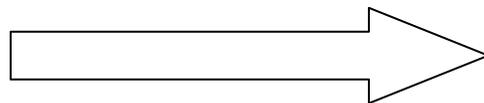
## Work Registration Codes

(Effective December 2004)

Use in the "STAT" field only

- ◆ **AB**      **Mandatory ABAWD in Non-Exempt Counties/Cities**
- ◆ **AE**      **Mandatory ABAWD in Exempt Counties/Cities or Exempt via the new 15% exemption**
- ◆ **FP**      **Mandatory ABAWD in Exempt Major Cities**
- ◆ **MR**      **Mandatory E&T, but not an ABAWD**

INTERVIEW Month 11 96	WORK REGISTRATION/PARTICIPATION	WORK	WORK 01
Client Name		Client ID 702000129	
----- Employment Services -----		- Applicant Job Search -	
Exempt Reason	Stat V	Partic Date	Number Supp DA/PE Non-Partic AJS Start Offenses Work Reason Date
-- FS ABAWD Non-Compliance --			
High School Grad/GED	Non-compliance Bnft mth/yr	Regain Dates Start End	2nd 3 Months Bnft mth/yr
Y	1		
	2		
	3		
Message			
16-phme	17-mo< 18-mo>	23-alau	



## Food Stamp Employment & Training Program County Designations April 1, 2006 to March 31, 2007

Non-Exempt Counties - Work Status Code "AB" in SUCCESS						
Baldwin	Catoosa	Colquitt	Gordon	Laurens	Newton	Tift
Barrow	Carroll	Coweta	Gwinnett	Liberty	Paulding	Troup
Bartow	Chatham	Dekalb	Hall	Lowndes	Polk	Walker
Ben Hill	Clarke	Douglas	Henry	Mitchell	Putnam	Walton
Bibb	Clayton	Floyd	Houston	Murray	Rockdale	Whitfield
Bulloch	Cobb	Glynn	Jackson	Muscogee	Thomas	Worth
<p><b>These counties:</b> Are not covered by the ABAWD Waiver or the 15% Exemption Must operate an E&amp;T Program</p> <p><b>ABAWDS in these counties:</b> Must be identified Must be coded correctly on SUCCESS Must participate in E&amp;T activities Are subject to 3-of-36 month time limit Are subject to penalty months for non-compliance</p>						

**ABAWD Waiver Exempt Counties and Cities**

These exempt counties and cities have annual unemployment rate over 10% or they have insufficient jobs as determined by the Labor Surplus List from the U.S. Department of Labor or by a 24-month unemployment rate that is 20% higher than the national average for the same period.

**Exempt Counties - Work Status Code "AE" in SUCCESS**

Appling	Glascok	Marion	Screven	Treutlen
Atkinson	Greene	McDuffie	Spalding	Upton
Burke	Hancock	Meriwether	Stewart	Warren
Calhoun	Jeff Davis	Montgomery	Sumter	Washington
Chattahoochee	Jefferson	Peach	Talbot	Webster
Clay	Jenkins	Quitman	Taliaferro	Wheeler
Crisp	Lamar	Randolph	Taylor	Wilcox
Dooly	Lincoln	*Richmond	Telfair	Wilkes
Dougherty	Macon	Schley	Toombs	

**Exempt Cities - Work Status Code "AE" in SUCCESS**

Atlanta	East Point	Albany	Bibb
---------	------------	--------	------

**ABAWDs in these counties or cities:**

- Must be identified
- Must be coded correctly on SUCCESS
- Do not participate in E&T activities
- Are not subject to 3-of-36 month time limit
- Are not subject to penalty months for non-compliance

\* Has volunteered to participate as a non-exempt ABAWD county.

Counties Exempt via the 15% Geographical Exemption				
These counties have been determined exempt via Georgia's new 15% geographical exemption for certain types of counties.				
Class 1 Counties - Work Status Code "FP" in SUCCESS				
Baker	Clinch	Lanier	Towns	
Banks	Echols	Miller		
Class 2 Counties - Work Status Code "AE" in SUCCESS				
Bacon	Crawford	Grady	Lumpkin	Pulaski
Berrien	Dade	Haralson	Madison	Rabun
Bleckley	Dawson	Harris	McIntosh	Seminole
Brantley	Dodge	Heard	Monroe	Tattnall
Bryan	Early	Irwin	Morgan	Terrell
Butts	Elbert	Jasper	Oconee	Turner
Candler	Evans	Johnson	Oglethorpe	Twiggs
Charlton	Fannin	Jones	Pickens	Union
Chattooga	Franklin	Lee	Pierce	White
Cook	Gilmer	Long	Pike	Wilkinson
Counties/Regions with a Low ABAWD Population or Counties/Regions without allocated E&T Program Staff- Work Status Code "FP" in SUCCESS				
Brooks	Decatur	Fayette	Hart	Wayne
Cherokee	Effingham	Forsyth	Stephens	
Coffee	Emanuel	Habersham	Ware	
Counties with Exempt Major Cities - Work Status Code "FP" in SUCCESS. The cities identified in parenthesis should be coded "AE."				
Fulton (Atlanta, East Point)		Dougherty (Albany)		
<b>ABAWDs in these counties:</b> Must be identified Must be coded correctly on SUCCESS Do not participate in E&T activities Are not subject to 3-of-36 month time limit Are not subject to penalty months for non-compliance				

## Objectives for Changes



### **Participants will:**

- ❑ Examine the elements of establishing representative income and expenses
- ❑ Calculate the amount of a missing pay stub using Year-to-Date pay amounts
- ❑ Determine representative income and expenses for initial applications
- ❑ Examine types of changes reported by an AU
- ❑ Determine actions which may be needed on a reported change

## Three Elements to Correctly Determining Representative Pay

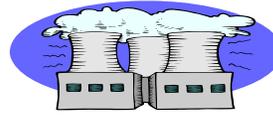


**1.** \_\_\_\_\_

**2.** \_\_\_\_\_

**3.** \_\_\_\_\_

*EXAMPLE 1: HOMER SIMPSON*



Homer Simpson is employed at the Meltdown Power Plant.  
He is paid weekly and provides the following pay stubs.  
Determine representative pay.

1/7/00	\$ 0
1/14/00	\$ 55.00
1/21/00	\$645.00
1/28/00	\$300.00



*EXAMPLE 2: DARIA JONES*

Daria Jones is employed at Kentucky Fried Chicken. She is paid weekly and provides the following pay stubs. She states that the 1/7 and 1/14 checks are not representative as they include overtime pay. Determine the representative amount.

1/7/00	\$500.00
1/14/00	\$503.00
1/21/00	\$400.00
1/28/00	\$412.00



*EXAMPLE 3: Fred Jones*

Fred works at UPS. He provides the following four check stubs to verify his pay.

12/31	\$520
12/24	\$569
12/17	\$560
12/10	\$540

Mr. Jones states that none of these checks are representative because he worked overtime all through the holidays.





**Food Stamp Phase 3 TM  
Changes**

**December 14, 2005**

INQUIRY **EARNED INCOME 1 - ERN1** ERN1 01  
 Month 03 05 01  
 Remarks  
 Client Name DARIA JONES Client ID 190427538

Do you have any of the following: wages, self employment, commissions/tips, Roomer/boarder income, rent, mortgage payment, sick pay, work program, JTPA, Job Corps, training allowance, use/sale of personal property, or other income?

Employer Name KENTUCKY FRIED CHICKEN AJS Employ N  
 Line 1 33 HWY 34 Line 2  
 City NEWNAN ST GA Zip 30263 Phone 770 253 9856  
 Begin First End Late SON \$30+1/3 \$30+1/3  
 \$30  
 Type Date Pay Date Date Rpt Ovr Ind Cntr End Date End  
 Date  
 EI 09 06 95 09 12 95 N  
 AFDC  
 ARM

Num of ABD Stdnt TANF Student JTPA  
 Bordrs EXCL Ind Cnt Ind Cnt

Excl

Message More Jobs  
 15-lett 17-mo< 18 mo>

**02/07/05 Ms. Jones is still employed at KFC. She began working there in 9/95. The enclosed DOL clearinghouse does not indicate any other employers for A/R. No discrepancies.  
 S. Savage v618**

CHANGE **EARNED VARIABLE INCOME CALCULATION - EVNC** EVNC 02  
 Month 03 00  
 Remarks  
 Client Name DARIA JONES Client ID 190427538

Del	Avg Hours	45	Freq WK	Day Week	Pd FR	Extra Pay
	PP End Date		Pd/Rcvd Date	Amount	V	Repres
	MM DD YY					
	01 04 05		01 07 05	500.00	CH	Y
	01 11 05		01 14 05	503.00	CH	Y
	01 18 05		01 21 05	400.00	CH	Y
	01 25 05		01 28 05	412.00	CH	Y

Message 24-del

**Food Stamp Phase 3 TM  
Changes**

**December 14, 2005**

CHANGE **EARNED INCOME 2 - ERN2** ERN2 02  
 Month 03 05 01  
 REMARKS  
 Client Name DARIA JONES Client ID 190427538  
 Employer Name KENTUCKY FRIED CHICKEN

		Avg Hrs	045	Freq	WK	Day	Week	Pd	FR	Extra	Pay
Del											
Amt 1	V	Amt 2	V	Amt 3	V	Amt 4	V	Extra	V		
453.75	VN										
-----				Work Expenses				-----			
---											
	Type	Amount	Freq	V	Type	Amount	Freq	V			

More Jobs

Message

15-lett      16-evnc      23-alau      24-del

02/07/05 Ms. Jones earns \$10 per hour. She provided 4 check stubs to verify her earnings. Ms. Jones said in the interview that these checks were not representative as they have overtime. Since more than half of the checks show overtime, it appears that overtime is representative of her normal pattern of work. Ms. Jones was given the option of providing additional verification to show that overtime is not representative. A/R chose to use the checks provided as representative.  
 S. Savage v618

**Food Stamp Phase 3 TM  
Changes**

**December 14, 2005**

INQUIRY  
Month 02 05

**EARNED INCOME 1 - ERN1**

ERN1 01  
01

Remarks

Client Name FRED

JONES

Client ID 190427538

Do you have any of the following: wages, self employment, commissions/tips, Roomer/boarder income, rent, mortgage payment, sick pay, work program, JTPA, Job Corps, training allowance, use/sale of personal property, or other income?

Employer Name UPS

AJS Employ N

Line 1 2100 WINDWARD PKWY

Line 2

City ATLANTA ST GA

Zip 30305

Phone 404 658 7412

Begin

First

End

Late

SON

\$30+1/3

\$30+1/3

\$30

Type

Date

Pay Date

Date

Rpt

Ovrd

Ind Cntr

End Date

End

Date

EI

08 01 94

08 19 94

N

AFDC

ARM

Num of ABD Stdnt

TANF Student

---JTPA---

Bordrs

EXCL

Ind Cnt

Ind Cnt

Excl

Message

15-lett

17-mo <

18 mo>

More Jobs

01/05/05 Mr. Jones is still employed by UPS. He began working at UPS in 8/94. DOL Clearinghouse establishes that there have been no other reported employers for Mr. Jones. No discrepancies.  
S. Savage v618



**Worksheet**  
**Determine a missing check amount**  
**based on Year to Date**

**Gross YTD from the check  
after the missing check** \_\_\_\_\_

-

**Gross Current amount from  
the check after the missing  
check** \_\_\_\_\_

=

**Gross YTD from the check  
before the missing check** \_\_\_\_\_

-

**Gross Amount of missing  
check** \_\_\_\_\_

=

ASSOCIATE NAME: TRACY KING

SSN: 258-98-7421

PIN NO: 2162

TAX NUMBER  
STATUS EXEMPT  
MEDICARE 0  
FICA-OASDI 0  
U.S. TAX S 2  
GA STATE S 2

PAY PERIOD BEGIN: 05/17/05 CHECK DATE: 06/04/05

PAY PERIOD END: 05/30/05 CHECK NUMBER: 7685

EARNINGS				DEDUCTIONS			TAXES		
DESCRIPTION	RATE	HOURS	CURRENT YEAR-TO-DATE	DESCRIPTION	CURRENT	YEAR-TO-DATE	DESCRIPTION	CURRENT	YEAR-TO-DATE
REGULAR	9.00	33.50	301.50	STD	6.11	54.99	MEDICARE	8.47	93.97
REGULAR	9.00	33.75	303.75	LTD	3.10	27.90	FICA-OASDI	37.06	401.80
DEM EMP MG			7.55-				U.S.TAX	42.64	454.91
REG ADJUST							GA STATE	10.79	115.51
OVERTIME			104.63						
<b>GROSS PAY: 597.70 6480.68</b>							<b>NET PAY: 489.33 5331.60</b>		

HOME DEPOT U.S.A. INC.

ASSOCIATE NAME: TRACY KING

SSN: 258-98-7421

PIN NO: 2162

TAX NUMBER  
STATUS EXEMPT  
MEDICARE 0  
FICA-OASDI 0  
U.S. TAX S 2  
GA STATE S 2

PAY PERIOD BEGIN: 06/14/05 CHECK DATE: 07/02/05

PAY PERIOD END: 06/27/05 CHECK NUMBER: 9863

EARNINGS				DEDUCTIONS			TAXES		
DESCRIPTION	RATE	HOURS	CURRENT YEAR-TO-DATE	DESCRIPTION	CURRENT	YEAR-TO-DATE	DESCRIPTION	CURRENT	YEAR-TO-DATE
REGULAR	9.00	40.00	360.00	STD	6.11	67.21	MEDICARE	8.50	111.51
REGULAR	9.00	28.50	256.50	LTD	3.10	34.10	FICA-OASDI	36.36	476.82
REG ADJUST	9.00	4.00-	36.00-				U.S.TAX	40.95	542.38
OVERTIME	13.50	1.00	13.50				GA STATE	10.11	137.96
DEM EMP MG			7.55-						
HOLIDAY			72.00						
<b>GROSS PAY: 586.45 7690.71</b>							<b>NET PAY: 481.32 6320.73</b>		

HOME DEPOT U.S.A. INC.

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## BUDGETING INCOME AND EXPENSES AT INITIAL APPLICATION

**Complete the following situations and check your answers on the following pages.**

1. Mr. Samuels' income varies from week to week. He applies on 10/28 and provides 4 pay stubs as verification of his income at the interview on 10/28; he states that these are representative of his normal pay. Case is approved on 11/12.

10/3	\$107.10
10/10	\$110.27
10/17	\$100.50
10/24	\$ 97.86

What amount of income will be budgeted for October? For November? For December?

2. Mr. Smith applies on 3/12. He is paid bi-weekly on Fridays. His income varies and he provides the following verification of wages at his interview on 3/12; he states that these are representative of his normal pay. The case is approved on 3/23.

2/20	\$286.27
3/6	\$273.81

What amount of income will be budgeted for March? For April?

3. Ms. Jones applies on 3/16. She is paid semi-monthly on the 15th and 30th. She verifies her recent two pay stubs; she states that the checks are representative of her normal pay. The 3/15 check includes some wages which were left off of an earlier check in error; you can see on the check that the additional \$20 is designated as "Other". She is approved on 4/6.

3/15	\$350.00
3/30	\$330.00

What amount of income will be budgeted for March? For April? For May?

4. Ms. Renard applies on 5/12. Her only income is a weekly contribution from her father, which varies from week to week. She also states that there is usually one week out of the month that he doesn't give her any money. The case is approved on 6/5. She provides the following verification which she states is representative:

5/22	\$50.00
5/15	\$35.00
5/8	\$40.00
5/1	\$ 0.00

What amount will be budgeted for May? For June?

5. Ms. Cook applies on 2/17. She just began working on 2/13, her hours vary and she states she is paid weekly on Thursdays. The case is approved on 3/15. She provided the following verification which she states is representative:

2/27	\$120.00
3/5	\$110.00
3/12	\$115.00

What amount of income will be budgeted for February? For March? For April?

6. Ms. Geritol applies on 10/20. Her only income is child support received weekly on Fridays directly from her daughter's father. The case is approved on 11/3. She provides the following verification which is representative of his normal pattern of payment:

9/25	\$100.00
10/2	\$ 80.00
10/9	\$ 75.00
10/16	\$ 85.00

What amount of income will be budgeted for October? For November?

7. Mr. Cornwall applies on 7/8. He just began working on 7/1. He provides a statement which verifies that he will be making \$5.75 per hour, he will work 30 hours per week and he will be paid weekly on Wednesdays. He will receive his first pay check on 7/15. The case is approved on 7/15.

What amount of income will be budgeted for July? For August?

8. Ms. White applies on 10/15. She verifies that her job ended on 10/8 and she received her last check today. She was paid weekly on Thursdays. The case is approved on 11/5. She provided the following pay stubs:

9/24	\$140.00
10/1	\$130.00
10/8	\$122.30
10/15	\$141.80

What amount of income will be budgeted for October? For November? For December?

9. Mr. Knight applies on 6/23. He states that he works three days per week and that he sometimes works between 8-12 hours per day. He is paid weekly. He states he pays child care expenses for his two children ages 1 and 4, that vary weekly depending on the hours he works. The case is approved 7/12. He provided the following verification of his wages and child care, he states that these are "normal" fluctuations:

<b>Wages:</b>	6/5	\$195.00	<b>Child Care:</b>	6/6	\$70.00
	6/12	\$220.00		6/13	\$75.00
	6/19	\$210.00		6/20	\$75.00
	6/26	\$230.00		6/27	\$80.00

What amount of income will be budgeted for June? For July? For August?

What will be the child care deduction for June? For July? For August?

10. Ms. Trendy applies on 8/10. She reports that she lost her job and she will receive her final pay check on 8/14. She was paid weekly on Fridays. The case is approved on 8/31. She provided the following verification at her interview on 8/10:

7/17	\$235.00
7/24	\$220.00
7/31	\$195.00
8/7	\$220.00

On 8/20, she provides a separation notice that verifies her last check was \$200.00.

What amount of income will be budgeted for August? For September?

**BUDGETING INCOME AND EXPENSES AT INITIAL  
APPLICATION  
KEY**

1. Mr Samuels' income varies from week to week. He applies on 10/28 and provides 4 pay stubs as verification of his income at the interview on 10/28; he states that these are representative of his normal pay. Case is approved on 11/12.

10/3 \$107.10  
10/10 \$110.27  
10/17 \$100.50  
10/24 \$ 97.86

What amount of income will be budgeted for October? For November? For December?

**Continuing income is converted for each of the application months.**

**$\$415.73 \times 4 = \$103.932 = \$103.93 \times 4.3333 = \$450.359 = \$450.35$**

**$\$450.35$  would be budgeted for Oct, Nov and ongoing.**

2. Mr. Smith applies on 3/12. He is paid bi-weekly on Fridays. His income varies and he provides the following verification of wages at his interview on 3/12; he states that these are representative of his normal pay. The case is approved on 3/23.

2/20 \$286.27  
3/6 \$273.81

What amount of income will be budgeted for March? For April?

**Continuing income is converted for each of the application months.**

**$\$560.08 \times 2 = \$280.26 \times 2.1666 = \$606.734 = \$606.730$**

**$\$606.73$  would be budgeted for March and ongoing.**

3. Ms. Jones applies on 3/16. She is paid semi-monthly on the 15th and 30th. She verifies her recent two pay stubs; she states that the checks are representative of her normal pay. The 3/15 check includes some wages which were left off of an earlier check in error; you can see on the check that the additional \$20 is designated as "Other". She is approved on 4/6.

3/15 \$350.00  
3/30 \$330.00

What amount of income will be budgeted for March? For April? For May?

**Continuing income is converted for each of the application months.**

**\$330.00 X 2 = \$660.00 for March, April, and May**

4. Ms. Renard applies on 5/12. Her only income is a weekly contribution from her father, which varies from week to week. She also states that there is usually one week out of the month that he doesn't give her any money. The case is approved on 6/5. She provides the following verification which she states is representative:

5/22 \$50.00  
5/15 \$35.00  
5/8 \$40.00  
5/1 \$ 0.00

What amount will be budgeted for May? For June?

**Continuing income is converted for each of the application months.**

**\$125.00 ) 4 = \$31.25 H 4.3333 = \$135.415 = 135.41**

**\$135.41 would be budgeted for May and June**

5. Ms. Cook applies on 2/17. She just began working on 2/13, her hours vary and she states she is paid weekly on Thursdays. The case is approved on 3/15. She provided the following verification which she states is representative:

2/27	\$120.00
3/5	\$110.00
3/12	\$115.00

What amount of income will be budgeted for February? For March? For April?

**In February, the income is new so we'll budget the actual amount of \$120**

**For March and April the AU will receive a full month, so the income will be converted.**

**\$345.00 ) 3 = \$115.00 H 4.3333 = \$498.32**

**\$498.32 would be budgeted for March and April**

6. Ms. Geritol applies on 10/20. Her only income is child support received weekly on Fridays directly from her daughter's father. The case is approved on 11/3. She provides the following verification which is representative of his normal pattern of payment:

9/25	\$100.00
10/2	\$ 80.00
10/9	\$ 75.00
10/16	\$ 85.00

What amount of income will be budgeted for October? For November?

**Continuing income is converted for each of the application months**

**\$340.00 )4 = \$85.00 H 4.3333 = \$368.33**

**\$368.33 would be budgeted for October and November**

7. Mr. Cornwall applies on 7/8. He just began working on 7/1. He provides a statement which verifies that he will be making \$5.75 per hour, he will work 30 hours per week and he will be paid weekly on Wednesdays. He will receive his first pay check on 7/15. The case is approved on 7/15.

What amount of income will be budgeted for July? For August?

**Income for which a full month is not received is not converted**

$$\mathbf{\$5.75 \times 30 = \$172.50 \times 4.3333 = \$747.49}$$

**\$517.50 would be budgeted for July (3 pay periods in July)**

**\$747.49 would be budgeted ongoing.**

8. Ms. White applies on 10/15. She verifies that her job ended on 10/8 and she received her last check today. She was paid weekly on Thursdays. The case is approved on 11/5. She provided the following pay stubs:

9/24	\$140.00
10/1	\$130.00
10/8	\$122.30
10/15	\$141.80

What amount of income will be budgeted for October? For November? For December?

**Income for which a full month is not received is not converted**

**\$130 + \$122.30 + \$141.80 = \$394.10 would be budgeted for October**

**No income would be budgeted in November or December**

9. Mr. Knight applies on 6/23. He states that he works three days per week and that he sometimes works between 8-12 hours per day. He is paid weekly. He states he pays child care expenses for his two children ages 1 and 4, that vary weekly depending on the hours he works. The case is approved 7/12. He provided the following verification of his wages and child care, he states that these are "normal" fluctuations:

<b>Wages:</b>	6/5	\$195.00	6/6	\$70.00
	6/12	\$220.00	6/13	\$75.00
	6/19	\$210.00	6/20	\$75.00
	6/26	<u>\$230.00</u>	6/27	<u>\$80.00</u>
		<b>\$855.00</b>		<b>\$300.00</b>

**Continuing income and expenses are converted for each of the application months**

What amount of income will be budgeted for June? For July? For August?  
**\$855 ) 4 = \$213.75 H 4.3333 = \$926.24 for June, July and August**

What will be the child care deduction for June? For July? For August?  
**\$300.00+ ) 4 = \$75.00 H 4.3333 = \$324.99 for June, July and August**

10. Ms. Trendy applies on 8/10. She reports that she lost her job and she will receive her final pay check on 8/14. She was paid weekly on Fridays. The case is approved on 8/31. She provided the following verification at her interview on 8/10:

7/17	\$235.00
7/24	\$220.00
7/31	\$195.00
8/7	\$220.00

On 8/20, she provides a separation notice that verifies her last check was \$200.00.

What amount of income will be budgeted for August? For September?  
**\$420.00 for August, \$0 for September**

## Verification Requirements for Deductions (ESS 3615 - 22)

<i>Initial Applications</i>		
DEDUCTION	VERIFICATION REQUIREMENTS	IF VERIFICATION IS NOT PROVIDED
Excess Medical Expense	Third Party Source: Current, non-reimbursable expenses	Do Not Allow Expense
Dependent Care Expense	Third Party Source: Actual cost of care incurred and expected to be paid by the AU	Do Not Allow Expense
Child Support Expense (payment)	Third Party Source: Legal obligation, amount of legal obligation, and amount actually paid	Do Not Allow Expense
Housing Expense (rent, mortgage, taxes, insurance, etc.)	Third Party Source: Current housing costs i.e., most recent bills received by the AU	Do Not Allow Expense
SUA (H/C, non-H/C, or Telephone)	Accept AU statement	N/A
Actual expense of one utility	Third Party Source: Verify actual utility expense for the dwelling for the previous 12 months	Do Not Allow Expense

<i>Interim Changes</i>		
REPORTED CHANGE	VERIFICATION REQUIREMENTS	IF VERIFICATION IS NOT PROVIDED
In: <ul style="list-style-type: none"> <li>- excess medical expense</li> <li>- dependent care expense</li> <li>- housing expense</li> <li>- utility deduction</li> </ul> which causes an increase in benefits	Verify by Third Party source  Exceptions: <ul style="list-style-type: none"> <li>- Accept A/R statement when SUA/telephone standard is used</li> <li>- Medical expense reported via third party which requires verification from A/R – do not act on until review</li> </ul>	Leave at original/lower amount
In: <ul style="list-style-type: none"> <li>- excess medical expense</li> <li>- dependent care expense</li> <li>- housing expense</li> <li>- utility deduction</li> </ul> which causes a decrease in benefits	Accept AU statement, process change	N/A
Child Support Expense	Verify by Third Party source if benefits increase	Do not allow the deduction
	Accept AU statement and process change if benefits decrease	N/A

<i>Reviews</i>		
DEDUCTION	VERIFICATION REQUIREMENTS	IF VERIFICATION IS NOT PROVIDED
Excess Medical Expense	Third Party Source: New non-reimbursable expenses of if amount of existing expense has changed by more than \$25 per month since last review and was not previously verified	Do Not Allow Expense
Dependent Care Expense	Third Party Source: If provider changes OR the total amount has changed by more than \$25 per month since last review and was not previously verified	Do Not Allow Expense
Child Support Expense (payment)	Third Party Source: If legally obligated amount has change OR the amount paid has changed	Do Not Allow Expense
Housing Expense (rent, mortgage, taxes, insurance, etc.)	Third Party Source: If the total amount has changed by more than \$25 per month since last review and was not previously verified OR the AU has moved	Do Not Allow Expense
SUA (H/C, non-H/C, or Telephone)	Accept AU statement	N/A
Actual expense of one utility	Third Party Source: If the amount has changed by more than \$25 per month since last review and was not previously verified OR the AU has moved.	Do Not Allow Expense

## NEW ADDRESS



Ms. Wallace, a FS recipient, reports on August 3 that she moved on August 1 and must now pay rent. Ms. Wallace states that she moved to 234 Tripoli Court, Apt. B-4, still in your city. FS benefits will increase.

- 1. Do we need to verify the rent amount at the new address?**
  
- 2. What policy areas may be affected by this change? List.**

## LOSS OF WAGES



Ms. Meriwhether, a FS recipient, reports on 2/19 that she lost her job on 2/17. She will receive one last check on 2/21 for \$123.00. This job was Ms. Meriwhether's only income; her monthly expenses are \$350. There are no other AU members; Ms. Meriwhether lives alone. FS benefits will increase.

1. **Effective what month must the income be removed from the budget?**
  
2. **What verification is necessary to process this change?**
  
3. **What policy areas may be affected by this change? List.**
  
  
  
  
  
  
  
  
  
  
4. **In addition to the policy areas listed above, what policy areas may be affected by this change if Ms. Meriwhether has children? List.**

## NEW WAGES



Ms. Marshall, a non-SRR AU, calls on 10/16 to report that she has a new job. She will be working 40 hours per week at \$5.25 per hour. She began work 10/7. She received her first check on 10/14. FICM takes action on 10/18.

- 1. Did Ms. Marshall report this change timely?**
- 2. Effective what month should this income be included in the budget?**
- 3. What amount of income will be budgeted?**
- 4. What other policy areas may be affected by this change? List.**

## NEW PERSON



Ms. Cato reports on March 23 that she had a baby on March 19. He has no income, she provides all necessary verification to add the baby on April 2. FS benefits will increase.

- 1. Effective what month should the baby be added to the FS AU?**
- 2. What verification is required to add the baby to the FS AU?**
- 3. What other policy areas may be affected by this change? List.**

## DECREASE OF INCOME



Ms. Amons reports on May 26 that her hours at work have decreased. She will earn about \$200 less per month as a result of this change. FS benefits will increase.

1. **Effective what month should the income be decreased in the FS budget?**
2. **What verification is necessary to process this change?**
3. **What policy areas may be affected by this change? List.**

---

## Objectives for Periods of Eligibility



### **Participants will:**

- ❑ Review the criteria for establishing Periods of Eligibility for SRR and Non-SRR Aus
- ❑ Review the current Food Stamp Periods of Eligibility
- ❑ Determine appropriate Periods of Eligibility

## FOOD STAMP PERIODS OF ELIGIBILITY



The POE should be consistent with the AU's circumstances. **SUCCESS** will assign the most appropriate POE based on the AU's circumstances.



AUs determined eligible for Simplified Reporting Requirements (SRR) and assigned the 6 month POE, can have the POE changed only at Review. FICM cannot shorten the POE for any reason.



For Non-SRR AUs, a shorter POE may be assigned when the AU's situation warrants a shortened POE due to:

- Questionable Management
- Change is anticipated

The POE can be shortened on the FSFI screen by changing the Review End Date. A POE can never be extended.

Regardless of the AU's situation, the FICM should check the FSFI screen to make sure the assigned POE is correct.

## FOOD STAMP PERIODS OF ELIGIBILITY



Types of Assistance Unit	Period of Eligibility
Non - SRR  ALL Adults in the AU are Elderly or Disabled and NO earned income	<b>Up to Twelve Months</b>
SRR  ✓ All Other AUs ✓ AUs with an ABAWD ✓ Homeless ✓ Seasonal/Migrant Farmworkers	<b>Six Months</b>

## Objectives for Shelter



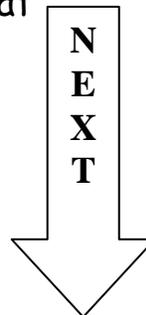
### **Participants will:**

- ❑ Discuss allowable shelter costs
- ❑ Examine the definition of a dwelling
- ❑ Analyze situations of shared and separate dwellings
- ❑ Identify types of interim changes that may affect the excess shelter deduction
- ❑ Review the verification requirements relating to shelter changes
- ❑ Calculate Total Shelter Costs

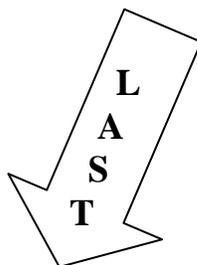
# Correctly Determining Shelter



Start with the dwelling.  
Ask A/R, "How do you heat  
or cool your home?"



Determine the types of utility  
expenses, how paid, and who  
shares the cost



Determine the Appropriate  
SUA Type or utility expense  
Deduction (telephone expense  
or actual)



## UTILITY EXPENSES

IF	THEN
<p>The AU incurs/expects to incur a heating or cooling expense separate from the rent or mortgage (paid to landlord or utility provider)</p> <p style="text-align: center;"><b>OR</b></p> <p>The AU incurs/expects to incur an excess utility expense for heating or cooling costs for <u>living in public housing</u>.</p> <p style="text-align: center;"><b>OR</b></p> <p>The AU has received LIHEAP in the past 12 months at the current address</p>	<p><b>Eligible for H/C SUA</b> <b>Currently \$323 per month</b></p> <p>This SUA includes: heating, cooling, water/sewage, electricity, cooking fuel, <b>basic service for one standard phone*</b>, garbage collection, and installation and maintenance for well or septic tank</p> <p>*Accept the applicant/recipient's statement unless questionable</p>
<p>The AU incurs/expects to incur at least two utility expenses other than a heating or cooling expense (paid to landlord or utility provider)</p> <p style="text-align: center;"><b>OR</b></p> <p>The AU incurs/expects to incur an excess utility expense for <u>living in public housing</u> other than a heating or cooling expense.</p>	<p><b>Eligible for non-H/C SUA</b> <b>Currently \$175 per month</b></p> <p>This SUA includes: cooking fuel, electricity not used for heating or cooling, water/sewage, <b>basic service for one standard phone*</b>, garbage collection, and installation and maintenance for well or septic tank</p> <p>*Accept the applicant/recipient's statement unless questionable</p>
<p>The AU incurs/expects to incur a telephone expense only (installed or cellular)</p>	<p>Eligible for the <b>Telephone Standard only*</b> <b>\$30.00</b></p> <p>Accept the applicant/recipient's statement unless questionable.</p>
<p>The AU incurs/expects to incur only one utility, other than a heating or cooling expense (paid to landlord or utility provider)</p>	<p>Eligible for <b>actual utility expense</b> to be used as the deduction. Actual utility cost must be verified. Actual expense must be verified by landlord if paid to him/her and amount is always the same OR with 12 months of verification if paid directly to utility company/provider.</p>

\*NOTE: The AU cannot receive both H/C or Non-H/C and the telephone standard, as the cost of the basic service for one standard phone is included in the SUA.

Consider **intent** to turn on the utility.

**Any person sharing the cost of utilities for the dwelling (pays a specific utility or pays a portion) is entitled to the full SUA for which the dwelling qualifies.**

## Objectives for Skill Building



### **Participants will:**

- ❑ Analyze case studies
- ❑ Explore follow-up questions to determine how an AU is managing income and expenses
- ❑ Resolve discrepancies in information
- ❑ Request appropriate verification

## **STEP 1**

You are an Intake Case Manager who has just received this application and expense statement from clerical support. Before you get Ms. Powell from the waiting room for her interview, you see what the application and expense statement tell you about her.

**1. What does the application tell you about Ms. Powell?**

**2. What does the expense statement tell you about Ms. Powell?**

Georgia Department of Human Resources

**APPLICATION FOR CASH, FOOD STAMP OR MEDICAL ASSISTANCE**

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin or political belief.

Today's Date: 10-2-99 Date Received by DFCS: 10-2-99

To apply for benefits, you only have to fill out the name of the head of household and address where you can be reached in Section I, sign your name and give us this application today. Write the telephone number where you can be reached during the day. If you cannot be interviewed today, leave this application with us, because some benefits, such as Food Stamps, are provided from the date you give us this application. We have 30 days from the day you give us the signed Food Stamp application to act on it, and 45 days to act on your application for Financial Assistance or Medical Assistance (Medicaid). If you are applying for Medical Assistance as a disabled person, we have up to 60 days to act on your application. If you are applying for Medical Assistance as a pregnant woman, we have up to 10 days to act on your application.

**I. Applicant's Name and Address (NAME)**

1. Name of head of household or person for whom you are applying for assistance:

First: DAWN Middle: S. Last: POWELL Suffix:

2. What is your primary language?  English  Spanish  Other  
Your Date of Birth: 10-19-61  
Your Social Security #: 204-92-1250

3. Are you visually/hearing impaired and need special assistance with application process?  Yes  No  
If yes, check one:  Visually Impaired  Hearing Impaired

4. Do you live in public housing?  Yes  No  
5. Phone Number: (770) 299-2929  
area code

6. Home Address:  
Street: 1865 WILLOW LN. Apt. #: 19 Box or Route #:

City: CROSSVILLE State: GA. Zip: 30051

7. Mailing Address: (If same as above write "same as home")  
Street: SAME Apt. #: Box or Route #:

City: State: Zip:

8. Signature of Applicant: Dawn Powell Date:

**II. Assistance Desired (KIND)**

- Check each type of assistance you are applying for:
- Financial Assistance, including Temporary Assistance to Needy Families and Refugee Cash Assistance.
  - Food Stamps.
  - Medicaid, including Right from the Start Medicaid for pregnant women and children under age 19.
  - Medicaid for the Aged, Blind and Disabled, including Nursing Home Medicaid, Qualified Medicare Beneficiaries and Medically Needy.
  - Foster Care or Adoption Assistance including IV-E Foster Care per diem and Adoption Assistance Medicaid.
  - Other Assistance (specify) \_\_\_\_\_

**III. Household Circumstances (CIRC)**

**IMPORTANT:** Your household may be able to get Food Stamps within 5 days of the date we receive your application if your household is in at least one of the following situations:

- \* You have monthly income of less than \$150.00 and resources (such as cash and money in the bank) of no more than \$100.00.
- \* The members of your household are migrant or seasonal farm workers with no more than \$100.00 in resources.
- \* The resources and combined monthly income of all members of your household is less than your monthly shelter costs.

Please answer the following questions below so that we can determine if you fit one of these situations.

**Note:** You need to answer 1-4 only if you are applying for Food Stamps. Answer 5-15 if you are applying for any type of assistance, including Food Stamps.

1. Total amount of income you and your household members have received for working this month: \$ 0

2. Total amount of other income you and your household members have received this month: (Specify, such as Social Security, SSI, Unemployment Compensation, etc.) \$400

3. Total amount you and your household members have in cash or in bank accounts:  
Cash: \$ 10.00 | Bank Account: \$ 0

4. Total amount each month you and your household members pay for rent, mortgage and utilities: \$300

**IV. Other Household Circumstances (CIRC)**

Check any of the following that apply to you or to the person(s) for whom you are applying for assistance. This will help us determine the correct class of assistance for your situation.

- 5.  Are you applying for Medicaid for a person over the age of 18 whose Supplemental Security Income (SSI) check has been stopped?
- 6.  Are you applying for Medicaid to cover unpaid medical bills from the past three months or from the three months prior to an SSI application?
- 7.  If you are applying for Medicaid, are you or your spouse currently covered by Medicare?
- 8.  Are you applying for Medicaid to help pay for community based waiver services provided under programs such as Community Care Services, Mental Retardation Waiver, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
- 9.  Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
- 10.  Are you applying for Medicaid to help pay for the care of an a person 65 years of age or older or disabled person who has been in a hospital for at least 30 days or who died in the hospital?
- 11.  If you are applying for Food Stamps, are you residing in a shelter for battered women and children?
- 12.  If you are applying for Food Stamps, are you a migrant worker or a seasonal farm worker?
- 13.  Are you a refugee?
- 14.  If you are an adult applying for Medicaid for your dependent child(ren) that live with you, do you need Medicaid for yourself because of a specific illness or medical problem you are experiencing?
- 15.  Do you want to appoint someone to act as your authorized representative in the application process, or to receive notices, or to cash in your Food Stamp benefits for you?



Have you recently received benefits in another COUNTRY?  Yes  No  
If Yes, what country and when? \_\_\_\_\_

Have you recently received benefits in another STATE?  Yes  No  
If Yes, what state and when? \_\_\_\_\_

**PLEASE ANSWER THESE QUESTIONS FOR ANY PROGRAM:**

1. Is anyone in your household fleeing to avoid prosecution, custody, or confinement after conviction, under the law?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Is anyone in your household in violation of his/her parole/probation?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household fraudulently misrepresented his/her identity or residence to receive any benefits?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Has anyone in your household been found guilty of felony related to a controlled substance (drugs)?  
 Yes  No (If Yes, who \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR TANF:**

1. Has anyone in your household been found guilty of a serious violent felony?  
 Yes  No (If Yes, who \_\_\_\_\_ What type of felony? \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR FOOD STAMPS:**

1. Has anyone in your household been found guilty by a court of selling food stamps of \$500 or more?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Has anyone in your household been found guilty of using food stamps to buy firearms, ammunition or explosive?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household been found guilty of using food stamps to buy illegal drugs?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Do you understand that some able bodied food stamp recipients (without dependents children) will only be eligible to receive food stamps for 3 month period, unless they work for at least 20 hours a week or participate in certain work and training program such as JTPA and Trade Assistance ACT?  
 Yes  No (If Yes, who \_\_\_\_\_)

I have read the parts of this form that apply to me and my household.  
All the information which I have provided is true and complete as far as I know. The answers I have given in my interview are true. I understand I must report changes to my caseworker within 10 days of the change occurring.

\_\_\_\_\_  
Signature Date 10-2-99

\_\_\_\_\_  
Authorized Representative Date

\_\_\_\_\_  
Caseworker Date

EXPENSE STATEMENT

Application    Review    Change  
Completion Optional

I. How does your household pay the following bills?

EXPENSE	AMOUNT DUE	HOW OFTEN PAID	LAST TIME PAID	PAID BY WHOM
Rent / Mortgage	236.00	MONTHLY	10-1-99	PARENTS
Utilities	HAVEN'T RECEIVED BILL YET			
a. Electricity				
b. Gas				
c. Fuel Oil, Wood, Kerosene				
d. Water / Sewage				
e. Garbage				
f. Telephone	65.00	MONTHLY	10-1-99	PARENTS
<b>SUBTOTAL</b>				
Furniture / Appliances				
Beepers				
Life / Health Insurance				
Charge Accounts / Credit Cards				
Auto Expenses (payments, insurance, maintenance)				
Other				
<b>TOTAL</b>	<b>301.00</b>			

EXPEDITED?  Yes    No

I. Comments / Documentation I JUST NEED HELP FOR A LITTLE WHILE UNTIL I CAN FIND A JOB!

II. I certify that the information given is true and correct to the best of my knowledge and belief.

Deann Powell  
Signature (Applicant / Recipient)

10-2-99  
Date

I certify that I have reviewed the information on this form with the applicant / recipient.

\_\_\_\_\_  
Signature (Eligibility Worker)

\_\_\_\_\_  
Date

COUNTY:	CASE NUMBER:
---------	--------------

## **STEP 2**

You have had your initial discussion with Ms. Powell prior to beginning your interview on SUCCESS. Look at what you learned in this conversation.

- 1. After reading the initial discussion, are there any other questions you would want to ask Ms. Powell to better understand her situation?**

## INITIAL DISCUSSION – Dawn Powell

*This is what was learned from Ms. Powell in the initial discussion that the case manager had before beginning the interview on SUCCESS.*

The A/R, Dawn Powell, states that she moved here from Florida last month. She has a Section 8 apartment and pays \$236/month rent. She has not received any utility bills yet. She has no income, but is looking for a job. She last worked for Atlantic Marketing in Marietta, but only briefly. Her parents, who live in Florida, send her \$400 each month to pay her bills. She doesn't want to apply for anything else because she expects to find a job soon. There is no one else in her household except her son. She doesn't own a car.



CHANGE HOUSEHOLD ADDRESSES - ADDR ADDR 01  
Month 03 00 \*\*71 01 21 00

REMARKS

CO 067 LO 199 Load ID 331D Client ID 797005656 Prev CO/LO  
HOH F Name DAWN MI L Name POWELL Suf

Auth Rep	Prim Lang	Voter Reg	Visually Impaired	Hearing Impaired	Public Hsng/ Rent Subsidy	Serial Number	Census Tract
N	E	N	N	N	Z		

Residential Address

Address Line 1	Line 2						
Street Number Dir	Name	Type	City Dir	Apt			
1865	WILLOW LN			19			
City	CROSSVILLE	ST GA	Zip 30051 8752	Phone 770 299 2929			

Mailing Address Del

Address Line 1	Line 2						
Street Number Dir	Name	Type	City Dir	Apt			
	SAME						
City	ST	Zip					

Previous Addresses in last 2 years N

Message

15-lett 21-narr 23-alau 24-del

UPDATE REMARKS - REMA REMA  
01 More

AR IS APPLYING FOR FS. SHE WITHDREW THE TANF CASE. SHE WANTED SOME JOB LEADS REFFERED TO JTPA OR DEPT OF LABOR. SHE WILL PROVIDE A COPY OF THE LEASE AND A LETTER FROM PARENTS THAT THEY PAY RENT. THEY WILL PROVIDE HELP WITH BILLS ONCE SHE GET THEM. SHE JUST MOVED HERE FROM FLORIDA. SHE HAS RECEIVED BEFORE. IN THE 1981 THRU 1982. HER RENT IS 236.00 A MONTH. HDG 10 12 99 CHECK AT NEXT REVIEW ON HER LIVING ARRANGEMENTS NO UINC OR RESOURCES. GDH 10 12 99

10/12/99 AR SUPPLIED REQUIRED VERIFICATION TIMELY, FS APPLICATION DATE WILL BE APPROVED.

AR IN FOR FOOD STAMP REVIEW. AR STATES NO CHANGES IN HOUSEHOLD HER PARENTS ARE STILL PAYING ALL BILLS. SHE IS NOT WORKING, YET. SHE ALSO STATES THE ENGINE IN HER CAR BLEW-UP. CURRENTLY AT SOUTHLAKE FORD ON TARA BLVD FOR REPAIRS WHICH COST 3500.00. SHE STATES SHE CANNOT PAY FOR THE REPAIRS.

F. HALL \*\*4C

120399 FS REV. CLST ADDR AND TEL. SAME. CLST NO CHAGES IN AU OR HH COMP. CL PROVIDED GA DL AS PROOF OF ID. E. LONG

CHANGE ASSISTANCE STATUS - STAT STAT B  
Month 03 00 \*\*66 10 02 99 01

AU ID 346861707 Prog FS Prog Type S Prev ABD Type Med COA Claim N  
CO 067 LO 199 Load ID \*\*1D Conversion Date

AU AU Status AU Stat Appl Begin Pd Thru ---Penalty--- Appeal  
Stat Reasons Date Date Date Date Type End Date Ind  
A 100299 100299 100299

-----  
First Last Rel V Mand Finl --Stat-- Rsn Appl Begin Pd Thru Penalty  
Name Name Incl Resp Date Date Date Date T Date  
DAWN POW SE OT Y RE A 100299 100299 100299  
ANTH POW CH BC Y RE A 100299 100299 100299

Message

20-rmen 22-alau(arch) 23-alau(curr)





CHANGE                      UNEARNED INCOME - UINC                      UINC 01  
Month 03 00                      \*\*71 12 03 99                      01

Remarks

Client Name DAWN                      POWELL                      Client ID 797005656

Do you have any of the following: RSDI, alimony, direct child support, contributions, VA, workers compensation, unemployment, sick/disability benefits, pension, railroad retirement, any other retirement, rent, interest, annuities, dividends, educational income, or striker benefits?

Type	Del	Freq	Claim Number	Ded	Ded Amt	V	Extra Pay
CO		MO					

Date Rcvd	Amount	V	Date Rcvd	Amount	V	Date Rcvd	Amount	V
10 01 99	400.00	LE						

Client Potentially Elig For Other Benefits?

More

Appl Type	Stat	Date	Appl Type	Stat	Date
Message					

15-lett	16-uvnc	23-alau	24-del
---------	---------	---------	--------

UPDATE	REMARKS - REMA	REMA
	01	

10/12/99

FORM 139 RECEIVED SHOWING MS. POWELL'S PARENTS GIVE HER 400.00 PER MONTH FOR LIVING EXPENSES.

F. HALL \*\*4C

120399 CLST SHE STILL RECEIVES 400.00 MONTH CONT FROM HER PARENTS. CW SENT FORM 139 TO MS. LIZ POWELL FOR VERF. E. LONG

122099 MS LIZ POWELL RETURNED COMPLETED F. 139 VERF SHE GIVES CL 400.00 PER MONTH CONT. E. LONG



CHANGE FOOD STAMP FINANCIAL ELIGIBILITY - FSFI FSFI B  
Month 03 00 \*\*71 12 20 99  
AU ID 346759707 Prog FS Prog Type S

Resources	Income Test (cont)		
Resources Limit	2000.00	Excess Shelter	103.00
Total Resources	.00	Medical Deduction	.00
Income Test		Dep Care Deduction	.00
Gross Income Standard	1199.	Child Support Ded	.00
Gross Count Earned	.00	Adjusted Net Income	163.00
Self Employ Expenses	.00	Net Income Standard	922.00
Earned Income Deduc	.00	Thrifty Food Plan	234.00
Net Earned Income	.00	Allotment Amount	185.00
Gross Count Unearn	400.00	Recoupment Amount	.00
AFDC / Refugee	.00	Benefit Amount	185.00
Standard Deduction	134.00	Previous Benefit	185.00

Bnft Eff Date 122099	Bnft Confirm	Reasons	Budgeting Method P
Notice Type	Waive Timely Notice Period		Notice Override
Review Begin Dt 01 00	Review End Dt 03 00	Strat 1	Issue Type

Message

13-note

DOL WAGE INQUIRY - WGEI		WGEI	
Next SSN		01	
SSN 204 92 1250		Benefit Year Begin Date	
Sel Employer Name	Emplr Num	Qtr/Yr	Wages Sur
STAFF LEASING OF GEORGI	54355829	4 98	335 POW
ADVANCED CALL CENTER	69662807	4 98	692 POW
ATLANTIC MARKET GRP INC	74273309	2 99	334 POW
ATLANTIC MARKET GRP INC	74273309	1 99	192 POW

Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total	Qtr/Yr	Qtr-Total
4/98	1,028	1/99	192	2/99	334	3/99	

Tot Wages 1,555 Potential Amt 39 Num of Wks 10 Max Amt 390  
Message

13-BNDX 14-SDX1 16-UCBI

FILE INQUIRY SUBMENU - OMEN OMEN  
Selection P

Client SSN 204 92 1250	Carrier Code
Client ID	Carrier Name
Client L Name	Worker ID
Client M Init	Worker L Name
Client F Name	LO/CO
Client DOB	Unit Type
Inc Match Type	Unit Supv
Tax Year	Load ID

- |                            |  |
|----------------------------|--|
| A. Inc Discrepancy Inquiry | J. DRS Inquiry                         |
| B. Inc Discrepancy Update  | K. DRS Update                          |
| C. DOL Wage Inquiry        | L. Federal Tax Intercept Inquiry       |
| D. DOL UCB Inquiry         | M. Federal Tax Intercept Update        |
| E. JTPA Inquiry            | N. Health Insurance Carriers - By Code |
| F. Error Log               | O. Health Insurance Carriers - By Name |
| G. BENDEX Inquiry          | P. W-4 ERS Inquiry                     |
| H. SDX Inquiry             | Q. SVES Request                        |
| I. Worker ID               |  |

Message  
0215 NO DATA AVAILABLE FOR DISPLAY

**HARMONY STATION APARTMENTS  
1250 OLD NORCROSS TUCKER ROAD  
TUCKER, GA 30084  
770-492-0024**

October 3, 1999

To Whom It May Concern:

This letter is to verify that Dawn Powell is a resident at Harmony Apartments. She moved in on October 1, 1999. Her current address is 1865 Willow Ln., Crossville, GA 30051.

If you need further information please call 770-492-0024.

Thank you,

Susan Simon  
Asst. Manager

Mr. and Mrs. Henry Powell Jr.  
2121 NE 23<sup>rd</sup> Street  
Fort Lauderdale, Florida 22211

To whom it may concern

I Mr. & Mrs. Henry Powell Jr., regarding our daughter Dawn Powell. We will take full responsibility for her rent payments.

Thank you in advance for this important matter.

Sincerely,

Mr. & Mrs. Henry Powell Jr.



Georgia Department of Human Resources

Gwinnett

County Department of Family and Children Services

CONTRIBUTION STATEMENT

10/8/99  
Date

TO: Mr & Mrs Henry Powell, Jr  
2121 NE 23rd St  
Fort Lauderdale Fl  
33221

RE: Dawn Powell  
346861707  
Case Number

LD

Dear Mr & Mrs Powell :

The above named person(s) has applied for or is receiving public assistance through the Gwinnett County Department of Family and Children Services. In order to determine eligibility it is necessary that we verify any contributions received by the family.

Please complete this form with the requested information and return it to this office in the enclosed envelope by 10/21/99. If you have any questions, please call me. If I am not in, please leave your name, phone number, and a time I may call you.

F. Hall

770 632 3698  
Telephone Number

Caseworker

Telephone Number

I give \$ 400.00 per month as a contribution for the above person(s).  
(Week/Month)

( ) I give this money directly to the above person(s) in the amount of \$ \_\_\_\_\_ per \_\_\_\_\_ (Week/Month)

In the months listed below I gave the following amounts:

Amount	in	Month/Year
\$ _____	_____	_____
\$ _____	_____	_____
\$ _____	_____	_____

( ) I pay the following bills directly to the provider/company for the above person(s): Mortgage company; Rent to landlord or Apartment office; Utilities (electric, gas, water, sewer, garbage collection, telephone companies); Finance companies; Bank or personal loans; Auto or truck payments; etc.

\$ \_\_\_\_\_ to \_\_\_\_\_ . \$ \_\_\_\_\_ to \_\_\_\_\_ .  
\$ \_\_\_\_\_ to \_\_\_\_\_ . \$ \_\_\_\_\_ to \_\_\_\_\_ .

NOTE: If you need more room please use the reverse of this form and continue to tell us the amount you pay and to which provider/company.

I DO (do or do not) intend to continue giving this money to the above person(s).  
If you do, please show amount you intend to give in the future: \$ 400<sup>00</sup> every month (Week/Month)  
If you do not, please show last date you gave any money: \_\_\_\_\_  
COMMENTS: this 400.00 is given to the above person for living expenses.

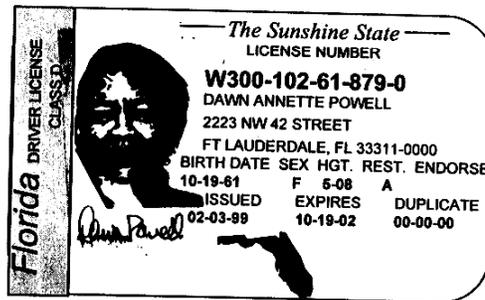
\*\*\*\*\*

PLEASE READ CAREFULLY BEFORE SIGNING:

The information provided on this form reflects my total contribution. If any of this information is found to be intentionally inaccurate I may be subject to criminal prosecution for knowingly providing false information. (See Georgia Code Section 49-4-15 for the full reference.) I understand the meaning of this paragraph.

Lucy Powell Signature of Person Completing this Form 10/20/99 Date  
2121 NE 23rd st Address  
Fort Lauderdale Fla 2221 City State Zip Code  
954 723 3698 Telephone Number

\*\*\*\*\*



Georgia Department of Human Resources

**APPLICATION FOR CASH, FOOD STAMP OR MEDICAL ASSISTANCE**

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin or political belief.

Today's Date: 12-3-99 Date Received by DFCS: \_\_\_\_\_

To apply for benefits, you only have to fill out the name of the head of household and address where you can be reached in Section I, sign your name and give us this application today. Write the telephone number where you can be reached during the day. If you cannot be interviewed today, leave this application with us, because some benefits, such as Food Stamps, are provided from the date you give us this application. We have 30 days from the day you give us the signed Food Stamp application to act on it, and 45 days to act on your application for Financial Assistance or Medical Assistance (Medicaid). If you are applying for Medical Assistance as a disabled person, we have up to 60 days to act on your application. If you are applying for Medical Assistance as a pregnant woman, we have up to 10 days to act on your application.

I. Applicant's Name and Address (NAME)	
1. Name of head of household or person for whom you are applying for assistance: First: <u>DAWN</u> Middle: <u>S.</u> Last: <u>POWELL</u> Suffix: _____	
2. What is your primary language? <input checked="" type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Your Date of Birth: <u>10-19-61</u> Your Social Security #: <u>204-92-1250</u>
3. Are you visually/hearing impaired and need special assistance with application process? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired	
4. Do you live in public housing? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	5. Phone Number: ( <u>770</u> ) <u>299-2929</u> area code
6. Home Address: Street: <u>1865 WILLOW LN.</u> Apt. #: <u>19</u> Box or Route #: _____ City: <u>CROSSVILLE</u> State: <u>GA.</u> Zip: <u>30051</u>	
7. Mailing Address: (If same as above write "same as home") Street: <u>SAME</u> Apt. #: _____ Box or Route #: _____ City: _____ State: _____ Zip: _____	
8. Signature of Applicant: <u>Dawn Powell</u> Date: _____	
II. Assistance Desired (KIND)	
Check each type of assistance you are applying for:	
<input type="checkbox"/> Financial Assistance, including Temporary Assistance to Needy Families and Refugee Cash Assistance.	
<input checked="" type="checkbox"/> Food Stamps.	
<input type="checkbox"/> Medicaid, including Right from the Start Medicaid for pregnant women and children under age 19.	
<input type="checkbox"/> Medicaid for the Aged, Blind and Disabled, including Nursing Home Medicaid. Qualified Medicare Beneficiaries and Medically Needy.	
<input type="checkbox"/> Foster Care or Adoption Assistance including IV-E Foster Care per diem and Adoption Assistance Medicaid.	
<input type="checkbox"/> Other Assistance (specify) _____	

**III. Household Circumstances (CIRC)**

**IMPORTANT:** Your household may be able to get Food Stamps within 5 days of the date we receive your application if your household is in at least one of the following situations:

- \* You have monthly income of less than \$150.00 and resources (such as cash and money in the bank) of no more than \$100.00
- \* The members of your household are migrant or seasonal farm workers with no more than \$100.00 in resources.
- \* The resources and combined monthly income of all members of your household is less than your monthly shelter costs.

Please answer the following questions below so that we can determine if you fit one of these situations.

**Note:** You need to answer 1-4 only if you are applying for Food Stamps. Answer 5-15 if you are applying for any type of assistance, including Food Stamps.

1. Total amount of income you and your household members have received for working this month: \$ 0.00

2. Total amount of other income you and your household members have received this month: (Specify, such as Social Security, SSI, Unemployment Compensation, etc.) \$400 - PARENTS

3. Total amount you and your household members have in cash or in bank accounts:  
Cash: \$ 10.00 Bank Account: \$ NA

4. Total amount each month you and your household members pay for rent, mortgage and utilities:

**IV. Other Household Circumstances (CIRC)**

Check any of the following that apply to you or to the person(s) for whom you are applying for assistance. This will help us determine the correct class of assistance for your situation.

5.  Are you applying for Medicaid for a person over the age of 18 whose Supplemental Security Income (SSI) check has been stopped?
6.  Are you applying for Medicaid to cover unpaid medical bills from the past three months or from the three months prior to an SSI application?
7.  If you are applying for Medicaid, are you or your spouse currently covered by Medicare?
8.  Are you applying for Medicaid to help pay for community based waiver services provided under programs such as Community Care Services, Mental Retardation Waiver, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
9.  Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
10.  Are you applying for Medicaid to help pay for the care of an a person 65 years of age or older or disabled person who has been in a hospital for at least 30 days or who died in the hospital?
11.  If you are applying for Food Stamps, are you residing in a shelter for battered women and children?
12.  If you are applying for Food Stamps, are you a migrant worker or a seasonal farm worker?
13.  Are you a refugee?
14.  If you are an adult applying for Medicaid for your dependent child(ren) that live with you, do you need Medicaid for yourself because of a specific illness or medical problem you are experiencing?
15.  Do you want to appoint someone to act as your authorized representative in the application process, or to receive notices, or to cash in your Food Stamp benefits for you?



Have you recently received benefits in another COUNTRY?  Yes  No

If Yes, what country and when? \_\_\_\_\_

Have you recently received benefits in another STATE?  Yes  No

If Yes, what state and when? \_\_\_\_\_

**PLEASE ANSWER THESE QUESTIONS FOR ANY PROGRAM:**

1. Is anyone in your household fleeing to avoid prosecution, custody, or confinement after conviction, under the law?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Is anyone in your household in violation of his/her parole/probation?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household fraudulently misrepresented his/her identity or residence to receive any benefits?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Has anyone in your household been found guilty of felony related to a controlled substance (drugs)?  
 Yes  No (If Yes, who \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR TANF:**

1. Has anyone in your household been found guilty of a serious violent felony?  
 Yes  No (If Yes, who \_\_\_\_\_ What type of felony? \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR FOOD STAMPS:**

1. Has anyone in your household been found guilty by a court of selling food stamps of \$500 or more?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Has anyone in your household been found guilty of using food stamps to buy firearms, ammunition or explosive?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household been found guilty of using food stamps to buy illegal drugs?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Do you understand that some able bodied food stamp recipients (without dependents children) will only be eligible to receive food stamps for 3 month period, unless they work for at least 20 hours a week or participate in certain work and training program such as JTPA and Trade Assistance ACT?  
 Yes  No (If Yes, who \_\_\_\_\_)

I have read the parts of this form that apply to me and my household.  
All the information which I have provided is true and complete as far as I know. The answers I have given in my interview are true. I understand I must report changes to my caseworker within 10 days of the change occurring.

Alan Powell  
Signature

12-3-99  
Date

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Caseworker

\_\_\_\_\_  
Date

## **STEP 4**

Based on the discrepancies found in the case, complete the verification checklist.

**Georgia Department of Human Resources  
VERIFICATION CHECKLIST**

\_\_\_\_\_ County Department of Family and Children Services

\_\_\_\_\_ Case Number

\_\_\_\_\_ Case Manager / Caseload

\_\_\_\_\_ Telephone Number

\_\_\_\_\_ Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The items checked below must be received by \_\_\_\_\_ (Due Date). If you cannot get the requested information and / or need more time, contact your case manager by phone or mail by \_\_\_\_\_ (Due Date). Your case manager may give you more time and may be able to help you get the information you need. Bring in or mail the items checked below or we will be unable to determine eligibility for an individual or the entire assistance unit.

TANF	Medicaid	FS		TANF	Medicaid	FS	
			Check stubs or statement from employer for:				Name and address of any person(s) giving you any child support, alimony, or any other contribution.
			Birth certificate / proof of citizenship/ proof of age for:				Address, social security number, phone number, and other information about the absent parent(s).
			Social Security card / application for:			NA	Proof you have applied for:
			Bank account statement – no more than 30 days old.				Statement from physician or health department to verify pregnancy and due date.
	NA	NA	Immunization Form 3231 for:				Letter of Award for Social Security, SSI, Veterans benefits, unemployment benefits, worker's compensation for:
			Other:				Other:

Bring in or mail proof of items checked below or we will not use the expense as a deduction in Food Stamps, and we may not be able to determine your eligibility for TANF, Food Stamps, or Medicaid.

TANF	Medicaid	FS		TANF	Medicaid	FS	
	NA		Proof of rent /mortgage payment.		NA		Proof of the amount of your gas, electric, telephone and other utility bills.
	NA		Proof of homeowner's insurance / property taxes.				Written statement of child care expenses for:
			Medical bills on which you still owe – physician, prescription drugs, health insurance premium, hospitalization.		NA		Proof of the legal obligation and the amount of child support paid to someone not in your home.
			Proof of the amount your insurance paid on your medical bills.				Other:

## **STEP 5**

As a result of the FPI referral the FS case has been closed.

Now that the case is closed, is there anything else that the case manager should do on this case?

## INDEPENDENT STUDY - NANCY MITFORD

This case is an FS review. As part of your preparation for the interview, you look at verification and SUCCESS "screens". The situation that you see has been unchanged for three years. Ms. Mitford has received FS during all of this time.

***In your initial discussion with Ms. Mitford, she states that her situation is still unchanged and she does not anticipate any change in her circumstances. She does not want to apply for TANF or Medicaid because she "doesn't want to get into that mess". Ms. Mitford is unhappy about having her case reviewed every three months because she says that she still has back problems from her car wreck three years ago and has a hard time getting a ride to the office for these appointments. Since her situation never changes, she wants to know if she could be certified for a year. Ms. Mitford says that she has never applied for SSI because she's heard that it's a lot of trouble.***

### PART 1

**Review the information on pages 34-52 prior to answering the following questions about the case situation.**

1. Based on what you read, does the case make sense to you? Yes or No.  
  
Why or why not?
2. Is there sufficient documentation in the case considering the amount of time Ms. Mitford has received benefits? Yes or No.
3. What other or additional documentation, if any, should be included in the case?  
List.

4. What verification, if any, would you request? List.

5. Should an OIS Referral be completed for this case?



FILE INQUIRY SUBMENU - OMEN

OMEN

Selection P

Client SSN 253 66 3816

Carrier Code

Client ID

Carrier Name

Client L Name

Worker ID

Client M Init

Worker L Name

Client F Name

LO/CO

Client DOB

Unit Type

Inc Match Type

Unit Supv

Tax Year

Load ID

A. Inc Discrepancy Inquiry

J. DRS Inquiry

B. Inc Discrepancy Update

K. DRS Update

C. DOL Wage Inquiry

L. Federal Tax Intercept Inquiry

D. DOL UCB Inquiry

M. Federal Tax Intercept Update

E. JTPA Inquiry

N. Health Insurance Carriers - By Code

F. Error Log

O. Health Insurance Carriers - By Name

G. BENDEX Inquiry

P. W-4 ERS Inquiry

H. SDX Inquiry

Q. SVES Request

I. Worker ID

Message

0215 NO DATA AVAILABLE FOR DISPLAY

CHANGE HOUSEHOLD ADDRESSES - ADDR ADDR 01  
Month 03 00 \*\*71 02 07 00

REMARKS

CO 067 LO 199 Load ID \*\*1D Client ID 999760992 Prev CO/LO  
HOH F Name NANCY MI L Name MITFORD Suf

Auth Prim Voter Visually Hearing Public Hsng/ Serial Census  
Rep Lang Reg Impaired Impaired Rent Subsidy Number Tract  
N E N N N Z

Residential Address

Address Line 1 Line 2  
Street Number Dir Name Type City Dir Apt  
515 LANGFORD DR  
City SENOIA ST GA Zip 30276 1849 Phone 770 958 7592

Mailing Address Del

Address Line 1 Line 2  
Street Number Dir Name Type City Dir Apt  
SAME  
City ST Zip  
Previous Addresses in last 2 years N

Message

15-lett 21-narr 23-alau 24-del

UPDATE REMARKS - REMA REMA  
01

110899 FS REV CLST ADDR AND TEL SAME. CLST SHE LIVES WITH DAUGHTER APRIL,AN  
CLST NO OTHER HH MEMB. E. LONG  
CLST AU SAME. NO OTHER HH MEMBS. CL PROVIDED GA DL AS PROOF OF ID.  
CLST SHE DOES NOT HAVE A CAR AND HAS TO  
WAIT ON FRIENDS TO GIVE HER A RIDE. E. LONG

CHANGE ASSISTANCE STATUS - STAT STAT A  
Month 03 00 \*\*54 07 30 99 01

Remarks

AU ID 992000054 Prog FS Prog Type S Prev ABD Type Med COA Claim N  
CO 067 LO \*99 Load ID \*\*1D Conversion Date 101798

AU AU Status AU Stat Appl Begin Pd Thru ---Penalty--- Appeal  
Stat Reasons Date Date Date Date Type End Date Ind  
A 072898 110197 112197

-----  
First Last Rel V Mand Finl --Stat-- Rsn Appl Begin Pd Thru Penalty  
Name Name Incl Resp Date Date Date Date T Date  
NANC MIT SE OT Y RE A 120197 110197 112197  
APRIL BRO CH OT Y RE A 120197 110197 112197

Message

20-rmen 22-alau(arch) 23-alau(curr)

UPDATE REMARKS - REMA REMA  
01

AR STATES SHE AND DAUGHTER ONLY IN HOUSEHOLD.050699GF

**Food Stamp Phase 3 TM  
Skill Building**

**March 28, 2006**

CHANGE CLIENT DEMOGRAPHIC 1 - DEM1 DEM1 01  
Month 03 00 \*\*71 02 07 00

Client Name NANCY MITFORD Suf Client ID 999760992  
Remarks

Alt SSA/SSN SSN Appl SSN1 V More DOB V Sex Race Eth  
Name Appl For Date SSNs (MM DD YYYY)  
253 66 3816 CS 02 24 1943 CS F B N

GA Marital Living RSM Min Par Boarder Amt Paid -- Family Planning --  
Res Status Arrngmt Ad/Ch /LA Num Meals for Meals Referral Date  
Y D AH

Concurr SSI Depriv V Prenatal Care ----- Pregnant ----- FTC  
Out of St Recip Ind Good Cse Term/Due Term/Due V Num V Code  
CA FS MA Code Date Exp  
N N N

Message

15-lett 16-crs 23-alau



---

CHANGE RESOURCES 2 - RES2 RES2 01  
Month 03 00 01  
Remarks  
Client Name NANCY MITFORD Client ID 999760992

Do you have any of the following: truck, motorcycle, tractor, farm equipment,  
licensed/unlicensed vehicle(s), boat, camper, income producing vehicle?

Del Type Use FMV V Encumb V Yr Make Mod Lic Num Registration  
MA/AF FS

VIN

Do you have any of the following: vacation home, real estate, or rental prop?

Address City ST Zip

Del Use FMV V Encumb V Try Annl Rate V Age Life  
to Sell Ret Amt Est Own

More

Message

0019 UPDATE COMPLETED SUCCESSFULLY  
15-lett 23-alau 24-del

UPDATE REMARKS - REMA REMA  
01  
AR STATES SHE DEPENDS ON RIDES FROM FRIENDS.050699GF





CHANGE                      SHELTER EXPENSES - SHEL                      SHEL 01  
Month 03 00

Client Name NANCY                      MITFORD                      Remarks  
Client ID 999760992

Primary	Receive	Public	SUA	Number	Phone
Heat/Cool	LIHEAP	Housing/Exc	Type	Sharing	STD
E	N	N	HC	1	

Expense Type	Amt	V	Expense Type	Amt	V
Rent			Mortgage		
Taxes			Insurance		
Gas			Electric		
Telephone			Water		
Sewer			Garbage		
Disaster Repair			Oil		
Other Fuel			Other Housing		

Landlord Name		Phone
Address	City	ST Zip

Message

15-lett

UPDATE                      REMARKS - REMA                      REMA  
01

AR STATES SHE LIVE IN UNCLE'S HOUSE AND ONLY NEEDS TO PAY ALL UTILITIES. AR CHOSE HUSUA FOR SUA.050699  
07/30/99 CLIENT CLAIMS SHE LIVES WITH HER DGT IN HOUSE OWNED BY UNCLE HE DOES NOT LIVEQ THERE HE LIVES ON HOLLY ST IN ATL. HE DOES NT CHARGE FOR RENT (CLIENT CLAIMS)THIS IS A TEN ROOM HOUSE!) HE SUBMITTED STATEMENT HE GIVES HER 200 PER MONTH TO PAY UTILITIES AND FOR SPENDING MONEY TW \*12  
110899 CLST SHE DOES NOT PAY RENT. CLST SHE IS RESPONSIBLE FOR PAYING UTIL.  
CW EXPLAINED ACTUAL, CL CHOSE HCSUA. E. LONG

020700 CLST STILL PAYS NO RENT AND WANTS TO CONTINUE SAME UTIL OPTION OF HC SUA. E. LONG

2-1-00

\$200 PER

MONTH

W. A. Smith

**POSTAL MONEY ORDER**

83072934606 990401 303011 \*200\*00

<small>SERIAL NUMBER</small>	<small>YEAR MONTH DAY</small>	<small>POST OFFICE NUMBER</small>	<small>DOLLARS AND CENTS</small>
			200 00
<small>PAY TO</small>	<small>CHECKWRITER'S IMPRINT</small>	<small>FROM</small>	
Money Mitford		W. A. Smith	
<small>ADDRESS</small>	<small>ADDRESS</small>	<small>CITY STATE ZIP</small>	
515 Langford Dr. Denon, Ct.	441 W. 160 St. Atlanta, Ga. 30318		
<small>C.O.D. NO. OR USED FOR</small>	<small>NEED NOT BE COMPLETED FOR POSSESSION</small>		

0000080021 83072934606

Georgia Department of Human Resources Food Stamp Review Form	Date Form Rec'd in Co. _____ <input type="checkbox"/> Standard <input type="checkbox"/> Alternate
<b>All questions must be answered and proof provided if required.</b> IMPORTANT: The answers on this form will be used to see if your household benefits continue or change. If you do not return this form with ALL questions answered, your food stamps will stop effective _____. Please mail or bring this form to the local county department by _____. Your caseworker must receive this form by the 15th of _____, or your stamps may stop or be late. For help, call your caseworker at _____.	

	<b>IMPORTANT! ALL QUESTIONS MUST BE ANSWERED</b>	Case No. _____ Load: _____
--	--	----------------------------

Is this address correct?     Yes     No    If no, enter correct address below.

Have you moved?     Yes     No    If yes, when? \_\_\_\_\_

What is your new/correct address? \_\_\_\_\_

Phone number where you can be reached? (770) 958-892

HAS ANYONE MOVED IN OR OUT OF YOUR HOME?     Yes     No    If yes, when? \_\_\_\_\_

	NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NO.	DATE MOVED		EMPLOYED		DOES HE/SHE EAT WITH YOU?	
					OUT	IN	YES	NO	YES	NO
1.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

DID ANYONE IN YOUR HOUSEHOLD QUIT A JOB WITHIN THE LAST 60 DAYS?     Yes     No

IF YES, WHO QUIT? \_\_\_\_\_

WHY DID HE/SHE QUIT? \_\_\_\_\_

EW DOCUMENTATION/FOLLOW-UP AREA - DO NOT WRITE

DOCUMENTATION OF HH COMP, LIVING ARRANGEMENTS / ELIGIBILITY OF NEW AU MEMBERS / WORK REQUIREMENTS / STUDENT ELIGIBILITY / ROOMERS & BOARDERS     NO CHANGE REPORTED     CHANGE

EXPLANATION AND VERIFICATION OF CHANGE

PLEASE ATTACH VERIFICATION (PROOF OF THE AMOUNT) FOR ANY "YES" ANSWER.

DOES ANYONE IN YOUR HOUSEHOLD WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>NO</b>	
PERSON WHO WORKED: _____	PERSON WHO WORKED: _____
EMPLOYER: _____	EMPLOYER: _____
DAY OF WEEK PAID: _____	DAY OF WEEK PAID: _____
HOW OFTEN PAID: _____	HOW OFTEN PAID: _____
PAY PER HOUR: _____	PAY PER HOUR: _____
HOURS OF WORK PER WEEK: _____	HOURS OF WORK PER WEEK: _____
ATTACH MOST RECENT PAY STUBS (AT LEAST ONE MONTH) OR WAGE STATEMENT FROM EMPLOYER.	
IF THIS IS A NEW JOB, WHEN DID IT START?	
EW DOCUMENTATION / FOLLOW-UP AREA - DO NOT WRITE HERE.	
CLEARING HOUSE: DISCREPANCY _____ NO DISCREPANCY _____ NO DATA _____	

DOES ANYONE IN YOUR HOUSEHOLD HAVE INCOME FROM ANY OF THE FOLLOWING?

SELF-EMPLOYMENT INCOME	YES	NO	WHO RECEIVES IT?	AMOUNT MONTHLY	EW DOCUMENTATION / FOLLOW-UP AREA DO NOW WRITE
<b>PART-TIME WORK</b> (BABYSITTING, YARD WORK, ETC.)					(Verification needed if changed by more than \$25)
<b>RENTAL PROPERTY</b>					
<b>ROOMERS OR BOARDERS</b> <b>OTHER SELF-EMPLOYMENT</b>					
UNEARNED INCOME	YES	NO	WHO RECEIVES IT?	AMOUNT MONTHLY	EW DOCUMENTATION / FOLLOW-UP AREA DO NOW WRITE
<b>AFDC</b>					
<b>GENERAL ASSISTANCE</b>					
<b>CHILD SUPPORT</b>					
<b>ALIMONY</b>					
<b>MONEY FROM FRIENDS OR OTHERS</b>	✓		ME	200.00	
<b>UNEMPLOYMENT</b>					
<b>RETIREMENT / PENSION</b>					
<b>SOCIAL SECURITY</b>					
<b>SSI</b>					
<b>DISABILITY / SICK PAY</b>					
<b>VETERANS CHECKS</b>					
<b>MILITARY ALLOTMENT</b>					
<b>JOB CORPS / TRAINING</b>					
<b>WORKERS COMPENSATION</b>					
<b>HUD (SECTION 8)</b>					
<b>INTEREST / DIVIDENDS</b>					
<b>STRIKE BENEFITS</b>					
<b>EDUCATIONAL GRANTS</b> <b>LOANS, SCHOLARSHIPS</b>					
<b>ANY OTHER INCOME</b>					

Check the YES or NO blocks below to show if you have any of these Resources.

TYPE OF RESOURCE	YES	NO	WHO OWNS IT?	VALUE	EW DOCUMENTATION / FOLLOW-UP AREA DO NOW WRITE
CASH		✓			(Treatment of Vehicles:)
CHECKING ACCOUNT		✓			
SAVINGS ACCOUNT		✓			
TRUST FUND		✓			
CERTIFICATES / STOCKS BONDS / NOTES		✓			
CAR		✓			
TRUCK, MOTORCYCLE		✓			
OTHER VEHICLE		✓			
LAND OR PROPERTY OTHER THAN WHERE YOU LIVE NOW		✓			
FARM EQUIPMENT		✓			
MACHINERY		✓			
BOATS		✓			
Other Resources		✓			

Check the YES or NO blocks below to show if you have any of these expenses.

TYPE OF EXPENSE	YES	NO	AMOUNT	HOW OFTEN ARE YOU BILLED	EW DOCUMENTATION / FOLLOW-UP AREA DO NOW WRITE
RENT		✓			
MORTGAGE					
PROPERTY TAXES					
PROPERTY INSURANCE					
ELECTRICITY	✓		66.22	MONTH	
GAS	✓		101.34	"	
FUEL / OIL / KEROSENE					
WATER					
SEWAGE					
TRASH					
OTHER _____ (LIST)					
TELEPHONE	✓		22.41	MONTH	

NOTE: If the amount you pay for rent or mortgage has changed, include verification (proof of the amount).

Do you receive Energy Assistance?  Yes  No

Do you cool your home in the summer?  Yes  No If yes, how? AC

Do you heat your home in the winter?  Yes  No If yes, how? GAS

Does anyone pay any shelter expense for you?  Yes  No

If so, which expense is paid? \_\_\_\_\_ Who pays it? \_\_\_\_\_

and to whom is it paid? \_\_\_\_\_

Do you or anyone in your household pay child support to someone who does not live with you?  Yes  No

Who pays child support? \_\_\_\_\_

To whom paid? \_\_\_\_\_ Court ordered  Yes  No

Actual amount paid? \_\_\_\_\_ Amount ordered to pay? \_\_\_\_\_

How often paid? \_\_\_\_\_

(EW needs to verify all information)

DO YOU PAY CHILD CARE OR DEPENDENT CARE COSTS?  YES (List below)  NO

PERSON WHO REQUIRES CARE	NAME OF CARE PROVIDER	AMOUNT PAID	HOW OFTEN PAID	DAY OF THE WEEK PAID	REASON NEEDED
1.					
2.					

**EW DOCUMENTATION / FOLLOW-UP AREA - DO NOT WRITE IN**

LIST MEDICAL EXPENSES FOR ALL HOUSEHOLD MEMBERS AGE 60 OR OLDER, OR WHO ARE DISABLED. ATTACH ALL MEDICAL BILLS YOU HAVE RECEIVED SINCE YOUR LAST REVIEW.

PERSON WHO OWES BILL	TYPE OF EXPENSE (DOCTOR, HOSPITAL, INSURANCE, ETC.)	AMOUNT OWED	DATE OF BILL	WILL INSURANCE PAY?	
				YES	NO
1.					
2.					

DOES SOMEONE ELSE PAY ANY OF THESE MEDICAL EXPENSES FOR YOU?  YES  NO

If so, which expense is paid? \_\_\_\_\_ Who pays it? \_\_\_\_\_  
and to whom is it paid? \_\_\_\_\_

**EW DOCUMENTATION / FOLLOW-UP AREA - DO NOT WRITE IN**

IS ANY CHANGE IN HOUSEHOLD CIRCUMSTANCES EXPECTED IN THE NEAR FUTURE?  YES  NO

IF YES, PLEASE EXPLAIN \_\_\_\_\_

YOUR SIGNATURE <i>Nancy Mitchell</i>	TODAY'S DATE 2-7-00
---	------------------------

IMPORTANT: BEFORE WE CHANGE YOUR BENEFITS WE WILL SEND YOU A NOTICE EXPLAINING WHAT WILL HAPPEN. IF YOU DO NOT AGREE WITH OUR DECISION YOU CAN REQUEST A FAIR HEARING.

ELIGIBLE  INELIGIBLE: DUE TO: \_\_\_\_\_  
SIGNATURE OF ELIGIBILITY WORKER \_\_\_\_\_ DATE: \_\_\_\_\_ CL#: \_\_\_\_\_

Georgia Department of Human Resources

**APPLICATION FOR CASH, FOOD STAMP OR MEDICAL ASSISTANCE**

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin or political belief.

Today's Date: 2-7-00 Date Received by DFCS: \_\_\_\_\_

To apply for benefits, you only have to fill out the name of the head of household and address where you can be reached in Section I, sign your name and give us this application today. Write the telephone number where you can be reached during the day. If you cannot be interviewed today, leave this application with us, because some benefits, such as Food Stamps, are provided from the date you give us this application. We have 30 days from the day you give us the signed Food Stamp application to act on it, and 45 days to act on your application for Financial Assistance or Medical Assistance (Medicaid). If you are applying for Medical Assistance as a disabled person, we have up to 60 days to act on your application. If you are applying for Medical Assistance as a pregnant woman, we have up to 10 days to act on your application.

I. Applicant's Name and Address (NAME)		
1. Name of head of household or person for whom you are applying for assistance:		
First: <u>NANCY</u>	Middle:	Last: <u>MITFORD</u> Suffix:
2. What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	Your Date of Birth: <u>2/24/43</u> Your Social Security #: <u>253-66-3810</u>	
3. Are you visually/hearing impaired and need special assistance with application process? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one: <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Hearing Impaired		
4. Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. Phone Number: ( <u>770</u> ) area code <u>958</u> <u>7592</u>	
6. Home Address:		
Street: <u>515 LANGFORD DR</u> Apt. #:	Box or Route #:	
City: <u>SENOIA</u> State: <u>GA</u> Zip: <u>30276</u>		
7. Mailing Address: (If same as above write "same as home")		
Street: <u>SAME AS HOME</u> Apt. #:	Box or Route #:	
City:	State:	Zip:
8. Signature of Applicant: <u>Nancy Mitford</u>		Date: <u>2-7-00</u>

II. Assistance Desired (KIND)	
Check each type of assistance you are applying for:	
<input type="checkbox"/>	Financial Assistance, including Temporary Assistance to Needy Families and Refugee Cash Assistance.
<input checked="" type="checkbox"/>	Food Stamps.
<input type="checkbox"/>	Medicaid, including Right from the Start Medicaid for pregnant women and children under age 19.
<input type="checkbox"/>	Medicaid for the Aged, Blind and Disabled, including Nursing Home Medicaid, Qualified Medicare Beneficiaries and Medically Needy.
<input type="checkbox"/>	Foster Care or Adoption Assistance including IV-E Foster Care per diem and Adoption Assistance Medicaid.
<input type="checkbox"/>	Other Assistance (specify) _____

**III. Household Circumstances (CIRC)**

**IMPORTANT:** Your household may be able to get Food Stamps within 5 days of the date we receive your application if your household is in at least one of the following situations:

- \* You have monthly income of less than \$150.00 and resources (such as cash and money in the bank) of no more than \$100.00.
- \* The members of your household are migrant or seasonal farm workers with no more than \$100.00 in resources.
- \* The resources and combined monthly income of all members of your household is less than your monthly shelter costs.

Please answer the following questions below so that we can determine if you fit one of these situations.

**Note:** You need to answer 1-4 only if you are applying for Food Stamps. Answer 5-15 if you are applying for any type of assistance, including Food Stamps.

1. Total amount of income you and your household members have received for working this month: \$

2. Total amount of other income you and your household members have received this month: (Specify, such as Social Security, SSI, Unemployment Compensation, etc.)

*200.00 Received from Uncle*

3. Total amount you and your household members have in cash or in bank accounts:

Cash: \$ *0*

Bank Account: *0*

4. Total amount each month you and your household members pay for rent, mortgage and utilities:

*I LIVE IN MY UNCLE'S HOUSE. I PAY NO RENT*

*UTILITIES VARIES 184.97*

**IV. Other Household Circumstances (CIRC)**

Check any of the following that apply to you or to the person(s) for whom you are applying for assistance. This will help us determine the correct class of assistance for your situation.

5.  Are you applying for Medicaid for a person over the age of 18 whose Supplemental Security Income (SSI) check has been stopped?
6.  Are you applying for Medicaid to cover unpaid medical bills from the past three months or from the three months prior to an SSI application?
7.  If you are applying for Medicaid, are you or your spouse currently covered by Medicare?
8.  Are you applying for Medicaid to help pay for community based waiver services provided under programs such as Community Care Services, Mental Retardation Waiver, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
9.  Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
10.  Are you applying for Medicaid to help pay for the care of an a person 65 years of age or older or disabled person who has been in a hospital for at least 30 days or who died in the hospital?
11.  If you are applying for Food Stamps, are you residing in a shelter for battered women and children?
12.  If you are applying for Food Stamps, are you a migrant worker or a seasonal farm worker?
13.  Are you a refugee?
14.  If you are an adult applying for Medicaid for your dependent child(ren) that live with you, do you need Medicaid for yourself because of a specific illness or medical problem you are experiencing?
15.  Do you want to appoint someone to act as your authorized representative in the application process, or to receive notices, or to cash in your Food Stamp benefits for you?



Have you recently received benefits in another COUNTRY?  Yes  No  
If Yes, what country and when? \_\_\_\_\_

Have you recently received benefits in another STATE?  Yes  No  
If Yes, what state and when? \_\_\_\_\_

**PLEASE ANSWER THESE QUESTIONS FOR ANY PROGRAM:**

1. Is anyone in your household fleeing to avoid prosecution, custody, or confinement after conviction, under the law?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Is anyone in your household in violation of his/her parole/probation?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household fraudulently misrepresented his/her identity or residence to receive any benefits?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Has anyone in your household been found guilty of felony related to a controlled substance (drugs)?  
 Yes  No (If Yes, who \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR TANF:**

1. Has anyone in your household been found guilty of a serious violent felony?  
 Yes  No (If Yes, who \_\_\_\_\_ What type of felony? \_\_\_\_\_)

**PLEASE ANSWER THESE QUESTIONS IF YOU ARE APPLYING FOR FOOD STAMPS:**

1. Has anyone in your household been found guilty by a court of selling food stamps of \$500 or more?  
 Yes  No (If Yes, who \_\_\_\_\_)
2. Has anyone in your household been found guilty of using food stamps to buy firearms, ammunition or explosive?  
 Yes  No (If Yes, who \_\_\_\_\_)
3. Has anyone in your household been found guilty of using food stamps to buy illegal drugs?  
 Yes  No (If Yes, who \_\_\_\_\_)
4. Do you understand that some able bodied food stamp recipients (without dependents children) will only be eligible to receive food stamps for 3 month period, unless they work for at least 20 hours a week or participate in certain work and training program such as JTPA and Trade Assistance ACT?  
 Yes  No (If Yes, who \_\_\_\_\_)

I have read the parts of this form that apply to me and my household.  
All the information which I have provided is true and complete as far as I know. The answers I have given in my interview are true. I understand I must report changes to my caseworker within 10 days of the change occurring.

Signature Nancy Mitzford Date 2-7-00

Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Caseworker \_\_\_\_\_ Date \_\_\_\_\_

## Part 2

Using the Benefit History (following page) Complete the Form 5667 to Refer Nancy Mitford to OIS

INQUIRY

BENEFIT HISTORY ISSUANCE LISTING - BENL

BENL

01 MORE

AU ID 062078054 HOH Last Name MITFORD

First Name NANCY

-----DETAIL-----									
Sel	Issn Date	Issn Number	Issn Sts	Status Date	Tot-Issn Amount	Benefit Month	Recoup Amount	Issn Amount	Issn Type
	02 01 00	802788183	CD	02 01 00	234.00	02 00		234.00	O
	01 01 00	802546482	CD	01 01 00	234.00	01 00		234.00	O
	12 01 99	802315534	CD	12 01 99	234.00	12 99		234.00	O
	11 01 99	802072678	CD	11 01 99	234.00	11 99		234.00	O
	10 01 99	801831509	CD	10 01 99	234.00	10 99		234.00	O
	09 01 99	801592901	CD	09 01 99	230.00	09 99		230.00	O
	08 01 99	801352433	CD	08 01 99	230.00	08 99		230.00	O
	07 01 99	801111229	CD	07 01 99	230.00	07 99		230.00	O
	06 01 99	800869614	CD	06 01 99	230.00	06 99		230.00	O

Sel	Issn Date	Issn Number	Issn Sts	Status Date	Tot-Issn Amount	Benefit Month	Recoup Amount	Issn Amount	Issn Type
	05 14 99	800734295	CD	05 14 99	230.00	05 99		230.00	O
	04 01 99	800378693	CD	04 01 99	230.00	04 99		230.00	O
	03 01 99	800129871	CD	03 01 99	230.00	03 99		230.00	O
	02 01 99	100775875	CD	02 01 99	230.00	02 99		230.00	O
	01 01 99	100536864	CD	01 01 99	230.00	01 99		230.00	O
	12 01 98	100335945	CD	12 01 98	230.00	12 98		230.00	O
	11 18 98	100239780	CD	11 18 98	230.00	11 98		230.00	C
	10 01 98	021078336	CD	10 01 98	230.00	10 98		230.00	O
	09 01 98	020902418	CD	09 01 98	224.00	09 98		224.00	O

Sel	Issn Date	Issn Number	Issn Sts	Status Date	Tot-Issn Amount	Benefit Month	Recoup Amount	Issn Amount	Issn Type
	08 01 98	020719401	CD	08 01 98	224.00	08 98		224.00	O
	07 01 98	044426109	CD	07 01 98	321.00	07 98		321.00	O
	06 30 98	044422050	CD	06 30 98	97.00	06 98		97.00	C
	06 01 98	044314406	CD	06 01 98	224.00	06 98		224.00	O
	05 01 98	044158655	CD	05 01 98	224.00	05 98		224.00	O
	04 01 98	043974687	CD	04 01 98	224.00	04 98		224.00	O
	03 01 98	043767296	CD	03 01 98	224.00	03 98		224.00	O
	02 01 98	043541985	CD	02 01 98	224.00	02 98		224.00	O
	01 01 98	043299599	CD	01 01 98	224.00	01 98		224.00	O

-----DETAIL-----									
Sel	Issn Date	Issn Number	Issn Sts	Status Date	Tot-Issn Amount	Benefit Month	Recoup Amount	Issn Amount	Issn Type
	12 01 97	043055261	CD	12 01 97	224.00	12 97		224.00	O
	11 21 97	043038804	CD	11 21 97	224.00	11 97		224.00	I
	10 01 97	042402606	CD	10 01 97	220.00	10 97		220.00	O
	09 01 97	042148457	CD	09 01 97	220.00	09 97		220.00	O
	08 01 97	041888365	CD	08 01 97	220.00	08 97		220.00	O
	07 01 97	041626946	CD	07 01 97	220.00	07 97		220.00	O
	06 01 97	041353279	CD	06 01 97	220.00	06 97		220.00	O
	05 01 97	041077494	CD	05 01 97	220.00	05 97		220.00	O
	04 01 97	040797601	CD	04 01 97	220.00	04 97		220.00	O



Georgia Department of Human Resources OFFICE OF INVESTIGATIVE SERVICES REQUEST FOR INVESTIGATION Two Peachtree Street, NW. Room 23-293 Atlanta, GA 30303-3142		1. COUNTY NAME/NUMBER: _____					
		2. HOTLINE REFERRAL NUMBER: _____					
		3. DFCS LOG NUMBER: _____					
<b>HEAD OF HOUSEHOLD INFORMATION</b>							
4. SOCIAL SECURITY # _____	5. DOB: _____	6. SEX: <input type="checkbox"/> M <input type="checkbox"/> F					
7. SUCCESS CLIENT ID# _____	8. RACE: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> H <input type="checkbox"/> O <input type="checkbox"/> W						
9. FIRST NAME: _____	10. INITIAL _____	11. LAST NAME: _____					
12. ADDRESS 1: _____	13. ADDRESS 2: _____						
14. CITY: _____	16. STATE: _____	17. AREA/PHONE/EXT. _____					
15. ZIP: _____							
<b>SECONDARY HOUSEHOLD INFORMATION</b>							
18. SOCIAL SECURITY NO.	NAME	DOB	RELATIONSHIP	SUCCESS CLIENT ID NO.	REPEAT OFF.		
					<input type="checkbox"/> Y <input type="checkbox"/> N		
					<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>SUSPECTED PROGRAM VIOLATION</b>							
19. CATEGORY	20. STATUS		21. ESTIMATED OVERPAYMENT		22. SUCCESS AU ID NO.		
PROGRAM	ACTIVE	CLOSED	FALSE STMT	START DATE	END DATE	AMOUNT	CHILD CARE CASE NO.
<input type="checkbox"/> EBT	<input checked="" type="checkbox"/> EBT Trafficking ONLY						
<input type="checkbox"/> FS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> TANF	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> CAPS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<b>NON EBT</b>							
<input type="checkbox"/> FS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> TANF	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
<input type="checkbox"/> CAPS	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				
23. METHOD OF DISCOVERY: <input type="checkbox"/> CLEARINGHOUSE <input type="checkbox"/> CLIENT REPORT <input type="checkbox"/> CSE <input type="checkbox"/> HOTLINE							
<input type="checkbox"/> QC <input type="checkbox"/> E4 LIST <input type="checkbox"/> PRISONER ALERT <input type="checkbox"/> UCB MATCH <input type="checkbox"/> OTHER							
24. SOURCE OF REFERRAL: _____							
<b>25. OP RESULTED FROM:</b>							
<input type="checkbox"/> A. UNREPORTED EARNED (Wages, Self Employment, ETC.)				Employer: _____ Employer Address: _____ (Address Continued)			
<input type="checkbox"/> B. UNREPORTED UNEARNED (SS, SSI, WC, UCB, VA, CS, ETC.)				Source: _____ Date Income Began: _____			
<input type="checkbox"/> C. RESOURCES (Insurance, Property, Bank Accounts, Etc.)				List Resources, Value, Property Location, Insurance Co.; Name of Bank, Etc.			
<input type="checkbox"/> D. HOUSEHOLD COMPOSITION/RESIDENCY (Child out of Home, Spouse in Home, Out of State, ETC.)				Name: _____			
<input type="checkbox"/> E. EBT TRAFFICKING (Card #, Store Name & Address, FCS #)				Name: _____			
<input type="checkbox"/> F. OTHER (Explain Dual Assistance)				Name: _____			
26. REPEAT OFFENDER: <input type="checkbox"/> Y <input type="checkbox"/> N							
27. Explain: (Describe Violation checked in #25. Include Names, Addresses, and Telephone Numbers, if known. Include Names of Respondent(s) if other than #18 above. Attach additional sheet if needed)							
28. WORKER/ORIGINATOR SIGNATURE				29. DATE		30. TELEPHONE NO.	

Form 5667 (Rev. 06/05)

<i>Sun</i>	<i>Mon</i>	<i>Tue</i>	<i>Wed</i>	<i>Thu</i>	<i>Fri</i>	<i>Sat</i>
<b>20% ineligible cases work calendar</b>					<b>1</b> <u><i>Ineligible</i></u>	<b>2</b>
<b>3</b>	<b>4</b> Eligible	<b>5</b> Eligible	<b>6</b> Eligible	<b>7</b> Eligible	<b>8</b> <u><i>Ineligible</i></u>	<b>9</b>
<b>10</b>	<b>11</b> Eligible	<b>12</b> Eligible	<b>13</b> Eligible	<b>14</b> Eligible	<b>15</b> <u><i>Ineligible</i></u>	<b>16</b>
<b>17</b>	<b>18</b> Eligible	<b>19</b> Eligible	<b>20</b> Eligible	<b>21</b> Eligible	<b>22</b> <u><i>Ineligible</i></u>	<b>23</b>
<b>24</b>	<b>25</b> Eligible	<b>26</b> Eligible	<b>27</b> Eligible	<b>28</b> Eligible	<b>29</b> <u><i>Ineligible</i></u>	<b>30</b>

## Objectives for Childcare Communication



### **Participants will:**

- Discuss the importance of timely communication between Food Stamp workers and Child Care workers
- Identify information the FS case manager should know concerning an Assistance Unit's child care arrangements
- Examine the types of changes that will affect both the FS and the Child Care case
- Discuss interviewing skills which will lead to information concerning child care
- Identify red flags which may appear related to child care

## *Childcare Communication*



1. *Why is it important for case managers to talk to clients about childcare arrangements?*
2. *If client states she pays childcare, what information do we need?*
3. *If client states she does not pay childcare, what information do we need?*
4. *Where do we enter data and documentation for childcare?*
5. *Why is it important that we communicate with the childcare worker?*
6. *What types of changes should be communicated to the childcare worker?*
7. *List 2 Open Questions to use when discussing childcare*

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## Childcare Communication

**INFOPAC Reports** – SUCCESS has a report of childcare cases and the related eligibility cases. The childcare report is the very last report listed. In your county, you need to see if you should access the report directly or if the childcare worker should forward it to you.

0726I-END OF REPORTS  
COMMAND ===>

TIME: 073137

\*\*\* REPORTS \*\*\*

OPTION REPORT ID      REPORT NAME  
-----

  \_    HRKALIST      LIST CHILDCARE CASES BY COUNTY, NAME  
  **S**    **HRKARCSE**      **CHILDCARE ALPHABETIC CASELOAD LISTING**

PF01=HELP      PF02=PRINT      PF03=END      PF04=MENU      PF05=RFIND      PF06=MARK  
PF07=UP        PF08=DOWN      PF09=        PF10=LEFT      PF11=RIGHT     PF12=QUIT

**Food Stamp Phase 3 TM  
Childcare Communication**

**September 22, 2005**

COMMAND ==>  
HRKARCSE 20000402 190013 HRKARCSE044  
HRKARCSE  
RUN DATE: 04/02/2000  
**COUNTY: 044 - DEKALB**

SCROLL ==> SCREEN  
P 12 R 1 C 1  
GEORGIA DEPARTMENT OF HUMAN RESOU  
DIVISION OF FAMILY AND CHILDREN SE  
CHILD CARE ALPHABETIC CASELOAD BY  
REPORTING MONTH/YEAR: 02/2000  
**CASELOAD: 9986**

<b>RESP NAME</b>	<b>RESP SSN</b>	<b>UAS CODE</b>	<b>MONTHLY FEE</b>	<b>CHILD</b>
NEBRIT, ANDREA	252-43-4723	544	20.00	CHELSE
SANDERS, TRACEY	269-72-4022	544	44.00	CLIFFO
		544	44.00	RAKIM
RICE, TAMARA	289-65-1037	544	32.00	JULIUS
		544	32.00	MICHEL

<b>UAS TOTALS</b>	:			
	:	NOVEMBER, 1999	517	1 CASE
	:	NOVEMBER, 1999	544	7 CASES
	:	DECEMBER, 1999	517	1 CASE
	:	DECEMBER, 1999	544	7 CASES
	:	JANUARY, 2000	544	3 CASES
	:	FEBRUARY, 2000	544	3 CASES

**C** **C**  
**h** **o**  
**i** **m**  
**d** **u**  
**C** **n**  
**a** **i**  
**r** **t**  
**e** **a**  
**n**

Use \_\_\_\_\_ Questions to get  
the \_\_\_\_\_ Picture.



Use \_\_\_\_\_ Questions to  
get the \_\_\_\_\_.

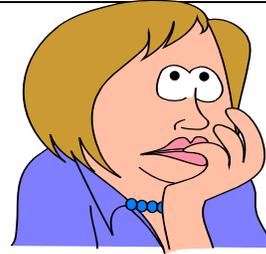
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# OBJECTIVES



- Participants will discuss resources which are available for informational purposes.
- Participants will identify and discuss barriers to the implementation of the presented techniques.
- Participants will complete course evaluations and receive individual final evaluations.
- Participants will establish a support system for implementation of the previously discussed tools and techniques.

# Can I Do This?



**YES!**

4 Reasons Why...

**Fewer Errors**

**More Effective  
Interviews**

**Correct Benefits for  
Eligible Clients**

**Work SMARTER  
not Harder**