

Division of Family Support
OPERATION MANUAL
Volume I

OMTL-603

General Administration
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MS 0001 FAMILY SUPPORT MANUALS AND PROGRAM INSTRUCTIONS (1)

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

A. The following manual material, cover letters, and forms are located online and available to staff at <https://chfsnet.ky.gov/dcbs/dfs/Pages/resources.aspx>.

1. Operation Manual that includes volumes devoted to:
 - a. General administration of all programs and claims;
 - b. Supplemental Nutrition Assistance Program (SNAP);
 - c. SNAP work provisions;
 - d. **【Cash assistance programs (KTAP, Kinship Care, FAST, WIN);】**
 - e. Kentucky Works Program (KWP);
 - f. Family Related Medicaid programs (only used for claims). For current Family Related Medicaid policy, access MAGIMedicaid;
 - g. Adult Medicaid programs and State Supplementation;
 - h. MAGIMedicaid, APTC/CSR and QHP;
 - 【i. Child Care Assistance Program (CCAP);】**
 - j. Clarifications and
 - 【k. OM Transmittal Letters.**
2. Forms Library that includes forms and procedural instructions that are manually-generated. Procedural instructions for some forms system-generated are also included on this site;】
3. Family Support Memorandums (FSM);
4. Tip Sheets; and
5. User Guides

B. The general public can access the Operation Manual at http://manuals.chfs.ky.gov/dcbs_manuals/DFS/index_dfs.asp. Other material is not accessible at this site. The local office makes material available for review at the request of a client or any interested party. To avoid copying an entire volume of information for manuals appearing in PDF format, use the file function for printing and enter the desired range of pages.

- C. Field staff is alerted on Worker Portal when new or revised material is added to the intranet site. Review all newly issued or revised material. Staff can locally print information.

MS 0010*

CABINET STRUCTURE

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

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

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

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

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

Family Support employees:

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

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

MS 0020 GENERAL CASE PROCESSING (1)

- A. [Eligibility determinations for KTAP, FAST, Kinship Care, SNAP, MAGI Medicaid, and Adult Medicaid (AMA) determinations are completed on Worker Portal.]
- B. All individuals contacting the toll free number or the local office requesting assistance are entered on Worker Portal by designated staff.
- C. Applications, recertifications and case changes can be processed by any worker statewide regardless of the county of residence. When a worker processes a case, the worker documents on Worker Portal comments any and all actions taken within the case at the time of processing.
- D. Workers cannot take or process an application of an individual who is a relative or close personal relationship. For procedural instructions on employee related case processing, refer to [MS 0025](#).
- E. Supervisors or designated persons accept and process applications filed by DCBS employees.
- F. All applications or reapplications must be acted on promptly. No longer than 30 days should elapse between the application date and authorization for action date, with the exception of unusual case situations. If the time frames required by the specific program are not met, document the reason for the delay on Worker Portal comments.
- G. To ensure authorizations are completed promptly, cases processed by workers without case decision must be reviewed immediately.
- H. Ongoing eligibility is reviewed periodically as required by specific program guidelines.
- I. Deny an application for assistance or discontinue benefits if:
 - 1. An individual withdraws the application or requests discontinuance;
 - 2. It is established a technical or financial factor is not met; or
 - 3. An individual fails to verify eligibility factors.
- J. All requested verification should be returned to the Centralized Mail Center. Staff in the Centralized Mail Center scans the verification into the Electronic Case File (ECF) which creates a task on the Worker Portal dashboard.

MS 0025* Employee Related Case Processing (1)

Confidential cases, such as those involving DCBS employees, an employee's relative, any individual in which a conflict of interest may arise, any individual that resides at same physical residence as a DCBS employee and/or any other individuals with whom an employee has a close personal relationship are required to be processed and maintained by a supervisor or designated staff member. This is done to avoid any conflicts of interest and to ensure privacy.

- A. A relative is defined as "a parent, foster parent, parent-in-law, child, spouse, brother, foster brother, sister, foster sister, grandparent, grandchild, son-in-law, brother-in-law, daughter-in-law, sister-in-law, cousin (up to first cousin), or other family member who resides in the same household."
- B. A conflict of interest exists whenever employees are placed in a position where, for some advantage gained or to be gained personally, they find it difficult, if not impossible, to devote themselves with complete energy, loyalty, and singleness of purpose to the general public interest as represented by their employment with the department.
- C. Close personal relationships may include, but are not limited to:
 - 1. Dating or co-habiting relationships;
 - 2. Relationships in which business transactions are regularly conducted;
 - 3. Personal friendships that transcend a casual acquaintance, such as: a person whose home is frequently visited by the employee, or vice-versa, or a person with whom the employee socializes "one-on-one" on a regular basis;
 - 4. Individuals who reside at the same physical residence of the employee; or
 - 5. Relatives as defined in item A.

Any DCBS employee should remove themselves from acting on any official matter which involves a relative, close personal relationship, or their own records. When potential conflicts arise, the DCBS employee must immediately alert his/her supervisor or appropriate manager to the conflict of interest.

- D. Workers cannot take or process an application of an individual who is a relative as defined in item A, or close personal relationship as defined in item C. The worker is responsible for advising supervisory staff if an applicant is a relative or close personal relationship. The worker cannot provide case status information or inquire the case for a relative. In addition, Family Support employees may not act on behalf of a payee

by receiving, cashing, or co-signing checks. Please reference [MS 0015](#) Ethics Policy for Family Support Employees.

- E. All cases that include a DCBS employee should have the question on the Application Information screen in Worker Portal, "Is there a DCBS employee living in the home?" answered as "YES". Supervisors and designated individuals are responsible for disposing all cases for DCBS employees.
- F. Report "DCBS Weekly Personnel File Match" is available in Worker Portal as an On-Demand report. Staff should be utilizing this report to assist in the integrity of staff self-reporting.

MS 0030

CASE RECORD

(1)

【The case record is the official document (electronic through Worker Portal or hardcopy) of the Department that establishes accountability for the expenditure of state and federal funds. Local management staff is responsible for ensuring case records are properly maintained, purged of obsolete material, and accessible to staff. This includes hard copy case records if the overpayment is pending or is established if the overpayment occurred prior to the implementation of ECF, and the electronic case file (ECF).

For purging of hardcopy records, refer to MS 0040, and for archiving, refer to MS 0045.

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

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

The KWP material retained in the case file includes:

- a. Participation verification records;

- b. Payment vouchers and verification of expenses;
 - c. Forms WIN-1 and WIN-2, if appropriate; and
 - d. All manually sent notices, such as form PA-105, Notice of Ineligibility.
- B. Case records are readily accessible to staff at all times. Each region has a plan for maintaining archived inactive hard copy cases which includes:
1. The location of inactive case record files;
 2. A designated individual responsible for maintaining archived inactive case record files;
 3. A method for tracking case records that are removed from files; and
 4. Procedures for sending and maintaining records in offsite storage, if applicable, to ensure they can be easily located and retrieved.
- C. Hard copy case records contain confidential material. To ensure information is not lost or misused, records are:
1. Opened one at a time except for comparative study;
 2. Purged of obsolete material that is disposed of by shredding or burning. For additional information on purging, refer to [MS 0040](#);
 3. Never stored in desks;
 4. Returned to the case record storage area on a timely basis; and
 5. **[Never removed from the local office except to transfer to another county, the Division of Administrative Hearings, Quality Control, Central or Regional Office, or offsite storage or archives.]**
- D. Discontinued case records are retained as a record of the expenditure of funds for audit purposes.

MS 0040 PURGING OBSOLETE MATERIAL (1)

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

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

Any claim established after the implementation of ECF must have the corresponding documentation noted as part of the claim case record in ECF.

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

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

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

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

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

Hard copy files that are marked "DO NOT PURGE" prior to ECF are maintained as a hard copy case record. Scan into ECF any part of a hard copy case record that applies to a newly discovered claim. Before a hard copy case record is purged inquire Worker Portal to determine the status of the case,

and to determine if there is a pending or established claim. DO NOT PURGE a claim case unless the claim is paid-in-full for 3 years. IPV claims should never be purged.

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

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

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

MS 0045*

ARCHIVING CASE RECORDS

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

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

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

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

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

MS 0050

[CASE RESPONSIBILITY

(1)

An application/reapplication for assistance, recertification, change report, or any information provided by or in behalf of a client is accepted by staff without regard to the county of residence of the client. Scan the documents into the Electronic Case File (ECF) for the specific case. Enter the application/reapplication, recertification or change on Worker Portal.

Cases do not have one specific county or worker that has ongoing responsibility with three exceptions.

- A. KTAP cases that involve participation in the Kentucky Works Program (KWP). Ongoing responsibility for KTAP/KWP activities belongs to the county where the client lives. Recertifications and changes can be completed by any staff regardless of county;
- B. Cases handled by a Department of Juvenile Justice (DJJ) worker are processed by Central Office; and
- C. SAFE cases are processed in Central Office.]

MS 0055 [KENTUCKY ONLINE GATEWAY (KOG) (1)

The Kentucky Online Gateway (KOG) provides for a single sign-on to most systems used by staff and automates the request process management staff uses for system access.

A. KOG provides a single sign-on for the:

1. DCBS Case Review;
2. Electronic Case Files;
3. E-Forms,
4. Kentucky Physicians Care;
5. KHBE Worker Portal;
6. KVETS (Birth Index);
7. ESEP, External Search and Exchange Portal (replaces KYNET/KYIMS); and
8. OTIS.

Users can log in once using a single user name and PIN and access multiple systems.

B. The KOG User Agreement must be accepted on the first use of KOG and may be required again if the User Agreement changes.

C. KOG automates the process for requesting, approving, and granting access to the applications on KOG. Supervisors use KOG to request access for employees, modify access, and update employee information. KOG provides e-mail notification regarding approval and other tasks in KOG.

D. Employees may make some changes to their contact information in Account Management in KOG. Employees may also change their security questions.

E. The KOG Help Desk in the Cabinet's Office of Administrative and Technology Services (OATS) assists with users' access to KOG and other applications. KOG provides automation of some Help Desk tasks previously done through manual processes.

F. The Help Desk can be contacted by phone toll free at 866-231-0003, locally at 502-564-0104 or by e-mail at Commonwealth Service Desk@ky.gov.

1. The Security Help Desk handles the following issues: access revoked on KOG, etc. The Security Help Desk is option 2 when calling.

2. The Network Help Desk handles the following issues: logging onto the workstation, KOG issues related to a user's account, server issues,

anything Network related for PC users, E-mail issues, printer issues, etc.
The Network Help Desk is option 5 when calling.]

MS 0090

RETURNED MAIL

(1)

[When mail is returned to the centralized mail center, use the following procedures.

- A. The mail center staff scans the envelope and contents into the Electronic Case File (ECF) and creates a task for the returned mail.
- B. The worker assigned to the task checks the address on Worker Portal.
 - 1. If the address is different, the worker determines if the mail needs to be resent to the new address listed on Worker Portal.
 - 2. If the address listed on Worker Portal matches the returned mail, the worker calls the household in an attempt to obtain the correct mailing address.
 - 3. If able to contact the household by phone, correct the address on Worker Portal to ensure written correspondence is delivered.
 - 4. If unable to contact the household by phone, generate an RFI requesting that verification of residency be provided within 10 days for SNAP and KTAP or within 30 days for MA. If the household does not respond to the notice of returned mail, the case will discontinue.
 - 5. If the household provides verification of the correct address, change address on Worker Portal.
- C. If the household does not respond to the request, take action on Worker Portal to discontinue the case.

If the contents are notices originating from the Department for Community Based Services (DCBS), shred the envelope and the contents. If the returned mail contains sensitive material such as, original birth certificates or check stubs, store in the hard copy file (if one exists) until the client is due to return to the office.

- D. Document in case comments regarding action taken.]

MS 0100

RETURNED CHECKS

(1)

Individuals must return any check for which they are not eligible. Individuals, their Authorized Representative (AR), or any other interested party may return checks to a Department for Community Based Services (DCBS) office. Checks may also be returned to Central Office.

[A. For checks, including KTAP, Kinship Care, SNAP Employment and Training Program, KWP supportive services, State Supplementation, FAD and FAST, which have been returned to Central Office, the Program Specialist will receive notification via email about the check and respond via email within 5 workdays. The response authorizes the appropriate action to:]

1. Cancel a check if:

- a. The recipient of the check died prior to the first day of the month for which the check was issued;
- b. The recipient has moved and cannot be located, and mail sent to the recipient by the local or Central Office has been returned to the local office. A check is not cancelled until procedures for returned mail in [MS 0090](#) are completed and the recipient cannot be located. If, after the check has been cancelled but prior to the last day of the month covered by the cancelled check, the location of the recipient becomes known, the check must be made available to the recipient;
- c. The recipient voluntarily returned a check to avoid an overpayment;
- d. A supportive services provider returns a duplicate payment;
- e. A supportive services payment is returned due to an incorrect amount or provider on the check. In this instance, the correct payment is issued on OTIS;
- f. The individual is discharged from a Personal Care Home (PCH), unless the individual is going to another PCH or is receiving Community Integration Supplementation (CIS);
- g. The individual is discharged from a Family Care Home (FCH), unless the individual is going to another FCH;
- h. The individual is no longer receiving Caretaker Services or CIS; or
- i. The payment was issued in error.

[Note: Once the cancelled KTAP, Kinship Care, FAD, FAST, or State Supplementation check has been redeposited, the Family Self-Sufficiency Branch (FSSB) will update the status on the Update Benefit Status screen to Cancelled. For a KWP supportive services check, OTIS is updated.]

2. Re-mail a check if return was due to an incorrect address and the current mailing address is established. Take action to correct the address on Worker Portal to ensure delivery of subsequent checks.
3. Reissue a KTAP or Kinship Care check for the original amount if there has been a change in payee and the new payee is eligible for the original amount.

[Do NOT change the payee for FAD, FAST, or supportive services. Cancel the erroneous payment on Worker Portal or OTIS and issue a new payment to the correct individual/provider.]

4. Reissue the check, if a recipient of KTAP or State Supplementation dies on or after the first day of the month for which the check was issued, to:
 - a. The widow, parent, or guardian; or
 - b. The executor or administrator of the estate. If the check is reissued to an executor or administrator, obtain a copy of the executor or administrator appointment order as verification.
- B. For mutilated checks, request the payee bring the remains of the check to a DCBS office. Mail the check along with a completed form PAFS-61, Disposition of Returned Check, to:

Division of Family Support
Family Self-Sufficiency Branch
KTAP Section
275 E. Main St., 3E-I
Frankfort, KY 40621

Once FSSB receives the form and mutilated check, FSSB will contact Treasury regarding a replacement. Once the check is replaced by Treasury, FSSB will mail the check to the DCBS office for the individual to pick up. At the time the individual picks up the check, form PAFS-62, Local Office Check Log must be completed and form PAFS-62 Sup. A, Affidavit of Check Receipt, must be signed.

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

[If a payee reports non-receipt of a check or that a check has been lost or stolen, the payee may request a replacement of a check (KTAP, Kinship Care, SNAP Employment and Training Program (ETP), KWP supportive services, FAST, RAP, and State Supplementation).]

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

Example: The issuance date of the check is 6/1/22. The individual may request replacement of the check until 5/31/23. If the individual reports non-receipt, loss, or theft of the check on 6/1/23 or after, the replacement request is denied.

A. When a payee reports non-receipt, loss, or theft of a check:

1. **[Inquire the appropriate system to determine the date the check was issued.**
 - a. For KTAP, Kinship Care, FAST, SNAP ETP, and State Supplementation, access Worker Portal for issuance information.
 - b. For RAP and KWP supportive services checks, access OTIS for check issuance information.]
2. The payee must wait 10 business days from the daily check issuance date before completing form PAFS-60, Affidavit, to request a replacement.
3. If the individual is reporting the non-receipt by phone, tell the individual that they have to go to the local DCBS office to sign form PAFS-60.

[If a FAST or KWP check is issued to a provider, send form PA-64, Provider Appointment Letter, to document the appointment to discuss non-receipt, loss, or theft of a check. Form PA-64 also provides instruction for the provider to return form PAFS-60 signed and notarized to the office.]

4. Determine if:
 - a. The payee recently moved and failed to provide a forwarding address to the Post Office or a change of address was submitted too late to redirect mailing of the check;
 - b. The check was lost or stolen and if the check was signed before the loss or theft; or
 - c. For a stolen check, the individual reported the theft to the police and obtained a copy of the police report.
5. Contact the Division of Family Support (DFS), KTAP Section at 502-564-3440 to determine if the check has been returned or cashed.

- a. If the check has not been returned or cashed, verbally schedule an appointment with the individual within 3 days to complete form PAFS-60.
 - b. If returned, the check is re-mailed to the correct address.
 - c. If cashed, follow procedures in [MS 0115](#).
- B. At the time of the appointment to complete form PAFS-60:
1. **[In OTIS, navigate to Payments and select the payment that is reported stolen, lost, or not received. Then choose "Issue PAFS-60" and enter comments in the "Supportive Service Request to Stop Payment" comment box. Once the comments have been entered, follow the steps B.2.– 6.**
 2. Complete the Update Benefit Status screen in Benefit Management in Worker Portal. This will create a task to the Family Self-Sufficiency Branch (FSSB).**]**
 3. Generate form PAFS-60 Part I on the Update Benefit Status screen for the individual to sign while in the office. For FAST payments or payments from OTIS issued to a vendor, form PA-64, Provider Appointment Letter, is used to notify the vendor of the need to sign the affidavit, form PAFS-60.
 - a. The form must be signed by the payee and Field Services Supervisor (FSS). If the FSS is unavailable, the form must be notarized.
 - b. If the payee is a vendor who is signing the form outside of the office, form PAFS-60 must be notarized.
 - c. Form PAFS-60 may also be signed by the Power of Attorney (POA) if verification of the POA is provided and scanned into ECF.
- Note:** Do not use a version of form PAFS-60 other than the one generated from Worker Portal. The use of any other version will be rejected and will result in an unnecessary delay for the individual. In addition, if form PAFS-60 Part I is not system generated, then form PAFS-60 Part II cannot be generated.
4. Explain the following to the payee:
 - a. The original check cannot be cashed once form PAFS-60 is signed and a stop payment has been placed on the check.
 - b. If the original check, which is issued in a self-sealed envelope known as thermo-bond, is received after form PAFS-60 is signed, it must be returned to the DCBS office. The replacement check has a different check number and date of issuance.
 5. Once the form is completed and signed, mail the original version to:

Division of Family Support
Family Self-Sufficiency Branch
KTAP Section

275 East Main St., 3E-I
Frankfort, KY 40621

Scan the form into the Electronic Case File (ECF). Copy versions of the form cannot be used to request a replacement.

6. When form PAFS-60 is received by FSSB, the status on the Update Benefit Status screen will be changed to Stopped and a replacement will be requested from Treasury. Once Treasury has replaced the check, FSSB will update the status to Replaced and mail the check to the DCBS office for the individual to pick up. CHK-1, Notice of Replacement Check, will be system generated informing the individual that the replacement has been processed and can be picked up at the DCBS office. When the individual picks up the check, form PAFS-62, Local Office Check Log, must be completed and form PAFS-62, Sup. A, Affidavit of Check Receipt, must be signed.

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

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

- A. The Division of Family Support (DFS) Central Office (C.O.) worker will update the Benefit Status on Worker Portal to "cashed". This generates a notice, CHK-1, Notice of Replacement Check, to the individual stating that the check was cashed and providing instructions on how to dispute that he/she cashed the check.

The C.O. worker obtains a copy of the cashed check and emails a copy to the Program Specialist.

- B. [When the individual comes to the local office to dispute the cashed check, have them view the cashed check signature. If the payee is a KWP supportive services provider, send form PA-64, Provider Appointment Letter, to the provider to complete form PAFS-60 Part II.

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

1. If the individual states he/she signed the check, send an e-mail to DFS at FSSBK-TAP@ky.gov explaining that the individual no longer claims non-receipt of the check.
2. [If the individual denies the endorsement is theirs, complete the Update Benefit Status screen. This will create a task to the Family Self-Sufficiency Branch (FSSB). Generate form PAFS-60, Part II on the Update Benefit Status screen and have the individual sign the form.

Note: Do not use any version of form PAFS-60 other than the one generated from Worker Portal. The use of any other version will be rejected and will result in an unnecessary delay for the individual. In addition, if form PAFS-60 Part I is not generated from Worker Portal, form PAFS-60 Part II cannot be generated from the system.]

Form PAFS-60 Part II MUST be signed by a Notary Public. The form cannot be signed by a staff person who is not a Notary Public. If a Notary Public does not sign the form, this will cause a delay in the replacement check. Treasury will return the form and require a new form PAFS-60 Part II be completed with all the necessary signatures.

3. If the individual denies the endorsement is his/hers, request the individual to provide a police report for the forged endorsement.
4. Scan the signed form PAFS-60 Part II and the police report into the Electronic Case File (ECF). Mail the **original** version of the form and police report to:

Division of Family Support
Family Self-Sufficiency Branch

KTAP Section
275 East Main Street, 3E-I
Frankfort, KY 40621

5. Once FSSB receives the form, it is forwarded to Treasury. Treasury has the final decision regarding the replacement of a check that has been cashed. Treasury may contact the individual for additional information regarding the endorsement of the check. There is no time frame in which Treasury must make the decision to issue the replacement. If Treasury replaces the check, FSSB will update the status to Reissued and mail the check to the DCBS office for the individual to pick up. When the individual picks up the check, form PAFS-62, Local Office Check Log, must be completed and form PAFS-62 Sup. A, Affidavit of Check Receipt, must be signed.
6. If the individual fails to view the endorsement, send an e-mail to FSSB at FSSBK-TAP@ky.gov explaining that the individual failed to view the endorsement.

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

- C. The Program Specialist must respond to FSSB within 10 calendar days from receipt of the request to view the endorsement.
- D. If, within six months of the first replacement check, a second replacement check is requested by the individual, follow the procedures for replacement check requests.

MS 0120 CHECKS RECEIVED BY THE LOCAL OFFICE (1)

[Checks may be mailed by Central Office to the local office for the payee shown on the check to pick up. These include checks that have been replaced by Treasury due to being lost, stolen, and/or damaged, or a rejected direct deposit. In addition, the local office may receive checks from individuals, their Authorized Representative (AR), provider, or any other interested party who needs to return checks. If someone other than the payee on the check picks up the check, there must be an explanation in Case Notes as to who authorized the individual to receive the check.

Any time a check is received in the local office, the worker must enter the check status information in Worker Portal under Benefit Management on the Update Benefit Status screen. This screen is also updated at the disposition of the check, whether picked up by the individual or returned to Central Office.

- A. Form PAFS-62, Local Office Check Log, is a mandatory form and must be completed and maintained for all checks received in the local office. Every check received in the local office must be entered on form PAFS-62 upon receipt, and the disposition of the check must be entered as well. It is extremely important that this form is updated appropriately with accurate information needed to track the checks received.]
- B. Form PAFS-62, Sup. A, Affidavit of Check Receipt, is a mandatory form and must be completed and signed by the recipient and worker when the check is picked up. The form should be scanned into the Electronic Case File (ECF).
- C. If in 30 days, the individual has not picked up the replacement check:
 - 1. Complete form PAFS-61, Disposition of Returned Check, to cancel the check. Scan the form into ECF.
 - 2. Mail form PAFS-61 and the check to:

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

Annotate the envelope: DO NOT FORWARD

MS 0130

DOCUMENTATION

(1)

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

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

A. Documentation for all programs:

1. At application or recertification case comments MUST contain a statement that rights and responsibilities were explained and understood by the client and that all required forms were given to the client;

It is not appropriate to comment that rights and responsibilities were explained if an interview is not conducted.

2. Resolution of Batch Matches;

3. Unusual circumstances pertaining to:

- a. The reason a request for an out-of-office interview is granted or denied;
- b. Deviation in normal office operating procedures;

[Example: Individual applies on 3/12/16, but Worker Portal is not accessible. A hardcopy application is taken and the action is not entered until 3/13/16.]

- c. Technical eligibility, program type, citizenship, household composition, or deviation from normal calculation procedures for income allocations;
- d. A statement explaining persons included or excluded in the household;
- e. A statement explaining the status of non-household and ineligible members and the consideration of their income and resources;
- f. Clarifications and program inquiries from Central Office that address issues present in the case;
- g. Reasons for any delays in case processing;
- h. The reason for determining information is questionable and how this was resolved;

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

MS 0131 ELECTRONIC INCOME VERIFICATION (EIV) (1)

[Electronic Income Verification (EIV) is a method of obtaining verification of an individual's earned income online. An online service may be used to assist individuals when verification of earned income is not readily available and the individual advises the worker that verification of the income is available by a free online service. Before EIV can be used, the individual must be contacted to confirm the information provided through EIV is current and correct. Comments must be entered in Worker Portal to explain the verification of the income. This also applies to information received from the Eligibility Advisor (EA).

Note: EA should be accessed before using any other online verification service.]

- A. It remains the individual's responsibility to provide verification of earned income if information provided on an online service is incorrect or incomplete.
- B. [It is the agency's responsibility to conduct thorough interviews to ensure that the employer's name, rate of pay, hours worked and pay schedule are documented in comments when earned income is reported and can be verified through an approved EIV.]
- C. EIV online services may have hidden fees that workers may not be aware of without completing additional research. Therefore, the online services must meet all of the following criteria:
 - 1. The online service must be free;
 - 2. The online service must not lead to a charge of any kind; and
 - 3. The information must be accessible to the caseworker directly.

[If the EIV online service meets the criteria above, forward the information to the appropriate program branch inbox through the Region's Public Assistance Program Specialist (PAPS) for approval to use the service. Once approval has been received from Central Office (CO), the service can be used.]

If the EIV online service is not approved, follow normal verification procedures.

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

MS 0140

ACRONYMS

(1)

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

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

EITC	Earned Income Tax Credit, also known as EIC	All Programs
EIV	Electronic Income Verification	All Programs
EPO	Emergency Protective Order	KTAP
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	MA
[ESAP	Elderly Simplified Assistance Project	SNAP]
ESI	Employer-Sponsored Insurance	MA
ESL	English as a Second Language	KTAP
[EXSNAP	Expedited Supplemental Assistance Program	SNAP]
FAD	Family Alternatives Diversion	KTAP
FAST	Family Assistance Short Term	FAST
FCH	Family Care Home	MA, State Supp.
FEIN	Federal Employer Identification Number	KTAP
FFY	Federal Fiscal Year	All Programs
FICA	Federal Insurance Contributions Act	All Programs
FLSA	Fair Labor Standards Act	KTAP
FMV	Fair Market Value	MA
FNS	Food and Nutrition Service	SNAP
FPL	Federal Poverty Level	All Programs
FRYSC	Family Resource and Youth Services Center	KTAP
FSSB	Family Self-Sufficiency Branch	All Programs
FTI	Federal Tax Information	All Programs
GED	General Equivalency Diploma	KTAP
HCBS	Home and Community Based Services	MA
HH	Household	All Programs
HOH	Head of Household	All Programs
HHS	Health and Human Services	KTAP, MA
HIPAA	Health Insurance Portability and Accountability Act of 1996	All Programs
HUD	Department of Housing and Urban Development	All Programs
ICF IID	Intermediate Care Facility for Individuals with an Intellectual Disability	MA
ICPC	Interstate Compact on the Placement of Children	KTAP, MA, Kinship Care
IDA	Individual Development Account	KTAP
IEVS	Income and Eligibility Verification System	All Programs
IHE	Inadvertent Household Error	SNAP
IK	In Kind	SNAP
IMD	Institution for Mental Diseases	MA
IPV	Intentional Program Violation	SNAP
IRS	Internal Revenue Services	All Programs
JRA	Job Readiness Training	KTAP
KAR	Kentucky Administrative Regulation	All Programs

KASES	Kentucky Automated Support and Enforcement System	All Programs
KC	Kinship Care	KC, KTAP, SNAP
KCHIP	Kentucky Children's Health Insurance Program	MA
KCTCS	Kentucky Community and Technical College Systems	KTAP
KMA	Kentucky Medical Association	MA
KMP	Kentucky Medicaid Program	MA
KOG	Kentucky Online Gateway	All Programs
KPC	Kentucky Physicians Care Program	MA
KRS	Kentucky Revised Statutes	All Programs
KTAP	Kentucky Transitional Assistance Program	All Programs
KWP	Kentucky Works Program	KTAP
LEP	Limited English Proficiency	All Programs
LIHEAP	Low Income Home Energy Assistance Program	SNAP
LOC	Level of Care	MA
LTC	Long Term Care	MA
MA	Medicaid/Medical Assistance	All Programs
MAGI	Modified Adjusted Gross Income	MA
MAID	Medicaid Identification Card	MA
MCO	Managed Care Organization	MA
MHP	Mental Health Provider	MA
MRT	Medical Review Team	KTAP, MA, State Supp.
MMV	Missing Mandatory Verification	All Programs
MSBB	Medical Support and Benefits Branch	MA, State Supp.
NAAB	Nutrition Assistance and Accountability Branch	SNAP
NCLEX	National Council Licensure Examination	KTAP
NCP	Non-custodial Parent	KTAP, MA
NEMT	Non-Emergency Medical Transportation	MA
OAG	Office of Attorney General	All Programs
OATS	Office of Administrative and Technology Services	All Programs
OIG	Office of Inspector General	All Programs
OTIS	Online Tracking Information System	KTAP
OVR	Office of Vocational Rehabilitation	KTAP
PA	Public Assistance	All Programs
PAPS	Public Assistance Program Specialist	All Programs
PASS	Plan for Achieving Self-Support	MA
PCH	Personal Care Home	MA, State Supp.
PL	Public Law	All Programs
POA	Power of Attorney	MA, State Supp.
PRO	Peer Review Organization	MA
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996	All Programs
PRTF	Psychiatric Residential Treatment Facility	MA

QC	Quality Control	All Programs
QDWI	Qualified Disabled Working Individuals	MA
QHP	Qualified Health Plan	MA
QIT	Qualifying Income Trust	MA
QMB	Qualified Medicare Beneficiaries	MA
R & R	Rights and Responsibilities	All Programs
RAP	Relocation Assistance Program	KTAP
RDS	Report Distribution System	All Programs
RFI	Request for Information	All Programs
RN	Registered Nurse	KTAP
RSDI	Retirement, Survivors, Disability Insurance	All Programs
RTW	Ready-to-Work Program	KTAP, SNAP
SAFE or SF	Simplified Assistance for the Elderly	SNAP
SAVE	Systematic Alien Verification for Entitlement	All Programs
SCL	Supports for Community Living Waiver Program	MA
SDX	State Data Exchange	All Programs
SFU	Standard Filing Unit	KTAP, MA (E&T only)
SI	System Inquiry	All Programs
SLMB	Specified Low Income Medicare Beneficiaries	MA
SNAP	Supplemental Nutrition Assistance Program	SNAP
SOLQ	State On-Line Query	All Programs
SP	Second Parent	KTAP
SR	Simplified Reporting	SNAP
SRA	Service Region Administrator	All Programs
SRAA	Service Region Administrator Associate	All Programs
SSA	Social Security Administration	All Programs
SSI	Supplemental Security Income	All Programs
SSN	Social Security Number	All Programs
SSP	Self-Service Portal	All Programs
SST	Short-term Training	KTAP
SUA	Standard Utility Allowance	SNAP
SYETP	Summer Youth Employment and Training Program	All Programs
TAA	Transitional Assistance Agreement	KTAP
TANF	Temporary Assistance for Needy Families	KTAP
TAP	Targeted Assessment Program	KTAP
TDD/TTY	Telecommunications Device for the Deaf and Hard of Hearing	All Programs
TMA	Transitional Medical Assistance	KTAP, MA
TOA	Type of Assistance	MA, State Supp.
TOP	Treasury Offset Program	Claims
TPL	Third Party Liability	KTAP, MA
TPR	Termination of Parental Rights	KTAP, MA
UI	Unemployment Insurance	All Programs

UIB	Unemployment Insurance Benefits	All Programs
USC	United States Code	All Programs
USDA	United States Department of Agriculture	SNAP
VA	Veterans Administration	All Programs
VES	Vocational Education Skills	SNAP
VISTA	Volunteers In Service To America	All Programs
VP	Vendor Payment	All Programs
VR	Vocational Rehabilitation	KTAP
WEP	Work Experience Program	KTAP, SNAP
WIOA	Workforce Innovation and Opportunity Act	All Programs
WIC	Women, Infant, and Children	All Programs
WIN	Work Incentive Reimbursement	KTAP

MS 0150

CONFIDENTIALITY REQUIREMENTS

(1)

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

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

"This electronic message is intended to be for the use only of the named recipient and may contain information that is confidential or privileged. If you are not the intended recipient, you are hereby

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

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

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

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

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

MS 0160* HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
ACT COMPLIANCE REQUIREMENTS

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

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

MS 0170

SUBPOENAED INFORMATION

(1)

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

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

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

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

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

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

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

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

MS 0190

AGREEMENT TO SAFEGUARD INFORMATION

(1)

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

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

MS 0200 [COMPLAINT MODULE ON WORKER PORTAL (1)

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

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

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

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

MS 0210

CIVIL RIGHTS OVERVIEW

(1)

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

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

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

4. The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance.
 5. Discrimination on the basis of religion is prohibited by a number of Federal laws and regulations.
- B. Ensure the following general requirements are met in the provision of all services and benefits to applicants and recipients:
1. Do not discriminate against any individual for reasons of age, race, sex, disability, religious creed, national origin or political belief in any aspect of program operation, including but not limited to the application process, benefit or claims determination, hearings, employability assessments, or work program components.
 2. Explain and provide the Civil Rights pamphlet at application and any time the individuals question or do not understand their rights. The pamphlet can be accessed at: <https://chfsnet.ky.gov/ohrm/Pages/ClientCivilRights.aspx>.
 3. Provide assistance to an individual needing accommodation due to a physical or mental disability he or she or another household member currently has or had in the past. A disability is a physical or mental impairment that substantially limits one or more of an individual's major life activities, having a record of such impairment, or being regarded as having such an impairment. Definitions of common disabling conditions and suggested accommodation, as well as other information relating to Title II of the Americans with Disabilities Act, can be found at www.ada.ky.gov.
 4. [Document the need for and provision of any accommodation in Worker Portal.]
- C. Accommodation in the provision of benefits and services may include, but is not limited to:
1. Visiting an individual's home to conduct interviews.
 2. Scheduling interviews that do not conflict with disability related appointments of the applicant/recipient or a disabled member of the household.
 3. Rescheduling interviews if notified a conflict exists with disability related appointments.
 4. [Making reminder calls regarding appointments or needed information. Document comments in Worker Portal when the call is made.]
 5. Reading and/or explaining letters and forms to an applicant/recipient.
 6. Providing a sign language interpreter for a deaf or hard of hearing applicant or recipient. See [MS 0220](#).

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

MS 0220

INTERPRETER SERVICES FOR DEAF AND
HARD OF HEARING INDIVIDUALS

(1)

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

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

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

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

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

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

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

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

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

MS 0230 LIMITED ENGLISH PROFICIENCY (1)

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

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

- A. When an individual comes into the local office to apply:
 1. Ask the individual what his/her primary language is. Based on the individual's statement, enter the language on Worker Portal. Do not assume an individual does not speak or understand English or assume the individual's primary language based on appearance. If the individual does not speak or understand English, use the "I Speak" language identification posters to determine the primary language;
 2. Inform the LEP individual that interpreter services are available at no cost to the individual using the "I Speak" posters; and
 3. If the individual indicates a primary language other than English and he/she does not want to use the approved interpreter service provided by the Cabinet, have the individual complete the form, Waiver of Interpreter Services – Limited English Proficiency (LEP). This form can be accessed at:
<https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.
- B. If an individual cannot understand verbal or written English, use one of the following options to access interpreter services:
 1. Language Access Section. If a Spanish-speaking interpreter or document translation is needed, contact the Language Access Section (LAS) at (502) 564-7770. LAS staff are available during regular work hours and can be scheduled in advance. For example, if a Spanish-speaking individual needs to be recertified, the worker should schedule a LAS interpreter for the recertification appointment.

When no Spanish speaking interpreter is available through LAS, use the Language Services Associates, Inc., item 4 of this section.
 2. CHFS Qualified Interpreter Service. If LAS staff is not available, choose an interpreter from the CHFS approved list of Cabinet employees who are qualified to provide interpreter services. The list can be accessed at:
<https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.
 3. CHFS Qualified Community Based Partner Interpreters. If neither a LAS interpreter nor a CHFS qualified interpreter is available, contact a qualified non-CHFS interpreter. This resource can provide interpreter

services for a variety of languages, including Spanish. The list can be accessed at:

<https://chfsnet.ky.gov/ohrm/Pages/InterpretationResources.aspx>.

[These services usually involve a cost. To pay for these services, scan a signed billing statement from the interpreter with a completed CHR-101 stamp or form CHR-101, and e-mail to Jamie Gaines in the Division of Administration and Financial Management (DAFM) at Jamie.Gaines@ky.gov.]

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

MS 0240

CIVIL RIGHTS COMPLAINTS

(1)

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

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

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

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

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

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

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

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

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

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

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

MS 0260

OVERVIEW OF EBT

(1)

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

- A. The EBT card is used to access the following:
 - 1. SNAP benefits;
 - 2. K-TAP benefits;
 - 3. Kinship Care benefits;
 - 4. KWP transportation payments; and
 - 5. WIN reimbursement payments.

- B. Acronyms used in relation to the EBT system are:]
 - 1. ATM - Automated Teller Machine
 - 2. CSR - Customer Service Representative
 - 3. EBT - Electronic Benefit Transfer
 - 4. FNS - Food and Nutrition Service
 - 5. IVR - Interactive Voice Response
 - 6. PIN - Personal Identification Number
 - 7. POS - Point of Sale

MS 0270

REQUIRED EXPLANATIONS OF EBT

(1)

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

- A. [EBT is the system used to deliver SNAP, KTAP and Kinship Care benefits and KWP transportation and WIN payments in Kentucky. EBT provides a safer, more secure method for recipients to receive benefits. EBT also eliminates the need to mail or have the recipients pick up benefits each month. Benefits are simply added to the recipient's EBT account when an issuance is processed and are automatically available on the EBT card.]
- B. EBT cards are the size and shape of typical bank credit cards. The card is red, white and blue with an American flag design. The EBT card contains the recipient's name and the EBT card number.
- C. [All EBT cards are mailed with an inactive status. The card should be received in approximately 7-10 days. When the recipient receives the EBT card, a sticker is attached to the card, advising the recipient to call the Customer Service Representative (CSR) to activate the card. THE CARD DOES NOT WORK UNTIL IT IS ACTIVATED.]
- D. [Only one EBT card is issued per individual regardless of the number of cases in the individual's name and SSN. Individuals who have an active EBT account for one type of benefit will not have a separate EBT account or be issued a separate EBT card for other types of benefits. The same EBT card is used to access SNAP, KTAP and Kinship Care benefits and KWP transportation and WIN payments.

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

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

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

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

- E. The EBT card is mailed in a card carrier, which is a two-sided heavy paper folder with slots cut to hold the card in place during mailing. Supplemental EBT educational information is printed on the card carrier covering such subjects as:

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

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

1. The EBT card cannot be used for any cash benefit transactions or withdrawals from ATM's in liquor stores, adult-oriented entertainment establishments, or any casino, gambling casino or gaming establishment.
 2. The individual can withdraw cash at an Automatic Teller Machine (ATM) which displays the Quest logo. The individual gets one free withdrawal per month. The individual is charged a fee of 85 cents per withdrawal for subsequent withdrawals. The individual will also be assessed normal bank charges if the ATM charges a processing fee. The fee is deducted from the EBT account.
 3. The individual can withdraw cash at a retailer's point of service (POS) terminal at authorized retailers with no charge at the time of a retail purchase. Individuals cannot request cash back from the SNAP benefits portion of the EBT account.
- H. Give all households authorized to receive benefits the toll-free telephone number when problems arise with their card and/or PIN. The CSR telephone number is 1-888-979-9949. The number is printed on the back of the EBT card and on the training material the recipient receives in the mail.
- I. The CSR is operational 24 hours a day, 7 days a week and is voice automated. Recipients may call from a touch-tone phone or a rotary dial phone. If calling from a rotary dial phone, the recipient is instructed to stay on the line to speak with a representative.

- J. All certified retailers are provided with a toll-free telephone number for use when problems arise with their equipment or completing a transaction. These numbers are:

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

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

- K. Recipients contact the CSR to:

1. Report their EBT card lost, stolen or damaged and request a new EBT card;
2. Activate their EBT card. To activate the EBT card, the individual must provide the 16-digit EBT card number and the individual's date of birth MMDDYY;
3. Check their benefit balance;
4. Review their last 10 transactions; and
5. Select and/or change a PIN.

- L. Explain the use of SNAP benefits as follows:

1. SNAP benefits may be saved from month to month, but the account must be used at least once within a 12-month period.
2. The household has the right to designate an authorized representative to use its SNAP benefits.
3. SNAP benefits can be used ONLY to purchase eligible food for their household, including seeds and plants to grow fruits and vegetables.
4. SNAP benefits CANNOT be used to pay on any kind of credit account even if it is for eligible food.
5. SNAP benefits CANNOT be used to purchase items such as tobacco, alcoholic beverages, pet foods, soap or other household products, and medicines.

- M. Explain that the Kentucky EBT card can be used in all states.

MS 0280 LOCAL OFFICE RESPONSIBILITIES (1)

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

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

[C. Ensuring that case information is accurately entered on Worker Portal.

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

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

MS 0290

SECURITY OF EBT CARDS

(1)

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

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

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

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

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

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

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

A. The Field Services Supervisor (FSS):

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

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

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

EBT cards are not to be mailed between local offices.

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

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

MS 0300 CENTRAL OFFICE RESPONSIBILITIES (1)

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

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

MS 0310 TIME LIMIT FOR USING EBT BENEFITS (1)

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

1. When the oldest SNAP benefit in the EBT account has not been used within nine months, the EBT system checks each benefit in the account to determine if it should be expunged. For a benefit to be expunged, the "available date" for that benefit must be at least nine months in the past.
2. The EBT system sends Worker Portal a file of all SNAP EBT accounts that have not had any debit activity for nine months. To ensure that the recipient is aware that they have had benefits removed from their EBT account, Worker Portal sends the household an expungement notice. This notice advises the recipients that they have not used their SNAP EBT account in the last nine months, the benefits listed on the notice have been expunged from their EBT account and they cannot get these benefits back. If the recipient has a claim, these expunged benefits will be applied to that claim.]

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

3. When benefits are expunged, Worker Portal updates the benefit segments with the amount expunged and the date. This information is available on the benefit inquiry screen.
- B. [The discontinuance of the case has no impact on the EBT account. As long as there are SNAP benefits in the account and the recipient is debiting the account at least once every nine months, the recipient has access to the EBT account.
- C. An EBT account must be debited every twelve months for KTAP and Kinship Care benefits, or the above benefit expungement process will take place.]
- D. Access the EBT System, at each reapplication to determine the status of an individual's EBT card.
- E. If the EBT card status is anything other than active or inactive or if the EBT card number is blank, do the following:
1. Answer yes to the question "Does the household need a new EBT card?"
 2. Tell the recipient their old EBT card will not work.
- F. The worker needs to check the EBT system to verify EBT card status at every reapplication. This will prevent confusion when the applicant tries to access current benefits with a card that has been deactivated and allows recipients

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

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

MS 0320 RECONCILIATION OF ISSUANCES (1)

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

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

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

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

MS 0330

EBT INQUIRY

(1)

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

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

CSD will process your request and you will receive an e-mail from the FIS Security System when the request has been processed.

B. To review EBT account information, go to the web and type in <http://www.ebtedge.com/gov/portal/PortalHome.do>. After selecting the appropriate option, you will be asked to log on. Enter your '7-digit HR user ID' and password.

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

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

- C. In addition to having access to the EBT system for inquiry, staff also has a Benefit inquiry screen on Worker Portal. This screen displays when the "Benefit Management" tab is selected.

The information displayed on this screen is:

1. Worker Portal Case and EDG Number;
 2. Client/Vendor Name;
 3. Benefit Program, Benefit Month, and Benefit Type;
 4. Allotted Amount, Issued Amount, Recoupment Amount;
 5. Benefit #
 6. EBT Availability Date; and
 7. Issuance Status
- D. In addition to having inquiry capability, designated staff at the Central Office level perform the following activities:
1. Debit the EBT account as the result of a claims repayment or returned KTAP or Kinship Care benefits;
 2. Add/update client's EBT account; and
 3. Issue an EBT card.]

MS 0340

REPLACING EBT CARD

(1)

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

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

A. Customer Service Responsibility

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

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

B. Local Office Responsibility

[In the above situations, the CSR refers the recipient to a DCBS office. Replacement cards are requested through the Benefit Management on Worker Portal.]

1. If the current card status on the EBT system is "11", determine why the card was returned. If the current card status is "09", that card has been deactivated and a new card must be issued.
 - a. [If the case is active or pending:]
 - (1) If there is a new address for the case, update the address through the address change function or update the pending case before requesting the card;
 - (2) Enter the case number and select "Option 1" on "Case Change Menu";
 - (3) Enter a 'Y' for the question "Issue EBT Card", and enter. 'C' or 'O' for the question, "DO YOU WANT EBT CARD MAILED TO THE CLIENT OR LOCAL OFFICE?" and press enter. (The case address will be uploaded and cannot be changed on this screen.); and

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

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

- b. If there is no active or pending case in the head of household's Social Security Number:
 - (1) Enter the case number and select "Option 1" on the "Case Change Menu".
 - (2) Enter a "Y" for the question "Issue EBT Card?"
 - (3) Enter the mailing address and press enter.
 - (4) When the message "REQUEST PROCESSED" is received, PF3 to return to the "Case Change Menu".

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

2. If the recipient's address has changed and their EBT card has been lost, stolen or damaged, follow steps as outlined in item 1.
3. For name changes, determine if the recipient wants to have a new card issued immediately. Explain to the recipient that if a new card is requested through KAMES, the current card becomes invalid that evening. Benefits will be inaccessible until the new card is received. Advise the recipient that, if requested, the card replacement can wait until the current month's benefits have been used or until access to benefits is not needed for several days. The recipient could call CSR to have the card replaced at a more convenient time. The advantage to waiting is the worker can make the name change on KAMES and KAMES can update the EBT system. This enables the CSR to authorize the replacement once the recipient calls.
 - a. Procedures for Delayed Card Replacement
 - (1) If the case is active:
 - (a) Make the name change on KAMES and end session. The name change will be sent to EBT that night.
 - (b) Advise the recipient to call the CSR when they do not need to use their card for several days and request a new card. Advise the recipient that once a request for a replacement card is made, the old card becomes inactive and cannot be used.
 - (2) If the case is inactive, NAB will make the name change on the JP Morgan website and issue a replacement card.
 - b. Procedures for Immediate Card Replacement
 - (1) If the case is active:
 - (a) Make the name change on KAMES.
 - (b) Request a replacement request through KAMES.
 - (2) If the case is inactive, NAB will make the name change on the JP Morgan website and issue a replacement card.

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

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

A. Sample cases are chosen monthly by means of systematic random sampling and are reviewed in depth to substantiate the worker's determination of eligibility and computation of the benefit allotment.

B. A QC review consists of:

1. Analysis of the case record including adequacy of each step taken by the agency in the process of determining eligibility and the benefit allotment;
2. Face-to-face interviews;
3. Other investigation, including any collateral contacts necessary to assure documentation of all eligibility factors and the accuracy of the benefit allotment; and
4. Preparation of QC-343, Review Findings Notifications, as appropriate to list errors and related observations, if any.
 - a. A positive QC error exists when the household receives an incorrect benefit allotment for any reason, resulting in either an over or under issuance of benefits. A positive QC error would also include households who were totally ineligible for benefits. These errors can be attributed to either the agency's action or failure to act, or a client related action.

Example: The household received \$300 in benefits for the month of March. A QC review found that during the March SNAP application, the household failed to report wages being received and was not entitled to receive any benefits during the application month due to being over the income limits.

- b. A CAPER QC error would include when a case denied or discontinued incorrectly, incorrect notices issued to a household, agency took incorrect action during certification, denied the case for incorrect reasons, etc.

Example: The household applied for SNAP benefits on 5/2/2022 via Call Services. A Request for Information (RFI) form was issued on the same date requesting verification of household composition. On 5/5/2022, the household returns a written statement completed by the head of household to confirm household composition. This verification is deemed insufficient

by the agency as completed by a member of the potential benefits group. Worker issues new RFI to return verification of household composition but does not specify why returned verification was insufficient. Household does not return additional verification and the application denies. CAPER errors exist as worker failed to follow second RFI procedure and notices generated to client were unclear.

- C. Findings on individual cases are reported on the QC-343 by the QC analyst and sent for review and corrective action. When during the review the QC analyst discovers a change which occurred after the sample month, that information is transmitted to the county to which the review or error is attributed to.]

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

Note: It is the responsibility of the Program Specialist to forward to the appropriate Field Services Supervisor (FSSV) and to track the timeliness of form PAFS 343.1 when required. If form PAFS-343.1 is required, it should be completed for SNAP and Long-Term Care (LTC) reviews. Form PAFS-343.1 is not completed for reviews for the Medicare Savings Program.

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

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

A. If the case is cited in error:

1. If the reported case findings are correct, take action to correct the case within 10 calendar days from the date on form QC-343.
2. If necessary, schedule an interview with the recipient.
3. If the recipient disputes the information as reported on form QC-343, additional collateral contacts may be necessary to substantiate or refute the QC findings.
4. If an under issuance was identified on form QC-343, review and issue a supplement or restoration, if appropriate.
5. If an over issuance was identified on form QC-343, review and determine whether a potential claim exists. If so, submit a claim referral via the Benefit Recovery Module within 20 calendar days from the date on form QC-343.
6. Scan form QC-343 into the Electronic Case File (ECF).
7. Within 20 calendar days from the date on form QC-343 and after corrections have been made to the case, the FSSV completes form PAFS-343.1. This form identifies the error, what caused the error, and details what corrective action has been taken to prevent future occurrences. Once completed by the FSSV, the form is then submitted to the Program Specialist for review. Once reviewed and determined complete, the FSSV scans the form into ECF.

Note: The FSSV and Program Specialist should ensure that the findings are shared with all staff in efforts to prevent the same type of error in the future.

8. The Program Specialist must then go on the QC Share Point and select that the PAFS-343.1 is complete. This action will send notification to the appropriate Central Office and QC staff.
 9. If an over or under issuance is identified on the QC-343, the Program Specialist should email the PAFS-343.1 to the Claims Management Section inbox upon completion to advise what determination was made and what actions were taken.
- B. If the case was cited as correct, review form QC-343 for "Related Observations" which may identify changes which occurred which were not reported to the agency resulting in a change in eligible benefit allotment. Take appropriate case action within 20 calendar days from the date on form QC-343.

Note: Form PAFS-343.1 must be completed for related observations on all Non-MAGI and SNAP reviews. If a response to a related observation is required for MAGI, KTAP, or KWP review, it will be noted on form QC-343. Otherwise, responses are not required for related observations.

- C. If form QC-343 indicates the recipient "refused" to cooperate with QC, take action to impose the disqualification. Please reference Volume I, MS 0390 to determine the appropriate action to take for each program.
- D. If, as a result of the investigation, it is clearly established that the findings reported on form QC-343 are erroneous as of the review date, take the following actions to dispute the QC decision:
1. Within 15 calendar days from the date on form QC-343, the FSSV provides the Program Specialist with the following information to take exception to the QC error as cited:
 - a. Case Name;
 - b. Case Number;
 - c. Region;
 - d. County;
 - e. Review Number;
 - f. Review Month; and
 - g. Explanation of why an exception to the error is taken and why the case is believed to be correct.
 2. If the Program Specialist agrees with the exception, within 20 calendar days from the date of form QC-343, the Program Specialist forwards the request to the applicable program branch in the Division of Family Support.

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

- E. Comments should be entered into the case record regarding the QC-343 being received, summarizing the error that was cited, and explaining the actions that were taken to correct the case ongoing. Comments should also annotate whether or not an over or under issuance was identified, the determination made, and actions taken to resolve.
- F. Hearings Based on Findings: If the recipient requests a hearing and the hearing officer rules that, as of the review date, the QC finding was in error, take appropriate action as indicated based on the Final Order. **HOWEVER, THE HEARING DECISION DOES NOT CHANGE THE QC DECISION. Follow procedures in item "D" when taking exception to the QC error.】**

MS 0390 REFUSAL TO COOPERATE WITH QC (1)

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

A. For Medicaid (MA):

[The QC analyst sends the individual an appointment letter advising them that an analyst will call them at the time specified on the letter. There are no sanctions placed against a recipient who refuses to cooperate with a QC review.]

B. For KTAP and KWP:

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

C. For Kinship Care:

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

D. For Supplemental Nutrition Assistance Program (SNAP):

1. [If a household refuses to cooperate with the QC analyst in completing the case review, disqualify the household from further participation until the household cooperates with QC and provides the necessary information to complete the review.
 - a. When notified by QC that a household has refused to cooperate, enter a disqualification on the individual who refused to comply with QC. QC will identify this person on form QC-343. If QC cannot determine which member refused to cooperate, apply the disqualification to the head of household. Document this in Case Notes.
 - b. Once the disqualification has been applied, Worker Portal discontinues the case and issues a notice to the household, indicating the household's refusal to cooperate as the reason for termination or denial of benefits and states the actions the household must take if it wishes to reapply and cooperate.]
 - c. If the household disbands and members reapply within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the penalty follows the person who refused to cooperate and the new household will be disqualified. The new household, containing the disqualified person, must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Follow the steps outlined in d1 and 2 below.

- d. [If the household remains intact and reapplies within the QC review period or within 125 days of the close of the annual review period (October 1 through September 30 of any given year), the household must cooperate with the QC analyst, even if the household is otherwise eligible for expedited services. Enter the application on Worker Portal and take the following steps:]
- 1) If the household states that it is unwilling to cooperate with the QC analyst, the disqualification remains on the system and the reapplication will be denied for that reason.
 - 2) If the household states that it is willing to cooperate with the QC analyst, hold the reapplication pending and take the following action:
 - (a) Notify the original QC Analyst or QC Branch Manager by email or phone at (502) 564-1908 within 3 working days of the date of reapplication, of the household's intention to cooperate with the QC analyst. Provide current identifying case information with the QC review number and review date from form QC-343.
 - (b) Upon notification that the household intends to cooperate, the QC analyst schedules an appointment with the household. After the QC interview is conducted, the analyst forwards a memorandum advising the local office either of the household's decision to cooperate or of the household's refusal to cooperate.
 - (1) If the QC notice indicates the household's refusal to cooperate, deny the reapplication.
 - (2) If the QC notice indicates the household's willingness to cooperate, delete the disqualification and process the reapplication.
 - (3) If the reapplication is approved, and QC later determines the household is no longer cooperating with the review process, follow steps in D. 1.a above.
- e. If the household reapplies more than 125 days after the end of the annual QC review period (September 30 of every year) cooperation with the state QC analyst for the prior review period is not required. However, the household must verify all eligibility requirements prior to being determined eligible.
- f. If the household is terminated for refusal to cooperate with a federal QC analyst and reapplies after 9 months from the end of the annual QC review period (September 30 of every year) cooperation with the federal QC analyst for the prior review period is not required. However, the household must verify all eligibility requirements prior to being determined eligible.
- g. If an individual does not want to reapply for SNAP but states they will cooperate with the Quality Control review, refer them to the Quality Control Section to ensure the completion of the review so the disqualification can be deleted once the household has cooperated.

2. [If the QC analyst did not have any contact with the household, (the household failed to respond to the appointment letters, did not contact the QC analyst personally or verbally, or contact DCBS concerning the appointment) it is considered as failure to cooperate and no disqualification is applied.]
 - a. However, if a QC analyst specifically requests that the local office contact the recipient in an attempt to gain the recipient's cooperation, do the following:
 - 1) Schedule an interview and notify the QC analyst of the interview date and time.
 - 2) If the recipient fails to keep the appointment, manually discontinue the case no later than close of business the day after the scheduled appointment, using the reason 'UNABLE TO LOCATE FOR QC REVIEW'.
 - b. [When the household reapplies for SNAP benefits and the last discontinuance reason was 'UNABLE TO LOCATE FOR QC REVIEW', the prompt 'NOTIFY QC-LAST ACTION WAS 685-UNABLE TO LOCATE FOR QC REVIEW' will appear. Instruct the household to contact QC and explain to the client that he/she must cooperate with the QC process as a requirement of receiving SNAP benefits.]

MS 0400*

AUDITS

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

The audit process includes the following procedures:

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

MS 0410 [QUALITY ASSURANCE CASE REVIEW (1)

All case reviews are completed on Worker Portal in the Quality Assurance (QA) Module. Reviews are completed to assess the accuracy of casework processing and to identify error trends and training needs to be addressed on a local, regional, or statewide basis.

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

1. A case is processed correctly;
2. Case decision is made according to Agency policy;
3. All information is obtained, reviewed, and evaluated to substantiate a case decision;
4. Impending changes are identified and processed appropriately;
5. Computer matches are acted upon timely and appropriately;
6. All required forms are scanned to the Electronic Case File (ECF) and all inconsistent information is clarified;
7. All areas of eligibility are documented;
8. All elements affected by an error are identified; and
9. All computations are correct.

B. Reviewer Functions

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

C. Review Process

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

1. Reviewers must read cases and review all elements.
2. When there are errors, the reviewer cites specific policy for the error identified.
3. If the case requires corrections, the reviewer indicates an error and that further action is necessary.

4. The worker is assigned a Case Review task and makes the necessary corrections within the allotted timeframe.
5. When the reviewed case is returned to the reviewer, the reviewer ensures that the necessary corrections are made. After all the necessary corrections are made, the reviewer updates the status to Complete.
6. If the worker disagrees with the error cited, a conference with the reviewer may be requested.
7. Reviewers may use the "Detailed Activity" report to track the status of case reviews.
8. The review outcomes are used in the performance evaluation of an employee to identify the caseworker's policy strengths and training needs.

D. Central Office Functions

1. Central Office staff will complete statewide 1st, 2nd, and 3rd level reviews.
2. When an error is identified, local staff must make corrections by the task due date. In some instances, other information may be needed by Central Office in order to complete the review. In the event that material is needed, the Program Specialist will be contacted to provide the information to Central Office within 5 work days from the date the information is requested if not already scanned into ECF.

E. Quality Assurance Reports

The information gathered by reports is used as a tool to monitor error rates by:

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

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

F. Deleting QA Reviews

A reviewer can only delete a review that has not been started by a worker. For example, a reviewer has read the wrong case. As long as the review task has not been started by a worker, the reviewer can delete the review.]

MS 0420 [QUALITY ASSURANCE REPORTS (1)

Quality Assurance (QA) captures the results of case reviews and compiles various reports. The reports summarize the reviews completed by each worker, unit, county, and region.

A. Quality Assurance reports are used to:

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

B. The following is a list of Quality Assurance reports available on Worker Portal. Employees and management at all levels are to use the data found in the reports to improve accuracy and performance and to initiate corrective plans as needed.

1. QA Case Actions: This report compiles totals for all case decision actions taken on Worker Portal. It can be broken down by DCBS Region, County, and Program. The report breaks the reviews down by caseworker region, caseworker county, case action, review counts, reviews in error, and percentages of errors. The total number in error is divided by the total number of reviews and the result is the percentage in error. The report lists issuance errors which occur when an action taken on a case resulted in an incorrect benefit issuance.
2. QA Cases in Error: This report is used to identify the programs in which the most errors occur. It can be broken down by DCBS Region, County, and Program. It summarizes all of the cases in error. The report breaks the reviews down by worker, case number, review date, review level, review status, action due date, corrected timely, and error categories.
3. QA Detailed Activity: This report is used to look at cases read by a 1st or higher level reviewer. It can be broken down by DCBS Region, County, and Program. It provides the total number of reviews read. The report breaks the reviews down by case decision, caseworker, case number, review date, review level, review status, case action, corrected timely, and error categories.
4. QA Case Review Summary: This report break reviews down by the review elements. It gives an overall total for the review period specified on elements cited in error.]

MS 0440 ADMINISTRATIVE HEARING OVERVIEW (1)

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

A. At the time of application and at the time of any adverse action affecting his/her status with the Department, inform the individual in writing of the right to discuss the situation with a worker and/or to request a hearing. Such information is included on various Agency forms mailed or given to the individual. In addition, applicants are provided the pamphlet, PAM-PAFS-326, Division of Family Support Administrative Hearing Procedures.

B. The hearing process consists of:

1. The request;
2. Preparation for and scheduling of the hearing;
3. The hearing itself;
4. Review of the recommended order; and
5. The final order.

[Additional recourse for the recipient following an adverse hearing decision is available through appeal to the Cabinet Secretary/Secretary's Designee or Judicial review.

C. For SNAP:

1. An AGENCY CONFERENCE is offered to households adversely affected by an agency action. The household is advised that an agency conference is optional and in no way delays or replaces the fair hearing process. The worker, supervisor and the household member and/or representative attend the agency conference. An agency conference may lead to an informal resolution of the dispute. However, a Fair Hearing must still be held unless the household makes a written or verbal withdrawal. If a written withdrawal is received by DCBS, the Agency needs to scan this document into the Hearings Module as "Letter – Withdrawing". After this is complete, the Agency must also select the "Postponement/Withdrawal Request" button and complete the request. If the client requests a withdrawal verbally, complete a withdrawal request via the Hearings Module by selecting the "Postponement/Withdrawal Request" button. Form PAFS-277, Hearing Withdrawal Confirmation Notice, will auto populate and mailed to client via the mail center. Form PAFS-277 is to be scanned into the Hearings Module as it is part of the official hearings record.]

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

2. The Agency must expedite hearing requests from households, such as migrant farm workers, who plan to move from the jurisdiction of the hearing official before the hearing decision would normally be reached. Hearing requests from these households are processed faster than others if necessary to enable them to receive a decision and a restoration of benefits, if the decision so indicates, before they leave the area.
3. Employment and Training Program (ETP) activity that may be appealed includes any denial, reduction, or termination of benefits due to a determination of nonexempt status or a determination of failure to comply with a work requirement. Individuals or households may appeal actions such as exemption status, the type of requirement imposed, or refusal to make a finding of good cause, if the individual or household believes that a finding of failure to comply has resulted from improper decisions on these matters.

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

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

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

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

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

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

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

MS 0450 THE HEARING PROCESS (1)

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

A. Upon receipt of a request for a hearing:

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

on RDS. Prior to uploading the evidence to the hearings module and mailing the client, ALL evidence must include a cover page labeled as: Exhibit 1, 2, 3 or Exhibit A, B, C, etc. During the hearing process if the agency is asked to waive the timeframes of hearing procedures, the agency's answer is always "NO". Additionally, if another worker had input in the case or gathered collateral information during the time of the claim, include that worker(s) as a witness. Attendance by a DCBS worker is mandatory under these circumstances so evidence is not considered "hearsay". If investigative material is submitted into evidence that was gathered by the Office of Inspector General (OIG), then the OIG investigator must also be present so the evidence is not considered "hearsay".

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

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

2. If the hearing issue involves a negative action, include a copy of the negative action notice (i.e., KIP-105 series, FS-105, MA-105, or PA-105), including the back page and forward to DAH. The KAMES-generated notices are maintained on RDS and may also be accessed through DocumentDirect. As RDS does not include the back page of a notice, it is advisable to have a current back page in the office and make a copy to include with the notice. The system-generated notices for Worker Portal are available in the Correspondence Module. The back page is included with the notices in the Correspondence Module. If the notice is not available at the time of the request, request the hearing through Worker Portal within 24 hours and forward the copy of the notice as it becomes available.
3. If the request is from an individual who has limited English proficiency and requires interpreter services or has a physical or mental condition which requires accommodation in order to participate in the hearing, annotate the hearing request with this information.
4. All requests must be sent to DAH, through the hearings module in Worker Portal, within 24 hours of receipt, with exception of a hearing related to Medicaid payments or covered services.
5. A request for a hearing related to Medicaid payments or covered services is heard by the Department for Medicaid Services (DMS).
 - a. Annotate a short description in Notes when requesting the hearing request through Worker Portal.
 - b. Forward the hearing request within 24 hours to:

Department for Medicaid Services
Administration & Financial Management

Administrative Service Branch
275 East Main Street, 6C-C
Frankfort, Kentucky 40621-0001

- c. DO NOT send the case record to DMS.
 - d. The DCBS worker does not attend the DMS hearing.
6. Clients can also request DMS hearings by calling the Administrative Services Branch directly, at (502) 564-8196, ext. 3175.
- B. Prepare for the hearing by reviewing the case record and writing a summary of the issue/action that prompted the request. If the hearing involves a claim issue, it may be necessary to contact the regional claims worker for additional information about the case record and give a copy of the summary to the supervisor.
1. Include in the summary all information, documentation, notices, forms, comments, etc., that support the action taken by the agency. Be clear and concise; but include pertinent information with the explanation in the case when you are unable to attend the hearing and the supervisor or another worker must represent the agency's position.
 2. If the issue involves proper notification, make multiple copies of any manual or system-generated notices that are related to the issue to present at the hearing. Ensure that the back page of every notice is included. As RDS does not include the back page of a notice, it is advisable to have a back page in the office and make a copy to include with the notice.
 3. Make copies of all manual sections that relate to the issue/action. Include any pertinent policy clarifications that support the agency.
 4. DO NOT include unprofessional language or comments in the summary.
- C. Upon receipt of the hearing request, the DAH schedules the hearing and may need to contact the client for clarification of the reason for the hearing. The DAH notifies the client, field staff, and appropriate Regional Contact of the issue to be heard, along with the date, time and place of the hearing. The Hearings PAPS is responsible for notifying field staff of the hearing.
- The worker and supervisor notify any witnesses of the scheduled date of the hearing. The worker, supervisor or designated individual, MUST prepare, attend and actively participate in the hearing. A review of the case record must be completed to determine if a worker verified information by collateral contact. If the case record reflects that this occurred, the worker who made the collateral contact "MUST" attend the hearing in order to avoid any "hearsay issues" that may arise. The Hearings Public Assistance Program Specialist is responsible for ensuring the Agency representative is fully prepared. Claims Management Section (CMS) staff will attend Administrative Hearings which involve claim compromise and/or State Tax Refund Intercept.
- D. At the hearing, the agency representative worker or individual attending the hearing must be prepared to present the facts surrounding the issue/action. Preparation is important because the hearing officer cannot consider any

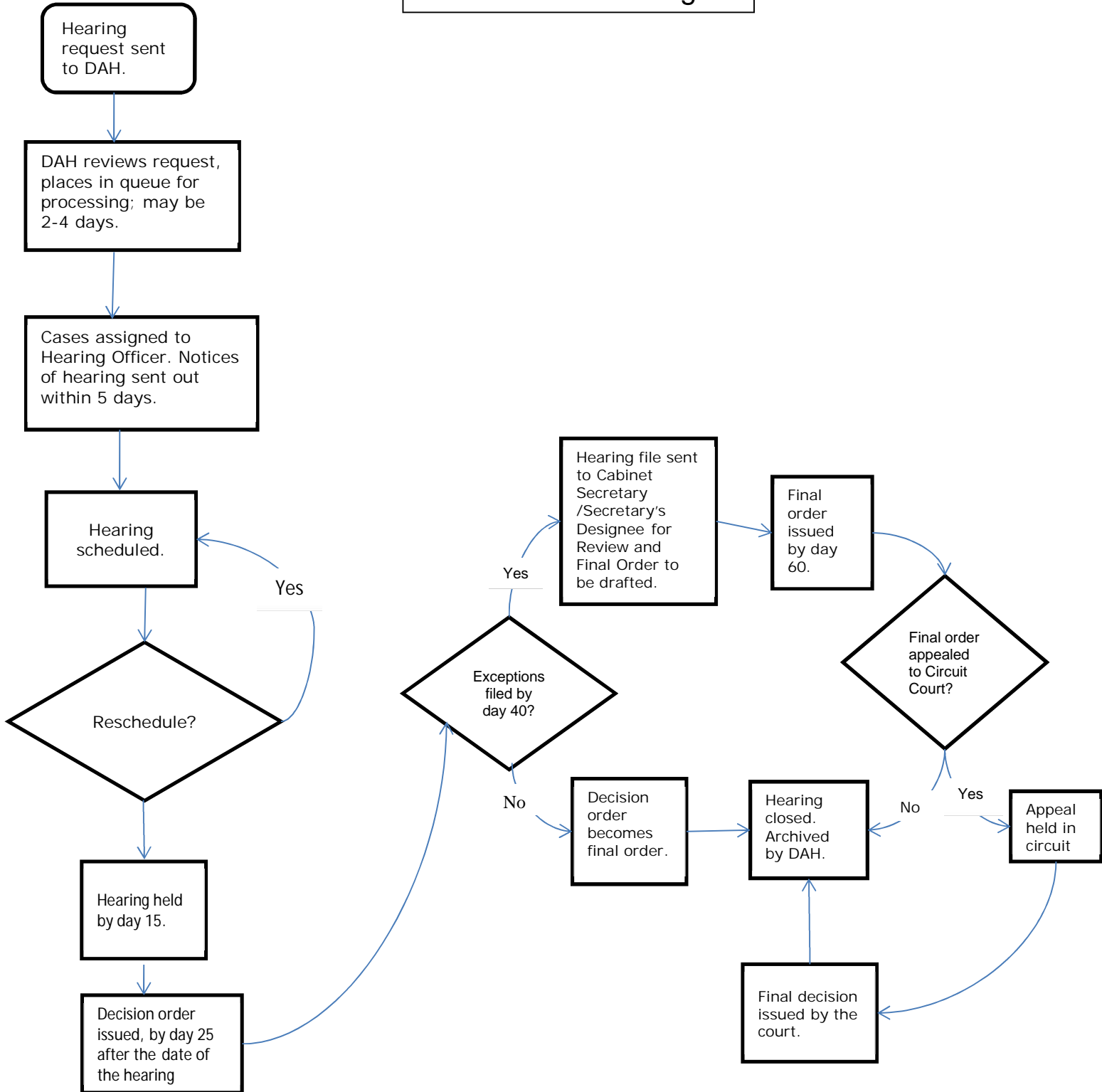
information or documentation not presented at the hearing. The burden of proof for the case action is the responsibility of the Agency.

- E. After completion of the hearing, the hearing officer drafts a recommended order. The recommended order is not a final order. DO NOT take any case action based on the recommended order. The recommended order is sent for review to:
1. The client and/or representative by mail;
 2. The Regional Contact person via the Hearings Module; and
 3. The Department for Medicaid Services, if the issue involved patient status in a skilled nursing home.

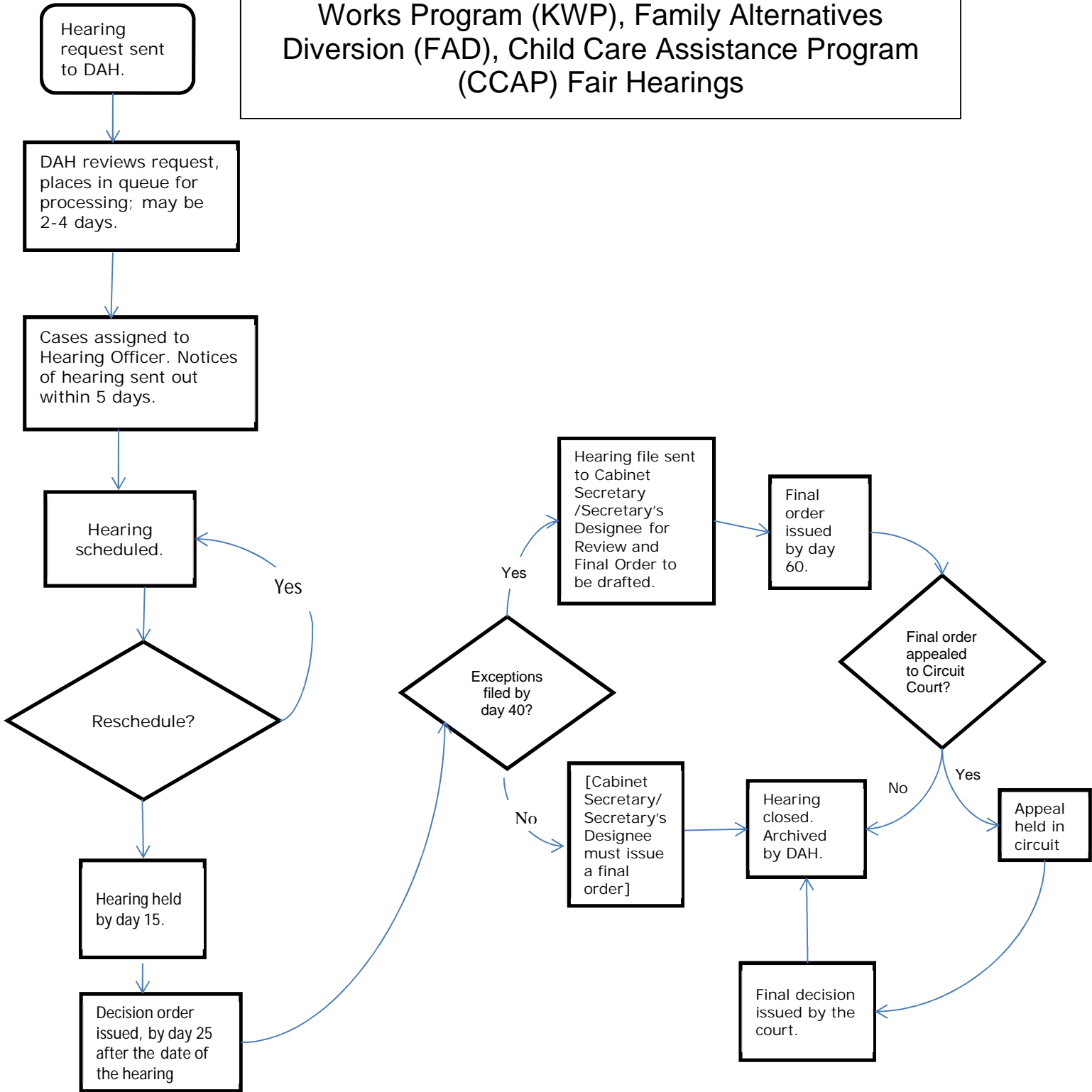
If any of the parties disagree with the recommended order, an exception can be filed with the Cabinet Secretary/Secretary's Designee within 15 calendar days of the mail date of the recommended order. For detailed procedures, refer to [MS 0510](#).

- F. Staff reviews all timely exceptions to the recommended order and drafts a final decision for submission to the Cabinet Secretary/Secretary's Designee.
- G. [If there are no exceptions taken to the recommended order, for all SNAP related hearings, the recommended order becomes the final order after the 15 calendar days. The agency can take appropriate action on the 16th calendar day. For ALL other programs, a final order must be issued by the Cabinet Secretary/Secretary's Designee before the agency can take action.]
- H. The Cabinet Secretary/Secretary's Designee signs the final order and sends copies to the client, representative, if any, and the Hearings PAPS via the Hearings Module.
- I. Once the final order is received in the local office, the case worker takes the appropriate action indicated by the final order. Refer to [MS 0520](#).

SNAP Fair Hearings



Medicaid (MA), Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Kentucky Works Program (KWP), Family Alternatives Diversion (FAD), Child Care Assistance Program (CCAP) Fair Hearings



MS 0460

THE HEARING REQUEST

(1)

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

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

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

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

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

A. At the point of the original request for a hearing, ask the client if there is new medical evidence or a change in the client's condition to justify resubmitting the case to MRT for redetermination.

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

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

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

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

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

- H. [After 30 days, or 60 days, if an extension was granted, if the hearing officer has not received the MRT determination, a recommended order can be drafted without MRT input. A final order is required to be issued by the Cabinet Secretary / Secretary's Designee. If the Agency is upheld in the final order, the client can request an appeal.
- I. The interim order process is designed to facilitate the process for cases that are remanded to MRT. Workers are not to act on recommended orders. A final order is required to be issued by the Cabinet Secretary / Secretary's Designee.]

MS 0470

MEDICAID HEARING REQUEST
DUE TO THE LOSS OF SSI

(1)

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

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

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

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

MS 0475 HEARING TIME FRAMES (1)

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

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

The form also contains information regarding:

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

MS 0485

PROGRAM PARTICIPATION
PENDING THE HEARING – IM PROGRAMS

(1)

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

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

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

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

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

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

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

- [3. For all other reasons for discontinuance, annotate case notes in Worker Portal.]
- 4. On the day of the hearing request, authorize approval of benefits at the level prior to timely notice with the current month as effective date.
- D. For checks received in the local office, follow procedures found in Vol. I, [MS 0120](#).

[A monthly printout of all checks with a local office address is generated for reconciliation purposes. The supervisor is responsible for ensuring each check on the printout was cancelled or delivered to the individual.]
- E. An individual may reapply for discontinued or denied benefits during the hearing process. Accept and process a reapplication based on a change in circumstances.

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

MS 0490

PROGRAM PARTICIPATION
PENDING THE HEARING – SNAP

(1)

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

A. PARTICIPATION IS CONTINUED IN THE FOLLOWING CIRCUMSTANCES:

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

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

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

MS 0495

DENIAL/DISMISSAL OF HEARING REQUEST

(1)

- A. The Division of Administrative Hearing (DAH) may dismiss a hearing request if:
1. The request is untimely;
 2. The issue relates to a determination by another agency;
 3. There is no issue; or
 4. The request is abandoned.
- B. [The client may withdraw a request for a hearing verbally or in writing at any time prior to the release of the hearing officer's decision. If the client wishes to withdraw the hearing request, complete a hearing request search through the Hearings Module, locate the client's hearing request, and click the "Postponement/Withdrawal Request" button. Form PAFS-277, Hearing Withdrawal Confirmation Notice, will generate automatically to the client. Print the system generated notice and attach in the Hearings Module as it is part of the official Hearings Record. In all instances in which the client has a representative or attorney, the client is advised to consult with the representative before requesting the withdrawal. If the original request was made by a representative, the worker personally assures that the representative concurs in the withdrawal. If the representative does not concur with the withdrawal request, indicate this on the Notes screen when submitting the request to withdraw from the hearing.]
- C. If the client or representative fails to appear for a hearing and the reason is unknown, a notice is mailed by the DAH. The notice advises the client to contact the hearing officer, in writing or by telephone within 10 days, if he/she wishes to continue the hearing and can present good cause for failing to keep the appointment. If the client replies but does not show good cause or fails to reply, the request is considered abandoned. If good cause is shown, the hearing is rescheduled.

MS 0497*

CLIENT'S HEARING RIGHTS

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

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

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

MS 0500 CONDUCT OF THE HEARING (1)

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

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

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

MS 0510

RECOMMENDED ORDER

(1)

[After completion of the hearing, the hearing officer drafts a recommended order. For Medicaid (MA), Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), Kentucky Works Program (KWP), Family Alternatives Diversion (FAD), Child Care Assistance Program (CCAP) hearings the recommended order is not the final order; therefore, action is not taken on the case until a Final Order is received. For SNAP related hearings, recommended orders will become the final order, if no exceptions are taken, after the 15th day from the mail date of the recommended order.]

A. The hearing officer:

1. Reviews all evidence and drafts a recommended order. A recommended order:
 - a. Summarizes the facts of the case;
 - b. States the reason for the recommended order;
 - c. Identifies the supporting evidence and the pertinent Operation Manual sections; and
 - d. Cites pertinent state and federal regulations.
 2. Ensures that the recommended order complies with federal and state law or regulation and is based on the hearing record.
 3. Mails a copy of the recommended order for review to:
 - a. The client;
 - b. The client's representative if one was present at the hearing; and
 - c. The Department for Medicaid Services (DMS) if the issue involved patient status in a skilled nursing home.
 4. Uploads the recommended order to the Hearings Module creating a task for the Hearings PAPS to review the order and take appropriate action.
- B. If at the hearing, the client presents new medical evidence which may affect the determination of incapacity, disability or good cause the hearing officer will issue an Interim Order sending the case back to the Medical Review Team (MRT) for a redetermination using the new medical information. The hearing record will be held open for 30 days. Refer to [MS 0465](#).
- C. The recommended order is reviewed by the parties listed in item A.3 and A.4. The parties have 15 calendar days from the mail date indicated on the recommended order to review and file any exceptions and/or rebuttals. Exceptions or rebuttals filed after the 15th calendar day are disallowed.
1. [If the Agency determines that no exception is required in response to a denied ADH or Fair Hearing recommended order, the worker must visit the Hearings Module within 5 calendar days and click on the "Exceptions Request" button and select "No" to answer the question, "After reviewing the recommended order, do you believe exceptions should be filed?" After making the selection, briefly provide your explanation in the comments box

and "Save" and "Submit". This will create a task for Central Office staff to review.

- a. For SNAP related hearings, if no exceptions to a recommended order are submitted to the Cabinet Secretary/Secretary's Designee by the 15th calendar day, the recommended order becomes the final order then on the 16th day and the agency can take appropriate action on the case.
 - b. For all other program related hearings (MA, CCAP, KTAP, KWP, FAD, KC) if no exceptions to a recommended order are submitted to the Cabinet Secretary/Secretary's Designee by the 15th calendar day, a final order is required to be issued by the Cabinet Secretary/Secretary's Designee. The agency does NOT take any action until a final order is received.
2. The recommended order is reviewed to ensure that it is in accordance with regulations. If there are no exceptions or rebuttals to a SNAP program related recommended order received within the 15-day period, then on the 16th day the recommended order becomes the final order.

Note: Central Office will no longer receive notification of the recommended orders from DAH or final orders from the Cabinet Secretary/Secretary's Designee. Hearings Public Assistance Program Specialists (PAPS) will receive notification through Worker Portal and be responsible for reviewing the orders to determine if an exception is required. If an exception is required, follow instructions below and follow the hearing procedure process for administrative disqualification hearings through Worker Portal.

3. Exceptions by the Agency are filed by DFS Central Office staff.
- a. Use the following procedures to file an exception;
 - 1) Upon receipt of a recommended order, the worker and his/her supervisor have 5 calendar days from the date it was mailed to determine if an exception is needed. An exception can only be based on the facts and evidence presented at the hearing. New information or evidence may not be used to take exception.
 - 2) The region drafts an exception outlining why the recommended order should be changed.
 - 3) If the Agency determines that an exception is required in response to the ADH or Fair Hearing recommended order, the worker must visit the Hearings Module by the 5th calendar day from the date it was mailed and click on the "Exceptions Request" button and select "Yes" to answer the question, "After reviewing the recommended order, do you believe exceptions should be filed?" After making the selection, briefly provide your explanation and specify the evidence you are referring in the comments box and "Save" and "Submit". This will create a task for Central Office staff to review. A draft copy of the exception should also be emailed to the respective program inbox.

CHFS DCBS DFS Claims CHFS.DFS.Claims@ky.gov

CHFS DCBS DFS FSSB K-TAP Section FSSBK-TAP@ky.gov

CHFS DCBS DFS Food Benefits Policy
CHFS.FoodBenefitsPolicy@ky.gov

CHFS DCBS DFS Medicaid Policy DFS.Medicaid@ky.gov

DFS Integrity and Analysis Section
DFS.IntegrityAnalysisSection@ky.gov

- 4) After review, Central Office staff submits the exception, if appropriate, along with a signed "verification of facts" form, to the designee with the Office of Legal Services (OLS) for review and appropriate application of law. Once reviewed by OLS, a final signed version of the exception will be provided to the agency.
- 6) Central Office staff are responsible for uploading the exception to the Hearings Module and mailing a copy of the exception to the client/client's designee.
- 7) After the exception is submitted to the Hearings Module, Hearings PAPS will receive a task to review the exception. A task will also generate to the Cabinet Secretary / Secretary's Designee to review and draft a final order. Field staff are required to scan a copy of the final filed exception to the Electronic Case File (ECF) on Worker Portal.
 - a) If an exception is filed timely by either party, the other party can file a rebuttal to the exception within the 15-day period. If the 15 days have elapsed, no rebuttal can be made.
 - b) The Cabinet Secretary/Secretary's Designee staff reviews all timely exceptions to the recommended order and will draft and sign a final order.]

MS 0515

THE FINAL ORDER

[The Cabinet Secretary/Secretary's Designee issues the final order for the hearing.

- A. The final order accepts the recommended order, rejects or modifies the recommended order, or returns the issue back to the hearing officer for further action before a final order is issued.
- B. The Cabinet Secretary/Secretary's Designee has 60-90 days to issue a final order from the date the hearing request
- C. The Cabinet Secretary/Secretary's Designee will sign the final order and upload it to the Hearings Module creating a task for the Hearings PAPS to review and assign for appropriate action. The Cabinet Secretary/Secretary's Designee will also mail a copy of the final order to the following:]
 - 1. The recipient;
 - 2. The representative;
 - 3. If the issue involved patient status in a skilled nursing home, to the Department for Medicaid Services.
- D. The final order becomes part of the record and approves or rejects the recommended order, and provides the available appeal rights.
- E. A final order is followed until the next time the household's eligibility is redetermined.

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

[When the final order signed by the Cabinet Secretary/Secretary's Designee is received in the local office, the final order and recommended order are reviewed by the supervisor and worker for any reference to future action in the case.

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

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

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

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

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

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

1. Within 2 days of receipt of the final order, send an appointment letter to the client to complete an MRT Referral. Request the client bring in new or updated medical information.
2. At the appointment, complete an MRT Referral and include any new or updated medical information the client presented at the hearing or has been received since the hearing. Also, have the client sign form MRT-15, Authorization to Disclose Information to Cabinet for Families and Children.
3. Once the MRT request is completed on Worker Portal, a task is generated for MRT staff to complete the disability/incapacity determination. Once a determination has been made, a task is generated for a worker to take appropriate action based on MRT's decision.

If the client disagrees with the action taken based on the new determination, the client can request a hearing.

- D. If the final order includes recommendations for referrals to, for example, Rehabilitation Services, immediately follow up such recommendations.
- E. In cases when the Agency is upheld, the notification advises the client of the right to file an appeal with the Cabinet Secretary/Secretary's Designee. In cases in which assistance has been continued during the hearing process, the worker

takes action based on the final order to correct the case and the amount of benefits.

Do NOT continue benefits pending an appeal to the Cabinet Secretary/Secretary's Designee.

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

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

MS 0530

APPEAL TO THE
CABINET SECRETARY/SECRETARY'S DESIGNEE

(1)

An appeal to the Cabinet Secretary/Secretary's Designee is the final administrative review available to a recipient dissatisfied with the decision of the hearing officer.

- A. Requesting an Appeal. If the recipient disagrees with the hearing decision, the recipient must appeal within 15 days of the date the hearing decision was mailed. The mailing date is the date on the hearing decision. The Cabinet Secretary/Secretary's Designee, if requested by the recipient, may grant a 10-day extension to the 15-day time standard, if good cause for the delay is established according to [MS 0475](#).

Whenever an appeal is not made within the 15-day time standard, submit a memorandum with the appeal explaining the cause of the delay and request the Cabinet Secretary/Secretary's Designee to determine if good cause for the delay exists.

The recipient's request for appeal may be either a verbal or written request. The date of the verbal request is the date of the appeal; however, any verbal request must be confirmed in writing by the recipient. The written request is a letter from the recipient that is uploaded as an "exception" in the Hearings Module. The date the letter is received establishes the date of the request for appeal. Encourage the recipient to make the appeal in the local office or via phone to avoid delay in requesting the appeal within the prescribed time frame.

- B. Forwarding the Appeal/Exception Request. Attach the appeal request in the Hearings Module as an "exception" document and annotate in comments that an exception was filed by the client. A task will be generated to the Cabinet Secretary/Secretary's Designee to take appropriate action. Do not send the case record unless it is requested. The Cabinet Secretary/Secretary's Designee will have the necessary material and tape of the hearing record.
- C. [Action after Submitting Request. Central Office will mail the client a copy of any exception filed by the Agency. All exceptions filed, regardless of origin, create a task for the Hearings PAPS to review. Parties may request permission within 7 calendar days from the date of the filed exception to submit written arguments or new evidence regarding the appeal to the Cabinet Secretary/Secretary's Designee. The Cabinet Secretary/Secretary's Designee will send Medicaid hearings recipients an acknowledgement letter indicating the receipt the appeal/exception request.]

If the Cabinet Secretary/Secretary's Designee orders a special examination, the recipient is notified of the date, time and place of the examination with a copy of the notification sent to the local office.

The recipient notifies the local office if they are unable to keep the appointment and the supervisor emails the Cabinet Secretary/Secretary's Designee at Hearings.BranchFC@ky.gov to advise and schedule a new appointment.

MS 0530

(2)

- D. Reapplication before Decision the Cabinet Secretary/Secretary's Designee. If the recipient reapplies during the appeal process, before a decision is reached, process the application.

MS 0535

HEARING OF APPEALS

(1)

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

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

MS 0540 [THE CABINET SECRETARY/SECRETARY'S DESIGNEE DECISION (1)

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

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

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

MS 0545 [JUDICIAL REVIEW OF THE CABINET SECRETARY/
SECRETARY'S DESIGNEE

The recipient may request the Circuit Court in the county of residence to review any Cabinet Secretary/Secretary's Designee decision.

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

If no further appeal is needed, official notification of reversal is issued by the Cabinet Secretary/Secretary's Designee.]

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

MS 0560 DOCUMENTATION OF IMMIGRANT STATUS (1)

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

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

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

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

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

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

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

The following list defines the specific letter codes:

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

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

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

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

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

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

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

MS 0562 [DOCUMENTATION FOR IMMIGRANT VICTIMS OF TRAFFICKING (1)

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

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

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

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

- A. Applications for KTAP, Medicaid, or SNAP who are victims of a severe form of trafficking must present their letter from ORR to the worker.
 1. Accept the ORR letters in place of INS documentation. Victims of a severe form of trafficking are not required to provide proof of their immigration status. Do not complete a SAVE inquiry on the victims.
 2. [Email ORR at information@orncc.com to confirm the validity of the ORR letter and to notify ORR of the type of benefits for which the individual has applied.]
- B. The entry date for the individual is the certification date that appears in the body of the ORR letter.
- C. [If the individual does not have documents to verify identify, contact ORR for assistance.]
- D. If the individual does not have or cannot obtain a Social Security Number (SSN) for work purposes, assist the individual in obtaining an SSN for non-work purposes by providing the individual a letter for the Social Security office that includes:

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

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

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

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

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

- F. [Contact the ORR by email information@orncc.com at recertification.

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

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

If during an interview it is determined that the applicant/recipient is not or is no longer eligible based upon email response received from ORR, determine eligibility using other criteria for immigrant.]

- H. Anytime an applicant or recipient believes he/she may meet the definition of a victim of "severe forms of trafficking", provide the individual the phone number of the Department of Justice, Division of Civil Rights, (888) 428-7581, or the Refugee State Coordinator with Catholic Charities of Louisville, (502) 636-9263.

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

MS 0565 [IMMIGRANTS SPONSORED ON OR AFTER 12/19/97 (1)

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

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

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

[These immigrants can be publicly sponsored by an organization or group. Publicly-sponsored immigrants are NOT subject to income deeming.]

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

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

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

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

C. Immigrants currently in the U.S. who previously completed sponsor agreements are NOT subject to the new affidavit requirements. Forms I-134, Affidavit of Support, or I-361, Affidavit of Financial Support and Intent of Petition for Legal Custody, were not obsoleted. These forms were used as sponsor agreements prior to 12/19/97.

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

MS 0566 CONSIDERATION OF THE SPONSOR'S INCOME AND RESOURCES (1)

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

A. Deeming the sponsor's income applies to all immigrant sponsored by individuals. Deeming continues until the immigrant gains citizenship.

1. The total income and resources of the sponsor and spouse are considered available to the immigrant's household. Consider the deemed income as unearned income.
2. If a change in sponsorship occurs during the recertification period, verify and recalculate the deemed income and resources.

B. There are exceptions for deeming a sponsor's income. Do not deem the sponsor's income to the immigrant if one of the following exceptions applies:

1. If the immigrant is determined indigent. Apply the following conditions to determine indigence:
 - a. The amount of the sponsor's income and resources given to the immigrant does not exceed the amount agreed to in the affidavit; AND
 - b. Without the assistance from the Cabinet, the immigrant would be unable to obtain food and shelter. In determining if the immigrant is indigent, consider the immigrant's own income, plus any cash, food, housing, or other assistance provided by other individuals including the sponsor.

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

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

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

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

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

MS 0570

SAVE

(1)

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

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

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

Use the following procedure when an immigrant applies for benefits.

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

1. Case name and number; and
2. For each immigrant member: name, the corresponding alien registration number, birthdate, the type of documentation provided, and if available, the Social Security Number (SSN) and the I-94 admission number; and
3. Worker name, code, and phone number.

[Only Medicaid and State Supplementation must be pended for a SAVE response before processing the case. All other programs may be processed without waiting for the response from SAVE.]

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

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

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

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

1. If SAVE verifies immigrant status: document the SAVE response in comments and scan into ECF.
2. If SAVE does not verify immigrant status and requests additional verification:
 - a. Regional Office completes form G-845, Document Verification Request. The form along with a scanned copy of the immigrant's document with or without additional information for verification is submitted electronically to USCIS.

DO NOT deny or discontinue the case based on immigrant status until a response is received.

- b. If the USCIS response on form G-845 indicates the immigrant status document is valid, document the response in comments and scan into ECF.
 - c. If the USCIS response on form G-845 indicates the immigrant status document is not valid, deny or discontinue benefits for the unverified immigrant.

MS 0590 FEDERAL BENEFIT CHANGES (1)

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

A. FEDERAL BENEFIT CHANGES

1. Medicaid and KTAP:

[All recipients who receive these benefits are affected and are responsible for reporting the change within the appropriate timeframe in guidance with each program requirement.]

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

2. SNAP:

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

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

B. [Worker Portal generates all required notices for any case action taken as a result of the conversion.]

C. Verifying Benefits

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

1. RAILROAD RETIREMENT (RR)

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

Counties:

Send to:

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

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

Boyd, Carter,

Huntington District Office

Elliott, Floyd, Greenup, Johnson, Lawrence, Lewis, Martin and Pike	New Federal Bldg., RM. 145 640 4TH Ave. Huntington, WV 25721 Telephone: (877) 772-5772
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Henderson and Union	Indianapolis District Office The Meridian Centre 50 South Meridian, Ste. 303 Indianapolis, IN 46204 Telephone: (877) 772-5772
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All other counties	Louisville District Office 629 South 4 th Street Suite 301 Louisville, Ky. 40202. Telephone: (877) 772-5772
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[The RR Board enters the new benefit amount on form PAFS-54 or the Worker Portal listing and returns the form to the local office sometime in the month following the change.]

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

2. VA BENEFITS

[Use form PAFS-53, Letter to Verify Veterans Benefits or "Active Cases with Black Lung, Railroad Retirement, or Veterans Income" to send ONE ALPHABETICAL LIST of claimants per local office to:

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

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

3. BLACK LUNG BENEFITS

Send a request for information to the recipient requesting verification of entitled benefit and convert as appropriate. Use the "Active Cases with Black

Lung, Railroad Retirement, or Veterans Income" listing to identify Worker Portal cases. Black Lung recipients usually receive a cost of living increase; this can be verified through the annual Federal Benefit Rate (FBR) for Black Lung.

4. SOCIAL SECURITY BENEFIT

If an increase in benefits is authorized by the Social Security Administration, the increase becomes effective January 1st of each year. Verify RSDI entitlement amount by BENDEX Inquiry or benefit verification letter at the next recertification. When BENDEX Inquiry is accessed to obtain the RSDI benefit amount, use the amount shown as "NET". "NET" is the amount before the SMI deduction. For all programs except Medicaid, DO NOT round. Enter the actual "NET" RSDI amount on Worker Portal. When the RSDI "NET" amount is entered for Medicaid, the cents MUST be dropped when entering the amount in the 'Amount Per Frequency' field. If there is an overpayment of RSDI retained in order to pay back an RSDI claim, for SNAP cases only, subtract the current overpayment amount from the "NET" amount to calculate the amount of RSDI to be counted in the case. Contact the individual for verification if unable to verify benefit amount from these sources.]

D. Use the following timeframes for completing manual conversions:

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

MS 0640

VOTER REGISTRATION

(1)

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

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

MS 0650

VOTER REGISTRATION PROCEDURES

(1)

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

1. For Face-to-Face Interviews:

Enter if the HOH wants to register to vote in Worker Portal.

Form PAFS-706, Voter Registration Rights and Declination, is system generated and uploaded with the case name and case number before printing. Form PAFS-706 is read by or to the HOH who signs and dates the form.

The Voter Registration Application, is generated when the HOH, who is age 17 or older and a US citizen, states he/she is not registered to vote at the current residence and would like to apply to register.

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

2. For Phone Interviews:

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

3. [For Mail-In Applications and Recertifications:

The system generates and mails a letter of explanation, form PAFS-706, and the Voter Registration Application to LIS Medicaid referrals. All SAFE cases are mailed the explanation letter, PAFS-706, and the Voter Registration application.

4. For Address Changes:

Anytime a home address is changed on the address case change screen, a letter of explanation, form PAFS-706, and the Voter Registration Application will be system-generated to the head of household.]

B. If the individual wants to register to vote, the individual completes the Voter Registration Application by checking the party affiliation, reads or is read the voter declination statement on form PAFS-706 and signs and dates the Voter Registration Application and form PAFS-706. The individual's name, SSN, date of birth, sex, county of residence and address is uploaded on the Voter Registration Application. The individual must be provided the opportunity to

complete the Voter Registration Application in private. Provide an envelope for the completed Voter Registration Applications.

- C. If the individual does not want to register to vote, form PAFS-706 is completed by the HOH.
- D. If the applicant/HOH refuses to sign the form PAFS-706, enter "refused" in the client signature space, sign and date the form and provide a copy to the applicant/HOH.
- E. [Form PAFS-706 is scanned into the Electronic Case File (EFC).]
- F. For a hard copy application or recertification (including FS-1, Application for SNAP, or PA-100, Application/Recertification for KTAP, Kinship Care, and Family/AFDC Related MA), provide the applicant/HOH form SBE 01, Commonwealth of Kentucky Mail-In Voter Registration Form and a hardcopy form PAFS-706. Form SBE 01 can be obtained at <http://www.elect.ky.gov/register.htm>. If the individual chooses to register to vote, form SBE 01 is completed and form PAFS-706 is read and signed. Provide an envelope for the completed SBE 01.
- G. Any person entering the local office can fill out a voter registration form if he/she so chooses. Provide the interested individual with form SBE 01.
- H. Instruct the individual to deposit the sealed envelope containing the system-generated Voter Registration Application or form SBE 01 (Mail-In) in the locked voter registration box in the local office.
- I. Completed registration applications must be transmitted to the local County Clerk's office every Friday. For applications completed within 5 days before the last day to register to vote in an election, ensure the applications are transmitted to the county clerk prior to the deadline.
- J. Form PAFS-706 is completed by the HOH at every application, recertification, and when a change of home address is reported.

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

IEVS is a federally mandated system designed to identify case discrepancies by means of various computer matches. IEVS compares the Social Security Numbers (SSN) of Kentucky Transitional Assistance Program (KTAP), Medicaid (MA), and Supplemental Nutrition Assistance Program (SNAP) applicants/recipients with SSN's contained on the computer files of other state and federal agencies. A hit or exception is generated when a discrepancy is identified between case record data and computer file information. Compare "hits" with income and resource information in the case record.

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

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

- A. On-line computer matches are uploaded by the system at application, recertification and member add. On-line match information appears on the appropriate income screens while the case action is pending. Match data must be reviewed and resolved prior to processing.
- B. [The Batch Match process matches computer file data against case and member information currently on Worker Portal. This includes all ineligible and disqualified household members. Resolve Batch Match hits through the Batch Match Task.]

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

MS 0675 RESOLVING MATCH DISCREPANCIES (1)

Use the following verification procedures when an Income and Eligibility Verification System (IEVS) discrepancy is identified in any program.

A. Match Data Requiring NO Independent Verification:

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

B. Match Data Requiring Independent Verification:

1. [Matching data from Wage Records, IRS (Computer Matching Data) and BENDEX (Wage and Pension) files require independent verification since the data obtained in the match is several months old and may not reflect current household circumstances.]

Attempt to resolve 100% of matching data requiring independent verification within 30 days after the control date/match date; however, on an individual worker basis, 20% may remain unresolved for up to 90 days pending verification from the data source. This remaining 20% must be resolved within 90 days after the control date/match date. The 30 and 90-day timeframes DO NOT apply if the case is due for recertification prior to those timeframes. Resolve all hits before the recertification is processed.

2. General Procedure for Independent Verification:
 - a. When a Match requiring verification is received the month prior to the recertification month, do not take action (issue an RFI) AFTER the date of Cut-Off or Negative Action. Document Case Notes that a match has been received, the reason for not acting on it at that time, and that it must be acted on during recertification.
 - b. For Matches acted on during the month of recertification, discuss the match during the interview and request the client provide the required verification to resolve the match before the recertification

due date. Explain to the client that the verification must be provided before the recertification can be approved. Document Case Notes thoroughly to ensure the worker processing the recertification is aware of the match and the requested verification.

[Note: For Medicaid cases without a recertification interview, contact the client to discuss the match and request the client provide the required verification to resolve the match. Issue an RFI and document in Case Notes.]

- c. For cases not due for recertification, enter the information on Worker Portal and allow the system to issue an RFI requesting the necessary verification. If the requested verification is not returned timely, the system will take appropriate action. Allow the household 10 calendar days from the date of the notice to provide the requested verification. For Medicaid, allow the household 30 calendar days to provide the requested verification. Follow the below procedures and if the client does not return the information, discontinue the case.]

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

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

[All screens containing FTI can be easily identified by the banner which states, "This screen contains IRS data – do not print."]

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

Example: A batch match shows that Bob earned wages of \$3,000 from Wal-Mart in the 3rd quarter. On the RFI, the worker requests that the client contact DCBS to discuss the income. The worker does not specify the name of the employer, amount of the wages, or any other information obtained from the batch match screens. When Bob contacts DCBS the worker asks if he works at Wal-Mart and requests his check stubs. No information from the match is listed on the RFI; therefore, no FTI is shared. The RFI and the check stubs are scanned into ECF.

- d. [When verification, other than what was originally requested, is required as a result of contact with the recipient prior to expiration of the 10-day period, prepare another RFI, as appropriate and allow 10 calendar days for the recipient to return the additional verification. For Medicaid, allow 30 days for the recipient to return the verification.]

- e. Upon receipt of verification, send the appropriate notice of eligibility/ineligibility, if required, and adjust benefits timely.
 - f. Document all actions thoroughly and completely.
 - g. [Resolve the exception through the Batch Match task.]
3. Wage Records. Use the following criteria to determine when a match requires independent verification.
- a. The matches which determine whether independent verification is required are the last available Wage Records quarter and the quarter prior to the last available Wage Records quarter.

Example: If the last available Wage Records quarter is the third quarter of 2010 (shown as 3/10) the quarter prior to the last available Wage Records quarter would be the second quarter of 2010 (shown as 2/10).

- (1) [If there are no matches for either of these quarters, no independent verification is required to resolve the Wage Records match. Resolve the exception through the Batch Match task.]
 - (2) If a match is shown for either or both of these quarters, determine whether the income is currently being received by the member.
 - (a) If the case record contains adequate verification for resolution, document accordingly and resolve the Batch Match.
 - (b) If independent verification is required, refer to item B. 2.
 - b. After IEVS resolution, process any possible claim in accordance with [MS 0870](#).
4. Computer Matching Data Information. Should recipients inquire about the source of Agency information, indicate the data was secured through computer matches made by the Agency. Use the following criteria to determine when a match requires independent verification.
- a. Independent verification is not required if the match data is currently considered in the case record or the case record contains adequate verification for resolution. Document accordingly and resolve the Batch Match.
 - b. Independent verification is required if the case record does not contain adequate verification. Refer to item B. 2. Additionally, if a bank account has been closed, a statement from the bank or source is required to verify the closure.
 - c. After IEVS resolution, process any possible claim in accordance with [MS 0870](#).

C. PARIS Veterans Match – Individual Summary:

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

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

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

Use the key below to determine the payment type.

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

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

1. If the VA income is already counting in the case for the member and the amount on the report differs within \$0.99 cents, no change is required to the case except documentation of the match.
2. If the VA income is already counting in the case for the member and the amount on the report differs more than \$0.99, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.
3. If the VA income is not counting in the case, consider the income verified upon receipt of the match, the match amount as accurate, and correct the case accordingly.

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

MS 0680

IRS SAFEGUARDING ISSUES

(1)

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

General Safeguarding Procedures:

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

1. [All Federal Tax Information (FTI) – including Batch Match, Income and Eligibility Verification System (IEVS), Bendex earned income, and any other information that comes from the IRS. Worker Portal screens containing FTI are identified by the banner stating, “This screen contains IRS data – do not print.” FTI must NEVER:
 - a. Be copied, e-mailed, printed or faxed; or
 - b. Be scanned into the Electronic Case File (ECF).]

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

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

2. [Any material containing an individual's Social Security Number (SSN) must be safeguarded. Limit access to the case and other recipient-related information.]

B. Minimize public access to confidential information:

1. Secure work areas against unauthorized and unsupervised access;
2. Ensure that during an interview, only the case record pertinent to that individual is visible on the desktop or surrounding areas;
3. Ensure that computer terminals only display information related to that individual during interviews; and
4. Sign off or lock computer terminals when not in use or when leaving the work area.

C. Keep mailed information secure:

1. Check mail trays for recipient information regularly; and
 2. Do not leave recipient information in mail trays overnight.
- D. Properly dispose of case record material and other recipient information as follows:
1. Shred the material into 5/16 inch or smaller strips; or
 2. Place in a designated box:
 - a. Seal the designated boxes and store in a secure location, preferably one which can be locked; and
 - b. Complete the Certificate of Disposal form.

Procedures for Safeguarding IRS Information – Batch Match:

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

NOTE: Form PAFS-7, Notification of Appointment/Request for Verification, is obsolete effective 5/1/11; however, the log used to track FTI is kept in a locked file and maintained for 5 years after the last item on the log is destroyed, at which point it is destroyed per procedures found in General Safeguarding Procedures, item D.

Procedures for Bendex Information:

- A. [Do not scan any Bendex information into ECF. Bendex information is:
 1. Earned income data found on Worker Portal screens identified by the banner which states, "This screen contains IRS data – do not print;" and

2. Retirement, Survivors Disability Insurance (RSDI) income data and earned income data found on Bendex Inquiry and KYIMS Job Menu, program 39, New Bendex.
- B. Do not mention Bendex in case comments. Document that the income amount was verified by system inquiry on mo/day/year.
 - C. If it is necessary to print and keep any Bendex screen information, it must be stored under two barrier security in a folder or file labeled with form DTA-FTI-1. The case record may only reference where verification is filed.
 - D. Do not copy, fax, or e-mail Bendex information.]

Purging IRS Federal Tax Information found in Case Records:

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

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

Penalties for Failure to Safeguard IRS Information:

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

Improper Inspection or Disclosure:

- A. If an improper inspection or disclosure is discovered or witnessed, report the violation to the Service Region Administration Associate (SRAA) for your Region. The SRAA forwards the report to the Director of Service Regions. The SRAA takes action to ensure the violation does not occur again.

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(4)

- B. Additionally, if an improper inspection or disclosure has occurred, notify the Internal Revenue Service (IRS) by calling the Chicago Field Division at (312) 886-0620 or 1-800-366-4484 or by writing to:

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

*MS 0690

PRISONER MATCH

(1)

Workers must check the prisoner match report, ANR-OR514, for all household members age 15 and older at each application, recertification and case change. This is an on-demand report and the Report ID is ANR-OR514.

When completing a SNAP application, recertification or case change:

- A. Check the SVES Prisoner report for each household member age 15 and older after eligibility has been ran and before the case is disposed. The report is found under the Reports tab on the Tools dropdown menu on Worker Portal. The only report criteria that needs to be entered is the client's social security number. All records must be discussed with the client and notes that include the date of confinement and discharge date for each record must be entered in case comments. Verification is not required for any periods of incarceration with a discharge date more than 6 months before the client received SNAP benefits.
- B. If a household member was incarcerated during the SNAP certification period, or 6 months prior to their SNAP application, verification of their release must be provided. Pend the case for verification of release date. An RFI is generated requesting verification. The client has 30 days to provide the verification if the record is reviewed at application or untimely recertification and until the end of the month for a timely recertification. At case change, the information must be provided within 10 days. If the client is unable to provide their release paperwork, a collateral contact should be made to the prison facility where they were housed. The facility's contact information is available on the report.

MS 0722

COMPUTER MATCH CODES

The IRS Computer Match displays the type of earnings towards the bottom of the Batch Match Screen. The following are definitions of computer match income. These are also located on RDS under report HRKRMR52 IM CODES-LIST.

The INCOME INDICATOR reflects the type of income reported.

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

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

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

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

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

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

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

MS 0723*

BENDEX INCOME CODES

A. BENDEX Earned Income Types.

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

B. BENDEX Unearned Income Types.

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

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

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

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

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

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

If the query results in a match:

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

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

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

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

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

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

MS 0740

STATE ON-LINE QUERY (SOLO)

(1)

[SOLO is a match process with the Social Security Administration (SSA) to verify a Social Security Number (SSN) in real time. The match occurs for numbers that have never been verified on Worker Portal. Once a number is verified by SOLO, the Social Security Number field is protected and the verification code "Verified Through SSA" is system applied.

- A. At application or member add if SOLO indicates the SSN is not verified, review the name, date of birth, and SSN with the applicant to ensure no mistakes were made in the entry of information.
 1. If corrections are needed to the initial entries, a second SOLO transaction is submitted.
 2. If the number remains unverified, Worker Portal assigns a pseudo number. When a pseudo number is assigned, request the individual verify an SSN by a copy of the SSN card or written verification from SSA.
 3. When the SSN is entered for an individual and cannot be verified by the Federal Hub, two additional attempts can be made. When the SSN for the individual fails to be verified by the Federal Hub, a pseudo number will be assigned.
- B. Names must match with SSA records. If the individual's name has changed since issuance of the SSN, the individual must report the change to SSA.]

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

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

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

MS 0810 HOW TO IDENTIFY A CLAIM (1)

- A. Identification of claims is an automatic process if an overpayment is detected by the Integrated Eligibility and Enrollment System (IEES). For example, Field Staff makes appropriate case changes and IEES detects a potential overpayment giving field staff an option at disposition to create an overpayment discrepancy task for Regional Claims Worker (RCW) to review. All other claims are manually referred.
- B. A Manual Claim referral is created when the following occurs:
1. SNAP benefits are trafficked;
 2. Benefits designated for a specific purpose are used to purchase unapproved items or services;
 3. Claims are identified as occurring prior to implementation of IEES and are not processed on Kentucky Claims Debt (KCD) Management System;
 4. Medicaid Fraud;
 5. Individual Child Care Fraud;
 6. Child Care Provider Fraud;
 7. Some supportive service payments are overpaid; or
 8. When any overpayment is detected by Field Staff that is not automatically detected by IEES.
- C. [Claims may be identified by review of the following sources and staff will utilize the appropriate correlating detection code when referring or establishing a claim:
1. Batch Match: Used when computer file data from the Income and Eligibility Verification System (IEVS) is matched against case and member information on Worker Portal and the discovery of unreported income/resources results in an overpayment or incorrect issuance of benefits for all Family Support assistance categories;
 2. Public Assistance Reporting Information System (PARIS): Used when a recipient match is received showing benefits were issued in more than one state for the same timeframe;
 3. Hotline: referrals from the Office of Inspector General (OIG) when a citizen reports unreported or unknown information to the agency pertaining to a benefit recipient resulting in an overpayment or claim referral;
 4. Quality Control (QC) reviews: Used once the QC process has been completed and a positive error for an over issuance has been detected;

5. Audit: A benefit overpayment is detected via the evaluation process conducted by the United States Department of Agriculture (USDA), Department of Health and Human Services (DHHS), Auditor of Public Accounts (APA), and the Government Accounting Offices (GAO);
6. Quality Assurance (QA) review: Used when an overpayment is found by a supervisor, principal, Case Review Team (CRT) or the Division of Family Support (DFS) during any case review process;
7. Management Evaluation (ME) reviews: Used when reviews for Supplemental Nutrition Assistance Program (SNAP) are conducted by ME staff to identify and correct any deficiencies in case processing resulting in an overpayment;
8. Central Office: An overpayment is detected by central office staff, when there is an overpayment involving an employee, and Simplified Assistance for the Elderly (SAFE) claims;
9. Worker: Used if a benefit over payment is found during the course of regular casework via application, recertification, case processing and the worker generates a claim referral, or FIS fraud alerts;
10. Office of the Inspector General (OIG): Used when an over payment is detected during the course of an OIG investigation;
11. Client: An overpayment results from the self-report of any household information;
12. Division of Child Support Enforcement (DCSE): An overpayment is caused by unreported child support income and DCSE informs DCBS of the income;
13. Third Party: Information is provided by a source outside of the agency (i.e., an employer) that results in a benefit overpayment; or
14. Eligibility Advisor: Used when an overpayment is caused by unreported income discovered via Eligibility Advisor.

D. Claims may also be identified by:

1. Changes – An individual reports a change, but after the worker verifies the situation, it is discovered the change was not reported timely;
2. Analysis of expenses vs. income – An individual's expenses exceed the income, which may be an indicator of unreported income;
3. Worker Interview – A thorough interview increases the likelihood of the applicant reporting other income, such as contributions from family members or friends, which may not be counted in the case;

4. Income – Check stubs reflect an increase due to a change in pay rates or overtime worked;
5. Deductions given in error - such as the Standard Utility Allowance (SUA), Basic Utility Allowance (BUA), 30 and 1/3 deduction;
6. Whistleblower complaints; or
7. SNAP Simplified Reporting (SR) Households – Determine:
 - a. If the household's monthly gross income exceeds the allowed limit for the household size; or
 - b. If any member of the household age 18 through 49, failed to report working fewer than 20 hours a week.】

MS 0820

BENEFIT MANAGEMENT

(1)

[Benefit Recovery within the Benefit Management Module provides automated support to manage claims and collection activity. Access is available on the Integrated Eligibility and Enrollment System (IEES) under Benefit Management located on the menu bar.

Benefit Management is used by claims staff to:

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

Benefit Recovery is used by field staff to manually refer potential claims for review.]

MS 0830 [RESPONSIBILITIES FOR CLAIMS] (1)

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

1. Enter a change to a case and run eligibility which prompts the Discrepancy Overpayment screen;
2. Enter the Discrepancy Overpayment detail, which creates a task for the Regional Claims Worker (RCW) to begin the claims process.
3. Manually process disqualifications that are not automatically imposed on the Integrated Eligibility and Enrollment System (IEES) (i.e. ETP disqualifications).
4. Create manual claim referrals as appropriate see [MS 0820](#).
5. Identifying and referring suspicious case situations prior to approval to the DETER program where it is operational. Refer to [MS 0900](#).

B. Regional Claims Workers (RCW) are responsible for the following:

1. Processing Automatic Claims;
2. Processing Supplemental Nutrition Assistance Program (SNAP) and Child Care Assistance Program (CCAP) individual-only disqualifications for Intentional Program Violations (IPV);
3. Determining whether to validate and establish or No Claim the referral and update the status in the system;
4. Determining the claim type and verify the claim amount;
5. Establishing a Manual Claim;
6. Initiating Fraud Referrals to OIG;
7. Submitting requests for claim adjustments;
8. Contacting the household to determine and discuss the reason for a claim and to explain the computation of the claim amount;
9. Scanning all claim related documents to the associated claim(s) electronic case files;
10. Screening claims for suspected fraud and taking the following action:
 - a. Referring the claim(s) meeting criteria to the Office of Inspector General (OIG) for further investigation and possible prosecution. See [MS 0910](#); or
 - b. For SNAP claims, sending forms FS-80, Notice of Suspected Intentional Program Violation (SIPV), and FS-80 Supplement A, Voluntary Waiver

of Administrative Disqualification Hearing, to a SNAP household with a claim that does not meet criteria for OIG referral or OIG does not pursue prosecution.

- c. Regional claims workers are to update comments on IEES whenever any action is taken on a claim and to ensure that all appropriate dates and codes are entered on the Benefit Recovery Screen, in order to document that appropriate action is taken during the claim process. For SNAP claims, update when:
 1. Form FS-80 and FS-80 Supplement A, are mailed to the recipient;
 2. Form FS-80 Supplement A is signed and dated by the recipient and returned;
 3. Form FS-111, Deferred Adjudication Disqualification Consent Agreement is signed and dated; or
 4. An Administrative Disqualification Hearing (ADH) is requested, scheduled, affirmed, or reversed.

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

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

MS 0840 CLAIMS MANAGEMENT SECTION INFORMATION (1)
AND RESPONSIBILITIES

- A. The Claims Management Section (CMS) is located in the Division of Family Support. The section can be reached by:
1. Phone - 502-564-3440;
 2. Fax - 502-564-9810;
 3. E-mail - CHFS.DFS.CLAIMS@ky.gov;
 - [4. Mail - send to the Cabinet for Health and Family Services, Division of Family Support, Program Integrity Branch, Claims Management Section, 275 East Main Street 3-EI, Frankfort, Kentucky 40621.
- B. CMS is responsible for:
1. Pursuing collection of all claims not repaid by benefit reduction.
 2. Responding to individual inquiries regarding the repayment of claims.
 3. Reviewing all field referrals to the Office of Inspector General (OIG).
 4. Monitoring the progress of claims referred to or identified by OIG.
 5. Reviewing recommended and final orders related to claims.
 6. Preparing and routing exceptions to recommended orders related to claims.
 7. Providing information to other states regarding food benefit disqualifications appearing on the electronic Disqualified Recipient Subsystem (eDRS).
 8. Processing repayment agreements.
 9. Accepting, posting, and providing receipts for payments on claims.
 10. Suspending or terminating collection efforts on claims.
 11. Monitoring collections on claims by various intercept programs.
 12. Maintaining and monitoring bankruptcy information.
 13. Completing actions on Integrated Eligibility and Enrollment System (IEES) to compromise a claim (if determined appropriate).
 14. CMS is responsible for approving all claim debt adjustments and applying corrections to the claim balance. This includes court compromised amounts which must be entered by CMS on IEES. After

the claim corrections or court compromised amounts are determined by the RCW, a claim adjustment is entered, and CMS will receive a task to approve or deny the adjustment. The RCW enters comments on IEES and clearly explains the intended action pending for CMS approval.]

MS 0850

ELECTRONIC CLAIMS FILES

(1)

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

- A. [Scan ECF information only relating to the claim not retained on another system. Claims that require Bendex verification will be maintained in a hardcopy control folder.
 1. Information used to establish the claim, such as:
 - a. Form PAFS-431, Claim Referral (for claims prior to the Integrated Eligibility and Enrollment System (IEES));
 - b. Verification such as Income and Eligibility Verification System (IEVS) records (see Volume I [MS 0680](#), IRS SAFEGUARDING ISSUES, regarding Federal Tax Information (FTI)); employer statements and written statements;
 - c. Recipient's signed DCC-90, Subsidized Child Care Assistance Application Summary;
 - d. Signed DCC-94, Child Care Service Agreement and Certificate;
 - e. DCC-99B, Claims Calculation Sheet;
 - f. DCC-99C, Client Provider Sheet, if applicable;
 - g. Information from the Office of Inspector General (OIG), such as form IR-1, Investigative Report;
 - h. Quality Control (QC) reports;
 - i. E-mails;
 - j. Hotline referrals; and
 - k. DETER investigation reports.]
 2. Legal documents and hearing results:
 - a. Correspondence from OIG;
 - b. Court order/decision;
 - c. Final order from a fair hearing;
 - d. Administrative Disqualification Hearing final order; and
 - e. FS-80, Notice of Suspected Intentional Program Violation, FS-80 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, FS-111, Deferred Adjudication Disqualification Consent Agreement, DCC-84, Notice of Suspected Intentional Program Violation, DCC-84 Supplement A, Voluntary Waiver of Administrative Disqualification Hearing, or DCC-83, Deferred Adjudication Agreement.
 3. [IEES maintains the comments, calculations, and notices. Copies of the following must be maintained in the ECF:
 - a. Claim-related correspondence manually sent to the individual;
 - b. Completed Repayment Agreement (KCD 1.11), if appropriate;
 - c. Correspondence to and from CMS;
 - d. Payments forwarded to CMS from the local office;]

4. Copies of receipts for payments received in the local office.
5. Refer to Volume I [MS 0040](#) for information on Purging Obsolete Material.

MS 0860 TIME FRAMES FOR ESTABLISHING A CLAIM (1)

[Claims must be established within 90 calendar days from the date of discovery. Pending claims not established within 90 days appear on the Pending Claims and Discrepancies Past Due report accessed via the Integrated Eligibility and Enrollment System (IEES).]

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

[The Division of Service Regions (DSR) Regional Claims Section monitors this report monthly and advises Regional Claims Staff to take action on pending and past due claims.]

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

MS 0870 GENERAL PROCEDURES FOR ALL CLAIMS (1)

Claims are identified on active and inactive cases both automatically and manually. When processing the claim, the designated staff for the region where the household or member lives, is responsible for completion of the claim when the case remains active. For households who move out of state or inactive cases, the last region of residence where benefits were received are responsible for completion of the claim.

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

1. Field Staff reports a change on a case, requiring them to complete the Discrepancy Overpayment information screen in the Integrated Eligibility and Enrollment System (IEES) OR manually creates a claim referral when IEES does not detect the potential overpayment;
2. Field staff creates a Claim referral under the Benefit Management tab. A manual claim referral will be created for Medical Assistance, TANF related, and SNAP trafficking potential claims;
3. Regional Claims Workers (RCW) receive a task notifying them that there is a Discrepancy Referral to Claims OR a Family Support Claim Referral Task;
4. A claim referral is not considered legitimate until a claim is established by an RCW.

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

- B. Review the circumstances to determine the reason for the error and correct any active cases.
- C. Determine if any companion cases exist which may be affected by the potential claim.
- D. After entering a change and running eligibility, you are directed to the Overpayment Discrepancies screen where you will proceed with the following steps.
 1. Scroll to the right of the screen to view all details that should be entered.
 2. Select the proper method under the **Detection** drop down.
 3. Select cause of the discrepancy under the **Reason** drop down.
 4. Select claim type under the **Category Type** drop down.
 5. Select refer or not refer to claims.

6. Enter specific details regarding the discrepancy in the comment box including why the claim was referred or not referred including all relevant details regarding the referral.
7. Click **Next** to submit the discrepancy.

E. A claim is referred and established at case level on IEES.

EXCEPTION: Medicaid, SNAP ETP, SNAP trafficking, KWP, and referrals with no associated case are submitted and entered on IEES under the individual level.

F. RCW's are required to enter all available information for the potential claim on IEES within 10 days of the discovery date. The discovery date of the claim is the date that the RCW starts the task.

G. Scan claim information into the Electronic Case File (ECF). See [MS 0850](#).

[H. Schedule an appointment with the household on IEES, if needed:

1. The scheduled appointment is to occur no later than 30 days from the discovery date.
2. Appointment notices should be sent to the household within 10 days of the discovery date of the claim.
3. Appointments are not required to be scheduled for Agency Error claims. Appointments are required for Inadvertent Household Error (IHE) and Suspected Intentional Program Violation (SIPV) claims and can be scheduled as a face-to-face or phone interview (except when a phone number is not available). See [MS 1020](#) for SNAP trafficking procedures.
4. The RCW is responsible for contacting the individual at the time the phone interview is scheduled. The face-to-face interview is scheduled in the local office of the county that the client is active or last received in. If the individual is not currently receiving benefits and has moved out of the county that has the claim, the individual may travel to the county for the interview, be given a phone interview, or the new region may be asked to handle the claims interview.
5. Comments regarding the interview are required to be entered at the time that it is scheduled as well as at the completion or attempt of the scheduled interview. If the individual is not reachable, the agency is required to leave a message on how to contact the RCW **and comment**. Do not leave any confidential information on the voice recording.]

NOTE: If the claim is split due to household members moving in or out, a 2nd appointment is not required. Only one interview is required.

I. Households who refuse to provide information required to determine ongoing eligibility are discontinued for non-cooperation.

J. Document in the claim comments as well as IEES case comments:

1. Every action taken and the date it happened.
2. List in chronological order the circumstances that resulted in the claim.
3. The date and time of the scheduled interview (if applicable), and result of the interview at the time it was scheduled.

Example: 2/12/2020 – interview appointment scheduled for 2/25/2020 at 1:00pm(EST). Appointment notice mailed to household on 2/12/2020. 2/25/2020 – claim comments should include the phone number you contacted the client at and thoroughly explain outcome of the interview appointment. This also includes reaching their voicemail and the need to leave a message for a return call.

4. False, misleading, or untimely statements made by the member(s).
5. List all verification used to determine the claim.
6. An explanation of the category of the claim.
7. An explanation of any corrective action taken to prevent future errors of the type that caused the claim.
8. For claims caused by unreported income, indicate who had the income, the type of income, name of employer if it is earned income, and the time period of receipt of the unreported income.
9. The hearing decision and other actions pertaining to the disposition of the claim such as completion of a waiver to a hearing, termination of an OIG referral, or court disposition.
10. Any action by the RCW that deviates from the normal procedures.

K. Compute the claim amount based on available information, i.e., wage records, batch match, Eligibility Advisor, driver license, etc. RCW's are not to investigate using Facebook, Google, or by calling family, friends, employers or landlords to seek information about the individual, that the household did not verify. If a collateral contact is used to substantiate a claim, request and obtain written verification from the source for the claim record.

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

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

- L. If verification of the claim cannot be substantiated by any available source, determine if the claim should be referred to OIG for further investigation. If the claim does not meet criteria for a referral to OIG, then no claim exists. If information later becomes available to establish the claim, it can be reentered as a potential claim on the Benefit Recovery Module.
- M. Potential fraud claims that meet the criteria in [MS 0910](#) are referred to the Office of Inspector General (OIG) for further investigation. If a disability exists or Limited English Proficiency (LEP) is present, prior to completing a referral to OIG, seek an assessment of the individual's ability to understand program rules from the DCBS Equal Employment Opportunity (EEO) Coordinator or CHFS EEO Compliance Branch, 275 East Main Street 5 C-D, Frankfort, Kentucky 40621 or call 502-564-7770.
- [N. State Supplementation claims are referred directly to the Medical Support and Benefits Branch (MSBB):
 - 1. If a detection is made by field staff of a potential State Supplementation claim, they will submit a manual claim referral on the Benefit Recovery Module.
 - 2. An RCW will need to reject the referral and submit an email referral to their Public Assistance Program Specialist (PAPS) to refer to MSBB, thoroughly documenting the reason for the potential claim.
 - 3. MSBB will review the referral and determine if a claim is valid.
 - a. If MSBB determines a claim is not valid, a response will be sent back to the PAPS advising of their findings and case comments will need to be updated accordingly.
 - b. If a claim is to be established, MSBB will complete and forward form PAFS-431, Claim Referral, to Claims Management Section (CMS) at CHFS.DFS.Claims@ky.gov to enter on the Benefit Recovery Module. The check endorsement verification requested by MSBB will need to be forwarded with the form PAFS-431 to CMS.
 - c. Once CMS receives the form PAFS-431 to establish the State Supplementation claim and enters the claim on the Benefit Recovery Module, the CMS staff member will scan the completed PAFS-431 into the claim ECF.
- O. Simplified Assistance for the Elderly (SAFE) claims are investigated by SAFE workers and referred directly to the Claims Management Section (CMS) by a SAFE worker by completing form PAFS-431, Claim Referral, and sent to CMS at CHFS.DFS.Claims@ky.gov for claim establishment. After the claim is entered on

the Benefit Recovery Module, CMS staff will scan the completed PAFS-431 into the claim ECF.】

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

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

A. Fraud is suspected when an individual:

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

B. **[Suspected fraudulent SNAP claims are established on the Benefit Recovery Module as a Suspected Intentional Program Violation (SIPV). After the claim has been established as SIPV, a change in status must be completed within 90 days. If the claim is not referred to OIG, pursue the Intentional Program Violation (IPV) by sending form FS-80, Notice of Suspected Intentional Program Violation, and form FS-80 Supp A, Voluntary Waiver of Administrative Disqualification Hearing, to the recipient for signature. If form FS-80 Supp A is not returned, is returned unsigned or without a date, submit a request for an Administrative Disqualification Hearing (ADH) within three calendar days. See [MS 1070](#) concerning ADH procedures.]**

C. A SNAP claim is not considered fraud unless:

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

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

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

- A. [For applications that are incorrectly processed based on information provided at the interview, the claim is established for the effective month of approval and continues for every subsequent month the incorrect information is used.

Example: The individual applies for benefits and fails to report a source of income. The claim begins the month of approval and continues until the income is considered in the determination of the benefit.

- B. The 10-10-10 formula is used to determine the first month of the claim.

1. Determine when the change became known to the household;
2. From that date, allow the household 10 days to report;
3. Allow the worker 10 days to act on the report; and
4. Allow 10 days for adverse action.
5. The month in which the adverse action period ends determines the first month of the claim. The beginning month of the claim is the next month after adverse action ends.

- C. Simplified Reporting households have until the 10th of the month following the month a change occurs to report a required change.

Example: A household's income increases above the permitted gross limit in August. The individual has until September 10 to report the change. The worker has 10 days to act on the change (September 20), and 10 days (September 30) are allowed for adverse action. The first month of the claim is October.

- D. A reportable KTAP or Kinship Care change is required to be reported within 10 days. When changes decrease benefits or result in discontinuance of a case, the change must be entered on the Integrated Eligibility and Enrollment System (IEES) by either the negative action cutoff or IM cutoff date, whichever affects the next month's benefits.

Example 1: An individual reports a member of the benefit group left the home on 9/5/10. CCAP/KTAP/MA cut-off is 9/21/10. Negative action cut-off is 9/20/10. As this change will decrease benefits, the change must be entered by 9/20/10 to be effective for 10/1/10. If the change is entered after the negative action date, an Agency Error (AE) claim exists for 10/10.

Example 2: An individual reports a member of the benefit group has left the home on 11/5/10. Due to holidays, CCAP/KTAP/MA cut-off falls on 11/17/10. Negative action cut-off is on 11/19/10. The change must be

entered by 11/17/10 in order to be effective 12/1/10 or an AE claim exists for 12/10.

- E. For KTAP or Kinship Care (KC) claims resulting from the failure of the household to report a child's absence from the home within 5 days, without good cause, the claim will begin the month after the child left the home. Please reference Vol III, MS 2338 for KTAP and KC good cause reasons.]

MS 0900 DETERMINING ELIGIBILITY THROUGH EXTENSIVE REVIEW (1)

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

- A. Refer only applications and reapplications that cannot be resolved through normal case processing. DETER is not used on expedited Supplemental Nutrition Assistance Program (SNAP) applications or State Supplementation applications. Only send a DETER referral if there has been a break in benefits. A break in benefits is defined as there is at least one month in between receipt of benefits.

Example: A individual received benefits in January. The case discontinued effective February. The individual reapplies in February. Do not complete a DETER referral as there has not been a break in benefits.

Example: An individual received benefits in January. The case discontinued effective February. The individual reapplies in March. A DETER referral can be completed since there has been at least a one month break in benefits.

- 1. [Access the DETER function on the case summary screen on the Integrated Eligibility and Enrollment System (IEES).]
 - a. Enter detailed comments in the DETER referral window regarding the allegation and what case type is being referred to DETER.
 - b. Scan all related information into the Electronic Case File (ECF)
 - 2. DETER is operational in all counties.
 - 3. Caseworkers must explore all avenues available to resolve the issue before referring the case to DETER. An inappropriate DETER referral will be returned to the worker.
- B. After satisfying the verification requirements or when all avenues have been exhausted, use the following guidelines to determine if a referral to DETER is appropriate.
 - 1. During the initial application, the caseworker suspects the individual may have withheld information during the course of the interview.
 - 2. The individual provides any verification relative to the eligibility determination that appears to have been altered or not authentic.
 - 3. The applicant provides contradictory information relative to any eligibility factor.
 - 4. The individual does not respond during application or reapplication to questions relating to eligibility.

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

- C. After the DETER referral is made pend the case for up to 15 days or until the case due date whichever occurs first to allow the investigator time to gather information and report findings. The investigator has up to 15 calendar days to complete the investigation and provide their findings unless the case due date is less than 15 calendar days from the date of the DETER referral. If there is not 15 days prior to the case due date you must specify, in the DETER comments box, the case due date. Once the DETER investigation is complete, OIG returns the final report to the worker who initiated the DETER referral and the worker's supervisor.
1. Comment thoroughly the reason for the DETER investigation and pending the application.
 2. Pend the case until forms DTR-2, Case Detail Summary Sheet; DTR-2A, DETER Response and Request for Action; and DTR-3, DETER Investigation Report, are received from the DETER investigator or until the case reaches its due date whichever comes first. Do not pend cases past their due date.

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

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

- D. Caseworkers will receive forms DTR-2, DTR-2A, DTR-3, and a document titled Report Attachments containing any supporting documentation obtained during the investigation via e-mail. Caseworkers must review all information provided by the DETER Investigator and weigh the findings against any contrary evidence provided by the household.
1. Review form DTR-3 and take appropriate action according to the DETER findings within 10 days or sooner if the case due date is less than 10 days from receipt of the findings.
 2. If the DETER findings are inconclusive, process the case, and if the case is approved, utilize the unclear information function located on IEES on the case summary screen.

3. If the findings are conclusive, do not automatically allow written statements provided by the individual that are contrary to the DETER findings to supersede the DETER report.
4. If a potential claim is identified follow procedures used to refer the case for a claim.
5. Workers have 30 calendar days from the date the investigation findings are received to return form DTR-2, annotated with the results the findings had on the case, to DETER. If a response is not provided to DETER within 30 days, DETER will send a follow-up request. A response to the follow-up request is due back to DETER within 15 days.

E. Document in IEES comments:

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

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

F. File all DETER forms in ECF.

MS 0910

REFERRAL OF CLAIMS TO
THE OFFICE INSPECTOR GENERAL

(1)

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

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

1. Medicaid (MA) claims, regardless of the amount, when an individual has withheld or provided false information to receive assistance. MA claims are not entered on the Worker Portal unless adjudicated through the court system.
2. [A KTAP, KTAP supportive services, KC, FAST, WIN, RAP, or SNAP case suspected of fraud, when the claim amount:]
 - a. Is estimated to be \$10,000 or more due to unreported wages, only;
 - b. Is estimated to be \$3,000 or more for reasons other than unreported income;
 - c. There are companion case(s) and the combined amount is estimated to be \$3,000 or more; or
 - d. There is a companion MA case with at least one month of suspected ineligibility.
 - e. Child Care recipient eligibility claims estimated to have a value of \$5,000 or more AND suspected to be fraudulent.

Note: Do not refer SNAP claims from Lincoln or Rockcastle counties to OIG. These claims should be handled administratively regardless of dollar amount.

3. SNAP trafficking cases/referrals that are believed to be \$10,000 or more.
4. SNAP trafficking involving controlled substances, firearms, ammunition, or explosives, regardless of the suspected amount.

Note: Any trafficking that does not meet the criteria of 3-4 will need to be handled administratively.

5. Low-Income Home Energy Assistance Program (LIHEAP) cases, regardless of the amount.

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

1. Calculate the claim based on available verification.

2. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, for claims that include Medicaid.
 3. Navigate to the OIG Fraud Claims Tracking SharePoint site and create a new PAFS-88 referral. Enter all relevant claim information in the referral, clearly explain the allegation, and indicate which programs are associated with the overpayment.
 4. Upload supporting documentation using the Doc Link hyperlink for the referral.
 5. Submit the PAFS-88 referral for supervisor review by updating the referral status. The assigned claims supervisor will review the referral, determine if the referral is appropriate, and ensure all required steps have been completed. The supervisor will have the option to reject the referral or approve and submit the referral for CMS review.
 6. CMS reviews the referral and supporting documentation before submitting the referral to OIG on the OIG Fraud Claims Tracking SharePoint site.
- C. OIG may request a claim to be re-calculated based on the findings of the investigation. Complete all re-calculations within 15 calendar days of the request by OIG. These computation requests are sent directly to OIG. Contact the OIG investigator and CMS inbox at CHFS.DFS.Claims@ky.gov if there will be a delay in completing computations.
- D. OIG has a 90-day time-frame to complete the investigation and determine if prosecution will be pursued.
1. If prosecution is not pursued, OIG closes their case and returns the claim to DCBS for administrative action, which must be taken within 10 calendar days.

For SNAP claims:

- a. If fraud is highly suspected, pursue administrative establishment of an Intentional Program Violation (IPV) claim. See [MS 1070](#).
 - b. If the claim was caused by the client but fraud cannot be determined, change the category on the Worker Portal form Suspected Intentional Program Violation (SIPV) and complete as an Inadvertent Household Error Claim (IHE).
 - c. If OIG determines the claim resulted from an Agency Error (AE), review the claim circumstances. The DCBS claims worker determines the appropriate category of a claim. If an AE is found, change the indicator on IEES, and take appropriate action on the claim.
2. If a portion of the claim is not prosecuted but returned to DCBS for administrative action, a separate claim is established and procedures for the appropriate claim category are followed. Only one disqualification period is entered if both claims are of the same circumstances.

3. If prosecution is pursued, OIG serves as liaison between DCBS and the courts and prosecutors.
 - a. When possible, OIG will notify field staff at least five days in advance of a court or conference that requires their appearance.
 - b. When the case is adjudicated, OIG will provide copies of the order or agreement and update the SharePoint referral status for DCBS to take action.
 - c. DCBS may contact the court directly to obtain court documents if adjudication has occurred. Copies of the court documents are forwarded to the regional claims worker and CMS as soon as they are obtained.
 - d. If the SNAP case is prosecuted and the individual found guilty, CMS changes the claim to Intentional Program Violation - Court (IPC) on the Benefit Management Module. A disqualification is entered on IEES within 3 days of notification of prosecution.
 - e. OIG can initiate an investigation without a referral from DCBS. If notified to do so by OIG, the pending claim is entered on the Benefit Management Module using the date the referral is created by OIG as the discovery date.
 - f. OIG may return a referral to DCBS when they are not able to complete the investigation within the required 90-day timeframe. If the claim is returned and the suspected fraud referral requires further investigation by OIG, another referral is completed on SharePoint and the referral is submitted back to OIG through CMS.
 - g. After disqualification periods have ended, the disqualified member must be added back to the SNAP case as a household member. Complete a case change to add the member.

MS 0920 FRAUD "HOTLINE" REFERRALS (1)

- A. The Office of Inspector General (OIG) maintains a toll-free hotline, 1-800-372-2970, to report suspected fraud.
1. When a caller contacts the local office regarding fraud for any program, provide the toll-free hotline number.
 2. Use this number to report alleged Medicaid vendor fraud.
 3. Use this number to report alleged employee fraud.
 4. When a caller indicates they are unable to leave a message on the toll-free hotline, take the information and email OIG at OIG.Claims@ky.gov.
- B. OIG screens complaints and sends valid hotline referrals to the designated DCBS contact for each region via email. The DCBS contact is required to respond within 20 calendar days with the outcome of the complaint.

When a hotline referral is received:

1. Scan a copy of the hotline referral to Electronic Case Filing System (ECF). Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure substantiating documentation. Document thoroughly in case comments any action taken which pertains to the referral.
2. If the hotline referral is determined to involve suspected trafficking allegations, refer to Vol. I, [MS 1020](#), Trafficking and Retailer Fraud.
3. If a change becomes known to the agency through a hotline referral, enter the change on the Integrated Eligibility and Enrollment System (IEES). IEES will generate an RFI requesting verification of the change. When the requested verification is returned, enter the verification in IEES and allow the system to process the change. If the verification is not returned, IEES will act on the change according to policy in Vol. II, [MS 6750](#) and [MS 6760](#), as appropriate.

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

4. If sufficient information is not provided to enter the change on the system, select the "Unclear Information" button on the Case Summary screen and send the Request for Information (RFI) notice requesting the specific verification needed to process the change. Document the case thoroughly as to why the question was utilized and what is requested on the RFI. Allow the household 10 days from the date the RFI is mailed to provide the verification. If the mandatory verification is not returned at the end of 10 days, the case will automatically discontinue/deny for non-cooperation.

5. [If it appears there is a possible claim, complete the Overpayment Discrepancies screen or enter a manual claim referral on IEES, within 15 calendar days from the date of the hotline referral.
 6. If it is determined no claim exists based on the hotline referral information, indicate the reason for no action on IEES and return to the designated DCBS contact within 15 calendar days from the date of the hotline referral.]
- C. The Food and Nutrition Service (FNS) maintains a hotline number for the general public to report fraudulent activity. Once FNS receives the hotline report, FNS emails the complaint to the Integrity and Analysis Section (IAS) for the state to take action on the complaint. IAS will email the report to the designated regional contact for the investigation.
1. Enter the complaint on the Complaint Module on IEES. All whistleblower complaints will not necessarily be fraud. Some complaints may be issues regarding case processing and other general case resolution issues.
 2. Review the case to determine if incorrect benefits were issued. Verify any necessary information and secure supporting documentation. Only use collateral contacts as a verification source as a last resort in these complaints.
 3. When a change becomes known to the agency, enter the change on IEES. IEES will generate an RFI requesting verification of the change. When the requested verification is returned, enter the verification on IEES and allow the system to process the change. If the verification is not returned, IEES will act on the change according to policy in Vol. II, MS 6750 and MS 6760, as appropriate.

Example: NCP is in the home with income. Enter the information on IEES and allow the case to pend for verification of HH comp and income.
 4. If enough information is not provided to enter the change on the system, click the "Unclear Information" button on the case summary screen under case action and send the Request for Information (RFI) notice requesting the verification needed to process the change. Document the case thoroughly as to why the question was utilized and what is requested on the RFI. Allow the household 10 days from the date the RFI is mailed to provide the verification. If the mandatory verification is not returned at the end of 10 days, the case will automatically discontinue/deny for non-cooperation.
 5. [If it appears there is a possible claim, complete Overpayment Discrepancies screen or enter a manual claim referral on IEES, within 15 calendar days from the date of the whistleblower complaint.]
 6. In instances of household composition allegations, please review the complaint thoroughly and if the complaint appears to be valid complete the Overpayment Discrepancies Screen or enter a manual claim referral within the timeframe mentioned above so the complaint can be reviewed and sent to OIG if necessary.

Example: A Whistleblower complaint is received and states the individual's reported household composition is fraudulent; the father of the youngest child is, and has always been in the home, and the oldest child, which the individual has included in the household, is not in the home. The complaint states there is proof of the individual's statements being false, arrest records can be found, and social services can be contacted to verify. In this instance, an Overpayment Discrepancies or a manual claim referral would be completed and sent to the Regional Claims Worker (RCW). The RCW would send the complaint to OIG as other documentation provided by the individual would be considered questionable and the complaint appears to be valid.

7. For unreported wage complaints, use any verification source available. If wages are found, complete Overpayment Discrepancies screen or enter a manual claim referral screen within the timeframe mentioned above.
8. For self-employment income complaints, complete the Overpayment Discrepancies screen or enter a manual claim referral in the timeframe mentioned above.
9. [If it is determined no claim exists based on the hotline referral information, indicate the reason for no action on IEES and respond to IAS within 15 calendar days from the date of the hotline referral.]
10. If the hotline referral is determined to involve suspected trafficking allegations, refer to Vol. I, [MS 1020](#), Trafficking and Retailer Fraud.
11. You must notify IAS by email at DFS.IntegrityAnalysisSection@ky.gov, using the proper chain of command, within 25 days of receipt of the whistleblower complaint. Include a brief summary of events taken on the complaint.

MS 0930

EMPLOYEE FRAUD

(1)

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

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

[Employee fraud claims are completed by a designated individual as determined by the Division of Family Support (DFS).

Do not enter a fraud claim which involves any Department for Community Based Services (DCBS) employee on the Integrated Eligibility and Enrollment System (IEES). This applies even if the individual is not responsible for administering an assistance program. To complete a SNAP overpayment, use the automated form FS-103 on the "Historical Allotment Calculator" located in the DFS Forms Library. For a KTAP overpayment, use form KTAP Assistance Budget, PA-30, located in the DFS Forms Library.]

MS 0940

WHO MUST PAY A CLAIM

(1)

The following persons are responsible for paying a claim:

- A. Each person who was an adult member of the household when the claim or Supplemental Nutrition Assistance Program (SNAP) trafficking occurred.

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

Example: A household consists of 4 members: 3 adults and 1 child. One adult is the HOH and the SNAP EDG is in his name. The second adult is disqualified for failure to comply with the Employment and Training Program. The third adult is an ineligible student. An overpayment is discovered, and a claim established. In this instance the only liable member is the HOH. Members that are disqualified or are ineligible and not included in the benefit group, are not liable for overpayments that occur while they are not included in the benefit group.

- [B. Head of Household (HOH), the individual who signs the SNAP application, regardless of their eligibility in the SNAP case.

Example: Household of 3 members: 2 adults and 1 child age 15. HOH, who completed the interview and signed the application is an ineligible student. An overpayment is discovered, and a claim is established. Both adults are liable for the claim, even though the HOH was an ineligible student and not included in the benefit group. The HOH signed the application taking responsibility for the benefits issued on behalf of the household.

Example: Household of 4 members: 2 ineligible immigrant adults and 2 children ages 15 and 16. Both adult ineligible immigrants would be liable for the claim established as they would otherwise be considered in the benefit group, citizenship aside.]

- C. A sponsor of an immigrant household member if the sponsor is solely at fault;

- D. A person connected to the household, such as an authorized representative, who trafficked food benefits or caused a SNAP claim;
- E. For claims relating to recipients residing in a Drug and Alcohol Abuse (DAA) treatment center, the designated representative of the center or the center. Refer to VOL I [MS1015](#).
- F. An individual court ordered to repay the Cabinet.

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

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

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

- H. For claims involving emancipated minors, collection is pursued only if the household contained no adults at the time the claim occurred.

Example: A teen couple living alone.

- I. The responsibility to repay a KTAP or Kinship Care claim is with the caretaker relative who was a member of the case or the payee. Repayment is never sought from the children.
- J. Collection may be pursued from a child member of the case at the time the AFDC claim occurred if all adult members are deceased.
- K. The individual or responsible party is liable for repayment of the value of benefits when a determination is made that the benefits were obtained by committing a medical program violation. Refer to Vol I [MS 1240](#).

MS 0950 CLAIM REPAYMENT METHODS (1)

Claims may be repaid using one of the following methods:

A. [LUMP SUM. For active or inactive households, if the household elects to pay the claim at one time, collect a lump sum payment. Acceptable methods of payment are a check or money order made out to the Kentucky State Treasurer, EBT benefits, or online via debit/credit card via kynect.ky.gov. DO NOT ACCEPT CASH.]

1. Do not require the household to liquidate all of its resources to make a lump sum payment.
2. It is permissible for the household to make a lump sum payment as partial repayment of the claim.
3. [If the household chooses to make a monthly or lump sum payment from Electronic Benefits Transfer (EBT) benefits, complete form EBT-6, Claims Repayment Request, for the Supplemental Nutrition Assistance Program (SNAP) claim. Submit to the Claims Management Section (CMS) via email at CHFS.DFS.Claims@ky.gov, via postal mail, or via fax to (502) 564-9810.
4. If the household voluntarily returns an issued benefit check to use as payment on a claim, issue a PAFS 30.3, Multi-Program Claims Receipt, to the individual. Forward the check along with a copy of the PAFS 30.3, to:

Department for Community Based Services
Division of Family Support
Program Integrity Branch
Claims Management Section
275 East Main Street, 3 E-1
Frankfort, Kentucky 40621

B. INSTALLMENTS. If the individual with an inactive benefits case chooses to pay by installment payments, form KCD 1.11, Repayment Agreement, is required to be completed and returned to CMS within a designated time frame. An individual who is paying a claim by benefit reduction in an active case can also choose to make additional payments by installment. Notify CMS of the individual's request. The chart below shows the minimum payment required based on the claim threshold:

\$0-\$1,000	\$25.00
\$1,001-\$5,000	\$50.00
\$5,001-\$10,000	\$75.00
\$10,001-\$15,000	\$100.00
\$15,001-\$20,000	\$125.00
\$20,001+	\$150.00

C. BENEFIT REDUCTION. If an adult household member is active in a case, the household's benefits are reduced to recover the remaining balance not paid by a lump sum payment. The Integrated Eligibility and Enrollment System (IEES)

reduces benefits automatically. The initial benefit, when a household is first certified, cannot be reduced. Benefit reduction cannot be used to pay SNAP E&T, FAD, WIN, Supportive Services, Remedial Health Care, or AFDC program claims.

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

MS 0960

COLLECTING PAYMENTS ON CLAIMS

(1)

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

- [A. The Benefit Management Module sends notices and pursues collection from households with claims. All repayment notices issued to individuals are maintained on the Integrated Eligibility and Enrollment System (IEES).
- B. IEES will automatically reduce benefits on active households with a claim, unless the claim was adjudicated in court.
- C. Once the court adjudicated claim is outside court jurisdiction and benefits are active, IEES begins benefit reduction.
- D. The local office's responsibilities are to:
 - 1. Tell the individual to send payments, made out to the Kentucky State Treasurer, to CMS at:

Department for Community Based Services
Program Integrity Branch
Claims Management Section
275 East Main Street, 3E-I
Frankfort, Kentucky 40621
 - 2. If the individual presents a check or money order in the local office for repayment, please complete form PAFS-30.3, Multi Program Repayments, and provide a copy as a receipt to the client. Local office staff will then need to send the payment and a copy of the PAFS 30.3 to CMS.
 - 3. If a payment is received via mail in the local office for repayment, local office staff will need to mail the payment to CMS with a date stamp on the envelope of when the payment was received.
 - 4. Never accept cash payments.
 - 5. Provide individuals with the kynect.ky.gov website if they request methods of paying with a credit or debit card.
 - 6. Notify CMS via CHFS.DFS.CLAIMS@ky.gov if the individual requests a hearing regarding their claim.
 - 7. Advise individuals to contact CMS at 502-564-3440 regarding any questions about their claim.
 - 8. The transfer of claims to or from other states requires the approval of the CMS Supervisor. Notify CMS by e-mail at CHFS.DFS.CLAIMS@ky.gov of all requests received from other states.]

MS 0965*

COMPROMISING CLAIMS

(1)

- A. The Claims Management Section (CMS) determines if a Supplemental Nutrition Assistance Program (SNAP) claim will be compromised. Staff are not to discuss or offer a compromise. If an individual contacts the local office about the inability to pay a claim, refer the individual to CMS at (502) 564-3440.

CMS will only compromise SNAP claims if one or more of the following apply:

1. All liable members have entered a medical care facility with no intent to return home; or
 2. All liable members are in prison without the possibility of parole.
- B. Agency error (AE) claims for all programs that are delinquent and have a balance greater than \$0 will be systematically changed to "Compromised—Not Cost Effective" 36 months from establishment date. This will stop the collection process on the claim generating a Claim Compromise notice to be sent out to an individual; KCD 2.19 for CCAP claims and KCD 1.19 for SNAP, SAFE, KTAP, KC, and the KWP program claims. Any payments made prior to compromise will not be refunded.
- C. Compromised claims differ from terminated claims in that the compromised amount can be added back to the claim amount if the household situation changes. If all liable claim members are deceased, the claim will be terminated.
- D. Advise the household of the right to request a fair hearing if the household disagrees with the agency's decision on compromising their claim.

MS 0970

WHEN A CLAIM IS OVERPAID

(1)

- A. [If it becomes known that a household has overpaid a claim by benefit reduction, the individual is refunded the overpaid amount. The household is refunded the SNAP or KTAP benefits even if it is currently ineligible for benefits.
- B. When a claim is overpaid through cash payments, CMS will authorize a refund for the overpayment if there are no other appropriate claims for the overpaid balance to be transferred to.]

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

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

- A. Agency Error (AE) – occurs when the claim is caused by a worker’s action or failure to take action which includes:
 - 1. Failure to take prompt action on a client reported change;
 - 2. Incorrectly computing income and deductions;
 - 3. Failure to take prompt action on a change known to the agency.
 - 4. Incorrect benefit issuance related to system defects or errors.

- B. Inadvertent Household Error (IHE) – occurs when the claim is caused by misunderstanding or an unintended error by the client.
 - 1. This includes claims caused by:
 - a. Failure to provide correct or complete information;
 - b. Failure to report a change in circumstances timely;
 - c. Receipt of benefits pending the outcome of a hearing that upholds the agency;
 - d. The agency’s inability to prove fraud in a hearing or court proceeding.
 - e. Suspected Intentional Violation Claims (SIPV) claims in which the head of household is deceased and there are other adult members in the home.
 - 2. If the agency has sufficient evidence to pursue an Intentional Program Violation (IPV) but the application(s) for the claim period cannot be located, pursue the claim as an IHE.

- C. Intentional Program Violation (IPV) – occurs when it is established by an individual signing form FS80A, Waiver of Administrative Disqualification Hearing, a hearing officer’s order is issued granting the IPV, an individual signing form FS-111, Deferred Adjudication Disqualification Consent Agreement, or prosecution through court.
 - 1. This includes claims caused by:
 - a. Deliberately made a false or misleading statement;

- b. Deliberately misrepresented, concealed, or withheld facts;
 - c. Purchased a controlled substance, guns, ammunition, or explosives with benefits;
 - d. Bought or sold SNAP benefits on or after 8/22/96;
 - e. Made false statements regarding identity or place of residence in order to receive duplicate benefits on or after 8/22/96.
 - f. Commits any act that violates the Food and Nutrition Act of 2008, federal SNAP regulations or state law, for the purpose of using, presenting, transferring, acquiring, possessing or trafficking Electronic Benefit Transfer cards used as part of an automated benefit delivery system.
2. Intentional Program Violation Court (IPC) – is an IPV as a result of a court's determination of guilt, due to fraud.
- D. Suspected Intentional Program Violation (SIPV) – is a claim category that occurs when fraud is suspected until a final determination is made. The SIPV claim category is temporary and updated to IHE or IPV, as appropriate.

If unsure if a client had intent to commit fraud, an SIPV should be pursued and the outcome will be decided by admission, hearing or prosecution.]

Process all claim referrals received for expedited benefits no matter the reason for the referral. Consider a Supplemental Nutrition Assistance Program (SNAP) overpayment a “No Claim” if:

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

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

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

- C. Once the claim has been completed, if “No Claim” is determined, document the case record regarding the basis of the determination.
- D. Reference MS 1010 Procedures for Specific Households for procedures on lost or unsigned applications and electronic signature applications.

MS 1010 PROCEDURES FOR SPECIFIC HOUSEHOLDS (1)

A. Categorically Eligible

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

B. Authorized Representatives

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

C. [Sponsored Immigrant

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

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

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

E. Voluntary Quit

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

F. Ineligible Members

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

G. Disqualified Members

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

H. Fleeing Felons

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

I. Simplified Reporting (SR)

1. SR policy was effective 2-1-02 and includes all cases with earned income, including self-employment.
2. SR policy was expanded effective 3-1-03 to include all cases except households with members who are elderly or disabled with NO earned income.
3. SR policy was expanded 4-1-09 to all households.
4. When processing SNAP benefit claims, use policy that was in effect at the time the claim occurred, please refer to [VOL II MS 6705](#).

J. Dual Participation (SNAP)

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

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

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

report receipt of benefits from other states in order for verification of benefits and closure of the other state's case to be obtained.

K. Missing/Unsigned Applications (SNAP)

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

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

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

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

[L. Electronic and Voice Signatures

Recipients can choose to sign applications electronically or via voice signature. The worker comments on IEES as to who is interviewed in completing the application or recertification. Applications completed with an electronic or voice signature are considered signed applications.]

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

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

[Establish a claim in the name of the resident if an agency error occurs. The resident is responsible for repayment of the claim. If the resident has an active case on the Integrated Eligibility and Enrollment System (IEES), it will be subject to benefit reduction.

- A. Establish separate claims for each resident whose benefits are overpaid if the treatment center is the cause of the overpayment or the misuse.
 1. DAA facility claims are established under provider/facility claim establishment.
 2. The claim is established as Inadvertent Household Error (IHE) on the Benefit Management Module.
 3. All DAA facility claims are in the name of the treatment center. The benefit Management Module will assign a 10-digit claim number when the claim is submitted.
 4. If there are multiple claims against the treatment center, each claim will have a different claim number.
 5. The resident of the drug treatment center is not responsible for the repayment of the IHE claim; therefore, if the client has an active SNAP case on IEES he/she is not subject to benefit reduction.

- B. If an Intentional Program Violation (IPV) is suspected, the Food and Nutrition Service (FNS) is contacted by the Program Integrity Branch.]

MS 1020

TRAFFICKING AND RETAILER FRAUD

(1)

A. Trafficking is the act of:

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

B. The Office of Inspector General (OIG) refers recipient trafficking hotline referrals to the Integrity & Analysis Section (IAS). IAS will refer the recipient trafficking hotline referrals to the regional claims staff for investigation. For more information regarding non-trafficking related hotline referrals refer to Vol I [MS 0920](#). If EBT account transactions indicate trafficking or misuse of benefits, follow the trafficking procedures outlined in D of this section, or Vol I MS 1025 for EBT misuse. The claim is only entered on the Benefit Recovery Module when one of the following requirements has been met:

1. The recipient signs and dates form FS-80 Supp. A (TR), Voluntary Waiver of Administrative Disqualification Hearing (ADH);

2. [An Intentional Program Violation (IPV) is granted by an ADH;]
 3. A completed FS-111, Deferred Adjudication Disqualification Consent Agreement, signed by the recipient and the prosecuting attorney is received; or
 4. The claim has been adjudicated in court.
- C. For allegations received and/or identified by local office staff, create a claim referral by accessing the benefit management screen on IEES for the regional claims staff to investigate.
- D. When allegations that a recipient has trafficked SNAP benefits are received by the regional claims staff, use the following procedures:
1. Access the recipient's account on the EBT website and review transaction information for the period described in the allegation. Review transaction history for the following activity. Include only transaction data which would support a strong pattern of trafficking exists through clear and convincing evidence.

Review transaction history for the following:

- a. Whole dollar transactions. These indicate payments of credit accounts, cash transactions or gas purchases.
- b. Back-to-back transactions within a time period too short for the scanning of eligible items. This indicates ineligible sales or cash transactions.
- c. Large purchases at a retailer who carries a minimum amount of eligible food items. This indicates payment of credit accounts or cash transactions.
- d. Vendor location. Determine if the recipient bypassed other EBT vendors to do business at the specific location indicated by EBT transactions. Utilize the SNAP Retailer Locator which provides locations of retailers who accept SNAP benefits. Access the Retailer Locator at <https://usda-fns.maps.arcgis.com/apps/webappviewer/index.html>. To bypass other retailers indicates the recipient has a unique reason for making transactions at that specific retailer. Question the recipient as to the reason.
Note: When the retailer trafficking fraud is believed to be occurring by assisting the recipient in committing fraud, retailers should be submitted to IAS so that the store may be investigated more thoroughly by the USDA.
- e. A large or questionable number of lost or stolen EBT cards and/or substantial requests for replacement EBT cards. This indicates the individual is selling the card, reporting it lost or stolen, and

requesting a new card and PIN to receive the next month's benefits.

- f. Rapid benefit depletion. When a recipient uses a large portion of their benefits quickly upon receiving them. This indicates purchasing food items for another household or buying food items with an intent to sell for cash.
- g. All day spending. When a recipient displays a pattern of shopping at the same store throughout the day during the review period. This indicates that the recipient is allowing unauthorized individuals outside the approved benefits group to use the EBT card to make purchases.
- h. An excessive number of invalid pin entries or insufficient fund attempted purchases. These indicate that the recipient is allowing unauthorized individuals outside the approved benefits group and unfamiliar with the EBT card access to use the card to make purchases.

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

Example 2: A fraud hotline report is received from OIG alleging that a recipient who has \$400 of benefits on the card, sold \$100 of SNAP benefits for \$50. It is the worker's responsibility to confirm that the actual transactions support the allegations in the fraud hotline report. The worker should identify all transactions that support the allegation. A review of transactions on the EBT website confirms the date and amount of the reported transaction and support the allegation that trafficking occurred. The amount of the claim is the amount of benefits trafficked as verified per transactions. During the interview to discuss the transactions, if the recipient admits to the violation that benefits were sold, signs and dates form FS-80 Supp. A (TR), or an IPV is established by an ADH, use disqualification code, Trafficking, administrative finding.

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

and Nutrition Services (FNS).]

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

2. If after reviewing the EBT transaction history, no suspicious activity is found, annotate IEES with detailed comments, as to the reason for the determination that no trafficking exists.
3. If trafficking activity has been identified, take the following action:
 - a. Make copies of the EBT account showing the identified trafficking activities and/or excessive card history.
 - b. Include all supporting documentation such as hotline reports or third party reports in the claim file.
 - c. Schedule a telephonic appointment with the recipient to discuss the trafficking activity identified. Schedule an appointment using the IEES scheduling system. If requested, an in-person appointment can be held in the local office of the county where the recipient resides. Discuss all documentation supporting the allegations with the recipient.
 - d. Thoroughly document the discussion with the recipient as the information obtained is the basis for action taken by DCBS.
 - e. If the household later contacts the agency to cooperate, an interview should be conducted. When a claims specialist is not available onsite for a walk-in recipient, each local office will have a designated worker to interview recipients who come in to resolve a fraud or trafficking complaint.
4. If after a review of the documentation and/or discussion with the recipient (if an interview was conducted), it is determined that no dollar amount can be established, no claim exists, or there was a valid reason for the excessive card replacements, indicate the reason for the action in detailed IEES comments and scan the documentation into the electronic case file.
5. If after a review of the documentation and/or discussion with the recipient (if interview was conducted), trafficking or another program violation is pursued, provide the household with form FS-80(TR), Notice

of Suspected Intentional Program Violation, and form FS-80, Supplement A (TR). If the recipient reviews the forms and signs and dates form FS-80, Supplement A (TR), enter a trafficking, administrative finding, disqualification on IEES.

6. If form FS-80, Supplement A (TR) is mailed and returned signed and dated; enter a trafficking, administrative finding, on IEES.
 7. If form FS-80, Supplement A (TR) is not returned, is returned unsigned or without a date, request an ADH. See Vol I [MS 1070](#).
 8. Claims pursued as trafficking are not established as Suspected Intentional Program Violation (SIPV) claims. The claim is only entered on the Benefit Recovery Module when one of the following requirements has been met:
 - a. The recipient signs and dates form FS-80 Supplement A (TR), Voluntary Waiver of Administrative Disqualification Hearing (ADH);
 - b. **[An Intentional Program Violation (IPV) is granted by an ADH;]**
 - c. A completed FS-111, Deferred Adjudication Disqualification Consent Agreement, signed by the recipient and the prosecuting attorney is received; or
 - d. The claim has been adjudicated in court.
- E. When an excessive card task is received by regional claims staff, use the following procedures:
1. When the first excessive card task is received, access the recipient's account on the EBT website and review transaction information for the prior 12 months from the task received date for trafficking activity.
 2. If after reviewing the EBT transaction history no trafficking activity is detected, annotate in IEES with detailed comments regarding the first excessive card task and the determination that no trafficking exists.
 3. **[If trafficking activity is detected, follow the same procedures outlined in item D of this section. When conducting the appointment, regional claims staff should also discuss proper card security and use with these recipients.**
 4. For subsequent excessive card tasks received by regional claims staff, take the following action:
 - a. Review EBT transaction history from where the prior excessive card

task review ended to present for trafficking activity.

- b. If trafficking activity is detected, follow the same procedures outlined in item D of this section. When conducting the appointment, regional claims staff should also discuss proper card security and use with these recipients.
 - c. If no trafficking activity is detected and the recipient was not contacted over the initial excessive card task, an appointment is required to be scheduled to discuss the reason behind the excessive number of cards that have been issued and to counsel the recipient on proper card security and use.
 1. During the appointment, question the recipient to determine if the number of replacement card requests is reasonable. Counsel the recipient on proper card security and use. Enter detailed comments about what was discussed. If the recipient continues to receive subsequent excessive card tasks, a new appointment is not required unless review of EBT transaction history shows additional patterns of trafficking. Comments should be entered to detail findings of the review.
 2. If regional claims staff are not able to reach the recipient for the scheduled appointment, annotate in IEES that the interview was attempted. With subsequent excessive card tasks, regional claims staff must continue to schedule an appointment with the recipient until contact is made to discuss why so many cards have been requested and proper card security and use. Once the recipient is reached and provides a reasonable explanation, if they continue to receive subsequent excessive card tasks a new appointment is not required unless review of EBT transaction history reveals a pattern that is indicative of trafficking. Review findings for each excessive card task should be annotated in IEES.]
- F. The Food and Nutrition Service (FNS) investigates, prosecutes, and disqualifies a retailer when fraud is substantiated.
1. FNS notifies the Integrity and Analysis Section (IAS) that a retailer is disqualified and provides a listing of SNAP benefit recipients that had transactions meeting trafficking criteria at that store during the investigated period.
 2. IAS forwards the information of the SNAP recipients involving high dollar amounts to OIG who makes a determination whether to pursue prosecution.

3. A list of recipients not pursued by OIG for prosecution is forwarded back to the IAS who will then forward to the appropriate claims staff. Staff are to follow the steps outlined in item D of this section.
 4. Recipients identified by IAS must be sent for ADH if the FS- 80A, Supplement A (TR), is not signed and dated or returned to the agency.
- G. For EBT cards and/or EBT card numbers that are received by the local office from law enforcement:
1. Ask law enforcement if they are investigating the household. If law enforcement is conducting the investigation, only document IEES comments that law enforcement is investigating the recipient for SNAP trafficking;
 2. If law enforcement is not conducting the investigation, follow procedures outlined in item D of this section.
 3. Destroy any EBT cards that are received in the local using procedures outlined in Vol I [MS 0290](#).
- H. Report any type of alleged retailer fraud directly to the OIG Fraud Hotline at 1-800-372-2970.
- I. Recipients can be convicted of trafficking as a result of an investigation by other law enforcement agencies. Department for Community Based Services (DCBS) staff are notified when a recipient is convicted of trafficking. If restitution is ordered, it is paid to the Claims Management Section (CMS) in the Cabinet for Health and Family Services. The claim must be entered on the Benefit Management Module. CMS will notify field staff to:
1. Create a claim file; and
 2. Enter the disqualification on IEES for the trafficking offense as indicated in the court order.

MS 1025 SNAP ELECTRONIC BENEFIT TRANSFER (EBT) MISUSE (1)

EBT misuse is defined as:

1. Using SNAP benefits for any way other than to purchase food for eligible household members.
2. If the benefits were used incorrectly, but not in a way that meets the definition of trafficking in MS 1020, consider the violation to be misuse. The most common example of misuse is maintaining a credit account with a retailer for the purchase of eligible food but redeeming SNAP benefits on a date other than when the food was received.

[EBT misuse should follow trafficking procedures when detected. If misuse is suspected, do not place a pending claim on IEES for investigation. Annotate in case comments the issue at hand and that field staff are not to discuss with the individual. Schedule an appointment and pursue an IPV disqualification, unless it is determined during the course of investigation that misuse is no longer suspected.]

A claim amount is not required to pursue EBT misuse.

If an ADH is necessary, the hearing type will be a trafficking ADH. Workers will need to comment that this hearing request is for EBT misuse in the hearing module.

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

[Example 2: Allowing a non-authorized designated representative access to the EBT card and pin number to make purchases even if the purchases are for the SNAP household. This includes if the only adult household member becomes incarcerated or moves into an ineligible facility. The only individuals authorized to access an EBT card are members of the approved SNAP benefits group, or an authorized designated representative that has been appropriately added to the case to use the card on behalf of the household.

Example 3: Purchasing food with EBT benefits intended for your SNAP household but giving the food to another household.

Example 4: Jimmy is incarcerated from January 1, 2020 through June 30, 2020. During this period of incarceration, Jimmy allowed Billy to use his EBT card even though Billy is not a member of the approved benefits group. An IPV disqualification is pursued against Billy due to misuse because he was accessing an EBT card of which he did not have ownership. In addition, upon Jimmy's release, an IPV disqualification penalty will be pursued against him along with a claim for the amount of benefits used by Billy during the incarceration period. Once the form FS-80 Supplement A is returned signed or an ADH is received affirming the decision of the agency, a disqualification penalty would be imposed, and the claim would be established on the benefit recovery module.]

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

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

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

All claims are calculated on the Benefit Recovery Module.

A. Date of Discovery:

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

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

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

B. Household Composition

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

Example 1: A claim contains three adult household members for the period of January through June. The head of household is an active member for the entire 6 months of the certification period. The second adult household member was only an active member of the case from March - April. The third adult household member was only an active member of the case from May -June. Three separate claims are established. The first claim would contain the head of household and would be established for the months of January and February. The second claim would contain the head of

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

Example 2: A claim contains three adult household members and one child for the period of July – December. The head of household was active six months of the certification period. The child and second adult household member were active from September – October. The third household member was active from November – December. Three separate claims are established. The first claim would contain the head of household for the months of July-August. The second claim would contain the head of household, the second household member and the child for the months of September and October. The third claim would contain the head of household, the second household member, the child, and the third household member for the months of November and December.

C. Utility Allowance:

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

D. Earned Income:

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

E. Cash Assistance and Other Related Program Payments:

All cash assistance payments received should be considered in the SNAP claim calculations if the cash assistance payment is not the basis of the claim.

Example: An individual applies for SNAP and KTAP benefits for herself and two children. The individual reports wages from employment as well as income from self-employment. The agency failed to enter self-employment income and SNAP and KTAP benefits are approved considering wages only for the household's income. A KTAP claim is established for the overpayment of KTAP benefits issued to the household due to incorrectly considered income. The full KTAP payment(s) will be considered in the SNAP claim calculations though a claim has been established to recoup the incorrectly issued payment(s).

F. Reported Information/Changes:

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

1. Reported income at application or recertifications does not have to be re-verified. Use the converted income that was used in the original allotment.
2. When calculating the claim, use all other household circumstances that were correctly considered. Include the actual income that was omitted in error.
3. If wages were known and not acted on, allow the actual dependent care expenses as a deduction. Budget the reported wages that were not acted on by using the anticipated converted income that should have been used in the original allotment.
4. [Reported, but unverified reported wages. If income were reported to the agency and verification was not provided, the worker should first attempt to obtain the missing income verification. If the verification is not returned, the worker may then use wage match data to calculate the claim. When using wage match data use the gross quarterly income, divided by three months, and round to the nearest dollar to obtain the average monthly amount. If the employment was less than three months, average the gross amount over the period of time between the begin and end dates of employment. This date may be determined by contact with the employer or client.

Example: An individual reports at the SNAP recertification that they began new employment 4 months prior to recertification date. The case was pended for verification of employment to confirm start date and to ensure household did not exceed gross income limits. No verification was returned to the agency and the case discontinued for failure to provide mandatory verification. A claim referral was later submitted over failure to report this income. When investigating, the worker would first attempt to obtain missing income verification before using wage match data.]

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

For unreported information/changes that were not considered in the original benefit, use the actual income for the appropriate household member(s) that

was not reported, actual household size, and any other household circumstances that were required to be reported.

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

Example: countable student income.

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

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

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

1. Enter the actual amount of benefits the household received during each month in question. To determine the amount the household actually received, do the following:
 - a. Access the Benefit Issuance screen from the IEES Benefit Management tab;
 - b. Search the associated case and benefit period as indicated for the overpaid benefits.
 - c. Any overpayment which occurred more than 12 months (1 year) prior to the discovery of the overpayment is not included in an AE claim. An overpayment which occurred more than 72 months (6 years) is not included in an IHE claim.]
2. Enter the issuance case data, correcting the AE or IHE claim factor but excluding the IPV factor.
3. The amount of the AE or IHE claim is the difference between the two allotment totals.
4. Establish the claim(s) as active to start recoupment.

B. IPV claim.

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

Example: An IPV claim is identified due to an individual's deliberate failure to report RSDI income. Upon further review it is discovered that the individual was given a medical deduction in error during the

same time period of the unreported RSDI. Compute the AE claim first, based on the incorrect medical deduction. A separate claim is computed for the IPV due to unreported RSDI, using the benefit amount that was determined to be correct in the AE claim.

MS 1050 HOW TO PROCESS AN INTENTIONAL PROGRAM VIOLATION CLAIM (1)

[If a potential Supplemental Nutrition Assistance Program (SNAP) benefits claim occurs in an active or inactive case, enter the claim on Integrated Eligibility & Enrollment System (IEES). A suspected fraud claim is calculated and established as a Suspected Intentional Program Violation (SIPV). The IEES SIPV category code can be calculated for up to 6 years from the discovery date. A claim is not categorized as an Intentional Program Violation (IPV) until fraud is established by:]

- The individual signing and dating form FS-80, Supp. A, Voluntary Waiver of Administrative Disqualification Hearing (ADH);
 - A final order issued by the Hearings Branch states IPV occurred;
 - The individual signing and dating form FS-111, Deferred Adjudication Disqualification Consent Agreement;
 - A court finding of guilt.
- A. Refer the following situations to the Office of Inspector General (OIG) for further investigation. See [MS 0910](#).
1. [The claim amount is estimated to be \$3,000 or more for reasons other than income
 2. Is estimated to be \$10,000 or more due to unreported wages only; or
 3. There is a companion Medicaid case with at least one month of expected ineligibility.]
- B. For claims that do not include at least one month of Medicaid ineligibility and do not meet the criteria above:
1. Send form FS-80, Notice of Suspected Intentional Program Violation, to the household within 10 days of establishing the claim.
 2. Include form FS-80, Supp. A with form FS-80 when mailing to a household in which the person suspected of fraud does not have a mental disability. The option to waive a disqualification hearing is not offered to a person with a mental disability.
 3. Allow 10 days for return of the FS-80, Supp. A.
 - a. If the household does not return form FS-80, Supp. A, refer for an Administrative Disqualification Hearing. See [MS 1070](#).
 - b. If form FS-80, Supp. A is returned and the individual waives a disqualification hearing by signing and dating the form:

[IEES is accessed, the date the form is signed by the individual is entered on the claim adjustment screen and the claim category is changed from SIPV to IPV. If the case is inactive, the Claims Management Section is contacted via email at CHFS.DFS.Claims@ky.gov.

- (1) The worker enters the appropriate disqualification for the member on IEES for active and inactive cases using the following steps from the IEES "manage IPV (eDRS)" on the individual screen:
 - (a) Select Program SNAP;
 - (b) Select YES under Sources (this is the only option);
 - (c) Select the IPV occurrence;
 - (d) Enter the decision date (the date the FS80A was signed);
 - (e) Enter the verification date (the date the FS80A was received by the agency)
 - (f) Enter the start date; and
 - (g) Enter the end date

If the SNAP benefits case is active, you must enter the case and rerun eligibility to impose the IPV disqualification. If there are no active cases, you must go to the individual summary screen and select "Manage IPV's". Once the recipient serves their disqualification period, eligibility will have to be ran before the recipient is added back to the SNAP EDG.]

- C. Per federal regulation, no further administrative appeal procedure exists after an individual waives his/her right to an ADH and a disqualification penalty is imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The individual is entitled to seek relief in a court having appropriate jurisdiction.
- D. When OIG advises they will not pursue prosecution in a case but fraud is still suspected, follow procedures in B. If fraud is ruled out, change the category of the claim to IHE or AE and recalculate the claim amount.
- E. If the final order from the Division of Administrative Hearings establishes an IPV, disqualify the member on IEES. If the final order does not establish IPV, change the category of claim to IHE or AE per the findings of the hearing officer. Recalculate an AE claims for 12 months (1 year) from the discovery date and an IHE claim for 72 months (6 years) from discovery date.

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

The burden of proof to establish an Intentional Program Violation (IPV) is on the agency. Evidence used to demonstrate this must support the accusation of IPV and prove intent to commit food benefits fraud. An IPV may also be pursued due to an out-of-state match via the Electronic Disqualified Recipient System (eDRS).

- A. Evidence may include, but is not limited to:
1. A signed Supplemental Nutrition Assistance Program (SNAP) benefits application used to determine eligibility for the claim period. A lost, unsigned, or otherwise unavailable application does not prevent establishing a claim;
 2. Computer printouts;
 3. Income and Eligibility Verification System (IEVS) records;
 4. Form PAFS-700 or CL-700, Verification of Employment and Wages;
 5. Form PAFS-76 or CL-76, Information Request;
 6. Form PAFS-702, Proof of No Income;
 7. [Prior IPV documentation; and
 8. Integrated Eligibility & Enrollment System (IEES) notices to the recipient.

Example 1: The individual applied for SNAP on 1/1/21 for a household of one. The individual reported no source of income for self, which was verified by use of a PAFS-702, Proof of No Income form. The SNAP application approved 1/16/21. On 4/1/21, the agency obtained verification confirming that the individual had went to work on 10/1/20 and was actively working at the time of the 1/1/21 application. During the claims interview, the individual admitted that the income was not reported so that more benefits could be obtained as the individual was struggling to pay bills. The evidence would include the application, PAFS-702, IEES comment entries from the SNAP application interview, SNAP approval notice, wage records confirming employment, claim interview comments, and any other documentation supporting the claim establishment and IPV disqualification penalty.

Example 2: The individual applied for SNAP on 1/1/21 for self and minor child. Household composition was verified by use of a PAFS-76, Information Request form. The SNAP application approved 1/16/21. On 4/1/21, the agency obtained verification confirming that the minor child has been in foster care since 8/1/20 and has not stayed with the individual at any time since entry into care. The individual has a prior IPV for application fraud. The evidence would

include the application, PAFS-76, IEES comment entries from the SNAP application interview, SNAP approval notice, records obtained from Protection & Permanency confirming child has not been in the home, prior IPV documentation, and any other documentation supporting the claim establishment and IPV disqualification penalty.

B. IEES will interface with eDRS to:

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

MS 1070 ADMINISTRATIVE DISQUALIFICATION HEARINGS (1)

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

- A. [Refer a case for a disqualification hearing via form FS-79, Request for an Administrative Disqualification Hearing, by submitting a hearing request from the claim adjustment screen, within three calendar days if there is sufficient evidence to substantiate a claim of IPV and one or more of the following situations apply:
1. The claim does not meet criteria for referral to the Office of Inspector General (OIG);
 2. The facts of the case do not warrant civil or criminal prosecution and OIG closes their case; or
 3. Form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing (ADH), is not received signed within 10 calendar days of being sent to the household.]
- B. Review Integrated Eligibility & Enrollment System (IEES) for previous disqualifications before completing the FS-80, Supplement A. Make DAH aware of the prior IPV that was established by indicating on the FS-80, Supp. A., whether it is a 1st, 2nd, or 3rd offense. If the individual commits an IPV after July 1, 2013, the waiver can be offered to establish an IPV for each program violation.
- C. Access the "Claim Adjustment" screen on your navigation panel through Benefit Management and click "request ADH" to start the administrative hearing process. For Trafficking related ADH requests, start the hearing request process via the "Hearings" tab, as a claim will not already be established.
- D. Complete form FS-79, Request for an Administrative Disqualification Hearing, and attach it with all the evidence that will be presented at the hearing in the Hearings Module under the appropriate hearing ID "Exhibits – Agency".
- E. Only evidence listed on form FS-79 can be introduced at the hearing. If information is not listed on form FS-79 or evidence is missing, submit a "Withdraw Request" via the Hearings Module before the hearing is scheduled and re-submit a new form FS-79 with the correct information and all necessary evidence following the process outlined in C above. ALL evidence must be labeled as: Exhibit 1, 2, 3 or Exhibit A, B, C, etc. prior to uploading to the Hearings Module and mailing to the individual. Complete the FS-79 using the following guidelines:
1. Provide a detailed explanation of the charges, attaching additional sheets if necessary.

2. Evidence should be listed in chronological order which led the worker and supervisor to suspect an IPV occurred, e.g., when and how the claim was discovered, the individual's history of not reporting changes, and the individual's statements regarding the situation, ONLY if it supports the IPV.
3. List each piece of evidence which should include but are not limited to the following: KIF-101, Supplemental Nutrition Assistance Program (SNAP) applications (includes electronically signed and voice recorded), Mid-Review forms, SNAP Approval & Information notices issued to the individual pertaining to program eligibility, PAFS-700, Wage Verifications & Wage History/Pay Stubs, Wage File Data, Eligibility Advisor Verification, Certified Court Orders, Written Statement/Emails from the individual or other parties that support the IPV, and policy which supports the claim establishment and IPV being pursued. Include the FS-79 as part of the list of evidence. Redact any private information that should not be disclosed at the hearing.

If your ADH is for SNAP trafficking, include evidence listed above as well as the following (if applicable): Retail Store Closure-Trafficking United States Department of Agriculture (USDA) Letter, Photos of Store Inventory, Electronic Benefit Transfer (EBT) Transaction History (detailed and summary), the summary of suspicious transactions/activity, Excessive EBT Card Replacement Notice issued to individual, EBT Card Issuance history, Change History for the review period (includes PIN changes, address changes, etc.), and IEES comments pertaining to the investigation which support the IPV being pursued.

4. Electronic Signature application(s) and dates are verified by IEES inquiry. However, in pursuing the IPV claim, provide the hardcopy application to show the electronic signature was used in order to process the SNAP application for the period of the claim.
5. Voice Recorded Signature applications and dates are verified through IEES. However, in pursuing the IPV claim, you must present the original Voice Signature Application, the completed Voice Signature Application Instruction Letter that was scanned into Electronic Case File (ECF) for the SNAP case (if available), and IEES comment entry showing who completed the interview for the associated application.
6. Any prior disqualification verification, i.e., FS-80 Supplement A, FS-111, court documentation, prior hearing affirmation, or out of state disqualification verification, must be included in an evidence packet and be presented during the ADH.
7. When a hearing is requested on IEES, tasks are systematically created for the requested hearings based on SNAP/Medicaid/KTAP/Child Care eligibility and Claims. A task will be sent to DAH along with any documentation associated with the hearing request. The type of hearing requested will determine the task that is created by DAH and the type of notice sent back to each region. The regions have assigned designated Hearings Public Assistance Program Specialist (PAPS) that will be a part of the queue to receive tasks concerning the notices for the different types

of hearings. The Hearing PAPS will log the hearing notices and assign a task to the appropriate supervisor/worker for that region. They will monitor the hearing process and track results.

8. Once an ADH has been requested through IEES, corrections cannot be made to the hearing request on IEES; instead, "Withdraw Request" will need to be done and a new hearing request completed if corrections are required prior to the scheduling of the hearing.
 9. Individuals who are not on IEES or have never had a case on KAMES, i.e., "caseless individuals", must first be assigned an Individual number prior to requesting a hearing. The Individual number is created by clicking on the Individual tab at the top of the navigation page through IEES. Enter the required information on the individual. Once all information is entered, the system navigation will take you to the Individual Summary screen. Now that the individual is known to IEES, the worker may create a manual claim against the individual and request a hearing through Benefit Management or the Hearings Module, whichever is appropriate.
- F. DAH schedules the hearing and provides written notice to the household at least 30 days in advance of the hearing date. The notice advising of the date and time of the hearing is sent to the household and a task is generated for the Hearings PAPS to review.
1. Hearings held telephonically – an agency representative must be present at each hearing. In the instance that the assigned claims worker is unable to attend the hearing, the agency cannot ask DAH to reschedule. Instead, another claims worker will be assigned the hearing to attend. Additionally, if another worker or individual gathered information for the claim/investigation, include that individual as a witness. Attendance by a Department for Community Based Services (DCBS) worker is mandatory under these circumstances so that the evidence is not considered "hearsay".

Example: A Protection and Permanency (P&P) worker reported to the local office that the individual lost custody of her children a year ago and they are all residing in foster care. The case was referred to claims for an investigation. The claims worker contacted the P&P worker and obtained written records to confirm the allegation and was the basis for claim establishment based on the household size not being reported accurately. The evidence should include verification obtained from P&P. The P&P worker must be requested to attend as an agency witness to the telephonic hearing to testify to the validity of the investigation and findings.

2. Hearings held face-to-face - an agency representative must be present at each hearing. In the instance that the assigned claims worker is unable to attend the hearing, the agency cannot ask DAH to reschedule. Instead, another claims worker will be assigned the hearing to attend. Prepare a copy of the evidence for the individual to receive at the scheduled face-to-face hearing. Additionally, if another worker or individual gathered information for the claim/investigation, include that individual as a

witness. Attendance by a DCBS worker is mandatory under these circumstances so that the evidence is not considered "hearsay".

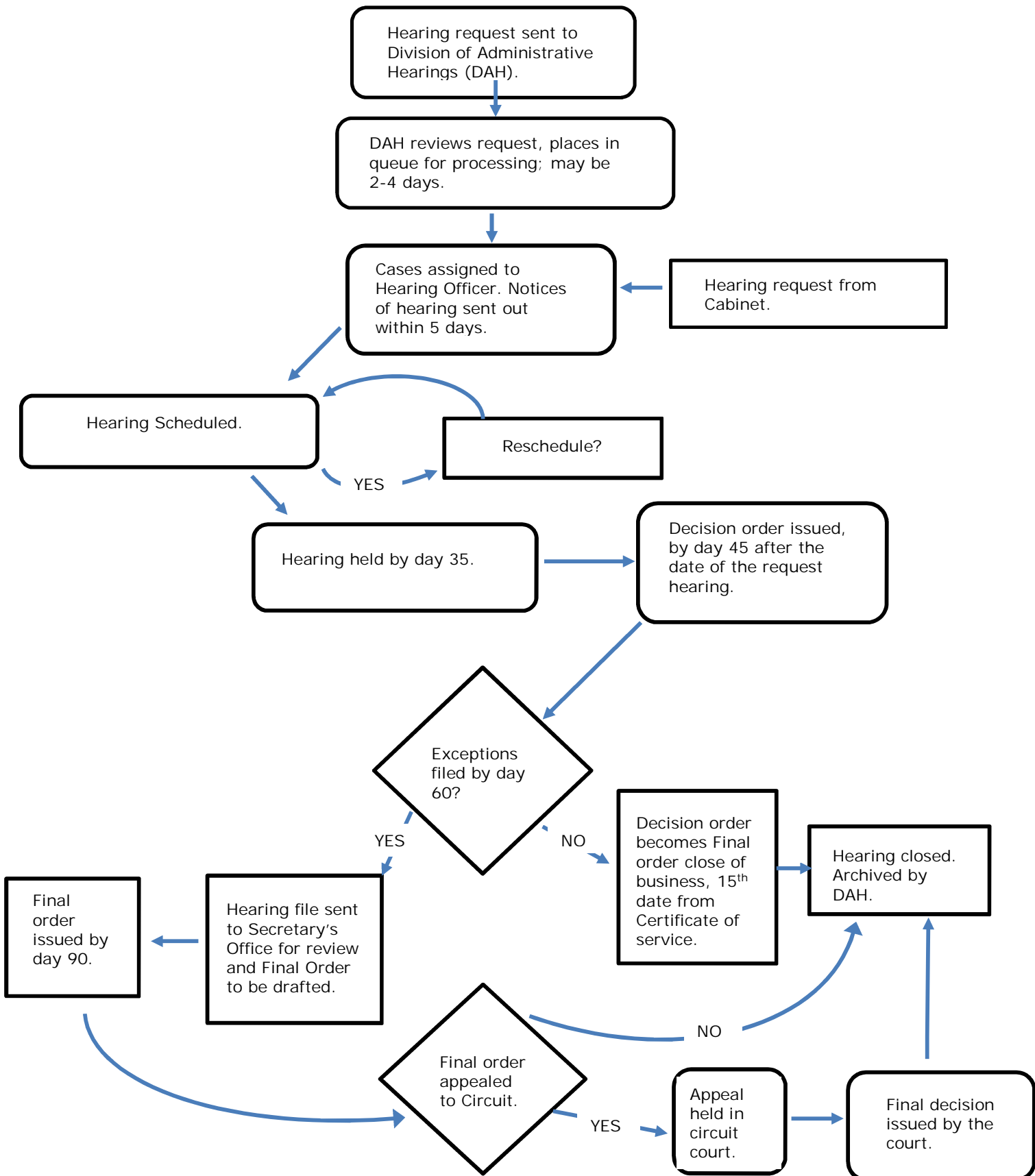
Example: The Office of Inspector General (OIG) conducted an investigation that substantiated an allegation that the recipient was not accurately reporting their household size and income. OIG was able to obtain multiple collateral contacts through the course of investigation, along with other verification sources to support the allegation. The evidence should include the OIG Investigation received in full. The OIG Investigator must be requested to attend as an agency witness to the face-to-face hearing to testify to the validity of the investigation and findings.

- G. A requested hearing may be withdrawn by utilizing the "Postponement/Withdrawal Request" button on the Hearings Summary page in the Hearings when:
1. Information becomes available that indicates IPV did not occur. Contact the individual when this occurs.
 2. The individual signs form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing.
 3. It is later discovered that information or evidence pertaining to the claim and its establishment is missing. Re-submit a new form FS-79 with the correct information and all the necessary evidence following the process outlined in C above prior to the scheduling of the hearing.
- H. The preparation for and conduct of an administrative disqualification hearing is the same as a fair hearing. Refer to [MS 0450](#) B for more information.
- I. After the hearing is conducted, the DAH issues a hearing officer's order, which is sent for review to all participants at the hearing. Follow policy in [MS 0510](#) C when filing an exception to a hearing officer's order.
- J. The Cabinet Secretary/Secretary's Designee issues the final order and copies are mailed to the individual and uploaded to the Hearings Module creating a task for the Hearings PAPS for review.
1. [If the final order determines an IPV occurred, enter the IPV disqualification on IEES and update the claim category within three calendar days of receiving the order.]
 2. If the case is active, change the category to IPV on IEES. If inactive, contact CMS to change the category at CHFS.DFS.Claims@ky.gov including the individual name and claim number in the subject line.
 3. If the final order determines an IPV did not occur and an SIPV claim has been established, recalculate the claim amount as appropriate and make system entry changes on IEES to show the correct claim category, IHE or AE. If the case is not active, contact CMS by e-mail at CHFS.DFS.Claims@ky.gov to change the category or terminate the claim

if the claim period is more than 12 months (1 year) prior to the discovery date for AE claims or 72 months (6 years) prior to the discovery date for IHE claims.

4. The claims worker updates IEES to reflect the dates that forms FS-80 and FS-80 Supplement A are sent and when the ADH hearing has been requested, scheduled, affirmed, or reversed.
- K. If the individual is dissatisfied with the final order, a petition can be filed in the Circuit Court of the county where the member resides within 30 days of receipt of the final order. Although a court appeal may be filed, the disqualification is imposed on IEES; however, it may be subject to change by the decision of the Court.

ADMINISTRATIVE DISQUALIFICATION HEARING
PROCESS FLOW CHART



MS 1100 REGIONAL CLAIMS STAFF PROCEDURES FOR ACTING ON ADMINISTRATIVE DISQUALIFICATION HEARING FINAL ORDER (1)

When a final order is received and:

- A. [The final order states that the member did not commit an Intentional Program Violation (IPV), take action on the case as directed by the final order within three calendar days.
- B. The member is found guilty of an IPV; refer to [MS 1110](#), if a claim has been established. The disqualification is entered within three calendar days of the notification.
- C. The hearing was dismissed:
 1. Update the Comments screen on the Integrated Eligibility and Enrollment System (IEES) to show the Administrative Disqualification Hearing (ADH) was dismissed making sure to annotate the reason for dismissal;
 2. Scan the final order and the recommended order into the Electronic Case Filing System (ECF) under the Hearings Tab under the associated Claim number upon receipt. Any hardcopy documents in local office storage will need to be scanned to ECF for cases that were prior to ECF;
 3. Due to a lack of service, also annotated as "Unclaimed" or "Undeliverable", if/when a new address becomes known to the Agency, a new FS-80, Notice of Suspected Intentional Program Violation, and FS-80 Supp. A, Voluntary Waiver of Administrative Disqualification Hearing, will need to be generated and mailed to the recipient. Allow 10 calendar days for the return of the FS-80 Supp. A, before requesting an ADH. If the FS-80 Supp. A is not returned, is returned unsigned, or is returned without a date, request a new ADH within three calendar days.
 - a. Request a new ADH by accessing the claim adjustment screen on the left navigation panel and click the blue "Request Administrative Disqualification Hearing (ADH)" button under the associated claim number to start the Administrative Disqualification Hearings request process.
 - b. Upload a new FS-79, Request for an Administrative Disqualification Hearing, and all associated evidence, along with a copy of the previous hearing decision/final order into the newly associated Hearing ID.
 - c. The agency must have the evidence submitted as an attachment to the associated hearing on the Hearings Module and mailed to the individual at least eight days prior to the scheduled telephonic hearing. Prior to attaching the evidence to the hearing and mailing to the individual, **ALL** evidence must be labeled as: Exhibit 1, 2, 3 or A, B, C, etc. Provide a summary of the evidence on the FS-79.

- d. Continue to pursue collection on the Inadvertent Household Error/Suspected Intentional Program Violation (IHE/SIPV) claim until another hearing can be requested and held.】

MS 1110 INTENTIONAL PROGRAM VIOLATION (1)
DISQUALIFICATION PENALTIES

A disqualification is entered on the Integrated Eligibility & Enrollment System (IEES) within three calendar days of notification that an individual has committed an Intentional Program Violation (IPV). The notification is:

- a signed form FS-80, Supplement A, Voluntary Waiver of Administrative Disqualification Hearing;
- an FS-111, Disqualification Consent Agreement;
- a final order from an administrative disqualification hearing (ADH); or
- a court decision or agreement that finds the member guilty.

- A. When it has been determined that an individual has committed an IPV, the individual is disqualified on IEES even if the individual is not currently participating in or has never received, Supplemental Nutrition Assistance Program (SNAP) benefits.
- B. When entering an IPV on IEES, take action within three calendar days and follow the below logic as it pertains to your case.

Example: A Recommended Order is received with a date stamp of 6/7/22. The Order becomes the Final Order at COB on the 15th day if no exceptions are filed. This order becomes Final COB 6/22/22 with the first day to act falling on 6/23/22. Timely action will need to be taken on 6/23/22 or 6/24/22, as 6/25/22 (3rd calendar day) falls on a weekend and would be lost as an action day.

Example: Form FS-80, Supplement A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, is returned signed and dated by the individual on 5/6/22. While the form can be acted on and appropriate action taken the day it is received, the three calendar day rule is still applied from the date the form is received for timeliness standards. Timely action will need to be taken by COB 5/9/22, with days 5/7/22 and 5/8/22 lost as they fall on a weekend.

- C. An individual committing an IPV indicated below is disqualified for the period shown. Multiple disqualifications may be imposed concurrently and not consecutively. Disqualification periods can overlap one another depending on the decision date entered. The disqualification is entered on IEES.
 - 1. Trafficking SNAP benefits of \$500 or more on or after 8/22/96. Disqualification can only be imposed based on a Federal, State, or local court order.

Disqualification: Permanent for the first offense.
Offense: Court Determined Trafficking \$500 or more on IEES.

- 2. Makes a fraudulent statement, or misrepresentation of identity or residence, in order to receive duplicate food benefits on or after 8/22/96. This applies to an individual who creates an alias to get SNAP

benefits at separate addresses and/or receiving in more than one state simultaneously.

- a. 10 years for the 1st offense;
- b. 10 years for the 2nd offense;
- c. Permanent for the 3rd offense.

Offense: Duplicate benefits on IEES.

3. Uses or receives SNAP benefits in a transaction involving the sale of a controlled substance.

- a. 24 months for the 1st offense;
- b. Permanently for the 2nd offense.

Offense: Drug trafficking less than \$500 on IEES.

4. Uses or receives SNAP benefits in a transaction involving the sale of firearms, ammunition, or explosives. Disqualification can only be imposed based on a Federal, State, or local court order.

Disqualification: Permanently for the first offense

Offense: Court Determined Trafficking \$500 or more on IEES.

5. Trafficking as determined by an administrative finding of fraud in a disqualification hearing or signed form FS 80, Supplement A "Voluntary Waiver of Administrative Disqualification Hearing".

- a. 12 months for the 1st offense;
- b. 24 months for the 2nd offense; or
- c. Permanently for the 3rd offense.

Offense: Trafficking, administrative finding on IEES.

6. Application fraud and/or non-report of changes.

- a. 12 months for the 1st offense;
- b. 24 months for the 2nd offense; or
- c. Permanently for the 3rd offense.

Offense: Application fraud/non report of changes on IEES.

Example: A recipient applies (or recertifies) for SNAP benefits and reports no income. It is later discovered the individual was employed and was receiving wages at the time of the application interview.

7. Commits an Intentional Program Violation (IPV), and another IPV listed above does not apply to the offense committed.

Disqualification:

- a. 12 months for 1st offense;
- b. 24 months for the 2nd offense;
- c. Permanently for the 3rd offense; or
- d. The length of penalty assigned by the court.

Offense: Application Fraud/Non Report of on IEES.

- D. The amount of time served while disqualified is determined by the offense and whether it is the 1st, 2nd, or 3rd occurrence. Disqualification occurrences are counted cumulatively for all the offenses.

Example: A person commits an Intentional Program Violation, then a Trafficking offense. The Trafficking disqualification is added to the IEES as a 2nd occurrence, not a first.

- E. For permanent disqualifications check the box titled "Permanent Disqualification" located under "Occurrence" on the IPV details screen. This will automatically upload "99" in the number of month's field. "99" in this instance is not the number of months disqualified, "99" is what is accepted on the Electronic Disqualified Recipient Subsystem (eDRS) for the permanent disqualification.

- F. When an IPV disqualification is entered on IEES, the "Disqual From Date" starts the first month action can be taken to change SNAP eligibility. For disqualifications that are the result of a court order, use the circuit/district court entered stamp date as the disqualification decision date. For disqualifications that result from form FS-80 Supplement A, Voluntary Waiver of SNAP Administrative Disqualification Hearing, the disqualification decision date is the date the individual signed and dated form FS-80A. Enter the date the Agency received the form as the verification date.

1. If the "Decision Date" is on or before SNAP cut-off, the "Start Date" is the first day of the following month.
2. If the "Decision Date" is after SNAP cut-off, the "Start Date" is the first day of the month after the month following the disqualification decision month.

- G. The "End Date" is entered based on the number of months the recipient is disqualified.

1. Individuals who are permanently disqualified have the "From Date" set as described in Item C above. The "Through Date" left blank.
2. The disqualification period is automatically uploaded after all the required disqualification information is entered.

- H. If a notice of IPV determination is received while the case is pending, enter the IPV disqualification on the system.

1. IEES sets the disqualification period based on the information entered.
2. After IEES uploads the disqualification dates, return to the pending

application and rerun eligibility.

3. If the disqualification period includes the pending eligibility period, the disqualification is applied when the application is disposed.
 - I. An IPV disqualification does not pend for adverse action.
 - J. Once a disqualification period begins, it continues uninterrupted for the entire number of months regardless of whether the disqualified member's household is eligible for benefits. The disqualification period does not start and stop depending on the household's eligibility.
 - K. After disqualification periods have ended, the disqualified member must be added back to SNAP case as a household member. Complete a case change to add member.
 - L. [If a disqualification is not imposed timely, impose the penalty showing the proper disqualification period. Establish an Agency Error (AE) claim for any month's benefits were received when the individual should have been disqualified in accordance with [MS 1030](#).]

Example: An individual should have been disqualified for the months of January through December the same year. In June, it is discovered that the disqualification penalty was not imposed. At the time of discovery, enter the disqualification on the IEES showing the disqualification period January through December. Establish an AE claim for January through June if the individual received benefits.

- M. When a determination of an Intentional Program Violation (IPV) is reversed by a court of appropriate jurisdiction, reinstate the member if the household is currently eligible. Restore any benefits lost as a result of the disqualification, not to exceed 12 months prior to the date of notification of the court's reversal of the imposed disqualification. A member is not entitled to restoration of lost benefits for the period of disqualification based solely on the fact that a criminal conviction could not be obtained, unless the member successfully challenges the disqualification in a separate court action.

MS 1120 DEFERRED ADJUDICATION OF INTENTIONAL (1)
PROGRAM VIOLATION CLAIMS

After the food benefits claim has been processed by the Office of Inspector General (OIG), an agreement not to prosecute may be reached between the court and the member suspected of the Intentional Program Violation (IPV). This agreement is called deferred adjudication.

- A. If adjudication is deferred, the member accused of the IPV is provided an opportunity by the court to sign form FS-111, Deferred Adjudication Disqualification Consent Agreement.
- B. By signing form FS-111, the accused member does not admit guilt. The member only consents to imposition of the appropriate disqualification period and repayment of the claim.
 - 1. The form must be signed by the accused member and the head-of-household, if different persons, and the prosecuting attorney.
 - 2. The member is under no obligation to sign such an agreement.
- C. OIG is responsible for providing a supply of forms FS-111 to the County/Commonwealth Attorney's office.
- [D. If a case is sent back to the Division of Family Support (DFS) indicating the member has agreed to deferred adjudication but the County/Commonwealth Attorney's office does not send form FS-111, OIG contacts the member and has the form signed.
- E. If the household consents to disqualification, impose a disqualification on the Integrated Eligibility and Enrollment System (IEES) upon receipt of form FS-111.]

MS 1150 TREASURY OFFSET PROGRAM (TOP) (1)

The Treasury Offset Program (TOP) is authorized by federal law to collect delinquent Supplemental Nutrition Assistance Program (SNAP) debts owed to the federal government. SNAP claims are considered federal debts and are subject to TOP collection efforts.

Note: Claims in other programs administered by the Department for Community Based Services are not subject to TOP collection efforts.

The Integrated Eligibility and Enrollment System (IEES) monitors collections of SNAP claims and systematically determines if the claim has reached delinquency status for submission to TOP. Individuals who contact the local office with questions about collection of their claim through TOP should be directed to the Claims Management Section (CMS) at 502-564-3440.

[Claims in which an intercept has occurred will display on the TOP Claims report on IEES. This report is monitored by CMS.

A. Individuals must do one of the following to avoid their debt being submitted to TOP:

1. Repay the debt by sending a check or money order payable to Kentucky State Treasury for the full amount owed to:

Cabinet for Health and Family Services
Division of Family Support
Claims Management Section
275 East Main Street 3E-1
Frankfort, KY 40621

2. Agree to and comply with a repayment plan, if unable to pay debt in full, by completing a Repayment Agreement form (KCD 1.11). The individual must agree to a repayment plan acceptable to CMS and make regular payments by the agreed date as required in the repayment plan.

Note: Only one repayment agreement will be accepted/entered on IEES. If a household fails to comply with their agreement the claim will be referred for TOP action.

3. Request a state review in writing if the individual believes the debt is not owed, past due, or legally enforceable. The individual must send evidence to support his/her position to:

Cabinet for Health and Family Services
Division of Family Support
Claims Management Section
275 E. Main Street 3E-1
Frankfort, KY 40621

CMS will notify the individual of the decision regarding the debt.

4. Verify bankruptcy: If the individual filed for bankruptcy and the automatic bankruptcy stay is in effect, the individual is not subject to offset or other collection actions. IPV SNAP claims established by court order, waiver, or administrative disqualification hearing, are not affected by the bankruptcy petition. CMS receives notification of bankruptcy from the federal court but will accept official documentation provided by the individual or legal representative.
- B. Criteria for sending a delinquent claim to TOP:
1. A SNAP claim;
 2. A current claim balance of greater than \$25;
 3. Not currently in benefit reduction status;
 4. Not in compliance with a Repayment Agreement (KCD 1.11) that was accepted by the agency or failure to return KCD 1.11 timely;
 5. Not included under an automatic stay due to bankruptcy; and
 6. Not currently under a court's restitution order or a restitution order was issued but the ordered amount to be paid is not being met by the individual.]
- C. Collection process before going to TOP:
1. [A claim is considered delinquent when a Repayment Agreement (KCD 1.11) has not been entered into and a payment has not been received within 30 days of the initial demand letter or is 1 day late on a previously arranged repayment plan.
 2. At 90 days after the debt becomes delinquent, the 60 Day Notice (KCD-1.60) is sent to the individual. This notice includes information on how the individual can avoid having the debt submitted to TOP and the type of Federal payments that may be offset to collect on the claim. A 60 Day Notice is sent to all adult liable members for claim period.
 3. If after 60 days from the date of the 60 Day Notice (KCD-1.60) the client has not responded, the debt is submitted to TOP.
- Note: A total of 120 days must elapse from the delinquent date before a claim can be submitted to TOP.]
- D. Eligible Federal Payments:
- TOP will reduce or withhold payments in the amount of the debt owed by the individual from the following federal sources:

1. Income tax refunds, including Earned Income Tax Credit;
2. Up to 15% of a federal salary payment, including military;
3. Up to 25% of a Federal Retirement payment;
4. Military Retirement;
5. Contractor/Vendor payments;
6. Other federal payments, including loans to the individual that are not exempt from offset;
7. Up to 15% of federal monthly payments such as Social Security Retirement, Survivors and Disability Benefits, Railroad Retirement (other than Tier 2) and Black Lung Part B Benefits. The client individual is entitled to keep at least \$750.00 per month of his/her federal payment; and
8. Stimulus payments.

Note: Supplemental Security Income payments (SSI) are not subject to TOP intercept. Stimulus payments received by SSI recipients can be intercepted by TOP.

- E. Once a debt is submitted to TOP, the individual's payments may be federally offset until the debt is paid in full.
- F. [TOP is authorized to add penalties, fees or other cost for each offset processed. The fee amount can fluctuate each Federal Fiscal year.]
- G. If an offset is taken from both spouses who filed a joint return and the debt belongs to only one, an amended tax return can be filed with an Injured Spouse form through the tax preparer. These forms may be obtained through their tax preparer or online at www.irs.gov.
- H. Individuals in TOP filing a rapid refund (which is a short-term loan) with their tax preparer may have their refunds delayed if the refunds are being offset. Any questions regarding how long their tax refund may be delayed will need to be directed to their tax preparer.
- I. TOP will offset only the amount owed. Any remaining tax refund will be sent to the individual directly from the IRS unless other debts for which the individual is responsible and eligible for intercept further prevent the remaining tax refund from being received.

MS 1200 CASH ASSISTANCE AND OTHER RELATED PROGRAM CLAIMS (1)

A. Claims occur in the cash assistance programs when the benefit issued exceeds the eligible amount and there is a loss to the Agency. This includes receipt of benefits pending resolution of a hearing when the Agency is upheld. Cash assistance programs are:

1. Aid for Families with Dependent Children (AFDC) - the last month benefits were issued in this program was September 1996. A claim must be established and collection pursued for all overpayments discovered on or after 4/1/82. Use claim type codes 'AFDC' on the Integrated Eligibility and Enrollment System (IEES).
2. Kentucky Transitional Assistance Program (KTAP) - the month benefits were first issued in this program was October 1996. Use claim type codes 'KTAP' on IEES.
 - a. Claims are established and collection pursued for all overpayments occurring due to recipient error, fraud, or non fraud, regardless of the discovery date.
 - b. Claims are established and collection pursued for all overpayments occurring on or after 2/1/05 due to agency error.
3. Kinship Care Program (KC) - the month benefits were first issued in this program was October 1999. Use claim type codes 'Kinship Care' on IEES.
 - a. Claims are established and collection pursued for all overpayments occurring due to recipient error, fraud or non fraud, regardless of the discovery date.
 - b. Claims are established and collection pursued for all overpayments occurring on or after 2/1/05 due to agency error.

B. Related program claims occur when an individual erroneously receives or uses a payment intended for Kentucky Works supportive services or short-term assistance. Use claim type code 'KWP' on IEES. Related programs are:

1. Kentucky Works Supportive Services. Claims are established and collection pursued for all overpayments occurring on or after 1/1/06. An overpayment occurs when the recipient is not eligible for KTAP but is authorized a supportive service or is KTAP eligible but fraudulently receives the payment.

Forgery of form PA-33, Verification of Kentucky Works Participation, does not automatically establish a claim.

Example: The participant received transportation assistance for August prospectively. In September, they return form KW-33 to verify

participation for August and to request transportation assistance for October. The worker discovers the participant has forged the information on form KW-33. Before authorizing transportation, the worker denies the request for transportation and begins conciliation. If the worker discovers the forgery after transportation has been issued, a claim is established on transportation issued for October.

Failure to meet KWP participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there is no claim.

Supportive services are:

- a. Transportation funds;
 - b. Items or services needed to participate in KWP activities or employment;
 - c. Tuition and short-term training;
 - d. Fees;
 - e. Remedial health care; and
 - f. Car repair funds.
2. Relocation Assistance Program (RAP). Claims are established and collection pursued for all overpayments occurring on or after 3/1/07. A claim occurs when:
 - a. A recipient is not eligible for KTAP but receives RAP; or
 - b. A recipient does not meet the eligibility criteria to receive RAP; or
 - c. A recipient misuses a payment.
 3. **[Family Assistance Short Term (FAST). Claims are established and collection pursued for FAST overpayment starting June 5, 2023.**
 - a. A recipient is technically or financially ineligible for FAST; or
 - b. A recipient misuses a FAST payment.]
 4. Family Assistance Diversion (FAD). Claims are established and collection pursued for all overpayments occurring on or after June 1, 1999. A claim occurs when:
 - a. A recipient is technically or financially ineligible for FAD; or
 - b. A recipient misuses a payment.

5. Work Incentive (WIN) reimbursements. Claims are established and collection pursued for all overpayments occurring on or after April 1, 2003. A claim occurs when:
 - a. A recipient is erroneously identified for a reimbursement; or
 - b. A recipient fails to report a change that impacts WIN eligibility.
6. Educational Bonus. Claims are established and collection pursued for all overpayments occurring on or after 1/1/06. A claim occurs:
 - a. When a recipient is not eligible for KTAP or Kinship Care; or
 - b. A payment is issued due to agency error; or
 - c. Verification of educational attainment is falsified.

MS 1210 HOW TO CALCULATE A CASH ASSISTANCE AND (1)
OTHER RELATED PROGRAM CLAIM

A. [Claims are calculated and computed on the Integrated Eligibility and Enrollment System (IEES) for Aid for Families with Dependent Children (AFDC), Kentucky Transitional Assistance Program (KTAP), Kinship Care (KC), and Family Assistance Short Term (FAST).]

1. Use the actual income and deductions to determine the benefit the case should have received for a given month.
2. A claim does not result solely from normal fluctuations in income which do not last over 30 days. Normal fluctuations include 5th or periodic paychecks or sporadic overtime.
3. Earnings deductions are not appropriate for any month when wages were not reported timely or at all.
4. If child support is collected by Child Support Enforcement (CSE) the amount of a claim may be reduced by child support collected and retained by the Cabinet. See [MS 1230](#).
5. When computing a claim for a prior period, use policy in effect at the time the claim occurred.
6. If the case is ineligible, a claim must be established for any supportive services, education bonuses, or relocation payments authorized to a member in the ineligible month.
7. If the claim is established and a subsequent claim for a different time period or different circumstance is discovered, DO NOT add the claims together. Complete the claim process; however, do not reduce the benefits or seek cash repayment until the first claim is repaid in full.

EXAMPLE: A claim has been established for January, February, and March due to unreported wages. Subsequently, the individual fails to report receiving unemployment benefits causing a claim for April and May. Separate calculations are completed for each circumstance. A separate ECF is maintained for each claim.

8. If it is discovered prior to the claim being established, that the individual has not cashed or used the benefits on the EBT card for the exact months for which the claim is being established, form EBT-61, EBT Benefits Account Adjustment Request, can be complete to correct the error. For returned checks, complete form PAFS- 61 Disposition of Returned Checks.
- B. Claims are manually computed and the total claim amount entered on Worker Portal for the following types of overpayments:
1. Supportive services overpayments occur when:
 - a. The individual is ineligible for KTAP but receives supportive services. The claim amount is the amount of supportive services authorized for or to the individual during the ineligible month. If it is later determined

the individual was ineligible for KTAP at the time payment was authorized, establish a claim.

- b. The individual purchases items or services that are not approved by the agency. The claim amount is the amount of supportive services payments not spent on approved items.
- c. The agency erroneously authorizes payments. The claim amount is the difference between the correct payment and authorized amount.
- d. If it is determined that the individual fraudulently received supportive services, establish a claim. The claim amount is the amount of supportive services that was authorized.

NOTE: Failure to meet KWP participation is not a reason to establish a claim on transportation payments. If transportation was authorized correctly at the time of issuance, there would be no claim.

2. [FAST and Family Alternative Diversion (FAD) overpayments occur when:
 - a. The individual is not technically eligible for FAST/FAD. The claim amount is the total of all FAST/FAD payments issued.
 - b. The individual purchases items not approved by the agency. The claim amount is the amount of FAST/FAD not spent on approved items.]
3. Relocation Assistance Program (RAP) overpayments occur when:
 - a. The individual does not meet eligibility criteria for a payment. The claim amount is the amount issued for relocation expenses.
 - b. The individual purchases items or services that are not approved by the agency. The claim amount is the amount not spent on approved items.
4. Education bonus overpayments occur when:
 - a. The individual receiving the bonus is not eligible for KTAP or Kinship Care in the month of graduation.
 - b. The payment is erroneously issued.
 - c. Proof of graduation is falsified.
 - d. In all instances, the claim amount is the amount of the bonus.
5. Work Incentive (WIN) reimbursement overpayments occur when:
 - a. The individual receiving WIN reimbursements is not employed.
 - b. The household does not contain a dependent child.
 - c. The income of the household exceeds 200% of the federal poverty limit.
 - d. The earned income that caused discontinuance of the KTAP benefit is not reported timely.

- e. In all instances, the claim amount is the amount of the reimbursement.

MS 1220

[KTAP CLAIMS FOR SSI RECIPIENTS]

(1)

When a Supplemental Security Income (SSI) individual is determined not eligible to receive an SSI payment regardless of the reason:

- A. Determine KTAP eligibility for each month the member was excluded from KTAP.
- B. Use actual resources and income received in the specific month, including the resources and income of the member who was receiving the SSI payment. DO NOT include the SSI payment as income.
- C. If the case was ELIGIBLE for KTAP, determine the correct payment and compare to the amount issued. If the correct amount is less than what was issued establish a claim for the difference.
- D. If the case was INELIGIBLE for KTAP for a given month, the KTAP issued is the claim amount.

EXAMPLE: In January 2008, it is discovered a parent receiving SSI was not eligible for SSI beginning January 2007. The resources and income of the SSI recipient had been excluded in determining KTAP eligibility. Re-determine financial eligibility using all resources and income (DO NOT count the SSI) for all months the family received K-TAP and SSI. If the family is KTAP ineligible, the claim amount is the KTAP benefit issued.

- E. No claim exists if the SSI individual is removed from the KTAP case effective the date given to the Social Security Administration (SSA). The initial SSI payment is reduced dollar for dollar by the individual's proportionate share of the KTAP benefit amount up to the month of the effective removal from the case.

MS 1230

RETAINED CHILD SUPPORT

(1)

Consider child support retained by the Agency when calculating any Kentucky Transitional Assistance Program (KTAP) or Kinship Care (KC) claim.

- A. Retained support is the amount of collected support reported by Child Support Enforcement (CSE) minus collections forwarded (e.g., escrow) to the recipient as verified on Child Support Enforcement External Search accessed from the Kentucky Online Gateway (KOG).
- B. If retained child support is equal to or more than the benefits issued for a month (before benefit reduction), there is no claim.
- C. [If the absent parent is known, access CSE to determine the retained support.
 1. Launch the CSE application from KOG and select participant/case inquiry to determine if child /spousal support is paid.
 2. Use the column "Distribution Date (MM/YYYY)" on the CSE Payment Distribution Inquiry Screen to determine the month of receipt.
 3. Use the column "CSUP Retained by State" to determine the amount of State retained support for the month.
 4. If more than one payment is received during the month, the screen will display the total dollars distributed to the participant and/or retained by the State.
- D. Calculate the amount of child support kept by the state and compare that monthly amount to the amount of benefits issued for each month of the potential claim.
 1. If the retained child support for an individual month equals or is greater than the KTAP benefits received for that month, no claim exists for that month. Update the Integrated Eligibility and Enrollment System (IEES) to show the claim was not established.]

EXAMPLE: The individual received \$235 KTAP benefits. The individual was only entitled to \$150. Child support was retained in the amount of \$235.

2. If the retained child support for the month is less than the KTAP issued, subtract the corrected benefit amount for that month from retained child support. Deduct the remaining child support from the overpayment for that month.

EXAMPLE: \$210 of KTAP benefits is issued. The correct amount is \$100. Child support of \$140 was retained by CSE.

Calculate using the following steps:

- a. Determine if a claim exists.

Benefits Issued \$210
Retained Child Support \$140
Child Support Retained is Less than Benefits - Claim Exists

- b. Calculate the overpayment.

Benefits Issued \$210
Corrected Benefits - \$100
Amount of Overpayment = \$110

- c. Determine if claim can be reduced by the retained child support.

Retained Child Support \$140
Corrected Benefits - \$100
Excess Child Support = \$40

- d. Deduct the excess child support from the claim amount.

Amount of Overpayment \$110
Excess Child Support - \$40
Balance of Claim = \$70

3. If the retained child support for the month is less than the corrected benefit for the month, there is no excess child support. Do not deduct child support from the overpayment.

EXAMPLE: \$230 is issued. The correct amount is \$180. Child support of \$80 is retained.

Corrected Benefit - 180
Remainder = \$ 0

There is no excess child support.

MS 1240 MEDICAL ASSISTANCE CLAIMS (1)

- A. Medical Assistance claims occur when a recipient or responsible party, age 18 or older, causes a financial loss to Medicaid by:
1. Deliberately making false or misleading statements in order to obtain MA benefits;
 2. Allowing an individual other than those listed on the KYHealth card to obtain health care benefits by use of the household's KYHealth card; or
 3. Inappropriately using a covered service (e.g., using Non-Emergency Medical Transportation (NEMT) to go to work, etc.).
- B. [When an overpayment of MA occurs due to suspected fraudulent actions:
1. Refer the suspected MA claim to OIG.
 2. When there are suspected Supplemental Nutrition Assistance Program (SNAP) Intentional Program Violation (IPV), Kentucky Transitional Assistance Program (KTAP), or Kinship Care (KC) fraud cases which involve at least one month of MA ineligibility, refer all cases to OIG regardless of the dollar amount.
 3. Enter comments on the Integrated Eligibility and Enrollment System (IEES) regarding the referral to OIG on all associated cases and/or claims.
 4. Complete form Claim/MA-1, Medical Assistance Eligibility Summary, indicating the eligibility status for each household member. OIG will obtain the dollar amount of Medicaid usage for each ineligible month. This will be added to the overpaid benefits from the other programs to determine if prosecution will be pursued.
- C. A Medical Assistance claim is entered on IEES only when the claim is adjudicated through the court. If OIG determines the medical card was not used during the ineligible period or fraud cannot be established, there is no claim on IEES.
- D. Payments on Medical Assistance claims are handled by CMS. OIG may recommend collection of erroneously issued Medicaid benefits where prosecution is not pursued. In those instances, collection efforts are the responsibility of Department of Medicaid Services (DMS).]